Alzheimer's Society Guidance: Patient Safety Incident Response Framework (PSIRF)
Incident Response Plan & Guidance

Guidance applies to: All Employees and Volunteers		Employees: All	Volunteers: All
		Contractors: Where appropriate	Other: non-defined
Version 2.2	Published November 2025	Average Read	

Contents

1. Introduction

A new approach to responding to Patient (Service User) Safety Incidents

The Patient Safety Incident Response Framework "PSIRF" is a key part of the NHS patient safety strategy. The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient (or service user) safety incidents for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF 2015) and represents a significant shift in the way the NHS responds to patient safety incidents. It is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including Alzheimer's Society services commissioned by NHS Trusts.

Please note that within the context of the Alzheimer's Society those people who use our services are referred to as service users rather than patients. For the purpose of this guidance, and to ensure alignment with NHS requirements, where patients are referred to, please read service users.

The PSIRF processes and accompanying guidance outlined in this document apply to all Alzheimer's Society employees, volunteer role managers and volunteers working within Service delivery teams.

The framework and learning response tools (details below) aim to involve colleagues at all levels of the organisation. The Framework includes four key aims:

1. Compassionate involvement of those affected by patient safety incidents (promoting a co-ordinated and data-informed approach to safety incident responses)
2. Use of a range of system-based approaches (details below) to learning from patient safety incidents
3. Considered and proportionate responses to safety incidents
4. Supportive oversight and management with a focus on strengthening response systems, learning and improvement rather than apportioning blame

Alzheimer's Society is committed to embracing the principles of the Patient Safety Incident Response Framework (PSIRF) to create a safe, transparent, and responsive environment for our service users, employees and volunteers.

Our focus is on ensuring that lessons are learned from incidents and that these lessons result in tangible improvements in our practices and processes. Reporting them supports Alzheimer's Society to learn from mistakes and to take action to keep patients safe.

2. Patient Safety Incident Response Standards

Alzheimer's society colleagues should uphold the Patient Safety Incident Response Standards to ensure they meet the minimum expectations of the PSIRF. Overall, the Society's Health and Safety Team and Quality of Practice Team are responsible for ensuring that PSIRF standards are adhered to.

The standards cover the following aspects of PSIRF:

- policy, planning and oversight
- competence and capacity
- engagement and involvement of those affected by patient safety incidents
- proportionate responses.

It is recommended that Society employees familiarise themselves with the PSIRF Standards document (found here). This provides the complete list of standards, and where relevant refers to specific supporting PSIRF documentation.

3. Purpose of the guidance

This guidance outlines the processes for Society colleagues and volunteers that must be followed in the event of a Patient Safety Incident, to ensure compassionate engagement of all involved, and a systems based, considered and proportionate response (in line with PSIRF aims).

Patient Safety Incidents are described as unintended or unexpected events (including omissions) in health-related care that could have or did harm one or more people.

Through this guidance, we hope to foster a culture of patient safety. We will prioritise learning from incidents, creating an atmosphere where staff feel comfortable reporting incidents without fear of blame.

4. Addressing Health Inequalities

Alzheimer's Society recognises that there are significant health inequalities in dementia risk, prevalence, diagnosis, and access to care and support. We will therefore apply a flexible approach, supported by smart data use to help identify any disproportionate risk to patients with specific characteristics. We will upskill the appropriate colleagues to uphold a 'system-based' approach to patient safety and investigation, supporting our 'no blame' culture.

The Society will respond to issues relating to health inequalities by ensuring PSIRF principles and standards are upheld throughout any investigation process, and that families and carers, are kept at the centre of the process, and their differing needs considered. As an example, it is widely recognised that people of diverse minority cultural and language backgrounds can have a poorer experience of health and social care than people from majority backgrounds. One way the Society will

address this inequality is to ensure that patients can access information in their preferred language and that interpretation services are used where appropriate.

5. Examples of Patient Safety Incidents:

Please note, the examples below are provided to support understanding of when the Society may need to follow PSIRF procedures only, they are not based on actual events and the list is **not** exhaustive:

1. Service User falls at group service where there is no trained first aider on site. A lack of first aid availability leads to more serious injury/impact on service user health/wellbeing.

2. Missed home visit for person with dementia without notice: Family member has suspended their own visit to person with dementia to allow Dementia Adviser home visit to take place. Home visit did not take place and no notice given. Person with dementia is subject to a fall and is subsequently left for a long period of time without assistance.

3. Dementia Adviser operates outside of service boundary by collecting medication for a service user and wrongly explains the usage instructions. Service user becomes ill as a result.

4. Dementia Adviser transports service user in their personal vehicle without risk assessment. Service user attempts to open the car door whilst the car is moving.

*** A note on the importance of Professional Boundaries.** We expect Society colleagues and volunteers to maintain professional boundaries in all aspects of work with our service users. Your working practices will reflect this, for example, by not operating outside of service boundaries, or by setting clear, appropriate and culturally sensitive relationship boundaries. You must let your manager know if you are concerned that professional boundaries may have been compromised in any way. You can access our Professional Boundary Policy and Procedures here. The policy also provides links to useful information on Whistleblowing and Conflicts of Interest. Colleagues working in NHS commissioned services, or with NHS partners, should note that the NHS now refer to Whistleblowing as 'Freedom to Speak Up' .

6. Collaborative Working & Transparency (our Duty of Candour)

We work towards openness and transparency in all matters related to patient safety incidents, in line with the Society's 'Duty of Candour'.

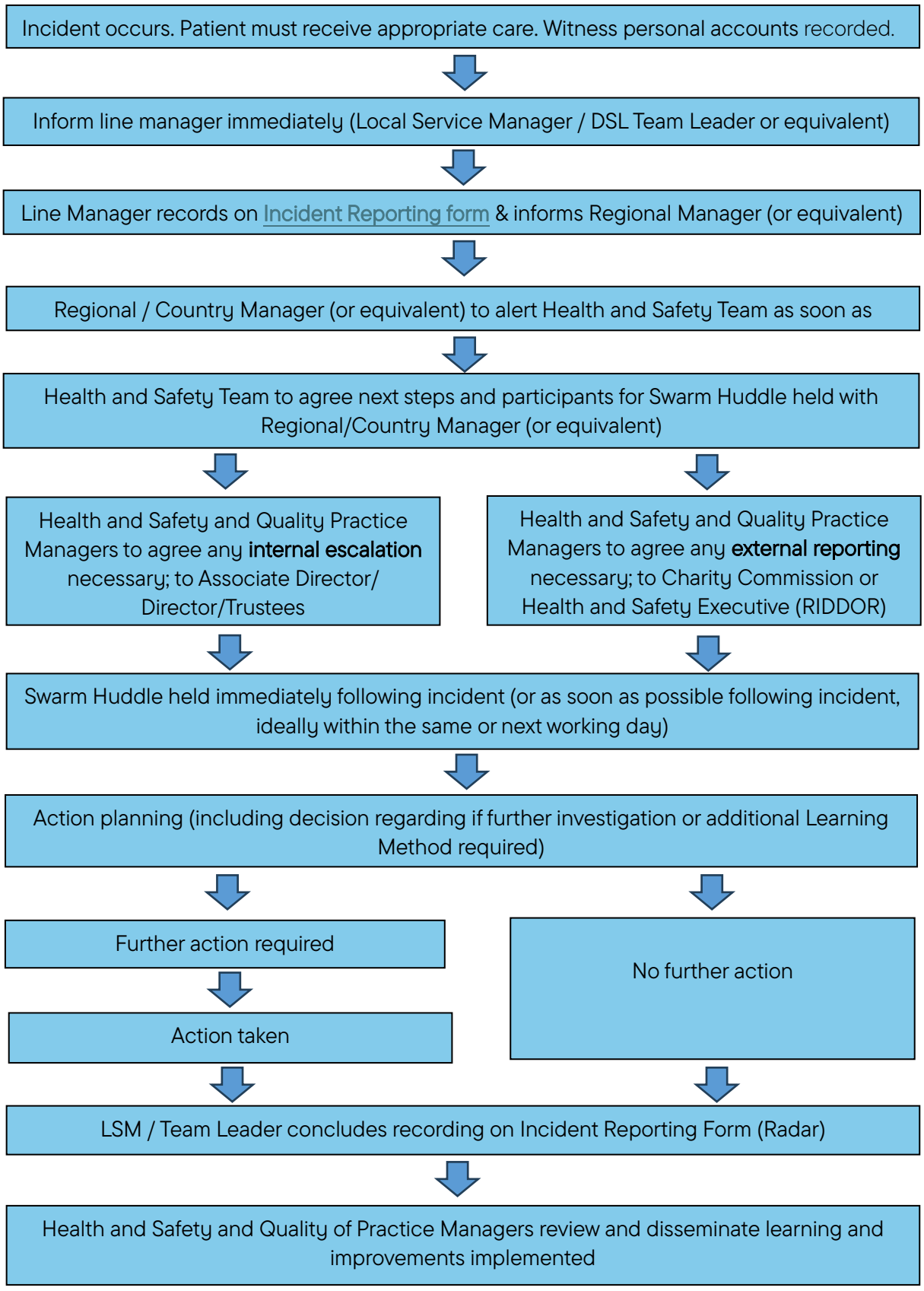
Our commitment is to ensure clear communication and information sharing with people with dementia, carers, families, staff, and key stakeholders. We recognise collaboration and information sharing are key to improving safety.

Where Society services are commissioned by external organisations such as NHS Trusts, Integrated Care Boards (ICBs) and Local Authorities, and we work in partnership with external organisations, we will work collaboratively to share learning and to provide a co-ordinated response to safety incidents where necessary.

We will inform our commissioning partners in line with our contractual requirements when a patient safety incident occurs, as well as contact them if we need support in our learning response to the incident. We will also work to support our commissioning and partner organisations in their learning responses to safety incidents (e.g. attend meetings, provide information etc.).

Information will be shared with partnership organisations in a timely manner, and in line with Information Governance procedures.

7. Responding to a Patient Safety Incident – Process Flow



The Dementia Support & Partnerships Learning and Development Reference Group provide governance and leadership accountability for continuous learning within practice. Identified learning relating to patient safety is shared with the Reference Group to enable the embedding, communication, and delivery of such learning across Alzheimer's Society Services, and to support in driving forward practice improvements.

8. Reporting and Recording Patient Safety Incidents/Events

At the point a Safety Incident occurs, the first action must be to ensure the patient receives the care required, i.e. first aid is administered, emergency services are called etc. The employee/volunteer or other party must then inform their Line Manager, or next available Manager, as soon as it is safe to do so. This should be at the point of incident or as soon as possible after the event, but always within the same working day.

Managers must then inform the Society's Health and Safety team as soon as they are aware of the incident, again within the same working day of the incident occurring. In line with the Safeguarding Adults Policy, where managers assess that the Safety Incident may also raise safeguarding concerns, they should make a referral to the Safeguarding Team.

The Health and Safety Team will report all Safety Incidents in NHS commissioned services via the online Learning from Patient Safety Events (LFPSE) portal. The Health and Safety Team will decide next steps with the manager reporting the incident, including which of the Learning Response Methods (see below) is most appropriate for the situation and which Learning Response Tools (see below) are relevant. The Health and Safety team are then responsible for informing and updating the Society's Senior and Executive Leadership Colleagues as required.

It is likely that in order to ensure that the incident is robustly understood, and all potential learning identified, a Swarm Huddle at the minimum will be held.

Use of Recording Systems

All Patient Safety Incidents must be reported using the Society Accident and Near Miss reporting system. This can be done by either logging into Radar or by completing the form on Arena. Employees who are unable to access the Radar system can use the form provided on our Health and Safety Arena pages to record details of an incident: Accident, Incident and Near Miss Reporting and Investigation as this will automatically create a record in Radar.

All discussions with the Health and Safety team should be recorded on the form (or if using Radar directly, recorded in the Radar system).

Additionally, where an incident involves people with dementia and/or carers, details of the incident will need to be added to their CRS (Computerised Record System) service usage record. Any other relevant fields within CRS will also need to be updated, such as recording a potential known risk under the 'medical/risk' section.

Further information on Accident and Near Miss reporting and investigation can be found on Arena.

When recording incidents, ensure that all records are factually correct and ensure that a person's opinion, or quotes are recorded as such. Records should be clear, and precise. Remember that information recorded is open to scrutiny and can be requested through a subject access request (SAR). Recordings should include why relevant outcomes and actions agreed were decided upon, to ensure that at a later date we are able to describe why a decision was taken at the time.

The Society's Quality Recording Standards can support with good recording.

9. Use of PSIRF Learning Response Methods and Tools

The Learning Response Methods are listed as stages below:

Stage 1. Swarm Huddle
Stage 2. Patient Safety Incident Investigation
Stage 3. Multidisciplinary Team Review
Stage 4. After Action Review (See Appendix B for example)

The PSIRF stresses that responses should be proportionate to the incident. Dependent on the severity and/or number of incidents, a Swarm Huddle and action plan may be a sufficient response. Incidents of a more serious nature may then require that each stage of the Learning Response Methods (details below) are carried out. The severity and type of learning response will be decided in discussion with the Health & Safety Manager (see Appendix A).

The Society will involve everyone affected by an incident in response planning in order to learn, as per PSIRF standards, and to invite all involved to be part of the solution. This could include Society management, colleagues, volunteers, services users and their families. The Society recognises that there is no one source of blame where safety incidents occur, and that in such cases, wider systems and processes require review.

Tools are available from the NHS to help in the initial stages of a learning response, including the following (the list is not exhaustive):

1. Information Gathering Log
2. Stakeholder Map
3. Stakeholder Map (visual)
4. Terms of Reference for an Investigation (template)
5. The Patient Safety Incident Investigation Report Template
6. Learning Response Review & Improvement Tools can be found via the above link.

Please click the link here to access the tools: NHS England PSIRF Toolkit

10. Actions required following an incident

Following any learning response or investigation, an Action Plan must be developed.

Potential actions could include one or more of the below:

- Changes to our service/intervention/event planning or delivery to mitigate repeat occurrence (agreed as larger systemic changes and/or changes from an individual person-centred planning perspective)
- Immediate ceasing of all services/interventions
- Consideration on who needs to know across the service/team, or wider services or directorates (such as the Media Team if there is believed to be reputational risk), to ensure that decisions and outcomes are fully implemented,
- Informing our Commissiong and Partner Organisations on the incident and learning response followed
- Reporting to relevant statutory services such as police and/or social care (must be notified to line management, and the Safeguarding and Quality team)
- Reporting to regulatory agencies such as Health and Safety Executive, or Charity Commission (reportable incidents are agreed through our Serious Incident policy and procedures)

11. Support available for those involved

PSIRF recognises that learning and improvement following a patient safety incident, can only be achieved if supportive systems and processes are in place. The Society therefore prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

The Regional Manager (or equivalent) as the person leading the investigation, will liaise with and keep patients and/or family members informed throughout the process. This may be with the support of the Local Service Manager (or equivalent) where appropriate. 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. Those affected include staff and families in the broadest sense; that is: the individual, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred. The Society will involve patients and families affected by significant incidents to ensure they are informed and any questions they have are answered as part of the investigation.

It is also important for staff to know that the PSIRF requires a culture of learning and understanding rather than seeking to place blame on the actions or otherwise of an individual. Patient safety incidents can have a significant impact on staff who were involved in, or who may have witnessed the incident, and they will want to be kept informed on what happened and why, and what can be done to prevent the incident happening again.

Colleagues should be made aware that there are a range of support mechanisms available that employees and volunteers can access in the event of a Patient Safety Incident, these are:

- Debrief session with line or role manager/or responsible person on duty.
- Line and role managers can ask if the colleague/volunteer requires any support to continue in role
- Well-being advice and support on Arena here: Wellbeing. For volunteers, role manager to send relevant document/resources.
- Use of the Thrive™ Mental Wellbeing app. Information on Arena here: Thrive.
- Contact your People Adviser if you need further guidance or support.
- Contact the Employee Assistance Programme on 0800 072 0353. (Option 3)
- Ongoing conversations within your 121's/volunteer supervision sessions.

12. Governance

The timely and effective recording of Patient Safety incidents is critical for Alzheimer's Society to fully recognise and respond to any thematic or systemic issues. It provides evidence for and supports, continuous learning and improvement and ensures we prioritise such work efficiently; it additionally ensures we respond to any regulatory reporting requirements.

All Patient Safety Incident Data and identified learning will be reviewed monthly by the Health and Safety and Quality of Practice Team's to inform service/team improvement work and to highlight any system risks or issues.

The Health and Safety and Quality Practice Teams will:

- Review Learning Response Action plans monthly to draw out themes and patterns and ensure that any improvements have been implemented
- Provide a quarterly Performance and Learning report for review by the Dementia Support & Partnerships Leadership and Senior Leadership Team
- Provide quarterly data and information related to Patient Safety Incidents to the Society's Executive Leadership Team. The Society's Trustees are informed via the Annual Safeguarding and Quality report.
- Learning will also be shared via the annual Alzheimer's Society Quality Account.

13. Training

NHS webinars on 'PSIRF Embedding' are available. Details can be found here on the NHS England website.

Specific knowledge and experience are required for those leading learning responses and those in oversight roles. This includes knowledge of systems thinking and system-based approaches to learning from patient safety incidents. Those involved in the quality assurance of patient safety incident response have the knowledge to constructively challenge the strength and feasibility of safety actions to improve underlying system issues. They must be able to recognise when the proposed safety actions following a patient safety incident response do not take a system-based approach; for example, where they inappropriately focus on revising policies without understanding 'work as done', or involve self-reflection for certain individuals rather than reviewing wider system influences.

Staff in oversight roles must be appropriately trained to support the practical application of PSIRF oversight principles and standards.

The following training will be provided:

- For all society employees in roles where there is direct contact with people with dementia and carers in a service delivery context, to support their understanding of Patient Safety Incidents and their responsibilities

- For Local and Universal Service Managers and to support their understand their responsibilities regarding responding to and reporting Patient Safety Incidents

- For Regional/Country Managers (or equivalent), Heads of Services, Health and Safety and Quality of Practice Managers to support their understanding of process, Learning Response Methods and Tools, and to ensure sufficient ability to apply a systems thinking approach to the investigation and learning aspects of Patient Safety Incidents:

14. Related Documents

- Health & Safety managing lone working
- Managing personal safety procedure and guidance
- Bullying and Harassment Policy
- Complaints and Compliments Policy
- Safeguarding Serious Incident Policy and Procedures

Arena pages

- Health and safety
- Wellbeing
- Safeguarding

Appendix A: Learning Response Method Guide

Learning Response Method	When might we use it...	Guide from NHS England on how and when to use it
Swarm Huddle	Is used to identify learning from safety incidents. Immediately after an incident, staff 'swarm' together (possibly at service delivery venue where required) to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Please note: 'Huddles' will vary in size dependent on the severity and/or number of incidents. (As an example, this could mean anything from a meeting between a Local Service Manager and a Dementia Adviser, to a whole service area meeting including Quality & Safeguarding Management, Health and Safety, Practice Learning).	Learning Response Guides: Swarm Huddle
Patient Safety Incident Investigation (PSII)	Is undertaken when an incident or repeated near-miss indicates significant safety risks and potential for new learning.	Learning Response Guides: Incident Investigation (PSII)
Multi-Disciplinary Team (MDT)	Is used to gather all relevant professionals/practitioners/service colleagues together to identify learning from multiple safety incidents; agree the key contributory factors and system gaps; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.	Learning Response Guides: MDT
AAR (After Action Review)	Is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.	Learning Response Guides: After Action Review

Appendix B: Example of After Action Review steps

Safety Incident Occurs

Colleagues have not reacted as expected / per process

'After Action Review' involves colleagues and helps the Society to understand why, and what the situation was at the time. We gain a picture of colleague situational awareness and their perception of events

Colleagues are invited to make their own recommendations for change and improvement (alongside those of other Society teams/colleagues) and are able to buy in to the required change. Colleagues feel involved and don't feel blame.

Changes are agreed with Regional Management (or equivalent) and Quality of Practice and Health and Safety teams.

Changes are implemented / Improvements are made.

Appendix C: NHS Supporting Documents

The PSIRF is supported by further detail in guidance documents found here. The documents cover the below (as well as the PSIRF standards mentioned above):

- Engaging and involving patients, families and staff following a patient safety incident
- Guide to responding proportionately to patient safety incidents
- Oversight roles and responsibilities specification

Appendix D: PSIRF Plan 2025 - 2026

Each year the Health and Safety and Quality Practice Teams will agree a minimum of three priority areas, from their review of Patient Safety Incident Action plans and Learning Responses undertaken, for further development and improvement over the upcoming year.

2025-26 will see the Alzheimer's Society continuing to embed our Patient Safety Incident Framework. This will require continued focus and attention to ensure that it is robustly implemented, with the delivery of the required training across practice combined with the continued promotion of the cultural approach that underpins the framework. The Society has to date not experienced any Patient Safety Incidents to draw on, nor any reported Serious Incidents. However, Quality Assurance activities have highlighted areas of risk which might lead to potential Patient Safety Incidents. As a result, the areas below have been identified as those for action in 25/26:

Patient Safety Type or Issue	Planned Response Method	Anticipated Improvement route
Continued and improved vigilance in identifying PSIRF reportable Health and Safety incidents and near misses	Multi-Disciplinary Team	Improvements to the Society's Health and Safety Incident Reporting System (Radar) to better support identification of potential PSIRF reportable incidents and near misses. Society Health and Safety Manager to identify NHS PSIRF Case Study to utitlise in learning review. Establishing working structures for learning responses. Impact reviewed March (Q4) 2026.
Inconsistent recording of Emergency Contacts on service case records	Multi-Disciplinary Team	Establish baseline data to assess level of potential current risk. Improved dissemination of guidance to service teams. Regular promotional communications across major Society channels. Improved reporting to monitor impact and improvement. Set targets for improvement from Q2 onwards; KPI 90% compliance by Q4 (March) 2026.
Inconsistent levels of First Aid training for all group facilitators and leaders	Multi-Disciplinary Team	Data collection and storing of current training. Establish baseline data to assess level of potential current risk. Further Development of tracking and mapping system for First Aid training in Group Services. Updated training offer and structure to monitor future compliance. Set targets for improvement from Q3 onwards; KPI 90% compliance by end Q4.

Document details

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Next review:	Policy Review (overall document) November 2026 Plan Review (appendix D) March 2026
Version published:	V2.2 November 2025