PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) POLICY

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APPROVED BY:	Patient & Family Services Committee
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Index:

1. Statement

1.1 Introduction

In August 2022 NHS England (NHSE) published the Patient Safety Incident Response Framework (PSIRF). The PSIRF is a key part of the National Patient Safety Strategy and supports the strategy's aim to help the NHS to improve its understanding of safety by drawing insight and learning from patient safety events.

The PSIRF replaces the Serious Incident Framework (SIF) and makes no distinction between 'patient safety events' and 'serious incidents.' 'Serious incidents' and their associated thresholds no longer exist under PSIRF. PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSIRF fundamentally shifts how the NHS responds to patient safety events for learning and improvement. Unlike the SIF, PSIRF is not an investigation framework that prescribes what to investigate. PSIRF advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety events. PSIRF embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

PSIRF focusses on improved engagement with those affected by an incident, including patients, families and staff. Ensuring they are treated with compassion and able to be part of any investigation. The Guide to engaging and involving patients, families and staff following a patient safety incident, published alongside PSIRF, sets out expectations for how Dorothy House (DH) engage with all those affected by patient safety incidents.

Although PSIRF is replacing serious incidents within the NHS, it is important to note that 'reporting serious incidents' remains the recognised language of the Charity Commission. Please see section 2.1 – Oversight Roles/Responsibilities for further detail.

1.2 Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out DH's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. The policy has been developed using the national NHSE template and will be supported by a detailed incident reporting and learning procedure.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents

2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents and safety issues
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. **Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.** This policy outlines the aims and objectives of patient safety incident management at DH and the framework within which this is achieved.

This policy reflects the move from NHS Serious Incident Framework (SIF) to the Patient Safety Incident Framework (PSIRF) 2023. This policy applies to all staff and should be read in conjunction with the policies and guidance outlined in section 7 – Related Policies, Procedures and Guidance.

1.3 Scope

This policy is specific to patient safety incidents conducted solely for the purpose of learning and improvement across the services provided by DH.

Patient Safety Responses will follow a “systems-based approach”. A system-based approach recognises that healthcare takes place in a work system composed of people, tasks, equipment and the different environments in which care is provided.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

Other processes that exist for that purpose include:

- claims handling
- complaints management
- human resources investigations into employment concerns
- professional standards investigations
- coronial inquests
- criminal investigations
- safeguarding concerns

1.4 Equality Implications

The Equality Impact Assessment indicates that it is it unlikely that this policy/procedure could treat people from protected groups less favourably than the general population.

2. Responsibility (Accountability)

Ultimate responsibility is held by the Chief Executive.

First line responsibility is held by the PSIRF Executive Lead.

All workforce members have a responsibility for ensuring that the principles outlined within this document are universally applied.

2.1 Oversight Roles and Responsibilities

2.1.1 Internal Reporting/Assurance

The oversight of PSIRF implementation and compliance will reside with the Clinical Governance Sub-Committee.

The Organisation wide Safety Improvement Plan will be discussed at the Health and Safety Meetings.

The Director of PFSD is assigned as DH PSIRF Executive Lead (DH Patient Safety Specialist (PSS) and they will:

- Ensure PSIRF is central to overarching safety governance arrangements
- Ensure the organisation meets national patient safety incident response standards
- Ensure that appropriate resources are allocated to PSIRF activities and safety improvement

The PSIRF Executive Lead will be responsible for reviewing PSII reports in line with the patient safety incident response standards and signing the report off as finalised, supported by relevant colleagues as appropriate.

2.1.2 Integrated Care Board (ICB) Reporting

As per our NHS Contracts.

2.1.3 Care Quality Commission (CQC)

DH will inform the CQC, (via the relationship lead), of any high profile and complex incidents, as well as those being provided as statutory notifications required by the Health and Social Care Act (2008), and as set out in CQC's guidance on statutory notifications.

The CQC will apply the PSIRF, and associated patient safety incident response standards, as part of its assessment of the strength of the organisation's systems and processes for preparing for and responding to patient safety incidents.

2.1.4 Medical Examiner (ME)/Learning from Deaths (LfD)

The Medical Examiner will report any patient safety concerns identified to DH via an email to DH Medics. All patient safety incidents/concerns raised by the Medical Examiner must be reported on RADAR and formally received/notified to Incident Response Group through the monthly decision making meetings. Following the review and the Medical Examiners findings; if this suggest that care provided is poor and/or if felt that the existence of a patient safety incident could have, or did, lead to harm/death a Patient Safety Incident Investigation (PSII) will be undertaken (See **Appendix A**).

52. # 3. Procedure

53. ## 3.1 Values and Behaviours Leadership Framework

54. DH supports and promotes a culture of fairness, openness and learning and actively encourages its staff to report incidents and to speak up when things go wrong without fearing unjust blame (Just Culture, NHS England » A just culture guide). We do this through consultation, committees, staff surveys, audits and Freedom to Speak Up/Whistleblowing procedures.

55. DH encourages incident & near miss reporting where a workforce member feels something has happened, may happen or caused, may cause harm to patients or workforce members. The Accident, Incident and Near-Miss Reporting Policy outlines the organisations responsibilities, arrangements and how incidents should be managed to provide an open and transparent investigation, focusing less on blame and more on lessons learned and sharing those lessons to improve processes.

56. DH conduct patient safety incident responses for the purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability and cause of death). While the organisational values and systems in place support a strong safety culture, the implementation of PSIRF is anticipated to improve this further. The new procedures being implemented as part of PSIRF will support the improvement of our organisations safety culture through compassionate engagement and sharing of learning responses and through monthly safety, learning, improvement, Patient Safety Incident Meetings and monitoring improvement.

57. DH benchmarks key patient safety risks from the Inpatient Unit against other hospices, this is managed by Hospice UK.

58. - Falls
59. - Medication errors
60. - Acquired pressure ulcers
61. - Patients admitted with pressure ulcers

62. Data is submitted to Hospice UK quarterly and DH receive a report and attend a quarterly seminar to discuss the results. We share this data at Clinical Governance meetings and with our commissioners so they can see how DH compares to other hospices.

63. Reporting at DH has improved with the introduction of a new electronic reporting system “RADAR” in August 2023, which provides ease of reporting, implementing actions, following up and sharing of learning.

64. DH is transparent with patients and families when something goes wrong though complying with Statutory and Professional Duty of Candour. There is a Duty of Candour policy and mandatory training for clinical staff. Professional Duty of Candour states every healthcare professional must be open and honest with patients and their families when something goes wrong with their treatment or care and causes, or has the potential to cause, harm or distress. This means all healthcare professionals must:

65. - Tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong

- Apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- Offer an appropriate remedy or support to put matters right (if possible)
- Explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened

3.1.1 Dorothy House Values

Additional work to improve the safety culture of DH includes the ongoing focus on working with our values '**We Care** for one another with compassionate, purposeful and authentic leadership, **We Connect** with each other and across our organisation to deliver excellence, **We Create** opportunities to innovate, learn and develop together'. To embed these values into our organisation they are incorporated into our recruitment and appraisal processes along with our Equality, Diversity and Inclusivity Strategy, 2022-2025.

3.2 Patient Safety Partners (PSPs)

The PSP is a new and evolving role developed by NHSE to help improve patient safety across the NHS. Patient Safety Partners will offer support alongside our people, patients, families and carers to influence and improve safety across our range of services by sharing their experiences and skills and providing a level of scrutiny. Our PSPs will provide objective feedback through a variety of approaches which may include attendance at safety meetings, governance committees, supporting the production of associated policies and procedures and patient safety training.

This new role will evolve over time with the main purpose of the role to be the voice of our patients and community who utilise our services, ensuring patients safety is at the forefront of all that we do.

DH recognise the benefits of patient safety partners being involved in the process of improving patient safety across our organisation. As of March 2024 we are exploring the ways this could work in a proportionate and valued way within DH.

3.3 Addressing Health Inequalities

DH has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of our population in an inclusive way.

Through our learning responses we will seek to support health equality and the reduction of inequalities and will apply a more flexible approach to how we use data to help us better identify any disproportionate risks to patients with specific characteristics.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families.

3.4 Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

PSIRF recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety

incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

81. We will further develop the foundations of a system that supports compassionate engagement and involvement of those affected by patient safety incidents.

82. It is recognised patients and families may have different perspectives, questions or needs arising from the circumstances around patient safety incidents. This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient- safety-incident-response-framework-and-supporting-guidance/#heading-2

83. Our aim will be to involve and support patients and families in any patient safety event reporting, ensuring duty of candour and to feedback and ask them about their experience of the process.

84. ### 3.4.1 Involving Staff, Colleagues and Partners

85. Similarly, involvement of staff and colleagues (including partner agencies) is important when responding to a patient safety event to ensure a holistic and inclusive approach from the outset. Again, this reinforces existing guidance such as our incident reporting and management policy, though it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incidents or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement.

86. It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue to promote an open and just culture to support this.

87. At the time of a patient safety event or at any time through the investigation it will be the manager's (or the most relevant persons) responsibility to offer support to any of our workforce who were involved.

88. ## 3.5 Patient Safety Incident Response Planning

89. PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

90. DH will take a proportionate approach to its response to patient safety incidents ensuring the focus is on maximising learning and improvement.

3.6 Dorothy House Patient Safety Incident Response Plan (PSIRP)

How we will respond to National and local Patient safety incidents

		Event ⟶	Approach ⟶	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigations	National Priorities	Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Respond to recommendations from external referred agency/organisation as required.
			Death thought more likely than not due to problems in care		
			Unexpected death of person with learning disability	Reported & reviewed by Learning Disabilities Mortality Review (LeDeR)	
			Safeguarding incidents meeting criteria	Reported to DH named safeguarding lead	
		Trust Priorities	Dorothy House Priorities; • Patient Falls • Medication • Pressure Ulcers Emergent area of risk	Patient Safety Incident Investigation where agreed (detail in DH policy)	A monthly internal meeting with members of the multi-disciplinary team meet to review all accidents and incidents reported that month. To ensure all learning has been gained and to improve feedback to teams. This is recorded on the Accident and Incident spreadsheets. Create Local organisational recommendations and actions and feed these into internal and external quality committees.
		Local Level	Incidents resulting in moderate or severe harm to patient	Statutory Duty of Candour and Chronological timeline	Update DH thematic analysis of patient safety risks.
			No/low harm patient safety incident	Confirmation of facts at local level – thematic analysis	

3.6.1 Resources and Training to Support Patient Safety Incident Response

PSIRF training is being provided to our workforce who require the skills and competencies to undertake learning response. This approved training programme, additional to the National Patient Safety Syllabus, will equip a designated cohort of staff appointed as investigators with the skills and expertise to support high quality learning responses.

3.6.2 Metrics for Workforce Training

Response/Skills Set	Plan
PSII – Level 2; Patient safety investigations : A systems Approach to learning from patient safety incidents	Director of Patient & Family Services, Clinical Quality Lead, Inpatient Unit Clinical Lead, Safeguarding Lead, Clinical Coach & Education Facilitator, Health & Safety Officer (Estates & Facilities) to undergo training and be able to perform PSII level investigation.
Other responses/methods • Patient Safety review/formal learning review • Roundtable • Chronological timelines • SEIPS Framework • Rapid review • MDT review *(plus others methods that may not require formal training)*	Plan to deliver training and documentation to all clinical staff in a phased approach starting with staff with line management responsibility.
e-Learning for Health Level 1- Essentials of patient safety for boards and senior leadership teams	For all boards and senior leadership team. Aim for 95% compliance.
e-Learning for Health Level 1 - Essentials Patient Safety	For all clinical staff. Aim for 95% compliance.
e-Learning for Health Level 2 - Access to Practice Part 1: Systems thinking and risk expertise. Part 2: Human factors and safety culture. (Including Self-Assessment)	For all clinical staff. Aim for 95% compliance.

3.6.3 Our Patient Safety Incident Response Plan (PSIRP)

Our plan sets out how DH intends to respond to patient safety events over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety event occurred and the needs of those affected, as well as the plan.

Our plan development was overseen by a small working group (Clinical Quality Lead, Health & Safety Officer (Estates & Facilities), Head of Governance, Clinical Coach & Education Facilitator and Director of Patient & Family Services).

Patient Safety data to support our PSIRP was obtained by reviewing 3 years' worth of reported incident data, incidents derived from complaints, claims and risks. These activities will also direct our safety priorities with consideration given to quality improvement (QI) priorities.

3.6.4 Reviewing Our Patient Safety Incident Response Policy and Plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan regularly, and at least every 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change.

This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes. Updated plans will be published on our website, replacing the previous version.

108. This PSIRF Policy will be subject to a planned review every three years as part of the DH policy review process. It is recognised that there may be updates required in the interim arising from amendments or release of new regulations, Codes of Practice or statutory provisions or guidance from the Department of Health or professional bodies. These updates will be made as soon as practicable to reflect and inform DH's revised policy and practice. It is supported by our Accident, Incident and Near-Miss Reporting Policy.

109. A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

110. ## 3.7 Responding to Patient Safety Incidents

111. ### 3.7.1 Patient Safety Incident Reporting Arrangements

112. Please see DH Accident, Incident and Near-Miss Reporting Policy.

113. Patient safety incidents will be reviewed monthly by the DH Incident Review Group (Inpatient Unit Nurses, Medics, Safeguarding Lead, Clinical Quality Lead, H@H Team Leader, Therapies and Day Services Clinical Lead, CPCT Leads, Clinical Coach & Education Facilitator). At a daily SitRep meeting teams can share any concerns about any patient safety incidents that have happened.

114. ### 3.7.2 Patient Safety Incident Response Decision-Making

115. Through the PSIRF Policy and Plan DH will have arrangements to meet the requirement to review patient safety incidents under PSIRF, ensuring those that require a mandated/recommended response, (**Appendix A**), are reported and investigated as required.

116. PSIRF itself sets no further national thresholds to determine what method of response should be utilised for learning and improvement. DH will continually develop a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work.

117. DH Incident Review Group (Inpatient Unit Nurses, Medics, Safeguarding Lead, Clinical Quality Lead, H@H Team Leader, Therapies and Day Services Clinical Lead, CPCT Leads, Clinical Coach & Education Facilitator) provide a monthly decision making group to review all accidents and incidents, and to identify those incidents that appear to meet the need for further exploration due to the possibility of meeting the criteria for a full review. The group will provide the oversight and scrutiny of incident response decision making and the application of learning response approaches, ensuring these are proportionate and reflect any required external reporting thresholds see **Appendix A**.

118. Any reviews of a specific incident or themes will be led by a member of the team who has completed their level 2 PSIRF Training (HSSIB Level 2: A systems approach to investigating and learning from patient safety events).

3.7.3 Responding to Cross-System Incidents/Issues

Where data and/or intelligence identifies an incident and/or an emerging theme that requires a cross-system learning response this will be communicated to the ICB who will support and facilitate the management of any incident that impacts upon more than one provider.

This will ensure that the learning response considers the view of all applicable organisations, and that clarity is sought for the management of patient/family engagement as appropriate (including Duty of Candour); DH will co-operate with any learning response that crosses organisational boundaries.

Commonly this will include local/neighbouring NHS Trusts, other NHS Trusts outside of the ICB, Primary Care, Ambulance services, and private providers and the learning response will be led by the organisation best placed to investigate the concerns, which will reflect capability, capacity or remit.

3.7.4 Timeframes for Learning Responses

We will seek to ensure that patient safety learning responses start as soon as practicable after the incident is identified. Learning response timeframes will be agreed in discussion with those affected, particularly the patient(s) and/or their carer(s) where they wish to be involved in such discussions.

Timeframe for completion will be agreed with those affected, as part of setting the terms of reference; a balance will be drawn between conducting a thorough review, the impact extended timescales can have on those involved and the potential for a delay in reporting to adversely affect safety.

We will seek to complete learning responses within one to three months and/or no longer than six months. Timeframes will be agreed by in conjunction with those affected and the Incident Review Group as part of the agreement of the terms of reference and the learning response approach/method to be adopted.

In exceptional circumstances, (i.e., when a partner organisation requests a pause, or processes of external bodies delay access to information), DH can consider whether to progress and determine whether new information would indicate the need for further review once this is received. The decision for this would be made by the Incident Review Group.

There may be occasions where a longer timeframe is required for completion, in this case, all extended timeframes will be agreed between DH and those affected.

3.7.5 Safety Action Development and Monitoring Improvement

DH acknowledges any form of patient safety learning response will allow the circumstances of an event or set of events to be understood, but this may only be the beginning. To reliably reduce risk, robust safety actions are required.

Safety actions will be developed to address areas of improvement arising from learning responses where it is meaningful to do so; these will be developed with relevant stakeholders, including those responsible for implementation.

A central repository of safety actions will held by the Clinical Quality Team which will be routinely discussed at the Clinical Governance Sub-Committee that meets quarterly and is chaired by the PSIRF Executive Lead for DH.

3.7.6 Safety Improvement Plans

There are no thresholds for when a safety improvement plan should be developed; DH will seek to create an organisation-wide safety improvement plan derived from knowledge gained through the learning response process and other relevant data. This will align to the Quality Improvement Plan generated annually as part of DH Quality Account. The organisation-wide safety improvement plan would stand as an agenda item on DH Health and Safety Committee.

3.8 Complaints and Appeals

DH recognises that there will be occasions when patients, families and carers are dissatisfied with the aspect of care and services provided by DH.

It is important to recognise the distinction between complaints and concerns, as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

See DH Complaints, Concerns and Compliments Policy.

4. Workforce Member Training Requirements

See section 3.6.2 – Metrics for Workforce Training.

All workforce members will be made aware of organisational policies and where to find them during their induction on joining the organisation.

5. Document Review

This policy will be subject to a planned review every three years as part of the DH policy review process.

It is recognised that there may be updates required in the interim arising from amendments or release of new regulations, Codes of Practice or statutory provisions or guidance from the Department of Health or professional bodies. These updates will be made as soon as practicable to reflect and inform DH's revised policy and practice.

6. References and Further Reading

- NHS England » Patient Safety Incident Response Framework

7. Related Policies, Procedures and Guidance

Dorothy House Policies and Procedures:

Accident, Incident and Near-Miss Reporting Policy

Administration of Medicines Policy

Central Alerting System Policy

Clinical Governance Policy

- Complaints, Concerns and Compliments Policy
- Consent by Patients and Clients to Treatment (including where incapacity for consent) Policy & Procedure
- Deprivation of Liberty Safeguards (DOLS) Policy and Practice Guidance
- Dorothy House Notifications to the Care Quality Commission (CQC) Policy & Procedure
- Duty of Candour Policy
- Equity of Access Policy & Procedure
- Falls Policy & Procedure for the Prevention of Patient Falls and Care After a Fall
- Fitness of Hospice Premises and Equipment Policy
- If a Patient Goes Missing Policy & Procedure
- Infection Prevention and Control Overarching Policy
- Information Governance Breach or Near-Miss Reporting Procedure
- Information Governance Handbook
- Major Incident Plan (Business Continuity) and Procedure
- Medical Oxygen Cylinder, Procurement, Handling and Storage Procedure and Management of Piped Gas Systems Procedure
- Monitoring the Quality of Treatment and Care Policy & Procedure
- Moving and Handling Policy
- Prescribing of Medicines Policy
- Pressure Ulcer and Prevention Policy
- Reporting of Patient Safety Incidents Involving Medicines Policy
- Responding to Concerns About Poor Medical Practise Policy
- Risk Management Policy & Procedure
- Sharps Safety Policy
- Speaking Out (Whistleblowing) Policy
- Suicide Risk Policy and Procedure
- Use of Bed Rails Policy
- Safeguarding Adults Policy & Procedure including Self-Neglect
- Safeguarding Children and Young People Policy & Practice Guidance
- **Regulations and Guidance:**
- Care Quality Commission (CQC) Regulations
- Never Events List (2018)
- Revised Never Events Policy and Framework
- The Patient Safety Incident Response Framework NHS England (2022) and its supporting guidance

8. Document Approval Journey

8.1 Individual Stakeholders and Reviewing Groups

Director of Patient & Family Services

Head of Governance

Clinical Quality Lead

Clinical Coach & Education Facilitator

Health & Safety Officer (Estates & Facilities)

Clinical Governance Sub-Committee

8.2 Document Approval Group

Patient & Family Services Committee

9. Amendment History

Issue	Date	Reason for Amendment	Amended By
1	05/06/24	New policy document in response to implementation of PSIRF.	Author, 8.1 and 8.2

10. Glossary

BSW	On 1 April 2020, **Bath and North East Somerset, Swindon and Wiltshire** Clinical Commissioning Groups (now known as Integrated Care Boards) merged and became a single commissioning organisation; BSW.
CPCT	The **Community Palliative Care Teams** are comprised of healthcare professionals who work alongside family doctors, district nurses and other care agencies, offering advice and support to patients and families in their own homes.
CQC	The **Care Quality Commission** is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England.
DH	**Dorothy House** provides compassionate care and support for people in our community with a life-limiting illness. Our focus is on quality of life, helping patients to live well and die well.
H@H	**Hospice at Home** is an integral component of community end of life care bringing the skills, ethos and practical care associated with the Hospice movement into the home environment; putting the patient and those who matter to them at the centre of the care.
HSSIB	The **Health Services Safety Investigations Body** is a fully independent arm's length body of the Department of Health and Social Care. It investigates patient safety concerns across the NHS in England and in

		independent healthcare settings where safety learning could also help to improve NHS care. It aims to produce rigorous, non-punitive, and systematic patient safety investigations and to develop system-wide safety recommendations for learning and improvement.
205.	ICB	An **Integrated Care Board** is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
206.	LeDeR	**Learning from Lives and Deaths of People with a Learning Disability and Autistic Adults** programme is a service improvement programme for people with a learning disability and autistic people.
207.	LfD	**Learning from Death** is a patient safety programme launched in the NHS in 2017. The programme aims to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence.
208.	MDT	A **Multi-Disciplinary Team** is a group of individuals from multiple disciplines who meet to pursue a common goal**,** such as recommending a treatment plan and developing the individual treatment pathways for patients.
209.	ME	A **Medical Examiner** is an official whose duty is to investigate deaths occurring under unusual or suspicious circumstances, perform post-mortems, and initiate inquests.
210.	NHS	The **National Health Service** is the publicly funded healthcare system of the United Kingdom.
211.	NHSE	**NHS England** provides national leadership for the National Health Service. They promote high quality health and care for all, and support NHS organisations to work in partnership to deliver better outcomes for patients and communities, provide the best possible value for taxpayers and to continuously improve the NHS.
212.	PSII	A **Patient Safety Incident Investigation** is undertaken when an incident or near-miss indicates significant patient safety risks and the potential for new learning. Investigations explore decisions or actions as they relate to the situation.
213.	PSIRF	The **Patient Safety Incident Response Framework** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
214.	PSIRP	A **Patient Safety Incident Response Plan** is a requirements of each provider delivering NHS-funded care. The PSIRP sets out how an organisation will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of their work to continually improve the quality and safety of the care they provide.
215.	PSP	The **Patient Safety Partner** is a new and evolving role developed by NHS England to help improve patient safety across health care in the UK. The main purpose of the role is to be a voice for the patients and community

who utiliser health care services and ensure that patient safety is at the forefront of all that is done.

216. PSS — A **Patient Safety Specialist** is a professional who works in health care settings to ensure that patients receive the best possible care and avoid any potential risks.

217. QI — **Quality Improvement** aims to make a difference to patients by improving safety, effectiveness, and experience of care by using understanding of our complex healthcare environment; applying a systematic approach, and designing, testing, and implementing changes using real time measurement for improvement.

218. SEIPS — **Systems Engineering Initiative for Patient Safety** is the systems-based framework endorsed by PSIRF. It is a framework for understanding complex systems which can be applied to support the analysis of incidents and safety issues more broadly.

219. SIF — The **Serious Incident Framework**, which preceded PSIRF, was designed to inform staff providing and commissioning NHS funded services in England who may be involved in identifying, investigating or managing a serious incident. It also sought to support the NHS to ensure that robust systems were in place for reporting, investigating and responding to serious incidents so that lessons were learned and appropriate action taken to prevent future harm.

220. Workforce — The **Workforce** are the people engaged in or available for work, either in a country or area in a particular firm or industry. The DH Workforce is made up of both volunteers and paid employees.

PATIENT SAFETY INCIDENT INVESTIGATION

NHS England Patient Safety Incident Investigation document.

Classification: Official

Publication approval reference: PAR1465

Patient safety incident investigation

Version 1, August 2022

What is a patient safety incident investigation?

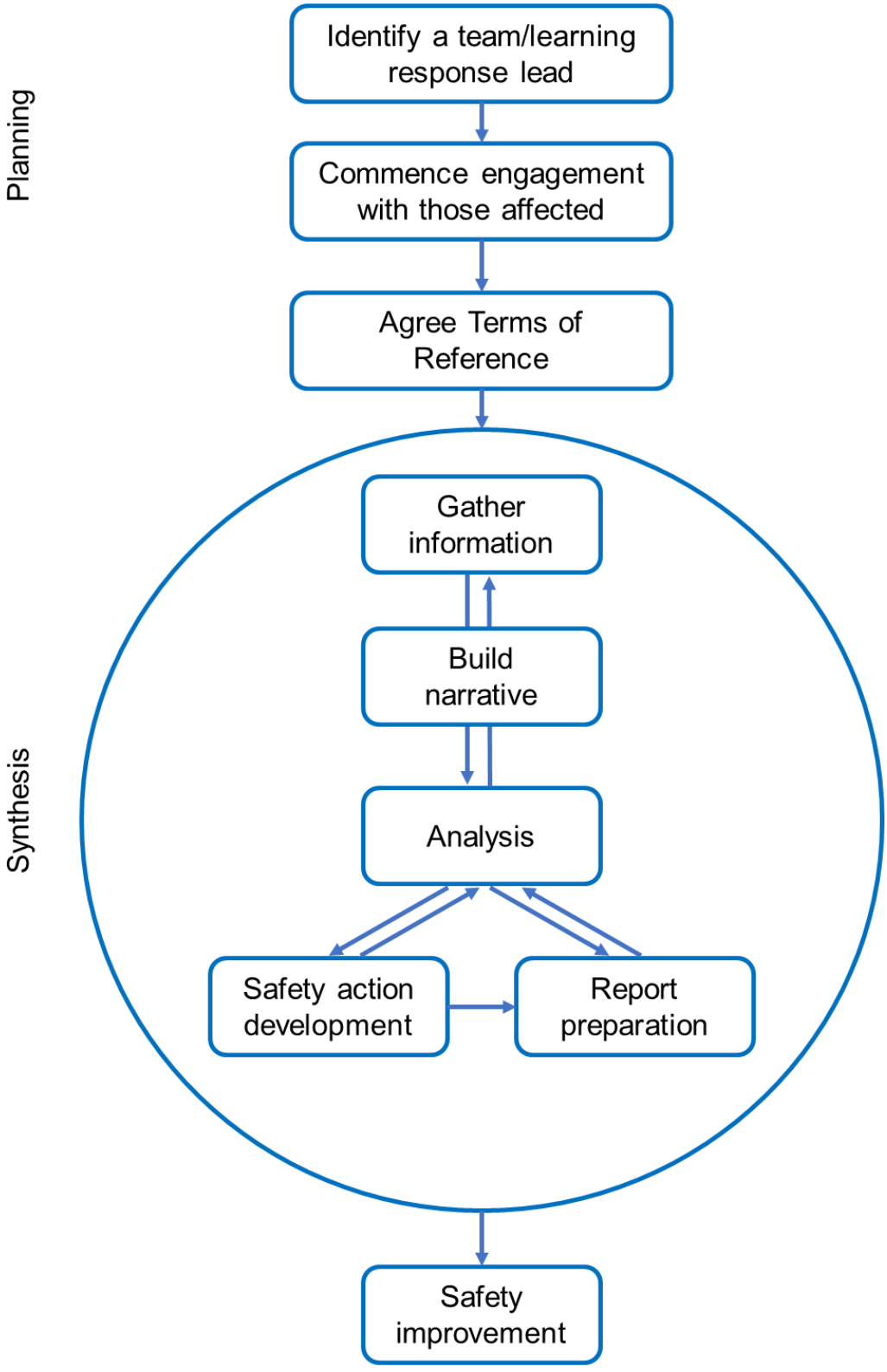
A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Process

Figure 1: Overview of patient safety incident investigation stages



Stage	Description
Identify a team/learning response lead	The investigation team should be formed based on factors including availability, systems-focused safety investigation knowledge and interests. The lead should be the single point of contact, participate in all phases of the investigation and collaborate with subject matter experts as appropriate. See Patient safety incident response standards for details on training requirements.
Commence engagement with those affected	This process should start as soon as possible. See Engaging and involving patients, families and staff following a patient safety incident.
Agree terms of reference (ToR)	The crafting of precise and clear ToRs is a critical stage as it will determine how effective the investigation is and satisfaction with its output. See: Terms of reference guide.
Gather information	In this stage the learning response leads look 'down and into' a patient safety incident. The objective is to gather as much information as possible about what happened. See: Evidence log for a template to list all information gathered. See: Everyday work guides (ie observations, link analysis, walkthrough analysis and interview tool) for different approaches to information gathering.
Build narrative	Build a detailed narrative from the information gathered. The narrative does not need to be broken down by time – often people operate from activity to activity rather than minute to minute. Unlike a film or a novel, incidents do not have a beginning, middle and an end. See: Timeline mapping template.
Analysis	The Australian Transport Safety Bureau (ATSB) Safety investigation guidelines (2011) defines analysis as: "the process of making conclusions or findings about something".[1] Analysis is an iterative process at the centre of an investigation (see Figure 1) – it may reveal the need for further information gathering, and when writing your investigation report you may identify the need for further analysis. Analysis starts at the beginning of an investigation but will be

[1] The ATSB also define analysis as "the process where available data is reviewed, evaluated and then converted into a series of arguments, which produce a series of relevant findings. It is the link between the collected data and the findings of an investigation" (ATSB, 2011).

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	more prominent after information gathering and continues until the investigation report is finalised. There are no detailed, prescriptive rules that can be applied in all situations. Ultimately analysis relies on informed judgement and is, to some extent, subjective. However, a system focused framework and/or tools should be used to reduce the risk of investigation conclusions and findings are overly subjective. The following structure can help develop useful, realistic findings that will be widely accepted: • application of a consistent framework throughout information gathering (eg SEIPS – see SEIPS quick reference and work system explorer) • structured set of analysis stages (see Appendix) • a team-based approach • knowledge about the domain being investigated. The output of the analysis stage is an agreed set of findings. See Work system scan and interaction map for a template to document findings.
Safety action development	See Safety action development guide.
Report preparation	Before writing your report consider: • Who is going to be reading it – are there language implications? • Who needs to be involved? • When is the report required – can you meet this timeline? • How will needs of the readers be accommodated? • How should the report be formatted, including how will findings be described?

Tips

Capture multiple perspectives to reduce bias

Bias can significantly change the way data is used or interpreted. Once people know the outcome of an incident, it will be impossible for them to be without bias when looking back at what happened. For this reason, it is important to avoid forming conclusions too early.

Remember that the recollections of individuals will already be filtered through their own bias, mental models, and rationalisation. Investigation team members are not objective observers of reality – they will also be making sense of an incident and introducing biases and heuristics when doing so.

The narrative should showcase the incident from as many perspectives as appropriate. Differences in perspective do not need to be resolved in one 'correct' narrative. All perspectives need to be valued and this is likely to result in a complex narrative.

Capture the 'view from inside the tunnel'[2]

Focus on understanding the actions as they appeared to the people 'inside the situation'.

Strive to enable readers to 'walk in the shoes' of the incident's key players. At a minimum, the narrative should use the information known at the time to show how the decisions taken made sense within the social and cultural context.

The investigation team should seek to understand how the incident was perceived by those involved and why their actions/decisions made sense at the time they were taken.

Do not use the term cause

In legal contexts the term cause is strongly associated with blame and liability. There are also semantic difficulties with the term; many complicated philosophical arguments surround what constitutes a cause.

Avoid ranking contributory factors by degree of 'contributory-ness'

Avoid differentiating contributory factors in terms of degree of connection or perceived importance in relation to the incident. Ranking in terms of degree of contribution can be perceived as a way of differentiating the level of responsibility or blame for the incident.

[2] Dekker. S. (2014). The field guide to understanding 'human error'. (3rd Ed) CRC Press

Appendix: Suggested structure for analysis

Adapted from Australian Transport Safety Bureau (2011)

Analysis phase	Description
Preliminary review	Organise information in a format suitable for analysis (eg into SEIPS 'buckets' – see SEIPS quick reference and work system explorer). Includes systematic review of narrative.
Finding identification	Search for patterns or themes in the information you have collected (see Thematic review top tips) to identify hazards (ie potential sources of harm). The investigation may identify a range of hazards: some may be 'contributory' (ie if they had not arisen the incident would 'probably'[3] not have happened); others may not be contributory but may be identified during an investigation. All should be considered findings. Try not to favour a particular finding, keep an open mind. Use a multidisciplinary team approach to ensure different perspectives are captured (see SHARE debrief guide).
Risk analysis	Use a structured process to determine the risk associated with identified findings. You could classify risk by estimating consequence and likelihood. Alternatively, simple rules of thumb can be used based on general principles such as: • starting where the patient will experience the most difference • starting with the most common failures. 'Increase in risk' needs to be interpreted realistically rather than pedantically (eg the process for starting an infusion would not normally be considered a safety factor unless it was done in such a way that increased risk relative to normal operations). Agree the findings to be included in your patient safety incident investigation report.
Analysis review	Review the agreed findings to identify gaps or weaknesses.

[3] In most situations, it is not possible to specify that a factor was contributory with absolute certainty. Those that can be specified with more certainty are usually those most closely connected in terms of time or physical proximity, eg individual actions.

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