Oxford University Hospitals
NHS Foundation Trust

Patient Safety Incident Response Framework (PSIRF) Plan on a Page

Key points of the policy

- This PSIRF Plan sets out how OUH intends to respond to patient safety incidents in accordance with PSIRF.
- We have identified four key themes that we will focus on in the next 12-18 months.
- The weekly Safety Learning & Improvement Conversation (SLIC) will review a range of patient safety information.
- A range of new learning response methods will be used to address patient safety incidents.

Key messages

The following four topics were chosen as the first PSIRF patient safety improvement workstreams:

1. **Handovers including communication and documentation.**
2. **Referral and cancer MDT processes and pathways.**
3. **Reporting and pathology/imaging endorsement.**
4. **Patients at risk (People with learning or intellectual disabilities, safeguarding and mental health issues).**

- These will be reviewed using a systems-based process
- Actions to reduce risk and improve safety will be generated for each area.
- Measures to monitor safety actions and the review steps will be defined.
- This will be an iterative process and will continue over 12 to 18 months.
- As the workstreams are very broad, resources may be focused on one aspect of the issue at a time.

PSIRF uses new methods to learn from issues and incidents.

- Patient Safety Incident Investigation (PSII) – an in-depth system-based investigation that seeks to identify and understand all the factors and issues that contribute to the incident.
- Learning MDT Review a multidisciplinary meeting to understand the wider organisational issues, including subject matter experts and other relevant stakeholders.
- After Action Review (AAR) a meeting with those involved in the incident and local area seeking to understand what happened, what had been expected to happen, why was there a difference and is there any local learning from the event, and whether there may be wider issues requiring further learning responses.
- Local learning – a brief investigation and response by the local manager where local actions may be identified and implemented.
- Hot debrief – a rapid meeting to review the event to answer the same questions as for the AAR review and to provide staff support.

Training is available for these, contact your Clinical Governance Risk Practitioner (CGRP) or the PSIRF Team or Patient Safety Team for details.

Patient Safety Syllabus training is available via Mylearninghub.