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|  | **Organisation logo** |

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.**

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| **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. |

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

# Distribution list

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

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| Name | Position |
|  |  |
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# 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](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-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](https://www.england.nhs.uk/patient-safety/a-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](https://www.england.nhs.uk/patient-safety/incident-response-framework/) and in the national [patient safety incident response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/).

# A note of acknowledgement

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| **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. |

# Executive summary

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| **Notes on writing the executive summary**  To be completed **after the main report has been written.** |

## **Incident overview**

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| **Notes on writing the incident overview for the executive summary**  Add a brief, plain English description of the incident here. |

## **Summary of key findings**

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| **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**

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| **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](https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/) for further details on how to write safety actions.  NB: The term ‘lesson learned’ is no longer recommended for use in PSIIs. |

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# Background and context

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| **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. |

# Description of the patient safety incident

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| **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’. |

# Investigation approach

## **Investigation team**

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

## **Summary of investigation process**

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| **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**

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| **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](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/).  A template is available in the learning response toolkit to help develop terms of reference. |

## **Information gathering**

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| **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. |

# Findings

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| **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. |

# Summary of findings, areas for improvement and safety actions

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| **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](https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/)).  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. |  |  |  |  |  |  |  |  |
| … |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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. |  |  |  |  |  |  |  |  |
| … |  |  |  |  |  |  |  |  |

# Appendices

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

# References

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