Harrow Health CIC Patient Safety Incident Reporting Framework (PSIRF) Policy Version 5 – May 2025. Next Review Date: November 2025

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1. Introduction

The NHS in the UK has a comprehensive framework and policy for patient safety incident reporting. This framework ensures that incidents affecting patient safety are reported, analysed, and used to improve care standards across the healthcare system. Harrow Health CIC is committed to adopting and embedding this framework in line with national guidance.

2. Definition of Patient Safety Incident

A patient safety incident is defined as an unexpected or unintended event or omission that could have or did lead to harm for one or more patients.

3. Purpose of Incident Reporting

The primary purpose of incident reporting is to learn from incidents, prevent recurrence, and improve patient safety. The process fosters a culture of transparency and openness, promoting systemic learning and improvement.

4. Incident Reporting System

- **National Reporting and Learning System (NRLS):** Traditionally used by the NHS to collect and analyse patient safety data.
- **Learn from Patient Safety Events (LFPSE) Service:** Currently replacing NRLS with a more streamlined platform for reporting and learning.

5. Classification of Incidents

Incidents are categorised based on the level of harm:

- **No Harm:** Incident occurred, but no harm resulted.
- **Low Harm:** Minor treatment or observation required; minimal harm.
- **Moderate Harm:** Increased treatment needed; significant but not permanent harm.
- **Severe Harm:** Permanent harm or life expectancy reduction.
- **Death:** Incident directly resulted in patient death.

6. Responsibilities for Reporting

- **Healthcare Professionals:** All Harrow Health staff (clinical and non-clinical) are responsible for reporting incidents.
- **Organisational Role:** Harrow Health CIC provides training, systems, and a supportive environment to facilitate incident reporting and learning.

7. Investigation of Incidents

Harrow Health follows a structured investigation pathway to:

- Identify the root cause.
- Determine contributing factors.
- Engage relevant stakeholders.
- Recommend and implement corrective actions.

8. Feedback and Shared Learning

8.1 Learning Mechanisms

- **Common Themes Analysis:**
  - What is the standard procedure?
  - What happened and why?
  - Could the incident have been avoided?
  - What would be done differently?
  - How can improvements be implemented?
  - Were all staff involved included in the resolution?
- **Role Plays and Simulations**
- **Workshops and Training**
- **Shared Learning Meetings**
- **Staff Surveys and Staff Champions**
- **Stakeholder Engagement**

8.2 Communication of Learning

- **Incident Reports** with root cause and actions
- **Regular Feedback Sessions** (e.g., huddles and debriefs)
- **Learning Bulletins/Newsletters**
- **Infographics/Posters**
- **Mentorship and Peer Learning**

9. Duty of Candour

It is a regulatory duty to be open and honest with patients and families when incidents occur that result in or could result in significant harm. It includes:

- Explanation of what happened.
- Formal apology
- Outline of actions taken to prevent recurrence
- Provision of support for those affected.

10. Governance and Monitoring

Patient safety is overseen by Harrow Health's governance structure. Incident reports and learning outcomes are submitted via the LFPSE portal and monitored to ensure compliance with national standards.

11. Continuous Improvement

Harrow Health promotes continuous improvement through:

- Regular audits
- Quality improvement projects
- Policy reviews and updates
- Integration of lessons into clinical practice

12. Confidentiality and Anonymity

Incident reporting can be conducted confidentially. Harrow Health promotes a no-blame culture, encouraging openness and protecting whistleblowers from retaliation.

13. Technology and Data Utilisation

Data from incident reports are analysed to:

- Identify patterns and trends.
- Predict potential risks.
- Inform system-level changes using digital and analytical tools.

14. Support for Staff Involved in Incidents

Harrow Health recognises the emotional toll of incidents and provides:

- Access to psychological support
- Debriefing and counselling services
- Just Culture principles to ensure fair treatment.

15. Complaints and Appeals

Complaints regarding this policy or its implementation can be formally submitted to the Harrow Health Governance Team, who will investigate and resolve concerns appropriately.

16. Recommendations for Ongoing Compliance

To ensure continued alignment with national PSIRF guidance:

- **Regular Policy Reviews:** Ensure alignment with NHS updates and best practices.
- **Staff Training:** Provide ongoing education on incident reporting systems and safety culture.
- **Stakeholder Engagement:** Involve patients, staff, and families in safety discussions.
- **Technology Integration:** Use advanced tools to enhance data analysis and risk prediction.
- **Feedback Loops:** Maintain robust systems to share learning outcomes and improvements.
- **Monitoring and Evaluation:** Regularly assess the effectiveness of incident responses and learning activities.

Conclusion Harrow Health's Patient Safety Incident Reporting Framework is designed to uphold the highest standards of patient safety by embedding a culture of openness, continuous learning, and system-wide improvement.

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