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An Roinn Sláinte
Männystrie O Poustie
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Framework for Learning and Improvement from Patient Safety Incidents

Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident

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Introduction

The Regional Framework for Learning and Improvement from Patient Safety Incidents[1] delivers a more streamlined and simplified process for reviewing Patient Safety Incidents.[2] This will help ensure that Patient Safety Incident Learning Reviews are concluded in a timelier manner with a focus on understanding how and why the Patient Safety Incident has occurred, that system wide learning is promptly identified, disseminated and effectively embedded in practice and leads to evidence of sustainable and demonstrable improvements in patient safety.

One of the earliest steps in the Patient Safety Incident Learning Review process is to consider and identify in a structured way who 'All those Affected' include in order to engage with them in accordance with the principles outlined in this document. Organisations should consider service users, patients, families, carers, victims, victim's families, and visitors that may be affected by a Patient Safety Incident, when determining who All those Affected are.

Similarly, Staff Affected by a Patient Safety Incident should also be considered and identified, and more detail is provided in the *Principles for Engaging, Involving and Supporting Staff Affected by a Patient Safety Incident*.

All those Affected by a Patient Safety Incident must be placed at the heart of the learning review process. Securing their involvement, at a level which is in line with their wishes enables/delivers a more complete and authentic learning review and allows their unique perspective and 'lived experience' to be a central component when undertaking Patient Safety Incident Learning Review. The aim of this document is to ensure that everyone involved regardless of their background or medical knowledge, can understand and actively participate in the process.

The Patient Safety Incident Learning Review Process can be a very difficult and traumatic time for those affected and the Framework recognises that compassionate, empathetic and meaningful involvement and support is an essential part of the process. All communication with those involved in a Patient Safety Incident Learning

[1] Hereinafter referred to as the Framework.
[2] A full list of terms and definitions used in this document can be found in the accompanying glossary (**Annex A**).

Review must be open, honest, transparent and fully aligned to the Department's Being Open Framework[3].

The purpose of this Principles document is to set out the expectations for All those Affected by the Patient Safety Incident Learning Review Process, regardless of the type of review undertaken and assist Health and Social Care (HSC) staff in appropriately engaging, involving and supporting All those Affected following a Patient Safety Incident.

HSC organisations should use these Principles to develop formal, robust and rigorous governance structures to assure and demonstrate the effective implementation of the Framework and the accompanying Regional Standards for the Conduct of the Review of Patient Safety Incidents.[4]

[3] The Department's Being Open Framework is currently in draft pending the outcome of public consultation.
[4] Hereinafter referred to as the Standards.

Principles for Engaging, Involving and Supporting All those Affected in the Patient Safety Incident Learning Review Process

Before an incident occurs, organisations must have in place:

- A Learning culture that promotes openness, honesty, and transparency, with a move away from a blame culture towards a more proportionate approach to accountability, where required.

- A culture that requires staff to proactively identify and raise any potential concerns around patient safety and to consider potential system improvements before an incident occurs.

- A culture that requires staff to listen to, record in writing and act on the concerns of professionals from other agencies and All those Affected before an incident occurs. All those Affected should be empowered to share their concerns openly and be assured that their input is welcomed as part of continuous improvement in patient safety.

- Regionally standardised training for staff to ensure they have the appropriate skills, knowledge and time to participate in Patient Safety Incident Learning Reviews and have a clear understanding of their roles and responsibilities.

When Involved in a Patient Safety Incident Learning Review, All those Affected should expect:

Early Engagement

- Acknowledgement and an apology that an incident has occurred and an open and honest explanation of the circumstances (if known) that led to the incident to help them understand what has happened and why.

- A single point of contact with the appropriate knowledge, skills, values and regionally standardised training to provide information, advice and to set the expectations for engagement and involvement from the beginning of the process. The single point of contact should also give an indicative timeframe for the review process, clearly explaining that final timeframes may need to be revised as the Patient Safety Incident Learning Review progresses.

- To be provided with guidance and clarity on the Patient Safety Incident Learning Review Process by the single point of contact, using easy to understand language that explains each part of the process and its purpose. The single point of contact should also clearly outline the rationale behind the decision making of the review method to be used. There should be no assumptions made about any prior understanding of All those Affected.

- To be provided with guidance and clarity on the level of independence required with any comments or concerns from All those Affected on the chosen review method or level of independence appropriately considered and recorded. If concerns cannot be resolved to the satisfaction of All those Affected this should be recorded and acknowledged in the final review report.

- Explanation and reassurance that any concerns they raise will not impact on the level of care provided to the patient.

- To be signposted to support services, to include those within the organisation where the Patient Safety Incident took place but also to independent advocacy services. Recognition that ‘one size does not fit all’ in terms of

support required and support should be provided at the level required, based on the individual's specific circumstances. If an advocate is appointed to engage on their behalf in the Learning Review process the same principles as described in this document should be applied.

- Appropriate arrangements to be made by the single point of contact for engagement and involvement that takes account of any cultural sensitivities and any other individual needs or preference. For example, assistance can be provided for person(s) with mental health issues, cognitive impairment, learning disabilities, different language or cultural considerations and person(s) who have communication needs such as hearing impaired and reduced vision.

- To be informed by the single point of contact when a review team is constituted, and a facilitator/chair identified.

Throughout the review

- Engagement and Involvement that is flexible and adaptable and in keeping with the individual and changing needs of those affected, with consideration being given to the sensitivities around the timing of all aspects of the Learning Review process. Single points of contact must agree the timing and structure/type of engagement with those affected and respect the rights of those who do not wish to engage in the review.

- Access to all relevant information related to the review in line with the organisations internal information governance policies and adhering to GDPR regulations. Information should be provided in an accessible format and at the appropriate time. In circumstances where information cannot be shared because it is not relevant or due to the duty of confidentiality these reasons should be explained clearly, as soon as possible, in a supportive manner with the rationale recorded appropriately.

- To have the opportunity to meet with the facilitator/chair in a location which is convenient to them, which must include offsite options if those affected do not wish to return to the facility in which the incident occurred. They should also expect to be listened to and to share their experience and unique perspective on what happened and for this to be taken account of in the review report.

- A collaborative approach where they can ask questions throughout the process and be provided with open, honest and transparent answers which directly address their concerns, all of which must be taken account of in the final review report. Answers must be provided in a timely manner, without jargon, in plain language and be easily understood.

- To be facilitated to provide information and concerns relevant to the Patient Safety Incident Learning Review that will help shape the Terms of Reference, to have an opportunity to review the draft Terms of Reference ahead of their finalisation and be given time to reflect and provide feedback on them before the Patient Safety Learning Review commences. Any comments or concerns regarding the Terms of Reference, which cannot be resolved to their satisfaction, should be recorded in the final report.

- To be continually and reliably engaged with and updated throughout the review process, being informed of any key developments, including any learning identified and potential delays. Communication must remain regular and consistent, as agreed with All those Affected during early engagement, even if no new information is to be provided.

- The HSC Organisation to consider any Health inequalities identified by the Patient Safety Incident Learning Review Process, as outlined in the Framework.

- That if during the course of Patient Safety Incident Learning Review an issue arises that should be managed by a separate process such as matters related to conduct or performance these elements should be immediately referred to the extant appropriate governance processes**.** The Patient Safety Incident

Learning Review should continue in order to identify relevant learning. The decision to follow a separate extant governance process for a particular issue must be made in the context of a structured decision-making process, be clearly documented by the HSC organisation, explained to All those Affected as soon as possible and be promptly acted upon.

- To have a copy of the draft review report shared with them by the single point of contact and be given the opportunity to comment on the factual accuracy of the report via their preferred communication method and/or meet with the chair or facilitator of the review team to discuss prior to the final report being issued.

- To have their comments on the draft review report responded to using their preferred communication method for example in writing, face to face meeting etc.

- To have their comments or concerns on the findings of the draft report, which cannot be resolved to their satisfaction, acknowledged and reflected in a separate section of the final review report.

- The final review report to document and clearly articulate conclusions of the review panel on the standard of care provided. If the Patient Safety Incident Learning Review determines that the level of care fell below the expected standard, a clear explanation and apology must be articulated in the final review report. In addition, if the standard of care was determined to be of a high quality this should also be acknowledged, and feedback provided to All those Affected.

- To be informed of the appropriate processes to follow if they feel the expectations set out in this Principles document are not being met by the organisation for example the HSC complaints process.

Following the final review report

- To be facilitated to provide feedback on their experience of the review process in line with their wishes and be provided with an update as to how this feedback has been acted upon by the organisation.

- To be provided with a copy of the final report and when the final report has been issued no further changes to be made unless new information is provided.

- To be updated on the lessons learnt, implementation of recommendations and safety actions from the findings of the review with specific evidence of how they have influenced positive change in patient safety practices. These updates should be provided periodically to ensure transparency and maintain trust in the ongoing improvement process.

- To be promptly informed and offered a meeting by the single point of contact in the event of new information emerging after the finalisation of a review report which may lead to a change in conclusion.

Annex A

Glossary

Unless stated otherwise these definitions are from the 'Conceptual Framework for the International Classification for Patient Safety.

Term	Definition
Advocate	An individual speaking on behalf of an individual affected by a Patient Safety Incident, and/or supporting them to speak for themselves when they can. *(PSIRF)*
All those Affected	One of the earliest steps in the Patient Safety Incident Learning Review process is to consider and identify in a structured way who 'All those Affected' include. Organisations should consider service users, patients, families, carers, victims, victim's families and visitors that may be affected by a Patient Safety Incident, when determining who All those Affected are. *(Adapted from the Conceptual Framework for the International Classification for Patient Safety definition of Person Affected.)*
Apology	'An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty'. (Compensation Act 2006) As soon as possible after you become aware something has gone wrong you should seek out the patient and or their family and say sorry and acknowledge what has happened and tell them that you will find out more. *(NHS Resolution)*
Carer	A carer is someone who regularly provides a substantial amount of care to a family member, friend or neighbour who is ill, disabled or is an older person. Carers (also referred to as informal carers or family carers) generally provide unpaid care as opposed to care workers who work in care and support jobs (e.g. domiciliary care) *(The Department of Health and Social Care - Carers | Department of Health)*
Compassionate	Being sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

Culture	The shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.
Empathetic	The ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation. (*Cambridge Academic Content Dictionary)*
Family	Family refers to the person or patient (the individual) to whom the Patient Safety Incident occurred, their family and close relationships. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who had a direct and close relationship with the individual to whom the incident happened. *(PSIRF)*
Openness	Being Open is a core value of the Health and Social care system in Northern Ireland. It is described as a commitment to 'being open and honest with each other and acting with integrity and candour'. *(Regional Being Open Framework.)*
Patient	A person who is receiving, or has received, care provided by, or on behalf of, a HSC body. *(The Health and Social Care Complaints Directions NI 2009)*
Patient Safety	The term used nationally and internationally to describe the freedom from unnecessary harm or potential harm associated with healthcare services and the reduction of risk of unnecessary harm to an acceptable minimum *(World Health Organisation, 2009).*
Patient Safety Incident	A Patient Safety Incident is an incident or circumstance (including omissions) which could have resulted or did result in harm to a patient or group of patients, and which provides an opportunity for system learning. *(Adapted from the WHO patient safety curriculum guide 2011.)*
Patient Safety Incident Learning Review	A Patient Safety Incident Learning Review: • examines the events leading up to the incident; • analyses what happened and why; • specifically identifies factors in the system, using systems-based methodologies, that contributed to the incident and what needs to change to prevent it from occurring again; • indicates how learning will be disseminated and embedded in future practice and systems, and how resulting enhanced practice and learning will be evidenced and verified. *(Framework for Learning and Improvement from Patient Safety Incidents.)*
Principles for Engaging, Involving and	These Principles describe the minimum requirements for the engagement, involvement and support of All those Affected by a Patient Safety Incident Learning Review and

Supporting All those Affected by a Patient Safety Incident	when followed can bring consistent improvements to the quality of a review, patient safety and All those Affected's rights in the process. *(Principles for Engaging, Involving and Supporting all those affected by a Patient Safety Incident.)*
Single Point of Contact	An assigned individual who provides information, support, and updates to All those Affected, and Staff Affected by a Patient Safety Incident.
Staff	Defined as anyone charged with carrying out the work of the HSC or sometimes on behalf of the HSC (ie working for, employed by or contracted to the HSC). *(PSIRF)*
Staff Affected	Staff Affected are those staff who have been directly involved in or impacted by a Patient Safety Incident. HSC organisations should at an early stage consider and identify in a structured way who all Staff Affected include. *(Framework for Learning and Improvement from Patient Safety Incidents)*
Victim	For the purpose of Patient Safety Incidents, a victim must be a close relative or someone acting lawfully on behalf of the "patient" and who witnessed the Patient Safety Incident or its immediate aftermath.