derian house children's hospice

Patient Safety Incident Response Policy (PSIRF)

Implementation Date:

September 2024

Author: Bridget Thomas

Clinical Director

Approved by:

Review Date	*Amendments*	*Author*
September 2027		

Contents

1. Policy Statement

This policy supports the implementation of the Patient Safety Incident Response Framework (PSIRF). It sets out Derian House Children's Hospice approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

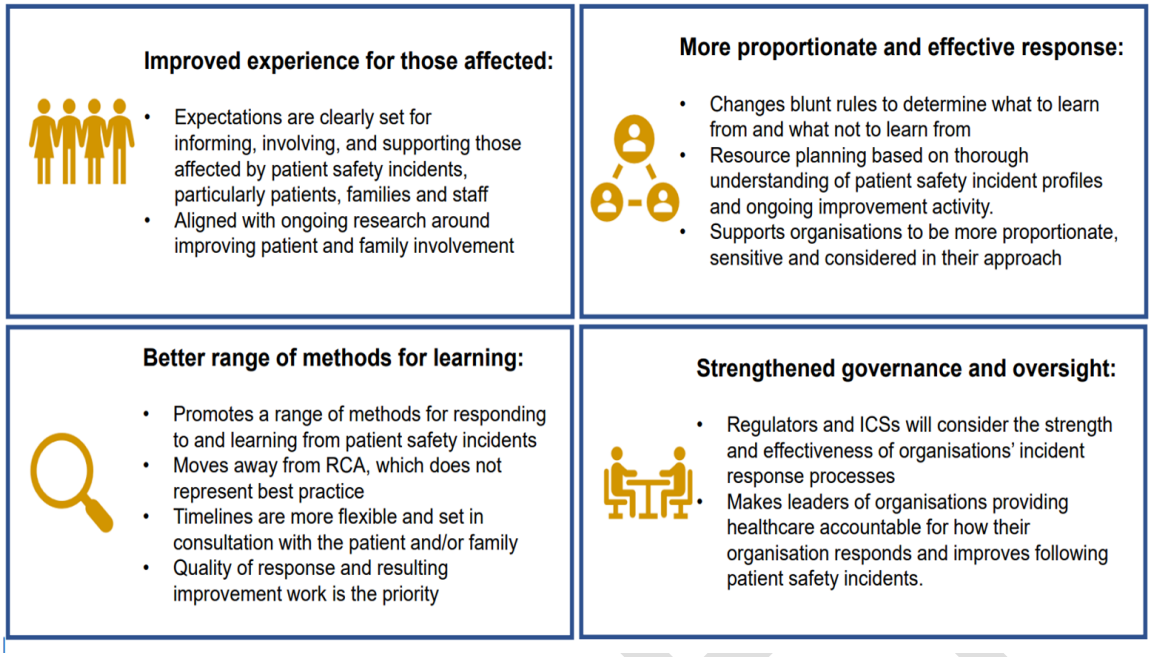
It is acknowledged that the PSIRF Framework is more aligned to large NHS organisations where multiple safety incidents occur at different levels on a daily basis and with infrastructures to provide full time oversight of PSIRF. In addition, there is no national guidance on how PSIRF should be embedded in Hospices or charities, therefore this policy follows NHS England guidance as it applies to the clinical services in Derian House children's hospice and is underpinned by the principles of just culture and duty of candour.

The PSIRF advocates a co-ordinated response to patient safety incidents to establish learning and improvement taking into account wider systems and processes and human factors. It promotes a significant and welcomed cultural shift towards system learning instead of focus on individuals and potential blame.

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

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

PSIRF aims to achieve the following –



2. Purpose/Scope

This policy applies to Derian House Children's Hospice, which is referred to as Derian House throughout this policy.

This policy covers all staff, including GPs, Consultants, contractors and volunteers (collectively referred to as staff in this policy). Failure to comply with this policy may result in further action including disciplinary procedures being taken where appropriate.

This policy does not form part of any employee's contract of employment and it may be amended at any time.

The purpose of this policy is to embed PSIRF processes across Derian House to develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety in line with the PSIRF framework.
This policy is specific to patient safety incident responses solely for the purpose of learning and improvement across Derian House.

The PSIRF replaces the Serious Incident Framework (SIF), (2015) removes the "serious incidents" classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF framework changes how organisations respond to patient safety events for learning and improvement aligning to the following principles -

- **A co-ordinated and data-driven** approach to patient safety responses that prioritises compassionate engagement with those affected, including staff.
- **A wider system of improvement** and prompts a cultural shift towards patient safety management.
- **A systems-based approach**, recognising that patient safety is achieved by interactions between different elements of care and not from a single component.
- **A system approach and NOT a person approach** to look at all elements that may have led to the incident and not just the person involved.

The PSIRF framework advocates a **no blame, just culture** with the purpose to learn and improve practice.

In cases where liability, preventability or cause of death needs to be determined, the statutory processes already in place will be used for these types of investigation as follows -

- Claim handling
- Coronial inquests
- Criminal investigations
- Human resources/ employee relations investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- Complaints (except where a significant patient safety concern is highlighted)

A patient safety response process can be undertaken alongside these other investigations, but the purpose of PSIRF is to learn and not to investigate. Investigations under the PSIRF Framework can be shared with those leading other types of responses, but other investigations should not influence the remit of a patient safety incident response.

For clarity, the principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

3. Responsibility/Accountability

The Board of Trustees (the Board) has overall responsibility for the effective operation of this policy, but has delegated day-to-day responsibility for its operation to the CEO. Responsibility for monitoring and reviewing the operation of this policy and making recommendations for change to minimise risks lies with the CEO.

All managers have a specific responsibility for operating within the boundaries of this policy, ensuring that all staff understand and comply with the requirements of this policy. Action could be taken for failure to comply with this policy in accordance with the staff handbook requirements.

All staff are responsible for compliance with this policy and should ensure that they take the time to read and understand it. Any breach of anything included within this policy should be reported to the policy author or their line manager. Questions regarding the content or application of this policy should be directed to the policy author.

4.1 Responsibilities in relation to PSIRF

- **The Board**
  The Board is responsible and accountable for ensuring effective patient safety incident management processes are in place and followed in Derian House.
- **Clinical Director/Head of Governance**
  The Clinical Director will be responsible for overseeing the implementation of PSIRF across Derian House in collaboration with the Head of Governance. This enables us to -
    - Ensure Derain House meets the national patient safety standards.
    - Ensure that PSIRF is central to overarching safety governance arrangements.
    - Quality assuring learning response outputs.
    - Provide direct leadership, advice, support in complex/ high profile cases, and liaise with external bodies, as required.
    - The Clinical Director has the overarching responsibility for the quality of patient safety learning responses and PSIIs.
    - The Clinical Director has overarching responsibilities for safety learning and improvement.

4. Related Policies and Procedures

This policy should be read in conjunction with the following policies and procedures;

Title	*Policy/Standard Operating Procedure/Clinical Guideline*
Staff Handbook	*Policy*
Medicines Management	*Policy*
Managing Medicines Errors	*Policy*
Complaints	*Policy*
Risk Management	*Policy*
Raising Concerns/Whistleblowing	*Policy*
Vantage Incident Reporting	*Standard Operating Procedure*
Notification to External Bodies	*Policy*
Information Governance	*Policy*

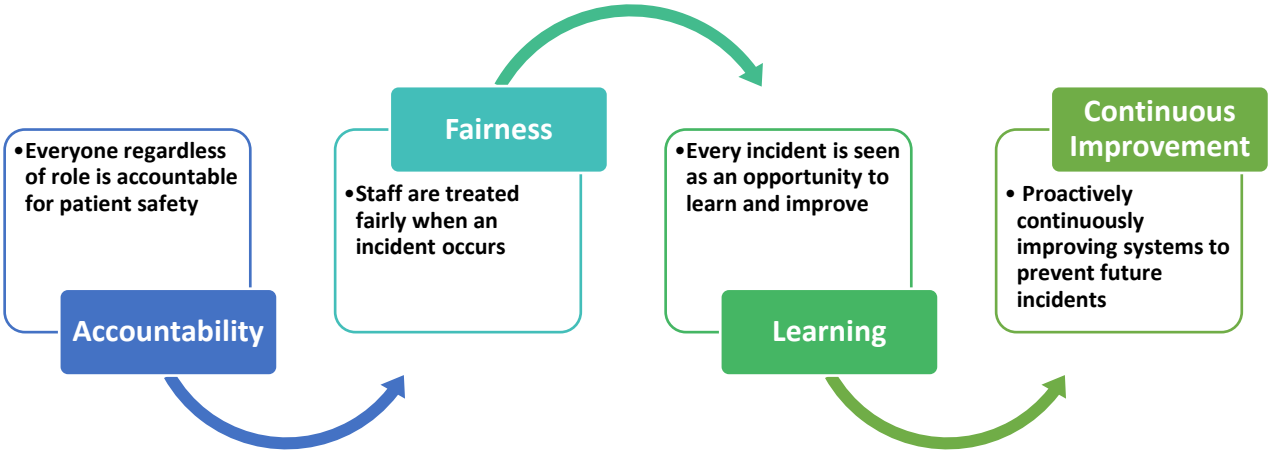
5. Patient Safety Culture

Derian House is committed to establishing a just culture in response to patient safety incidents. All leaders in Derian House are required to proactively embrace this approach in transitioning to a just culture.

The goals of just culture include:

Shared Accountability	Acknowledgment that **safety responsibility extends from frontline workers to leadership**. Every individual within the Derian House plays a role in ensuring patient safety.
Open Communication	Encouraging **open communication** is crucial for the success of Just Culture. Incidents are reported without fear of retribution, fostering transparency and creating opportunities for learning from mistakes.
Focus on Systems	**Errors are viewed as indicators of systemic flaws** rather than individual failings.
Supportive Environment	Staff members who make **mistakes are not punished** but given support and guidance for learning and improvement.

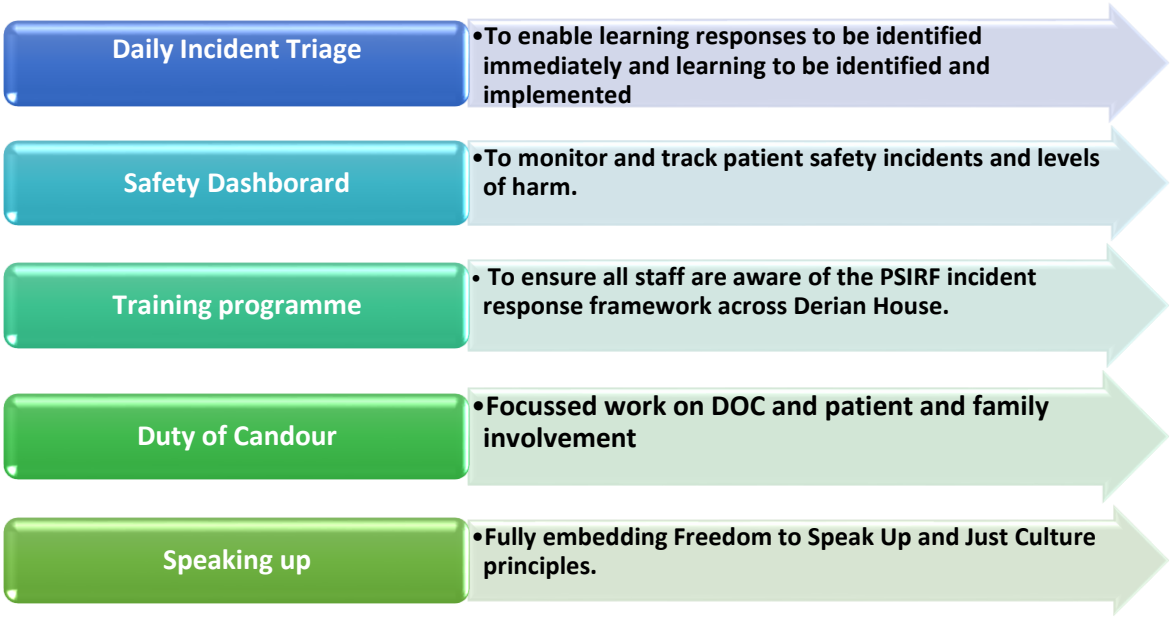
These goals are underpinned by the 4 pillars of Just Culture



PSIRF will enhance these by creating stronger links between patient safety events and learning for improvement.

Derian House is clear that patient safety event responses are conducted for the sole purpose of learning and identifying system wide improvements; they are not to apportion blame.

Our safety culture within Derian House is a key organisation priority, with the following implemented as part of the PSIRF framework – ***See Appendix 1 for Triage Template.***



5.1 Patient Safety Partners

The Patient Safety Partner (PSP) role is a new under the PSIRF framework. PSPs can be patients, carers, family members or other lay people (including staff from another organisation) and offers opportunities to share experiences and skills and provide a level of scrutiny.

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

5.2 Addressing Health Inequalities

All organisations have a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way.

Derian House is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data to assess any disproportionate patient safety risk to patients from across the range of protected characteristics.

Any incident which indicates that a health inequality or protected characteristic may have contributed to harm must be reviewed for the appropriate response to ensure that BCYP and families are treated fairly and consistently.

Engagement of those involved which include patients, families/carers, and staff, following a patient safety event is crucial to learning, therefore consideration must be given to the following when engaging with parents and families –

- Translation, and interpretation services alongside any other method appropriate to meet needs and maximise the potential of a patient or family being involved.
- Alternative formats, such as easy read or large print.
- Information in different languages.
- Consideration of families with hearing or visual impairment.
- Consideration of Families who do not read or write.

Derian House has a zero tolerance of any form of racism or discrimination, and unacceptable behaviours from and towards our babies, children and young people, parents, carers, families and staff will be addressed and managed appropriately.

5.3 Engaging and involving staff, patients and families following a patient safety event

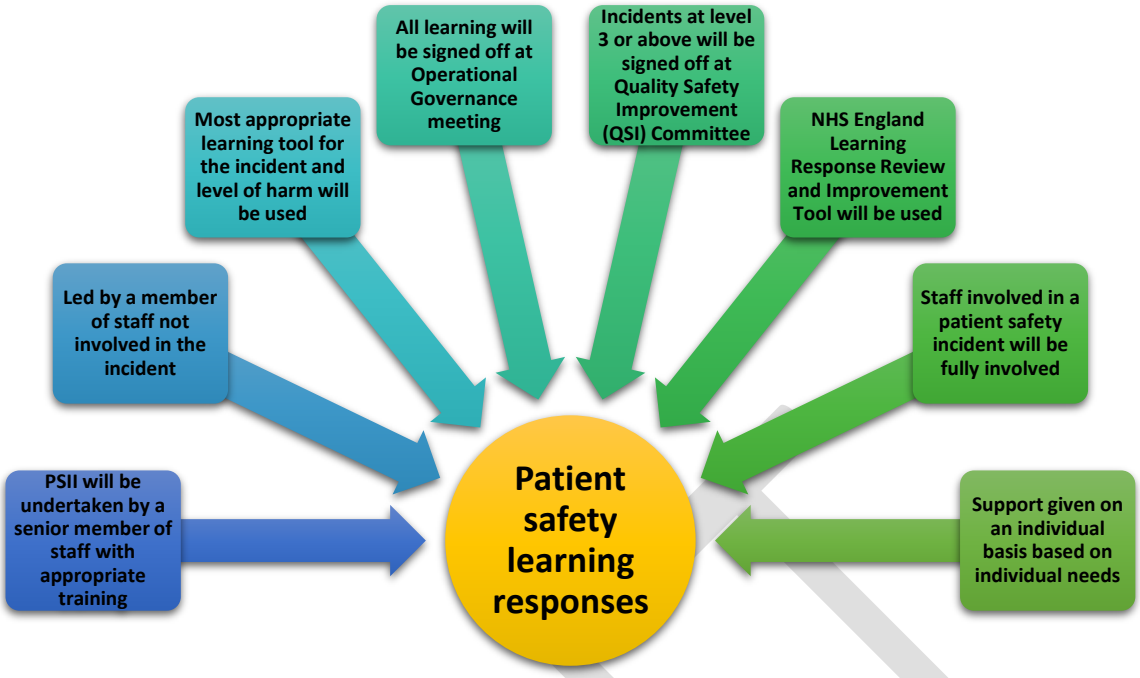
Learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. Therefore, compassionate engagement and involvement of those affected is vitally important. This involves working with all those affected to understand and answer any questions in relation to the event and signpost to relevant support as required.

Getting involvement right with patients and families is crucial, particularly to support the improvement of the services we provide. This involves being open and honest whenever there is a concern about care/ treatment provided, or when a mistake has been made.

Alongside professional and statutory requirements for Duty of Candour, Derian House will be open and transparent about all care incidents regardless of the level of harm caused by an event and support will be offered to parents and families.

5.4 Resources and training to support patient safety responses

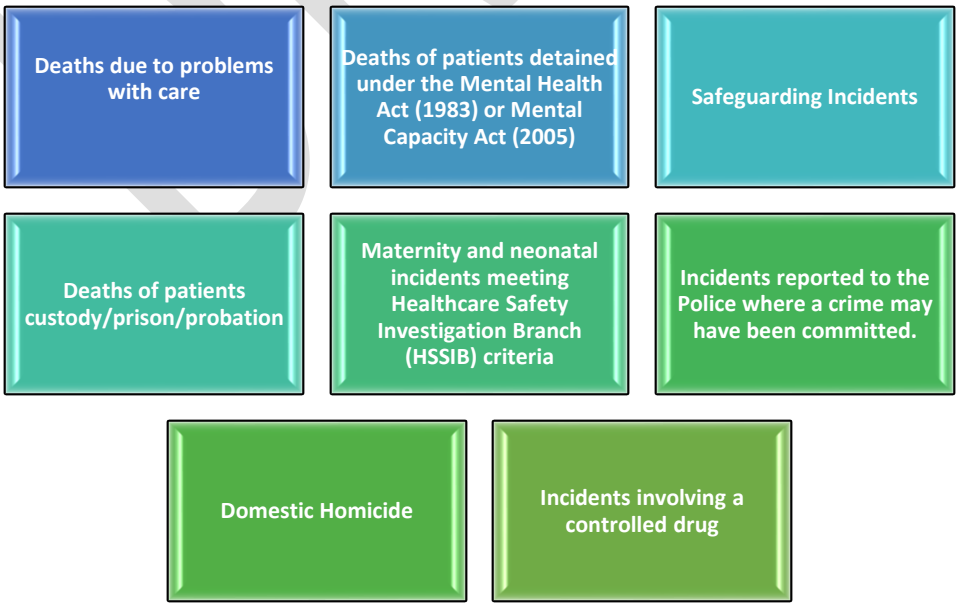
Derian House has utilised NHS England Patient Safety Response Standards, (2022) to provide resources and the training required to implement PSIRF. **See Appendix 2.**



6. Responding to patient safety events

6.1 Patient Safety Reviews

6.1.1 Patient Safety Incident Investigation (PSII) can be used if deemed appropriate for an internal investigation. NHS England PSIRF only requires the following mandatory events to be investigated as a PSII and these are incidents that require external reporting and another statutory investigation as follows -



- **Purpose** - PSIIs are undertaken to identify new opportunities for learning and improvement with a focus on improving healthcare systems; they do not look to blame individuals. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

- **Aim** - The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved.

- **Timeframe** - PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

- **Outcome -** If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later.

- **Duty of Candour** - The investigation team follow the Duty of Candour process and engage and involve families and staff at the earliest opportunity to help identify what happened and how this resulted in a patient safety incident. Investigators follow the Just Culture guide in the minority of cases when staff may be referred for disciplinary or are part of a further investigation process **(See Appendix 5).**

- **Investigator** - PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.
  See appendix 4 for the PSII Investigation template.

6.2 Other Types of Review

The nature of the incident and level of harm and risk will determine the type of review required.

The following is on overview of the types of reviews that can be undertaken for learning under PSIRF. ***See Appendix 4 for templates***

Patient Safety Incident Investigation (PSII)	An in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. This is mandatory in certain circumstances (see 7.1)
Swarm Huddle	Undertaken as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to gather information about what happened and why it happened and decide what needs to be done to reduce the risk of the same thing happening in the future.
After Action Review (AAR)	A structured facilitated discussion, the outcome of which gives individuals involved understanding of why the outcome differed from that expected and the learning to assist improvement. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?
Multidisciplinary Team review (MDT)	Supports teams to learn from patient safety incidents that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, to agree the key contributory factors and system gaps that impact on safe patient care.
Thematic Review	To understand common links, themes or issues within a cluster of investigations, incidents or patient safety data.
Horizon scanning	To support teams to take a forward look at potential or current safety themes and issues from other areas. It can be used to proactively identify safety risks and put mitigations in place

6.3 Reviewing incidents

- All staff and volunteers are responsible for recording and reporting potential or actual patient safety events on the Vantage system.
- The reporter will record the level of harm they believe to have been experienced by those affected using the risk matrix ***(See Appendix 3)***.
- A daily triage ***(See Appendix 1)*** of any incident that occurred in the last 24 hour period incidents will take place each morning, led by a team leader, ACP or any other senior member of staff. If no incidents have occurred, this can be stood down for that day. This will identify,
    - Immediate response required,
    - Immediate learning
    - Staff Support
    - Duty of Candour
    - Escalation if appropriate
    - Learning tool to be utilised
    - Re grading of incident as appropriate on review and on receipt of further information.
    - Closure of incident if appropriate.
    - Assigning incident to the appropriate manager.

Any incidents highlighted that meet requirements for reporting externally will be escalated to and managed by the Head of Governance and Clinical Director.

6.4 Timescales for Patient Safety Incident Investigations (PSIIs) (*See Appendix 6 for Flow chart)*

Where a full PSII is indicated, the following process will be followed –

- Investigator appointed
- Terms of reference agreed with Head of Governance and Clinical Director
- PSII commenced within 2 weeks of incident occurring as agreed by Head of Governance, Clinical Director and family if patient involved.
- PSII to be completed within 3 months of start date. Any delays or extensions required must be discussed and agreed with Head of Governance, Clinical Director and family, with a clear rationale for extension/delay.
- Final report to be submitted to PSIRF panel for review and sign-off.
- Final report to be presented at QSI for oversight and assurance regarding learning
- Learning identified shared with all involved.
- Action plans outlining learning and changes in practice to be monitors via QSI.

7. PSIRF Training

Derian House will undertake a Training Needs Analysis and training will be delivered to all staff as part of mandatory training requirements as outlined by NHS England. Additional training will be offered to PSII investigators to ensure consistency and objectivity and learning.

8. Patient safety incident response plan (PSIRP)

Derian House incident response procedures will be underpinned by the local PSIRP which will be reviewed on a yearly basis. Derian House response to PSI will remain flexible and consideration will be given to the specific circumstances in which each patient safety event occurred, and the needs of those affected as well as the plan.

9. Monitoring Improvement

It is vitally important to monitor the implementation of learning from any PSI learning event and ensure any changes reduce risk and support high quality clinical care.
Derian House will utilise processes for development of safety actions as outlined by NHS England; Safety Action Development Guide, (2022):

- **Agree areas for improvement**: Specify where improvement is needed, without defining how the improvement is to be achieved.
- **Define context**: Agree approach to develop safety actions.

- **Define safety actions to address areas of improvement**: Collaborate with the team focus on the system using a Human Factors approach.
- **Prioritise safety actions**: Base actions on fact and subjectivity not intuition and opinion.
- **Define safety measures**: Collate data to determine to monitor the effectiveness of the safety actions taken.
- **Monitor and Review**: Monitor impact and sustainability of the actions.

Derian House learning will be underpinned by a robust action plans which will be monitored through Operational Governance and assurance given to the Board via QSI Committee.

Learning will be disseminated to staff both formally and informally and any changes to practice will be supported by the Education team. Any policies or documents that need to amended, updated or implemented following learning will be scrutinised and approved via the Policy Development and Review Group.

10. Failure to Comply

All staff are responsible for adhering to this policy. Failure to follow this policy may result in disciplinary action being taken in accordance with the disciplinary policy and if applicable, notification to appropriate professional bodies or relevant authorities.

11. Training Requirements

Staff are responsible for highlighting any training needs as part of their professional development which should be discussed and agreed during One to One, Supervision or Appraisals. During the Appraisal process, the Appraisee is required to confirm they have read and understood the policies to carry out their role.

12. Reporting a Breach

Every user of this policy is responsible for reporting any incident which may represent an actual or potential breach of this policy or any related policy. To the following:

- Line Manager
- HR Manager
- Senior Manager
- Chief Executive

Employees also have the anonymous option of following the protocols set out in the Whistleblowing Policy.

13. References

https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-culture-guide/

https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

https://www.england.nhs.uk/long-read/patient-safety-incident-response-framework/

14. Information Governance

This policy complies with the requirements of good Information Governance and compliments the Information Governance Policy. All staff should make themselves aware of the Policy.

15. Review

The CEO in conjunction with the Board shall be responsible for reviewing this policy on a three year basis to ensure that it meets legal requirements and reflects best practice. The Policy Development and Review Group encourage feedback and comments on this policy.

16. Equality and Diversity Impact Statement

POLICY STATEMENT:

Derian House Children's Hospice is committed to creating a culture in which diversity and equality of opportunity are promoted actively and in which unlawful discrimination is not tolerated.

Derian House Children's Hospice believes in the principles of social justice, acknowledges that discrimination affects people in complex ways and is committed to challenge all forms of inequality.

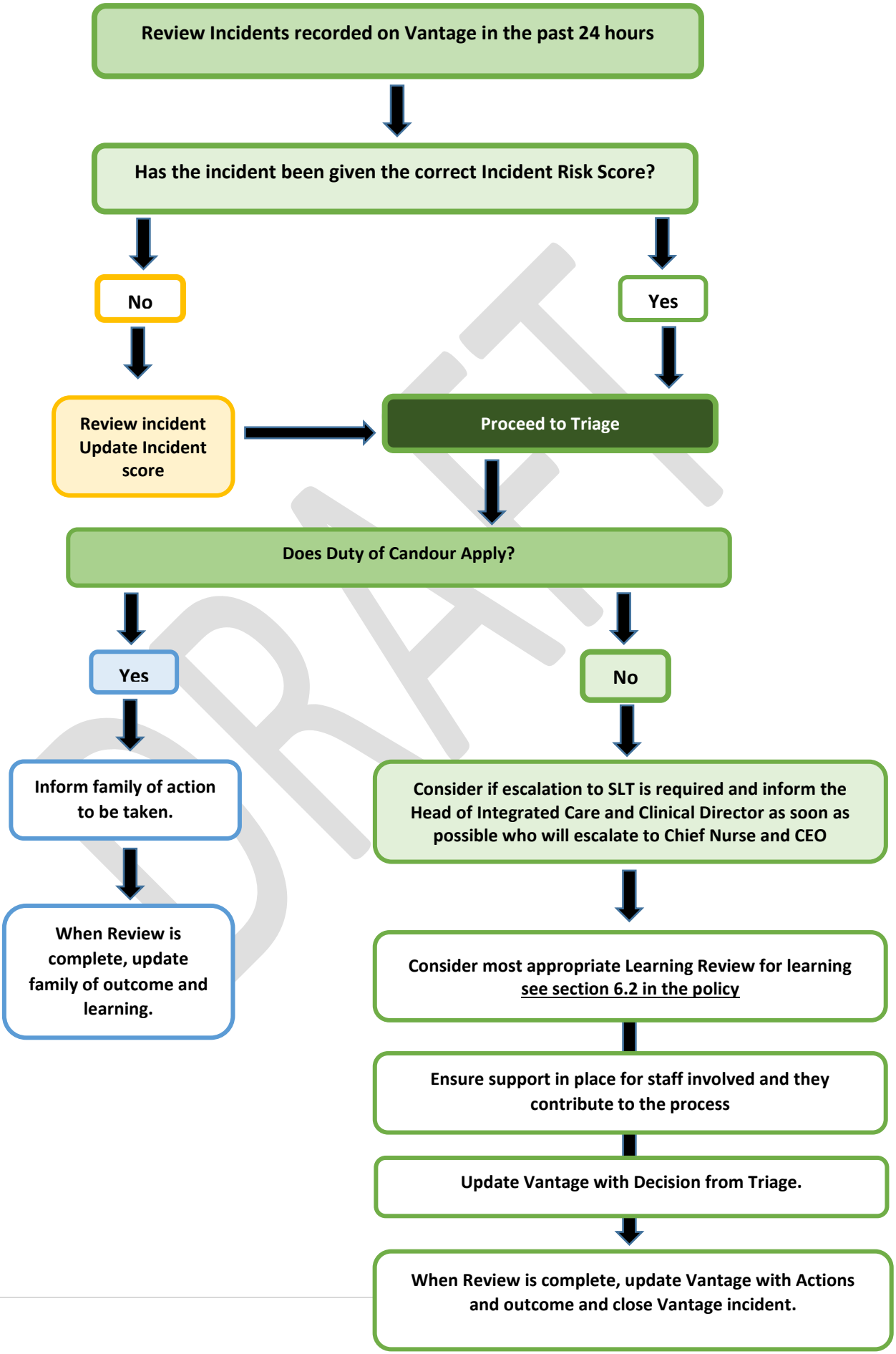
To this end, The Hospice will aim to ensure that:

- Individuals are treated fairly, with dignity and respect regardless of their age, marital status, disability, race, faith, gender, language, social/ economical background, sexual orientation or any other inappropriate distinction;
- It affords all individuals, volunteers and employees the opportunity to fulfil their potential;
- It promotes an inclusive and supportive environment for staff, volunteers and visitors;
- It recognises the varied contributions to the achievement of the Hospice's, mission made by individuals from diverse backgrounds and with a wide range of experiences.

1. Briefly describe the aims, objectives and purpose of the proposal	To ensure incidents are reviewed and learning is embedded in practice to improve patient safety
2. Are there any associated objectives of the proposal, please explain	To support staff by adopting a no blame and just culture.
3. Who is intended to benefit from the proposal and in what way?	All employed staff and volunteers and all Derian BCYP and their families
4. What outcomes are wanted from this proposal?	That each incident is reviewed appropriately to extract learning for improvement and that staff and families are supported through the process.
5. What factors/forces could contribute/detract from the outcomes	Failure to comply with PSIRF requirements
6. Who are the main stakeholders in relation to the proposal?	All staff, Patients and parents.
7. Who implements the proposal and who is responsible?	Clinical Director
8. Is it likely that that the proposal **could** have a positive or negative impact on minority **ethnic** groups. What existing evidence (either presumed or otherwise) do you have for this?	This policy ensure that all staff, patients and their families are treated consistently, fairly and equitably. The process for incident reviews in this policy follows the NHS PSIRF framework, Human Factors and Just Culture guidance
9. Is it likely that that the proposal **could** have a positive or negative impact due to **gender.** If so, please outline what the impact might be. What existing evidence (either presumed or otherwise) do you have for this?	No impact
10. Is it likely that that the proposal **could** have a positive or negative impact due to **disability.** If so, please outline what the impact might be. What existing evidence (either presumed or otherwise) do you have for this?	No impact
11. Is it likely that that the proposal **could** have a positive or negative impact on people due to **sexual orientation.** If so, please outline what the impact might be. What existing evidence (either presumed or otherwise) do you have for this?	No impact
12. Is it likely that that the proposal **could** have a positive or negative impact on people due to their **age.** If so, please outline what the impact might be.	No impact

What existing evidence (either presumed or otherwise) do you have for this?	
13. Is it likely that that the proposal **could** have a positive or negative impact on people due to their **religious belief.** If so, please outline what the impact might be. What existing evidence (either presumed or otherwise) do you have for this?	No impact
14. Is it likely that that the proposal **could** have a positive or negative impact on people with **dependants/caring responsibilities?** If so, please outline what the impact might be. What existing evidence (either presumed or otherwise) do you have for this?	No impact
15. Is it likely that that the proposal **could** have a positive or negative impact on people due to them being **transgender or transsexual.** If so, please outline what the impact might be. What existing evidence (either presumed or otherwise) do you have for this?	No impact
16. Can any adverse impact be justified on the grounds of promoting equality of opportunity for a particular group? (For example, the proposal may be deliberately designed to promote equality for disabled people but may run the risk of this being at the expense of non-disabled people).	No impact
17. Is a full Equality Impact Assessment necessary?	No
18. If Yes date on which full impact assessment is to be completed by	

APPENDIX 1 – Daily Triage Flow chart and Documentation



PSIRF Incident Triage

Date		**Attendees**	
Time			

Vantage incident number	**Brief summary of incident**	**Incident Reportable?**	**Risk Score**	**Type of learning/ review/ actions recommended or conducted** i.e. swarm huddle, After Action Review, Information gathering, reflections, debrief

Triage Tool- Reportable Incidents
Is this incident reportable? Death due to errors in care, safeguarding incidents, incidents reported to the police, incidents involving a controlled drug

Yes	No
• Ensure the safety and wellbeing of the BCYP/family/staff involved • Duty of candour, inform family • Swarm huddle as soon as possible • Escalate to the Senior leadership team • Report to the relevant external bodies e.g. ambulance, police, social care, RIDDOR, CQC, MHRA, UK Health Security Agency (Formerly Public Health England), appropriate professional bodies e.g. NMC, LADO. • Relevant documentation completed • PSII (Patient Safety Incident Investigation) • Medications error- follow matrix • Update vantage report	• Review the level of harm/ risk of harm • Review the frequency of the incident • Errors involving the same staff member • Errors involving the same BCYP • Use the scoring tool to determine risk rating using the consequence score and likelihood score

			Consequence Score	Will occur, possibly frequently	Likely to occur but not persistently	Possible occasional occurrence	Unlikely to happen but it is possible	Rarely or Highly unlikely to ever happen
INJURY/HARM	SERVICE	REPUTATION		Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
LIKELIHOOD SCORE								
Very minor No Harm	No impact on service delivery	Minor negative publicity no impact on service	None 1	LOW 5 (1x5)	LOW 4 (1x4)	VERY LOW 3 (1x3)	VERY LOW 2 (1x2)	VERY LOW 1 (1x1)
Minor impact will resolve without treatment	Minor disruption to services	Regular negative publicity	Minor 2	MODERATE 10 (2x5)	MODERATE 8 (2x4)	LOW 6 (2x3)	LOW 4 (2x2)	VERY LOW 2 (2x1)
Moderate impact requires clinical intervention and recovery	Loss of service (less than a month)	Loss of public and patient confidence	Moderate 3	HIGH 15 (3x5)	MODERATE 12 (3x4)	MODERATE 9 (3x3)	LOW 6 (3x2)	VERY LOW 3 (3x1)
Major impact Life threatening	Loss of service with high impact on patients	Regulator involvement due to negative publicity	Major 4	HIGH 20 (4x5)	HIGH 16 (4x4)	MODERATE 12 (4x3)	MODERATE 8 (4x2)	LOW 4 (4x1)
Catastrophic, Death or life changing impact	Permanent loss of service threatening viability of organisation	Damage to reputation causing potential permanent closure.	Catastrophic 5	HIGH 25 (5x5)	HIGH 20 (5x4)	HIGH 15 (5x3)	MODERATE 10 (5x2)	LOW 5 (5x1)

APPENDIX 2

Learning Response Review and Improvement Tool

Adapted from NHS England

Report Title				
Area of Review	**Rating Scale**			**Comments**
People affected by incidents are meaningfully engaged and involved Evidence that all those affected e.g., staff, patients, families and carers have been actively listened to and emotionally supported where required.	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
The systems approach is applied The report demonstrates consideration of system-based factors (e.g. task complexity, technology, work procedures, workplace design, information transfer, clinical condition of patient, stress, fatigue, culture, leadership/management, policy/regulation) and how these interacted to contribute to the incident in question.	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
'Human Error' is considered as a symptom of a system problem 'Human error' or is not concluded to be the cause of the incident. Instead, multiple contributory factors which influenced the event are explored.	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
Blame language is avoided Language does NOT directly or indirectly infer blame of individuals, teams, departments, And/or focus on human failure.	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
Local rationality is considered The report clearly explains why the decisions and actions taken by individuals involved felt right at the time (i.e. the situation and context faced by those individuals is explored and described).	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
Counterfactual reasoning is avoided The report focuses on what happened and understanding why an incident happened. The report does not make a judgement on what people, 'could' or 'should' have done during or before the incident.	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
Safety actions/recommendations are effective - Have been developed collaboratively with staff/stakeholders - Focus on system elements not individuals - Are specific, robust and actionable - Are accompanied by a plan to monitor progress - Are linked to the evidence and findings	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	
The written report is clear and easy to read The report is concise, written in plain English and uses inclusive language i.e. it is written to 'inform rather than impress'.	**Good evidence** ☐	**Some evidence** ☐	**Little evidence** ☐	

APPENDIX 3

Risk Matrix

INJURY/HARM	SERVICE	REPUTATION	Consequence Score	Will occur, possibly frequently	Likely to occur but not persistently	Possible occasional occurrence	Unlikely to happen but it is possible	Rarely or Highly unlikely to ever happen
LIKELIHOOD SCORE				Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Very minor No Harm	No impact on service delivery	Minor negative publicity no impact on service	None 1	LOW 5 (1x5)	LOW 4 (1x4)	VERY LOW 3 (1x3)	VERY LOW 2 (1x2)	VERY LOW 1 (1x1)
Minor impact will resolve without treatment	Minor disruption to services	Regular negative publicity	Minor 2	MODERATE 10 (2x5)	MODERATE 8 (2x4)	LOW 6 (2x3)	LOW 4 (2x2)	VERY LOW 2 (2x1)
Moderate impact requires clinical intervention and recovery	Loss of service (less than a month)	Loss of public and patient confidence	Moderate 3	HIGH 15 (3x5)	MODERATE 12 (3x4)	MODERATE 9 (3x3)	LOW 6 (3x2)	VERY LOW 3 (3x1)
Major impact Life threatening	Loss of service with high impact on patients	Regulator involvement due to negative publicity	Major 4	HIGH 20 (4x5)	HIGH 16 (4x4)	MODERATE 12 (4x3)	MODERATE 8 (4x2)	LOW 4 (4x1)
Catastrophic, Death or life changing impact	Permanent loss of service threatening viability of organisation	Damage to reputation causing potential permanent closure.	Catastrophic 5	HIGH 25 (5x5)	HIGH 20 (5x4)	HIGH 15 (5x3)	MODERATE 10 (5x2)	LOW 5 (5x1)

The score tool in the chart which aligns with the Vantage system.

- A score of **1- 3** is **VERY LOW RISK** - indicating no or very minor harm
- A score of **4-6** is **LOW RISK** – Indicating minor injury or harm
- A score of **7 – 12** is **MODERATE RISK** – Indicating that harm requires treatment and recovery
- A score **above 12** is **HIGH RISK** – Indicating death or life changing injury

APPENDIX 4 - Template 1

Patient safety incident investigation (PSII) report

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

General writing tips

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

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

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

Distribution list

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

Name	Position

A note of acknowledgement

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

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

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

Executive summary

Notes on writing the executive summary
To be completed **after the main report has been written**.

Incident overview

Notes on writing the incident overview for the executive summary
Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary
Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

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

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan. Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

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

Refer to the Safety action development guide for further details on how to write safety actions.
NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

Contents

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

Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.
It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event

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

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

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

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

Investigation approach

Investigation team

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

Summary of investigation process

Notes on writing about the investigation process

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

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

Terms or reference

Notes on writing about scope

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

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

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

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

Information gathering

Notes on writing about information gathering

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

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

Recorded reflections, e.g. those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.
Statements are not recommended. Interviews and other information gathering approaches are preferred.

Findings

Notes on writing your findings

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

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.
Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

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

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.
You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

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

Use clear, direct language, e.g. 'The investigation found…'
If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

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

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

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

Summary of findings, areas for improvement and safety actions

Notes on writing the final summary
The purpose of this section is to bring together the main findings of the investigation.
Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

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

Safety action summary table

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

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

Appendices

Notes on appendices

Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none).

APPENDIX 4 - Template 2

After Action Review (AAR)

Date		**Time**		**Incident Number**	
Lead				**Designation**	
Attendees					
Terms of Reference	• Everyone has equal opportunity to input and learn • Focus on the learning, not who has done what- No blame culture • Everyone should feel comfortable to share their experiences and views				
What was the expected outcome /expected to happen?					
What was the actual outcome/what actually happened?					
What was the difference between the expected outcome and the event?					
What is the learning?					
Proposed recommendations/actions:					

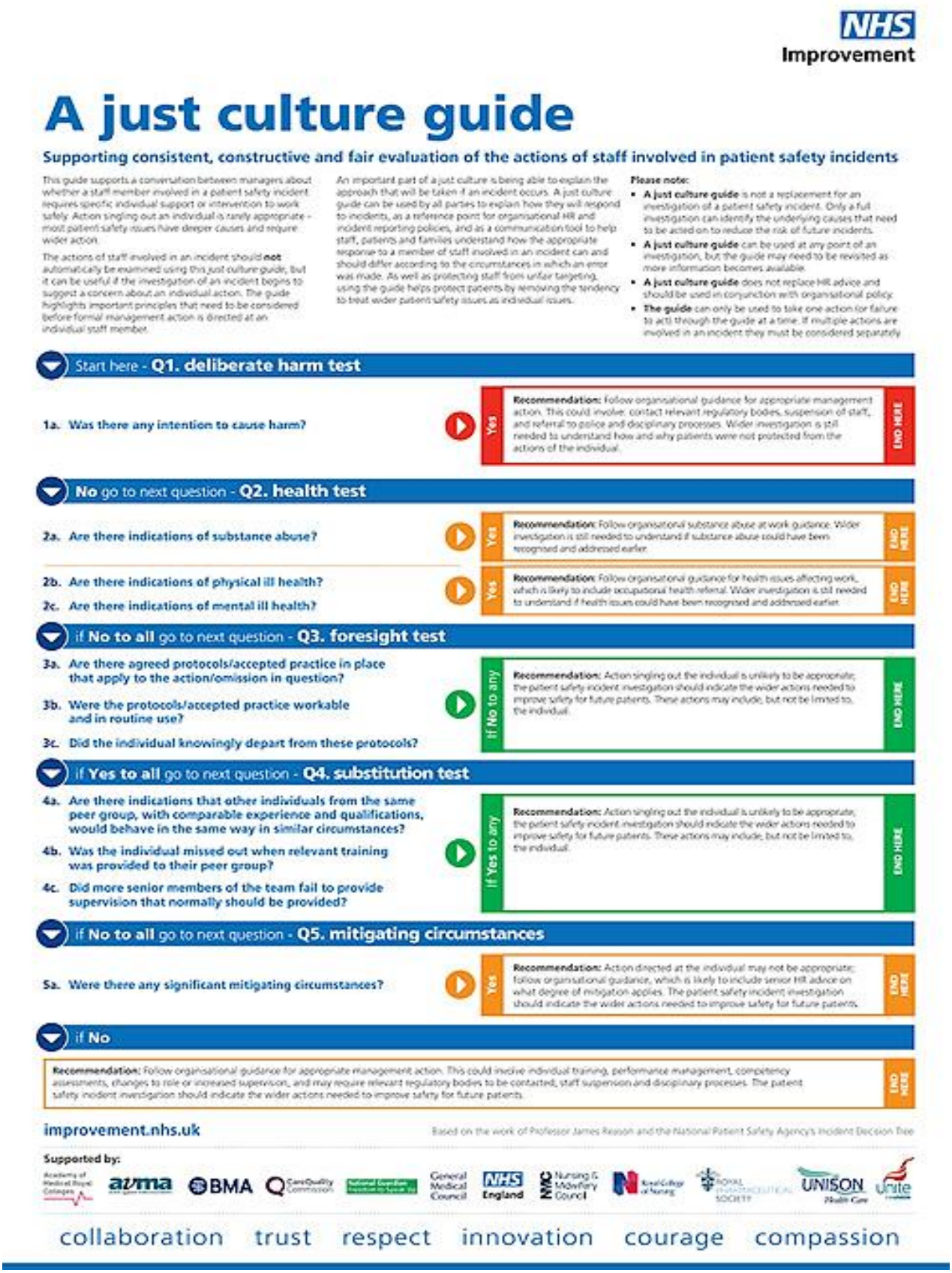
APPENDIX 4 - Template 3

Swarm Huddle

Time		**Date**	
Incident Number		**Swarm Lead**	
Attendees			
What happened? Give a brief summary of the incident/ event.			
Safety- Is the patient/ staff member safe? Is any staff support needed?			
Why did the incident happen? Explore reasons why this incident occurred. Consider human factors, procedures, equipment failure, organisation, task and environment.			
What could have prevented this incident? What processes could have been in place? How can we reduce the likelihood of this happening again?			
Proposed actions:			

APPENDIX 5 – Just Culture Guide

https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf



NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate – most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action for failure to act through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. **Was there any intention to cause harm?**

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

No go to next question - **Q2. health test**

2a. **Are there indications of substance abuse?**

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

3c. **Did the individual knowingly depart from these protocols?**

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

4c. **Did more senior members of the team fail to provide supervision that normally should be provided?**

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. **Were there any significant mitigating circumstances?**

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

collaboration trust respect innovation courage compassion