BEYOND LIMITS

Beyond the limits of conventional support

PERSON SAFETY INCIDNET RESPONSE FRAMEWORK POLICY & PLAN

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This policy explains how we respond when things go wrong or could go in the future. Our focus is always on learning, improving safety, and supporting people, rather than blame.

INTRODUCTION

This policy aligns with the NHS England's Patient Safety Incident Response Framework (PSIRF) 2022 and outlines Beyond Limits' approach to maintaining effective systems for responding to safety incidents.

We aim to maintain an established culture where everyone feels confident to raise concerns, ensuring people's safety remains paramount, and driving continuous improvement in our care and support.

Please note that Beyond Limits do not use the term "patient." We support people to live independently and do not regard them as patients. Sas such, we have designated this policy as 'Person Safety Incident Response Framework,' using the same 'PSIRF) abbreviation as applied throughout this policy.

AIMS

The PSIRF advocates a co-ordinated and date-driven response to safety incidents. It embeds person safety incident response within a wider system of improvement and promotes a significant cultural shift towards the safety management of the people we support.

OUR COMMITMENT

Our commitment to providing person-centred support is at the very heart of everything we do. How we practice and deliver our support, how we talk about people and how we refer to people will always reflect the values of the organisation. The health, safety and welfare of the people we support, our colleagues and visitors are and will remain a priority.

We will listen to the views of the people we support, we will listen to their concerns, and we will treat everyone with dignity, kindness and respect.

This policy supports the development and maintenance of an effective safety incident response system that integrates the four key aims of the PSIRF.

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

THE IMPORTANCE OF LEARNING

Effective person safety management and response relies upon having a positive learning culture. This means that colleagues are keen to learn from incidents and events, and crucially they can demonstrate this in practice.

A culture where learning is valued is essential to maintaining an effective incident reporting process, which is results in robust, shared investigation, insight and learning.

This policy should be read in conjunction with our current PSIR Plan, which is a separate document setting out how this policy will be implemented.

THE SCOPE OF THIS POLICY

This policy relates to responses to person safety incidents that are solely for the purpose of learning and improvement in Beyond Limits.

Responses under this policy follow a systems-based approach. This recognises that the safety of the people we support is an emergent property of the healthcare system, specifically that:

"Safety is provided by interactions between components and not from a single component."

We believe that most incidents happen because of system issues, not because people intend to cause harm. Staff should - and are encouraged to - feel safe to speak up without fear of blame or punishment.

Honest mistakes are treated differently from reckless or unsafe behaviour. There is no remit to apportion blame or determine liability, preventability or cause of death.

We seek to promote a just culture, a fair and supportive workplace where people are treated properly when things go wrong. Supporting staff to be open allows valuable lessons to be learnt, so the same errors can be prevented from being repeated.

PLEASE NOTE:

Information from the response process involving a person we support can be shared with those people leading those types of investigations, but other processes should not influence the remit of an incident response involving any of the people we support.

Other processes outside the scope of this policy are clarified below:

- Claims management.
- Human resources investigations into employment concerns.
- Professional standards investigations.
- Coronial inquests.
- Criminal investigations.
- Information governance concerns.
- Medical examiner review.
- Estates and facilities concern.
- Financial investigations and auditing.
- Complaints and safeguarding concerns (except where a significant patient safety concern is highlighted).

Information from a patient safety response process can be shared with those leading other types of responses, but other processes will not influence the remit of a patient safety incident response.

OUR PERSON SAFETY CULTURE

We seek at all times to safeguard the people we support, and we believe that promoting a strong safety culture where colleagues can – and will – report any concerns is fundamental to the safety of the people we support.

We hold with the principles of a psychologically safe environment, one that actively promotes a culture where our staff have confidence that they won't suffer any detriment (i.e. humiliation, targeted etc.) for speaking up with ideas, questions, concerns or mistakes.

A psychologically safe environment is one that nurtures a working culture that is free from ego and fear or retribution. The promotion of a "just culture" and a commitment to fair blame is most effective when built upon the foundations of a psychologically safe environment.

Our ongoing work with Karen Mason (author of Pause: Rethinking Leadership to Cultivate Healthy Workplace Cultures) is all with the aim of supporting and maintaining our workplace culture. Our organisational training calendar which features training on:

- Giving and receiving feedback
- Developing Emotional Intelligence
- Developing the Leader Within
- Promoting Self Direction and Autonomy
- Understanding our best self and shadow self
- The role of Ego and how to be develop an awareness of this in decision making

In addition, our work and training with Trisha Nicol from Gloriously Ordinary Lives which focuses on use of language and how we think about people with support needs, all contribute to the development of a just culture.

Beyond Limits are committed to promoting and improving the quality and safety of support people receive, as well as preserving the safety of colleagues, visitors, and others. We believe a safety conscious organisation is one which is receptive to adverse incidents so it can learn, develop, and change practice. We have embedded these principles into our procedures for the review of incidents. These non-exhaustively include:

- Monthly Governance meetings where incidents are reviewed for learning and to ensure continuing good practice.
- Group supervisions undertaken in a psychologically safe environment where colleagues are encouraged to speak candidly about their thoughts and feelings in respect of incidents, including what went well and what can we learn from the incident or event.

Beyond Limits fully understands the significant impact being involved in a person safety incident can have on staff. This is something seriously because we know that staff welfare and wellbeing can impact upon a person's presentation and demeanour. Therefore, we will always ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place in a way that is suitable and sensitive.

Beyond Limits understands and promotes the reporting of incidents, including near misses, as an opportunity to learn and to improve safety and services. Colleagues will also be supported through the Duty of Candour Policy and Whistleblowing Policy.

PLEASE NOTE:

This policy should be read in conjunction with the following Beyond Limits policies:

- Code of Conduct Policy
- Duty of Candour Policy
- Whistleblowing Policy

ADDRESSING HEALTH INEQUALITIES

Beyond Limits are an inclusive in all we do, ensuring that we recognise and celebrate diversity. We will ensure, through our data collection and analysis that we identify any disproportionate risk to people with specific characteristics, which can in turn inform our person safety incident responses.

When undertaking our reviews and subsequent actions we will consider whether there are any areas of health inequalities and whether these have contributed to risk or harm. This will include all protected characteristics. Findings will be assessed for learning, transformation or quality improvement.

When completing our reports and plans we will use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our person safety incident response.

Person safety incident responses will continue to consider health inequalities through a variety of routes. These routes will consider:

- Outcomes for people across a range of specific characteristics to ensure any unwarranted variation is identified as an area for improvement for consideration.
- Specific support needs to encourage engagement in person safety responses from all persons, focusing on what each person can add to the learning process and collectively removing any barriers to participation. The focus includes an emphasis upon attunement and enablement.

When engaging and involving the people we support, families, carers or staff following a person safety incident we will take into consideration their different needs as required, including but not limited to:

- Black and minority ethnic groups
- People with a learning disability and autistic people
- People with dementia
- People who need accessible communication including Deaf people and people who do not speak English
- Lesbian, gay, bisexual and transgender people

Beyond Limits ensure that staff have the relevant training and skill development to support this approach.

ENGAGING WITH & INVOLVING PEOPLE

PSIRF recognises that learning and improvement following a person safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports the development of an effective person safety incident response system that prioritises compassionate engagement and involvement of those affected by safety incidents (including the people for whom support is provided, families and staff).

This involves working with those affected by person safety incidents to understand and answer any questions they have in relation to the incident and provide them with direct or signposted support as required.

Beyond Limits are committed to maintaining a culture of openness with the people we support, their families and their wider support networks. This is particularly important when outcomes are not as expected or planned.

This is not only consistent with our values and approach but is also a statutory requirement under CQC Regulation 20, Duty of Candour, for all healthcare organisations to be open and transparent with people and their families when things go wrong. In accordance with our Duty of Candour policy, we will involve the people we support, their family and any other relevant individuals in the investigation process unless there is an identified and documented reason not to do so.

When engaging after a person safety incident, the people we support, and their families will be treated with respect, dignity, openness, and transparency at all times. The term engagement describes everything an organisation does to communicate with and involve people affected by a person safety incident in a learning response. PSIRF emphasises the need for compassionate engagement which prioritises and respects the needs of people who have been affected by a person safety incident.

Those affected by person safety incidents will be:

- Provided with a named main contact with whom to liaise about any learning response and support.
- Communicated with in a way that takes account of their needs and requirements.
- Fully informed about what happened.
- Given the opportunity to provide their perspective on what happened, with an assurance that their voice will be heard.
- Given an opportunity to raise questions about what happened and to have these answered openly and honestly.
- Supported to access counselling or therapy where needed.
- Given the opportunity to receive information from the outset on whether there will be a specific learning investigation 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.
- Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in.
- Informed who will conduct any learning investigation and of any changes to that arrangement (in a timely way).
- Given the opportunity to input to the terms of reference for the investigation, including being given the opportunity to request the addition of any questions especially important to them (Please note that this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
- Given the opportunity to agree a realistic timeframe for any investigation.
- Informed in a timely fashion of any delays with the investigation and the reasons for them.

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- Updated at specific milestones in the investigation should they wish to be.
- given the opportunity to review the learning report with a member of the investigation team while it is still in draft form, and there is a realistic possibility that their suggestions may lead to amendments. (Please note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them).
- Invited to contribute to the development of safety actions resulting from the learning report
- Given the opportunity to feedback on their experience of the learning response and report (for example, timeliness, fairness, and transparency).

THE FOUR STEPS OF ENGAGEMENT

ONE: BEFORE CONTACT

- Identify the family contact.
- Assess inclusivity need.
- Assess potential support needs.
- Ensure familiarity with incident.
- Assess potential for parallel responses and prepare guidance.

TWO: INITIAL CONTACT

- Provide a clear introduction.
- Offer a meaningful apology.
- Identify key point of contact.
- Explore support needs.
- Discuss the incident.
- Explain what happens next.
- Address questions.
- Schedule or discuss next contact (if required).

FOR INVESTIGATION:

- Confirm involvement preferences.

THREE: CONTINUED CONTACT

- Agree timeframe for responding to questions.
- Revisit support needs.
- Check for additional questions.
- Share experience of the incident.

FOR INVESTIGATION:

- Define or discuss terms of reference
- Agree timeframe for completion of investigation
- Revisit involvement preference
- Discuss report preferences
- Share the draft report

FOUR: CLOSING CONTACT

- Address questions.
- Reiterate meaningful apology.
- Final contact (formal end).
- Ongoing support.

FOR INVESTIGATION:

- Final report
- Discuss any further investigations
- Opportunities for further involvement

Beyond Limits have a clear 4-Stage Complaints process in place. This is made available to the people we support, their families and feedback (including complaints) can be provided through our website. All complaints are taken very seriously, and we remain committed to resolving any concerns effectively and without compromise, taking full account of our need to maintain our duty of candour.

In all situations, complaints and concerns will be managed supportively and sensitively, with attunement and understanding.

We recognise that there might also be other forms of support that can help those affected by a person safety incident and will work with the people we support, their families, and other relevant people to signpost to their preferred source for this.

POST INCIDENT OR EVENT

The nominated person in charge must ensure all staff and people involved in a traumatic or stressful incident are offered support following an incident. Staff may suffer high levels of stress and distress immediately after an incident and throughout the investigation and learning period. Therefore, it is essential to maintain both person safety and staff wellbeing, ensuring that staff are well supported throughout the process.

A "huddle" should be held as soon after the event as possible to allow staff the opportunity to reflect on the situation and explore how it has made them feel. This would usually be organised and facilitated by the relevant manager.

Where a Person Safety Incident Investigation (PSII) has taken place staff should be supported to collaborate in the development of learning action. A debrief and a learning event will be held within the staff team to share the findings of the investigation and to enable reflection and learning to be undertaken.

PERSON SAFETY INCIDNET RESPONSE PLANNING

PSIRF supports organisations to respond to incidents and safety issues in a way that ensures we identify and capture learning and improvement rather than basing responses on definitions of harm.

Beyond Limits will actively explore safety incidents relevant to the context of our services. We take a proportionate approach to our response to person safety incidents to ensure that the focus is upon learning and improvement.

RESOURCES & TRAINING

Beyond Limits has committed to ensuring that we fully embed PSIRF and meet its requirements.

A range of resources to support person safety incident investigations and learning responses are available through the person safety incident response framework and these, where relevant to the context of what we do and how we work, have been adopted by Beyond Limits.

All systems-based person safety incident investigations will be carried out by a nominated person safety incident investigator. They will have undertaken specific training in systems-based investigation methodology delivered by a relevant, suitably qualified professional.

PLEASE NOTE:

Training for managers is being sourced, and we aim to ensure that relevant staff will complete the Level 2 (2-day) learning from 'patient' safety incidents training. Training will be subject to ongoing review and development as we continue to embed principles of the PSIRF.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses.

OUR PERSON SAFETY INCIDENT RESPONSE PLAN

Our plan is available in addition to this policy. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

REVIEW

Our person safety incident response plan is a live document that will be appropriately amended and updated as we use it to respond to person safety incidents. We will review the plan every 12-months to ensure our focus remains up-to-date. It also provides an opportunity to re-engage with all relevant people to discuss and agree any changes made in the previous 12-months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every two years and more frequently if appropriate to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, person safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider "stakeholder" engagement.

RESPONDING TO PERSON SAFETY INCIDNETS

All staff are responsible for reporting any potential or actual person safety incident to the responsible manager, who will inform the relevant senior manager. They and will record the level of harm they know has been experienced by the person affected, based upon their professional judgement. Incidents must be reported as soon as possible following the event and wherever possible, before the end of the working day the incident occurred in.

It is expected that all incidents will be reported within 24-hours of them occurring. Beyond Limits will monitor any patterns of delays in incident reporting and report back to the Board. Delays will be discussed in governance meetings and there will be remedial action to ensure that any blockers to timely reporting are addressed robustly.

When an incident is deemed to have caused significant physical or psychological harm to a person, the following applies:

- Monday to Friday 9am to 5pm, the incident must be recorded and reported to the Designated Safeguarding Lead (DSL) as soon as possible. The classification of harm must be accurately selected. The person in charge of the service must be informed as soon as possible to assist in the management of the incident, and to ensure that the people we support who are affected are safeguarded effectively.
- A Board Notification must be sent within 24-hours to ensure that any additional support and resources are made available.
- The Director of Safeguarding must be informed. They will take an active and leading role in ensuring that safeguarding remains paramount and all due process is followed, as consistent with the context of our services.

Out of hours 5 p.m. to 9 a.m., the incident must be logged, managed and reported as above, additionally, the manager or person in charge must contact the silver on-call manager, who will then notify the gold on call director.

INITIAL RESPONSE TO AN INCIDENT

When a significant patient safety incident occurs on trust property, staff involved must:

- Secure the area as required by the circumstances of the incident.
- Ensure the safety of all those affected by the patient safety incident and provide emergency or life-saving care if required.
- Ensure the safety of the environment, in the most serious of person safety incidents this may need to be kept secure to aid with any potential police investigation.

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- Notify emergency services as appropriate or required, for example: Fire and Rescue, Ambulance and, or the Police.
- ensure any equipment involved in the incident is retained in a safe area for further examination or inspection or calibration, if required.
- Offer meaningful support where required.
- Notify the person's next of kin or nominated individual (if or where applicable)
- Escalate to the manager (or on-call if out-of-hours), and the DSL.
- Ensure that the Director of Safeguarding is informed if the incident or event has resulted in harm to a person.
- Ensure that recording is accurate, capturing the facts and any harm caused.
- Write down their recollection of events, as soon after as practically possible, to aid memory capture and information gathering to assist future learning.
- Attend huddle or briefings and, or interviews, as required, in conjunction with their team or service manager and the lead investigator, in order to gather information and understand the learning.

REVIEWING THE INCIDENT

All incidents reported in the preceding 24-hour period (midnight to midnight) will be reviewed as soon as possible thereafter, during ordinary working hours. Incidents that occur over the weekend will be discussed on the first working day of the week.

All incidents that have been identified as needing further actions or discussion will be reviewed by relevant managers and staff. This will be chaired by the relevant senior manager.

Some incidents may require a person safety incident investigation (PSII) and an immediate escalation may be required. These will be escalated to the Board without delay.

PATIENT SAFETY INCIDENT RESPONSE DECISION-MAKING

Beyond Limits will ensure arrangements are in place to allow it to meet the requirements for review of person safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event.

Our person safety incident response plan (PSIRP) supports the proactive allocation of person safety incident response resources.

Where a person safety incident indicates an unexpected level of risk and, or potential for learning and improvement but it falls outside the issues or specific incidents described in our PSIRP, decision-making will be led by the Managing Director for organisational learning and safety in consultation with relevant people.

PERSON SAFETY INCIDENT RESPONSE

Please refer to our Person Safety Incident response Plan (Appendix One). This confirms how we will respond the person safety incidents.

LEARNING RESPONSE TOOLS

We use our monthly Governance meetings to discuss incidents and events. This is a focused opportunity to ensure that person safety and compliance in relation to the people we support is assessed and evaluated for learning opportunities.

Relevant learning outcomes are cascaded to staff and embedded into practice. This is subsequently reviewed for impact and assurance purposes.

Where patterns or trends in respect of incidents or events are identified, there will be a *thematic analysis* that involves an in-depth review to identify further opportunities for learning and development.

HUDDLE

A "huddle" is initiated as soon as possible following an incident or event, usually within 24-hours. This will involve relevant senior colleagues, including the DSL, and the staff involved. The purpose is to 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 the same thing happening in future.

ACTION AFTER REVIEW (AAR)

The purpose of the AAR is to gather those involved in the incident together in a safe space to look at what happened, what should have happened, why there may have been a difference, and is there any learning identified. This takes place as soon as possible after an event. It will be led by the lead professional involved in managing the PSIR.

PERSON SAFETY INCIDENT INVESTIGATION (PSII)

A PSII is an in-depth review of a person safety incident or event to understand what happened and how. It will be undertaken by a trained person safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report.

Beyond Limits have a clear process for our response to incidents and the PSII provides oversight of incident management and our PSIRF response.

Beyond Limits person safety incident review group will have overall oversight of such processes and will challenge decision-making to ensure that we can be assured that the true intent of PSIRF is being implemented within our organisation, and we are meeting the National "patient" safety incident response standards.

RESPONDING TO CROSS-SYSTEM INCIDENTS OR ISSUES

Beyond Limits will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's "patient" safety team or equivalent. Beyond Limits will work with other providers where relevant to maintain procedures to facilitate the free flow of information to ensure effective joint working on cross-system incidents.

TIMEFRAMES FOR LEARNING RESPONSES

PSIRF supports Beyond Limits to respond to incidents in a way that maximises learning and improvement.

When a PSII has been identified the review starts as soon as possible after an incident is identified and is usually completed within one to three months.

PSII's should not take longer than 6-months, <u>but this is not a new default target</u>. If responses are taking more than 6-months, or exceeding timeframes set with those affected, then processes should be reviewed to understand how timeliness can be improved. This also applied to learning response investigations, such as thematic analysis.

The timeframe for completing a PSII will be agreed with those affected by the incident, as part of setting the terms of reference for the PSII, provided they are willing and able to be involved in that decision.

In exceptional circumstances (for example, when a partner organisation or agency 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 agreed with those affected (including the person being supported, family and staff). The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety, or further checks will be required to ensure the recommended actions remain relevant.

Where external bodies cannot provide information, to enable completion within six months or the agreed timeframe, we will work with all the information we have to complete the response to the best of our ability. It may be revisited later, should new information indicate the need for further investigative activity.

Deaths referred to the coroner will follow PSIRF guidance in relation to timeframes.

SAFETY ACTION DEVELOPMENT & MONITORING IMPROVEMENT

Any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning.

To reliably reduce risk safety actions are needed which will be captured within the safety improvement plan. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from the Beyond Limits team and all relevant professionals and agencies external to Beyond Limits as required.

Safety improvement plans will be a mixture of approaches depending on the incident. Beyond Limits will/may:

- Create an organisation-wide safety improvement plan summarising improvement work create individual safety improvement plans that focus on a specific service or individual.
- Collectively review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues. This takes place during the monthly governance meetings, but extraordinary meetings will be arranged as required.
- Create a safety improvement plan with the term 'areas for improvement' being used as well as actions.
- Develop areas for improvement by identifying and understanding aspects of the work system that need to change to reduce risk and potential for harm (for example, areas for improvement). Actions to reduce risk (for example, safety actions) will then be created in relation to each defined area for improvement. It will be a collaborative process and aims to capture valuable insights that may not otherwise be considered.

OVERVIEW OF SAFETY ACTION DEVELOPMENT PROCESS

1. Agree areas for improvement, specify where improvement is needed, without defining how that improvement is to be achieved.
2. Define context, agree approach to developing safety actions by defining context.
3. Define safety actions to address areas for improvement:

    - Continue to involve the team, make this a collaborative process.

4. Prioritise safety actions:

    - Avoid prioritising action based on intuition or opinion alone.
    - Where possible, test prior to implementation

5. Define safety measures:

    - Identify what can be measured to determine whether the safety action is influencing what is intended
    - Prioritise safety measures (consider the practicalities of measurement)
    - Define measure including who is responsible for collecting, analysing, reporting and acting on the data collected.

6. Write safety actions, document in a learning response report or safety improvement plan as appropriate including detail of measurement and monitoring.
7. Monitor and review, continue to be curious and monitor if safety actions are impactful and sustainable. Safety actions will be SMART (specific, measurable, achievable, relevant, time-bound). They will also:

    - Be documented in a learning response report or in a safety improvement plan as applicable
    - Be concise and succinct.
    - Standalone, that is, readers should know exactly what it means without reading the report.
    - Make it clear and obvious why it is required (for example, given evidence in the learning response report or safety improvement plan), when finalising safety actions, we will continue to work with those to whom they are directed to ensure they are on board and willing to implement change.

SAFETY ACTION MONITORING

Safety actions will be monitored by the Beyond Limits to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions including the outcomes of any measurements will shared at the Operational Governance meetings.

SAFETY IMPROVEMENT PLANS

Safety improvement plans will bring together findings from various responses to person safety incidents and issues. They can take different forms. For example:

- Creating an organisation-wide safety improvement plan summarising improvement work
- Creating individual safety improvement plans that focus on a specific service or the support provided to an individual person.
- Collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying factors.

Beyond Limits will consider the approach best suited to the information we have (it may be a mixture of the above). The key will be to demonstrate why a specific safety improvement plan approach is the right one based on available data, the views of people involved, improvement priorities, safety incident profile(s) and insight from person safety incident responses.

There are no thresholds for when a safety improvement plan should be developed, for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

COMPLIANTS & APPEALS

This section should be read alongside our Duty of Candour Policy and our Complaints Policy.

Beyond Limits are committed to dealing with any complaints that may arise as quickly and as effectively as possible. In line with the processes set out in the person safety incident response framework, people who we support and their families, staff and other relevant individuals and professionals will be supported to be able to input into learning responses, person safety incident investigations and in the development of safety actions.

However, we fully recognise the people we support and/or their families may wish to complain. The reviewers and investigators of the person safety incidents will ensure that the people we support and their families have the required information in order to complain and will support if agreed to escalate to a formal complaint (Stage Two).

Complaints can be raised directly through our website.

EQUALITY, DIVERSITY & INCLUSION (EDI)

PRIVACY, DIGNITY & RESPECT

Beyond Limits are unequivocally committed to the principle that the people we support should feel that their privacy and dignity are continuously respected.

All procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity, and respect.

MENTAL CAPACITY ACT (2005)

Central to any aspect of care and support delivered to adults and young people aged 16 years or over will be the consideration of the individuals' capacity to participate in the decision-making process. Consequently, no intervention should be carried out without either the individual's informed consent, or the powers included in a legal framework, or by order of the court.

Therefore, Beyond Limits will ensure that all staff working with the people we support are familiar with the provisions within the Mental Capacity Act (2005) as required. For this reason, all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act (2005) to ensure that the rights of individual are protected and they are supported to make their own decisions where possible and that any decisions made on their behalf (when they lack capacity) are made in their best interests and least restrictive of their rights and freedoms.

Beyond Limits (Plymouth) Limited
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