NursingDirect

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PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

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PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK POLICY

1. PURPOSE

1.1 To describe the arrangements in place at Nursing Direct for the reporting and notification of safety incidents.

1.2 To support the requirements of the Patient Safety Incident Response Framework (PSIRF) and set our Nursing Directs 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.

1.3 To support the 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.

1.4 This policy will be used alongside the suite of incident-related policies and procedures at Nursing Direct, which include:

- Accident and Incident Reporting Policy and Procedure
- Safeguarding Policy and Procedure
- Duty of Candour Policy and Procedure

1.5 To support Nursing Direct in meeting the Key Lines of Enquiry/Quality Statements as set out by the Care Quality Commission (CQC).

1.6 To meet the legal requirements of the regulated activities that Nursing Direct is registered to provide:

- Care Quality Commission (Registration) Regulations 2009
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Health and Social Care Act 2008 (Registration and Regulated Activities) (Amendment) Regulations 2015
- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Safeguarding Vulnerable Groups Act 2006
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012

2. SCOPE

2.1 The following roles may be affected by this policy:

- All Staff including Agency Workers

2.2 The following Service Users may be affected by this policy:

- Service Users

2.3 The following stakeholders may be affected by this policy:

- Family
- Representatives
- Commissioners
- External health professionals
- Local Authority
- NHS/CCG/ICB

3. OBJECTIVES

3.1 To ensure that service users, staff including Agency Workers and other stakeholders are aware of who to report to when a safety incident occurs

3.2 To ensure that procedures are in place at Nursing Direct for Staff including Agency Workers to report, in a timely manner, to the appropriate bodies when a safety incident occurs.

3.3 To promote a culture throughout Nursing Direct where proactive systems are in place to ensure that incidents are reported and investigated, with the objective of preventing future similar incidents.

3.4 To ensure that 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.

3.5 Improve the safety of the care we provide to our patients, and improve our patients', their families', and carers' experience of it.

3.6 Further develop systems of care to continually improve their quality and efficiency through a comprehensive quality assurance structure integrated into the governance of our service to ensure that improvements are identified and implemented in a timely manner.

3.7 To ensure that all Service Users have the same level of protection and assurance in all care provision, implementing standardised safeguarding protocols.

3.8 Improve the experience for patients, their families, and carers wherever a patient safety incident or the need for a PSII is identified.

3.9 Improve the working environment for Staff including Agency Workers in relation to their experiences of patient safety incidents and investigations.

4. POLICY

4.1 Nursing Direct Staff including Agency Workers will ensure that all safety incidents are reported in a timely manner and that appropriate action is taken based on the Accident and Incident Reporting Policy and Procedure.

4.2 Management at Nursing Direct must ensure:

- There are clear reporting processes in place for service users and other stakeholders, with management oversight of all incidents on the Radar Healthcare Reporting system.
- A system is in place to determine which incidents need investigating.
- Adequate resources are available to ensure Staff including Agency Workers have enough time to conduct a meaningful investigation.
- Review from the Quality Assurance Team and management to ensure effective management, and continuous learning and improvement.

4.3 Nursing Direct will ensure that it complies with the Mental Capacity Act 2005 and Code and will ensure that procedures are in place should a safety incident arise, and the Service User involved lacks mental capacity. This will involve ensuring that the person who has lawful responsibility for them is notified of the incident.

4.4 **OUR PATIENT SAFETY CULTURE**
Nursing Direct is dedicated to fostering a culture of Service User safety, prioritising learning from incidents and creating an atmosphere where Staff including Agency Workers feel comfortable reporting incidents without fear of blame.

4.5 If a safety incident or incident involves a Service User, Staff including Agency Workers will ensure that the Duty of Candour Policy and Procedure at Nursing Direct is referred to and followed.

4.6 **PATIENT SAFETY PARTNERS**
Current funding contracts will be reviewed to determine whether they require notification of safety incidents. In the event of doubt, the funding authority or authorities for any Service Users involved in a safety incident or whose well-being was threatened by a safety incident, will be notified.

4.7 Where a notification is required, safety incidents and accidents will be reported to the CQC within 24 hours of occurrence.

4.8 The Local Authorities, CCG's and other service users Safeguarding Team will be notified of safety incidents where concerns are raised about abuse or potential abuse or relate to adults, children, or young people in vulnerable circumstances.

4.9 The local Police force will be informed by the management team of safety incidents where there is evidence or suspicion that the actions leading to harm (including those of omission) were reckless, grossly negligent, wilfully neglectful or that harm/adverse consequences were intended.

4.10 The relevant Coroner, within the local Police force, will be notified of cases of unexpected deaths or deaths under state detention grounds (refer to the Deprivation of Liberty Safeguards (DoLS) Policy and Procedure or the Deprivation of Liberty in Community Settings Policy and Procedure).

4.11 The Health and Safety Executive will be notified where safety incidents fall under the scope of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

4.12 The Medicines and Healthcare products Regulatory Agency (MHRA) will be notified via the Yellow Card Scheme of safety incidents caused by suspected problems with medicines or medical devices.

4.13 Following discussion and agreement with senior managers and other bodies, professional regulators i.e. the Nursing and Midwifery Council will be notified of safety incident as a result of individual professional practice misconduct.

4.14 **ADDRESSING HEALTH INEQUALITIES**
Nursing Direct patient safety incident response processes facilitates health equality and reduces inequality by capturing disparities related to the Protected Characteristics that are outlined in the Equality Act 2010 utilising system-based approaches.

4.15 **ENGAGING AND INVOLVING SERVICE USERS, FAMILIES AND STAFF FOLLOWING A PATIENT SAFETY INCIDENT**
Nursing Direct will conduct weekly meetings to review patient safety incidents with both the management team and the clinical lead team. These meetings will focus on discussing recent incidents and addressing any immediate concerns.

4.16 Nursing Direct will hold monthly Clinical Governance Meetings to analyse incidents, resolve ongoing issues, and share insights. These meetings provide a key opportunity to discuss unresolved cases and, once resolved, to review lessons learned from patient safety incidents.

4.17 Nursing Direct acknowledges that learning and improvement after a patient safety incident can only be achieved when supportive systems and processes are in place. It advocates for the development of an effective patient safety incident response system that prioritises compassionate engagement and the involvement of all those affected, including service users, families, and staff including Agency Workers. Where additional emotional support is needed, guidance on how to access this support will be provided through our Welfare process.

5. PROCEDURE

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)
The PSIRF has replaced the Serious Incident Framework 2015. This new framework ensures that investigations are strategic, preventative, collaborative, fair and people focused. It looks at the cause of the incident within the system, rather than seeking someone to blame.
THE PSIRF SUPPORTS THE DEVELOPMENT AND MAINTENANCE OF AN EFFECTIVE PATIENT SAFETY INCIDENT RESPONSE SYSTEM THAT INTEGRATES FOUR KEY AIMS: • 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 • Supportive oversight focused on strengthening response system functioning and improvement.
THE PSIRF OFFERS: • Increased Service User Safety by prioritising incident reporting and investigation • Enhanced Quality of Care • Learning from incidents leads to improved practices and policies, resulting in better quality care for Service Users • Increased Transparency • Creating trust amongst Service Users and their families • Continuous Improvement • The culture of learning and improvement at Nursing Direct can drive ongoing enhancements in the delivery of social care services. • Empowered Staff including Agency Workers • Encouraging incident reporting and providing support to Staff including Agency Workers nurtures a sense of encouragement and dedication to providing safe care.
THE PSIRF NO LONGER USES ROOT CAUSE ANALYSIS (RCA). IT SEES PATIENT SAFETY EMERGING FROM COMPLEX INTERACTIONS AND IS NOT THE RESULT OF AN INDIVIDUAL CAUSE, SUCH AS ONE PERSON, AND: • Recognises that outcomes in complex systems result from the interaction of multiple factors. • Learning should not focus on uncovering a root cause, but instead should explore multiple contributory factors. • Does not distinguish between care and service delivery problems. • Explores contributory factors, including individual acts in the context of the whole system. • Uses tools to explore multiple interacting contributory factors rather than forcing a single analytical pathway.
THE PSIRF IS SUPPORTED BY NHS GUIDANCE DOCUMENTS WHICH INCLUDE: • A guide to prepare for and implement the framework. • Engaging and involving patients, families, and Staff including Agency Workers , following a patient safety incident • Guide to responding proportionately to patient safety incidents. • Oversight roles and responsibilities specification • Patient safety incident response standards

Patient Safety Incident Response Planning

5.1 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.

5.2 Nursing Direct will ensure that clear procedures are in place for taking immediate action following safety incidents. Staff including Agency Workers should also refer to the Accident and Incident Reporting Policy and Procedure at Nursing Direct.

5.3 Nursing Direct will implement a comprehensive Patient Safety Incident Response Plan (PSIRP) specifically tailored to our services. This plan will address the unique health and care needs of our service users, prioritising their safety and well-being.

5.4 A well-maintained list of contacts and telephone numbers is held in an accessible location to aid the notification of safety incident to the appropriate bodies. Where applicable, this includes how notifications will be made to each body.

5.5 The office hours, from 05:30 to 22:30, Monday to Sunday, 365 days a year, will be clearly displayed in an easily accessible location. This arrangement includes the Nursing Direct team, available Monday to Friday from 08:00 to 18:00, and the Out-of-Hours team, providing coverage during all remaining hours.

5.6 Nursing Direct will ensure that vulnerable Service Users receiving social care services have the same level of protection and assurance as people in healthcare settings and will handle incidents with care, openness, and a focus on learning and improving.

5.7 Our patient safety incident response policy and plan are a dynamic, evolving document that will be regularly updated and refined as we continue to respond to patient safety incidents. We will review the plan every 12 months as a minimum, to ensure it remains current and aligned with our priorities.

5.8 Our Patient Safety Incident Response Policy and Plan will be accessible on our website to ensure transparency and clarity.

RESPONDING TO PATIENT SAFETY INCIDENTS

PATIENT SAFETY INCIDENTS ARE ACTS AND/OR OMISSIONS THAT RESULT IN:

- Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death and homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm, unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user or serious harm.
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or here abuse occurred during the provision of NHS-funded care.
- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - Failures in the security, integrity, accuracy, or availability of information often described as data loss and/or information governance related issues.
  - Property damage;
  - Security breach/concern;
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/unit closure or suspension of services
  - Activation of Major Incident Plan (by provider, commissioner, or relevant agency).
  - Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

5.9 Patient Safety Incidents are systematically documented and tracked using the internal Radar Healthcare Incident and Complaints system. This system guides the investigative process by following a structured workflow and presenting tailored questions aligned with the details of the reported incident. The specific inquiries are designed to extract pertinent information, ensuring a thorough and focused investigation based on the responses provided.

5.10 Our internal process mandates that all staff, including agency workers, report incidents within 24 hours, ensuring timely documentation on the system. The workflow then assigns the incident to the appropriate clinical lead or manager, allowing us to address and manage each incident promptly.

5.11 All Staff including Agency Workers will comply fully with any associated investigations required following a safety incident. Where an incident has been notifiable to other bodies, Nursing Direct will act in accordance with their advice in relation to undertaking its own internal investigations.

5.12 When it is deemed necessary to conduct an internal investigation, safety incidents will be thoroughly examined to identify and understand the underlying causes. This investigation aims to delve into the root cause of the incident, providing a comprehensive understanding that facilitates effective corrective measures and preventive actions.

5.13 The Management team must ensure that those conducting investigations have specific knowledge and experience gained through training.

5.14 It is up to Nursing Direct to decide when a Patient Safety Incident Investigation (PSII) should take place, depending on the circumstances and factors. However, there are some categories of incident where carrying out a PSII is mandatory, and these include:

- Service User deaths thought more likely than not to be due to problems in care under the 'learning from deaths' criteria.
- Deaths of Service Users detained under the Mental Health Act
- Incidents that meet the 'never events' criteria (or its replacement)

These are set out in the Guide to Responding Proportionately to Patient Safety Incidents.

PSII – PATIENT SAFETY INCIDENT INVESTIGATION

PSII's are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

The selection of incidents for PSII is based on the;

a) Actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc.)
b) Likelihood of recurrence (including scale, scope and spread)
c) Potential for learning in terms of:
d) Enhanced knowledge and understanding
e) Improved efficiency and effectiveness (control potential)
f) Opportunity for influence on wider systems improvement.

There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. PSII's 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 the healthcare organisation with the service user and/or next of kin. No local PSII should take longer than six months.

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. Incidents requiring other types of investigation and decision-making, which lie outside the scope of PSII, will be appropriately referred as follows:

a) Professional conduct/competence – referred to human resource teams.
b) Establishing liability/avoid-ability – referred to claims or legal teams.
c) Cause of death – referred to the coroner's office.
d) Criminal – referred to the police.

5.15 Nursing Direct will monitor Patient Safety Incidents (PSII's) to enhance the effectiveness of care delivery. This involves a systematic examination of incidents, reviews, and processes to assess their impact on safety and service quality. Through close scrutiny, valuable insights are gained, enabling targeted improvements in protocols, training, and procedures. This ongoing evaluation not only prevents adverse events but also cultivates a proactive, patient-centred approach, fostering continuous learning.

5.16 The PSIRF promotes a range of system-based approaches for learning from patient safety incidents. Nursing Direct may use the national tools and guides available in the PSIRF learning response toolkit that incorporate the SEIPS framework (Systems Engineering Initiative for Patient Safety).

5.17 **Responding to cross-system issues**
To manage cross-system incidents, Nursing Direct will ensure clear communication by assigning specific contacts for each involved system and providing regular updates to all stakeholders. We will implement a coordinated response plan that integrates workflows and involves joint investigations with relevant parties to address the incident effectively. Using a centralised system like Radar Healthcare, we will track and manage incidents across different systems with integrated dashboards for a unified view. Collaboration will be fostered through regular meetings with all agencies involved and shared resources to ensure consistent management. Compliance with regulations will be maintained, and comprehensive documentation will be kept for all actions and decisions.

5.18 **Statutory and Regulatory Notifications**
Staff including Agency Workers with the relevant skills and competence will complete the appropriate notification form which can be accessed via the CQC website. A copy will be held by Nursing Direct before sending to the CQC.

5.19 Staff including Agency Workers with the relevant skills and competence will, where appropriate, complete the relevant notification form which can be accessed via the HSE website. A copy will be held by Nursing Direct following submission.

5.20 **Audit and Review**
Nursing Direct will collaborate closely with all multidisciplinary teams within the service user's professional network to address and review safety incidents. We will actively support investigations by attending meetings, providing necessary information, and ensuring follow-up on agreed actions, all with the shared goal of achieving a positive outcome. Lessons learned will be integrated into our protocols to enhance future care.

5.21 The Radar Healthcare Reporting System will capture all incident-related information, assign tasks and actions to be completed before case closure, and facilitate comprehensive reporting that can be easily shared with the multidisciplinary team for clear oversight. The system will perform trend analysis to identify recurring issues and patterns, enabling proactive improvements and informed decision-making.

5.22 Feedback will be sought in relation to notifications made to external bodies to ensure that all information is communicated as expected and necessary. Spot checks will be made by managers on the notifications process as part of the quality assurance process and completed investigations will be used to implement changes to practice to reduce the risk of re-occurrence.

5.23 Nursing Direct will conduct a post-incident review to identify areas for improvement and update our response strategies accordingly. Improving and developing Nursing Direct involves a combination of strategic planning, continuous assessment, and implementation of effective mechanisms. Examples of these mechanisms include;

- Establish and maintain robust quality assurance systems to monitor and evaluate the delivery of care services.
- Regularly review and update policies and procedures to ensure compliance with regulatory standards and best practices.
- Invest in ongoing training for care Staff including Agency Workers to enhance their skills and keep them updated on the latest best practices.
- Collecting feedback from service users, clients and their families to identify areas for improvement.
- Use data-driven insights to identify trends, areas of improvement, and areas of excellence.
- Conduct regular internal audits and inspections, through senior management meetings and clinical governance, to identify compliance issues and areas that need improvement.

By implementing these mechanisms, Nursing Direct can create a culture of continuous improvement and provide high-quality care services.

5.24 **Support Post Incident**
Nursing Direct will give the person(s) involved in the incident all reasonable support necessary to help them overcome the physical, psychological, and emotional impact of the incident. This could include some or all of the following:

- Treating them with respect, consideration, and empathy
- Offering the option of direct emotional support during the notifications, for example, from a family member, a friend, or a care professional.
- Providing the choice of direct emotional support during notifications through our Well-being Lead.
- Offering help to understand what is being said, for example, through an interpreter, non-verbal communication aids, written information, or Braille.
- Providing the relevant person with details of specialist independent sources of practical advice and support or emotional support/ counselling
- Providing the relevant person with information about available impartial advocacy and support services, their local Healthwatch and other relevant support groups, for example, Cruse Bereavement Care and Action against Medical Accidents (AvMA), to help them deal with the outcome of the incident.
- Providing support to access the Complaints, Suggestions and Compliments Policy and Procedure for any potential complaints or appeals.

5.25 **Training and Education**

All Staff including Agency Workers at Nursing Direct have been trained and are aware of their role when dealing with safety incidents. As a minimum, all Staff including Agency Workers have been made aware of the reporting procedures in place. Staff including Agency Workers have also been provided with information regarding the associated bodies that may be involved when a safety incident occurs.

Staff including Agency Workers involved in reporting safety incidents to other bodies all have the skills, knowledge, and experience to do this in a professional and competent manner.

Staff including Agency Workers involved in the undertaking of investigations will have the appropriate skills, knowledge, and experience to do this.

6. DEFINITIONS

6.1 **Staff including Agency Workers**

6.1.1 **Staff**

Denotes the employees of Nursing Direct Healthcare Limited.

6.1.2 **Agency Workers**

Refers to individuals who are contracted with Nursdoc Limited or another employment business as an Agency Worker (temporary worker) provided to Nursing Direct Healthcare Limited to perform care services under the direction of Nursing Direct.

6.2 **Nursing Direct**

Nursing Direct, also known as Nursing Direct Healthcare Limited, is the entity regulated by the CQC (Care Quality Commission) and responsible for the care service provision, contracted to provide homecare services to service users in their homes, in placements, essential healthcare facilities and in the community.

6.3 **Nursdoc Limited**

As the sister company to Nursing Direct Healthcare Limited, Nursdoc Limited acts as an employment business, specialising in providing staffing solutions to the healthcare sector.

6.4 **CQC (Care Quality Commission)**

CQC throughout this policy, the term "CQC" refers to the Care Quality Commission (CQC) which is the independent regulator of health and social care in England.

6.5 **A Patient Safety Incident**

An unplanned or unintended event or circumstance which could have resulted or did result in harm to a patient.

6.6 **Safety Incident (previously known as a Serious Incident)**

An event that has, or could have, caused harm. It may result in death, permanent or disabling injury, property damage, release of hazardous material or environmental impacts. An event where the potential learning and consequences are so significant that they warrant a comprehensive investigation and response.

6.7 **Patient Safety Incident Response Framework (PSIRF)**

The PSIRF advocates a coordinated 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.

6.8 **Patient Safety Incident Response Plan (PSIRP)**

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a co-production approach with the divisions and specialist risk leads supported by analysis of local data.

6.9 **Patient Safety Incident Investigation (PSII)**

PSII's are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors and help deliver safer care for our patients effectively and sustainably.

6.10 **Root Cause Analysis (RCA)**

Root cause analysis is a systematic process for identifying "root causes" of problems or events and an approach for responding to them.

OUTSTANDING PRACTICE

To be 'outstanding' in this policy area you could provide evidence that:

- Nursing Direct has an open culture where safety issues are identified and incidents and near misses recorded.
- Staff including Agency Workers are aware of their roles and responsibilities in relation to the reporting of incidents. The relevant Staff including Agency Workers are clear on who to notify in the event of a safety incident or accident.
- The wide understanding of the policy is enabled by proactive use of the QCS App
- Root cause analysis and investigations are used as a means of identifying cause and changing practice to reduce the risk of re-occurrence.
- There is a culture of proactive management of risk rather than reactive.

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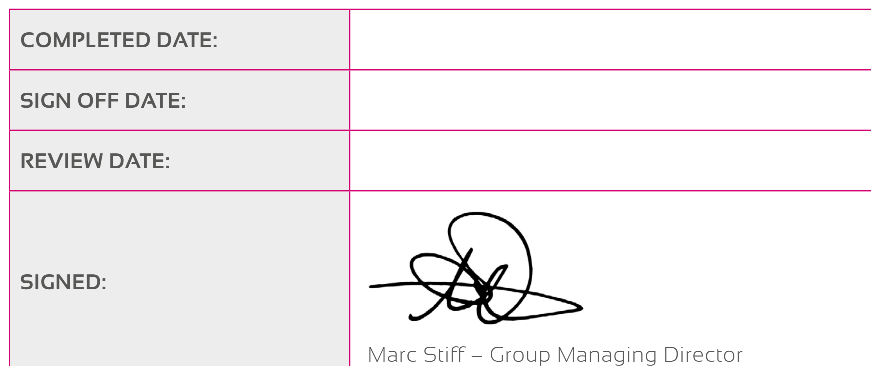
SIGNED:	 Marc Stiff – Group Managing Director