Patient Safety Incident Response Plan (PSIRP)

Effective date: March 2025

Estimated refresh date: September 2026

	NAME	TITLE	SIGN OFF DATE
Author	**Carole Oliver**	**Quality & Compliance Manager**	06/03/2025
Reviewer	**Ian McKendrick**	**Audiology Clinical Lead**	06/03/2025
Authoriser	**Nick Wingate**	**Professional Services Director**	06/03/2025

Contents

Introduction

Our Company

OutsideClinic are a leading provider of optical and hearing services to patients in their own homes.

Our mission is to extend the highest quality health care services beyond the high street, to make these essential services more accessible, more personal and more effective.

With more than 35 years of service, we are the UK's leading home eye and hearing care provider. We bring together a team of over 500 dedicated healthcare professionals, conducting over 200,000 home clinics each year.

With the support of Optimism Health Group Ltd, we continue to grow and meet the increasing demand for outstanding care. We are always looking forward and seeing new ways to develop our business and practice to provide extraordinary care to those who need us the most.

Our Patient Safety Incident Response Plan (PSIRP)

This plan sets out how **OutsideClinic Ltd (OC)** intends to respond to patient safety incidents over a period of 18 months in line with the Patient Safety Incident Response Framework (PSIRF). This plan is designed to provide an overview into the arrangements in place, but it is not a permanent set of rules that cannot be changed.

We remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The PSIRP aligns with our core values of:

We Deliver Extraordinary Care – We are dedicated to delivering exceptional are in every interaction prioritising customer needs with empathy and respect.

We Collaborate as One Team – We promote a unified culture of support and open communication, empowering all to contribute and succeed together.

We Take Ownership and Keep our Promises – We empower every individual to make impactful decisions and fulfil commitments with initiative and expertise.

We Get Things done with Agility – We rapidly adapt and improve, maintaining quality while responding proactively to the evolving needs of our market.

Our services

OutsideClinic Ltd are an independent private Company, who provide the following services to the NHS:

- Audiology services, including hearing tests, fitting of hearing aids and aftercare for patients in their own homes. We also visit care homes, hospitals and secure facilities.
- Optometry Services; including eye tests and manufacture of lenses and supply of glasses.

Further information on our services is available on our website http://outsideclinic.co.uk/

Our Audiology service provides services in England, Scotland and Wales, and for NHS Patients, to patients living in England under the Any Qualified Provider (AQP) contract model to circa 50 contracts around the country.

Our Optical Service provides sight tests in England, Scotland and Wales under a General Ophthalmic Services (GOS) Contract.

Whilst the requirements may be different across the various services and contracts, we have adopted the PSIRF Framework as best practice and it is applied across our entire service. As allowed for in the framework, we will take a proportionate approach, and have produced this one overall PSIRP, designed to reflect the service provided across all contracts.

Our Approach

The identification and management of Patient Safety Incidents forms part of our organisation's Incident Management Policy and Process. However, we acknowledge that these types of incidents have different characteristics and will prioritise the 4 aims of PSIRF when dealing with these incidents. These are:

PSIRF Aim	What it means to us
. Compassionate engagement and involvement of those affected by patient safety incidents.	Taking the time to involve and listen to patients, families and staff involved in incidents with respect and care and involving them meaningfully throughout the process.
. Application of a range of system-based approaches to learning from patient safety incidents.	Using tools to help understand all the different factors at play that have come together to contribute to the incident and facilitate cross-organisation learning where appropriate, i.e. withing our Patient Safety Network.
. Considered and proportionate responses to patient safety incidents.	Ensuring we choose actions that are appropriate to the situation and to help understand what happened, learn from it and reduce the risk of any future harm.
. Supportive oversight focussed on strengthening response system functioning and improvement.	Ensuring Managers support staff to apply the lessons learned from incident reviews and investigations so that the team and wider organisation work in a safer way.

Defining our patient safety incident profile

We undertook the following steps when developing our patient safety risk profile:

- Reviewed data from our Incident Reporting System to identify the number of patient safety incidents reported during the previous 2 year period.
- Consulted with the Clinical Lead and Director of Professional Services to identify the types of Incidents we are likely to experience based on the services we offer.
- Developed a Risk Profile based on the data obtained.

Below are the types of incidents which may fall under the PSIRF definition and be managed in accordance with the Policy.

Please note that these are indicative only and each incident will be assessed individually at the time of reporting and managed accordingly.

Service	Potential Incidents	Seriousness Criteria
Audiology	Ingestion of hearing aid and/or battery	**Serious** – Adverse outcome i.e. illness/hospitalisation/death
	Perforated ear drum during Microsuction	**Serious** – Adverse outcome i.e. illness/hospitalisation/death
	Failure to Refer, leading to serious clinical outcome i.e. Hearing Loss, Tinnitus	**Moderate** – Serious dependant on specific incident.
	Slips / Trips / Falls	**Minor** – Moderate, i.e. Px injured due to actions/ inaction of staff member.
	Clinical Incident	**Minor / Moderate** – i.e. skin tear / abrasion.
Optometry	Corneal Abrasion	**Serious** – Triggers Patient Safety Investigation
	Incidents involving Medication / eye drops	**Moderate** – Dependant on specific incident.
	Slips / Trips / Falls	**Minor** – Moderate, i.e. Px injured due to actions/ inaction of staff member.
	Clinical Incident	**Minor** – i.e. skin tear / abrasion.

Review of Data

A review of Incidents submitted via our Incident Reporting System for a 2 year period between 01/01/2022 and 31/12/2023; across both services, showed the following:

Type of Incident	Number	Comment
Obstruction in Ear Canal	21	Object observed at appointment.
Slips / Trips / Falls	22	During or just prior to visit.
Hearing Aid and/or Battery Ingestion / Near Miss	3	2 Ingestion 1 near miss
Abrasions / Skin Tear / Injury	14	Injury occurring or observed during treatment
Patient Unwell	14	Patient reporting feeling unwell during treatment
Reaction to or Ingestion of eye drops	5	Reported during or following visit

There were **two** Incidents which would be classified as a **serious/severe** Patient Safety Incident – where Patients ingested a hearing aid including the battery, and one where they ingested the battery. No fault found with our service.

As we are a domiciliary service, we accept that we have limited control over the environment where we operate our services, and as such, must react as necessary, i.e. call an ambulance / next of kin / carer, dependant on the circumstances.

The other category is medical emergency, either prior to our arrival or during the appointment. These are responded to immediately as above by calling an ambulance / next of kin / carer.

There have been no 'Never Events' or Deaths in Service reported in the period assessed associated with our service.

Risk Profile

We applied the risk methodology of (Consequence x Likelihood) when determining the overall risk rating for serious Patient Safety Incidents, which would trigger within our service and based on this we have determined that the overall rating is **Low.**

Defining our patient safety improvement profile

Our patient safety improvement profile has been agreed with relevant Stakeholders and takes into account the Low-risk rating and proportionality.

Actions to demonstrate transformation and drive improvements across our service:

- We will ensure all relevant staff are aware of the requirements of PSIRF and receive the necessary training to fulfil their role. Specifically the courses on E-Larning for health Essentials for Patient Safety and Essentials of Patient Safety for Boards and Senior Leadership Teams
- Ensure PSIRF is included on the Agenda of Clinical Governance Meetings.
- Include Serious Incident Response to our internal Monthly / Quarterly Quality Reports to the Senior Leadership Team.
- Implement the Patient Safety Incident Response Policy which provides the authority and guidance for management of Patient Safety Incidents within OC.
- Report Patient Safety Incidents to relevant ICBs and where appropriate via the LFPSE reporting system.

Our patient safety incident response plan: national requirements

Below we describe how we would respond to patient safety incidents that meet the national event response requirements set out in PSIRF.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Clinical Governance Meeting
Incident leading to Death thought more likely than not due to treatment provided by the service.	Patient Safety Incident Investigation (PSII)	Clinical Governance Meeting
Safeguarding Incident involving adults (over 18)	Follow guidance from local authority safeguarding lead	Local Authority Designated professionals for adult safeguarding.

Our patient safety incident response plan: local focus

Below we describe how we will respond to patient safety incidents relating to the patient safety incident profile. The improvement route will be via our Clinical Governance Meetings where Incident is serious/severe these will be managed in collaboration with our Senior Leadership Team where required.

Patient safety incident type or issue	Planned response
Obstruction in Ear Canal	Follow Incident Management process and discuss at Incident Review Meeting, unless severity or frequency indicates further follow up required as follows: • **Adverse outcome for Patient -** Conduct an After Action Review • **Severe Harm (i.e. infection or repeat occurrence for patient) -** Undertake a Patient Safety Incident Investigation.
Slips / Trips / Falls	Follow Incident Management process and discuss at Incident Review Meeting, unless severity or frequency indicates further follow up required as follows: • **Adverse outcome for Patient -** After Action Review • **Severe Harm (i.e. infection or repeat occurrence for patient/s) -** Undertake a Patient Safety Incident Investigation.
Hearing Aid and/or Battery Ingestion / Near Miss	Follow Incident Management process and discuss at Incident Review Meeting, unless severity or frequency indicates further follow up required as follows: • **Adverse outcome for Patient -** After Action Review

	• **Severe Harm (i.e. hospitalisation of patient, or death) -** Undertake a Patient Safety Incident Investigation.
Abrasions / Skin Tear / Injury	Follow Incident Management process and discuss at Incident Review Meeting, unless severity or frequency indicates further follow up required as follows: • **Adverse outcome for Patient -** Conduct an After Action Review • **Severe Harm (i.e. hospitalisation of patient, or death) -** Undertake a Patient Safety Incident Investigation.
Patient Unwell	Follow Incident Management process and discuss at Incident Review Meeting, unless severity or frequency indicates further follow up required as follows: • **Adverse outcome for Patient -** Conduct an After Action Review • **Severe Harm (i.e. hospitalisation of patient or death)** - Undertake a Patient Safety Incident Investigation.
Reaction to or Ingestion of eye drops.	Follow Incident Management process and discuss at Incident Review Meeting, unless severity or frequency indicates further follow up required as follows: • **Adverse outcome for Patient -** Conduct an After Action Review • **Severe Harm (i.e. hospitalisation) -** Undertake a Patient Safety Incident Investigation.

Follow up / Improvement Activities

Improvement activities for the above listed incident types will depend on the severity / frequency.

- **One-off and minor incidents** the improvement route is via the Incident Management Process which involves a review by Line Manager, fortnightly Incident Review Meeting where any further actions are discussed and decision to close incidents is taken.
- **Serious Incidents** Reviewed locally and where necessary an AAR or PSII will be undertaken. Outcomes including proposed Improvement Activities from these reviews will be reported to the Clinical Governance Meeting.
- **Severe / Death** Immediate action taken overseen by Senior Leadership, with Improvement Activities signed off by the SLT or Risk and Compliance Board (RCB).