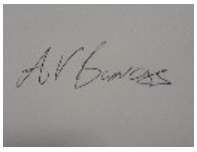
# Patient safety incident response plan

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| | NAME | TITLE | SIGNATURE | DATE |
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# Introduction

This patient safety incident response plan sets out how Home**-Start Blackburn & Darwen** intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

# Our services

Home-Start Blackburn & Darwen is commissioned by Lancashire and South Cumbria Integrated Care Board to:

- Support Parent and Infant Mental Health during the 1001 days (0-2 Years)

Home-Start Blackburn & Darwen receive referrals from a variety of agencies including Midwives, Perinatal services, Health Visitors, Schools, Nurseries, Social Prescribers, GP's and other statutory and voluntary agencies.

In line with the charitable aims, Home-Start Blackburn & Darwen supports families with their health, education and connection to their community. Recruiting volunteers, we offer families a bespoke package of support either in the family home or in groups in the community. Trained staff assess the needs of families with children from pre-birth to the age of 5 and then match and supervise volunteers who, in turn, enable parents to manage the everyday struggles of family life. Working to complement existing services, Home-Start Blackburn & Darwen work with young pregnant parents/parents-to-be (including Dads); those suffering from mild mental health difficulties; parents/carers of children with neurodiversity and disabilities; minority communities, including asylum seekers; those with inherited genetic conditions. The service is responsive and flexible to the needs of our local families.

## Defining our patient safety incident profile

Home-Start Blackburn & Darwen has a continuous commitment to learning from patient safety incidents. Safety incidents would include a safeguarding issue relating to a child or vulnerable adult, a safety issue with regards to a volunteer or staff member visiting a family home, an accident occurring at one of our community groups or a breach of confidentiality.

Stakeholder involvement for Child or Vulnerable Adult Safeguarding will include BwD MASH and Adult Safeguarding Team. Discussions have taken place among our staff team, and we will consult ICB patient safety team to fully understand the requirements of PSIRF and to understand the practicalities of planning and implementation.

Data sources:

To define our patient safety response profile, we have reviewed our incidents for any themes and trends and considered feedback from families/patients. Where possible we have considered what the data tells us about inequalities in patient safety and will support larger organisations with patient safety incident investigations and the ICB when necessary

Home-Start Blackburn & Darwen has a commitment to learning from patient safety incidents. When an improvement has been identified, plans will be produced to identify actions which would be shared with staff and volunteers.

## Our patient safety incident response plan: national requirements

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Home-Start in East Lancashire do not currently meet the national criteria to undertake investigations, however we will remain flexible and consider improvement plans as required where a risk or a patient safety issue is identified from our own external sources.

| **Patient safety incident type** | **Required response** | **Anticipated improvement route** |
|---|---|---|
| Incidents meeting the Never Events criteria | PSII | Would support larger organisations to develop local organisational actions. |
| Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident | PSII | Would support larger organisations to create local organisational actions. |

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| investigations (PSIIs)) | | |
| Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies. | PSII | Would support larger organisations to create local organisational actions. |
| Mental health-related homicides | Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII | As decided by the RIIT |
| Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place. | Refer to HSIB or SpHA for independent PSII | Would support larger organisation to develop local organisational actions |
| Child deaths | Refer to Child Death Overview Panel review.<br>PSII | As directed by the Child Death Overview Panel |
| Safeguarding incidents | Refer to local authority safeguarding lead. | Identify greatest potential for learning. Create local safety actions. |
| Domestic homicide | A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case.<br>Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel.<br>The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of | As directed by the DHR panel, meeting the obligations of The Domestic Violence, Crime and Victims Act 2004. |

| | | |
|---|---|---|
| | organisations and commissioners of health services in relation to DHRs | |

# Our patient safety incident response plan: local focus

| Patient safety incident type or issue | Planned response | Anticipated improvement route |
|---|---|---|
| Safety issue relating to staff and/or volunteers visiting a patient/family home | **After-Action Review**<br><br>Facilitated discussion following an event or issue alongside an understanding of "everyday work" | Identify greatest potential for learning. Review risk assessments. Create local safety actions from understanding wider system influences. |
| Breach of confidentiality | **After-Action Review**<br><br>Structured discussion of the event to provide an understanding of why the breach occurred. | Identify if underlying system issue or isolated incident. Develop local safety actions to reduce risk and share with whole team. |
| Accident/injury occurring at one of our Family Groups/Outdoor Activities | **After-Action Review**<br><br>Team discussion of the event | Use review to look at what changes could be made within the group and create local safety actions to reduce the risk of event occurring again. |