Patient Safety Incident Response Policy

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Version control

Issue No.	Date of review	Job title of person making amendment	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated appendices, minor amendments – detail section number etc)
V1		Head of Nursing & AHPs, Quality and Governance	New policy launch – this document supersedes the Management, Learning and Reporting of Serious Incidents in Health & Social Care Policy (POL HC ML1) for services in England.

Sue Ryder

Because no one should face death or grief alone

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Regulations and standards

Health and Social Care Act 2012 https://www.cqc.org.uk/guidance-regulation/providers/regulations	Regulation 12: Safe care and treatment.	Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.
	Regulation 17: Good governance	To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes. This must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.
	Regulation 20: Duty of candour	The duty of candour requires registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also define 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.
NHSE (National Health Service England)	The NHS Patient Safety Strategy	The NHS Patient Safety Strategy set out how the NHS will support staff and providers to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety.

Organisational objectives and Sue Ryder values

Organisational objectives:		Sue Ryder values:		
Better grief support for everyone		Supportive	Equality, diversity and inclusion	
			Our people	☑
Helping people who are dying live well	☑	Connected	Working collaboratively	☑
			Our supporters and volunteers	
Speaking up for people who are dying or grieving	☑	Impactful	Putting people who are grieving or living with a life-limiting condition at the heart of our work	☑

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			A sustainable organisation	

Equality statement

Sue Ryder aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been screened and relevant changes made to the policy to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Related Sue Ryder written control documents

This written control document is related to the following written controls within Sue Ryder.

Written control document	Date accessed
Accidents and Incidents	August 2023
Adult Support & Protection Policy	August 2023
Complaints Policy & Procedure	August 2023
Datix Reporting	August 2023
Datix Full User Guide	August 2023
Datix Guidance Managing a Complaint, Concern or Compliment (Healthcare)	August 2023
Datix Guidance to Reporting Pressure Ulcers	August 2023
Datix Guidance Managing an Incident (Organisation)	August 2023
Datix Guidance Reporting an Incident (Organisation)	August 2023
Incident and Near Miss Reporting Policy	August 2023
Preparing A Statement Procedure	August 2023
Safeguarding Adults at Risk Policy and Procedure	August 2023

1. Introduction

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1.1 Sue Ryder is committed to providing safe and effective care. We recognise that errors occur, and that key learnings need to be identified and shared with the whole organisation.

1.2 The Patient Safety Incident Response Framework (PSIRF) 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.

1.3 The PSIRF replaces the Serious Incident Framework (SIF) (2015) in England and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

1.4 Incidents that occur in Sue Ryder are reported through Datix. Some incidents are classified as a Patient Safety Incident (PSI). Guidance on how to report an incident can be located within the Incident and Near Miss Reporting Policy.

1.5 A PSI can be defined as any unintended or unexpected incident (including omissions) which could have or did lead to harm.

1.6 A PSI may require a Patient Safety Incident Investigation (PSII) (Appendix 2, Proportionate Response; Appendix 4, PSIRF Investigation Process Diagram) which is a system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving and facilitation of national collection of findings for learning purposes.

1.7 Details on how incidents are classified can be found within each service specific Patient Safety Incident Response Plan (PRIRP). PSIRF is not an investigation framework that prescribes what to investigate (Appendix 2, Proportionate Response; Appendix 4, PSIRF Investigation Process Diagram). Instead, it advocates a coordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents, and embeds patient safety incident response within a wider system of improvement, prompting a significant cultural shift towards systematic patient safety management.

1.8 The PSIRF approach is flexible and adapts as Sue Ryder learns and improves, to support exploration of patient safety incidents relevant to their context and the populations Sue Ryder serves.

2. Terminology

2.1 A detailed and comprehensive glossary and additional resources are available in the appendices and on RyderNet (for Sue Ryder staff).

3. Purpose

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

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

3.2 This policy supports the requirements of the PSIRF and sets out the Sue Ryder approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

3.3 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.

3.4 This policy should be read in conjunction with our current Patient Safety Incident Response Plan (PSIRP), which is a separate document setting out how this policy will be implemented.

4. Scope

4.1 This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all our healthcare services in Sue Ryder.

4.1.1 This policy covers the following services within Sue Ryder:

i. Hospices.
ii. Community services.
iii. Bereavement services.

4.2 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 'human error' or the actions or inactions of people are stated as the cause of an incident.

4.3 The system approach recognises that all adverse events have multiple contributing factors, many of which are outside an individual's control. Once system contributions are identified, steps can be taken to change the latent hazard or contributing factors and avoid repeats of the same event.

4.4 This policy relates to responses to patient safety incidents that are solely for the purpose of learning and improvement.

4.5 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.

4.6 Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope of this policy.

i. Claims handling.
ii. Workforce related investigations into employment concerns (such as competence and performance issues).
iii. Professional standards investigations.
iv. Information governance concerns.
v. Financial investigations and audits.
vi. Safeguarding concerns.
vii. Coronial inquests and criminal investigations.

4.7 For clarity, Sue Ryder considers these processes as separate from any patient safety investigation or response. Information from patient safety response processes can be shared with those leading other types of processes, but these should not influence the remit of a patient safety incident response.

4.8 Where an incident involving multiple providers and/or services across a care pathway too complex for Sue Ryder to manage, the ICB or commissioning body will be contacted to support the co-ordination of a cross-system response.

4.8.1 Sue Ryder will work with relevant external providers to establish and undertake cross-system learning responses.

5. Our patient safety culture

5.1 Sue Ryder is committed to improving patient safety through the adoption of the PSIRF, supporting a systematic, compassionate and proficient response to patient safety incidents; embedded in the principles of 'just culture' (openness, honesty and fair accountability) shared learning and continuous improvement.

5.2 A fair and 'just culture' approach to incident reporting and responding is encouraged at Sue Ryder. This ensures an approach to errors that will contribute to a learning environment.

5.2.1 "A 'just culture' considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. Generally, in a just culture, inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to a sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts' (Gov.uk, 2018). (Williams Report 2018).

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5.3 In line with Duty of Candour/Being Open, patients, residents and/or their families must be informed of the incident and guided through the Sue Ryder complaints and concerns process in the event that they want to raise any concerns. (Please see Duty of Candour (England) Procedure (PC HC D1) and the Complaints Policy & Procedure (PC HC C2).

5.4 It is a priority of Sue Ryder to deliver care in a safe environment to protect patients, residents, visitors, staff and the organisation from harm.

5.5 In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising the things that go right and minimising the things that go wrong. While patient safety incidents are rare, Sue Ryder prioritises compassionate engagement with patients, family and staff affected by them. This provides vital insight into how to improve care, ultimately making services safer for our patients and residents.

5.6 Sue Ryder Executive and Senior Leadership have strongly embraced this work with support from staff side colleagues who have been instrumental in establishing the organisational transition to a restorative just culture. In the wake of an incident, restorative practices ask who are impacted, what their needs are and whose obligation it is to meet those needs.

5.7 Restorative practice aims to involve participants from the entire community in the resolution and repair of harms to create a sustainable just, restorative culture. We ensure that our conduct and our dealings with colleagues is honest, kind and emphasise that we are willing to learn. We have developed a culture where we support patients/residents, family members, advocates and staff involved in an incident and encourage openness and honesty.

5.8 The main goals of restoration when an incident has occurred have been outlined as follows:

i. Moral engagement.
ii. Emotional healing.
iii. Reintegration of the practitioner.
iv. Organisational learning.
v. Prevention.

5.9 PSIRF will enhance the links we have embedded between patient safety incidents and continuous learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients/residents, families and advocates – to arrive at learning and improvement within the just culture. This will continue to ensure transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well as well as where things have not gone as planned.

5.10 We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvement to reduce risk.

5.11 To enhance our safety culture, we have a strong system of shared learning throughout the organisation. Learning is shared from all types of incidents regardless of severity, including learning from complaints, feedback and safeguarding investigations.

6. Patient Safety Partners

6.1 The Patient Safety Partner (PSP) is a new evolving role developed by NHS England to help improve patient safety across the NHS, which Sue Ryder will implement accordingly.

7. Addressing health inequalities

7.1 Sue Ryder recognises that health services have a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the population in an inclusive way.

7.2 Sue Ryder as an independent charitable organisation is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

7.3 Within our patient safety response toolkit, we will directly address if there are any particular features of an incident that indicate health inequalities may have contributed to harm, or demonstrate a risk to a persons' human rights or a particular population group, including all protected characteristics.

7.4 When constructing our safety actions in response to any incident, we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

7.5 We will also address apparent health inequalities as part of our safety improvement work. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development processes for future versions of our PSIRP and this policy. We consider this as an integral part of the future development process.

7.6 Engagement of patients, residents, families and staff following a patient safety incident is critical to the review of patient safety incidents and their response.

7.7 We will ensure that we use available tools such as easy read, talking mats, translation and interpretation services (and other methods as appropriate) to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident responses.

7.8 Sue Ryder's commitment to transforming organisation culture to that of restorative justice has been outlined. Further to this, Sue Ryder has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/residents, families and advocates.

7.9 With explicit role modelling led by the Board of Directors and Executive Management Team, we will use these principles to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

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

8.1 The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place.

8.2 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.

8.3 We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected for our patients/residents, their families or advocates to prevent recurrence and promote learning.

8.4 We recognise and acknowledge the significant impact patient safety incidents can have on patients/residents, their families or advocates. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made. As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients/residents, their families or advocates because it is the right thing to do. This is regardless of the level of harm caused by and incident. Thus, at Sue Ryder it has become the norm for patients/residents, their families or advocates to be informed when an incident affecting their care has occurred and to discuss with them the findings of investigation.

8.4.1 This aligns with our mission of leading the delivery of excellent palliative, end-of-life and bereavement care, working in partnership with the patient/resident, their family and all others involved in their support.

8.5 As part of our new policy framework, we will be outlining procedures that support patients, families and carers – based on our existing Duty of Candour (England) Procedure (PC HC D1).

8.6 In addition, at Sue Ryder we have an Experience and Engagement Lead as part of the Quality & Governance Team who provides support for patients/residents, their families or advocates in raising concerns and providing feedback in relation to care and service. Anyone with a concern, comment, complaint or compliment about care or any aspect of Sue Ryders services are encouraged to speak up.

8.7 We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients/residents, their families or advocates to signpost their preferred source for this:

8.7.1 Healthwatch: Healthwatch is an independent statutory body who can provide information to help make a complaint, including sample letters. (www.healthwatch.co.uk)

8.7.2 Parliamentary and Health Service Ombudsman (PHSO): The PHSO makes the final decisions on complaints patients / residents, their families or advocates deem not to have been resolved fairly by the NHS in England, government departments and other public organisations. For patients and residents whose care is NHS funded, stage 3 complaints are handled by the PHSO. In the first instance mediation is preferred, but if resolution via mediation is not reached, they will consider completing a full investigation. (www.ombudsman.org.uk)

8.7.3 Citizens Advice Bureau (CAB) provides UK citizens with information about healthcare rights, including how to make a complaint about care received. (www.citizensadvice.org.uk)

9. Patient safety incident response planning

9.1 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.

9.2 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.

9.3 Sue Ryder will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement.

9.4 To fulfil this, we will undertake planning of our current resource for patient safety responses and our existing safety improvement workstreams.

9.5 We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

9.6 Our patient safety incident response plan will detail how this has been achieved as well as how Sue Ryder will meet both national and local docus for patient safety incident responses.

9.7 The PSIRP 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 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 24 months.

9.8 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 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.

9.9 Sue Ryder has arrangements in place to allow us to meet the requirements for review of patient safety incidents under PSIRF.

9.10 Some incidents will require mandatory PSII, others will require review by or referral to another body or team depending on the event. (Appendix 2 Proportionate Response to Patient Safety Incidents).

9.10.1 These are set out in our PSIRP.

9.11 PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Sue Ryder has adapted its governance structure under the now obsolete (in England) Serious Incident Framework to support PSIRF. (Appendix 3, PSIRF Governance Structure).

10. Resources to support patient safety incident response

10.1 Sue Ryder has committed to ensuring that we fully embed PSIRF and meet its requirements.

10.2 We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required.

10.3 Sue Ryder will have governance arrangements in place to ensure that learning responses are not led by staff who were involved in the patient safety incident itself (Appendix 3, PSIRF Governance Structure).

10.4 Responsibility for designating leadership of any learning response sits within the Quality & Governance Team in liaising with senior leaders across the organisation.

10.5 A learning response lead will be nominated for each incident, and the individual should have an appropriate level of experience and training to respond to an incident. This may also depend on the nature and complexity of the incident and response required, but learning responses are led by staff at the Sue Ryder equivalent of Band 6 and above.

10.5.1 Although national guidance states that learning response leads should be an NHS Band 8a or above, Sue Ryder is a small organisation with limited resources, and so it is accepted practice that NHS Band 6 and 7 equivalent staff will be trained to complete local incident responses.

10.6 Sue Ryder has governance arrangements in place to ensure that where possible learning responses for more complex cases are not undertaken by staff working in isolation.

10.7 The Quality & Governance Team will support learning responses wherever possible and can provide advice on cross-system and cross divisional working where this is required.

10.8 Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given opportunity to participate in learning responses.

10.9 All Sue Ryder managers will work within our just and restorative culture principles and utilise other services such as Health and Wellbeing to ensure that there is a dedicated staff resource to support them.

10.10 Sue Ryder has processes in place to ensure that managers work within this framework to ensure psychological safety.

10.11 Sue Ryder will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process.

11. Training to support patient safety incident response

11.1 Sue Ryder has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

11.1.1 Induction training: This comprises local training at induction for all new staff, setting out Sue Ryder's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour and PSIRF.

11.1.2 Level 1 Essentials for Patient Safety: This is an e-learning module that all staff are required to complete.

11.1.3 Level 2 Access to Practice: This is an e-learning module that managers and staff at NHS Band 6 equivalent or above, with potential to support or lead patient safety incident management are required to complete.

11.2 They will be trained to:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a range of resources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Review conflicting information from different internal and external sources.

12. Responding to cross-system incidents or issues

12.1 The Quality & Governance Team will forward those incidents as presenting potential for significant learning and improvement for another provider directly to that organisation.

12.2 Sue Ryder will work with system partner providers and ICB's to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents, appointing a liaison for this process.

12.3 Learning from cross-system incidents and issues will be cascaded internally by the following methods:

- Patient Safety Steering Group.
- Learning for Safety Memos.

- Clinical Effectiveness and Engagement Group.
- PSIRF Learning Group.
- Joint Professional Forum.

13. Responding to patient safety incidents

13.1 All staff are responsible for reporting any potential or actual patient safety incident on the Sue Ryder incident reporting system (Datix) and will record the level of harm they assess has been experienced by the person affected (please see the Incident and Near Miss Reporting Policy (POL HC C3)).

13.2 Incidents which appear to meet the requirements for reporting externally must be escalated to the Quality & Governance Team. This may be to allow Sue Ryder to work in a transparent and collaborative way with our ICB and/or regional NHS teams, CQC, and the Charity Commission if an incident meets the national criteria for PSII, supportive co-ordination of a cross-system learning response is required.

13.3 Where external bodies and system partner providers are contacted, a single point of contact will be identified to ensure effective communication processes are followed.

13.4 Incidents escalated to or by the Quality & Governance Team will be reviewed at the Weekly Incident Review Group. Incidents that may require escalation to this meeting are:

- Any incident with an outcome of more than minor harm to the patient.
- Any safety incident that has required the individual to be escalated to acute hospital.
- Any safety incident that potentially there will be staff disciplinary action.
- Any safety incident that the police are asked to respond to / a 999 call made.
- Any safeguarding incident.
- Any incident that comprises the safety of the unit.
- PSI incidents as identified in the PSIRP.
- PSII incidents as outlined in the PSIRP.

13.5 The Weekly Incident Review Group may commission thematic/index reviews of incidents to consider and understand potential emerging risks.

13.6 All Sue Ryder services must take immediate actions to ensure the safety of patients, public and staff and mitigate the concern until further review is possible.

13.6.1 Where further review is required, Rapid Review should be carried out following an incident to inform decision making and onward escalation needs.

13.7 Incidents falling under the following categories are supported by a specific Rapid Review template:

i. Falls (Appendix 5).
ii. Medicines (Appendix 6).
iii. Pressure ulcers (Appendix 7).

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14. Timescales for learning responses

14.1 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date.

14.2 No local PSII should take longer than six months.

14.3 The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are will and able to be involved in that decision.

14.4 There must be a balance 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 patient safety or require further checks to ensure they remain relevant.

14.5 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between Sue Ryder and those affected.

14.6 Quality improvement projects may have longer term timescales applied, depending on their complexity and resources available.

15. Learning for Safety Memo development and monitoring improvement

15.1 Sue Ryder acknowledges that any form of patient safety learning response will allow for the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reduce risk, safety actions are needed which are presented in a Learning for Safety Memo (LfSM).

15.2 Sue Ryder has systems and processes in place to design, implement and monitor safety actions within LfSMs using an integrated approach to reduce risk and limit the potential for future harm.

15.3 This process follows on from the initial findings of any form of learning response that might result in the identification of further areas for improvement.

15.4 The Quality & Governance Team will generate and/or sponsor LfSMs in relation to each of these defined areas for improvement including measures to monitor any safety action and set out review steps.

15.5 Sue Ryder will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) (Safety Action Development Guide 2022) as follows:

i. Agree areas for improvement – specify where improvement is needed, without defining solutions.

ii. Define the context – this will allow agreement on the approach to be taken to safety action development.
iii. Define safety actions to address areas of improvement – focused on the system and in collaboration with teams involved.
iv. Prioritise safety actions to decide on testing for implementation.
v. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibilities any resultant metrics.
vi. Safety actions will be clearly written and follow SMART principles and have a designated owner.

15.6 LfSMs and safety actions will continue to be monitored within the PSIRF governance structure (Appendix 3, Governance Structure) to ensure that they remain effective and sustainable. Reporting on the progress of safety actions will be reported to the Board by the Executive Leadership Team (ELT).

16. Safety improvement plans

16.1 Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

16.2 Sue Ryder will use the outcomes from existing patient safety incident reviews (Serious Incidents (SI) or Root Cause Analysis (RCA) reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

16.3 The Quality & Governance Team has a centralised actions tracker in place to centrally manage quality improvement projects.

16.4 The Sue Ryder PSIRP outlines the local priorities for focus of investigation under PSIRF.

16.5 Where overarching systems issues are identified by learning responses outside of the local priorities, a safety improvement plan will be developed.

16.6 These will be identified through the PSIRF governance structure. (Appendix 3, PSIRF Governance Structure) and progress will be reported to the Board by the Executive Leadership Team (ELT).

17. Oversight roles and responsibilities

17.1 Principles of oversight

17.1.1 Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

- Improvement is the focus.
- Blame restricts insight.

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- Learning from patient safety incidents is a proactive step towards improvement.
- Collaboration is key.
- Psychological safety allows learning to occur.
- Curiosity is powerful.

17.2 **Responsibilities**

17.2.1 Alongside our NHS England and local NHS ICB structures and our regulators, the Care Quality Commission (CQC), we have specific organisation responsibilities with the Framework.

17.2.2 In order to meet these responsibilities, Sue Ryder has designated the Chief Nursing Officer to support PSIRF as the executive lead ensuring that the organisation meets the national patient safety standards through the following.

i. Overseeing the development, review and approval of Sue Ryder's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the just working culture that Sue Ryder aspires to.

ii. Achieving the development of the plan and policy supported by internal resources within the Quality & Governance Team.

iii. Defining the patient safety and safety improvement profile, Sue Ryder will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders overseen by the Chief Nursing Officer.

17.3 **Ensuring that PSIRF is central to overarching safety governance arrangements**

17.3.1 The Sue Ryder Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms.

17.3.2 The Head of Nursing & AHPs, Quality and Governance will provide assurance to the Chief Nursing Officer that PSIRF and related work streams have been implemented to the highest standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

17.3.3 Senior Management within the Sue Ryder services will have arrangements in place via the PSIRF governance structure (Appendix 3, PSIRF Governance Structure) to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

17.3.4 Sue Ryder will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate

to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

17.3.5 Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan will be actively monitored during the implementation of PSIRF with the ambition for review to be undertaken at least every three years to comply with Sue Ryder's guidance on written control development alongside a review of all safety actions.

17.4 Quality assuring learning response outputs

17.4.1 Sue Ryder PSIRF governance structure (Appendix 3, PSIRF Governance Structure) will ensure that PSIIs are conducted to the highest standards, support the executive approval process, ensure that learning is shared and safety improvement work is completed and monitored effectively.

18. Staff responsibilities

18.1 Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

18.2 Sue Ryder has a PSIRF governance structure in place that enables effective incident management oversight of learning and safety actions completion and monitoring of their effectiveness. (Appendix 3, PSRIF Governance Structure).

18.3 Alongside our NHS regional and local ICB structures and our regulators, the Care Quality Commission (CQC) and Charity Commission, we have specific organisational responsibilities within the framework.

18.4 The leadership and management functions of the PSIRF oversight are multifaceted as detailed below.

18.5 The Chief Executive Officer (or their delegated deputy)

18.5.1 Has ultimate responsibility for ensuring compliance with the Health and Social Care Act 2022 and all associated legislation and that this policy is effective.

18.5.2 Is the accountable officer in respect of Corporate Governance with overarching responsibility for patient and staff safety.

18.5.3 Has overall responsibility for ensuring Sue Ryder has processes that support an appropriate response to PSIs (including contribution to cross system/multi-agency reviews and/or PSIIs (where required).

18.5.4 Ensures that the organisation complies with internal and external reporting/notification requirements.

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18.5.5 Acts as spokesperson in complex/high profile cases where the media/public is engaged.

18.6 **The Chief Medical Director**

18.6.1 Ensures that all incidents that require consideration as a PSI are reported to and discussed with the Chief Nursing Officer immediately or as soon as practicably possible.

18.6.2 Ensures the incident is treated with openness and transparency ensuring the Duty of Candour is followed, that patients / residents and their close family / friends (where authorised by the patient / resident to know about their condition) are informed of the PSI which has occurred that the Duty of Candour process is followed as per policy.

18.7 **The Chief Nursing Officer (or their delegated authority)**

18.7.1 Sits within the Executive Leadership Team and has overall responsibility for the effective management of all patient safety incidents, including contribution to cross system / multi-agency review and / or investigations where required.

18.7.2 Models behaviours that support the development of patient safety reporting, learning and improvement systems.

18.7.3 Oversees the development of and review of the organisations' PSIRP.

18.7.4 Agrees sufficient resources to support the delivery of the PSIRP.

18.7.5 Ensures that Sue Ryder complies with the national patient safety investigation standards.

18.7.6 Oversees the professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety incident management.

18.7.7 Ensures that systems and processes are adequately resourced including funding, management time, equipment and training.

18.7.8 Supports collaboration as a meaningful approach to oversight.

18.7.9 Assumes a consultative and advisory role in the clinical aspects of all PSIRF incidents.

18.7.10 Will identify the lead investigator to manage this process where an incident is deemed to require a PSII.

18.8 **Chief Operating Officer**

18.8.1 Ensures that the safety of staff, visitors, volunteers and people who use our services is at the forefront of all decision making.

18.8.2 Promotes a culture where shared learning enables staff to reflect on practice.

18.8.3 Ensures that all staff are aware of, understand and comply with this policy and procedure.

18.8.4 Safeguards systems in place in line with this policy to ensure that all potential serious incidents are escalated to the Service Director with operational responsibility for the service.

18.8.5 Ensures that all incidents that require consideration as a serious incident are reported to and discussed with the Chief Nursing Officer and / or Chief Medical Director immediately or as soon as practicably possible.

18.8.6 Ensures the incident is treated with openness and transparency ensuring the Duty of Candour is followed, that people who use our services are informed of PSIs and, where they are required, that the Duty of Candour process is followed as per policy.

18.8.7 Where death has occurred the Chief Operating Officer ensures that personal representatives (e.g., key family members, named executors or other names personal representatives) are informed and supported. Please refer to the Duty of Candour policy to follow the agreed process.

18.9 Senior Leadership Team (SLT) **(Deputy Chief Nursing Officer, Head of Nursing & AHPs, Quality and Governance and Head of Nursing & AHPs, Workforce and Education)**

18.9.1 Must familiarise themselves with the PSIRP and each service specific risk profile to ensure awareness of what type of incident would be treated as a PSI and require a PSII.

18.9.2 Are required to report any incident confirmed as a PSI requiring PSII to the ELT and Chief Nursing Officer (or their designated deputy).

18.9.3 Where a concern is raised which has the possibility of impacting Sue Ryder's reputation the SLT should contact the Deputy Director of Marketing, Communication and Digital Services or the Head of Public Relations (PR).

18.10 **Head of Nursing & AHPs, Quality and Governance**

18.10.1 Deputises for the Chief Nursing Officer (or their designated deputy) where required in relation to PSIRF incidents.

18.10.2 Supports the work of the Clinical and Quality Team with incident management including the provision of advice and guidance.

18.10.3 Maintains oversight of the functions of the Quality & Governance Team, maintaining arrangements for clinical governance.

18.10.4 Provides assurance of the quality of clinical care and patient safety.

18.10.5 Is responsible for confirming an incident as a PSI.

18.10.6 Leads the Quality & Governance Team in the timely identification of potential PSIs.

18.11 **Quality & Governance Team**

18.11.1 Will support the implementation of PSIRF and act in an advisory capacity for patient safety incidents to all staff, especially Service Directors and Heads of Clinical Services.

18.11.2 Ensures that PSIIs are undertaken for all PSIs that require this level of response.

18.11.3 Provide dynamic senior patient safety leadership.

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18.11.4 Are dedicated to providing expert support within Sure Ryder and are expected to have direct access to the ELT, which facilitates the escalation of patient safety issues or concerns.

18.11.5 Play a key role in the development of a patient safety culture, safety systems and improvement activity.

18.11.6 Ensures that Sue Ryder has procedures that support the management of patient safety incidents in line with the organisations PSRIP (including convening review and investigation teams as required and appointing trained named contacts to support those affected).

18.11.7 Formulates procedures to monitor / review investigation progress and the delivery of improvements.

18.11.8 Works with services across Sue Ryder to address identified weakness / areas for improvement in the organisation response to PSIs including gaps in resources including skills and training.

18.11.9 Develops and maintains local risk management systems and relevant incident reporting systems to support the recording and sharing of PSIs and monitoring of incident response processes.

18.11.10 Ensures that Sue Ryder has procedures that support the management of PSIs in line with the organisation's PSIRP (including convening review and investigation teams as required and appointing trained named contacts to support those affected).

18.11.11 Supports and advises staff involved in the patient safety incident response.

18.11.12 Are responsible for gathering data and preparing reports to provide to relevant teams and committees. The reports will identify trends, detail improvement actions and facilitate shared learning processes.

18.11.13 Will use data on known trends within Sue Ryder to identify organisational risk to patient safety and co-ordinate an appropriate response in line with PSIRF guidance to mitigate such risks.

18.11.14 Will act as the main point of contact for matters relating to patient safety.

18.11.15 Will liaise with healthcare providers and commissioners where a cross-system response may be required.

18.12 Experience and Engagement Lead

18.12.1 Will support the Patient Safety Partners (PSP's) in their honorary role and provide expectations and guidance for the role.

18.12.2 Will hold regular scheduled reviews and one-to-one sessions with PSP's assessing training needs.

18.12.3 Will follow PSIRF procedures and processes when reviewing and supporting concerns and complaints.

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18.13 **Service Directors**

18.13.1 Ensures that the safety of staff, visitors, volunteers and the people who use our services is at the forefront of all decision making within their designated services and will take appropriate action following an incident to protect the people who use our services, colleagues and visitors from further harm.

18.13.2 Promote a culture where shared learning enables staff to reflect on practice.

18.13.3 Ensures that all staff are aware of, understand and comply with this policy and procedure.

18.13.4 Will ensure that all staff understand how to identify and report all incidents appropriately, including the use of Datix.

18.13.5 Are responsible for all PSIs and PSIIs to ensure all documentation is completed to the required standard.

18.13.6 Delegates where required to a responsible patient safety lead in their service (Head of Clinical Services, Quality Manager, Ward Manager/Clinical Team Manager).

18.13.7 Will ensure they receive relevant training under the support of the organisation's designated Patient Safety Lead.

18.13.8 Must ensure that all staff members involved in a safety incident are offered timely support and referrals where required to additional services.

18.13.9 Are responsible for the overseeing documentation in relation to any incidents requiring escalation.

18.13.10 Are responsible for providing staff, people who use our services and/or other persons involved in the incident with appropriate professional or personal support.

18.13.11 Safeguard systems in place in line with this policy to ensure that all potential PSIs are escalated to the Quality & Governance Team and the Chief Nursing Officer.

18.13.12 Ensure that all incidents that require consideration as a PSI are reported to and discussed with the Quality & Governance Team and the Chief Nursing Officer immediately or as soon as practicably possible.

18.14 **Head of Clinical Services (HoCS)**

18.14.1 Will ensure that all staff understand how to identify and report all incidents appropriately, including the use of Datix.

18.14.2 Are responsible for ensuring that the PSIR policy is followed across their service(s) and that incidents are reported in line with the reporting framework and escalation procedure.

18.14.3 Are responsible for all PSIs and PSIIs to ensure all required documentation is completed to the required standard and, if needed, there is delegation to a responsible patient safety lead in their service (Quality Manager, Ward Manager or Clinical Team Manager)

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who has received relevant training under the support of the organisation's designated Patient Safety Lead.

18.14.4 Will take appropriate action following an incident to protect the people who use our services, colleagues and visitors from harm.

18.14.5 Will take responsibility for incidents within their service to include wellbeing mechanisms.

18.14.6 They will nominate the main contact person in relation to the incident. For continuity and consistency of communication, a co-contact should be assigned to act as lead contact during time when the first named contact is absent.

18.14.7 Must ensure that all staff members involved in a safety incident are offered timely support and referrals where required to additional services.

18.14.8 Will be responsible for the generation of documentation in relation to any incidents requiring escalation.

18.14.9 Will be responsible for ensuring, where an incident involves medicines or equipment, they are quarantined, labelled and stored as appropriate.

18.14.10 Are responsible for providing staff, the people who use our services or other persons involved in the incident with appropriate professional or personal support.

18.14.11 Will provide protected time for training in patient safety disciplines and for participation in reviews/PSIIs as required.

18.15 Health, Safety and Estates Team

18.15.1 Ensures any investigations are undertaken following the PSIRF and PSIRP policy and guidance where a health and safety and or estates incident has occurred.

18.15.2 Health and safety incidents are defined as work-related accidents (defined as separate, identifiable, unintended incidents which cause physical injury), diseases, dangerous occurrences, and gas incidents. It should be noted that accidents are only reportable under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) if they happen out of or in connection with work. Reportable injuries include the death of any person, specified injuries to workers, injuries to workers which result in their incapacitation for more than seven days, and injuries to non-workers which result in them being taken directly to hospital for treatment, or specified injuries to non-workers which occur on Sue Ryder premises. RIDDOR reportable incidents are likely to be serious incidents.

18.15.3 The Serious Incident Management Policy should be the primary policy used to manage this type of incident.

18.16 The Workforce & Education Team

18.16.1 The Education Lead/Practice Educator (where there is no educator this is the responsibility of the Head of Clinical Services) ensures that all new staff are introduced,

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as part of their induction, to this policy and accompanying risk management software (Datix) and guidelines, and that corresponding records of this training are maintained.

18.17 Service User Participation Team

18.17.1 Will facilitate access to relevant support services.

18.18 All staff, including bank, contractors, agency staff and volunteers

18.18.1 Have the responsibility to familiarise themselves with this policy and to be aware of what could be a PSI and have an understanding of the PSII process.

18.18.2 Share the responsibility of highlighting any incident that is a cause for concern. Incidents need to be reported promptly to enable them to be managed appropriately and report externally where necessary. Confidentiality must be maintained, and incidents should not be mentioned outside of the Charity (e.g. in any social media communications).

18.18.3 Will report any concerns to a line manager face-to-face, where able, and via the incident reporting system (Datix) without delay. Supporting documentation will also be passed on without delay. If the incident occurs out of hours, then staff, including bank, contractors, agency staff and volunteers should report it through their directorates on call process, or to the ELT director on call.

18.18.4 Are expected to assist with Service Directors/Head of Clinical Services and the Quality & Governance Team to ensure that where an incident has occurred, the PSIR policy is followed and PSII completed, to ensure improvement of services and patient care through shared learning and development across Sue Ryder.

18.18.5 Are required to fully participate in any PSII openly and honestly, in order to assist with establishing the facts and the reasons for the incident, and to support the identification of ways in which lessons can be learned to avoid reoccurrence.

18.18.6 Will be assured that 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 which aligns to the PSIRF methodology.

18.18.7 Are responsible for adherence to the Sue Ryder Duty of Candour (PC HC D1) in relation to patient safety incidents, in line with Regulation 20 of the Health and Social Care Act.

18.19 Local safeguarding leads

18.19.1 Has a responsibility to ensure that all safeguarding matters are dealt with appropriately and that the local safeguarding boards are informed of any relevant matters arising from patient safety incidents.

18.19.2 Safeguarding incidents are defined as 'incidents where beneficiaries of charity (vulnerable adults or children) have been, or are alleged to have been abused or mistreated while under the care of Sue Ryder, or by someone connected with Sue

Ryder, for example a trustee, staff member or volunteer; incidents where someone has been abused or mistreated (alleged or actual) and this is connected with the activities of Sue Ryder; or incidents where there has been a breach of procedures or policies within Sue Ryder which has put staff, volunteers or beneficiaries at risk, including failure to carry out checks which would have identified that a person is disqualified in law, under safeguarding legislation, from working with children or adults'.

18.20 **People Team**

18.20.1 Will act as a point of contact for staff members involved in any patient safety incidents to provide pastoral support and any additional support or signposting required to staff, where needed, through any developments as part of the PSII.

19. Complaints and appeals

19.1 Concerns and complaints are a valuable resource for monitoring and improving patient safety.

19.2 Sue Ryder recognises that there will be occasions when patients / residents, family members, friends or advocates are dissatisfied with aspects of the care and services provided. All types of feedback are managed via the Complaints Policy & Procedure (PC HC C2).

20. Stakeholder consultation

20.1 In the process of drafting this document, stakeholder consultation was carried out with the following groups/people to seek evidence and views from groups affected by the policy and/or with relevant knowledge, both internal and external to Sue Ryder:

- Chief Nursing Officer.
- Deputy Chief Nursing Officer.
- Clinical Quality and Safety Manager and Patient Safety Lead.
- Health, Safety and Estates Business Partner.
- Associate Director of People.
- Service Directors.
- Head of Clinical Services.
- Database Manager.
- Organisational Department Business Partner.
- Director of Risk and Governance.
- Chief Medical Director.
- Deputy Chief Operating Officer.
- Head of Nursing & AHPs, Workforce and Education.
- Experience and Engagement Manager.

- Quality Managers.

21. References

21.1 NHS England (2024) Patient Safety Incident Response Standards. https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/ (Accessed 09 September 2024).

21.2 NHS England (2022) Safety Action Development Guide. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf (Accessed 09 September 2024).

Appendices

22. Appendix 1 – Glossary

Acronym	Term	Definition	Link/Resource
PSIRF	Patient Safety Incident Response Framework	Sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.	https://www.england.nhs.uk/patient-safety/incident-response-framework/
PSIRP	Patient Safety Incident Response Plan	Service specific - In response to the framework. It describes what is being done to prepare for "go live" with PSIRF and what comes next.	https://www.england.nhs.uk/patient-safety/incident-response-framework/
SEIPS	Systems Engineering Initiative for Patient Safety	A framework for understanding outcomes within complex socio-technical systems.	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf
RCA	Root Cause Analysis	The process of examining what happened in order to establish how and why an adverse event occurred. It should result in preventative measures to minimise future risk of reoccurrence.	https://www.england.nhs.uk/wp-content/uploads/2022/02/qsir-using-five-whys-to-review-a-simple-problem.pdf
NRLS	National Reporting and Learning System	This is a central database of patient safety incident reports.	https://report.nrls.nhs.uk/nrlsreporting/

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LFPSE	Learning From Patient Safety Events	LFPSE is replacing the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), to offer better support for staff from all health and care sectors.	https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/
PSP	Patient Safety Partner	Relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.	https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/
SIF	Serious Incident Framework	Framework to manage reporting of serious incidents. Is being replaced by PSIRF.	https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf
LRMS	Local Risk Management System	Software that enables healthcare providers to record patient safety incidents. (Sue Ryder uses Datix)	https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/lrms-suppliers/
StEIS	Strategic Executive Information System	Currently being replaced by LFPSE (previously used in conjunction with NRLS)	https://www.rdash.nhs.uk/news-and-events/new-reporting-system-to-be-launched
PSII	Patient Safety Incident Investigation	A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving.	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-PSII-Report-Template-v1.1.docx
PSCs	Patient Safety Collaboratives	The PSCs are making their impact by identifying and rolling out safer care initiatives within the NHS and industry, ensuring these are shared throughout the health and care system.	https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#patient-safety-collaboratives
ICS	Integrated Care System	Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.	https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

ICB	Integrated Care Board	A statutory NHS organisation 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 the ICS area. The establishment of ICBs resulted in clinical commissioning groups (CCGs) being closed down.	https://www.england.nhs.uk/publication/integrated-care-boards-in-england/ https://www.nhsconfed.org/articles/what-are-clinical-commissioning-groups
OPR	Operational Performance Report	Sue Ryder internal data and evidence gathering operational report, individualised per service.	
QAG	Quality Assurance Group	An internal Sue Ryder assurance group for clinical governance to enable the organisation to do its reasonable best in providing high quality health and social care. The group provides assurance that there is continuous and measurable improvement in the quality of services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care.	https://sueryder.sharepoint.com/sites/Document%20Hub/H&SC%C2%A0Quality%20Assurance%20Group%20(QAG)/Shared%20Documents/Forms/AllItems.aspx
QIG	Quality Improvement Group	Internal Sue Ryder quality improvement group specific to each service	
AAR	After Action Review	An After Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.	https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2015/08/learning-handbook-after-action-review.pdf
HSIB	Healthcare Safety Investigation Branch	Highly skilled investigators and analysts who are experienced in healthcare and other safety-critical industries, and are trained in human factors and safety science. HSIB carry out patient safety investigations through two programmes: 1. National investigations 2. Maternity investigations	https://www.hsib.org.uk/
SBAR	Situation Background Assessment Recommendation	SBAR consists of standardised prompt questions in four sections to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively,	https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-sbar-

		reducing the need for repetition and the likelihood of errors.	communication-tool.pdf
PSI	Patient Safety Incident	A patient safety incident can be defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare.	https://www.england.nhs.uk/patient-safety/
SI	Serious Incident	Serious Incidents (SIs) are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.	https://www.britishjournalofnursing.com/content/patient-safety/learning-the-lessons-from-patient-safety-incidents/
	Safety Culture	A positive safety culture is one where the environment is collaboratively crafted so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by: Continuous learning and improvement of safety risks/Supportive, psychologically safe teamwork/Enabling and empowering speaking up by all.	https://www.england.nhs.uk/patient-safety/safety-culture/
	Psychological Safety	This is the belief that you will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.	https://www.england.nhs.uk/long-read/safety-culture-learning-from-best-practice/#5-psychological-safety
	Just Culture	Just Culture is about creating a culture of fairness, openness and learning in the NHS. This is to make colleagues feel confident to speak up when things go wrong, rather than fearing blame.	https://www.england.nhs.uk/patient-safety/a-just-culture-guide/
	NHS Patient Safety Strategy	This strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.	https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/
	Duty of Candour	Every health and care professional must be open and honest with patients and people in their care when something that goes wrong	https://www.nhsprofessionals.nhs.uk/en/partners/academy-

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		with their treatment or care causes, or has the potential to cause, harm or distress.	courses/patient-safety-courses/duty-of-candour-and-being-open-principles
	Caldicott Guardian	A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.	https://www.gov.uk/government/groups/uk-caldicott-guardian-council#:~:text=A%20Caldicott%20Guardian%20is%20a,must%20have%20a%20Caldicott%20Guardian. https://www.ukcgc.uk/caldicott-guardians-manual
	Freedom to Speak Up Guardian	Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.	https://www.england.nhs.uk/ourwork/freedom-to-speak-up/
	Engagement Lead	Anyone who leads on engaging with and involving those affected by a patient safety incident. This may be a person leading a learning response or a family liaison officer (or similar).	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf
	System-Based Approach	A system-based approach recognises that patient safety is an emergent property of the healthcare system: that is, safety arises from interactions and not from a single component, such as actions of people. A system-based approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.	https://kennedyslaw.com/en/thought-leadership/article/2023/patient-safety-incident-response-framework-implementation-of-the-new-approach-and-the-anticipated-benefits/
	Clinical Governance	A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high	https://www.england.nhs.uk/mat-transformation/matrons-

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		standards of care by creating an environment in which excellence in clinical care will flourish.	handbook/governance-patient-safety-and-quality/
	SWARM Huddles	Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Swarm-huddle-v1-FINAL.pdf
	MDT Review	Involves drawing appropriately from multiple disciplines (the multidisciplinary team) to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations.	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-MDT-review-v1_FINAL.pdf
	Learning from Death	Learning from death in an NHS context refers to the process of examining patient deaths to identify areas where improvements can be made in healthcare practices and patient safety. It involves analysing the circumstances surrounding a death to learn valuable lessons and implement changes that can prevent similar incidents in the future.	https://www.england.nhs.uk/patient-safety/learning-from-deaths-in-the-nhs/
	Link analysis	Link analysis visualises the frequency of interactions in a specific location or environment. It can be used to highlight the frequently used paths taken in an environment and those that are critical for safety.	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Link-analysis-v1-FINAL.pdf

23. Appendix 2 – Proportionate response to patient safety incidents

Patient safety incident type	Required Response	Anticipated Improvement Route
Incidents meeting the Never Event criteria	Patient Safety Incident Investigation (PSII)	Safety Learning Panel
Deaths due to a problem in care (meets learning from deaths criteria)	Patient Safety Incident Investigation (PSII)	Learning from Deaths Incident Learning Panel
Death of a Person with Learning Difficulties where there is reason to believe death was contributed to by	Patient Safety Incident Investigation (PSII)	Safeguarding Assurance Group

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one or more patient safety incidents / problems in the healthcare of a service commissioned by the NHS	LeDer Review https://leder.nhs.uk/	Learning from Deaths Safety Learning Panel
Safeguarding Incidents	As recommended by Safeguarding Requirements	Safeguarding Steering Group Incidents, Complaints, Concerns Committee Meeting Safety Learning Panel
Notification of Infectious Disease	Post Infection Review (PIR)	Incidents, Complaints, Concerns Committee Meeting

24. Appendix 3 – PSIRF governance structure

Meeting / Process	Meeting Purpose / Process Description
Incident reported and reviewed on Datix	• Incidents are reported on Datix by staff online. • Required staff receive email notification of incident reported. • All incidents are reviewed and escalated as appropriate by the Quality & Governance Team and Operations Team. • Investigators are assigned to each incident. • Potential incidents of concern, that may require a more in-depth investigation, are requested to be escalated to the Quality & Governance Team for discussion at the next available Incident, Concerns and Complaints Committee. • Potential safeguarding referrals are made to the Safeguarding Team.
Death of Sue Ryder Patients	• CQC notification for patient death. • Identification of any potential issues that need further review or escalation. • Any potential concerns are firstly discussed with the patient's clinical team for clarification. • Potential incidents of concern will be escalated to the Quality & Governance Team and discussed at the Incident, Concerns and Complaints Committee and further escalated to legal services and the Executive Leadership Team. • Datix completed where Coroner involvement required.
Incident, Concerns and Complaints Meeting	• Meeting led by the Head of Nursing & AHPs, Quality & Governance. • Attended by: ◦ Head of Nursing & AHPs, Quality & Governance.

	◦ Clinical Quality & Safety Manager and Patient Safety Lead. ◦ Experience & Engagement Manager. ◦ Chief Nursing Officer. ◦ Deputy Chief Nursing Officer. ◦ Deputy Chief Operating Officer. ◦ Health & Safety Business Partner. ◦ Head of Nursing & AHPs, Workforce & Education. ◦ Medicines Optimisation Pharmacist Lead. ◦ Professional Education Lead • Trackers/dashboard used to identify trends and highlight concerns (accessible by Executive Leadership Team (ELT)). • Weekly meeting covers: ◦ Datix concerning incidents update. ◦ Review of trackers / dashboard & trends identified. ◦ Complaints and concerns. ◦ Investigation progress. ◦ Learnings identified or actioned by services. ◦ Action plan oversight
Safeguarding Workstream bimonthly meeting	• Meeting led by the Chief Nursing Officer. • Attended by: ◦ Chief Nursing Officer. ◦ Deputy Chief Nursing Officer. ◦ Head of Clinical Services (All). ◦ Safeguarding leads (All). ◦ Head of Nursing, AHPs, Quality and Governance. ◦ Human Rights Lead. ◦ Head of Nursing, AHPs, Workforce and Education • Meeting covers: ◦ Safeguarding quarterly report. ◦ Safeguarding training. ◦ Safeguarding audit results. ◦ Safeguarding board assurance actions.
Joint Professional Forum Quarterly meeting	• Meeting led by Chief Nursing Officer • Attended by: ◦ Chief Nursing Officer. ◦ Deputy Chief Nursing Officer. ◦ Head of Clinical Services (All). ◦ Safeguarding leads (All). ◦ Head of Nursing, AHPs, Quality and Governance. ◦ Human Rights Lead. ◦ Head of Nursing, AHPs, Workforce and Education. ◦ Clinical Leads (All).

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	◦ Therapy Leads (All) • Meeting covers: ◦ Promote and facilitate continuous quality improvement across all Sue Ryder Services. ◦ To discuss any newly produced national guidelines, standards, reports or discussion documents which might influence the provision of care to patients/residents and their carers. ◦ Provide the forum for feedback from conferences related to care. ◦ Exchange ideas, skill and knowledge, and to share innovation and information. ◦ To support audit initiatives and discuss implications for care. ◦ To encourage peer support, professional excellence, reflective practice and self-development. ◦ To work together within an environment that both supports and challenges. ◦ Provide a forum where workforce issues can be discussed.
PSIRF Steering Group	• Meeting chaired by Head of Nursing, AHPs, Quality & Governance. • Attended by: ◦ Chief Nursing Officer. ◦ Deputy Chief Nursing Officer. ◦ Head of Clinical Services (all). ◦ Safeguarding leads (all). ◦ Head of Nursing, AHPs, Quality and Governance. ◦ Human Rights Lead. ◦ Head of Nursing, AHPs, Workforce and Education. ◦ Chief Medical Officer. ◦ Service Directors (all). ◦ Experience & Engagement Manager. ◦ Deputy Chief Operating Officer. ◦ Director of Risk, Governance and Compliance. ◦ Head of People, Health and Fundraising. ◦ Health and Safety Business Partner – Compliance & Risk. ◦ Database Manager. ◦ Database Business Partner • Meeting covers: ◦ Oversee the delivery and implementation of PSIRF
Healthcare Workforce Steering Group	• Meeting chaired by Head of Nursing, AHPs, Workforce and Education. • Attending by: ◦ Head of Nursing, AHPs, Workforce & Education. ◦ Head of Clinical Service (All). ◦ Service Directors (All). ◦ Practice Educators (All).

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	◦ Senior Practice Educators (All). ◦ Deputy Chief Operating Officer. ◦ Professional Education Lead • Meeting covers: ◦ New approaches or current recruitment advertising. ◦ People team update. ◦ Healthcare roles. ◦ Learning and Development updates. ◦ Clinical education induction plans. ◦ Education calendar update. ◦ CPD and healthcare grant review. ◦ Sickness absences review. ◦ Exit interview feedback. ◦ Policy and procedure review
Datix Working Group	• Meeting led by Database Manager. • Attended by: ◦ Database Manager. ◦ Database Assistant. ◦ Healthcare Operations Administrator. ◦ Chief Operating Officer. ◦ Head of Nursing & AHPs, Quality & Governance. ◦ Palliative Representative Lead. ◦ Neurological Representative Lead. ◦ Head of Operations Representative Lead. ◦ Bereavement Representative Lead. ◦ Retail Operations Representative Lead. ◦ Finance Representative Lead. ◦ Fundraising Representative Lead. ◦ IT Representative Lead. ◦ Health & Safety Representative Lead • Action Plan (Asset Owner), Newsletter, Compliance Report. • Quarterly meeting covers: ◦ Datix actions, risks and current projects. ◦ Quarterly newsletter. ◦ Training updates and dates. ◦ Compliance Report (organisation wide).
Medicines Management Workstream Meeting	• Meeting Chaired by Chief Medical Officer & Chief Nursing Officer. • Attended by: ◦ Chief Nursing Officer. ◦ Deputy Chief Nursing Officer. ◦ Head of Clinical Services (all). ◦ Medicines Optimisation Pharmacist.

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	◦ Head of Nursing, AHPs, Quality and Governance. ◦ Head of Nursing, AHPs, Workforce and Education. ◦ Chief Medical Officer. ◦ Service Pharmacist (all). ◦ Deputy Chief Operating Officer. ◦ Clinicians & Medicines Leads • Meeting covers: ◦ To discuss learning and share best practice across the charity with regard to the management of medicines. ◦ To share learning with regard to any medicine's incidents and clinical audit across healthcare including preventative and improvement actions. ◦ To support developments in medicines management to drive quality and continuous improvement. ◦ To discuss and disseminate relevant research, changes in practice or legislation to enhance clinical practice. ◦ Ensuring that the risks associated with the management of medicines are identified and managed appropriately.
Quality Improvement Group (QIG)	• Specific to each service and completed monthly. • Meeting led by the Head of Clinical Services for the location. • Meeting agenda items: ◦ Action points from previous meetings. ◦ Risk register review. ◦ Audit outcome review. ◦ Operational Performance Report (OPR) outcomes. ◦ Pressure ulcer review. ◦ Medicines Management. ◦ Workforce management. ◦ Education compliance. ◦ Quality improvement programme. ◦ Patient Dependency review. ◦ Incident review. ◦ Learning from incidents. ◦ Policy updates and amendments. ◦ Safeguarding ◦ Investigation progress. ◦ Service User Participation feedback.
Operational Performance Report Meeting (OPR)	• Meeting led by Chief Nursing Officer & Deputy Chief Operating Officer. • Meeting covers: ◦ Data for all needs of the services covering operational and healthcare oversight

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Internal Quality Visits	• Undertaken by the Clinical Quality Team and wider Quality & Governance Team. • Assurance about the quality and safety of services. • Enables key risks to be identified & managed. • Central to continuous improvement. • Carried out 6 monthly. • Full report and feedback provided to services with action plans.

PSII Review Panel Meetings	• Draft PSII investigation reports reviewed prior to external submission.
	• Chaired by Chief Nurse / Deputy Chief Nurse.
	• Attended by:
	  ◦ Lead investigator.
	  ◦ Investigation Team.
	  ◦ Any other relevant staff.
	  ◦ Patient and or family may be invited to attend.
	  ◦ Representatives from ICB.
	• The lead investigator will present the investigation report, its main findings, recommendations, learning and proposed actions.
	• Discussion in relation to the investigation to identify any areas requiring clarity, any gaps in the investigation report and to agree the proposed action plan.
	• Once finalised the report is submitted for final approval.

Executive Leadership Team (ELT) Meetings	• Oversight of patient safety incidents and review. • Review of quality improvement project plans. • Approved PSII reports submitted externally to ICB, NHSE, CQC and any further required. • Action points are documented into the locations OPR for tracking and updates.
Patient Safety & Quality Committee Meeting	• New, ongoing & closed PSII review. • PSII action follow up since last review (open & overdue). • Trends analysis on patient related incidents. • Patient outcomes and experience review. • Shared learning circulation process and progress. • Learning for Safety Memos (LfSM) in draft, newly published, action plan updates. • Quality improvement project updates. • PSIRF update.
Board of Trustees Meetings	• Updates provided on new, ongoing and closed PSIIs • External referral updates.

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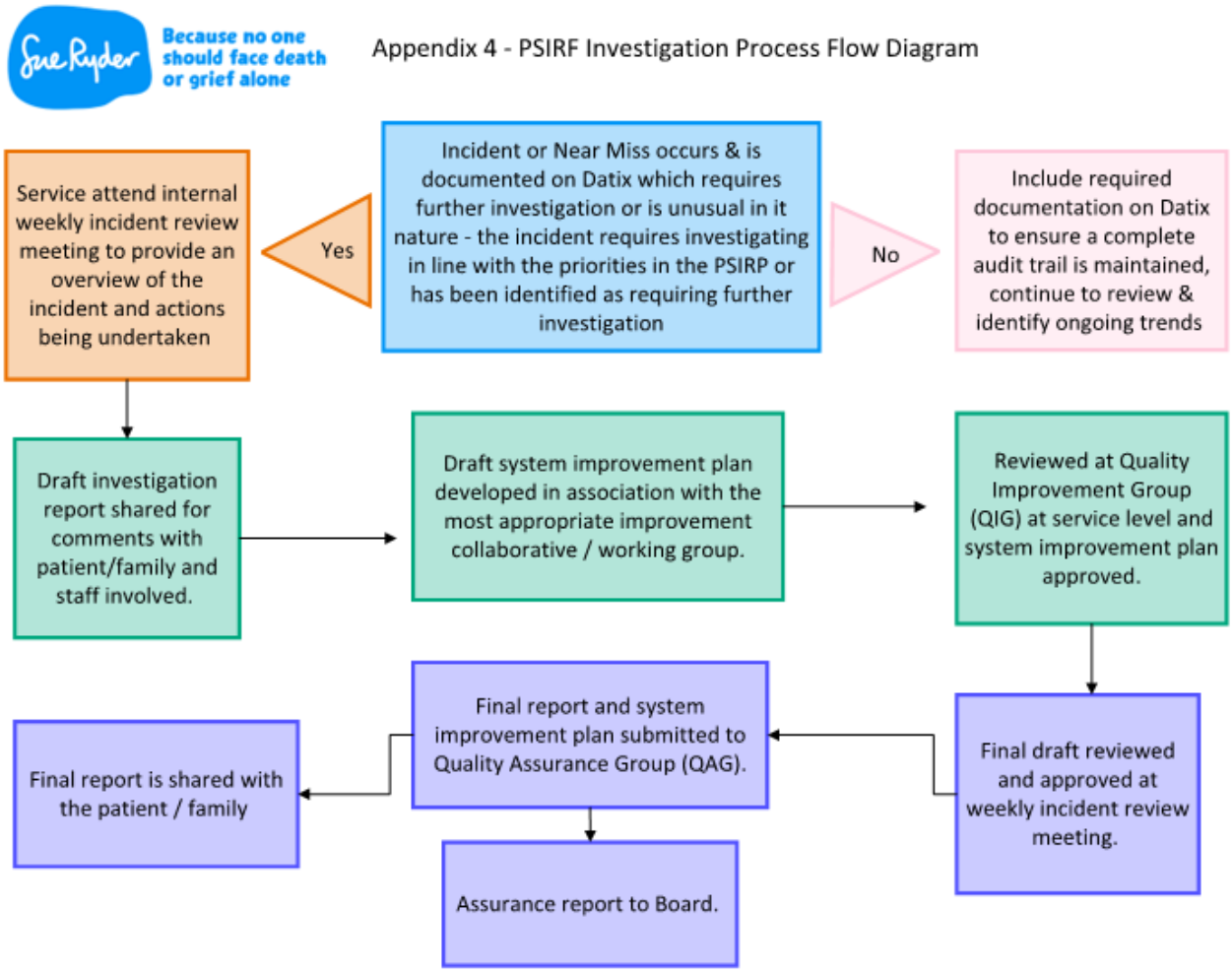
25. Appendix 4 – PSIRF investigation process flow diagram



26. Appendix 5 – PSIRF rapid review falls example

Rapid review report - EXAMPLE

Falls

Datix ID	12345	Date of incident	24/01/2023	Place / department	Sue Ryder Hospice	Incident type	Fall with skin tear to right arm
Level of harm	Minor	Duty of Candour	Verbal apology 24/01/2023	Date rapid review completed	26/01/2023	Date discussed at QIG meeting	08/02/2023
Previous history of falls (inpatient and outpatient)?	No previous falls identified prior to admission.	Days since last fall	0 – first fall as an inpatient.	Days since admission	3 days	Date of last risk assessment update / change	On admission – 21/01/2023
Author & designation	Jane Doe, Senior Nurse	Level of investigation training	Essentials of patient safety – level 1	Report approved by & designation	Jo Bloggs, Head of Clinical Services	Level of investigation training	Level 2

Points to consider:

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Patient was admitted from hospital 3 days prior to the fall. The hospital team informed the inpatient unit nurse that the patient was at a low risk of falls.

Assessment on admission indicated that the patient had fluctuating capacity and may be disorientated at times. Conversations with the family confirmed this.

The patient had an unwitnessed fall in their bedroom whilst mobilising to the toilet. The only injury was a skin tear to their right arm.

Pre-disposing factors:

- Confusion
- Urinary urgency
- Glasses wearer
- Polypharmacy

Environmental factors:

- Support equipment out of reach

Who was impacted? What did they need?

Patient – Patient had an injury following a fall. The patient voiced that they felt unsure about the new environment and were anxious.

Family / Next of Kin – upset by their family member falling and injury and were keen for enhanced observation.

Staff – concern at missing a risk of falls in this patient.

Organisation – potential for reputational damage.

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Work as prescribed (what was expected): SEIPS guidance below.	Work as done (what happened): SEIPS guidance below
Tasks: • Care plan development & implementation. • New admission risk assessments. Tools and Technology: • Appropriate footwear review. • Bed rails assessment. • Equipment review & assessment. • Pressure mats and lasers were not in use at the time of the fall as they were not considered necessary. Staff: • Reassess falls risk at MDT. Organisation of work factors: • The Falls Risk Management Policy states that on first assessment, or within the first 12 hours of admission all service users should be assessed using a multi-factorial falls risk assessment tool (appendix 2) for their risk of falling whilst mobilising or their risk of falling from bed.	Tasks: • Risk assessment was completed fully on admission. A large part of the assessment related to information handed over from the hospital. • Referral was made for review by physio and OT as per the care plan. • Safe and seen was started as new admission and set for hourly however there was a delay in the safe and seen check being carried out. Technology: • Appropriate footwear was not in place at the time of the fall. Staff: • Staff compliance with Falls Strategy and Risk Management e-learning was below 90%. Organisation of work factors: • Falls leaflet was not shared as none could be found at the time of admission.

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• Information leaflet to be shared with patient and/ or family as per policy. Person factors: • Falls risks identified on admission through falls risks assessment. • Capacity assessment confirmed fluctuating capacity. Internal environment: • Cleaning schedules in place. • Ward and environment orientation completed on admission. External environment: • New national bed rail guidance to prevent entrapment followed.	Person factors: • The safe and seen check was delayed due to an emergency occurring delaying the handover of the required check to the relevant member of staff. • Capacity was assessed on admission and the patient was deemed to have fluctuating capacity. Internal environment: • Domestic staff had cleaned the patients room 10 minutes prior to the fall, possibility of wet / damp floor leading to a slip or layout altered leading to confusion. External environment: • Bedrails assessment carried out, not deemed necessary so not implemented.

Analysis:	**Learning:**
• The risk assessment was thorough however it was based on information provided by the NHS hospital. We may need to consider how we manage new admissions until we fully understand the falls risk from our own assessment and supervision. • It was appropriate to commence safe and seen though the time between checks may have been shorter if the	• On admission of a new patient, equipment to reduce falls should be in place wherever possible until a full understanding of the patients care needs are achieved. • Full capacity assessment should be completed on admission and the patient orientated to their new surroundings. • Offer emotional support services to new patients / family including spiritual etc.

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patient's confusion / disorientation had been fully recorded. The delay in the check was due to another emergency and a short delay in handing over the task to the relevant member of staff. It is likely the patient had already fallen in this instance. • Better use could have been made of technology for a new patient where risk of falls was more unclear due to their new arrival on the unit. • Falls leaflets had not been ordered before the current batch ran out due to the volunteer who helped with this being off sick.	• All staff to be up to date with Falls Strategy and Risk Management training. • Ensure that each volunteer has a 'buddy' to assist with work when others are not available. • Safe and seen checks should be clearly allocated and discussed in the huddle alongside roles allocated in the event of an emergency.

Outcome: (Where actions will be added to current action plan, please see Safety Action Table) (Appendix 1)

No further investigation required - actions to be added to current action plan.

Actions:	Yes (include date and by whom).	No (state reason).
CQC notified		X – not required
ICB notified		X – not required
Safeguarding referral made		X – not required

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Appendix I: Safety action table

Please list actions that will be added to relevant current plan.

	Recommendation	Action for Improvement	Safety action owner (role, team directorate)	Target date for implementation	Tool/measure	Measurement frequency (e.g. daily, monthly)	Responsibility for monitoring/ oversight (e.g. specific group, individual)	Planned review date (e.g. annually)
1.	All staff to be up to date with Falls Strategy and Risk Management training.	Schedule all remaining staff to complete this.	Practice educator	March 2024	Record of training	Monthly (to be discussed at QIG).	Quality Improvement Group	Annual
2.	Falls risk equipment to be used for new admissions where possible/ consent. Review after 48 hrs.	Ensure there is sufficient equipment to achieve this. Amend admission process and cascade to staff.	HOPS Ward manager	Feb 2024	Completed audits Safety huddle review	Monthly	Quality Improvement Group	Quarterly
3.	Add safe and seen checks and emergency situation roles at safety huddle.	Add to safety huddle	Ward Manager	Feb 2024	Safety huddle review	Quarterly Review data	Quality Improvement Group	Annually
4.	Volunteers who undertake specific		HOCS in discussion with	Mar 2024	Volunteer allocation and review	Monthly	Quality Improvement Group	Annually

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	tasks to have a buddy for cover.		volunteer coordinator.					

Engage stakeholders in completing the safety action table using SMART principles to write the required actions. The actions will say how the recommendations are going to be taken forward and are separate from the investigation process.

Actions should be risk assessed to ensure no untoward consequences arise from their introduction.
This report must be uploaded to the Datix record.

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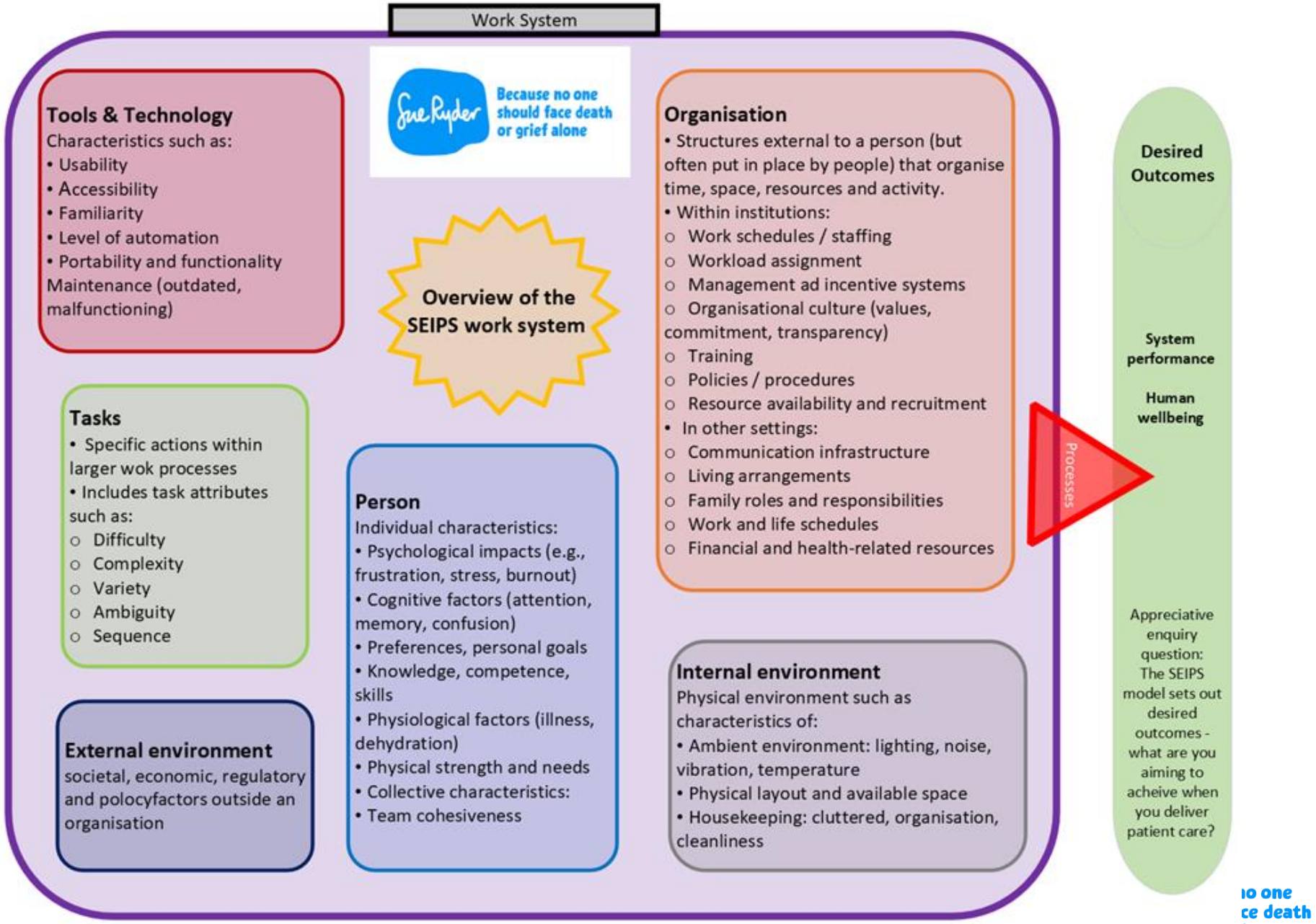
Work System
Tools & Technology
Characteristics such as:
• Usability
• Accessibility
• Familiarity
• Level of automation
• Portability and functionality
Maintenance (outdated, malfunctioning)
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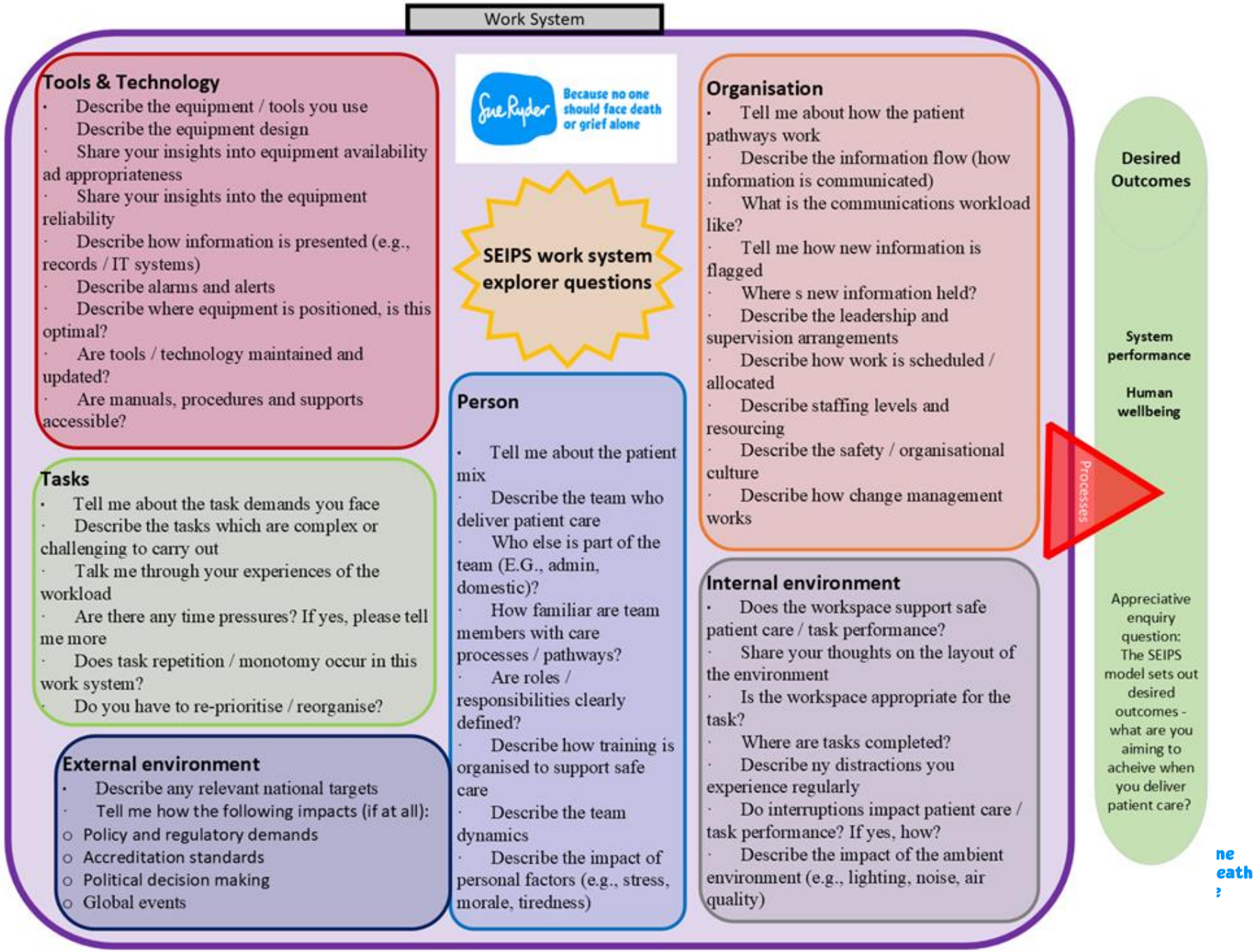
Overview of the SEIPS work system
Organisation
• Structures external to a person (but often put in place by people) that organise time, space, resources and activity.
• Within institutions:
o Work schedules / staffing
o Workload assignment
o Management ad incentive systems
o Organisational culture (values, commitment, transparency)
o Training
o Policies / procedures
o Resource availability and recruitment
• In other settings:
o Communication infrastructure
o Living arrangements
o Family roles and responsibilities
o Work and life schedules
o Financial and health-related resources
Processes
Desired Outcomes
System performance
Human wellbeing
Appreciative enquiry question: The SEIPS model sets out desired outcomes - what are you aiming to acheive when you deliver patient care?
Tasks
• Specific actions within larger wok processes
• Includes task attributes such as:
o Difficulty
o Complexity
o Variety
o Ambiguity
o Sequence
Person
Individual characteristics:
• Psychological impacts (e.g., frustration, stress, burnout)
• Cognitive factors (attention, memory, confusion)
• Preferences, personal goals
• Knowledge, competence, skills
• Physiological factors (illness, dehydration)
• Physical strength and needs
• Collective characteristics:
• Team cohesiveness
Internal environment
Physical environment such as characteristics of:
• Ambient environment: lighting, noise, vibration, temperature
• Physical layout and available space
• Housekeeping: cluttered, organisation, cleanliness
External environment
societal, economic, regulatory and polocyfactors outside an organisation


Work System
Tools & Technology
· Describe the equipment / tools you use
· Describe the equipment design
· Share your insights into equipment availability ad appropriateness
· Share your insights into the equipment reliability
· Describe how information is presented (e.g., records / IT systems)
· Describe alarms and alerts
· Describe where equipment is positioned, is this optimal?
· Are tools / technology maintained and updated?
· Are manuals, procedures and supports accessible?
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SEIPS work system explorer questions
Organisation
· Tell me about how the patient pathways work
· Describe the information flow (how information is communicated)
· What is the communications workload like?
· Tell me how new information is flagged
· Where s new information held?
· Describe the leadership and supervision arrangements
· Describe how work is scheduled / allocated
· Describe staffing levels and resourcing
· Describe the safety / organisational culture
· Describe how change management works
Tasks
· Tell me about the task demands you face
· Describe the tasks which are complex or challenging to carry out
· Talk me through your experiences of the workload
· Are there any time pressures? If yes, please tell me more
· Does task repetition / monotomy occur in this work system?
· Do you have to re-prioritise / reorganise?
Person
· Tell me about the patient mix
· Describe the team who deliver patient care
· Who else is part of the team (E.G., admin, domestic)?
· How familiar are team members with care processes / pathways?
· Are roles / responsibilities clearly defined?
· Describe how training is organised to support safe care
· Describe the team dynamics
· Describe the impact of personal factors (e.g., stress, morale, tiredness)
Internal environment
· Does the workspace support safe patient care / task performance?
· Share your thoughts on the layout of the environment
· Is the workspace appropriate for the task?
· Where are tasks completed?
· Describe ny distractions you experience regularly
· Do interruptions impact patient care / task performance? If yes, how?
· Describe the impact of the ambient environment (e.g., lighting, noise, air quality)
External environment
· Describe any relevant national targets
· Tell me how the following impacts (if at all):
o Policy and regulatory demands
o Accreditation standards
o Political decision making
o Global events
Processes
Desired Outcomes
System performance
Human wellbeing
Appreciative enquiry question: The SEIPS model sets out desired outcomes - what are you aiming to acheive when you deliver patient care?

27. Appendix 6 – PSIRF rapid review medicines example

Rapid review report - EXAMPLE

Medicines

Datix ID	12357	Date of incident	22/01/2023	Place / department	Sue Ryder Hospice	Incident type	Medicines - prescribing
Level of harm	Minor	Duty of Candour	Verbal apology 22/01/2023 Letter posted 25/01/2023	Date rapid review completed	22/01/2023	Date discussed at QIG meeting	08/02/2023
Author & designation	Jane Doe, Senior Nurse	Level of investigation training	Essentials of patient safety – level 1	Report approved by & designation	Jo Bloggs, Head of Clinical Services	Level of investigation training	Level 2

Points to consider:
Past medical history = patient admitted with inferior vena cava (IVC) low grade leiomyosarcoma and renal vein compression leading to renal failure (Estimated Glomerular Filtration Rate (EGFR) = 9) with reoccurring ascites and was admitted for symptom management of their condition which would likely progress to end of life care. Patient was admitted late in the afternoon as an emergency and the admission was further delayed due to late transport.

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The inpatient unit was busy with two discharges and 10 inpatients.

Patient medications:

- Enoxaparin 90mg Once Daily
- Aluminium hydroxide/magnesium hydroxide/oxethazaine 10ml Four times daily
- Ensure Plus Juice 220mls Twice Daily
- Fluconazole 100mg Once Daily
- Lansoprazole 30mg Once Daily
- Benzydamine 0.15% mouthwash when required
- Glycerol suppository when required
- Macrogol 1-2 sachets when required
- Gaviscon when required
- Letrozole 2.5mg Once Daily (patient reportedly still taking)
- Continuous subcutaneous infusion (CSCI): Metoclopramide 30mg + Oxycodone 7.5mg over 24 hours
- Pre-emptives – midazolam, oxycodone, haloperidol

Who was impacted? What did they need?

Patient – Was upset that there had been a medication error and required some additional monitoring for a short period.

Family / Next of Kin – they were made aware of the incident and were keen to understand lessons learnt.

Staff – Both prescribing doctor and nurse were concerned about the incident by the impact of the incident

Organisation – potential for reputational damage.

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Work as prescribed (what was expected):	Work as done (what happened):
Tasks: • New medicines should be clearly communication to the nurse in charge of the shift. • The patient and their medications should be discussed at handover as part of the multidisciplinary team review. Tools and Technology: • E-prescribing • SystmOne documentation Staff: • Staff to have completed training in medicines management. Organisation of work factors: • The medicines policy states that medicines reconciliation should take place on admission by the doctor or other healthcare professional (pharmacist or NMP). • Reconciled medicines should be put on the drug chart or medicines that have been stopped or withheld should be included on a separate form. • Person factors:	Tasks: • There was an error in the prescribing of paracetamol which was prescribed regularly (1 gram every 4 to 6 hours with a maximum of 4 grams) but it was also prescribed as required (PRN). This led to one dose of paracetamol being given in addition to the regular dose. • The drug chart was written in two stages due to interruption of the doctor and the discovery of more medicines in another of the patients bags. • The medicines round was completed by two different nurses. Tools and Technology: • E-prescribing not operational. • SystmOne documentation did not detail full process followed or medications given. Staff: • Medicines management training compliance = 96% • Organisation of work factors: • Reconciliation was completed by the doctor on admission, but it proved confusing as there were a number of different bags containing different medicines. Some of the medicines were old and not being used. • New medical staff not aware of policy and procedure.

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• Patient has regular episodes of confusion and disorientation as per their risk assessment. Internal environment: • Admission and discharge processes kept separate. • Medicine storage maintained in a neat and tidy process. External environment: • Patients own medicines are to be reviewed and logged into the system with clear documentation to support.	• There were two packets of paracetamol with the patients name in the cupboard. Person factors: • The patient was not able to confirm that they had previously been administered paracetamol or that this had been a recent administration. • Staff report difficulties in ensuring the patient understood all the medicines they were taking. Internal environment: • The ward was busy, the patient was admitted as an emergency • The ward was busy, the patient was admitted as an emergency. Medicines were not thoroughly reviewed when being stored which led to multiple open packets of medication relating to the same patient, leading to confusion and staff not being able to identify medications administered. External environment: • Upon admission the patient was found to have multiple bags of medications which had been precariously collected and not stored safely which led to confusion upon the admission.
Analysis:	**Learning:**
• The inpatient unit was very busy at the time of admission. The admission had been planned for what	• Admissions should be arranged wherever possible at a time when staff teams are expecting them and there is sufficient staff to manage them.

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should have been a quieter time on the unit but the delay in transport then meant the admission occurred just before the evening medicines round. • There were a several patients on the unit who required review by a doctor which led to the interruption of the prescribing doctor as they completed the admission and medicines reconciliation. • As the unit was busy, a nurse undertook a medicines round for a colleague to enable them to spend time with a poorly patient. The second nurse later attend the new admission and gave the as required paracetamol. • The paper drug chart had the as required medication on the back page so it was possible to see that without looking through the whole chart. As the nurse was busy they picked up the chart and saw only the as required medication. • The patients medicines were left in the medicines trolley which caused confusion as there were several different boxes of the same medicine.	Staff should have plans in place if patients are admitted later (or earlier) than anticipated). • Staff who are admitting patient should not be disturbed when completing an admission and/ or drug reconciliation. • Nursing staff should wherever possible complete their own medicines rounds and where this does not happen, full communication/ handover should be held with the nurse who completed the round. • Drug charts should always be fully read prior to administering a medicine. • Patients own medicines should be managed inline with local policy.
Outcome: (Where actions will be added to current action plan, please see Safety Action Table) (Appendix 1)	
No further investigation required - actions to be added to current action plan.	

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Actions:	Yes (include date and by whom).	No (state reason).
CQC notified		X – not required
ICB notified		X – not required
Safeguarding referral made		X – not required

Appendix I: Safety action table

Please list actions that will be added to relevant current plan.

	Recommendation	Action for Improvement	Safety action owner (role, team directorate)	Target date for implementation	Tool/measure	Measurement frequency (e.g. daily, monthly)	Responsibility for monitoring/ oversight (e.g. specific group, individual)	Planned review date (e.g. annually)
1.	Staff admitting patients should have protected time to complete the admission/ drug reconciliation.	Ensure protected time. Consider a space to be used/ red apron	Name Head of Clinical Services	March 2024	Record of discussion Identified changes to practice	Audit at 1 and 3 months	Quality Improvement	Annual
2	Staff completing medicines rounds should be undisturbed. Where another nurse	Ensure the red apron is in continued use. Discuss in safety huddle.	Ward manager	Feb 2023	Completed audits	Weekly	Quality Improvement	Monthly

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	completes a drug round this should be fully handed over.	Add into SOP regarding staff handover following medicines round.			Safety huddle notes			
3.	Drug charts	Document discussion with staff regarding full review of drug chart prior to administration of medication. Further discussion on the introducing of an electronic medicine administration record.	Ward Manager HOCS	Febr 2024	Record of discussion and quality audit. Records of meetings discussions	Weekly	Quality Improvement	Monthly

Engage stakeholders in completing the safety action table using SMART principles to write the required actions.
The actions will say how the recommendations are going to be taken forward and are separate from the investigation process.
Actions should be risk assessed to ensure no untoward consequences arise from their introduction.
This report must be uploaded to the Datix record.

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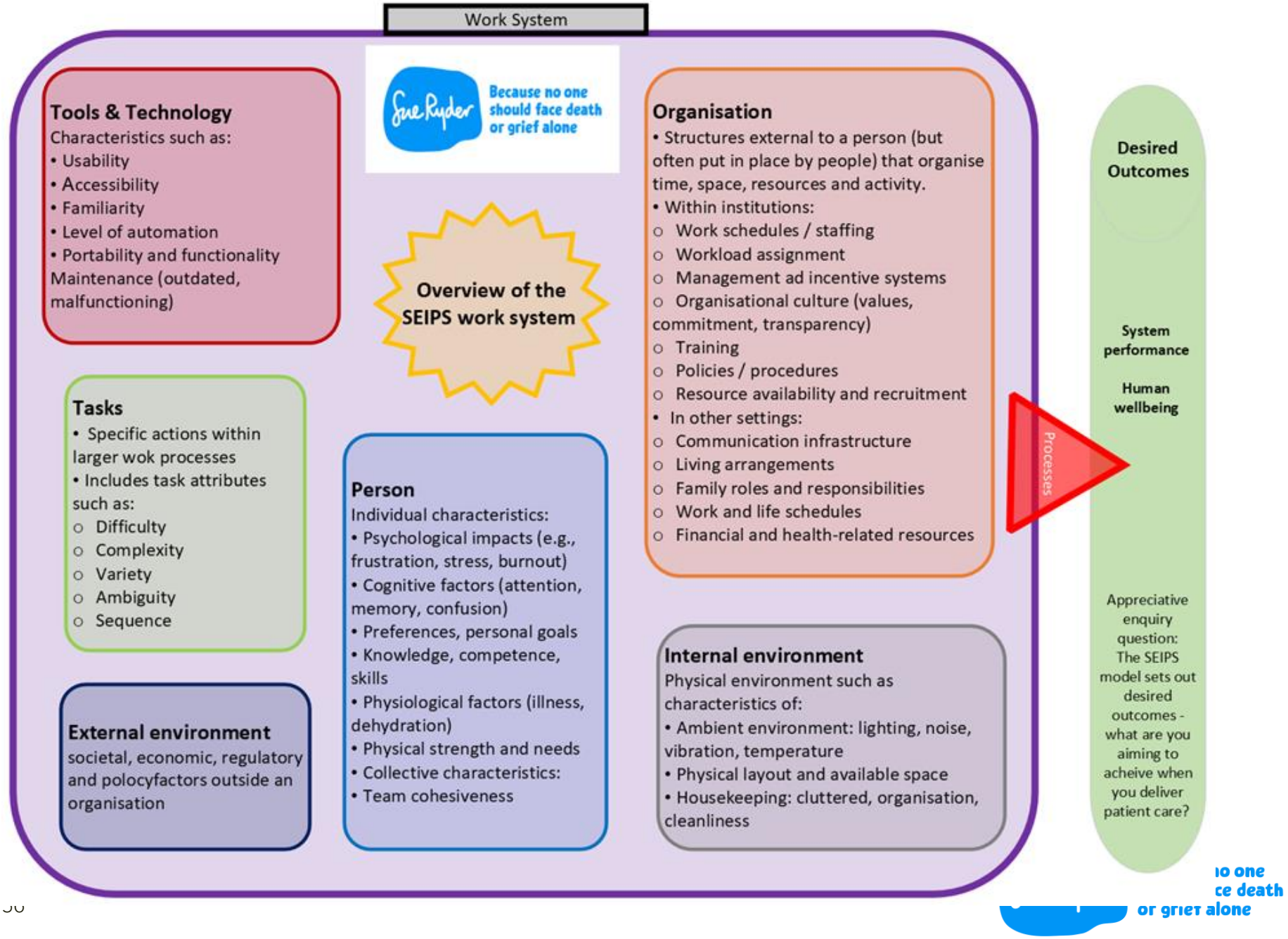
Work System
Tools & Technology
Characteristics such as:
• Usability
• Accessibility
• Familiarity
• Level of automation
• Portability and functionality
Maintenance (outdated, malfunctioning)
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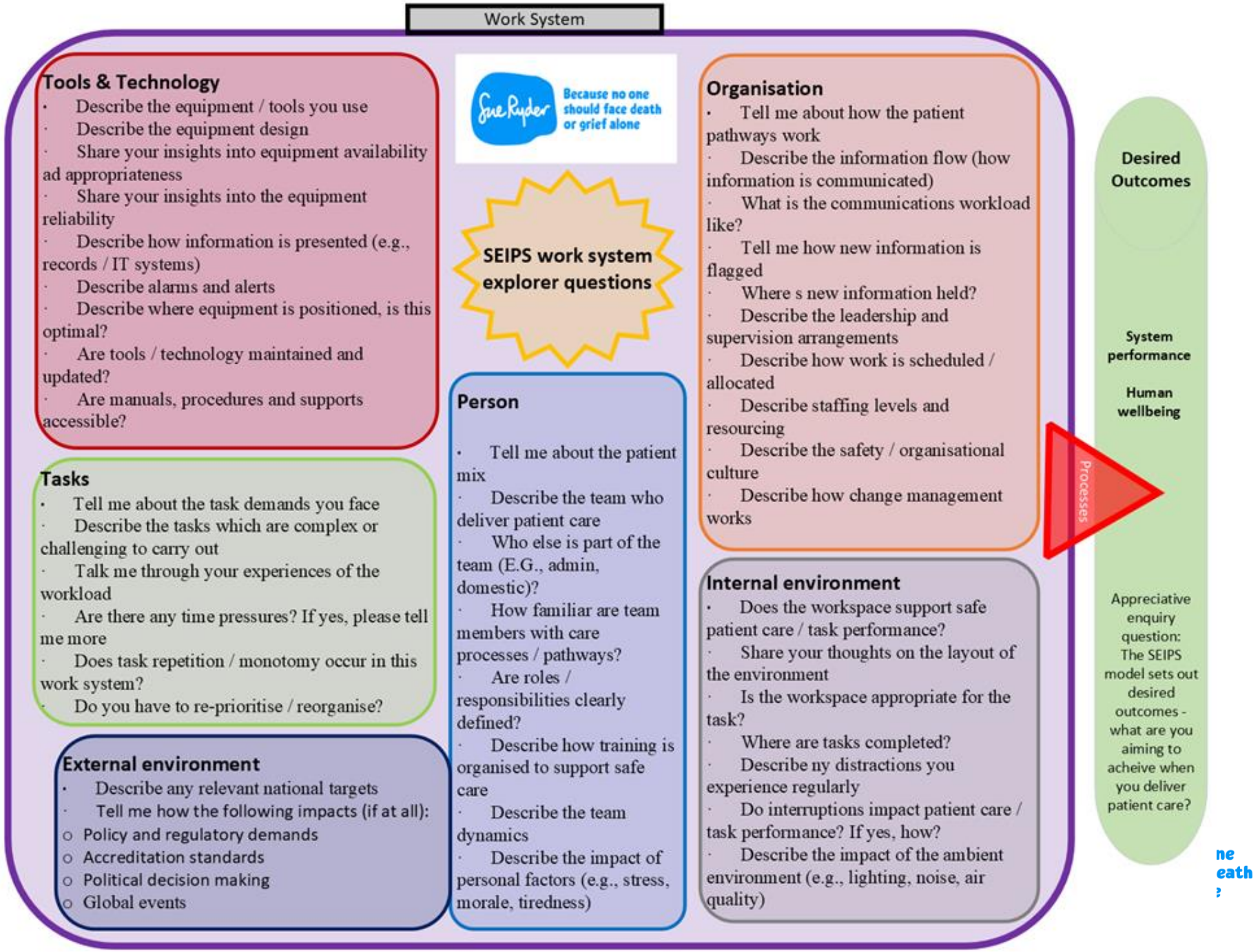
Overview of the SEIPS work system
Organisation
• Structures external to a person (but often put in place by people) that organise time, space, resources and activity.
• Within institutions:
o Work schedules / staffing
o Workload assignment
o Management ad incentive systems
o Organisational culture (values, commitment, transparency)
o Training
o Policies / procedures
o Resource availability and recruitment
• In other settings:
o Communication infrastructure
o Living arrangements
o Family roles and responsibilities
o Work and life schedules
o Financial and health-related resources
Tasks
• Specific actions within larger wok processes
• Includes task attributes such as:
o Difficulty
o Complexity
o Variety
o Ambiguity
o Sequence
Person
Individual characteristics:
• Psychological impacts (e.g., frustration, stress, burnout)
• Cognitive factors (attention, memory, confusion)
• Preferences, personal goals
• Knowledge, competence, skills
• Physiological factors (illness, dehydration)
• Physical strength and needs
• Collective characteristics:
• Team cohesiveness
Internal environment
Physical environment such as characteristics of:
• Ambient environment: lighting, noise, vibration, temperature
• Physical layout and available space
• Housekeeping: cluttered, organisation, cleanliness
External environment
societal, economic, regulatory and polocyfactors outside an organisation
Processes
Desired Outcomes
System performance
Human wellbeing
Appreciative enquiry question: The SEIPS model sets out desired outcomes - what are you aiming to acheive when you deliver patient care?


Work System
Tools & Technology
· Describe the equipment / tools you use
· Describe the equipment design
· Share your insights into equipment availability ad appropriateness
· Share your insights into the equipment reliability
· Describe how information is presented (e.g., records / IT systems)
· Describe alarms and alerts
· Describe where equipment is positioned, is this optimal?
· Are tools / technology maintained and updated?
· Are manuals, procedures and supports accessible?
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SEIPS work system explorer questions
Organisation
· Tell me about how the patient pathways work
· Describe the information flow (how information is communicated)
· What is the communications workload like?
· Tell me how new information is flagged
· Where s new information held?
· Describe the leadership and supervision arrangements
· Describe how work is scheduled / allocated
· Describe staffing levels and resourcing
· Describe the safety / organisational culture
· Describe how change management works
Tasks
· Tell me about the task demands you face
· Describe the tasks which are complex or challenging to carry out
· Talk me through your experiences of the workload
· Are there any time pressures? If yes, please tell me more
· Does task repetition / monotomy occur in this work system?
· Do you have to re-prioritise / reorganise?
Person
· Tell me about the patient mix
· Describe the team who deliver patient care
· Who else is part of the team (E.G., admin, domestic)?
· How familiar are team members with care processes / pathways?
· Are roles / responsibilities clearly defined?
· Describe how training is organised to support safe care
· Describe the team dynamics
· Describe the impact of personal factors (e.g., stress, morale, tiredness)
Internal environment
· Does the workspace support safe patient care / task performance?
· Share your thoughts on the layout of the environment
· Is the workspace appropriate for the task?
· Where are tasks completed?
· Describe ny distractions you experience regularly
· Do interruptions impact patient care / task performance? If yes, how?
· Describe the impact of the ambient environment (e.g., lighting, noise, air quality)
External environment
· Describe any relevant national targets
· Tell me how the following impacts (if at all):
o Policy and regulatory demands
o Accreditation standards
o Political decision making
o Global events
Processes
Desired Outcomes
System performance
Human wellbeing
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28. Appendix 7 – PSIRF rapid review pressure ulcer example

Rapid review report - EXAMPLE

Pressure ulcer

Datix ID	12379	Date of incident	24/07/2023	Place / department	Sue Ryder Hospice	Incident type	Deterioration of pressure ulcer
Level of harm	Moderate	Duty of Candour	Verbal apology 24/07/2023	Date rapid review completed	24/07/2023	Date discussed at QIG meeting	08/08/2023
Category of worst pressure ulcer	Category 3	Site and size cm2	Sacrum 2.5cms x 2.5cms	Other pressure ulcers (sites and categories)	Category 2 – left hip bony prominence	Recurrent pressure ulcer history?	Previous heeled category 2 – left heel
Author & designation	Jane Doe, Senior Nurse	Level of investigation training	Essentials of patient safety – level 1	Report approved by & designation	Jo Bloggs, Head of Clinical Services	Level of investigation training	Level 2

Points to consider:
Past medical history: Admitted with metastatic colorectal Ca post sepsis caused by a perforated gallbladder.

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Pressure injury history: Patient was admitted from home, the handover detailed a previously healed pressure ulcer on the patients left heel. Patient was admitted with moisture lesions and multiple breaks to the skin surface around buttocks.

Appearance of the wound(s): discoloured and sloughy.

Exudate type and level: exudate is from moisture lesions surrounding the pressure ulcer.

Signs of infection: no.

Dressings in situ: none, not applicable.

Skin pigmentation / ethnicity: patient has dark skin

Predisposing factors:

Intrinsic	Extrinsic
cognitive deficit due to progression and stage of disease. poor nutrition due to progression and stage of disease. Patient aged 88 years.	Humidity – Heat wave temperatures. Pressure – patient not tolerant of repositioning / offloading (unable to lay on left side).

Who was impacted? What did they need?

Patient – Was upset that had developed pressure ulcers, additional support and education given.

Family / Next of Kin – they were made aware of the incident and were keen to understand lessons learnt and how to prevent further tissue damage occurring.

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Staff – Staff were saddened by the deterioration of the patients' tissue viability. Organisation – potential for reputational damage.	
Work as prescribed (what was expected): SEIPS guidance below.	**Work as done (what happened): SEIPS guidance below.**
Tasks: • Patient identified as pressure injury risk through risk assessments. • Comprehensive skin assessment including body map completed within 6 hours of admission. • Patient's skin condition documented daily or as clinically relevant. • Moving and handling risk assessment completed. • Nutritional assessment completed – MUST. • Continence assessment completed. • Pressure ulcer prevention plan in place. • Preventative care delivered in line with care plans, SSKIN and equipment. • Medical photography completed and consented to. • Wound care plan implemented. • Evaluation and modification of care including failure to escalate undertaken at the point of deterioration.	Tasks: • Patient was not referred to TVN team following deterioration. • Safeguarding notification made 24/01/2024. • Identified actions from the previous pressure ulcer incident had been fully implemented through a thorough handover from previous care providers on admission. • MUST used to assess nutritional status however PLANC implemented and not used despite being more appropriate to patients needs. • Purpose T completed within recommended timeframes. • Skin inspection prescribed frequency not always achieved, unclear through documentation if the importance of this process reiterated. • Skin care and barrier products available & advised and used due to incontinence. • Dry skin (heels) managed with emollient. • Heels offloaded due to previous pressure ulcer located to heel and associated risks. • Care rounding not completed 4 hourly as per risk assessment outcome due to agency staff not being familiar with the care rounding process.

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- Care rounding 4 hourly implemented following risk assessment outcomes.

Tools and technology:

- Appropriate equipment used (redistribution or off-loading devices).
- Medical devices in use and risk assessed to prevent pressure concerns.

Staff:

- Correct referrals made and MDT staff involved in the care plan.
- Organisation of work factors:
- Pressure risk category reassessed as per policy upon change of condition.
- Daily huddle meetings to review patients risk factors and changes.

Person factors:

- Repositioning offered however often declined.
- Internal environment:
- Patient advisory leaflet provided.
- External environment:
- NICE Quality Standard QS89:

Technology and tools:

- Patient cared for on OSKA 5 mattress in full working order (last maintenance review (17/02/2023).
- Pressure relieving equipment assessed and implemented according to assessment outcomes without delay.
- Patient slide sheets available within room and documented as used by staff to support moving patient within the bed.
- Staff supported patient to move using a hoist, sling appropriately measured and correct sizing used to meet patient and equipment needs.

Staffing factors:

- Ward was fully staffed according to safe staffing levels.
- Ratio of permanent / temporary staff was high due to permanent staff annual leave, sickness and maternity leave, this could have had an impact on the patients care.
- Nursing staff regularly receive pressure ulcer prevention and management training and updates, compliance currently at 96%.
- Staff know how to use pressure ulcer equipment appropriately and have received training in the selection and operational arrangements for this equipment, training compliance currently at 94%.

Organisational work factors:

- Incident form completed following identification of deterioration however not fully documented or escalated.

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	• Huddle meetings not consistently completed due to lower permanent staff on shift. Person factors: • Patient has experienced previously healed pressure ulcers and was compliant with supportive measures to achieve this outcome. • Patient deterioration resulted in declining offloading procedures and not tolerating care rounding, patient unable to lay on left hand side. • Internal factors: • In the last 12 months the ward has had 4 Category 3 develop or deteriorate within our care. • Patient advisory leaflet given, however no documentation found to evidence support provided to read & understand the information contained within it. External factors: • NICE Quality Standard QS89 guidance followed.
Analysis:	**Learning:**
• The patient had dark skin and therefore early warning signs of deterioration were not picked up on by staff. • TVN referral was not made in a timely manor due to the rapid deterioration of the patient. • The inpatient unit was very busy during the time of this patient's admission, this may have been a contributory	• Agency staff to be given a thorough induction. • Referrals to be made in a timely manner. • Documentation to be reviewed by all staff to support understanding of the importance of this. • Training to be provided to ensure staff area able to identify skin changes on different skin tones.

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factor to documentation being missed or not correctly completed and timely referrals not being made. • There was a high number of agency staff on shift most days during the patients admission, some of the agency staff are regular however there were some relatively new agency staff members who are less familiar with the Sue Ryder processes and who were additionally unable to access electronic care records. • The ward staff had not been provided information in relation to a policy change and the implementation of PLANC providing the choice of the most suitable nutritional assessment as per the patients individual needs compared to MUST. • The patients deteriorating condition resulted in declined offloading procedures, documentation did not evidence if PRN medicines had been explained and offered to support these procedures.	• A process to be implemented to support dissemination of information following policy changes.

Outcome: (Where actions will be added to current action plan, please see Safety Action Table) (Appendix 1)
No further investigation required - actions to be added to current action plan.

Actions:	**Yes (include date and by whom).**	**No (state reason).**

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CQC notified		X – not required
ICB notified		X – not required
Safeguarding referral made		X – not required

Appendix I: Safety action table

Please list actions that will be added to relevant current plan.

	Recommendation	Action for Improvement	Safety action owner (role, team directorate)	Target date for implement ation	Tool/measu re	Measuremen t frequency (e.g. daily, monthly)	Responsibility for monitoring/ oversight (e.g. specific group, individual)	Planned review date (e.g. annually)
2.	Staff admitting patients should have protected time to complete the admission.	Ensure protected time. Consider a space to be used	Name Head of Clinical Services	September 2023	Record of discussion Identified changes to practice	Audit at 1 and 3 months	Quality Improvement	Annual
2	Agency staff induction	Ensure induction document drafted with staff involvement Discuss in safety huddle.	Ward manager	September 2023	Completed audits Safety huddle notes	Weekly	Quality Improvement	Monthly

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		Add into SOP regarding staff handover following medicines round.						
3.	Training	Refresher Huddle training Recognising changes in tissue viability on all skin tones training to be completed by all staff	Ward Manager HOCS	Feb 2024	Record of discussion & completion and quality audit. Records of meetings discussions	Weekly	Quality Improvement	Monthly

Engage stakeholders in completing the safety action table using SMART principles to write the required actions. The actions will say how the recommendations are going to be taken forward and are separate from the investigation process.
Actions should be risk assessed to ensure no untoward consequences arise from their introduction.
This report must be uploaded to the Datix record.

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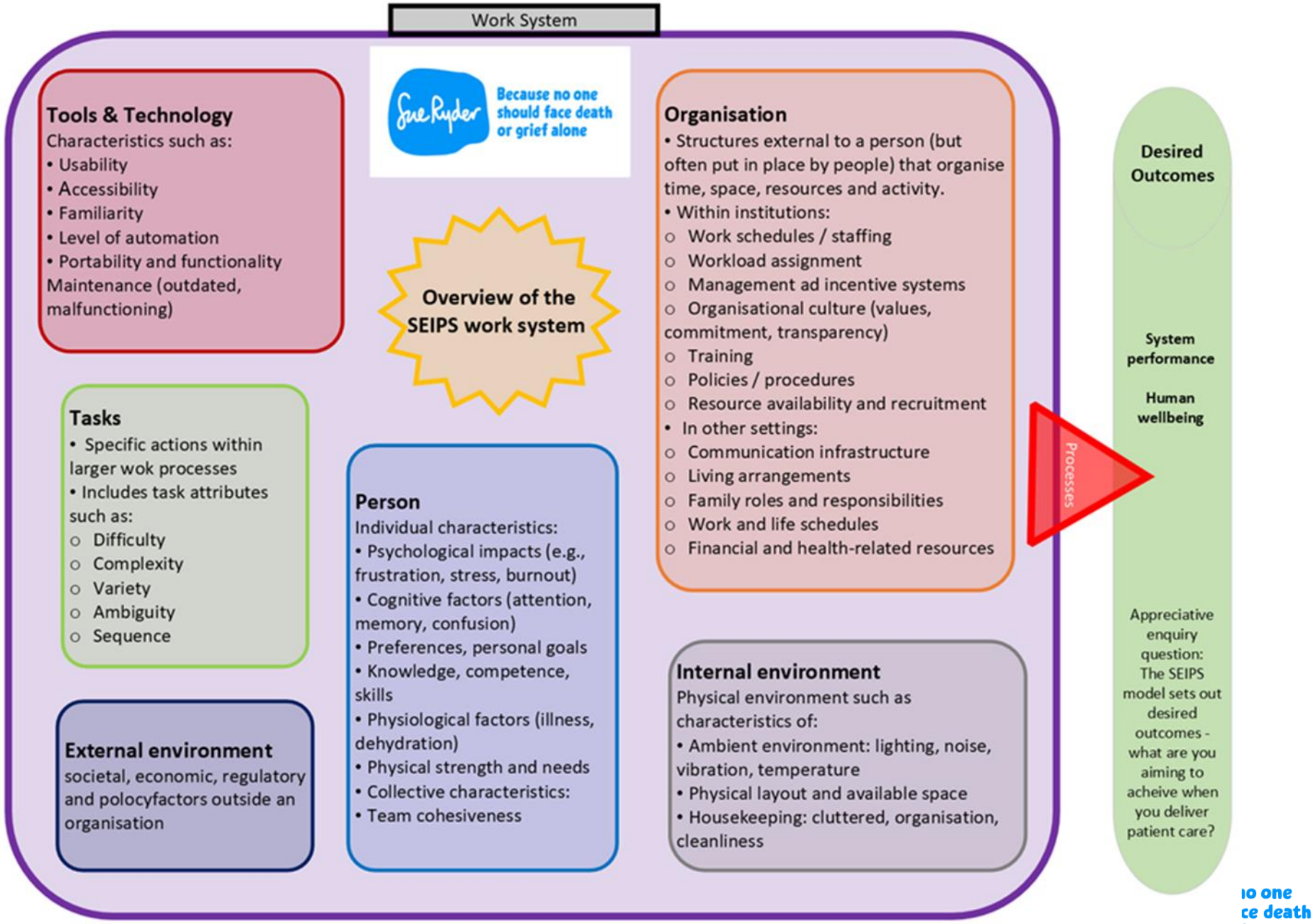
Work System
Tools & Technology
Characteristics such as:
• Usability
• Accessibility
• Familiarity
• Level of automation
• Portability and functionality
Maintenance (outdated, malfunctioning)
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Overview of the SEIPS work system
Organisation
• Structures external to a person (but often put in place by people) that organise time, space, resources and activity.
• Within institutions:
o Work schedules / staffing
o Workload assignment
o Management ad incentive systems
o Organisational culture (values, commitment, transparency)
o Training
o Policies / procedures
o Resource availability and recruitment
• In other settings:
o Communication infrastructure
o Living arrangements
o Family roles and responsibilities
o Work and life schedules
o Financial and health-related resources
Processes
Desired Outcomes
System performance
Human wellbeing
Tasks
• Specific actions within larger wok processes
• Includes task attributes such as:
o Difficulty
o Complexity
o Variety
o Ambiguity
o Sequence
Person
Individual characteristics:
• Psychological impacts (e.g., frustration, stress, burnout)
• Cognitive factors (attention, memory, confusion)
• Preferences, personal goals
• Knowledge, competence, skills
• Physiological factors (illness, dehydration)
• Physical strength and needs
• Collective characteristics:
• Team cohesiveness
Internal environment
Physical environment such as characteristics of:
• Ambient environment: lighting, noise, vibration, temperature
• Physical layout and available space
• Housekeeping: cluttered, organisation, cleanliness
External environment
societal, economic, regulatory and polocyfactors outside an organisation
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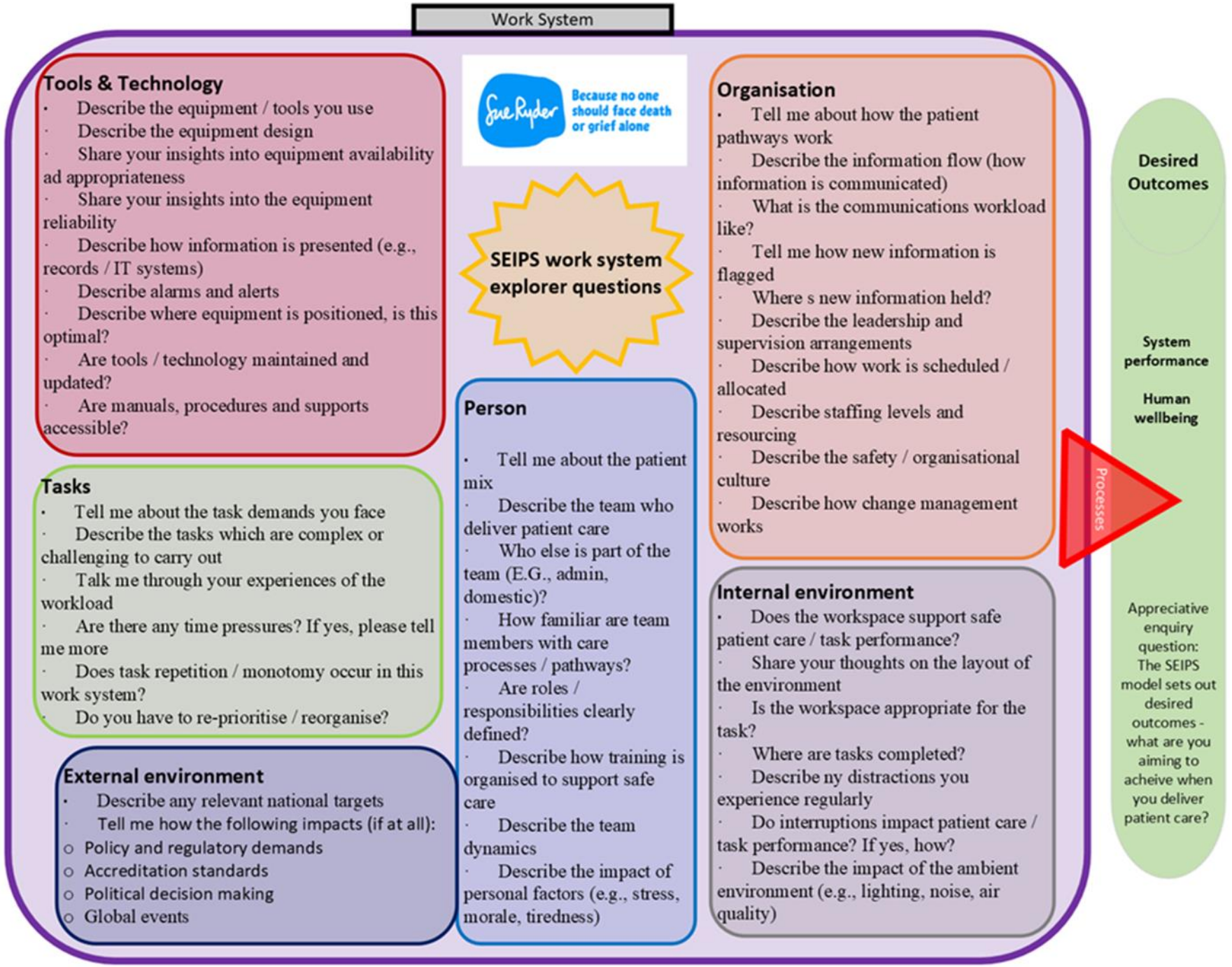

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