POLICY TITLE: Patient Safety Incident Response

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Policy Owner:	Nicola Harrand, Senior Investigations and Inquest Manager
Ratified by:	Kath Mason, Associate Director of Patient Safety & Experience
Responsible Signatory:	Colin Quick, Chief Quality Officer
Outcome:	This policy: • Sets out Priory's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Cross Reference:	OP03	Complaints
	OP03.1	Duty of Candour
	OP03.3	Duty of Candour (Scotland)
	OP04	Incident Management, Reporting and Investigation
	OP04.5	Learning from Deaths
	OP21	Whistleblowing
	OP31	Risk Management Framework and the Corporate Risk Register
	OP67	Freedom to Speak Up
	H08	Clinical Governance

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender identity and expression, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

Patient Safety Incident Response

CONTENTS

1 PURPOSE

1.1 This document details a combined plan and policy, which sets out Priory'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.

1.2 This document supports the requirements of the Patient Safety Incident Response Framework (PSIRF) published by NHS England in August 2022 and builds upon the previous NHS England Serious Incident Framework 2015, and the current Learning from Adverse Events through Reporting and Review: A National Framework for Scotland 2019, and the current NHS Wales National Policy on Patient Safety Incident Reporting 2021.

1.3 Priory embraces the PSIRF as 'best practice' in terms of responding to patient safety incidents. This document demonstrates how Priory will implement this framework within the Healthcare division across England, Scotland and Wales for both NHS and privately funded care for consistency. Where there are differences between nations, this will be clearly highlighted.

1.4 The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds the patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

1.5 This document supports the development and maintenance of an effective patient safety incident response system that integrates:

- 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

2.1 Patient safety incidents are unintended or unexpected events (including omissions) that could have or did harm one or more patients.

2.2 This document is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Priory Healthcare division. **OP04 Incident Management, Reporting and Investigation** policy should be referred to for guidance on the management, reporting and review of all other incidents.

2.3 Responses under this policy follow a systems-based approach by examining the components of a system (e.g. persons, tasks, tools and technology, the environment and the wider organisation) and understanding how they influence each other and how they may contribute to patient safety. 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.

2.4 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 complaints, claims handling, human resources investigations into employment concerns, coronial inquests and criminal investigations exist for that purpose. The principle aims of each of these responses differ from those of a patient safety incident response and are outside the scope of this policy.

2.5 Information from a patient safety incident 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.

3 PATIENT SAFETY CULTURE AT PRIORY

3.1 Priory promotes a climate that fosters a just and open culture.

3.2 The fair treatment of Priory colleagues supports a culture of fairness, openness and learning by ensuring that colleagues feel confident to speak up when things go wrong, rather than fearing blame. A Just Culture guide, produced by NHS England (refer to **Appendix 1**) has been shared across Priory services encouraging managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.

3.3 All incidents and near misses should be reported on Datix, Priory's risk management information system and colleagues should be regularly reminded of this requirement and the benefits of such reporting.

3.4 Priory has adopted the National Freedom to Speak Up agenda as a provider of NHS services and because we recognise its value in ensuring patient and colleague health, safety and well-being. **OP67 Freedom to Speak Up** policy explains to colleagues Priory's position on speaking up about concerns and references the different ways in which colleagues are able to raise their concerns and the response that they can reasonably expect. **OP21 Whistleblowing** policy also relates.

3.5 An annual colleague survey provides helpful insight into the culture across Priory services and provides an opportunity for good work to be recognised whilst also enabling the focus of improvement works to continue to develop and improve the culture across Priory.

3.6 **H08 Clinical Governance** policy outlines the clinical governance agenda within the Priory Healthcare division and this is accompanied by the **Priory Healthcare Divisional Quality Governance Framework**. Priory Healthcare have also developed a Quality Improvement Framework, focusing on the four stages of i) Quality Planning, ii) Quality Control, iii) Quality Assurance and iv) Quality Improvement.

3.7 Patient Safety Leads are in post at all Priory Healthcare services and work with the Patient Safety Team to both share key learning messages across the service whilst also feeding back from colleagues directly to the Patient Safety Team. A weekly healthcare cascade is used to share learnings and good practice and a monthly triangulated learning forum brings together learning from various disciplines across Priory Healthcare.

3.8 The Healthcare Patient Safety Strategy sets out Priory's patient safety aims and priorities alongside planned and current improvement, which is supported by quarterly updated patient safety work streams.

4 ENGAGING AND INVOLVING PATIENTS, FAMILIES AND COLLEAGUES FOLLOWING A PATIENT SAFETY INCIDENT

4.1 Learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. Priory have developed an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and colleagues). 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.

4.2 Openness and honesty not only reassures the patient, their families and colleagues that the incident has been recognised and their concerns acknowledged, but also helps to prevent such events becoming formal complaints and litigation claims that can only add to the upset and distress to all involved.

4.3 Refer to **OP03.1 Duty of Candour** policy or **OP03.3 Duty of Candour (Scotland)** for additional information on Priory's standards and expectations in relation to the Duty of Candour.

4.4 Those affected by patient safety incidents to include patients, their families/carers and colleagues should be:

- Fully informed about what happened.
- Given the opportunity to provide their perspective on what happened.
- Communicated with in a way that takes account of their needs.
- Given an opportunity to raise questions about what happened and to have these answered openly and honestly.
- Signposted to counselling or therapy services where needed.
- Given the opportunity to receive information from the outset on whether there will be a specific learning response and what to expect from the process.

Signposted to where they can obtain specialist advice and/or advocacy and/or support from independent organisations regarding learning response processes.

4.5 Priory colleagues should be directed to the services offered by Care First, Priory's employee assistance programme and a request should be made for Care First to attend at a Priory service should the senior management team feel staff would benefit from additional counselling and information support following a patient safety incident.

5 PATIENT SAFETY INCIDENT RESPONSE PLANNING

5.1 Priory responds to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm whilst maintaining compliance with any nationally set requirements.

5.2 To identify Priory's patient safety incident profile, extensive work was completed. This began by mapping Priory's services, reviewing Priory's response capacity, reviewing organisational data to include i) patient safety incidents, ii) areas for improvement action plans, iii) complaints, iv) whistleblowing reports v) safeguarding reports and vi) annual staff survey results. Applying a more flexible approach and intelligent use of data helped to support health equality and

reduce inequality. Discussions thereafter commenced to describe the safety issues demonstrated by the data, identify any ongoing improvement work both within Priory and nationally and agree Priory's response methods.

5.3 An implementation team was initiated and met at regular intervals to discuss the progress. The group consisted of expertise in patient safety incident response, quality improvement, human factors, risk management, and clinical and quality governance. Consultation was also had with clinical specialities and with wider stakeholder engagement.

5.4 The below sets out how Priory intend to respond to patient safety incidents within the Healthcare division. This policy will be reviewed annually and remains flexible, adapting as Priory continues to learn and improve to ensure efforts continue to be balanced between learning and improvement.

6 RESPONDING TO PATIENT SAFETY INCIDENTS

6.1 Patient safety incident reporting arrangements

6.1.1 Refer to **OP04 Incident Reporting, Management and Investigation** policy for full guidance on the initial reporting and management of a patient safety incident.

6.2 Patient safety incident response decision-making

6.2.1 A patient safety incident regulatory group will meet weekly. The group is chaired by the Chief Quality Officer and attended by the Associate Director of Patient Safety & Experience, Chief Medical Officer, Senior Investigations and Inquest Manager, Specialist Directors and the four regional Associate Directors of Nursing and Quality. The group will review and discuss all patient safety incidents that have been reported on Datix in the last seven days that meet the criteria as outlined within the Priory Patient Safety Incident Response Plan (national and local criteria) outlined below. Following review and discussion, a decision will be made as to the most appropriate and proportionate response with reference to Priory's Patient Safety Incident Response Plan.

6.2.2 The group will also maintain oversight of any significant unexpected trends in incidents for example a cluster of self-harm incidents, a cluster of abscond incidents or a cluster of inpatient/outpatient deaths at a particular hospital or service. These will be reviewed and the appropriate level of intervention commissioned. This may include a thematic review as outlined in Priory's Patient Safety Incident Response Plan below or a clinical safety review, clinical safety intervention or enhanced support may be commissioned.

6.2.3 Priory's Patient Safety Incident Response Plan supports proactive allocation of patient safety incident response resources, but there will always need to be a reactive element in responding to incidents. A learning response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the plan. For this purpose, when meeting, the regulatory group will also review all patient safety incidents that have been reported on Datix since the last meeting where the level of harm/impact is reported to be severe or above and a decision will be made as to the most appropriate and proportionate response with reference to Priory's Patient Safety Incident Response Plan.

6.3 Learning response methods

6.3.1 Several system-based learning response methods are used within Priory to respond to a patient safety incident or cluster of incidents (see Table A below). These should be applied where contributory factors are not well understood and national or local improvement work is minimal - that is, there is the greatest potential for new learning and improvement.

6.3.2 **Table A - Learning response methods**

Method	Description	Timeframe
Safety Huddle	A safety huddle is designed to be initiated as soon as possible after an event and involves a team discussion. Staff come together at the site and gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of a repeated occurrence.	Within 2 hours
Team Incident Review	A team incident review is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. This is useful where contributory factors are not fully understood. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care. A team incident review generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes in addition to learning. It is based around four questions: i) What was expected to happen? ii) What actually happened? iii) What is the difference between the expected outcome and the actual outcome? iv) What is the learning?	Within 14 days
Mortality Case Record Review	A mortality case record review tool is used to consider the care provided to the deceased as recorded in their case records in order to identify any learning.	Within 6 weeks
Desktop Review	A desktop review offers a concise overview of a single patient safety incident through review of the documentation and records available. Should the review determine that there were problems in care that require further exploration, consideration should be given to the commissioning of a patient safety incident investigation.	Within 6 weeks
Patient Safety Incident Investigation	A patient safety incident investigation offers an in-depth review of a single patient safety incident to understand what happened and why using a systems based approach to maximise learning. Undertaken where an incident meets the national or local priority as outlined in Table B and C.	Within 3 months
Tools to respond to broad patient safety issues		
Thematic Review	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety.	Dependent on scope
Horizon Scan	A horizon scan supports teams to take a forward look at potential or current safety themes, issues or changes. It can be used to identify future safety risks.	Dependent on scope

6.3.3 The following learning response templates should be used:
OP Form: 46R Safety Huddle Template

OP Form: 46 Upwards Reporting Patient Safety Incident Report (24hr, 72hr and TIR)
OP Form 46Q Mortality Case Record Review Template
OP Form: 46T Desktop Review Template
OP Form: 46C Patient Safety Incident Investigation Template
OP Form: 46CA Thematic Review Template

6.3.4 It is important to supplement finding out what happened using the learning response methods described in Table A with an understanding of 'everyday work'. Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work.

6.3.5 Where an incident type is well understood, for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness, resources may be better directed at improvement rather than repeat investigation.

6.3.5 If the patient safety incident regulatory group is satisfied that risks are being appropriately managed and/or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type and efficacy of safety actions is being monitored, it is acceptable not to undertake an individual learning response to an incident other than recording that it occurred and ensuring those affected are engaged.

6.4 Priory's patient safety incident response plan: National requirements

6.4.1 Some events require a specific type of response as set out in national policies or regulations. These responses include a mandatory patient safety incident investigation in some circumstances or review by, or referral to, another body or team depending on the nature of the patient safety incident. Table B summarises the guidance on nationally mandated responses to certain categories of event.

6.4.2 **Table B - Events requiring a specific response as set out in national policies or regulations**

Patient safety incident type	Required national response
Deaths thought more likely than not due to problems in care (to include all deaths where bereaved families and carers or colleagues have raised a significant concern about the quality of care provision)	Internal patient safety incident investigation
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	Internal patient safety incident investigation
Incidents meeting the Never Events criteria 2018 or its replacement	Internal patient safety incident investigation
Mental health-related homicides of or by a current or previous service user	Refer to Regional Independent Investigation Team (RIIT) for consideration for an independent patient safety incident investigation. An internal patient safety incident investigation may be required (as decided by the RIIT)
Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB)	Refer to HSIB or SpHA for independent patient safety incident investigation

criteria or Special Healthcare Authority (SpHA) criteria when in place	
Deaths of persons with learning disabilities	Refer to Learning Disability Mortality Review (LeDeR). An internal patient safety incident investigation may be required alongside the LeDeR
Safeguarding incidents in which: • young people are on a child protection plan, looked after plan or are a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to female genital mutilation, radicalisation to terrorism, modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards

6.4.3 For all externally commissioned learning responses, Priory will respond to the identified areas of improvement as required and feed any actions into our quality improvement strategy as appropriate.

6.5 Priory's patient safety incident response plan: Local requirements

6.5.1 Table C summarises how Priory will respond to certain categories of event that occur in Priory Healthcare services.

6.5.2 **Table C - Priory Healthcare: Events requiring a specific response as set out by Priory**

Patient safety incident type	Required Priory response
Unexpected death of a current inpatient	Internal patient safety incident investigation
Self-harm incidents that result in life-changing injuries	Internal patient safety incident investigation
Unexpected death of a current day/outpatient who has been in contact with Priory services within the last one month and is receiving active treatment	Internal patient safety incident investigation / Mortality Case Record Review
Unexpected death of an inpatient/outpatient who was discharged from Priory services within three months of death	Team incident review / Mortality Case Record Review
Unexpected death of a current outpatient who has not been in contact with Priory services within the last one month and is not receiving active treatment	Team incident review / Mortality Case Record Review
Serious self-harm incidents for example involving a ligature, self-mutilation or swallowing item(s) that meant that the service user was at risk of death and/or life changing injuries and which required medical treatment	Team incident review
All suspended ligature incidents	Team incident review
Patient injury as a result of planned/unplanned physical intervention	Team incident review
Any incident of abscond from inpatient wards where the patient absconds via the	Team incident review

garden/courtyard fence or via the door after 'tailgating' another person	
A cluster of self-harm incidents or inpatient/ outpatient/ service user deaths at a particular hospital	Thematic review

6.5.3 A safety huddle will be initiated by the most senior colleague on site, but can also be delegated to the Director of Clinical Services, Therapy Services Manager, Ward Manger or other as appropriate, as soon as possible after all incidents where the level of harm/impact is reported to be severe or above

6.5.4 Particular incidents and near misses in addition to those listed above will benefit from a team incident review held locally by the MDT. Such reviews are undertaken at the discretion of the Hospital Director/ Director of Clinical Services or at the recommendation of the Chief Quality Officer. Should a team incident review determine that there were problems in care that require further exploration, consideration should be given by the Chief Quality Officer to commissioning a desktop review or patient safety incident investigation.

6.5.5 An investigation that is independent to Priory may be undertaken in response to patient safety incidents where Priory is unable to conduct an effective, objective, timely and proportionate investigation. The decision to commission an independent investigation will be taken by the Priory Chief Executive Officer following consultation with the General Counsel, Chief Quality Officer, Senior Investigations and Inquest Manager, regional Managing Director and any relevant stakeholders such as commissioners and regulators (within six months of the patient safety incident).

6.5.6 Where required, an Integrated Care Board (ICB) can commission an independent investigation following a patient safety incident involving an NHS funded patient. Further details on the threshold for this can be found within the PSIRF supporting guidance produced by NHS England in August 2022 titled 'Oversight roles and responsibilities specification'. There is no similar guidance in place for NHS Wales and Health Improvement Scotland.

7 UNDERTAKING A PATIENT SAFETY INCIDENT INVESTIGATION

7.1 Scoping meeting

7.1.1 Following the most serious of patient safety incidents (those resulting in serious injury or death), a patient safety incident 'scoping meeting' should be held as soon as possible to enable early identification of the pertinent issues. A decision as to whether a call is required is to be agreed between the Chief Quality Officer and Senior Investigations and Inquest Manager. Participants in the scoping meeting will include the Hospital Director/Service Manager or delegate, Chief Quality Officer, Associate Director of Patient Safety and Experience, Senior Investigations and Inquest Manager, Inquest Risk Manager, regional Managing Director and Associate Director of Nursing and Quality and others as required. **Appendix 2** details an aide-memoir of matters to be discussed.

7.2 Agreeing the terms of reference

7.2.1 The Senior Investigations and Inquest Manager in conjunction with the regional senior management team is responsible for drafting the terms of reference when a patient safety incident investigation is commissioned. These should be shared and discussed with those involved (patient or their family/carer) and adjusted where appropriate provided they are willing and able to be involved in the learning response. If the scope of the investigation will not provide answers to their questions, support should be offered to guide them to access different sources of information and types of investigation.

7.2.2 Patient safety incident investigation's which concern death or serious injury will be undertaken with a degree of oversight from the Inquest Risk Manager and team, given the fact that there will likely be collaboration with Priory insurers and require legal input as required.

7.3 Appointing a patient safety incident investigation team

7.3.1 Often, patient safety incident investigations will be led by the Senior Investigations Officer following allocation by the Senior Investigations and Inquest Manager. The Senior Investigations Officer is a designated role with dedicated time to respond to patient safety incidents. However, certain patient safety incident investigations may also be undertaken by trained colleagues across Priory, within the same region where possible. Where this is required, a patient safety incident investigation lead should be appointed by the regional Associate Director of Nursing and Quality in conjunction with the Senior Investigations and Inquest Manager. The lead needs to have workload capacity to respond to the patient safety incident.

7.3.2 Patient safety incident investigation leads should have the following attributes:

(a) Be independent to the patient safety incident.
(b) Be competent in effective report writing.
(c) Have the confidence and ability to engage with the patient and/or family/carers.
(d) Have the ability to communicate well in a formal setting for example at a coronial Inquest.
(e) Have at least two days formal training and skills development in learning from patient safety incidents and/or experience of patient safety incident response.
(f) Have completed level one (essentials of patient safety) and level two (access to practice) of the NHS patient safety syllabus training.
(g) Undertake continuous professional development in patient safety incident response skills and knowledge.

7.3.3 Where appropriate, a patient safety incident investigation team should be established involving subject matter experts with relevant knowledge and skills to provide expertise, advice and proofreading.

7.4 Conducting a patient safety incident investigation

7.4.1 A patient's family/carer should be helped to make an informed decision about whether to be involved in a patient safety incident investigation by being given appropriate information about the process and how they could be involved and supported. Sharing **H Form: 159A Patient Safety Incident Investigation - Information Booklet for Patients, Families and Carers** may assist this process.

7.4.2 Families/carers must be offered the involvement of an independent advocate in the event that a patient safety incident investigation is commissioned into the unexpected death of a patient/service user. This is to be offered to families within the condolence letter shared and if requested arranged by the Senior Investigations and Inquests Manager. The purpose of the independent advocate is to assist the family/carer to raise questions, support them during any discussions they are involved in and to offer their assistance when reviewing and understanding the patient safety incident investigation report.

7.4.3 Should a patient's family/carer want to be involved in the investigation process, they should be involved in a meaningful way. Those affected should be:

(a) Provided with a named main contact and informed who will conduct the patient safety incident investigation.
(b) Allowed to bring a friend, family member or advocate with them to any meeting that is part of the investigation process they are involved in.
(c) Given the opportunity to input to the terms of reference for the patient safety incident investigation, including being given the opportunity to request the addition of any questions especially important to them (note: this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).

(d) Given the opportunity to review the patient safety incident investigation report with a member of the investigation team while it remains in draft with a realistic possibility that their suggestions may lead to amendments (note: this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them).

7.4.4 Colleagues affected by patient safety incidents are to be given advanced notice and be supported to participate in a patient safety incident investigation discussion. Explanation as to what a patient safety incident investigation is and their role in the process is to be explained to them. Sharing **H Form: 159 Patient Safety Incident Investigation - Information Booklet for Colleagues** may assist this process. Should a colleague request an additional person be present who can offer them support, this is to be agreed. Legal representation is not required for a learning investigation and any requests for this should be discussed with the Senior Investigations and Inquest Manager.

7.4.5 Notes will be taken of the patient safety incident investigation discussion. The notes will be held in a file and should be concise and relevant to the patient safety incident.

7.4.6 All patient safety incident investigations will follow these seven key principles:
(a) Openness and transparency: The needs of those affected should be the primary concern of those involved in the review.
(b) Preventative: The focus of the review is to understand what happened and what should be done to prevent recurrence.
(c) Objective: Those involved in the review should be sufficiently independent.
(d) Act in a timely and responsive manner.
(e) Systems based: The review must be conducted systematically using a methodology which identifies the problems, the contributory factors and the fundamental issues.
(f) Proportionate to the nature and implications of the incident.
(g) Collaboration: Liaising and working with stakeholders as required.

7.4.7 A patient safety incident investigation report should be:
- Written using **OP Form 46C - Patient Safety Incident Investigation Template**
- Written in a clear, concise and accessible way
- Factual and objective
- System-based using Safety Engineering Initiative for Patient Safety (SEIPS) or another systems based framework

7.4.8 Areas for improvement must be linked to the findings of the investigation.

7.4.9 Information collated in respect of the patient safety incident investigation including reports, emails and minutes of meetings should be kept in a file and not be filed with a patient's records. In cases where there may be legal implications for Priory, a copy of the patient safety incident file and any documentation arising from the patient safety incident investigation may be requested by the Inquest Risk Manager.

7.4.10 It is the responsibility of the patient safety incident investigation team to raise any immediate and serious concerns with the Senior Investigations and Inquest Manager and the regional Managing Director who will take the responsibility of alerting the Chief Quality Officer at the earliest opportunity.

7.4.11 Action in relation to Human Resources policy and procedure may be taken if a colleague is suspected or found to be in breach of their contract of employment, code of professional practice or to have acted with wilful harm or wilful neglect. Where it is suspected that a criminal act may have taken place, the matter should be promptly reported to the police. Any actions which may give rise to such interventions are to be raised with the Senior Investigations and Inquest Manager at the earliest opportunity and thereafter discussed with the Chief Quality Officer and Chief Medical Officer to agree the most appropriate and proportionate response.

7.5 Timeframes

7.5.1 Timescales must be set where possible for all patient safety incident investigations. A response must start as soon as possible after an incident is identified, and usually be completed within three months.

7.5.2 The timeframe for completing a patient safety incident investigation should be agreed with those affected as part of setting the terms of reference, provided they are willing and able to be involved in that decision. Those involved should be informed in a timely fashion of any delays and the reasons for them.

7.5.3 In exceptional circumstances (e.g. when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be discussed with those affected (including the patient, family/carer and colleagues) and agreed by the Senior Investigations and Inquest Manager. The time needed to conduct a patient safety incident investigation must be balanced against the impact of long timescales on those affected and the risk that for as long as findings are not described, action may not be taken to improve patient safety.

7.5.4 Where external bodies cannot provide information to enable completion within six months of the agreed timeframe, the patient safety incident investigation lead should work with the information they have to complete the report to the best of their ability. It is possible that the report may need to be revisited at a later date should new information come to light that indicates the need for further review.

7.6 Sign off process

7.6.1 A meaningful approach to oversight cannot be developed and maintained by individuals working in isolation, it must be done collaboratively. Oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.

7.6.2 All patient safety incident investigation reports are overseen by the Senior Investigations and Inquest Manager.

7.6.3 All patient safety incident investigation reports will only be signed off following collective review during the weekly patient safety incident regulatory group meeting, which includes sign off by the Chief Quality Officer and Chief Medical Officer.

7.6.4 In instances where the patient safety incident presents a potential high risk to organisational reputation, the report will require final ratification by the company General Counsel.

7.6.5 Following final sign off, patient safety incident investigation reports will be discussed during the monthly Triangulated Learning Forum.

7.6.6 Where necessary the final patient safety incident investigation report will be shared with external parties such as the patient, their family/carers, commissioners, regulators and HM Coroners.

7.7 Responding to cross-system incidents

7.7.1 Learning responses should be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates.

7.7.2 It is acknowledged that on occasions, some patient safety incidents will require a cross-system learning response through a joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially

requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion. Where a cross-system learning response is required, The Senior Investigations and Inquest Manager is to liaise with the relevant services and agree which organisation will lead on the learning response.

7.7.3 Where a police investigation has already begun, the Senior Investigations and Inquest Manager should discuss the purpose of a patient safety incident investigation with the police and explain how a police investigation and learning response can run in parallel wherever possible.

8 SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

8.1 All Priory colleagues have a responsibility to learn from incidents and near misses and make timely improvements to the way in which learning is undertaken. Hospital Directors have a responsibility to be able to demonstrate and evidence those improvements.

8.2 Priory require processes to ensure that all areas for improvement identified in response to patient safety incident learning responses are implemented and monitored, to check they are delivering the required improvement.

8.3 Acting in response to a patient safety incident may take different forms. Sometimes rapid action is needed in response to imminent risk e.g. removing broken/faulty equipment. When identified, these actions should be addressed as soon as practicable without waiting for a learning response report to be finalised.

8.4 **OP Form 46L Patient Safety Incident Investigation - Areas for Improvement Action Plan** should be completed following each patient safety learning response where areas for improvement are identified, to document and evidence the actions taken and how the implementation has been tested. Overall responsibility for the implementation and embedding of the actions sits with the Hospital Director with oversight at appropriate intervals by the regional Managing Director.

8.5 Priory services should consider involving the team in the development of the action plan. People work in different parts of the 'system' and have different views and experiences of how work is carried out and collating these views will most likely produce strong safety actions to address any improvement needs.

8.6 The NHS England document 'Safety action development guide' dated August 2022 details the Safety Engineering Initiative for Patient Safety (SEIPS) Human Factors Intervention Matrix (HFIX) which provides a useful series of questions to prompt ideas about how to address identified areas for improvement (refer to **Appendix 4** for further details).

8.7 Safety actions should be SMART (specific, measurable, achievable, relevant and time bound).

8.8 Each safety action should have a named individual identified with responsibility for development.

8.9 Individual actions should be added to the hospital's site improvement plan and progress should be monitored at governance meetings until there is sufficient assurance that learning has been embedded. The site risk register must be used to record ongoing risks that cannot be quickly and easily resolved.

8.10 While one safety action is unlikely to resolve a defined area for improvement, it is important to ensure all safety actions are meaningful. Do not implement change for the sake of change. We must ensure improvement results from change and continue to monitor this.

8.11 Final action plans should be submitted to the Inquest Risk Manager ahead of any coronial Inquests to provide assurance to HM Coroner and a patient's family/carer that actions have been implemented and the learning is embedded.

8.12 The Chief Quality Officer together with the Senior Investigations and Inquest Manager and the Associate Director of Patient Safety and Experience will review transferable learning from patient safety incidents and any particular trends and advise and take corporate action accordingly. Such action may include adjusting policy and procedure, adjusting the content of training, publishing lessons learnt via the weekly Priory Healthcare cascade and include the lessons learnt in compliance and health and safety audit schedules.

8.13 The Senior Investigations and Inquest Manager will seek to reduce duplicative and/or disconnected safety actions by conducting regular reviews of ongoing safety action plans as part of continuous patient safety incident response planning. The Senior Investigations and Inquest Manager will keep a central log of any divisional actions to monitor development and progress.

8.14 **Safety improvement**

8.14.1 The findings from learning responses into patient safety incidents will support Priory's safety improvement planning and guide future iterations of Priory's Patient Safety strategy.

8.14.2 Priory's organisational data will be reviewed annually to understand how the learning from patient safety incidents has impacted upon the patient safety priorities and Priory's patient safety incident response plan: Local requirements will be adapted as required as new identified areas of potential learning are established.

9 COMPLAINTS AND APPEALS

9.1 Priory hope to respond to any questions or concerns any patient or family/carer have. However, should they not be satisfied with the response received, they can raise a complaint directly with the hospital in writing at any time and will receive a written response to the issues raised.

9.2 Full details about Priory's complaints process and procedure and details of other organisations that can support patients and or their family/carers should they remain unsatisfied can be found within **OP03 Complaints** policy.

10 REFERENCES

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B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf (england.nhs.uk)

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20191216-AE-framework-4th-Edition (4).pdf

National Guidance on Learning from Deaths, National Quality Board March 2017
nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

National Policy on Patient Safety Incident Reporting & Management, NHS Wales May 2023
https://du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/

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2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

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B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)

Patient Safety Incident Response Framework, NHS England August 2022
B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)

Patient Safety Incident Response Standards, NHS England August 2022
B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

Safety Action Development Guide, NHS England August 2022
B1465-Safety-action-development-v1.1.pdf (england.nhs.uk)

11 ASSOCIATED FORMS

11.1

OP Form: 46 Upwards Reporting Serious Incident Form 24hr, 72hr, TIR
OP Form: 46AB Patient/Service User Safety Incident Scoping Call Summary
OP Form: 46C Patient/Service User Safety Incident Investigation Report Template
OP Form: 46CA Thematic Review Template
OP Form: 46E Information Gathered from Colleagues Following an Incident
OP Form: 46L Patient Safety Incident Investigation - Areas for Improvement Action Plan
OP Form: 46T Desktop Review Template
OP Form: 46R Safety Huddle Template
OP Form 46Q Mortality Case Record Review Template

12 EQUALITY IMPACT ASSESSMENT

12.1

How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?			
Protected Characteristic (Equality Act 2010)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	None		
Disability	None		
Gender identity and expression	None		
Marriage or civil partnership	None		
Pregnancy or maternity	None		
Race	None		
Religion or beliefs	None		
Sex	None		
Sexual orientation	None		
Other, please state:	N/A		
EIA completed by:			
Name: **Role/Job Title:**	Nicola Harrand, Senior Investigations & Inquest Officer		
Date completed:	28/09/2023		

13 APPENDICES

13.1

Appendix 1 - A Just Culture Guide - NHS England
Appendix 2 - Patient Safety Incident Scoping Call Aide-Memoir
Appendix 3 - Never Events
Appendix 4 - Overview of the SEIPS - HFIX

APPENDIX 1

A JUST CULTURE GUIDE - NHS ENGLAND

NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

if No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

if Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

if No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

Improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement

APPENDIX 2

PATIENT SAFETY INCIDENT SCOPING CALL AIDE-MEMOIR

(Not all areas will be applicable)

- Overview of the patient safety incident
- Any immediate learning and improvements required (sharing immediate learning) and ensuring the safety of other patients/service users/colleagues
- Patient/service user support - immediate and longer term
- Colleague support - immediate and longer term
- Family/carer support and next of kin duty of candour arrangements
- Scene preservation
- Secure paper records e.g. shift handover sheets, observation records, audits (e.g. wheelchairs and bedrails). Consider freezing CareNotes. Retain any emails of relevance.
- CCTV retention - download to specific folder and/or save to data storage device
- Early collection of colleague written accounts using **OP Form: 46E Information Gathered from Colleagues Following an Incident**
- Actions to be taken to safeguard other patients/service users: review of physical health care plans (Adult Care/Healthcare), review of swallowing risk assessments (Adult Care/Healthcare) ligature point audit (Healthcare), review of banned and restricted items (Healthcare), courtyard/garden risk assessment (Healthcare) - ensure actions are documented
- Replenish emergency drugs and equipment
- Staff training
- Datix incident report
- 72-hour fact finding report
- Notification to commissioners, local authority safeguarding team and regulators e.g. CQC/HSE
- Notification to agencies e.g. a mental health trust that are or recently have been involved in the patient/service user's care to include insurance companies (PMI patients) where required
- Consider communications team notification and board briefing
- Consider any environmental issues
- Consider any black and minority ethnic issues
- Discuss required learning response with reference to Priory's Patient Safety Incident Response Plan
- Consider any prosecution/CPS issues - contact from police/CQC
- Consider any Coronial/Inquest issues - contact from Coroner's Office
- Respectful packaging of patient belongings
- Any other actions
- Next meeting

APPENDIX 3

Never Events List - NHS Improvement

2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

No.	Never Event	Description
1.	Wrong site surgery	An invasive procedure performed on the wrong patient or at the wrong site (e.g. wrong knee, eye, limb).
2.	Wrong implant/prosthesis	Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure.
3.	Retained foreign object post procedure	Retention of a foreign object in a patient after a surgical/invasive procedure.
4.	Mis-selection of a strong potassium solution	When a patient is intravenously given a strong potassium solution rather than the intended medication.
5.	Administration of medication by the wrong route	The patient is given one of the following: - intravenous chemotherapy by the intrathecal route - oral/enteral medication or feed/flush by any parenteral route - intravenous administration of an epidural medication that was not intended to be administered by the intravenous route
6.	Overdose of insulin due to abbreviations or incorrect device	Overdose refers to when: - a patient is given a 10-fold or greater overdose of insulin because the words 'unit' or 'international units' are abbreviated - a healthcare professional fails to use a specific insulin administration device - a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle
7.	Overdose of methotrexate for non-cancer treatment	Overdose refers to when: - a patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose
8.	Mis-selection of high strength midazolam during conscious sedation	Mis-selection refers to when: - a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation - excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas where its use has been formally risk-assessed in the organisation
9.	Failure to install functional collapsible shower or curtain rails	Involves either: - failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide - failure to install collapsible rails and an inpatient attempts or completes a suicide using non-collapsible rails
10.	Falls from poorly restricted windows	A patient falling from a poorly restricted window. This applies to: - windows 'within reach' of patients - windows located in facilities/areas where healthcare is provided and that patients can and do access - where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled,

		but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall - where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the 'key' provided.
11.	Chest or neck entrapment in bed rails	Entrapment of a patient's chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance.
12.	Transfusion or transplantation of ABO-incompatible blood components or organs	Unintentional transfusion of ABO-incompatible blood components.
13.	Misplaced naso- or oro-gastric tubes	Misplacement of a naso- or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration.
14.	Scalding of patients	Patient scalded by water used for washing/bathing.
15.	Unintentional connection of a patient requiring oxygen to an air flowmeter	This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter.
16.	Undetected oesophageal intubation	This Never Event has been temporarily suspended pending further clarification.

APPENDIX 4

OVERVIEW OF THE SEIPS - HFIX

Safety Engineering Initiative for Patient Safety (SEIPS) adaptation of the Human Factors Intervention Matrix (HFIX) - Taken from NHS England Safety Action Development Guide - August 2022

The SEIPS adaptation of the Human Factors Intervention Matrix (HFIX) provides a series of questions to prompt ideas about how to address identified areas for improvement. Use the system factors and accompanying questions to begin generating as many safety action ideas as you can to address each identified area for improvement.

Person(s)

Includes both characteristics of an individual and of a team

When considering ways of influencing individual and team characteristics, ask:

- How could changes be made to the way individuals are recruited or selected for employment to ensure that they have the appropriate knowledge and skills necessary to perform their required tasks safely and efficiently?
- How could the content of training programmes be developed or modified to improve individual's knowledge of procedures or tasks?
- How could the method of training delivery be improved or modified to enhance its impact on individual's knowledge and skills (e.g. use of simulation)?
- How could an individual's stress and fatigue be reduced or monitored to improve safety and performance?
- How could verbal communication procedures be improved to reduce the likelihood of miscommunication among team members (e.g. standardisation, read back)?
- How could the use of non-verbal communication (e.g. gestures or hand signals) be developed and standardised to improve communication?
- How could team briefings/planning sessions be developed or improved to improve communication and co-ordination?
- Could procedures be developed to improve interactions between team members? When individuals are working as a team, how could the responsibilities of each team member be more clearly defined?
- How could changes be made to ensure that team leaders are identifiable and responsible?
- How could handoffs/handovers be developed or improved to facilitate the communication between team members?

Tasks

Specific actions within larger work processes

When considering ways of modifying the tasks people perform, ask:

- How can the task be restructured so that it requires less reliance on human memory (i.e. use checklists or technology that signals next step in task)?
- If the task is done simultaneously with other tasks (divided attention), can it be done on its own? How can the mental workload/timesharing be reduced?
- How could checklists be developed to guide the task or verify that the task has been performed properly?
- How could immediate feedback be integrated into the task to allow operators to know when they have done things correctly or incorrectly?
- How can procedures or checklist be redesigned to be clearer or more user friendly?
- If a task is repetitive, monotonous or boring, how could it be made more interesting? How could 'time on task' be changed to reduce vigilance decrements or mental lapses in attention?
- How could procedures be rewritten so that they are less ambiguous or inapplicable to the safety critical tasks operators perform?
- When operators switch tasks, what procedures could be developed to reduce negative transfer (habit interference)?

- How could a task be modified to reduce the demands on the operator's physical or perceptual limitations?

Tools and Technology
Equipment, tools, software and documents used to perform work

When considering ways of modifying tools and technology, ask:

- How can warnings or alarms be improved to increase awareness of hazards or the presence of abnormal conditions?
- How could tools, checklists, manuals or displays be redesigned to reduce confusion and errors (e.g. highlight with bold text the items in a checklist that are the most important and/or should be memorised)?
- Are better tools currently available but not purchased? What are these tools and how would they reduce errors on the job?
- How could technologies be developed to reduce the task demands on the human decision-making processes, perceptual processes or physical limitations?
- How could controls be more easily identified and/or better designed in terms of shape, size and other relevant considerations?
- How could information sources be integrated or located in a more effective manner?
- How could equipment be redesigned for more convenient maintenance?
- How could inspection or troubleshooting aids be developed to ensure equipment is in proper working order?
- How could maintenance procedures or schedules be improved to prevent equipment from failing during use?

Internal Environment
Physical working environment in which individuals and teams perform their tasks

When considering ways of modifying the internal environment, ask:

- How could the number of distractions in the environment be reduced to allow the operator to focus attention more fully on the task?
- How could workspace arrangements or dimensions be modified to improve task performance?
- How could the workspace be made better suited to the range of individuals who will use the facility?
- How could lighting be changed to reduce shadows, glare or stark lighting changes (e.g. going from light to dark settings)?
- How could the noise level be modified or reduced to reduce fatigue, improve concentration or enhance communication?
- How could the temperature conditions be modified or improved to improve concentration, mood or performance?
- How could physical/technological barriers to performance or communication be modified or rearranged?
- How could the physical arrangement of workspaces/rooms be standardised to reduce confusion, delays or errors?
- How could floor surfaces be modified or improved to allow for better movement or rearrangement of equipment when needed?
- How could clutter be reduced or housekeeping improved to make the working environment more conducive to safe and productive work?

External environment
Societal, economic, regulatory and policy factors outside an organisation

When considering ways of influencing the external environment, ask:

- How can manufacturers be influenced to improve the design of their products?
- How can regulation be changed to improve safety?
- How can external oversight/monitoring be improved to impact safety?
- How can national safety programmes be redesigned to improve safety?

Organisation

Structures external to a person (but often put in place by people) that organise time, space, resources, and activity

When considering ways to modify the organisation of work, ask:

- How could standard operating procedures (SOPs) be modified to reduce risks and improve safety?
- How could the organisation ensure that SOPs are in place and that they are relevant and not out-of-date?
- How could operational risk management procedures be implemented to reduce safety hazards?
- How could tools that help supervisors plan activities and set goals be improved?
- What tools or job aids could be developed to help supervisors create schedules, improve team composition or reduce operator fatigue?
- How could the organisation improve its process for recruiting and hiring people who are better qualified or more experienced?
- How could the organisation improve its process for evaluating and purchasing equipment that is user friendly and designed for safety?
- How could leadership better communicate the importance and value of safety?
- How could the organisation better disseminate and share safety information or lessons learned from safety events across units (i.e. become more transparent)?
- How could the organisation better promote, reinforce or encourage safe practices?
- How could the organisation's structure be redesigned to improve the co-ordination and integration of activities across divisions/departments?
- How could policies (promotion, sick leave, overtime, etc.) in the organisation be changed to improve safety?
- How could leadership become more engaged with staff or more aware of safety issues (e.g. leadership 'walk-arounds')?
- How could the organisation improve its contingency planning for possible staff shortages, equipment failures or budgetary restrictions?
- What tools could be developed to help supervisors identify problems with workplace design or layout?