Patient Safety Incident Response Policy

Effective date: July 2023

Estimated refresh date: January 2025

	NAME	TITLE	SIGNATURE	DATE
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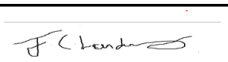
Reviewer	James Landucci-Harmey	Senior Compliance Officer & Company Secretary		21/7/23
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Change Record

Date of Change	Details of Change	Change made by

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Cera's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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.

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.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across 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
- 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
- North West Community Services Training Ltd
- Premier Care (Housing) Limited
- Premier Care (Lancashire) Limited
- Premier Care Limited

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.

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. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principal aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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.

For clarity, the use of the term 'Patient' throughout this policy will be applicable for Clients, Tenants, Residents and people we support.

Our patient safety culture

Cera is committed to:

Promoting a fair, open, inclusive and *just* culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of individual staff but also focuses on the system in which they were working in order to learn lessons.

- Improving communication and the development of a safety culture, encouraging a positive approach to the reporting and investigation of patient safety incidents.
- Openness in the handling of patient safety incidents and the application of the policy for Duty of Candour.
- Justifiable accountability and a zero tolerance for inappropriate blame. The NHS Improvement *just* culture guide should be used to determine a fair and consistent course of action towards staff.

Patient safety partners

The introduction of patient safety partners will be considered as part of Cera's commitment to patient involvement and engagement in the local implementation of the principles of PSIRF. This will be with the support of Subject Matter Experts (SME) that may differ for each investigation due to the differing needs required at the time.

Addressing health inequalities

Cera will apply a flexible approach and intelligent use of data to help identify any disproportionate risk to patients.

Cera will respond to any issues related to health inequalities as part of the implementation of this policy and follow the guidance in our Equality and Diversity Policy.

To meet the needs of the people involved in any Patient Safety Incident Investigation, any specific communication needs will be accounted for, following our policies on Accessible Information and Communication.

At the start of any PSII, the Terms of Reference will need to be agreed by all stakeholders. This is to include the patients and SME's preferred methods of communication will be agreed upon and timelines set. While Cera will welcome the input and participation of patients in the PSII, there is no guarantee that they choose to be a part of the process.

By following a SEIPS (System Engineering Initiative for Patient Safety) approach to the PSII the investigation will look at not only the person, but also the environment, the tools used and the company as part of the process. Cera will ensure staff have the relevant training and skill development to support this approach. This will support the development of a just culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce.

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

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.

The Duty of Candour is a legal duty requiring providers to ensure that patients and their families are informed when things go wrong resulting in moderate harm, severe harm or death. This includes receiving an apology, and sharing the investigation findings and actions to prevent recurrence. Please see the Duty of Candour Policy for further information. It is important to recognise that patient safety incidents can have a significant impact on staff who were involved in or who may have witnessed the incident. Like patients and families they will want to know what happened and why and what can be done to prevent the incident happening again. Staff involved in patient safety incidents should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services.

Patient safety incident response planning

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.

Resources and training to support patient safety incident response

In line with PSIRF Cera has identified key roles and responsibilities to ensure the local and effective implementation of the national patient safety incident response standards. Please refer to the section covering Roles and Responsibilities

Our patient safety incident response plan

Our plan sets out how Cera intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

In developing and reviewing the plan Cera will engage with key internal and external stakeholders, identify our patient safety incident profile and consider the patient safety and quality improvement priorities.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review

the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident reporting arrangements

It is Cera's responsibility to ensure that all incidents and near misses are reported, investigated and actioned to prevent or minimise similar instances in the future. Any incident or near miss can be defined as: "An unintended/unexpected event which has the potential to cause harm" Staff should use Cera's approved incident reporting system to report all patient safety incidents

Patient safety incident response decision-making

Any patient safety incident meeting the criteria for a patient safety incident investigation (PSII) as defined in the agreed patient safety incident response plan will be escalated and reported to Cera's Patient Safety Panel who will confirm if the incident fulfils the PSII criteria. Cera's Patient Safety Panel is jointly chaired by the Director of Specialist Services, Clinical Governance Lead and the Director of Health and Safety.

In circumstances when it is not immediately clear if the incident meets the criteria for a patient safety incident investigation (PSII), as defined in the agreed patient safety incident response plan, the Clinical Governance Lead will undertake an initial review of the incident, liaise with the relevant staff, gather further information and complete an incident review and escalation form to be presented at the Patient Safety Panel.

When potential patient safety incidents are identified through clinical negligence or inquest process the incident will be escalated to the Health and Safety or Legal Services teams where an incident review will take place.

The Patient Safety Panel will be responsible for identifying any themes and emergent issues in relation to patient safety matters.

Responding to cross-system incidents/issues

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that is commissioned for the service and who identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and action. All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate. The integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for coordinating the investigation process.

Timeframes for learning responses

Cera will aim to complete all PSII within 60 working days of the PSII being confirmed. No PSII takes longer than six months to complete (in line with national guidance). Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the PSII leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later should new information indicate the need for further investigative activity.

In rare and exceptional circumstances where there is an external investigation into a patient safety incident; for example police or Healthcare Safety Investigation Branch, Cera's PSII will not commence until permission from the external agency has been granted

Safety action development and monitoring improvement

All learning from PSII will be recorded on a safety action summary table in the PSII report. A SMART approach to action planning is essential. That is, the actions should be: Specific, Measurable, Attainable, Relevant and Time-bound.

Safety improvement plans

Where the learning from patient safety incident responses identifies the need for safety improvements these will be recorded within Cera's authorised software platforms and monitored through the company wide governance framework for implementation, sustainability and effectiveness.

All safety improvements will consider health inequalities and any disproportionate risk to patients with specific characteristics

Oversight roles and responsibilities

Director of Specialist Services.

- To provide executive lead & oversight.

- To ensure that Cera meets the National Patient Safety Incident Response Standards (PSIRS)
- To provide quality assurance and oversight of learning response outputs.
- To be compliant with the national PSIRF training requirements.

Director of Health and Safety

- To provide Executive lead & oversight.
- To report/escalate patient safety incidents in accordance with this policy.
- To take responsibility for analysis and sharing the learning from learning response output.
- To ensure that appropriate action is taken to implement any recommendations arising from learning outputs.
- To ensure that staff are compliant with the relevant national PSIRF training requirements.

Clinical Quality Lead

- To ensure that PSIRF is central to Cera's overarching clinical governance arrangements.
- To ensure that appropriate action is taken to implement any recommendations arising from learning outputs.
- To collate and complete PSII reports and share outcomes.

Quality Team.

- To ensure that this policy and associated company approved documents are implemented within their areas of responsibility.
- To ensure that appropriate action is taken to implement any recommendations arising from learning outputs
- To ensure that PSIRF is central to Cera's overarching governance arrangements.

Quality Business Partners.

- To dedicate time to conduct learning responses.
- To contribute to a PSIRF PSII as required.
- To engage with the patient/family/other relevant stakeholder as appropriate in relation to their involvement in the learning response.
- To ensure that any audits are undertaken in a timely manner to monitor compliance.
- To ensure that appropriate action is taken to implement any recommendations arising from learning outputs
- To collate and complete PSII reports and share outcomes with stakeholders and ICB's

Learning and Development Team

- To ensure the delivery of appropriate training to the appropriate individuals.

Investigation Officers

- Are not involved in the incident or directly manage staff involved in the incident
- Are identified and nominated by the leads of a PSII
- To dedicate time to conduct learning responses

Complaints and appeals

Any patient/carer/family member complaints related to Cera's patient safety incident response process should be made through the company's formal complaints process.

Please refer to the following policies for any staff complaints related to the Cera's patient safety incident response process:

- Complaints and compliments Policy
- Care Communication and Information Policy
- Accessible Information Standards Policy
- Accident and Incident reporting Policy and Procedure
- Whistle-blowing Policy and Procedure