Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
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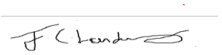
Reviewer	James Landucci-Harmey	Senior Compliance Officer & Company Secretary		01/03/2025
Authoriser	**Steve McEwen - Quality Manager Mid and South Essex ICB**			**02/10/2023**

Change Record

Date of Change	Details of Change	Change made by
02/10/2023	Tie into policy as advised by agreeing Local Authority and sign off authoriser	Tara Penn
01/03/25	Included new Business Entities	Tara Penn
29/10/2025	Annual update with internal stakeholders updated	Tara Penn

Contents

1. Introduction

This patient safety incident response plan sets out how The Complex team of Cera intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Cera will seek to learn from patient safety incidents reported by staff, clients, and their families as part of our work to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficiency of our local patient safety incident investigations (PSIIs) by:

- Refocusing PSII towards a systems approach in line with PSIRF and the identification of connected causatory factors and systems issues.
- Focusing on addressing these factors to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (clients, families and staff) confidence in the improvement of patient safety through learning from incidents.
- Demonstrating the added value from the above approach.
- Ensuring our policy reflects the needs and actions required.

Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

Cera will continue to develop the planning aspects of this PSIRP with the assistance and approval of our local commissioner(s).

The aim of this approach is to continually improve. As such this document will be reviewed annually and approved by the senior team at Cera in conjunction with the PSIRF policy.

2. Our Services

Cera.

The Cera family is made up of many companies who have joined together to live out our values and mission.

These companies include:

- Advanced Community Healthcare Limited
- Allied Health-Services Limited (Trading as Allied Healthcare)
- Allied Health Support Limited
- Apex
- Care at Home Services
- Cera Care Central Limited
- Cera Care Limited
- Cera Care Operations Limited
- Cera Care Operations (Scotland) Limited
- Cera Care Technology Limited
- Cera Homecare Limited (Previously CRG Homecare Limited)
- Cyprian Care Ltd
- Gemcare South West Limited
- HomeCare4U Limited
- Mediline Home Care Limited
- Nobilis
- North West Community Services Training Ltd
- Premier Care (Housing) Limited
- Premier Care (Lancashire) Limited
- Premier Care Limited

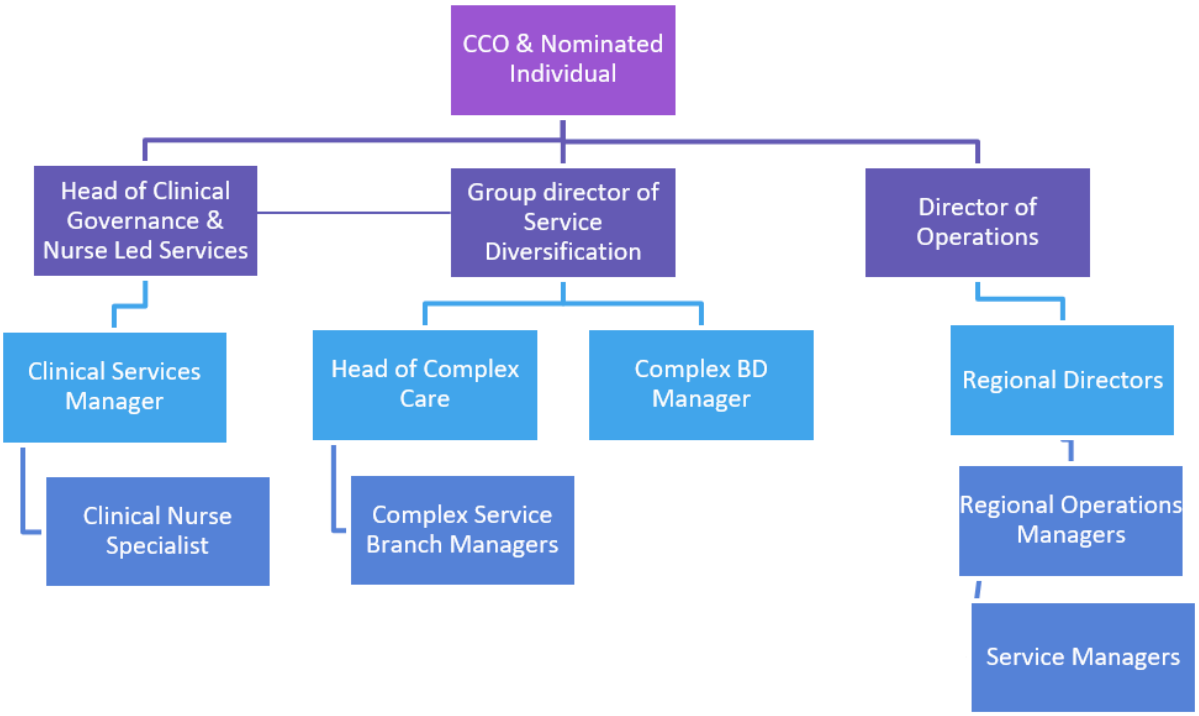
Cera provides care and support in a variety of settings for a diverse level of clients with needs ranging from domiciliary visits, extra care schemes and complex health care needs.

As the requirements for PSIRF relates to individuals who fall under NHS funding, the remit of the reporting is linked to the packages of care that are supported by our Specialist Services. This therefor narrows down the provider list from Cera to be,

- Allied Health-Services Limited (Trading as Allied Healthcare)
- Cera Care Limited
- Mediline Home Care Limited

Internal Stakeholders

The list of internal stakeholders for the complex elements of Cera would include representatives from different clinical and non-clinical staff (e.g. Management, Governance, Safeguarding, HR and Health and Safety and operational teams).



External Stakeholders

Depending on the incident to be investigated, the external stakeholders may vary depending on their subject matter expertise. This may include patient groups and patient and public representative organisations (eg local Healthwatch, Local Authority safeguarding, ICB leads, NHS England commissioning leads eg health and justice, NHS Resolution), Members of the Multi Disciplinary Team, The Police, and professional body representatives and the CQC.

To ensure that GDPR regulations are adhered to and information shared with external parties would need to be either with consent from the individual or in their best interests.

Through the process of any PSIRF process all internal and external stakeholders will need to be kept updated of any outcomes, updates or for the purpose of sharing information. This can be undertaken through, for example organisational briefings, newsletters, staff meetings, team briefings and workshops.

At the start of any PSIRF, the Terms of Reference will need to be agreed. This will identify who is required to be involved in the process, what their role is, who has the oversight of the workflow and process and how the information is to be communicated.

By reflecting the spirit of collaboration and partnership working, Cera will agree ways of working with the relevant ICB leads.

3. Defining our Patient Safety Incident Profile

Aim of a Patient Safety Incident Investigation (PSII)

PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causatory factors that may appear to contribute towards patient safety incidents. These factors must then be targeted with effective system improvements to either prevent or continuously and measurably reduce repeated incidents.

There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

There are several other types of investigation which, unlike PSIIs, may be undertaken. Examples include complaints, human resource, professional regulation, regulatory bars or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted by the subject matter experts as separate entities to be effective in meeting their specific intended purposes.

Selection of Patient Safety Incidents for PSII

In view of the above, the selection of incidents for PSII is based on the:

- Actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc.)
- Likelihood of recurrence (including scale, scope and spread)
- Potential for new learning in terms of:
    - Enhanced knowledge and understanding of the underlying factors,
    - Improved efficiency and effectiveness,
    - Opportunity to influence wider system improvement.

Timescales for Patient Safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

PSIIs should ordinarily be completed within one to three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between Cera and the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

Nationally-Defined Priorities to be Referred for PSII or Review by Another Team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2020 to 2021 are:

- Child deaths (Child death review statutory and operational guidance):
    - Incidents must be referred to child death panels for investigation
- Deaths of persons with learning disabilities:
    - Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme
- Safeguarding incidents:
    - Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation.

Nationally-Defined Incidents Requiring Local PSII

Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

- Incidents that meet the criteria set in the Never Events list 2018
- Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care.

Locally-Defined Incidents Requiring Local PSII

Based on a local analysis and review of the local incident reporting profile, local priorities for PSII have been set by Cera for the period of 18 months.

- Locally-defined patient safety incidents requiring PSII.
- An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.
- Locally-predefined patient safety incidents requiring investigation. Key patient safety incidents for PSII have been identified through analysis of local data and intelligence from the past two years of available data.

Criteria for Selection of Incidents for PSII:

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

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Data Sources

The patient safety Incident risks for the complex packages has been profiled using the organisations incident reporting platform. This has been filtered for the selected time periods, for Incidents only for the branches that support complex care.

July to July	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025
Never Events	0	0	0	0	0
Serious Incident Investigations	0	0	0	0	0
Other Root Cause Analysis Investigations (internal/departmental only)	0	0	0	1	1
Client related Incidents	Nil recorded	12	35	21	9

This gives the numbers of all incidents relating to the clients for the period, and the number in each category with the highest number of occurrences being related to Medication errors and slips, trips or falls.

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A local priority of incidents for PSIIs is detailed in the table below. Each incident type has been allocated a set number of PSIIs which will be conducted in the set 12 month period.

Incident type	Specific risk or incident sub type identified through risk assessment process and described with the support of client safety teams	Number of PSIIs	Planned response for specific incident type - selected based on risk assessment and with the potential for new learning or insight.
Medicine Management	Medication errors. Errors that occur during the preparation or administration of medication with or without harm to the client	4	1 to be undertaken per quarter to identify any common causative factors.
Slips, Trips or Falls	Slips trips or falls may be witnessed or unwitnessed	2	2 to be undertaken per year to identify any common causative factors
Missed visits	Where the client has been placed in a position of risk due to the staff visit not taking place	2	2 to be undertaken per year to identify any common causative factors
Staff sleeping on shift	Where the client has been placed in a position of risk due to the staff falling asleep while on duty	2	2 to be undertaken per year to identify any common causative factors

A PSII will be declared where the criteria (listed above) is met as well as taking into account any similar PSIIs already being investigated and the area in which the incident occurred. This will ensure that PSII are selected for incidents occurring across the group as well as allowing actions from previous PSIIs to be implemented

This approach will allow Cera to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

- Being explored and addressed as a priority in current PSII work or
- The subject of current improvement work that can be shown to result in progress or
- Listed for PSII work to be scheduled in the future.

As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

- Professional conduct/competence – referred to the clinical team/ human resource teams
- Establishing liability/avoidability – referred to claims or legal teams
- Cause of death – referred to the coroner's office
- Criminal - referred to the police
- Safeguard concerns - raised to the local safeguard board with appropriate registration notifications being made.

In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered.

Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff.

Different investigation techniques can be adopted, depending on the intended aim and required outcome. Cera will use the following investigation methods.

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: ● Discomfort, injury, or threat to life ● Damage to equipment or the environment
'Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case recording/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a client by a particular service. (To routinely identify the prevalence of issues)

Structured Judgment Review for delays	Clinical documentation review	This approach will be used to assess delays in both thematic reviews and individual cases. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. This potential bias needs to be taken into account when collating the report.
Debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle/Swarm	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: ● Improve situational awareness of safety concerns ● Focus on the patients most at risk ● Share understanding of the day's focus and priorities agree actions ● Enhance teamwork through communication and collaborative problem-solving ● Celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.

4. Defining our Patient Safety Improvement Profile

In line with the national PSII standards the following resources have been identified to enable delivery of the potential investigation programme, that is:

- National priorities:
    - Never Events
    - 'Learning from Deaths'-related incidents (identified via structured judgement review to be more likely than not due to problems in care)
    - unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway)

that they warrant the use of additional resources to mount a comprehensive PSII response.

- Identified local priorities
- Excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

Improvement and Safety Transformation Work

The Cera family is made up of many companies who have joined together to live out our values and mission. This has however led to a variety of different working methods, platforms and forms of documentation to be used. To streamline the processes, work is underway to review all of the documentation used within the complex packages to streamline and standardise them and work towards a digital platform being built and implemented.This improvement will pave the way for further expansion of the complex side of Cera. By centralising the tools used onto one platform will increase oversight.

Investigation Stages.

The table below outlines the different stages of the investigation process and the resource required for each patient safety incident investigation. The exact resources required will depend on the specific incident, and therefore the resources stated are estimations. It also provides an indication on the differing resource requirements for the relevant staff groups. This should be reviewed in conjunction with the PSIRF policy.

Investigation Stage	Responsibility
1. Plan the Investigation	
• Appoint investigators who are trained, competent, have secure protected time and sufficient support. • Inform and engage with the patient/family and staff involved in agreeing scope.	• Governance, Health and Safety and Operational Team • Investigation Supervisor and/or Lead
2. Gather and map the information (WHAT Happened)	
• Identify the WHO, WHERE and WHEN of the incident. • Identify WHAT happened • Map the incident timeline from the HCR, incident report and/or complaint letter. • Add further detail and achieve mutual understanding via meetings/interviews with the patient/family and staff involved	• Lead Investigator/ Investigation Supervisor
3. Identify Problems (HOW it happened and variations from what was expected to happen)	
• Identify and reference good practice requirements (work as imagined) • Identify the key problems arising	• Lead Investigator/ Investigation Supervisor /Subject Matter Expert
4. Analyse contributory and causal factors (WHY these key problems arose)	
• Observe and discuss how work is routinely done (work as done) • Search for contributory and causal factors for each key problem (deep-seated reasons WHY)	• Lead Investigator/ Investigation Supervisor
5. Write Investigation Report- with clarity, openness and in full consultation with patient/family and staff	

• Write investigation report	• Lead Investigator/ Investigation Supervisor
6. Develop Recommendations and Action Plan	
• Identify and develop strong systemic improvements (using HF principles) • Develop an action plan. • Review effectiveness of actions/improvements in reducing or preventing repeat incidents	• Lead Investigator/ Investigation Supervisor QIL Team/Safety Investigation Assurance and Learning Group

5. Our Patient Safety Incident Response Plan: National Requirements

In line with the national PSII standards the following safety issues have been identified as part of the national requirements. The response required and anticipated improvement route are as follows.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the Quality Framework
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the Quality Framework
Accidents and Incidents that are of a reportable nature	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation, LeDeR, RIDOR	Respond to recommendations as required and feed actions into the Quality Framework

Death of a person with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Create local organisational actions and feed these into the Quality Framework
Safeguarding incidents in which: ● babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence ● adults (over 18 years old) are in receipt of care and support needs from their local authority ● the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Create local organisational actions and feed these into the Quality Framework To ensure that staff, families and service users are supported at all stages of any investigation
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case.	Respond to recommendations as required and feed actions into the Quality Framework

	Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	

6. Our Patient Safety Incident Response Plan: Local Focus

In line with the national PSII standards the following safety issues have been identified as part of the local requirements. The response required and anticipated improvement route are as follows.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Accidents or Incidents that mirror the current CQuin strategy appropriate to the service delivered relating to • CQUIN07:Recording and the appropriate use of NEWS2 to prevent hospital admissions • CQUIN12:Assessment and Documentation of Pressure Ulcer Risk • CQUIN12:Malnourishment screening in the community	PSII	Create local organisational actions and feed these into the quality improvement strategy
Accidents or Incidents that have shown to have a high frequency of occurrences and common factors.	PSII	Create local organisational actions and feed these into the quality improvement strategy

Incidents that have occurred, with or without harm to the client relating to, ● Medication Management and administration ● Slips, Trips and Falls ● Missed Visits ● Care staff sleeping on duty	PSII	Create local organisational actions and feed these into the quality improvement strategy

Safety Improvement Plans

The type of response to a local PSII would depend on :

- The views of those affected, including clients and their families
- Capacity available to undertake a learning response
- Available resources to share the learning
- 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
- If Cera and its ICB's are satisfied, risks are being appropriately managed.

Safety improvement plans bring together findings from various responses to client safety incidents and issues. They can take different forms and may include,

- Creating an organisation-wide safety improvement plan summarising improvement work
- Creating individual safety improvement plans that focus on a specific service, Incident type or situation
- Collectively reviewing output from SUII's of single incidents when it can be evidenced that there are underlying, interlinked system issues
- Creating a safety improvement plan to tackle broad areas for improvement (ie overarching system issues).

Cera will decide upon the best approach to take as an outcome based on the available data following a PSII. This may be following a single plan or be a mixture of the above and should be reviewed in conjunction with the PSIRF policy.