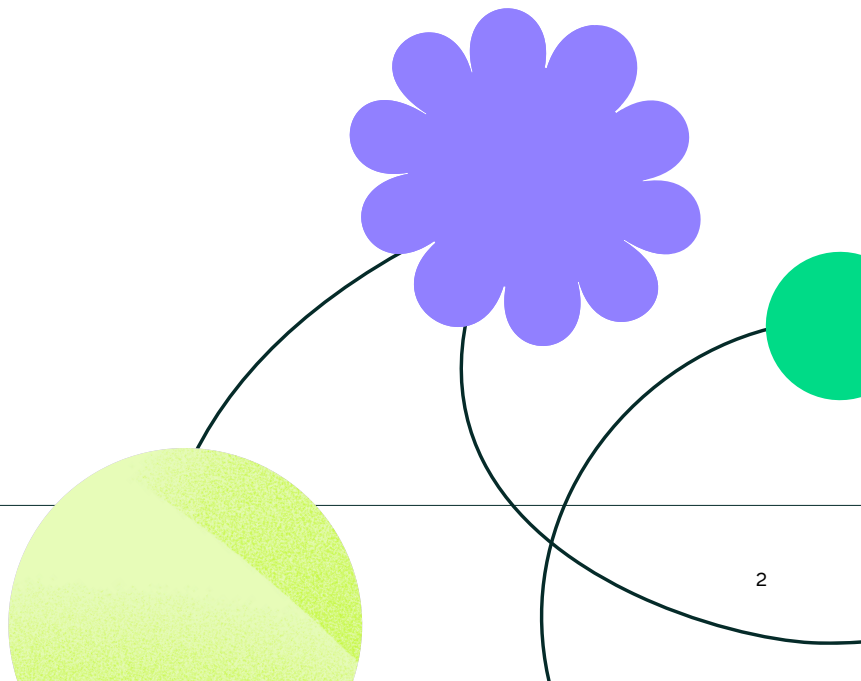
Patient Safety Incident Response Plan

PSIRP

Plan Ver 1.0 April 2026

Brainkind

Contents



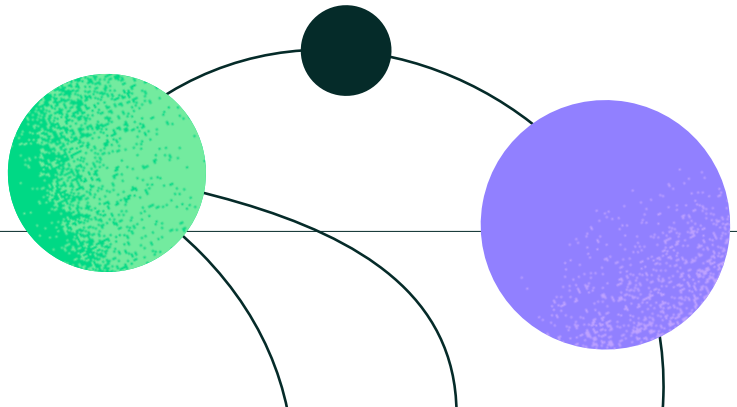
Foreword

Brainkind is committed to improving the quality of life for the people we serve. We can do this through continually learning which will improve the quality of our services through co-production and people, family, carer and public feedback.

Historically we have taken learning from a variety of sources including learning from when things go wrong and how we respond to such incidents. Historically, the Serious Incident Framework (NHS England, 2015) supported the need to take a whole-system approach to improvements when serious incidents occurred in care. The framework described what to investigate and the process for undertaking the investigation which explores the incident, contributory factors (which was the 'how') and then the root cause (why).

The Patient Safety Incident Response Framework (PSIRF) which commenced in 2022 has a clear focus on the response to incidents that occur, learning and action taken. PSIRF allows for organisations to be responsible for the entire process including what investigations take place and what tools we use to draw out the richness of learning. (Brainkind refers to individuals requiring care support from our services as 'People')

Brainkind has undertaken a comprehensive thematic review of incident data and other associated insights to set out our National and Local priorities for investigation. Awareness and PSIRF and relevant training have been implemented to support teams and individuals in their preparation to do things differently.



At the very heart of this we are committed to ensuring people who use are services are involved, and those involved in their care are heard, we identify learning and act. This needs to be built on the foundation that everyone involved feels psychologically safe to explore difficult events openly and honestly, hear feedback, we support everyone involved and we respond as a team. We will seek to find learning but in a way that supports all of those involved, we know this won't take away the pain from people affected by incidents so our kindness and compassion will support those very difficult conversations, and the outcomes remain that we learn in a meaningful way was in partnership with those effected.

Thank you for helping us to change our approach and make changes to the people we support and their families that we serve.

Ayesha Trott,
Executive Director of Service Delivery

Introduction and Scope

The Patient Safety Incident Response Framework (PSIRF) is a key part of the National Patient Safety Strategy.

Published in August 2022, it outlines how NHS and non-NHS healthcare providers should respond to People we Support (patient safety incidents = PSIs), for the purpose of learning and improvement. PSIRF supports the development and maintenance of an effective patient safety incident response system, that integrates four key aims:

- Application of a range of system-based approaches to learning from patient safety incidents
- Compassionate Engagement and involvement of those affected by patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement
- Considered and proportionate responses to patient safety incidents

PSIRF also delivers a system-based approach to learning and improvement, considering proportionate responses and supportive oversight. It will seek to understand how incidents happen rather than apportioning blame on individuals, Brainkind fully supports a safety culture allowing for more effective learning and improvement with a focus on making our care services safer.

Organisations are required to apply this framework in the development and maintenance of their Patient Safety Incident Response Plan (PSIRP).

This PSIRP sets out how Brainkind intends to respond to PSIs over a 12-month period. This plan is intended to be reviewed at regular intervals no longer than 12 months. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Learning from incidents requires timely incident reporting in a fair, open and 'Just Culture'. Blame is not a useful lever for learning because: "…a patient safety incident cannot simply be linked to the actions of the individual healthcare staff involved. All incidents are also linked to the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring".

1. Our Organisation

The culture at Brainkind embeds values and behaviours that equate to aiming high, with the people we support, our colleagues, our customers and for the organisation; fulfilling potential in the people we support and in our colleagues; exploring new ideas and continuing to learn together – whilst being accountable; striving to do things better and to make a positive difference.

2. Our Services

Brainkind supports people with living with acquired brain injuries and other neurological conditions in the UK to access the best specialist rehabilitation available to achieve their goals and exceed expectations. We provide a high level of support of rehabilitation, to meet people's needs at every stage of their rehabilitation pathway. This includes offering specialist supported living accommodation so the people we support can live independently in the community. All the people we support have a personalised rehabilitation package with clear goals and identified outcomes.

We have a network of 24 services across the UK that support people with acquired brain injury and other neurological conditions. Our neurological centres and residential homes, hospitals and supported living services are there to support and help people wherever they are in their recovery journey.

3. Defining our People Safety Incident (PSI) profile

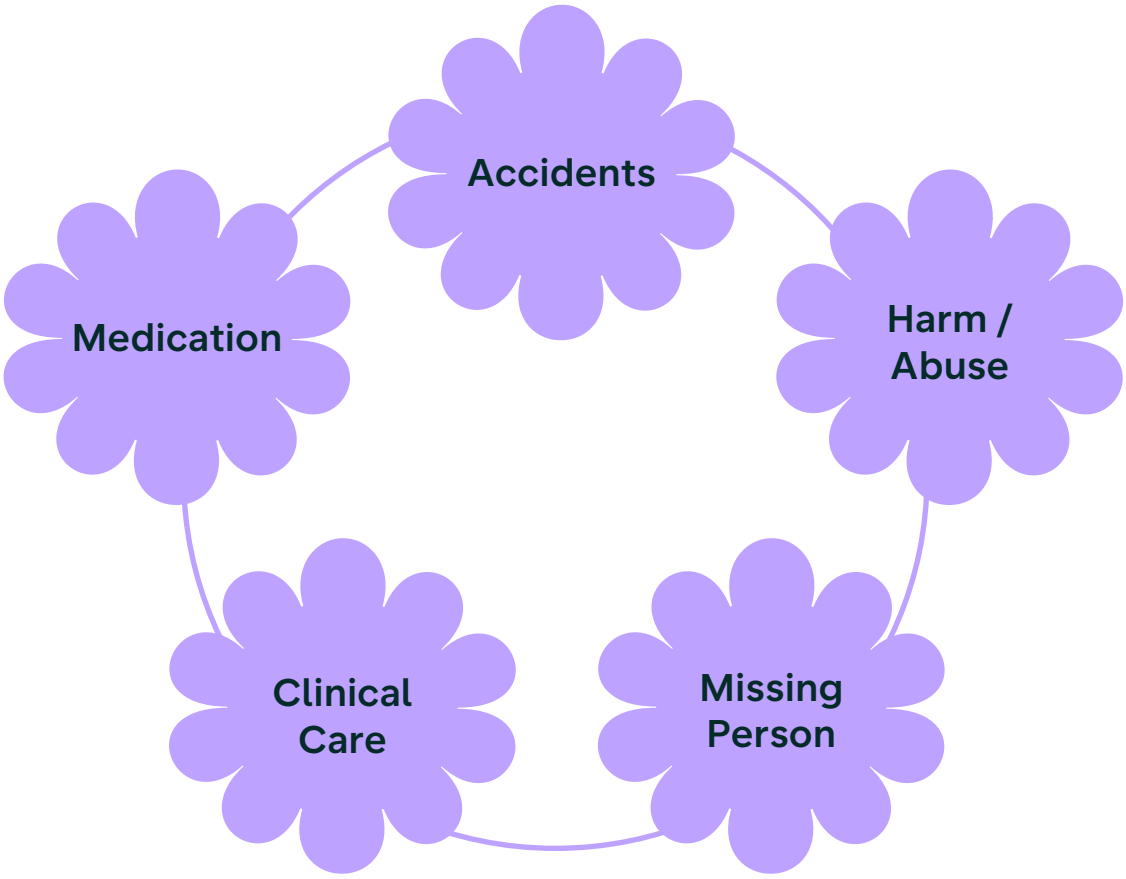
Brainkind Quality Assurance team undertook a thematic analysis to determine which areas of patient safety would inform our PSIRP.
This themed approach was used to identify our patient safety priorities with data being provided by various sources:

- Review of incident data over a three-year *period (April 2022 through to April 2025)
- Themes and learning from completed incident review investigations
- Review of audit data
- Review of Quality assurance visits and reported findings
- Review of Care Quality Commission (CQC) visits and findings
- Review of feedback received from Mental Health Act commission visits
- Risk Registers
- Safeguarding data reports
- Insights from Brainkind People Services and Brainkind Legal services
- Insights from Safeguarding reviews
- Insights gathered from complaints

4. Data analysis

Brainkind has an incident reporting system (DATIX) and an incident management Policy that categorises incidents as Level 1 level 2 and level 3. While our analysis included a review of all category levels The outcome of the thematic review focused on level 2 and level 3 incidents, these being where moderate or significant harm had occurred.

The following top 5 patient safety priorities were identified, and these will inform year 1 of our PSIRP.



Appendix 1

This chart evidences the number of incidents in the top 5 categories (2022 to 2025)

Top 10 incident categories	No/Low harm	Moderate Harm	Severe Harm / Fatality	Total
Accident 19 reporting categories under this domain 68.8% fell under the category of falls, witnessed and un-witnessed	3589	199	36	3824
Harm or Abuse	4912	491	22	5425
Clinical Care	2043	299	21	2363
Medication	3731	103	9	3843
Missing person	173	43	9	225

Falls

Analysis under this category revealed a theme related to falls. Over the corresponding three-year period there have been different thresholds of incidents however, the majority can be categorised as: Witnessed falls, Unwitnessed falls

Harm/abuse

Analysis under this category is aligned to ‘safeguarding’. Level 2 and Level 3 incidents highlighted three predominant themes of: Physical abuse, harm to self/others due to behaviours and verbal psychological abuse.

Clinical care

Analysis drawn from Level 2 and Level 3 incidents identified three predominant themes: Skin integrity, pressure sores and significant deterioration in physical health.

Medication

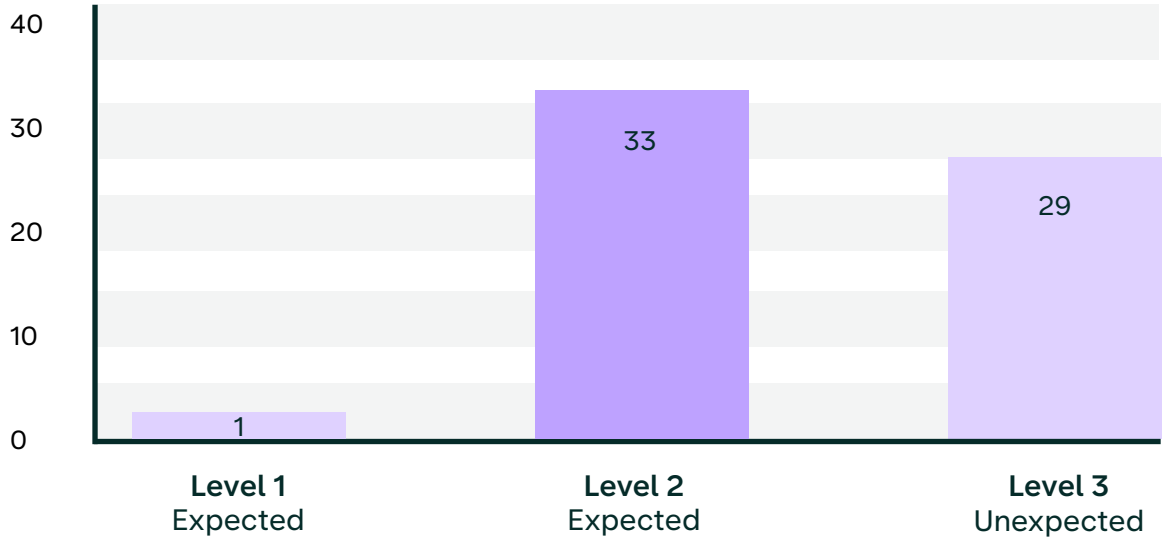
Analysis drawn from Level 2 and Level 3 incidents identified a number of themes however, the emerging top three are: administration error, missed dose of medication and medication stock discrepancy

Missing person

Level 2 and Level 3 incidents were varied and included incidents of: missing staff aware, missing while on leave, missing while being escorted, missing during a home visit

Appendix 2

Fatalities April 2022 through to March 2025



Fatalities

Analysis evidences a total of 63 fatalities over the corresponding 3 year period. Level 2 expected deaths where for example an individual would have sadly been on an end-of-life pathway or died as a result of known morbidities. All unexpected fatalities reached a Level 3 threshold and met the criteria threshold for a serious incident review threshold. Analysis of these incidents has been undertaken, and an emerging theme of a deteriorating physical health status was predominant.

Brainkind has in place existing work streams around these five priorities that are monitored through use of local Safety Improvement Plans, Risk Registers and Organisational governance processes.

5. Our patient safety incident response plan: local focus

Having reviewed the data sources available and engaged with key stakeholders to identify local priorities for patient safety. This section of the Patient Safety Incident Response Plan sets out what our local priorities are and how our learning will inform improvement at Brainkind.

It is acknowledged that the local priorities are a focused list of incident types where the Trust has decided to invest its resources to learn and improve. It is important to note that all other patient safety incidents reported will continue to be reviewed and responded to within our risk management system. Where necessary teams will utilise appropriate incident response tools to enable learning and improvement across all patient safety areas.

Although the local priorities below have been agreed and will be the focus of resource until the plan is reviewed, it is recognised that the Trust may gain new insight or reason throughout the time of the plan that requires additional responses to be agreed and take place.

Incident Type	Planned local response tool	Anticipated learning/improvement
Accident Focusing on Witnessed falls	IMR for all witnessed falls Learning Bulletin (when required) PSII / Thematic PSII following scrutiny process if systemic factors become apparent	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Medication Focusing on administration errors and missed dose medication	Incidents that resulted in harm of moderate or above will require an IMR. Learning Bulletin (when required) PSII/Thematic PSII following scrutiny process if systemic factors become apparent	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Safeguarding Harm/abuse Focus on neglect and Physical abuse	All incidents reported as neglect or Physical abuse will require an IMR (corresponding section 42 investigations used to augment learning) Learning Bulletin (when required) Outcome of IMR will determine PSII/Thematic PSII	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Fatality Focus on Unexpected fatalities and where problems in care occurred	IMR followed by a PSII Learning Bulletin (when required)	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy

Incident Type	Planned local response tool	Anticipated learning/improvement
Missing Person Focus on AWOL while on escorted leave	An IMR following each incident Learning Bulletin (when required) Scrutiny process will determine a PSII/Thematic PSII following scrutiny process if systemic factors become apparent	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Clinical care Focus on deterioration in physical health Skin integrity Pressure sores = Grade 2, 3 or 4	All pressure sores of Grade 2 or above will require an IMR Learning Bulletin (when required) Outcome of IMR will determine a possible PSII/Thematic PSII	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy

6. Our patient safety incident response plan: National requirements

Although Brainkind provides some of our services under a standard NHS contract we are not an NHS organisation. NHS England describes a measure of PSIRF proportionality for these organisations. This proportionate approach to National PSII thresholds assists Brainkind to identify which incidents this PSIRP will recognise:

Incident Type	Planned local response tool	Anticipated learning/improvement
Deaths clinically assessed as thought more than likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII) Focusing on Witnessed falls	PSII	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Death of a patient where the Mental Capacity Act 2005 applies where there is reason to think that the death may be linked to problems in care (incidents meetings the learning from deaths criteria)	PSII	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Incidents meeting the Never Event criteria 2018 or its replacement	PSII	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Incidents meeting the criteria for reporting to Medicines Healthcare products Regulatory Agency (MHRA) and Serious Hazards of Transfusion (SHOT) and local Quality Management Systems	PSII Report to MHRA	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy

Incident Type	Planned local response tool	Anticipated learning/improvement
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR = Learning from Lives and Deaths – people with a learning disability and autistic people) Additional PSII may be required alongside Mortality review – to be agreed on individual basis.	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy
Death of a person due to problems in care	PSII	Identify organisational safety actions which feed into local quality improvement projects and organisational Quality Improvement strategy

7. Implementation of PSIRP

This PSIRP will be implemented from April 2026 and will be subject to reviews at designated intervals within an annual cycle whereby the national and local priorities will be examined against any themes that are emerging within year one. This review process will allow this PSIRP to be amended accordingly to ensure the philosophy of proportionality is maintained.

Review processes will be jointly completed by Service leadership teams, and Quality assurance team. The agendas of monthly scrutiny meetings and existing governance forums will include data aligned to national and local priorities.

- PSIRP priorities
- Incident Reporting rates
  (as compared to Learn from Patient Safety Events benchmark data).
- Timeliness of reporting associated with the expectations
  as set out with this PSIRP.

In addition, Brainkind's Patient Safety Incident Response Framework Policy and Procedure will be reviewed on an annual basis. This Policy defines the PSIRP processes Brainkind have in place and will be our benchmark for compliance.

An audit measuring the standards of the Patient Safety Incident Response Framework Policy and Procedure will be undertaken by the Quality assurance team in March/April 2027. The audit will be inclusive of response process leading to a PSII, IMR process, compliance to PSII standards and monitoring action plans / safety actions resulting from completed Patient Safety Incident Investigations, After action reviews (AAR's) and Multi-disciplinary Safety Reviews (MDT).

Audit results will be shared with SLT and shared with Brainkind's Executive. PSIRF data and audit findings will also be included in Brainkind's quality account reporting structure. Feedback received from SLT and Executive will be a mechanism for informed amendments to this PSIRP.

8. Safety action development / monitoring improvement

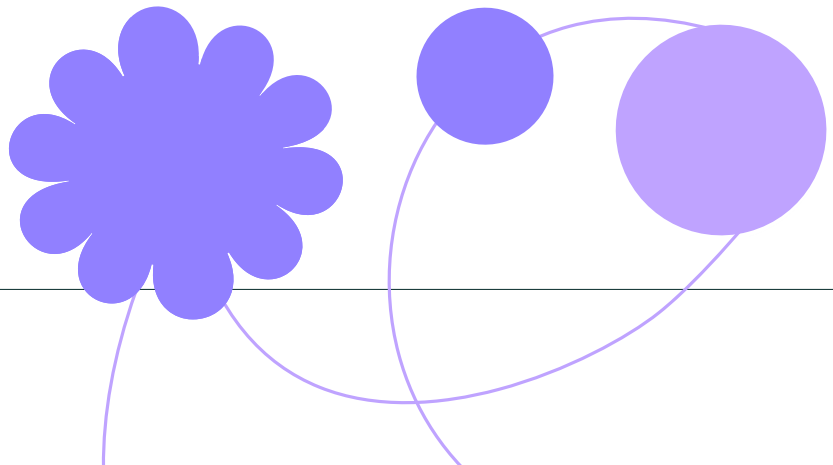
Brainkind recognises that following a patient safety incident, any identified learning response will allow the circumstances of the incident to be understood through systems-based thinking. Development of safety actions will enable Brainkind to develop their patient safety culture and reduce potential risks. Learning responses will be underpinned by a quality improvement methodology and will inform improvements across our organisation. Safety actions will be developed based on whether it is learning that is local to the team, service, Division or whether it is something that has wider organisational. Brainkind will follow the process as outlined in the NHS England Safety Action Development Guide:

- **Agree areas for improvement:** Specifying where improvement is needed without defining how the improvement is to be achieved.

- **Define the context:** Agree the approach to developing safety actions by defining the context.
- **Define safety actions to address the areas for improvement**: Continue to involve the team in a collaborative way and focus on the system.
- **Prioritise safety actions:** Avoiding prioritising actions based on intuition or opinion alone.
- **Define safety measures:** to demonstrate whether the safety action is influencing what is intended as well as describing who will be responsible for the use of the data.
- **Safety actions will be clearly written and follow SMART principles** (specific, measurable, achievable, relevant, and time-bound) and have a designated action owner

All learning responses completed by local service managers are monitored and will be presented to Brainkind 'oversight and scrutiny committee' on a monthly basis. It is anticipated safety actions resulting from IMRs and PSIIs will be underpinned by Quality Improvement methodology (QI).

QI can provide a systematic approach to tackling identified organisational learning and implementing system wide changes that will lead to better patient outcomes, working environments and enhancements in professional development. Brainkind's Quality Assurance Business Partners will responsively support the implementation of safety actions and will work with teams and individuals to develop QI projects.



9. Ratification

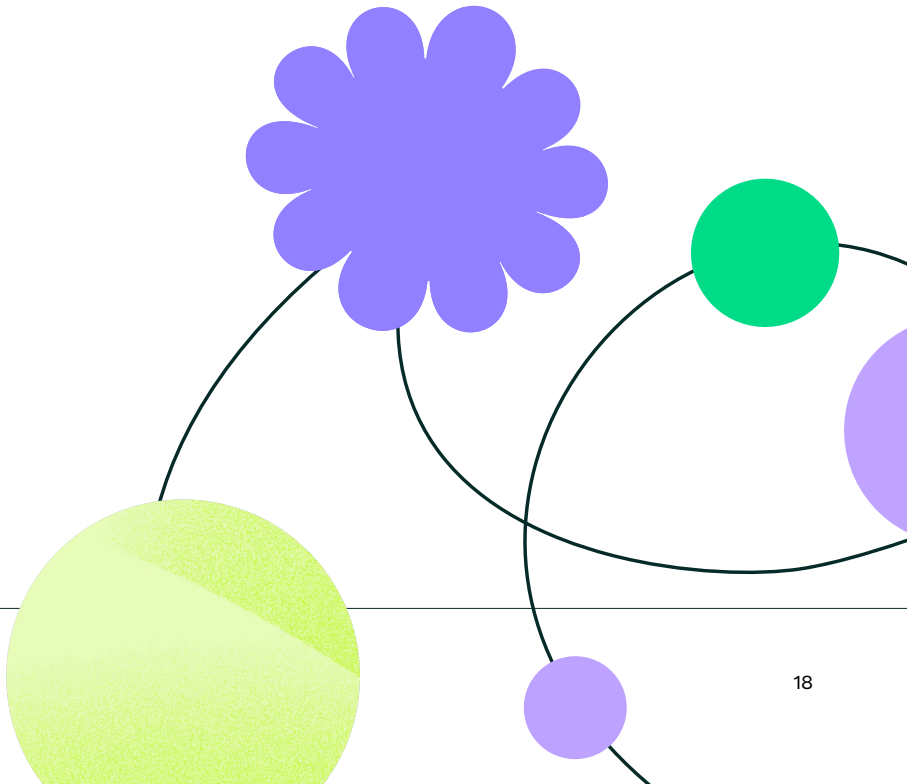
Ratification of this PSIRP will be jointly completed by Brainkind Executive Leadership team and by Lead ICB (Integrated Care Board) - SNEE (Suffolk and North East ICB)

Integrated care boards (ICBs) will be invited to review and or participate in oversight and scrutiny processes aligned to the PSIRP, acquired data and progression of our PSIRP will be shared with the ICB in line with their governance structures.

This PSIRP is scheduled to be implemented over a 12-month period commencing April 2026 has been ratified through Brainkind's Policy Committee, Senior Management Team, and Executive leadership team.

An audit of the PSIRP will occur at a designated interval in year 1 as a mechanism to measure standards of incident investigation and to evaluate the priorities and response tools.

Year 2 and year 3 of the PSIRP will continue to be subject to a ratification process.



Brainkind

About Brainkind

We are the UK's leading charity helping people to thrive after a brain injury and to live with other neurological conditions.

Our services include neurological centres, rehabilitation and supported living. We provide innovative, personalised and compassionate rehabilitation and ongoing support to people with brain injuries and other neurological conditions.

Find out more at **brainkind.org**

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