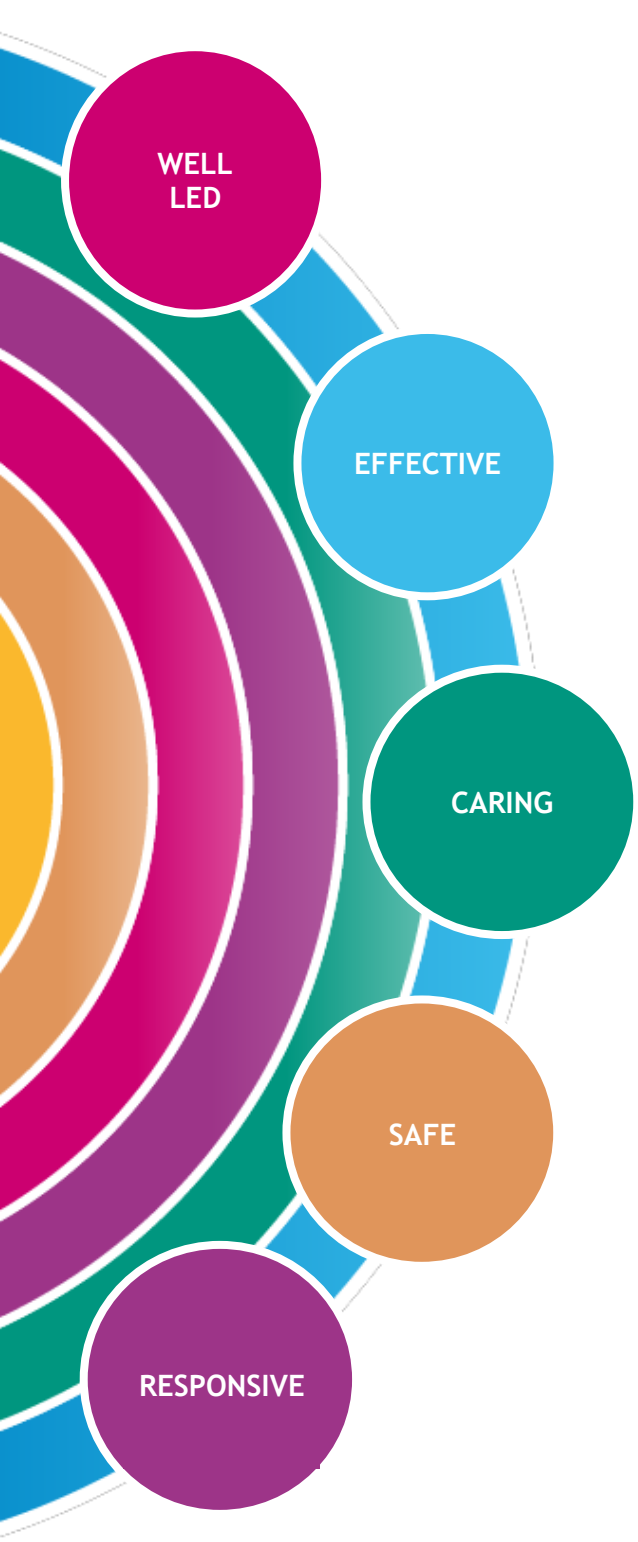

Rowcroft's Patient Safety Incident Response Plan (PSIRP)

"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."

Effective Date:	01 January 2024
Estimated Refresh Date:	01 January 2025
Author(s):	Director of Patient Care Quality Lead
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Supported by:	Patient and Public Representative
Reviewed by:	RISE Committee
Approved by:	Senior Management Board

Contents

1. Introduction

"We will respond to all aspects of Patient Safety & Experience, responding to, learning from and Reflecting on those times when something goes differently to how we expected, look at how those involved were affected, and celebrate our successes. We will seek new Innovative ways of working and enable everyone to have a voice to Suggest ways to help shape our services, and Engage and work together with our Patients, Families, Staff, Volunteers, and other Key Stakeholders."

The NHS Patient Safety Strategy, published in 2019, describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and challenges us to think and respond differently when a Patient Safety Incident (PSI) occurs. It is a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP) and sets out how Rowcroft Hospice will respond to patient safety incidents. PSIRF is designed to promote learning and systemic improvement, moving away from the previous Serious Incident Framework which focussed more on process than emphasising a culture of continuous improvement in patient safety.

This framework is designed to focus on doing investigations in a collaborative way, led by those who are trained to conduct them. It ensures the involvement of patients, their carers, families, and staff and volunteers in an embedded system that responds in the right way, appropriate to the type of incidents and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any investigation, with an emphasis on systemic improvement.

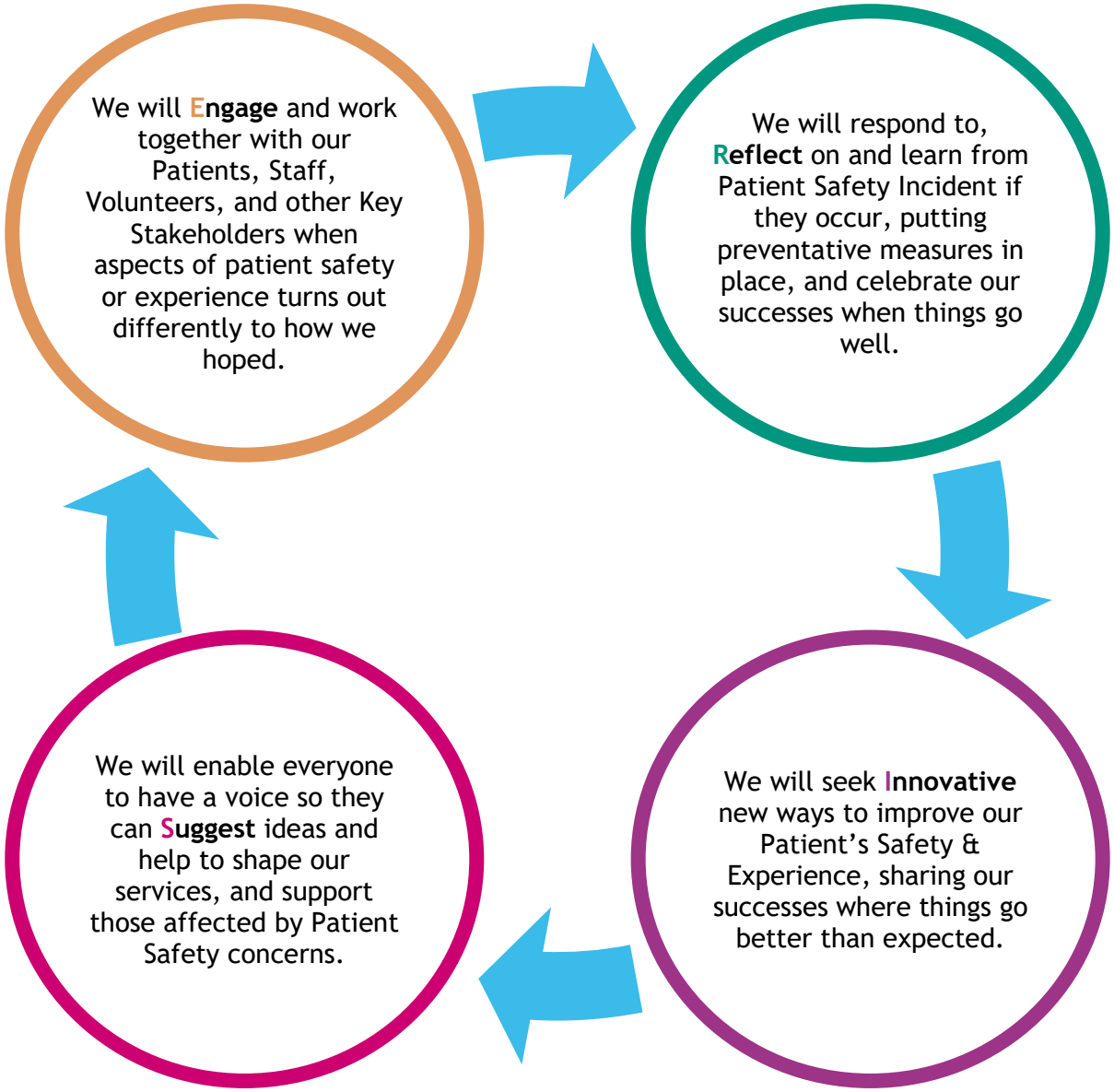
At Rowcroft Hospice we recognise that, although the levels of harm that incidents reported within our organisation is low, PSIs do happen and there are occasions when the experience of our patients and their families may differ to what we hoped. It is our responsibility to ensure that we support and work with those affected when something does go different to how we hoped to show our commitment to Patient Safety. We also recognise how important it is for us to capture and celebrate all of our successes when things go really well.

Rowcroft Hospice has embraced PSIRF and we are committed to continuously improving our patient safety culture; this patient safety incident response plan sets out how we intend to respond to patient safety incidents, learning as we go, sharing success stories, and promoting our no blame culture to give our teams the confidence to raise concerns when the arise. The plan is not a permanent rule that cannot be changed; we are committed to continuously improving and learning from our response to patient safety. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Vicky Bartlett

Director of Patient Care

2. Our Aims


We will **E**ngage and work together with our Patients, Staff, Volunteers, and other Key Stakeholders when aspects of patient safety or experience turns out differently to how we hoped.
We will respond to, **R**eflect on and learn from Patient Safety Incident if they occur, putting preventative measures in place, and celebrate our successes when things go well.
We will seek **I**nnovative new ways to improve our Patient's Safety & Experience, sharing our successes where things go better than expected.
We will enable everyone to have a voice so they can **S**uggest ideas and help to shape our services, and support those affected by Patient Safety concerns.

3. Our Services

Our vision is to make every day the best possible day for patients, and those closest to them, living with life-limiting illnesses in South Devon.

Rowcroft Hospice are an independent charity dedicated to providing specialist care and unwavering support to individuals facing life-limiting illnesses.

Our team of specialists (on our Inpatient Unit (IPU), and in our Community and Hospice at Home teams) including doctors, nurses, occupational therapists, social workers, physiotherapists, complementary therapists, bereavement counsellors, a spiritual care specialist, a music therapist, and an art therapist, plus a range of support staff, work tirelessly for thousands of patients and their families every year.

We are also very fortunate to have a wonderful team of volunteers. Whether they're helping out on our reception desk, supporting the IPU as a ward attendant or hospitality volunteer, organising or volunteering at a fundraising event, working in our shops or cafes, or passing you a hot cup of tea, these volunteers make a real difference to the hospice and our patients.

4. Our Patient Safety & Experience Profile

At Rowcroft Hospice we actively promote and honest and an open, "no blame" culture. We always encourage incident reporting and raising concerns, whether these are from our patients and family, or concerns raised by staff, volunteers or those organisations we work with.

In January 2023, our senior Patient Safety team, with the support of Information and Health and Safety Leads and a Patient and Public representative, formed a group, to review our response to PSIRF. The group reviewed incidents and patient and family feedback over the past two years and also looked at existing processes in place for management of incidents relating to patient safety.

The number of incidents involving patients under the care of Rowcroft Hospice that met the previous NHS England "Serious Incident[1]" criteria and resulting in moderate harm and above totalled 1 (between 2021 and March 2022), with this relating to a patient fall resulting in Moderate Harm (a fractured neck of femur). A total of 3 category 3 (full thickness skin loss) Hospice Acquired pressure ulcers had been reported, however these

[1] serious-incidnt-framwrk-upd.pdf (england.nhs.uk)

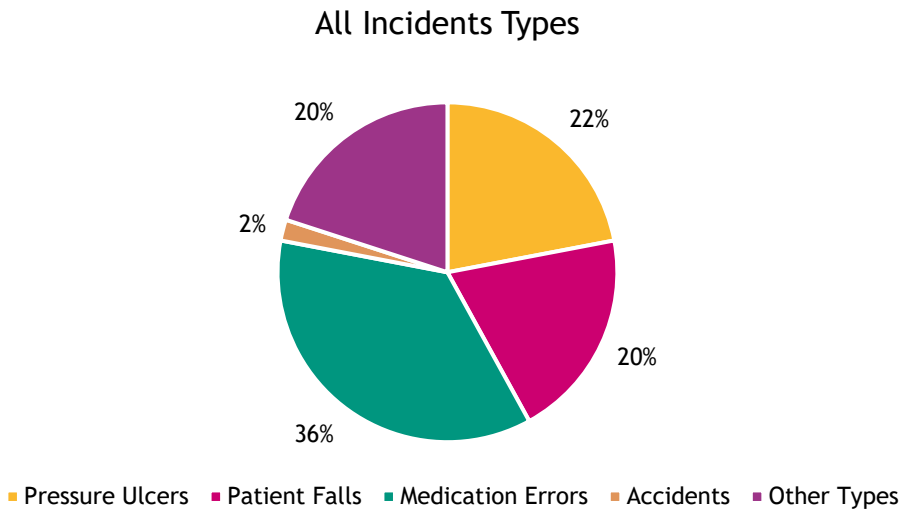
pressure ulcers were as a result of SCALE (skin changes at end of life) and did not require full investigation (CQC reporting requirements are also upheld by Rowcroft Hospice).

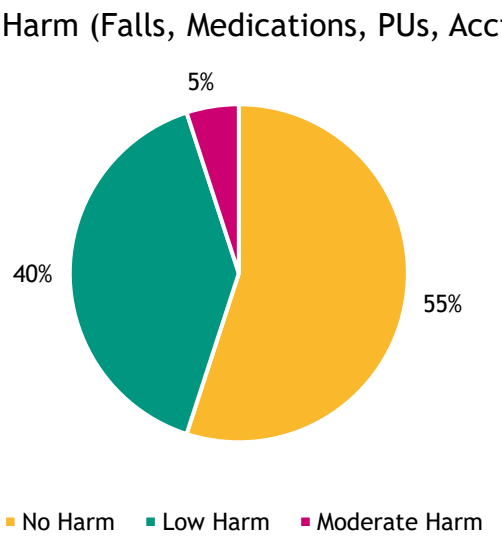
However, we acknowledge that at Rowcroft we report a high number of low-level patient safety incidents through our internal processes which we always seek learning from to minimise any concerns relating to patient safety, including near misses. Learning has included improvements to our education and training processes, policies and procedures, and looking at new equipment needed within the Inpatient Unit (for example, High Low beds were explored and purchased for IPU following a falls investigation in 2023).

The PSIRF Implementation group identified that between April 2021 and March 2023, 55% of incidents (medication errors, pressure ulcers, falls and accidents) resulted in no harm, and 40% resulted in low harm. Only 5% of incidents resulted in moderate harm (falls and pressure ulcers category 3 and over).

No incidents resulted in severe harm or death.

Rowcroft's Patient Safety Profile (April 2021 to March 2023)





In addition, the group acknowledged a number of improvements to our management of patient safety have taken place in the past 2 to 3 years, including:

- The full implementation of electronic incident reporting, review and management (on Vantage), moving away from paperless reporting and reviews, and the introduction of email alerts once an incident is reported.

- The introduction of Weekly Incident Review meetings, chaired by the Director of Patient Care, and attended by IPU and Community managers, the Quality Lead, Professional and Infection Prevention and Control Lead, and the Health and Safety Compliance Officer. This included on screen reviews of incidents taken place within the previous 7 days.

- Live Patient Safety dashboards on Vantage to ensure oversight of all incidents and enhanced reporting of incidents within monthly and quarterly reports.

- Electronic action plans within vantage, with trigger notifications to action leads.

- The introduction of Learning and Reflection from Incidents meetings (in November 2022) for thematic reviews to look at common themes from a specific incident type within a set period of time (for example, patient falls occurring within a 3-month period).

In July 2023, we implemented a new initiative to engage with all staff and raise awareness of the new CQC patient safety, Rowcroft's RISE (Reflect, Innovate, Suggest, Engage), and we felt it was appropriate to link this to PSIRF. We are committed to meeting the requirements of the new CQC framework, and proactively promoting a positive culture of safety based on openness and honest.

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.

5. Our Patient Safety & Experience Response Plan: National Requirements

Under our PSIRF Plan and Policies, it is a requirement that we will continue to undertake full investigations in relation to national requirements.

Patient safety incident type	Rowcroft PSIRF Level	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSI Level 5	PSII	Create local organisational actions and feed these into the quality improvement strategy.
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSI Level 5	PSII	Create local organisational actions and feed these into the quality improvement strategy.

We acknowledge that there are other reporting requirements, for example, reporting to the Accountable Officer, Care Quality Commission and the Charity Commission, and these processes will continue in line with our registration requirements.

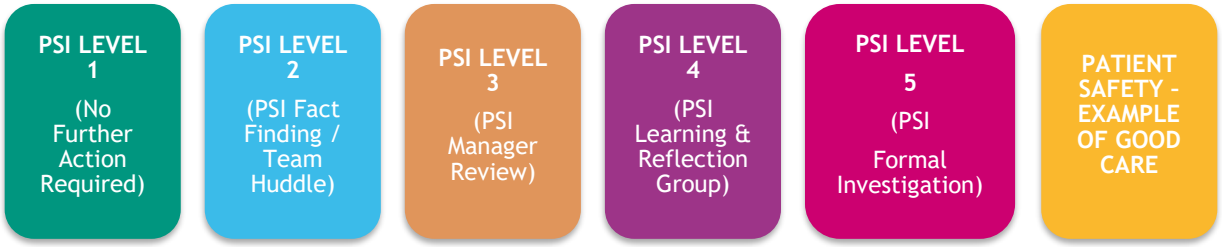
6. Our Patient Safety & Experience Response Plan: Local Focus

To meet our own responsibilities as part of PSIRF, the Rowcroft PSIRF implementation group created 5 new levels of incidents which incorporate process we have in place, and in addition to this recording of Examples of Good Care has been incorporated.

It is important to note that the types of responses will depend on:

- The views of those affected, including patients and their families.
- Capacity available to undertake a learning response.
- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect/benefit.

All incidents can be rereviewed at any time and the level can be escalated as part of other reviews E.g., as part of a Level 2 Huddle or a Level 4 (PSI Reflection and Learning Group).



Incident Levels will be decided by our Weekly PSI Review meeting, and updates shared monthly with our RISE Committee (previously knowns as the Quality and Patient Safety Committee), and also the Clinical Committee (chair by one of Trustees) as part of our Quarterly Quality Report.

Incident responses at Level 5 will be reviewed and signed off by the Rowcroft Senior Management Board and shared with Trustees via Clinical Committee and Board of Trustees as and when required.

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.

6.1 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.

6.2 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.

6.3 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).

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.

6.4 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 RISE Committee, and in summary via the Quarterly Quality Report to Clinical Committee.

6.5 PSI Level 5

PSI LEVEL 5

PSI Investigation (PSII)

Definition:

Any PSI (or groups 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. Full support for those carrying out PSIIs will be provided by the Director of Patient Care and Quality Lead, as the PSI specialists.
- Online training slides are being developed by the Quality Lead and will be implemented during 2024.
- PSI Investigations will be shared with the RISE Committee and 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.

6.6 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.

7. Our Response to Patient Safety Incidents

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.

8. Our Response to Patient, Family & Carer Feedback and Complaints

We aim to continually provide high standards of care throughout all Rowcroft Hospice Service, and all feedback, from our patients, families, carers, supporters, customers, visitors, and volunteers, is gratefully received. If we don't meet expectations or we exceed them, we are keen to know about it.

It is important to us that all our patients, family members, customers and other users and stakeholders know how to give feedback, suggest ideas on how to improve our services, raise a concern, or make a formal complaint. Rowcroft aims to ensure that our feedback processes are person-focused, simple, that everyone feels engaged and involved, and confident to speak up, feel listened to and understood. Our aim is that all complainants feel that their complaint is heard, has made a difference and that they feel we've sought to put things right by using feedback to improve our patient, family, and customer experience.

Rowcroft Hospice will investigate all complaints as quickly as possible, with courtesy, honesty, impartiality, and confidentiality, in line with our no blame culture, to maintain an effective response system that integrates the four key aims below (in line with PSIRF):

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

Concerns or complaints raised in relation to patient safety will be reviewed alongside PSIRF (as PSI Level 5). 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.

9. Roles and Responsibilities

9.1 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 ICB.

9.2 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.

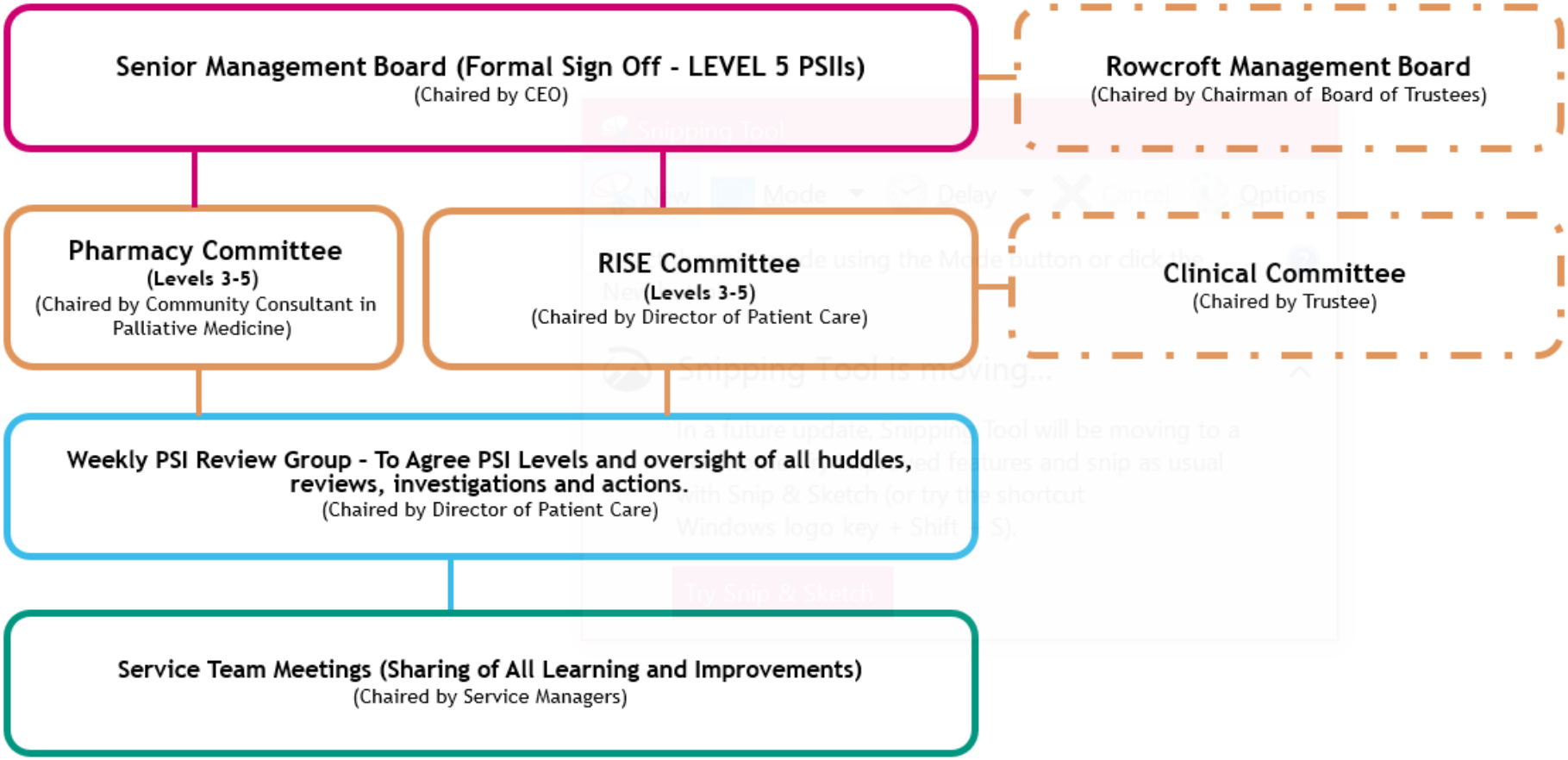
- Some incidents or complaints can occur within multiple healthcare systems involving multiple stakeholders, and collaborating with other organisations helps understand the broader context of incidents and complaints and develop strategies for improved coordination and communication.

- 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.

9.3 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).

Our Governance Process for all PSIs is for below:



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

a. LFPSE (Learning from Patient Safety Events)

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).

b. 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 CCG. This includes occasions where fire alarms or nurse call bells that malfunction for a continuous period of more than 24 hours. 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.

c. 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).

d. 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.

e. 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.

10. Engagement with Patients, Families and Carers

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.

It is our responsibility to ensure that our Staff and volunteers 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.

10.1 Duty of Candour

One of the fundamental standards identified by the CQC (Regulation 20) 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.

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 (as appropriate) either to the patient or a relative as relevant.

11. Involvement with Staff and Volunteers

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.

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

We have and will continue to promote 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 will ensure that we engage with our teams as part of our PSI processes, and we remain thankful to them 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.

12. Conclusion

Rowcroft Hospice recognise and agree that adopting the NHS Patient Safety Incident Response Framework Plan represents a crucial step forward in our ongoing commitment to patient safety and ensuring the well-being of patients within Rowcroft, and also the wider healthcare system in Devon.

By establishing a comprehensive framework that prioritises the identification, reporting, and learning from safety incidents, our plan demonstrates our dedication to continuous improvement and the delivery of high-quality, safe healthcare services. As the framework is implemented and refined

over time, it will help us to continue to embed a “no blame” culture of transparency, accountability, and innovation, ultimately contributing to a safer and more effective healthcare environment for all.

13. 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