Patient Safety Incident Response Policy

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Version Number	Date	Revisions from previous issue
1.0	09.08.2024	New PSIRF Policy
1.1	11.09.2024	Updated AAT template and MDT review meeting template
1.2	09.10.2024	Updated Governance - Datix workflow

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out St Andrew's Healthcare'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 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:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across St Andrew's Healthcare. This includes inpatient and community services.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. 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.

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. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Our patient safety culture

It is of paramount importance within St Andrew's Healthcare to promote a climate that fosters a just culture. The NHS Just Culture guide is available to support our teams as and when it is fit for purpose based on the particular patient safety incident.

The NHS Just Culture Guide supports a conversation between the manager as to whether the member of staff involved in a patient safety incident requires specific individual support or intervention work to improve safe outcomes.

NHS_0932_JC_Guide_A3 (england.nhs.uk)

- The Just Culture Guide asks a series of questions that help clarify whether there truly is something specific about an individual that raises a need for support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counter-productive.
- The Just Culture Guide helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly no matter what their staff group, profession or background.

The Just Culture Guide should not be used routinely. It should only be used when there is already suspicion that a member of staff requires some support or management to work safely, or as part of an individual practitioner performance/case investigation.

The guide does not replace the need for patient safety investigation and should not be used as a routine or integral part of a patient safety investigation. This is because the aim of those investigations is system learning and improvement. As a result, decisions on avoidability, blame, or the management of individual staff are excluded from safety investigations to limit the adverse effect this can have on opportunities for system learning and improvement.

St Andrew's Healthcare aims to create a restorative just and learning culture of openness, in which staff do not feel afraid of reporting adverse events or feel blamed when they are involved in an incident. In this way learning can take place and improvements made locally and which can be shared across other services. St Andrew's Healthcare will ensure that, apart from the exceptions below, incident reporting is not associated with blame or disciplinary action. St Andrew's Healthcare may only consider using disciplinary or legal action against individuals in untoward events when there is:

- Alleged gross or repeated misconduct,
- Alleged professional mal-practice or criminal behaviour,
- An incident which results in a police investigation.

Patient safety partners

Patient Safety Partners actively work with Integrated Care Board staff to design safer healthcare throughout our area, to gather insights from local people and communities and challenge the Integrated Care Board to ensure they learn and change how they work to improve the health and wellbeing of our local people.

Addressing health inequalities

St Andrew's Healthcare strives to support health equality and reduce inequality. The Patient Safety Incident Response Process.

A flexible approach and intelligent use of data can help identify any disproportionate risk to patients with specific characteristics.

- Data sets are used in St Andrew's Healthcare to review themes on a regular basis to ensure that any health inequalities are identified and these themes feed into the consideration of investigation types used.
- Each Division within the Charity has trained Engagement Leads. These Leads are responsible for ensuring patients and their families are involved in every step of the process and their voice is heard within Lessons Learnt. The Engagement leads will work within their own divisions and also cross divisions (assessed on a case by case basis), to ensure impartial support is provided.
- For PSII investigations the patients and family members have the opportunity, built into our processes, to voice their feeling and feed into lessons learnt following each investigation. They will be offered options to do this based on their preference and needs. These options include;
    (1) Attending the charities Lessons Learnt group for an allocated slot
    (2) Feeding back verbally to the Engagement Leads to take this on their behalf
    (3) Providing a written statement to feed into lessons learnt.

Engaging and involving patients, families and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident 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.

St Andrew's Healthcare strives to ensure there is a process embedded within PSIRF which will ensure that our patients and their family and carers voices are heard and that they are supported through compassionate engagement.

Duty of Candour will be upheld in line with the Duty of Candour Policy, Procedure and Decision Making Flowchart (see DOC Procedure).

Each Division within St Andrew's Healthcare has trained Engagement Leads whose role it is to ensure that patients and their family/carers are supported throughout the investigation process under PSIRF. Engagement leads will not be carrying out the investigation as the same time as acting as an Engagement Lead. This is to ensure that their full focus is to support the patient/family/carer.

Meaningful involvement of those affected in a learning response

When a learning response takes place, those affected should be involved in a meaningful way. The following standards are endorsed for all learning responses but must be upheld where a patient safety incident investigation is undertaken.

Those affected should be:

- Provided with a named main contact within the organisation with whom to liaise about any learning response and support.
- Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in.
- Informed who will conduct any learning response and of any changes to that arrangement.
- Given the opportunity to input to the terms of reference for the learning response, including being given the opportunity to request the addition of any questions especially important to them (note this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
- Given the opportunity to agree a realistic timeframe for any learning response.
- Informed in a timely fashion of any delays with the learning response and the reasons for them.

- Updated at specific milestones in the learning response should they wish to be.
- Given the opportunity to review the learning response report with a member of the learning response team while it is still in draft and there is a realistic possibility that their suggestions may lead to amendments. Note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them.
- Invited to contribute to the development of safety actions resulting from the learning response.
- Given the opportunity to feedback on their experience of the learning response and report (eg timeliness, fairness, and transparency)

To ensure that the patient/family/carers voice is heard, for each PSII they will be invited to share their views and feed into the Charity wide learning via attendance of the Learning Lessons group. If they not wish to attend options will be offered as to their preference to share their views. This could be through the Engagement Lead, via letter, via teams call. This will ensure the flexibility allows the individual to feel valued and for the rich learning to be included within any future decision making.

Patient safety incident response planning

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. This approach ensures that a proportionate approach is taken for each Patient Safety Incident Response.

Agree response methods

There are many ways an organisation can respond to a patient safety incident to learn and improve.

Patient Safety Reviews (PSRs) include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected patient, family or carer.

Different PSR techniques can be adopted depending on the intended aim and required outcome.

All PSRs are conducted locally by our organisation.

There are five broad categories of PSRs (refer to appendix 2):

- Patient Safety Incident Investigation (PSII)
- SWARM Huddle
- MDT review
- After Action Review (AAR)
- Walk Through

Patient Safety Incident Investigations (PSIIs) are distinct from PSRs and include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

Some types of patient safety incidents have been identified as national priorities and require a specific response. See Appendix A for a full list of national priorities, and what response is required to them.

All patient safety incidents leading to moderate harm or above and all incidents for which a patient safety incident investigation is undertaken trigger the Duty of Candour (refer to Duty of Candour Policy).

Resources and training to support patient safety incident response

A central Patient Safety team is in place within STAH. Within this team there are two full time posts for Response Leads (Investigators). Within this team there will be two full time posts for Patient Safety Practitioners, the Practitioners will support the divisions with the co-ordination of responses and actions to support learning. There is also a PSIRF Oversight Lead who is the Manager of this Patient Safety team. This central team holds oversight for the Charity.

Within each Division of the Charity, there are a number of lead roles under PSIRF. Each Division has 1-2 Quality Matrons whom are trained as Response Leads and/or Engagement leads. The Quality Matrons will support their own division in regards to supporting their clinical teams to review incidents in line with the Learning Response Methods. For any PSII investigations; the Response lead will only investigate Patient Safety Incidents from another division. This is to ensure transparent working and impartiality. It has been agreed through consultation with Patient Experience that the same person cannot act as a Response Lead and an Engagement lead for the same patient safety incident. This is to ensure that the family/carer and patient involved received impartial support.

Within each Division there are also 1-2 General Managers. Some of whom are clinical and some non-clinical. The General Managers are trained as Learning Response Leads. As specified above the investigations will be carried out within divisions other than their own.

STAH has identified 4 PSIRF oversight leads;

- 1x Head of Patient Safety
- 1x Executive Lead
- 1x Lead for Essex Site
- 1x Lead for Birmingham site

All STAH staff have been allocated via SAP to complete level 1 Patient Safety Syllabus training as recommended by NHS guidelines.

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 every 12 to 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 made in the previous 12 to 18 months.

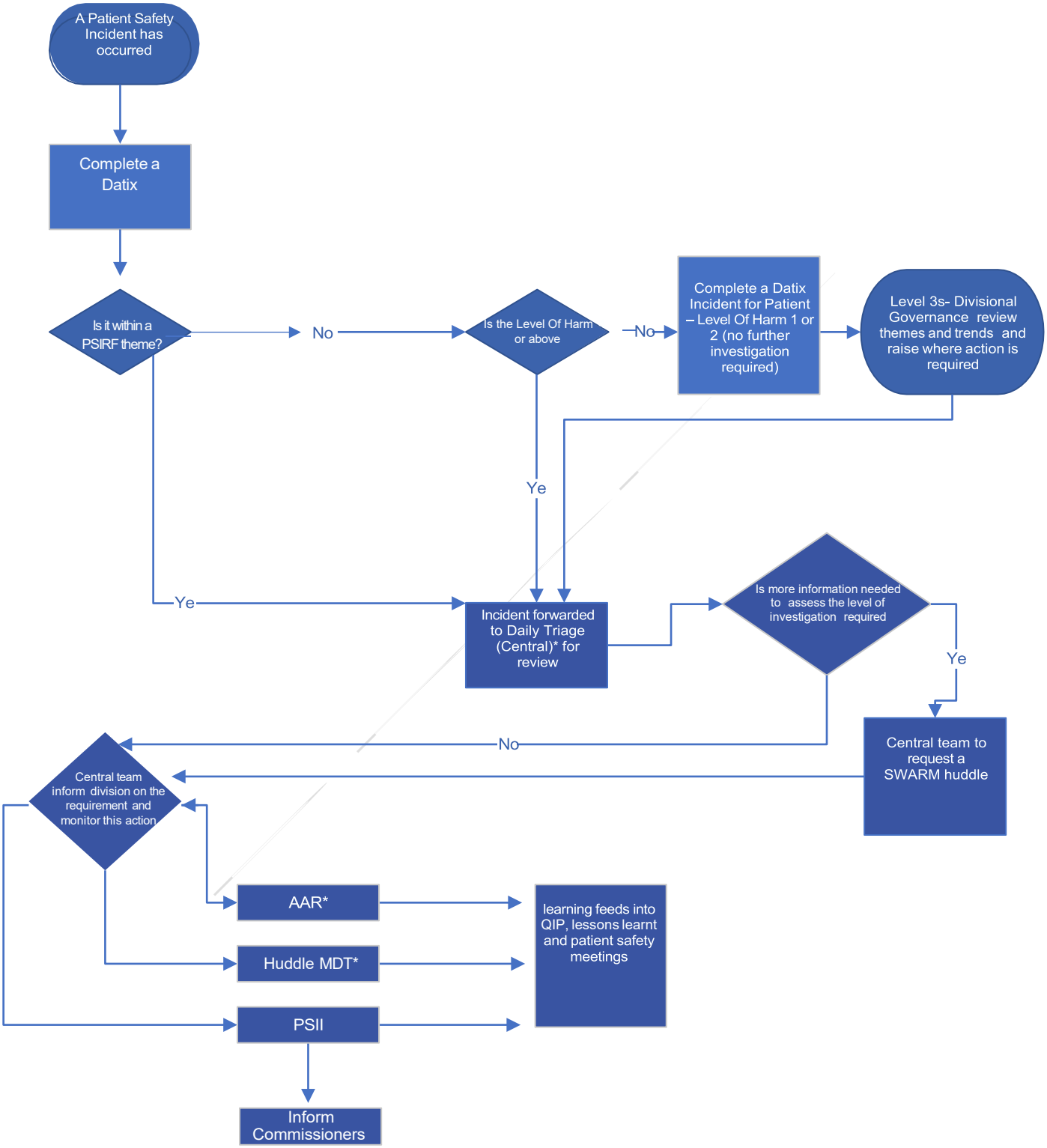
Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate, as agreed with our integrated care board (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.

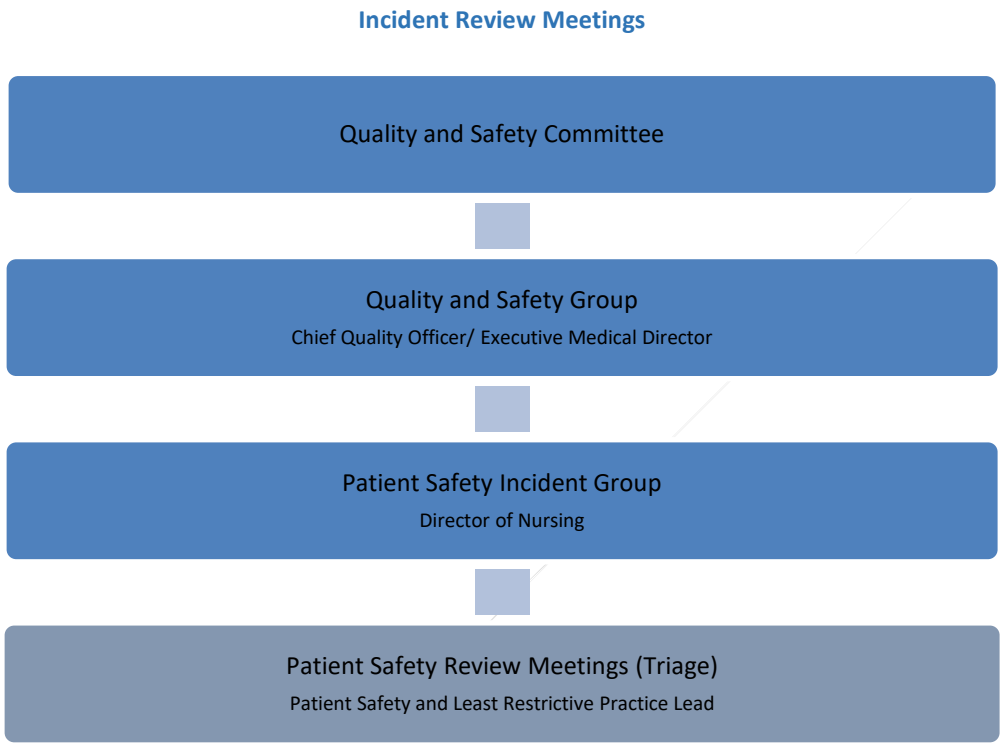
Governance Process - Datix

A triage process is in place via the central Patient Safety team to ensure standards.



Governance Structure

A structure of meetings have been put in place to ensure standards and learning is maintained.



Information and themes from the Patient Safety Incident Group will feed into the charity wide Lessons Learnt group.

Meetings will take place with external stakeholders in order to provide assurance in regards to the implementation of PSIRF and the learning taken from PSIRF responses.

Patient safety incident response decision-making

Patient Safety Incidents that require PSII:

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local safety actions Circulated Charity wide Feed into Charity and divisional improvement plans
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Create local organisational actions and feed these into the quality improvement strategy Mortality Reviews
Child deaths	PSII	Create local organisational actions and feed these into the quality improvement strategy Mortality Review
Death of persons with learning disabilities or autism	PSII	Create local organisational actions and feed these into the quality improvement strategy Mortality Review
Domestic Homicide	PSII	Create local organisational actions and feed these into the quality improvement strategy Mortality Review

Patient Safety Incidents Requiring PSII agreed for STAH

Criteria for selection:

- actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
- likelihood of recurrence (including scale, scope and spread)
- potential for learning in terms of:
  – enhanced knowledge and understanding
  – improved efficiency and effectiveness
  – opportunity for influence on wider systems improvement.

Locally-defined emergent or unexpected patient safety incidents which signify an extreme level of risk for patients / service users, families and carers, staff or organisations, and where

the potential for new learning and improvement is great will also warrant the use of resources to mount a comprehensive PSII response.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Harm to patients whilst being supported through ES	To be agreed by subject experts as to one of the following: PSII, After Action Review MDT review	Create local safety actions Circulated Charity wide Feed into Charity and divisional improvement plans Initiate CQI
Falls ,resulting in hospital admission with a break or serious injury	To be agreed by subject experts as to one of the following: PSII, After Action Review, MDT review	Create local safety actions Circulated Charity wide Feed into Charity and divisional improvement plans Initiate CQI
Physical health - Deteriorating patients inadequately monitored/lack of escalation	To be agreed by subject experts as to one of the following: PSII, After Action Review, MDT review	Create local safety actions Circulated Charity wide Feed into Charity and divisional improvement plans Initiate CQI
Security incidents including; Searches (risk items resulting in harm, including illicit substances, absconding)	To be agreed by subject experts as to one of the following: PSII, After Action Review, MDT review	Create local safety actions Circulated Charity wide Feed into Charity and divisional improvement plans Initiate CQI

Safety action development and monitoring improvement

Findings from PSIIs and PSRs provide key insights and learning opportunities, but they are not the end of the story.

Findings will be translated into effective improvement design and implementation.

Quality Improvement Collaborative and specialist working groups will oversee collation and execution of Quality Improvement Plans.

If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, these actions will be made as soon as possible.

To aggregate learning, findings from each individual response linked to a specific risk will be collated to identify common contributory factors and any Improvement Plans will be shared with those involved in the incident including patients, families, carers and staff.

Patient Safety Actions will directly become part of the Divisions, or Charity wide Quality Improvement Plans. Learning from incidents and cross Charity learning is embedded within the Charity Lessons Learnt Group in which learning is discussed on a Monthly basis. Urgent learning will be embedded within the Charities Learning Responses (as specified below), which are sent across all divisions and discussed in divisions Governance meetings.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms. St Andrew's Healthcare will action improvement plans in the form of;

- Charity wide Quality Improvement Plan summarising improvement work
- Divisional Quality Improvement Plans that focus on a specific service, pathway or location
- Collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- Actions feed into CQI programmes across the divisions

In addition to the Quality Improvement Plans there are notices for learning which are distributed via the Lessons Learnt group which takes place on a monthly basis. These include;

- Patient Safety action notice
- Learning lessons notices

Oversight roles and responsibilities

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan.

Lead roles

Oversight Leads

Three PSIRF Oversight Leads have been established and trained. There is one Oversight lead within each demographic location (Essex, Birmingham, Northampton). In addition, there is one Executive Oversight Lead per site.

The oversight leads are responsible for;

- Ensuring Improvement is the focus PSIRF

- Ensure that Learning from patient safety incidents is a proactive step towards improvement, responding to a patient safety incident for learning is an active strategy towards continuous improvement

Engagemant Leads

Engagement leads have been trained in each division and centrally to allow to a large enough privision of Engagement leads to work across services and provide inpatrial support.

Our engagement leads will;

Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.

Listen and hear the distress of others in a measured and supportive way.

Maintain clear records of information gathered and contact with those affected.

Identify key risks and issues that may affect the involvement of patients, families, and staff.

Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Learning Response Leads

Learning Response Leads have been trained in each division and centrally to allow to a large enough privision of Learning Response leads to work across services and provide inpatrial support.

Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Learning response leads should have an appropriate level of seniority and influence within an organisation – this may depend on the nature and complexity of the incident and response required, but it is recommended that learning responses are led by staff at Band 8a and above. This role will sit across a number of disciplines at senior levels to allow for the investigations to be carried out by subject matter experts where possible.

Learning responses are not undertaken by staff working in isolation. The Learning Response Leads form part of the central Safety Incident team and also there are trained members across divisions.

Patient Safety Incident Response Standards

There are links and alignment between patient safety and quality improvement systems and processes, and related clinical governance systems and processes, including complaints.

Insight is shared between patient safety and quality improvement teams, and teams benefit from collective expertise.

Information governance agreements allow information sharing within and between relevant bodies to support effective communication during both incident response and improvement endeavours.

Oversight must be provided using quantitative and qualitative methods

Quantitative: The safety Dashboard and Datix themes

Qualitative: Staff, patient and family friends feedback. Via surveys, complaints.

Quality assure learning response outputs

Sign-off of provider-led PSIIs is the responsibility of the board/leadership team of the organisation(s) involved. The PSIRF executive lead should be responsible for reviewing PSII reports in line with the patient safety incident response standards and signing it off as finalised. They may be supported in this by relevant colleagues as appropriate.

Local reporting of patient safety incidents

All staff (including bank, agency, locum and volunteers) has the responsibility to report all incidents and near misses via Datix (electronic management system).

A record of the incident or near miss should be contemporaneously and objectively reported in the patient's clinical records.

All incidents reported as causing moderate, severe, catastrophic harm will be discussed At Daily Triage to determine if further information is required and advise on type of investigation required.

Incidents requiring consideration as a potential patient safety incident investigation (PSII) will be reviewed and discussed at the weekly Patient Safety Meeting.

National reporting of patient safety incidents (PSIs)

The Charity undertakes its external reporting and notification requirements in line with national guidance (NHSE, 2020).

Patient Safety Incident reporting arrangements

In line with the PSIRF, reporting incidents previously defined as 'serious incidents' to the national 'STEIS' database will cease. Reporting PSIs and PSIIs to the new 'learning from patent safety events' system will follow when this replaces the NRLS and further guidance is issued.

Statutory Care Quality Commission notification requirements will be met by reporting incidents to the national reporting and learning system (NRLS) and its successor system.

One notable exception is the death of a patient detained under the Mental Health Act which, in line with national guidance, will be reported directly to the CQC.

Appendices	
Appendix 1	National priorities
Appendix 2	Responses
Appendix 3	Patient Safety Incident Investigation (PSII) report
Appendix 4	AAR Template
Appendix 5	MDT Review Meeting template
Appendix 6	Swarm template
Appendix 7	Patient safety incident reporting arrangements - Timescales for PSIIs

Appendix 1 National priorities

National priorities are set by the PSIRF and other national initiatives for the period 2020 to 2021. These priorities require a PSII to be conducted by the organisation.

There are three categories of national priorities requiring local PSII: incidents that meet the criteria set in the Never Events list (2018); incidents that meet Learning from Death criteria; and Death or long-term severe injury of a person in state care or detained under the Mental Health Act. Further detail is provided below.

Incidents that meet the criteria set in the Never Events list 2018

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. Incidents that meet the 'Learning from Deaths' criteria;

Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Examples include:

- deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
- deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS.

In these circumstances a PSII must be conducted in addition to the LeDeR review

- deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Appendix 2 Responses

SWARM Huddle

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
"A novel rapid approach to RCAs [root cause analysis]… to establish a consistent approach to investigate adverse or other undesirable event" (Jing Li et al 2015)	After any event where patient safety was at risk	No more than 30 minutes	Normally chaired by a senior lead who generates a report	There is some research literature on its use in healthcare	People directly involved in the incident

STRENGTHS?

- Immediate learning occurs with early actions identified.
- Connecting immediately after event may reduce social isolation/ ruminating/stress for staff.
- Evidence shows it can increase the reporting of incident.
- Quick and responsive.
- Quick and easy to undertake so increases likelihood of being done.
- Reduces key information being lost by its immediacy.

WEAKNESSES?

- Scope of learning narrowed by limits on who is participating.
- Learning is focused on a single event rather than the interactions in the system that come with wider participation.
- Psychological safety is assumed to be present so full participation may not be achieved.
- It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses.
- Weak governance arrangements for tracking actions and collating learning through many SWARMs.

MDT Review

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done	After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability	No defined time allocated. Likely to include a workshop lasting 2 to 3 hours	Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme	No specific research on the structures, processes and outcome of MDT reviews has been carried out	Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians

STRENGTHS?

- The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered.
- Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.

WEAKNESSES?

- Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence.
- Whilst participants will contribute and learn, it is not the specific purpose of the activity.
- It is a planned event and it may take many weeks to set up and ensure full MDT representation is available.
- Resource intensive to undertake.

After Action Review (AAR)

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
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. AAR generates insight from the various perspectives of the MDT	After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected	Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating	Led by a trained AAR Conductor - this could be anyone from within the MDT, local or remote to the participants	Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety	Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included

STRENGTHS?

- The individuals learn for themselves what was happening and identify similarities and differences between themselves and others.
- Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement.
- It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety.
- It is highly adaptable, suitable for a wide range of events.
- Psychological safety is actively created and maintained throughout.
- Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.

WEAKNESSES?

- Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority.
- There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR.
- Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.

Patient Safety Incident Investigation (PSII)

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how	When there has been serious harm to a patient or patients	20 to 80 hours, over several weeks	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report	Extensive research has been undertaken into the structures processes and outcomes of PSII across the world	People directly involved in the incident and senior clinicians

STRENGTHS?

- It is a well-established approach which is widely recognised and valued by patients and their families.
- PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified.
- Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements in each provider.

WEAKNESSES?

- Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed.
- Outcomes are less system focused than other tools.
- The quality of PSIIs varied before PSIRF mandated training for investigators.
- Staff are only involved when they are interviewed and this can feel very stressful.

Appendix 3 Patient Safety Incident Investigation (PSII) report

On completion of your final report, please ensure you have deleted all the blue information boxes and green text.

Notes on the PSII template

This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips

A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

Distribution list

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

List who will receive the final draft and the final report (eg patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position

A note of acknowledgement

Notes on writing a note of acknowledgement

In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.

You could consider referring to the patient by name or as 'the patient' according to their wishes.

Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

Executive summary

Notes on writing the executive summary

To be completed **after the main report has been written.**

Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

Contents

To update this contents table, click on the body of the table; select 'update field'; and then 'update page numbers only'; and then click 'ok'.

Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – eg by day or by contact with different services on the care pathway.

It should be written in neutral language, eg 'XX asked YY' not 'YY did not listen to XX'. Avoid language such as 'failure', 'delay' and 'lapse' that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to '[NAME]'s story/experience'.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

Terms of reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

Summary of findings, areas for improvement and safety actions

Notes on writing the final summary

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (eg refer to other ongoing improvement work, development of a safety improvement plan)

Area for improvement: [eg *review of test results*]								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.								
2.								
…								

Area for Improvement: [eg *nurse-to-nurse handover*]								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.								
…								

Appendix 4 PSIRF Response - After Action Review

After action reviews should include as many people as possible who were involved in the activity or event so that a wide range of viewpoints can be explored.
A prerequisite of an AAR is that everyone feels able to contribute without fear of blame or retribution - AARs are about learning, not holding people to account

Incident date/time:		**Datix/Ref No:**		**Patient Initials/Rio No:**	

Facilitator Name:		**Job Title:**	

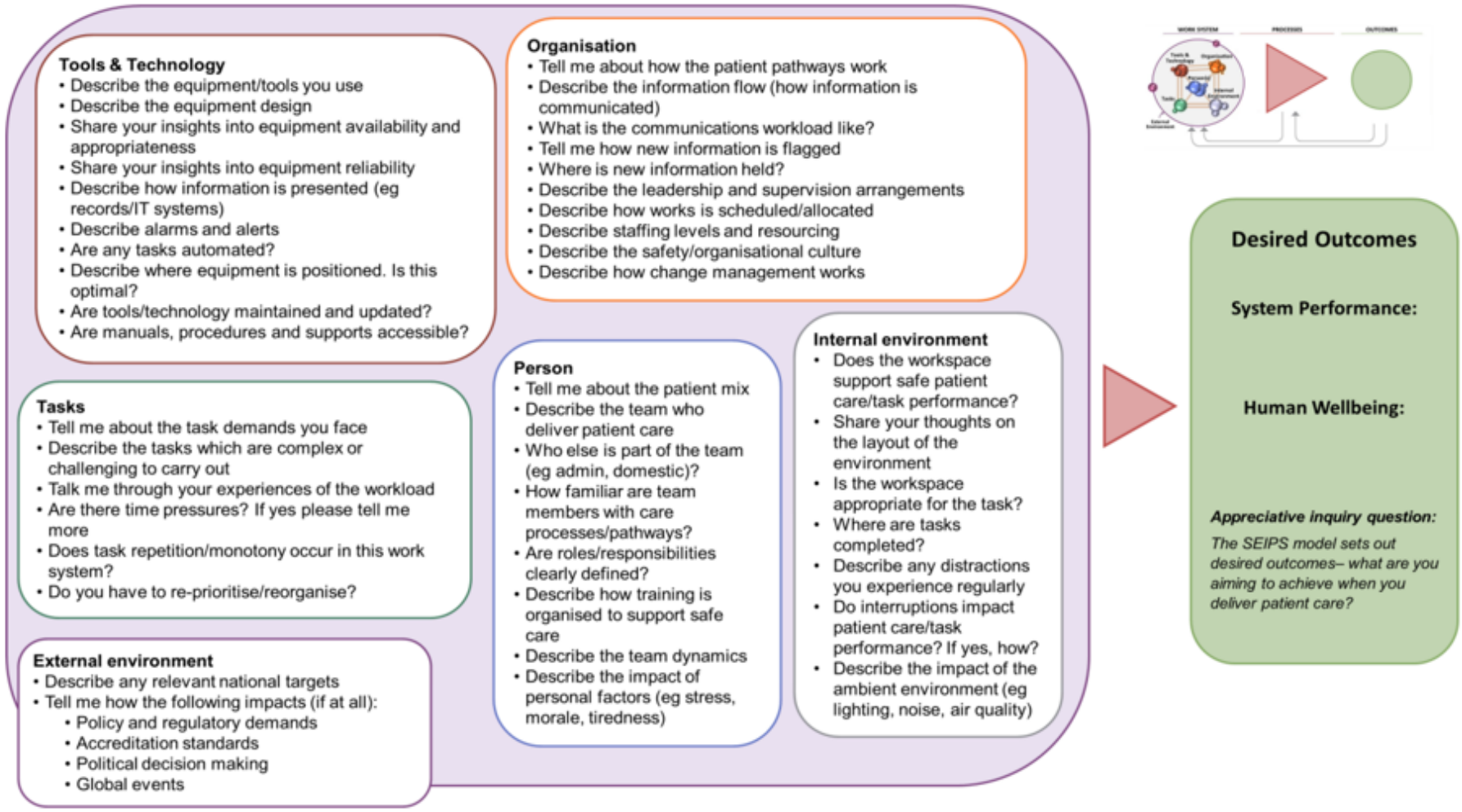
Attendees:-

Name:	**Job Title:**	**Name:**	**Job Title:**
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

Duty of Candour/ Compassionate engagement of people affected (describe what has been put in place to support, engage and meet the needs of patients, families and staff affected e.g. Has Patient and Carer involvement been considered/ Have we considered if actions should be shared?)	
What did we set out to do? (*What should have happened? What was the expected outcome?)*:	**What actually happened?**
Analysis *(What was the difference between what we expected to happen and what actually happened?)*:	**System learning** *(Why was there a difference? Focus on the design of the work system, not the actions of individuals)*
Good practice identified throughout the review *(What went well? Why?)*	

Action Plan (must be logged on QIP) - *Safety actions to be carried forward*					
Are there any other services or Division where this learning needs to be shared?					
How you are going to share the learning more widely and who will take responsibility for this?					
Agreed SMART Action	**Priority Rating (High/Med/Low)**	**Lead/Owner**	**Due Date**	**Evidence of Completion**	**Date Closed**

SEIPS Explorer Prompts:



Appendix 5 PSIRF Response – Multidisciplinary Team Review (MDT)

Preparing for an MDT review under patient safety incident response framework (PSIRF)

Identify	Identify the stakeholders whose insights on 'work as done' need to be explored.
Do	Do some preparatory work to scope out the review to understand the context.
Invite	Invite stakeholders to an MDT review workshop. Your invitation should clearly describe the purpose of the workshop.
Be	Be clear in the invitation that the outputs of the MDT review will be recorded and explain how you plan to capture the discussion.
Create	Create a 'safe space' at the outset by co-creating clear ground rules ensuring all participants feel able to contribute and share any concerns.
Be	Be clear how outputs will be used.

PURPOSE

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 staff recollections of events either because of the passage of time or staff availability.

1. Identify learning from multiple patient safety incidents (including incidents were multiple patients were harmed or where there are similar types of incidents)

2. Agree, through open discussion, (and other approaches such as observations and walk-throughs undertaken in advance of the review meeting(s)), the key contributory factors and system gaps that impact on safe patient care

3. To gain insight into 'work as done' in a health and social care system.

4. To explore a safety theme, pathway, or process. There will be many, but examples are:
    - delayed recognition of deteriorating patients' physical health
    - Patients self-harming on enhanced support
    - safety issues relating to unescorted leave

Present (staff present at the incident/s, must inc. RC, WM case specific person):

Facilitator Name:		**Job Title:**	
Attendees			
Name	**Job title**	**Name**	**Job Title**
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

Incident date/time:		**Datix/Ref Number:**		**Pt Initials/Rio No:**	

Duty of Candour/Compassionate engagement of people affected (describe what has been put in place to support, engage and meet the needs of patients, families and staff affected e.g. Has Patient and Carer involvement been considered/ Have we considered if actions should be shared?)

1. Details of incident/s - Please provide a brief summary of incident/s: Include details of the following where relevant: dates when incident started/ended; description, number and nature of relevant incidents; care areas/locations affected; enhanced surveillance of interventions, any hypotheses and themes e.g. time of day; location; staff;
2. Work as done - How care is delivered in the **real world**, not how it is envisaged in policies and procedures (work as prescribed) or recounted in a walk through or a talk through (work as described).
3. Identify systems gaps and areas of improvement - use the SEIPS work system diagram below to collate information then insert
• **Tools and Technology** Gaps: Improvement:

- **Organisation**

  Gaps:

  Improvement:

- **Tasks**

  Gaps:

  Improvement:

- **Person**

  Gaps:

  Improvement:

- **Internal Environment**

  Gaps:

Improvements:

- **External Environment**

  Gaps:

  Improvement:

4. Please provide details of any learning points or recommendations:

5.Action Plan - ***Safety actions to be carried forward*** **- (must be logged on QIP)**	
Are there any other services or Division where this learning needs to be shared?	

How you are going to share the learning more widely and who will take responsibility for this?					
Agreed SMART Action	***Priority Rating (High/Med/Low)***	***Lead/Owner***	***Due Date***	***Evidence of Completion***	***Date Closed***

Compassionate engagement of people affected (describe what has been put in place to support, engage and meet the needs of patients, families and staff affected e.g. Has Patient and Carer involvement been considered/ Have we considered if actions should be shared?)

6. MDT lead details	
Name:	Email:
Job Title:	Address:
Contact number:	Contact number (mobile):

Appendix 6 PSIRF Response - SWARM Huddle

Incident date/time:		**Datix/Ref No:**		**Pt Initials/Rio No:**	
Incident Description:					
Duty Of Candour status:					
Swarm facilitator name:			**Facilitator role:**		
Attendees: (Name and Designation)					

Specific issue to be addressed by the Swarm:	

What is it: A meeting to explore an incident in a non-punitive way and deliver learning, it is a facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.

Safe space, invitees only (those involved in incident, agreed by the Division/Patient Safety team).

When to use it: SWARMs can be used soon after any activity or event (within a working week ideally) where care has not gone as planned - this can prevent key information being lost. SWARMs can reduce blame and rumours about an incident by focussing on learning and improvement and an understanding of 'work as done'.

Introduction and Create a safe and 'brave space'
Facilitator to introduce all participants and their role in the Swarm
Explore exactly what happened and why

Replay the events that led to the SWARM	

Explore what happened and why (use the SIEPS prompts):
• **Tools and Technology** • **People** • **Tasks** • **Organisation** • **Environment / Internal and external**

Identify where else in the organisation the learning may be relevant	
Are there any other services or Division where this learning needs to be shared?	
How you are going to share the learning more widely and who will take responsibility for this?	
Safety actions to be carried forward	
Ward Action Log / Divisional QIP to be taken with designated lead	
Does this contribute learning or confirm actions in any overarching safety improvement plan	Please share this document with Patient Safety Team: PatientSafety@stah.org and Divisional Quality Matron.

Date reviewed at PSIRF Response Panel	
Actions/Next Steps agreed	

Appendix 7 Patient safety incident reporting arrangements

Timescales for PSIIs

Activity	Timescale	Detail
Incident reporting	As soon as possible following incident occurring	It is vital to ensure that incidents are reported promptly so that all relevant details can be entered and key facts are not lost
Triage	Within 24 hours of incident being reported (72 hours if following a weekend).	To ensure that the local procedure is followed in reporting and that actions have been identified/assigned to relevant investigator
Incidents for local level validation at ward huddles	To be reviewed within 24 hours of incident being reported	To ensure that immediate safety actions can be taken to mitigate risk to patients and staff
Information gathering for potential PSII PSR	Within 5 working days following incident being reported	To ensure that an initial review is undertaken by the SMT and that immediate actions have been taken to minimise risk to patient safety
Actions agreed to be completed following PSR	All evidence for each action within 60 working days of completion and approval of report	To ensure that all actions have been undertaken to provide assurance to patients and external parties that areas have improved practice and quality of care to maintain patient safety
Patient Safety Incident Investigation (PSII)	Complete investigation and provide approved report within 3 months and no longer than 6 months	Nationally agreed in alignment with PSIRF, timescales to be agreed. Safety recommendations will inform new or ongoing Quality improvement and will be monitored through Governance routes.

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified.

Patient safety learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.

No PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity