PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) POLICY

Approved:	January 2024 **(awaiting Final ICB Sign off)**
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Ratified by:	Senior Management Board RISE Committee
Policy Holder:	Senior Management Board RISE Committee
Policy Author:	Director of Patient Care Quality & Patient Safety Lead

It is expected that this policy, alongside Rowcroft's PSIRF Plan, will be reviewed on an annual basis.

"We will respond to all aspects of Patient Safety & Experience when something goes differently to how we hoped, Reflecting on what happened and how those involved were affected, seeking new Innovative ways of working, enable everyone to have a voice to Suggest ways to help shape our services, and to Engage and work together with our Patients, Staff, Volunteers, and other Key Stakeholders."

1. Policy Statement

At Rowcroft Hospice we are committed to acting within our values of Honesty & Integrity, Generosity of Spirit, and Respect and as Team Players. We believe we are all responsible for delivering our purpose to make every day the best day possible for our patients and their families in South Devon, and for ensuring we behave in an ethical, values driven, and patient focussed way.

This policy is specific to patient safety incident responses conducted in line with a no blame culture, solely for the purpose of learning and improving patient safety. It supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Rowcroft Hospice's approach to developing and maintaining effective systems and processes for responding to Patient Safety Incidents (PSIs) and events.

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.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

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.

This policy is written in accordance with:

a) The Care Quality Commission (CQC) Guidance for Providers on Meeting the Regulations Regulation 20 (Duty of Candour) and Regulation 12 (Safe Care and Treatment).
b) The Health and Safety Act 1974, Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 1995 (RIDDOR)
c) Openness and honesty when things go wrong: the professional duty of Candour (RCN and GMC)
d) NHS Patient Safety Incident Response Framework (PSIRF)

This policy and our plan have been developed over time since October 2023, with a group of specialists within the hospice and a member of the public representing our patients and families.

2. Corresponding Policies

- Feedback and Complaints (ref: 281)
- Safeguarding Adults Policy (ref: 290)
- Safeguarding Children's Policy (ref: 292)
- Whistleblowing policy (*ref: 199*)
- Quality Assurance Policy (ref:
- Major Incidents Policy *(ref:*
- Waste Management Policy *ref:*
- Performance Management Policy (ref: 235)
- Disciplinary Policy and Procedure *(ref: 210)*

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3. Our Patient Safety Culture

Rowcroft's Patient Safety culture supports an open and transparent approach to incident reporting and raising concerns. 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. We aim to ensure that our teams feel supported to raise concerns when something goes differently to expected. We have an open and transparent investigation process, and we aim to engage with our teams to seek learning outcomes.

Processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Any of these responses may take place concurrently with, or following, the trust-level response to a patient safety incident.

3.1 CQC Compliance

Learning Culture	We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
Safe Environments	We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Governance, Management and Sustainability	We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
Learning, improvement and innovation	We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

4. Types of Patient Safety Incidents (PSIs)

A PSI is any unplanned event which causes, or has the potential to cause, harm to a patient. All staff are required to report all PSIs and near misses so that risks to patient safety are recognised and action is taken to prevent recurrence.

4.1 Rowcroft (Internal) Incidents

The types of incidents we report within clinical teams can include:

- Medication Errors (this can involve a patient)
- Patients with Pressure Ulcers present on admission.
- Patients that develop new Pressure Ulcers while on IPU
- Falls by patients.
- Clinical Accident, Incident or Near Misses involving patients.
- Medical Device problems (i.e., syringe pumps, call bells, falls mats).
- PPE concerns
- Waste disposal of inappropriate clinical waste.
- Infection Control outbreaks
- Delays in Discharge, Referrals or Admissions.
- Events which prevent our clinical services from running safely.
- Any other type of incident which could cause harm or potential harm to a patient and loss or misuse of patient data.

4.2 External Incidents (Other Organisations)

PSIs reported also include incidents involving Rowcroft patients that also involve external organisations. Engagement with other organisations to work together with our partners to learn from incidents is paramount when teams cross over to support patient care.

All incidents relating to external organisations will be shared with those organisations involved by the relevant Service Manager or the Director of Patient Care only. Teams should always raise concerns via Vantage, for discussion at the weekly PSI Review Group prior to sharing information externally.

For Level 3 (and over) Pressure Ulcers identified on admission to Rowcroft's IPU or Identified in the Community, and where a patient is under the care of the TSDFT Community / District Nursing Teams – these will be shared by the Quality & Patient Safety Lead to the TSDFT Patient Safety Team one logged within Vantage.

4.3 Examples of Good Care

In addition to reporting PSIs, we recognise that it is really important to capture good examples of care given. We have a new category within the Vantage Incident Reporting system, where our teams can now celebrate their success stories and record examples of good care given to support our patients and enhance their experience of care.

4.4 Reporting of PSIs

All incidents and near misses that occur within Rowcroft (both non-clinical / Health and Safety and PSIs) are reported using an external, secure system hosted by Vantage. It is the expectation that all managers will contact the Quality & Patient Safety Lead, Business Support Manager/PA, or Hospice Services Secretary, for a user account to be created as part of new starters induction processes. If you have any concerns in relation to accessing the system, please contact our Quality & Patient Safety Lead on Ext. 844.

It is everyone's responsibility to report Incidents.

Incidents are reported on Vantage as soon as practically possible.
Incidents should be reported no later than 24 hours from when the incident occurred.

Where incident reports are delayed longer than 24 hours – it is expected that the person reporting the incident provides an update on the delay within the reporting form where specified.

You can access the Incident Reporting system in a number of ways:

From our Intranet Page, The Hub, by clicking on this icon on the home page:

Or you can visit this link on your smart phone, laptop or tablet:

https://www.vantage-modules.co.uk/ROWCROFT

User guides and video guides on how to use Vantage are found on The Hub, and you can find them by searching Vantage or Incidents.

5. Rowcroft's PSIs Levels and Definitions

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

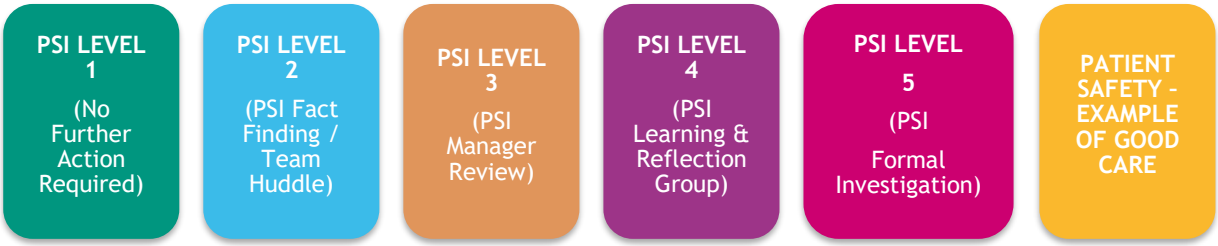
All PSIs reported will be shared with the relevant senior Patient Care Team through an automated notification system and reviewed at the weekly PSI Review Group (and documented within Vantage). The PSI Review Group consists of the following members:

- Director of Patient Care (Chair)
- IPU Ward Manager (and / or Deputies)
- Hospice at Home Manager
- Head of Community, Therapies and Support Services (to be invited as and when required)
- Professional Practice & IPC Lead
- Quality & Patient Safety Lead
- Health & Safety Compliance Manager

In addition to the above group, team members from all services can be invited on an ad hoc basis where it is considered beneficial and appropriate for them to be part of discussions or where they have been involved in Huddles, Fact Finding, or Learning and Reflection Groups. Other team members are welcome to join to shadow meetings on an ad-hoc basis to gain insight into the incident review process.

The PSI Review Group will agree the PSI Level of each incident reported at the weekly Review Group. A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

Rowcroft's new PSI Levels (2023) are outlined below (including Good Practice Examples):



All PSI Levels can be escalated to a higher level at any time where required; for example, if initial fact finding highlights further concern, this can be escalated to a PSI Level 5 and require a formal investigation. Full definitions are below.

5.1 PSI Level 1

PSI LEVEL 1

No Further Action Required

Definition:

Any individual PSI which caused no harm to a patient, is not related to any similar incident or is not a concern that has occurred previously. All immediate actions were taken at the time of incident and no further actions required.

Incidents agreed as Level 1 can be signed off by the Director of Patient Care and closed. However, these incidents will be monitored as part of themes arising from multiple groups of incidents to ensure that this does not reoccur.

5.2 PSI Level 2

PSI LEVEL 2

PSI Huddle / Fact Finding

Definition:

Any PSI (near miss) where similar near misses have occurred previously relating to process errors or minor concerns (i.e., documentation errors or where a policy might need reviewing) will be reviewed for brief fact finding or a team huddle (to be agreed by the PSI review group as appropriate).

- **Fact finding will be undertaken by someone involved in in the incident (for example, the person highlighting the concern)**
- **A Huddle should take place with those directly involved and have oversight from the Service Lead to ensure this takes place.**

It is expected that the individual involved, or a representative of the team will provide a brief verbal update of the outcome at the Weekly PSI Review Group (or to the Service Manager where this is not possible). Outcome of a Huddle will be recorded during the meeting within Vantage.

All learning and actions taken will be monitored at the Weekly PSI Meeting and summarised within the quarterly Quality Report to RISE Committee and Clinical Committee. Service improvements and developments that will require wider approval will be reviewed and approved at RISE Committee (or Pharmacy Committee for medication incidents.

5.3 PSI Level 3

PSI LEVEL 3

PSI Service Manager Review

Definition:

PSIs which caused no or low harm to a patient but no potential to cause moderate or severe harm (this includes all falls, medication incidents directly relating to a patient).

A Service Manager review includes occasions where informal concerns relating to care are raised by a patient or family member, where multiple incidents relate to the same patient, where multiple PSI relate to the same staff member, or where a staff member has raised concerns).

Performance concerns, grievance processes, or disciplinary processes should be carried out in line with Rowcroft's policies and not alongside PSIRF.

- An outcome and summary of this review (by way of an SBAR or similar template – Situation Background Assessment Recommendations) will be completed on Vantage following this review.

- All SMART actions and learning are held within Vantage and monitored and followed through to completion by the Weekly PSI Group.

- All learning and actions taken from this review will be shared in summary with the RISE Committee and via the quarterly Quality Report to Clinical Committee.

- Concerns from a staff or volunteer about a staff member or volunteer are expected to be reviewed under HR process and managed by the people team as per existing policy.

- Concerns raised by patient or family members will ensure they are involved (where they wish to be involved) in outcomes / recommendations (see also Engagement and Involvement with this policy).

- These reviews should consider any Human Factors (patient, staff, task, communication, environment, medication, working conditions, equipment and resources, and organisational/strategic).

- As mentioned above, performance concerns, grievance processes, or disciplinary processes should be carried out in line with Rowcroft's policies and not alongside PSIRF. All guidance and advice should be sought through Rowcroft's People Team where required.

5.5 PSI Level 4

PSI LEVEL 4

PSI Reflection and Learning Group

Definition:

A PSI Reflection and Learning Group is a thematic review of a group of incidents or good practice examples where there are consistent themes, or where there is a significant number of the same types of incidents reported within a short period of time.

- For example, where a number of falls within a specific period of time have occurred at the same time of day or in the same bed space, or multiple medication documentation errors relating to the same issue).

- A brief Reflection and Learning from Incidents Report will be produced following this review, and consideration given to further reviews to ensure any actions and learning are followed through to completion.

- All learning and actions taken from Reflection and Learning Groups will be shared with the Quality & Patient Safety Committee, and in summary via the Quarterly Quality Report to Clinical Committee.

- *See Reflection and Learning Overview at Appendix 1.*

5.5 PSI Level 5

PSI LEVEL 5

PSI Investigation (PSII)

Definition:

Any PSI (or group of PSIs) which has the potential to cause or causes moderate harm (and over) to a Patient, including Category 3 and over Pressure Ulcers* in line with HospiceUK patient safety definitions, or any PSI which raises significant concerns relating to patient safety (this includes formal complaints received from patients or family members in relation to care and clinical services).

This also includes PSIs meeting CQC reporting criteria (e.g., allegations of abuse (safeguarding), events that stop a service running safely and properly, serious injury to a person using the service), and any nationally defined Incidents including those as set out in the Never Events Framework.

*Category 3 Pressure Ulcers that are considered to be due to SCALE and occurring within 7 days prior to a patient's death will be reviewed individually prior to agreeing the PSI level.

- Level 5 PSIs will be investigated in life with PSIRF Framework. The Rowcroft PSII template and guidance can be found on the Hub. Full support for those carrying out PSIIs will be provided by the Director of Patient Care and Quality & Patient Safety Lead, as the PSI specialists.
- Online training slides are being developed by the Quality & Patient Safety Lead and will be implemented during 2024.
- PSI Investigations will be signed off by the Senior Management Board and shared with Clinical Committee.
- Formal complaints will be investigated as part our existing policy (with the initial outline of the investigation to be agreed with the complainant prior to the start) and signed off by the Director of Patient Care, Medical Director and CEO, with a summary shared at SMB.
- Formal Duty of Candour will apply, and patients / family members will be invited to be involved (where they wish to be involved) to give feedback in relation the investigation.
- Investigations should consider any Human Factors (patient, staff, task, communication, environment, medication, working conditions, equipment and resources, and organisational/strategic).
- All SMART actions and learning are held within Vantage and monitored and followed through to completion by the Weekly PSI Group.
- *See the PSIRF PSII template at Appendix 2.*

5.6 Patient Safety Good Care Example

Patient Safety Good Care

Patient Safety Good Examples of Care and Experience

Definition:

An opportunity for teams to celebrate their success stories and record examples of good care given to support our patients and enhance their experience of care, and also share examples of new ideas and innovation that can be adopted by other teams.

Types of Good Care examples can include:

- How a team (or individual) has worked really well together to manage a challenging or complex situation in relation to a patient.

- How a team (or individual) worked well together to arrange an event or special moment for a patient (for example, for a birthday, wedding or other special celebration).

- How a team (or individual) worked well to support a patient's wishes to go home.

- How a team (or individual) worked well to support a patient with complex needs or a patient in a hard-to-reach area.

- How a team (or individual) worked to either prevent a patient safety incident or support a patient after a PSI occurred.

5.7 Concerns and Complaints from Patients and / or the Families

Concerns or complaints raised in relation to patient safety will be reviewed alongside PSIRF. Those raising concerns will be invited to be involved in our processes, and it will be important that the basis of our investigation is agreed with this person to ensure we have correctly captured their concerns.

Also see our Feedback and Complaints Policy.

6. Engagement and Involvement

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Please also refer to the PSIRF guidelines in relation to engaging and involving with Patients, families and staff.

6.1 Patients and Families

As part of our Patient Safety culture, it is important that we involve those patients and / or their families when something goes differently to how we expected or when someone raises concerns.

We welcome all feedback (including concerns, complaints, learning and improvement suggestions, and positive feedback). We will always offer for those involved to be involved in our investigation processes and be part of learning and improvements.

Engaging with patients and families when it comes to incident investigations and complaints is a crucial aspect of providing quality health care. Complaints can be seen as an opportunity to learn

from mistakes, improve services, and restore trust. By listening to the concerns and experiences of patients and families, health care providers can gain valuable insights into their needs, expectations, and preferences. Moreover, engaging with patients and families can help to resolve complaints in a timely and satisfactory manner, preventing escalation and litigation. Engaging with patients and families also demonstrates respect, empathy, and accountability, which are essential for building a positive and collaborative relationship.

Staff should understand their responsibilities in identifying and reporting incidents and in informing patients (and/or their relatives as appropriate) when an incident or error involving them has occurred.
It is the expectation of all staff that this conversation is documented within the incident report on Vantage (under people involved), which can also capture information reason for a discussion not taking place, or notes relating to informing a patient's next of kin.

Saying Sorry

It is important to remember that saying sorry or giving an apology, whether written or verbal, does not mean admitting blame or liability when something goes wrong.

Saying sorry to a person that has, or could have, experienced harm, or where their experience differs to what we would have hoped, acknowledges how that person may feel. It the first step we can take to seek learning from what happened to ensure we take steps to prevent it from recurring.

6.2 Duty of Candour

One of the fundamental standards identified by the CQC (Regulation 20 – see appendix 1) is the Duty of Candour. As a provider of care, Rowcroft Hospice must make reasonable efforts to ensure that staff at all levels understand and operate within a culture of openness and transparency, including by means of providing the relevant training. The combined training for Complaints and Incidents found on the Hive contains a short video which outlines your responsibilities under this legal required.

There is also a joint publication by the Nursing and Midwifery Council and the General Medical Council regarding Duty of Candour. Clinicians should be familiar with the contents (see references and link).

The link to the CQC guidance (Regulation 20) is noted below:

https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour

Where moderate or serious harm has occurred, and where a PSI is graded as a Level 5 (for investigation), a letter of apology will be sent by the Director of Patient Care, either to the patient or a relative as relevant. See templates at Appendix 3.

Where a patient and / or their family declines a written letter (for example, due to a patient being at end of life, or where a patient has since passed away), this should be documented within the incident record to capture this discussion.

We recognise that there are times when patients and / or their families may wish to decline to be involved in discussions relating to incidents and investigations; however, teams must ensure they take all steps required to give the opportunity of involvement to the patients and / or their families and this offer shall remain open.

We audit compliance with Duty of Candour on an annual basis; this includes a review of all conversations that took place with patients and / or their family relating to incidents when they occurred.

6.3 Staff and Volunteers

Engagement with our Staff and Volunteers when a PSI occurs is important as part of our Patient Safety culture.

We have a no blame culture and support our teams to be part of investigations and feel able to raise concerns and report PSIs when they occur. It is important to note that PSIRF is not a route to identify blame but to seek learning and recommendations as a result.

We are thankful to our teams for their involvement in all investigations, fact finding, huddles, and reflection and learning opportunities when they are needed to enable them to have a voice and to be part of changes we make.

We recognise that there are occasions when investigations might require review through other processes, for example other HR processes, and staff will be supported through those processes if they arise, separately to PSIRF investigations.

6.4 Addressing Health Inequalities

Complaints management is a crucial aspect of health service delivery, as it provides an opportunity to identify and address the needs and concerns of patients and their families and must be accessible and inclusive for all patients and their families, regardless of their background or circumstances.

Our complaints process provides clear and timely information about how to make a complaint and offering support, ensuring confidentiality and privacy, and providing appropriate communication channels and formats. For example, we can offer translation and interpretation services, alternative formats such as Braille or audio, and culturally appropriate methods of communication.

The outcomes from all complaint's investigations will be fair and equitable for all complainants, regardless of individual's background or circumstances. Responses will be consistent and transparent, ensuring we learn from experiences and events, providing appropriate remedies and redress, and monitor and evaluate the impact of complaints on health outcomes.

6. Oversight Roles and Responsibilities

6.1 Reporting of Incidents on NHS England's LFPSE (Learning from Patient Safety Events) and Sharing with the Integrated Care Board (ICB)

The Learn from Patient Safety Events (LFPSE) service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare.

Rowcroft are required to report PSIs and also examples of good care within LFPSE; a module within Vantage which links to NHS England's LFPSE service is currently in development and will be used by Rowcroft to report incidents. These incidents will also be shared with the Integrated Care Board (ICB).

6.2 Systemic Working with Other Organisations

Working with other organisations is crucial when it comes to learning from incidents, and also complaints. Where an incident occurs and involves another organisation, we will share this with that organisation and offer to work with them where this is beneficial to look at how we can prevent this from reoccurring.

The importance of collaboration with external entities in learning from incidents includes:

- Partnering with other organisations brings diverse perspectives and experiences. Learning from incidents across sectors provides a broader view of potential issues and innovative solutions.

- Sharing information about incidents, near misses, and lessons learned fosters a culture of openness and transparency. Collaborating with external organizations allows for the exchange of valuable insights, technologies, and methodologies.

- Some incidents or complaints can occur within multiple healthcare systems involving multiple stakeholders, and collaborating with other organisations helps understand the broader context of incidents and complaints and develop strategies for improved coordination and communication.

- Learning from incidents is a huge part of continuous improvement. Collaborating with other organisations facilitates ongoing learning cycles, where shared experiences contribute to the development and refinement of policies, procedures, and safety protocols.

6.3 Review and Sign Off of PSI Level 5 Incident Investigations (PSIIs)

The board sign-off of investigation reports by Senior Management Board (SMB) is a crucial step in our PSIRF investigation process of addressing and resolving patient safety concerns and issues within Rowcroft. Once the investigation is complete, a formal report will be prepared to document the findings and recommendations (using our PSII template).

The board sign-off, or approval, of an investigation report by SMB is required to ensure that the report is accurate, comprehensive, and aligned with Rowcroft's values, non-blame culture and patient safety processes and policies.

SMB will review the PSII report to ensure that it meets the necessary standards of quality, objectivity, and thoroughness. They may engage in discussions with the individuals who conducted the investigation or with relevant stakeholders to seek clarification, ask questions, and gain a deeper understanding of the issues at hand.

Based on the information presented in the investigation report and subsequent discussions, SMB decisions regarding the recommended actions and any additional steps that need to be taken.

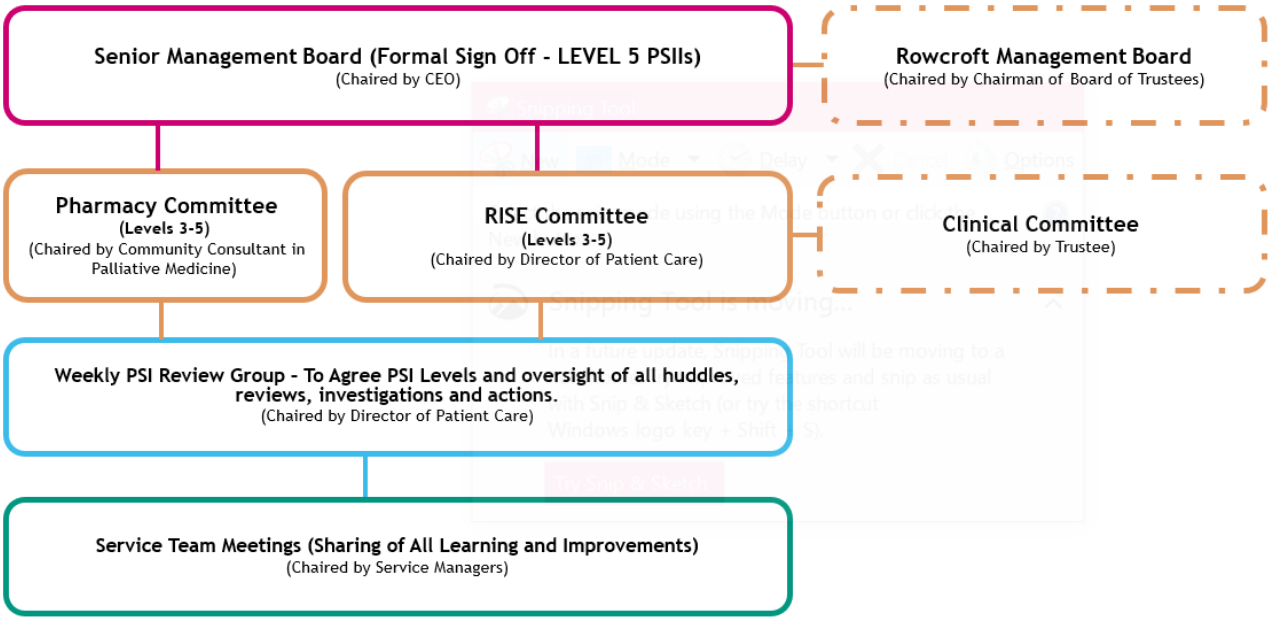
It is expected that SMB's approval of the PSII is documented in the minutes of the meeting, and it is important that documentation is held as a record of SMB's acknowledgment and endorsement of the investigation report.

Following sign off on the investigation report by SMB, there may be a need to communicate the outcomes to relevant stakeholders, including employees, volunteers, shareholders, regulatory bodies, or the public, depending on the nature of the incident.

All PSIIs will be shared with Clinical Committee for awareness, and updates included within the Quarterly Quality Report.

Updates will be required to be shared with SMB by the Director of Patient Care, and all action plans and progress of them will be monitored by the Weekly PSI review group and RISE Committee to ensure they are completed (SMART action plans will be kept within Vantage under the relevant incident record).

Our Governance Process for all PSIs is for below:



No PSI report should be closed until all processes within our governance structure as outlined above are complete.

All incidents will require formal sign off on Vantage by the Director of Patient Care prior to closure on Vantage being agreed.

6.3 Reporting to Other Organisations (e.g. CQC, NHS England, RIDDOR and Charity Commission)

a. Care Quality Commission (CQC)

The CQC require notice of any notifiable incident within 24 hours of the event occurring in accordance with Regulation 18 and as stipulated by the individual's professional code of practice.

Any incidents where services, such as gas and electric, are interrupted for a continuous period of more than 24 hours, therefore affecting patient care or clinical service provision must be reported to the CQC and the ICB. This includes occasions where fire alarms or nurse call bells that malfunction for a continuous period of more than 24 hours. It is the responsibility of the Director of Patient Care as CQC Manager and Quality & Patient Safety Lead to ensure these notifications are complied.

Physical damage to the building that provides the regulated activity, which could have a detrimental effect on the care of the service users, must also be reported to the CQC.

Care Quality Commission Notification Forms are available on the CQC's website: https://www.cqc.org.uk/guidance-providers/notifications/notification-finder or they can be completed via the CQC portal. Notification forms should only be sent by the CQC Registered Manager, Quality & Patient Safety Lead, or Business Support Manager / PA once fully approved.

b. NHS England / Accountable Office for Controlled Drugs

All incidents involving controlled drugs should be reported to Rowcroft's Accountable Officer when they occur. This provides assurance that any risks have been mitigated and prompts any action to be taken if they are not. Reporting also allows for the identification of themes in reported incidents from which learning can take place.

Rowcroft's Accountable Officer will report incidents to NHS as and when required, and this includes a quarterly report occurrence report which will also be submitted (an update will be shared with the Clinical Committee and Pharmacy Committee).

c. Charity Commission

As a charity, Rowcroft Hospice has a responsibility to report serious incidents to the Charity Commission. We need to report what happened and, importantly, let the Charity Commission know how you are dealing with it, even if we have also reported this to other organisations where we also have responsibility.

The Director of Patient Care and Quality & Patient Safety Lead will liaise with the Chief Executive and Executive Assistant to ensure that all information required is passed to them to report to the Charity Committee as and when required.

d. RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)

If an incident has involved an accident which fulfils RIDDOR's reporting criteria this must be reported to RIDDOR within 10 days of the accident occurring. This is completed by telephoning the call centre or online - the report should be submitted by "responsible persons" only, and this includes the Health & Safety Compliance Officer, Hospice Services Secretary, Director of Patient Care or Quality & Patient Safety Lead.

Reports can be submitted online: How to make a RIDDOR report - RIDDOR - HSE

7. Training and Resources

All managers and staff should be aware of organisational policies, and managers should facilitate staff to access policies and the combined complaints and incident e-learning module, available to on the Hive, to ensure that all are aware of relevant reporting processes for incidents and their responsibilities to prevent and manage incidents.

7.1 Vantage Training

User guides and videos are available on the hub, outlining how to report an incident within Vantage. It is a manager's responsibility to arrange a user account for Vantage and induction training when a new person starts in their team as part of their induction process.

1:1 training is available for all staff should this be required; please contact the Quality & Patient Safety Lead to arrange on Ext. 844.

7.2 PSII Training

A new PSII training module is in the process of being developed for all those that would be part of a PSII team. At this time, this is available as support and guidance from the Director of Patient Care and Quality & Patient Safety Lead.

8. References

NHS England PSIRF Framework - NHS England » Patient Safety Incident Response Framework

NHS Improvement (2018) Never Event Framework - Revised-Never-Events-policy-and-framework-FINAL.pdf (england.nhs.uk)

LFPSE - NHS England » Learn from patient safety events (LFPSE) service

RIDDOR - RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 - HSE

Care Quality Commission Single Assessment Framework -Our new approach to assessment - Care Quality Commission (cqc.org.uk)

CQC Regulations:

- Regulation 12: Safe care and treatment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good Governance
- Regulation 14: Notice of absence
- Regulation 15: Notice of changes
- Regulation 16: Notification of death of service user
  Regulation 18: Notification of other incidents

APPENDIX 1

PSI LEVEL 4

PSI Reflection and Learning Group

Group Lead:
Date of Meeting (s):
Terms of Reference:
1. Refine terms of reference specific to the incident type (falls, medication errors of falls). 2. To reflect on recent incidents and scope current risk factors associated with them, highlighting any reoccurring themes and harms that are known. 3. To explore best practice and propose SMART actions / changes / improvements and learning opportunities. 4. To report regular via the RISE Committee 5. Formal review of incident type and levels and actions/changes/improvements at the end of each quarter for the next year.
Outcome from Reflection and Learning Group:
Recommendations:
Date of Next Meeting:
(Please state if there are no follow up meetings planned).

APPENDIX 2

PSI LEVEL 5

PSI Investigation (PSII)

Incident ID Number:
Date Incident Occurred:
Incident Investigation Lead:
Investigation Team:
Report Approved Date:
Approved By:

(Guidance Notes for PSII's are attached at the end of this template)

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1. Acknowledgement

Template

2. Executive Summary

2.1 Incident Overview

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2.2 Summary of Key Findings

Template

2.3 Summary of Areas for Improvement and Safety Actions

Template

3. Background and Context

Template

4. Description of the Patient Safety Incident

Template

5. Investigation Approach

5.1 Investigation Team

Role:	Initials	Job title	Department
Investigation Requested By:			
Investigation Lead:			
Investigation Team Members:			

5.2 Summary of Investigation Process

Template

5.3 Terms of Reference

Template

5.4 Information Gathering

Template

6. Findings

Template

7. Duty of Candour and Engagement with Patient / Family

Template

8. References

Template

9. Appendices

Template

10. Safety action summary table

Area for improvement: [e.g. r*eview 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: [e.g. *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.								
…								

Guidance Notes for PSIIs

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

General writing tips

- A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:
- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

Patient Safety Incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

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. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

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.

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, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

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.

A note of acknowledgement

Notes on writing a note of acknowledgement
In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.
You could consider referring to the patient by name or as 'the patient' according to their wishes.
Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

Executive summary

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

Incident overview

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

Summary of key findings

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

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary
Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.
Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.
Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.
Refer to the Safety action development guide for further details on how to write safety actions.
NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

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

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 (e.g. 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)

Appendices

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

References

Notes on references
Include references to national and local policy/procedure/guidance, and other data sources as required.

APPENDIX 3

DUTY OF CANDOUR TEMPLATE ONLY
To be personalised as required

Private and Confidential
[insert]

[date]

Dear [insert]

Our Reference:

I am writing to you on behalf of Rowcroft Hospice, to you to say how sorry we are that [you or your relative] had a fall resulting in harm whilst in our care on our Inpatient Unit (IPU).

As a statutory requirement of our registration with the Care Quality Commission (CQC) we have reported this incident to them and also share this incident with the local NHS Integrated Care Board (One Devon ICB).

We are required to now undertake a full investigation into the events leading up [this incident], to look at learning, improvement and any associated safety actions that we need to take as a result of this incident. We would be happy to talk with you as part of this investigation and to explain the process we will be taking if you would like to be involved. If you have any questions or concerns you would like to be answered also as part of this process, or any parts of your experience you wish to share with us, please do let me know.

We will be able to share the outcome of the investigation once this is complete.

If you have any further questions or require any support in relation to this incident, please do not hesitate to contact me on [insert number].

Yours faithfully,

Director of Patient Care
CQC Registered Manager