Patient safety incident response plan

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Contents

1.0 Introduction

This patient safety incident response plan (PSIRP) sets out how Buckinghamshire Healthcare NHS Trust intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that lead to patient safety incidents. These findings are then targeted with strong systemic improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

The Trust will review patient safety information regularly through governance and safety meetings, providing updates to the workstreams within the plan.

2.0 Glossary

Term/Abbreviation	Definition
After Action Review	A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement.
BOB ICB	The Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB)– plan and provide health and care services for nearly two million people who live and work in the local authority areas of Buckinghamshire, Oxfordshire, and Berkshire.
Debrief	A rapid meeting to review the event to answer the same questions as for the AAR review and to provide colleagues support
Information Governance breaches	Personal Data Breach" means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
Initial Findings Report (IFR)	This is a written initial review of the incident/event, usually completed by one author. This will include a timeline of events, highlighting any immediate risks and whether there are any concerns that may require a subsequent learning response. They will usually be requested to determine whether a PSII response may be required (as per our PSIRP).
Learning Response	A tool that is designed to facilitate learning in response to a patient safety incident
Maternity Statutory Investigations (MNSI)	A new statutory body, The Maternity and Newborn Safety Investigations (MNSI) programme is formed from 1 October 2023, to undertake investigations into brain injuries in babies and maternal and neonatal deaths and stillbirths. This programme is hosted by the Care Quality Commission (CQC), having replaced the temporary role of the HSSIB (Health Services Safety Investigations Body).
Multidisciplinary (MDT) Review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect colleagues' recollections of events either because of the passage of time or colleagues' availability

Patient Safety Incident	Unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients
Patient Safety Incident Investigation (PSII)	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. It is an in-depth review of a single patient safety incident or cluster of events to understand what happened and how.
Patient Safety Response (PSR)	A response to patient safety incidents for the purpose of learning and improving patient safety.
Thematic Analysis	A thematic review can identify patterns in data to help answer questions, show links, or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues to review multiple cases of a similar nature to derive themes.

3.0 Our services

Buckinghamshire Healthcare NHS Trust (BHT) is an integrated provider of acute hospital and community services for people living in Buckinghamshire as well as some people living across the borders in surrounding counties. We provide care to over half a million patients every year in our hospitals, community settings and in people's own homes. Our vision is to provide outstanding care, create healthy communities and make BHT a great place to work.

Our patients are at the heart of everything that we do, providing safe and compassionate care, every time. Our focus is on providing the right care, in the right place, at the right time, everything we do is aimed at delivering high-quality care.

We deliver this care in a range of ways; from community health services provided in people's homes or from one of our local bases, to hospitals at Stoke Mandeville, Wycombe, and Amersham. Stoke Mandeville Hospital is home to the internationally recognised National Spinal Injuries Centre; our stroke service is one of the best in the region and we are a regional centre for burn care, plastic surgery, and dermatology.

Our acute hospitals

- Stoke Mandeville Hospital
- Wycombe Hospital

Our main community facilities

- Amersham Hospital
- Buckingham Hospital
- Chalfont & Gerrard's Cross Hospital
- Marlow Hospital
- Thame Community Hospital
- Florence Nightingale Hospice (Stoke Mandeville Hospital)
- Rayners Hedge Rehabilitation Unit (Aylesbury)

Our services are managed through the following four Clinical Care Groups:

- Surgery and Critical Care Group
- Community and Rehabilitation Care Group
- Specialist Clinical Services Care Group
- Integrated Medicine Care Group

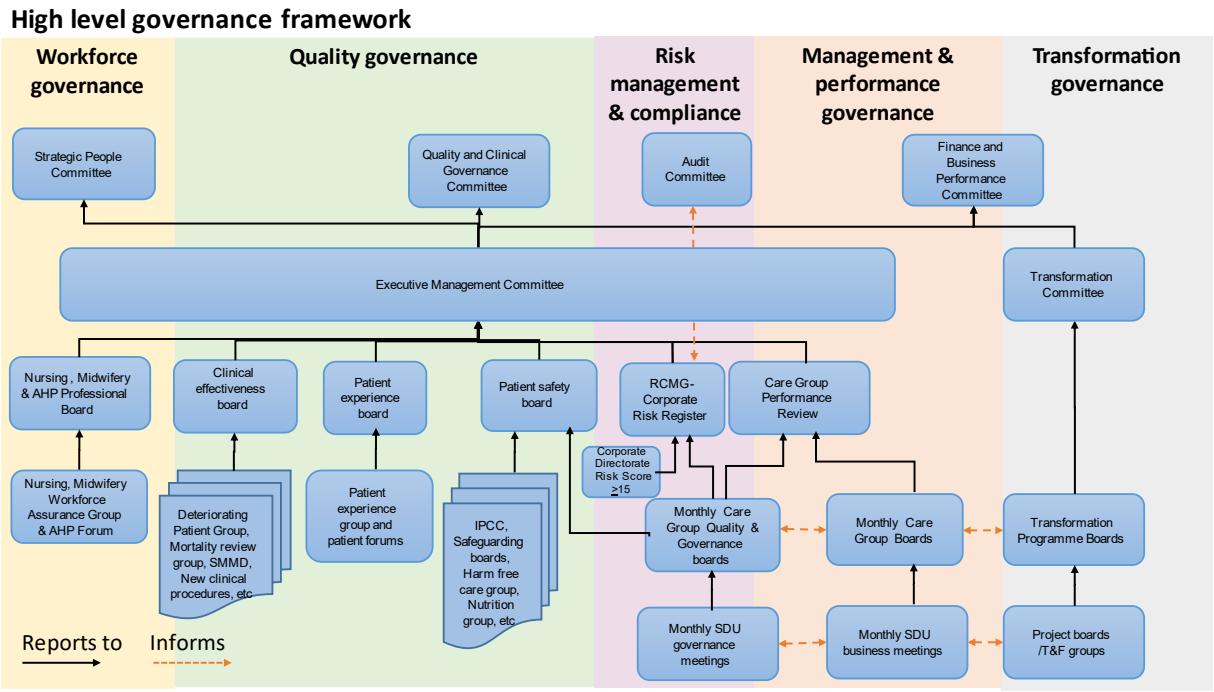
To find out more about the Trust and the services we provide go to our website.

The Care Groups are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies, and procedures. The Care Groups contain service delivery units covering specific areas. Each Care Group is led by a triumvirate composed of Care Group Director of Operation, Clinical Director, and Care Group Director of Nursing. The triumvirate leadership will be supported by Operational Service Managers, Matrons, and other relevant subject matter experts.

Safety and governance are embedded within the organisations through the corporate and care group structure. There is a central Patient Safety Team within the Corporate and non-clinical services Care Group.

The Trust's Executive Management Committee (EMC) has responsibility for monitoring the Trust's Governance (including patient safety) framework. The reporting structure of governance framework can be seen in Figure 1.

Figure 1: High level governance framework



4.0 Our patient safety culture

At BHT providing **'Personal and compassionate care every time'** remains our mission statement. The importance of an open, just, and compassionate culture across the organisation is paramount to ensuring that we always put patient care first, and that we continually look at ways to learn. Colleagues and patients are encouraged to raise any concerns about the quality of care, patient safety and poor behaviours and we have developed a range of ways people can do this, including through our Freedom to Speak up guardian, our Datix system and Staff survey. Our CARE value framework supports the identification and expectations at an individual and organisational level. The Trust is undertaking a review of its current Safety Culture which will be integral to providing an open and transparent culture of learning and improvement. Engaging our people is ongoing and fundamental to ensuring our plans are realistic, deliverable, and sustainable. This work continues to evolve by removing negative behaviours and continuing to promote a positive and psychologically safe environment for our patients and staff.

The transition to Patient Safety Incident Response Framework (PSIRF) is a significant shift in thinking towards learning from everyday work as well as incidents. Establishing psychologically safe cultures and practices is essential to meaningful learning and applying improvements to enhance patient care. At BHT this work continues through continued engagement with our people to ensure it is ongoing and fundamental to ensuring our plans are realistic, deliverable, and sustainable. We have introduced the national Patient Safety level 1 training for all colleagues to complete within our online training platform and we further have secured funding for a number of

places for specific Patient Safety PSIRF Oversight and pathway training through an external agency. We continue to have a positive incident reporting culture in the Trust with high numbers of incidents and near misses reported, the majority of which result in no harm to patients. When an incident is reported this is used as an opportunity to learn through our established safety forums and quality governance arrangements as well as regular data analysis to identify trends and emerging themes which are reported through the Harm Free Care Group.

The introduction of the concept of patient safety partners is a national initiative as part of the patient safety strategy. The Trust has committed to employing a dedicated Family Liaison Officer who will lead on the patient safety partner programme. Our patient safety partners will work alongside clinical colleagues and patients/families to co-design and implement patient safety initiatives, training, resources, support activities around governance and other opportunities to improve the safety of care. We envision that this role will grow and develop over the course of time.

5.0 Addressing health inequalities

In Buckinghamshire alone we are expecting significant population growth. In our most deprived areas, there is higher prevalence of low birthweight and infant mortality and higher levels of long-term conditions. There is lower uptake of health screening and higher rates of emergency admissions. In our most deprived areas, the premature death rate (deaths under 75) is twice that of the least deprived areas. Transforming what we do will involve developing new ways of working and creating new partnerships. The Trust has an important role to play in reducing inequalities in health by improving access to services and tailoring services around the needs of the local population to be inclusive. We are committed to reducing this variation through developing colleagues' knowledge and awareness and continuing to collect and use data to assess existing or potential future patient safety risks from across the range of protected characteristics. At BHT the areas of race, age and disability equality standards are regularly reviewed and overseen by the Quality and Clinical Governance Committee. To meet the changing needs of the population, especially those living in deprived areas, will require significant transformation of how we and our partners provide care. One example is defining a direct access and admission pathway for people with eating disorders in collaboration with multi agency partners.

Engagement of patient, families and colleagues following a patient safety incident is essential to how we can review and learn from patient safety incidents, therefore we ensure that we use available tools such as no abbreviations, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved and work with us to identify improvements to care.

6.0 Key Benefits to PSIRF

- Patients and families involved much earlier and engaged with for their perspective
- Improvement themes highlighted to QI Team for inclusion in QI Strategy
- Learning from investigations shared Trust-wide via Knowledge and Learning Framework
- Investigations completed by team who have been trained and have designated time as a formal part of their role and can provide 'fresh eyes'
- Opportunity for colleagues to be supported and learn in a structured way soon after an incident
- Improved just safety culture

- We will have more autonomy to investigate local issues in accordance with our safety priorities
- Investigations will be carried out by trained impartial investigators with the aim of identifying system learning without apportioning blame

7.0 Defining our Patient Safety Incident profile

As part of this process, consideration was given to the wider local and national picture influencing patient safety reporting and improvement plans. The following were considered within the decision-making process and in conjunction to stakeholders' feedback:

- National Patient Safety Improvement Programmes
- Nationally defined never-event incidents requiring a local Patient Safety Incident Investigation (PSII) response.
- National Learning from Death guidance and Structured Judgement Review (SJR) guidance
- Other national guidelines linked to incidents reporting and improvements (I.e., NHS England Policy Guidance on Recording Patient Safety Events)
- Existing local agreements
- BHT Breakthrough (strategic) objectives
- Approved trust Quality Improvement Programmes

7.1 Stakeholder engagement

As part of the preparations to transition to the PSRIF we started by mapping our key internal and external stakeholders. We have used this mapping to guide our engagement work as well as our communication plan to ask for support and to share the changes we have made to improve how we respond and learn from patient safety incidents. The incident response plan was developed with stakeholders who helped to prioritise what safety areas we start on in year 1, through a consultation period.

We set up a PSIRF Core Group to oversee and steer the work to implement the PSIRF requirements. Initially the work programme is for 12 months but we expect this to evolve and each year to set out our next ambition, the work programme will be regularly reviewed through EMC. The PSIRF Core group programme meets at least monthly and is chaired by the Deputy Chief Nurse and Deputy Chief Medical Officer for Quality & Patient Safety.

We collaborated with key stakeholders in the following ways.

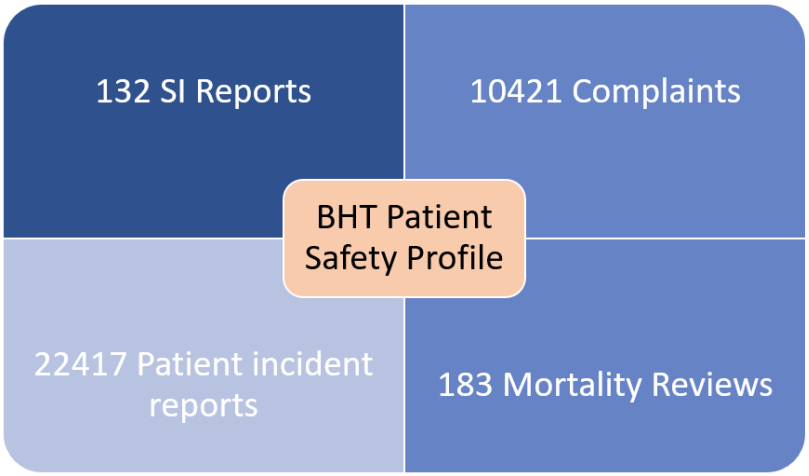
- Hosting bespoke safety summits/workshops on PSRIF and to develop our incident response plan in conjunction with Care Group PSIRF Champions.
- Working with our commissioners- the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and the Provider Collaborative leads through our preparations for PSIRF, existing SI closure forums and feedback on this plan and our approach to PSRIF.
- Joining existing internal and external meetings with colleagues and patients/families
- Presenting and hearing from colleagues in Trust-wide webinars

7.2 Review of data sources

The PSIRF Core Group used multiple sources of information and data to identify the overarching and key patient safety issues that are contributing to risk at the Trust. Additionally, conversations were held with representatives from each clinical care group to identify the key issues affecting

patient safety. Open sessions were held over Microsoft Teams and in PSIRF face to face summits where colleagues were able to hear about PSIRF and share safety concerns.

Figure 2: Data sources used to develop the BHT Safety Profile



In addition to our stakeholder feedback, a significant amount of data also had to be reviewed to provide us with the current intelligence to develop a robust patient safety incident profile. Data from the last 2 years was reviewed from several sources including our:

- Complaint's themes
- Compliment's themes
- Coroner feedback/Preventing Future Deaths notice for BHT/elsewhere
- Domestic Homicide Review reports where BHT involved
- Freedom to Speak Up themes within reports
- GIRFT data action plans
- Infection, Control and Prevention reviews
- Internal deep dive reviews of incidents reported across the system
- Learning from Deaths
- NHS Staff survey results
- Patient safety incidents reported on to the Local Risk Management system (Datix)
- Prevention of Future Deaths within the trust and elsewhere (Coroner concerns)
- Safeguarding feedback/Section 42s
- Serious incidents reported to the national database, StEIS
- Structured Judgement Reviews (Learning from Deaths)
- Subject matter expert views – e.g., Pharmacy, VTE Leads, Tissue Viability team, Falls lead,
- Harm Free Care trust wide group
- Unexpected Cardiac Arrest review data

7.3 Key BHT Safety Priorities:

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The key priorities were selected following an extensive review of all incidents reported at the Trust followed by consultation with key stakeholders.

Safety Priority 1 and 2 were identified following the reporting of a number of serious incidents. The learning and safety action plans were found to have Trust-wide learning with significant cross 'care group' actions.
Safety Priority 3 and 4 were identified following review of no/low harm incidents and reports received from board papers, steering groups, and feedback from clinical staff.

** This list excludes statutory National Safety priorities which include Never events, unexpected deaths, Maternity Statutory Investigations / MNSI and Serious IG breaches.*

Table 1: BHT Safety Priorities

	BHT Safety Priorities
1	Reduction in diagnostic delays e.g., test or follow-up from an abnormal test/scan result.
2	Review of all invasive procedures to develop LocSSIPs (Local Safety Standards for Invasive Procedures) which will help provide safer care for patients undergoing invasive procedures in all settings including outpatients.
3	Improve the unexpected deteriorating adult/child pathway through review and refinement of communication and escalation processes across the Trust.
4	Focused review of specific care discharge processes

High volume no and low harm incidents will be individually reviewed by each Care Group and if appropriate will be included in a thematic review which will be overseen by the Harm Free Care Group. This will include Pressure Ulcers, Falls, VTE's, Healthcare Associated Infections and medication incidents.

Excellence Reports, Compliments and positive feedback will be collated and used to promote a positive learning culture and share success with colleagues. Key positive care with be used as benchmarks for success when establishing other new improvement programs

Below is our Patient Safety Incident Response Plan Priorities, this includes the NHS England national requirements (further details about the national requirements are available) and the local safety areas/incidents identified in collaboration with key stakeholders.

7.4 Learning Responses

Our incident learning responses will take a systems perspective to understand the different factors and how they interact so that we can identify learning that will inform improvements. We are using the methodology of Systems Engineering Initiative for Patient Safety (SEIPS) within our learning responses, further details can be found in this brief guide. SEIPs recognises the importance of exploring everyday work (how work is done in reality) and how people are routinely adjusting to match the ever changing conditions and demands of work.

We have identified a range of learning responses in the incident response plan to recognise there is no 'one size fits all' and the application of suitable learning methods needs to be based on the situation, incident type and what is already known about the safety area. We will be taking a considered and proportionate approach, therefore will not always respond to a specific incident if we are familiar with the factors that need addressing and there is no new learning identified. This will enable us to focus on spreading the learning and making the changes to improve the safety of care.

7.5 Learning Response Methods

PSIRF uses new methods to learn from issues and incidents, there are six main learning responses:

1. 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.
2. 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.
3. MDT Review - a follow up-multidisciplinary meeting to understand the wider organisational issues, including subject matter experts and other relevant stakeholders.
4. Debrief – a rapid meeting to review the event to answer the same questions as for the AAR review and to provide colleague's support.
5. Thematic Analysis – A thematic review can identify patterns in data to help answer questions, show links, or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.
6. Initial Findings Review (IFR) -This is a written initial review of the incident/event, usually completed by one author. This will include a timeline of events, highlighting any immediate risks and whether there are any concerns that may require a subsequent learning response. They will usually be requested to determine whether a PSII response may be required (as per our PSIRP).

7.6 Responding to cross-organisational/multi-agency incidents

We will identify incidents that require a cross-organisational/multi-agency learning response when incidents are first reviewed, and we have an understanding of the care provided to a patient. We will then actively engage relevant partner organisations to identify an appropriate learning response, coordinate a single learning response outcome and a single point of contact for patients/families. The Patient Safety Team will act as the liaison point to support and/or lead on cross-organisational reviews. We expect to be supported as needed by our commissioner, the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board, to facilitate cross-organisational reviews.

Table showing Patient Safety Incident with anticipated response option			
Category		**Patient safety incident or event**	**Anticipated learning response method**
National (NHS England)	1	Incidents meeting the Never Events criteria (nationally defined incidents that are considered preventable - NHS England » Never events)	Patient Safety Incident Investigation or alternative as agreed with the Integrated Care Board. To be reviewed through Patient Safety Incident Panel (PSIP) -previously known as LRDP & SIEDM panels.
	2	Deaths thought more likely than not due to problems in care (meeting the learning from deaths criteria)	Mortality review and then as required a Patient Safety Incident Investigation. To be reviewed through Patient Safety Incident Panel (PSIP). Annual Thematic analysis of SJR care issues to be completed and presented through Clinical Effectiveness Board.
	3	Unexpected deaths of people with a learning disability or under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think the death may be linked to problems in care	Mortality review usually completed by the Care Group lead and then as required a Patient Safety Incident Investigation. To be reviewed through Patient Safety Incident Panel (PSIP)
	4	Maternity incidents that fall within MNSI criteria	MNSI investigation to be reviewed at the Patient Safety Incident Panel (PSIP)
	5	Unauthorised absence/missing patient	Patient Safety Incident Investigation. To be reviewed through Patient Safety Incident Panel (PSIP)
	6	Child deaths (all deaths for children aged 0-17)	Case record review, usually completed by the Safeguarding Team or clinical team. Child death overview panel multi-agency review – coordinated by the Local Authority.
	7	Safeguarding incidents meeting national criteria	Initial Findings Review (IFR). Refer to Local Authority safeguarding lead.
	8	Blood transfusions resulting in serious adverse reactions, a serious adverse event or significant near miss (PSIRF-and-impact-on-haemovigilance-in-England)	Patient Safety Incident Investigation. To be reviewed through Patient Safety Incident Panel (PSIP)
	9	Reduction in diagnostic delays e.g., test or follow-up from an abnormal test/scan result.	1. Currently work being undertaken by the Trust including a review of all first and follow-up outpatient appointments and identification of any missed appointments and potential harm to patients. 2. A summary report monthly oversight to the Patient Safety Board is provided to monitor progress.

Table showing Patient Safety Incident with anticipated response option			
Category		**Patient safety incident or event**	**Anticipated learning response method**
Local			3. Following this review a full investigation with Safety Improvement actions will be provided 4. 6-monthly and annual thematic analysis to be monitored and reviewed through Patient Safety Incident Panel (PSIP) and Clinical Effectiveness Board
	10	Maternity incidents which do not meet criteria for Patient Safety Incident Investigation or HSIB (usually classified as low or no harm).	1. Incidents will be individually reviewed in a governance MDT meeting to confirm learning response. 2. No and low harm incidents will be included in a Quarterly and annual thematic analysis and reviewed through the Harm Free Care Group. The Harm Free Care Group has been in place for 9 months and continues to provide assurance and learning for these incidents. The focus is on implementing and monitoring the impact of learning improvements in progress and identifying any new emerging themes.
	11	Focused review of specific care discharge processes	1. Improvement programme not currently started and once commenced will involve a focused key stakeholder group to review the discharge processes across the Trust. 2. 6-monthly and annual thematic analysis to be monitored and reviewed through Patient Safety Incident Panel (PSIP).
	12	Medication	1. Incidents will be individually reviewed in a governance MDT meeting to confirm learning response. 2. No and low harm incidents will be included in a Quarterly and annual thematic analysis and reviewed through the Harm Free Care Group. The Harm Free Care Group has been in place for 9 months and continues to provide assurance and learning for these incidents. The focus is on implementing and monitoring the impact of learning improvements in progress and identifying any new emerging themes.

Table showing Patient Safety Incident with anticipated response option			
Category		**Patient safety incident or event**	**Anticipated learning response method**
Local	13	Positive Care feedback	Excellence Reports, Compliments and positive feedback will be collated by the governance teams, the patient safety team and complaint team and reported through the Patient Safety Incident Panel (PSIP). This is currently included in all board reports and will continue to be an important source of learning. Key positive care with be used as benchmarks for success when establishing other new improvement programs.
	14	Falls	1. Incidents will be individually reviewed in a governance MDT meeting to confirm learning response. 2. No and low harm incidents will be included in a Quarterly and annual thematic analysis and reviewed through the Harm Free Care Group. The Harm Free Care Group has been in place for 9 months and continues to provide assurance and learning for these incidents. The focus is on implementing and monitoring the impact of learning improvements in progress and identifying any new emerging themes.
	15	VTE/HAT	1. Incidents will be individually reviewed in a governance MDT meeting to confirm learning response. 2. No and low harm incidents will be included in a Quarterly and annual thematic analysis and reviewed through the Harm Free Care Group. The Harm Free Care Group has been in place for 9 months and continues to provide assurance and learning for these incidents. The focus is on implementing and monitoring the impact of learning improvements in progress and identifying any new emerging themes.
	16	Hospital Acquired Infections (HCAIs)	1. Incidents will be individually reviewed in a governance MDT meeting to confirm learning response. 2. No and low harm incidents will be included in a Quarterly and annual thematic analysis and reviewed through the Harm Free Care Group. The focus is on implementing and monitoring the impact of learning improvements in progress and identifying any new emerging themes.

Table showing Patient Safety Incident with anticipated response option			
Category		**Patient safety incident or event**	**Anticipated learning response method**
	17	Pressure ulcers developed whilst under our care – inpatient and community services (defined nationally as developed in service)	1. Incidents will be individually reviewed in a governance MDT meeting to confirm learning response. 2. No and low harm incidents will be included in a Quarterly and annual thematic analysis and reviewed through the Harm Free Care Group. The Harm Free Care Group has been in place for 9 months and continues to provide assurance and learning for these incidents. The focus is on implementing and monitoring the impact of learning improvements in progress and identifying any new emerging themes.
	18	Improve the unexpected deteriorating adult/child pathway through review and refinement of communication and escalation processes across the Trust.	Review of Trust-wide pathway with specific senior ownership through focused a Quality Improvement workstreams with annual review through End of Life Steering Group, Deteriorating Patient Group, and the Mortality Reduction Group.
	19	Review of all invasive procedures to develop LocSSIPs (Local Safety Standards for Invasive Procedures) which will help provide safer care for patients undergoing invasive procedures in all settings including outpatients.	Review of Trust-wide review of LocSSIP guidelines and standard operating procedures (SOPs) in all clinical areas where invasive procedures are undertaken. Annual review through Patient Safety Board and Clinical Effectiveness Board.

We aim for learning responses to start as soon as possible after the incident is identified and expect most responses to be completed within 6 weeks although this will be flexible and we will work at the pace of those affected, particularly patients, families, and colleagues. If a response requires the involvement of a number of partner organisations or we are carrying out a full in-depth patient safety incident investigation this may also take longer but we will still aim to complete this within 6 months. During all of the learning responses we recognise communication with those affected is crucial so we will provide routine updates on progress and any changes to the timescale

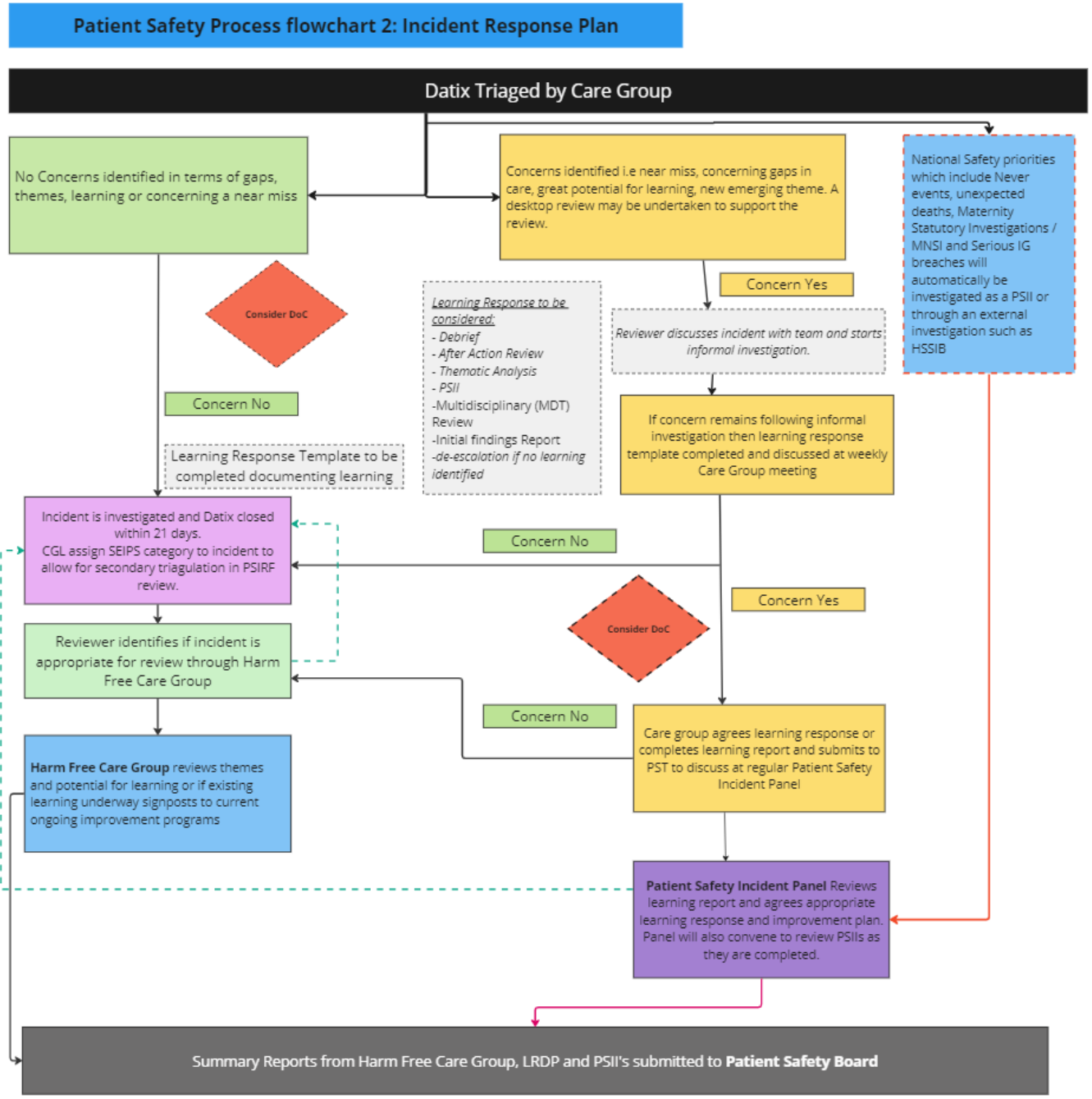
8.0 Training Requirements

As part of the PSIRF programme an extensive training programme will be offered to colleagues in order to support and enable staff.

Figure 3: PSIRF Learning Overview

Topic	Minimum Duration	Content	Learning Response Leads	Family/Patient Liaison Officer	Those involved in PSIRF oversight Roles
Systems approach to learning from patient safety incidents	2 days/12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		✓	✓
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of colleagues • Avoiding inappropriate blame when things do not go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (e.g., through conferences, webinars, etc.) • Contribute to a minimum of two learning responses	✓	✓	✓

Appendix 1: PSIRF Incident Response Plan



Appendix 2: PSIRF Incident Response Plan- Infection Prevention and Control