TITLE	Patient safety incident response policy
APPLICABLE TO	Staff and volunteers
REVIEW DATE	June 2026
KEYWORDS	Patient, safety, reporting
POLICY NO	341v1

Group	**Approved Date**
Clinical Governance Steering Group	

	Author	**Lead Reviewer**	**Approved by**	**Authorised by**
Name	Emma Mills			
Title	Senior Sister & Patient Safety Lead			
Date	June 2023			

Weldmar Hospicecare Policy Equality Impact Assessment (EQIA)

An EQIA should be completed by the author/reviewer for every for new policy and when a policy is being reviewed. The purpose of the EQIA is to identify if any Weldmar policy could have any negative or unfavourable impact on certain groups of individuals known to have protected characteristics, as stated in the Equality Act 2010. For any help in completing this assessment please contact People Services	
Name, number and version of the Policy	Patient safety incident response policy
Aims and objectives of the Policy:	This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF
Who is the policy intended for:	All staff and volunteers
Date of Assessment:	23/06/2023
Name and Job Title of assessor:	Emma Mills Senior Sister

Stage 1 Initial Assessment

Consider how this policy could have a potential impact on individuals who have one or more of the nine protected characteristics as stated in the Equality Act 2010.
Please tick all that apply.

Protected Group	Summary of impact	Negative Impact	Neutral Impact	Positive Impact
Age	Increase staff awareness of the importance of involving people who identify as having protected characteristics, in any incident investigation	☐	☐	☒
Gender reassignment	As above	☐	☐	☒
Marriage and Civil Partnership		☐	☒	☐
Pregnancy and Maternity		☐	☒	☐

Disability	As above	☐	☐	☒
Race	As above	☐	☐	☒
Religion of Belief	As above	☐	☐	☒
Sex	As above	☐	☐	☒
Sexual Orientation	As above	☐	☐	☒

Patient Safety Incident Framework mentions the importance of considering the impact of patient safety investigations on those with protected characteristic and the need to take this into account. This is a new policy so has the potential to be a positive move to ensure this happens in any investigation at Weldmar

What's next? Go on to complete Stage 2 if you identify any negative impact. If only positive or neutral are ticked then please set a date below for a further initial screening when the policy is reviewed.

Stage 2 Asses the level of risk and Mitigation

Please list the impacts, and who is affected and assess any risk of the impact using the matrix in the Policy Process.

What is the impact and to whom	**Likelihood X**	**Severity =**	**Risk**	**Any Proposed changes to the policy and how this has reduced the risk**
Please add more rows if required				

How will you monitor changes to the policy?	
If any negative impacts remain please provide an explanation	
Date of review for this EQIA	01/06/2026
Signature	

Please forward a copy of this form/policy to People Services.

1.	**AIMS OF THE POLICY**
	This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Weldmar Hospicecare'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.
2.	**SCOPE**
	This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Weldmar Hospicecare. Responses under this policy follow a systems-based approach. 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.
3.	**GLOSSARY / ABBREVIATIONS**
	CGSG - Clinical Governance Steering Group CGC – Clinical Governance Committee PSIRF – patient safety incident response framework PSI – patient safety incidents PSII – patient safety incident investigation
4.	**POLICY APPLICABLE TO**
	All staff and volunteers

5.	POLICY

5.1 Patient Safety Culture

Weldmar Hospicecare is committed to:

- Promoting a fair, open, inclusive culture which understands that both human and systemic factors can influence incidents
- Improve communication and development of a no-blame culture that encourages a positive approach to reporting and investigation of patient safety incidents
- An open and transparent approach, ensuring application of the duty of candour
- A fair and consistent approach

5.2 Patient safety partners

Engagement and introduction of patient and/or volunteer experience groups will be considered as part of the PSIRF principles.

5.3 Addressing health inequalities

The Equality, Diversity and Inclusion Development Group will use data to help identify any disproportionate risk to patients with specific characteristics, which will inform our patient safety incident response.
When patient safety incidents are investigated, there will be consideration of inequalities, including when developing safety actions.
Patients, families and staff will be involved following a patient safety incident with consideration of their different needs.
Our approach will follow a system-based approach (not a 'person focused' approach) and ensure staff have the relevant training and skill development to support this approach to support the development of a just culture.

5.4 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 timely inclusive and compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff) and considers individual and specific needs. 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 which requires 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. See Duty of Candour and Being Open Policy for further information.

The importance of supporting staff involved in patient safety incidents is recognised and staff are able to access support via:

- Staff counselling
- Debrief/reflection
- Line manager
- Advice from their professional body or union

5.5 Patient safety incident response planning

Our patient safety incident response plan was shared with our NHS commissioners in May 2023 and will be reviewed and updated as the NHS implements this new approach locally.

5.6 Responding to patient safety incidents

Patient safety incident reporting

It is the responsibility of Weldmar Hospicecare to ensure that all incidents and nears misses are reported, investigated and actions identified in a timely manner.
All incidents/near misses must be reported through the RADAR reporting system.

Patient safety incident response decision making

Patient safety is closely audited, monitored, scrutinised and benchmarked through our clinical governance system.

Any patient safety incident meeting the criteria for a patient safety incident investigation (PSII) as defined in appendix 1 will be escalated and reported to the Director of Clinical Services and/or Patient Safety Lead who will confirm if the incident fulfils the PSII criteria.

Timeframe

All PSII aim to be completed within 60 working days, and no longer than 6 months (in line with national guidance).

Safety improvement plans

All learning from PSII will be recorded 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 action development and monitoring improvement

All Patient Safety Incidents are reviewed by the Clinical Governance Steering Group (CGSG) and monitored by the Clinical Governance Committee.
Anonymised incidents can be used in internal education & development programmes, such as medication management workshops, to ensure internal learning from incidents.
Lessons learnt will be recorded on the RADAR.

5.7 Complaints and appeals

	Any patient/carer/family member complaints related to the patient safety incident response process should be made through the formal complaints process**.**
6	**ROLES AND RESPONSIBILITIES**
	Board of Trustees • Seeks assurance that all reasonable measures are in place to protect and promote the safety of patients receiving care from Weldmar Hospicecare. The Clinical Governance Committee scrutinises quality information, including patient safety data. The Clinical Governance Steering Group (CGSG) • Ensures the progress of implementation of PSIRF, risk and other types of patient safety reviews, reporting to the CGC Director of Clinical Services • To provide executive lead and oversight • To ensure the PSIRF is central to overarching safety governance arrangements Senior Sister/Patient Safety Lead • To oversee the monitoring of incidents on the IPU • To provide an annual report to the Clinical Governance Committee and Board of Trustees on patient safety across Weldmar. Champions • To lead on reporting via audit • Promote best practice and provide education and training Investigation officers • To complete a PSII if appropriate. • To ensure that there is compassionate engagement and involvement of those directly affected by patient safety incidents All staff and volunteers should familiarise themselves with this policy. Line managers should ensure awareness of the policy is included in induction.
7.	**DISSEMINATION, IMPLEMENTATION & MONITORING COMPLIANCE**
	• This policy will be available on Weldmar Hospicecare's Intranet. • The policy will be reviewed by the Patient Safety Lead every three years.

8.	**RELATED POLICIES**
	Duty of Candour and Being Open policy Falls Policy Health & safety Policy Medicines Administration policy Moving and Handling policy No Smoking policy Pressure Ulcer policy RADAR policy Risk management policy Safeguarding for Adults at risk
9.	**RELATED INFORMATION**
	Never Event list 2018 updated 2021 (NHS Standard Contract)
10.	**REFERENCES**
	Patient Safety Incident Response Framework, Aug 2022, NHS England
10.	**APPENDICES** (if applicable)
	1. Response framework 2. PSII report template

Appendix 1

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	PSII reviewed by CGSG and CGC and action plan shared with relevant clinical governance group and CQC and NHS Dorset Quality team
Death (care related)	PSII	PSII reviewed by CGSG and CGC and action plan shared with relevant clinical governance group and CQC and NHS Dorset Quality team
Patient safety priorities • Medication errors • Falls • Pressure ulcers • Safety related Complaints	Reviewed by champions, IPU Sister, IPU Senior Sister or relevant Director Local determination if PSII required	PSII reviewed by CGSG and CGC and action plan shared with relevant clinical governance group and CQC and NHS Dorset Quality team

Appendix 2

Patient safety incident investigation (PSII) report

On completion of your final report, please ensure you have deleted all the blue information boxes and green text.

Notes on the PSII template

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

General writing tips

A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

1. Distribution list

List who will receive the final draft and the final report (eg patients/relatives/staff involved, board). Remove names prior to distribution.

Name	Position

2. About patient safety incident investigations

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

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

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

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

3. A note of acknowledgement

Notes on writing a note of acknowledgement

In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.

You could consider referring to the patient by name or as ‘the patient’ according to their wishes.

Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

4. Executive summary

Notes on writing the executive summary

To be completed **after the main report has been written.**

Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

Contents

To update this contents table, click on the body of the table; select ‘update field’; and then ‘update page numbers only’; and then click ‘ok’.

5. Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

6. Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – eg by day or by contact with different services on the care pathway.

It should be written in neutral language, eg ‘XX asked YY’ not ‘YY did not listen to XX’. Avoid language such as ‘failure’, ‘delay’ and ‘lapse’ that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to ‘[NAME]’s story/experience’.

7. Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

Terms or reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

8. Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

9. Summary of findings, areas for improvement and safety actions

Notes on writing the final summary

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (eg refer to other ongoing improvement work, development of a safety improvement plan)

Safety action summary table

Area for improvement: [eg r*eview of test results*]								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
1.								
2.								
…								

Area for Improvement: [eg *nurse-to-nurse handover*]								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
1.								
…								

10. Appendices

Notes on appendices

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

11. References

Notes on references

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