BrisDoc Patient care by people who care

NHS

Learning Event Policy Patient Safety Incident Response Plan

Version:	Owner:	Created:
7.0	Sarah Pearce (Governance Manager)	01/03/2022
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13/11/2025	Rhys Hancock (Director of Nursing, AHPs and Governance)	13/11/2027

Contents

Introduction

BrisDoc is committed to providing safe, effective, and compassionate care by fostering a culture of openness, learning, and continuous improvement. Reporting and learning from both clinical and non-clinical events, including near misses, is central to this commitment and forms part of our statutory duties under the NHS England Patient Safety Incident Response Framework (PSIRF).

The reporting of learning events is fundamental to BrisDoc's risk management strategy. BrisDoc has a statutory duty to ensure that all users of our services are cared for in a safe environment; that staff can work in a safe environment; and that risks are reduced to a minimum. This policy supports:

- a non-punitive learning culture, where mistakes and near misses are openly reported, addressed quickly, and shared to prevent recurrence
- a rapid response to safety concerns
- staff to be empowered to report events, feeling supported and valued
- learning and improvement to be embedded into daily practice
- improvements in efficiency are identified while safe service delivery is protected

This policy also covers matters of:

- Duty of Candour
- BrisDoc's Patient Safety Incident Response Plan
- Notifications

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed. This Patient Safety Incident Response Plan (PSIRP) has been created with reference to the PSIRF resources available here: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

Scope

As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred and managed as follows:

- professional conduct/competence – referred to the people team/senior clinicians/PAG as appropriate
- establishing liability/avoidability – referred to claims or legal services
- cause of death – referred to the coroner's office
- criminal – referred to the police

As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

Aim

Our aim, through learning, is to:

- develop systems of care to improve quality
- improve the experience for patients, their families and carers
- improve the use of valuable healthcare resources,
- improve the working environment for staff in relation to their experiences of patient safety incidents and investigations
- increase efficiency
- act on feedback from patients, families, carers and staff about the current problems
- engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- promote ownership, rigour, expertise and efficacy in a system response to incidents

Importantly this policy seeks to make effective use of resources by emphasising the quality of investigations over the quantity of investigations, making them more proportionate.

Responsibilities

Executive Directors

- Ensure risk management systems, resources, and governance are in place across all BrisDoc services. The provision and implementation of this policy and its compliance with the Patient Safety Incident Response Framework sits with the Director of Nursing, AHPs and Governance.

Heads of Service

- Promote a safe reporting culture, support staff to report events and following events (which may include Occupation health referral and the application of other relevant policy), oversee learning event investigations managed by their service/team, and ensure timely feedback to staff and the governance team.

All Staff

- All co-owners, bank/agency staff, volunteers, and contractors should report learning events, including near misses, and comply with this policy, including cooperating with any investigation.

Governance Manager

- Central contact for monitoring, reporting, and analysis of learning events (including reporting of themes) ensures external liaison and reporting and escalating where required.

Programme/Service Directors

- Lead responses to system failures affecting business continuity.

Caldicott Guardian/IG Lead

- Lead on information governance or data security events.

Definitions

Learning event

The generic term learning event is defined as '*any clinical or non-clinical adverse event, including near misses, that resulted in harm or had the potential for harm, or a risk'* to:

- Staff
- Patients
- Members of the public/ visitors
- External contractors
- Property
- Information integrity or security
- System functionality
- Reputation

This may include personal injury, ill health, harm, patient dissatisfaction, property and vehicle loss or damage, system(s) failure, failure to adhere to a policy or procedure.

Significant Incident

BrisDoc follows NHS England guidelines when assessing the criteria to decide if an event meets the threshold to be declared as a Significant Incident (SI):

"Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response."

Reference: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Examples include:

- Unexpected or avoidable death(s)
- Severe harm or events requiring further treatment to prevent harm or death
- Never Events
- Major system failures affecting service delivery

Further information on cases which require referral to other bodies or teams for review or PSII (described in the PSIRF) should be used to inform decision making and is available in Appendix Two.

Patient Safety Incident Investigation (PSII)

The aim of a patient safety incident investigation (PSII) is to:

- conduct systems learning and safety improvement
- identify the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents
- target action using strong (effective) system improvements to prevent or measurably reduce repeat patient safety risks and incidents

There is no remit in PSII to apportion blame or determine liability, preventability or cause of death. A template to support the delivery of a PSII is provided in appendix Three.

The Learning Process

Reporting

All learning events MUST be reported as soon as practicable.

- Corporate Services & Severnside
  - via the learning event portal (https://learning event.brisdoc.co.uk)
- Practice Services
  - via GPTeamnet (see appendix for how to use)

Investigating the Event

Most learning events will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. Different review techniques can be adopted, depending on the intended aim and required outcome. Some examples are:

Technique	Circumstances	Aim/Outcome
Simple Debrief (May be Hot or Cold)	Single person involved and learning does not extend beyond individual reflection	To conduct a post-incident review by discussing and answering a series of questions.
Learning Event Management Plan	Formulation of an event which linked multiple people or factors that need exploring but remain in the 'known' space and within BrisDoc service delivery.	A robust incident review with clear recording of findings and risks. With consideration given to system factors and the opportunity to escalate to higher level review if required.
After Action Review (AAR)	Formulation of an event which linked multiple people or factors that need exploring but main be in the 'unknown' space or extend beyond BrisDoc's service delivery.	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
Specialist Review	LeDeR (Learning Disabilities), Perinatal and other Mortality Reviews	Systematic, multidisciplinary, high-quality audit and review to determine the circumstances and care leading up to and surrounding the death

Immediate Safety Actions must be considered and implemented in all techniques. In addition, there may be specific processes defined by other policies which may apply following a learning event. E.g. medicines management.

Selection of events for PSII

The selection of an event or events for PSII is based on the:

- actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc)
- likelihood of recurrence (including scale, scope and spread)
- potential for new learning in terms of:
- enhanced knowledge and understanding of the underlying factors
- improved efficiency and effectiveness (control potential)
- opportunity to influence wider system improvement.

In additional to locally a determined event/theme of events as defined by the assessment above. **Any event which meets the definition of a Significant Incident (above) will be managed via PSII.**

For the avoidance of doubt, where the score is high or moderate, please contact the governance team who can advise on whether a PSII, AAR or specialist review are required.

Timescales for Events

All Learning events should be investigated, and where appropriate an action plan put in place within one month of the learning event being reported

PSII Timescales

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

PSIIs should ordinarily be completed within one to three months of their start date. But, in exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Delays

Where the processes of external bodies delay access to some information, a completed learning event or PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Assessing Risk

The risk as a result of the event should be assessed in accordance with BrisDoc's Risk Management Policy.

Recording of risk scores is included at multiple stages of the learning event process.

Notifications & Reporting

Where the threshold for a Significant Incident (SI) – see definitions - has been met, the necessary Patient Safety Incident Investigation report will be completed within the agree deadlines.

This will include liaison with:

- ICB
- NHSE (via the PSII reporting system)
- HSIB

Any event will be reported to external bodies (including statutory agencies) in the timescales required when necessary. Examples include:

- Suspect adverse drug reaction to the UK-wide yellow card scheme run by the medicines and Healthcare Products Regulatory Agency (MHRA)
- Medical devices issues to the MHRA
- Care Quality Commission
- Police

Insurer

All serious learning events and significant events that may give rise to legal or indemnity claims will be reported promptly to insurers in line with CNSGP (e.g. Negligence), CNA (e.g. Inquest) and other contractual obligations. This will be managed by the Governance Team. Where in doubt, advice will be sought from the insurance broker via the governance team and notification will be submitted for the avoidance of error.

Failure to notify about a relevant **circumstance*** may result in legal support or a claim not being covered by the policy. Such notice should include:

- details of what happened and the services and activities that were being performing at the relevant time; and
- the nature of any, or any possible, bodily injury; and
- details of how BrisDoc first became aware of the claim or circumstance; and
- all such further particulars as the insurer may require.

*A "**circumstance**" is defined in the policy as:

"Any circumstances of which you become aware, or should reasonably have become aware, that may reasonably be expected to give rise to a Claim."

Some examples include but are not limited to:

- Any complaint, written or verbal, in which the patient or patient's representative expresses dissatisfaction regarding the treatment received and alleges that, as a result, the patient suffered bodily injury.
- A request for access to medical records received from a solicitor or third party on the basis that a claim against you/the service is being contemplated.
- Any learning event in which a Significant Event/PSII Report is generated.
- Any unexpected or unusual death of which you become aware.
- Any adverse outcome or clinical "near miss" in which you believe there may have been a negligent act, error or omission, irrespective of whether the patient is aware of this or whether the patient or patient's representative has made a complaint.

Documented

Where the event is very simple (only required a debrief), and does not require any further action, a summary can be provided via email from the investigating manager. The event can then be closed with this evidence only. This is at the discretion of the governance team.

Otherwise, all steps and information related to the learning event, its investigation, and actions will be recorded via the Learning Event Management Plan (Appendix One) and logged on the relevant system.

Where a PSII is instigated, the full report and template will be used.

All other correspondence and notifications will be recorded logged and stored via the Learning Event management system.

Complaints and appeals

Where a complaints or appeals is related to BrisDoc's response to a patient safety incident, these should be referred to the Public Health Service Ombudsman (https://www.ombudsman.org.uk/).

Being Open & Duty of Candour

BrisDoc is committed to openness, honesty, and transparency when things go wrong. In line with Regulation 20 of the Health and Social Care Act 2008, staff have a **statutory and professional duty of candour** to be open with patients, relatives, and carers ("relevant persons") following a safety incident that results in harm.

Key principles:

- **Report and investigate** all incidents promptly, using the NHSE patient safety framework and this policy, where appropriate.
- **Communicate openly** with the relevant person as soon as possible, led by a senior clinician/manager. Discussions must be factual, compassionate, and avoid jargon.
- **Apologise appropriately**, ensuring the apology includes what happened, how harm is being managed, and what will be done to prevent recurrence. Apologising does not mean admitting legal liability.
- **Support patients, families, and staff**, recognising that all parties may experience distress. Additional support (e.g. advocacy, bereavement counselling, occupational health) should be offered where needed.
- **Special considerations** apply for children, people with mental health needs, those lacking capacity, bereavement situations, and where translation or cultural support is required.
- **Maintain confidentiality** and comply with GDPR/DPA 2018 when sharing information.
- **External reporting** may be required to regulators, commissioners, NHS Resolution, MHRA or CQC.

- **Learning and improvement**: Incidents must be used to identify system improvements, training needs, and audit actions to reduce future risk.

BrisDoc will ensure staff are supported throughout this process and will foster a culture where raising concerns, learning from incidents, and communicating openly are core to safe, high-quality care.

Supporting Patients & Their Relatives/Carers

Being open means to acknowledge, appropriately apologise and explain the event and learning taken during the investigation. This should be done wherever practicable, but always where and event has led to moderate harm or above and all events for which an PSII is undertaken.

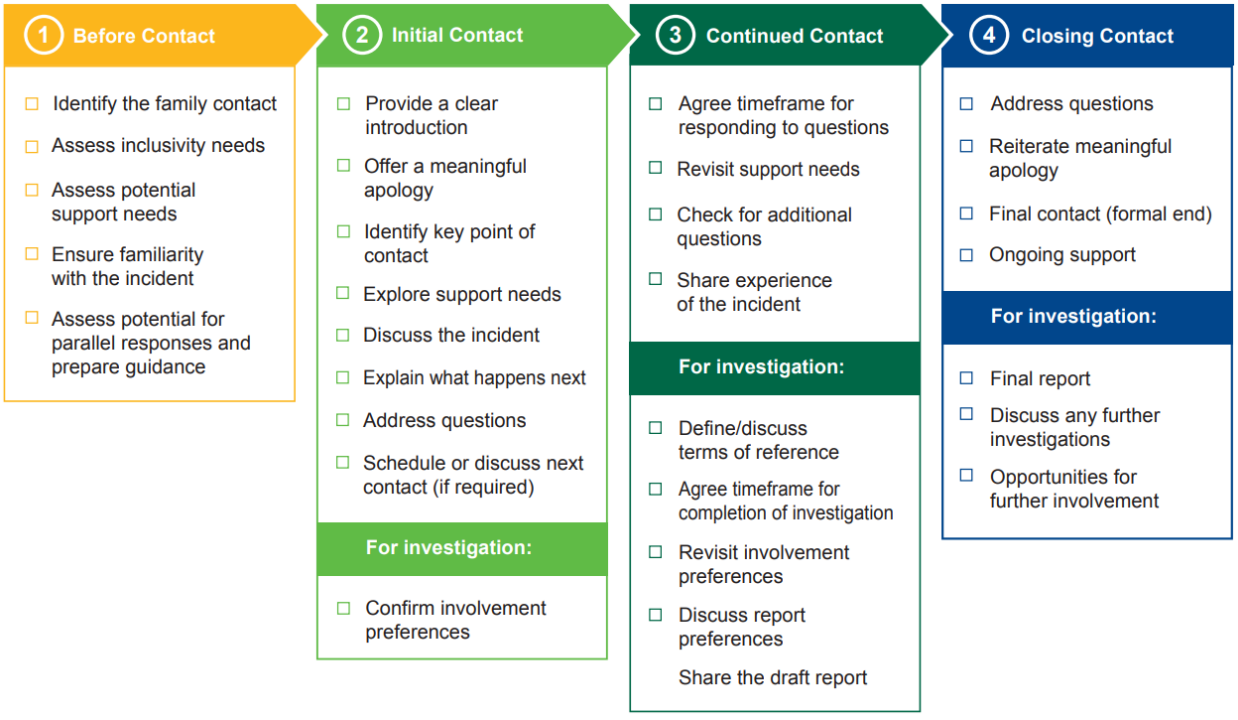
Where there has been a patient death or serious harm, then a director or their deputy will hold the duty of candour conversation unless there are exceptional circumstances.

All duty of candour conversations should be recorded. Either audio or written notes which are confirmed as accurate by all parties.

Information and learning regarding serious patient related learning events must be provided as soon as practical after the event and where appropriate to relatives/ carers.

If a patient feels that they need further information or support, they should be referred to their GP for additional support.

The below figure summarises the steps to consider when contacting a patient/their family or carer after an incident.



Patients Who Do Not Wish to Participate or Disagree

Sometimes, despite the best efforts of staff, the relationship between the relevant person(s) and the healthcare professional is difficult or breaks down altogether. They may not accept the information provided, may desire a higher level of investigation or may not wish to participate in the process.

Ensure they are aware of formal complaints procedures, including NHS complaints and independent advocacy services. If relations are strained, offer support services, consider postponing discussions, use an impartial mediator, and document all actions and statutory duties.

Young People (16+ Years)

Young people 16 or older can legally consent to treatment and may be seen alone. Best practice involves including parents/carers with the young person's agreement.

People with Mental Illness

If disclosing information may cause psychological harm, it may be advisable to withhold it. A second opinion is recommended.

Patient consent is usually required before informing carers or relatives. Always follow the Mental Capacity Act and assess capacity as needed.

Where learning disabilities exist, parental/carer involvement may be appropriate with consent.

People Who Lack Capacity

If a patient lacks capacity, notify their legal representative (e.g., family, IMCA, lasting power of attorney). Involve the patient where possible, clarify the authority of any power of attorney, and act in the patient's best interests if no representative exists. Advocacy support should be offered to assist communication.

Translation and Communication Needs

Provide formal translation services for patients with limited English. Plan meetings to address communication needs and avoid unofficial translators (family/friends) to prevent miscommunication.

Cultural Considerations

Consider cultural sensitivities, such as gender preferences of staff. Seek guidance from advocates or translators on sensitive discussions to ensure culturally appropriate communication.

Bereavement

For incidents resulting in death, offer prompt verbal apologies and condolences. Consider relatives' emotional state when planning discussions and involve them in deciding timing.

Coordinate communication with the coroner and keep relatives informed, providing support as needed. In cases in which the coroner is involved, the aim will be to have a discussion and investigation before a Coroner's Inquest, whilst noting the coroner's report on post-mortem findings is a key source of information that will help complete the picture of events leading up to the patient's death.

Continuity of Care

If the incident occurs within a BrisDoc GP practice and results in a patient expressing a preference for any future healthcare need to be managed by a different person within BrisDoc, or indeed at a completely separate GP Practice.

Supporting and Feedback to staff

Staff will have the option to ask for feedback about the outcome of the investigation into the learning event they reported. Providing feedback is the responsibility of the investigatory manager working with the line manager as appropriate.

Welfare Link

It is essential that BrisDoc staff are themselves actively supported throughout the investigation, because they may be suffering stress or anxiety as a result of the event.

Where applicable, staff may be offered external counselling support and/or occupational health advice in addition to supportive meetings with their Line Manager and/or HR. In cases in which the staff involved are self-employed, the senior nominated manager will make a judgement about ongoing support for that individual.

Training

To comply with PSIRF, the following standards of training and education must be met. All training will be logged via BrisDoc's Development Hub. Levels one and two will be logged via mandatory compliance processes.

Role / Staff Group	Training Requirement	Frequency	Delivery Method	Source / Link
All Staff	Level One – Essentials for Patient Safety	Induction + Annual refresher	Development Hub e-Learning	NHSE elfh Hub
Clinical & Non-Clinical Leaders / **Managers (Investigators)**	Level Two – Access to Practice	Induction + Annual refresher	Development Hub e-Learning	NHSE elfh Hub
Governance Manager & Director of Nursing, AHPs and Governance	- NHS England PSII Investigation Training - Human factors & systems analysis - Writing proportionate, learning-focused reports - Engaging patients, families & staff compassionately - Data security & IG in investigations	Initial training + Ongoing CPD	HSIB Training	HSIB - A systems approach to investigating and learning from patient safety incidents
Senior Leaders, **Directors** and **Board Members / NEDs**	Level one - Essentials of patient safety for boards and senior leadership	Induction + Annual update	Development Hub e-Learning	NHSE elfh Hub

	teams PSIRF vs Serious Incident Framework			

Additional training can be supported where requested via the Governance team. It is recognised that training will be delivered as part of the introduction of this PSIRP and therefore, not all roles will have been through the training prior to introduction.

Governance and Oversight

Learning events will be reviewed and discussed at regular learning event meetings across all services. In addition, the SevernSide Quality Group meeting is attended by Practice Plus Group colleagues.

The meetings will focus on collated learning events, complaints, and receive any feedback of learning and actions put in place relevant for sharing. Action points will be discussed and learning outcomes developed to ensure that BrisDoc learns from all learning events and puts processes in place to ensure risk of recurrence is reduced as far as is practicably possible.

Each Service will provide a monthly report to the Quality Board which will summarise learning events, incidents and complaints, providing an analysis of learning and trends. The Quality Board will then create the space for additional cross service learning and agree and monitor action plans that will reduce occurrence and manage risks.

The Quality Board will also escalate any incidents which meet the threshold for a PSII to the BrisDoc Trust Board.

Evaluating and monitoring Outcomes

Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story. Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

Improvement work should be shared to enable monitoring and demonstrate successful and sustainable adoption, and that the changes have measurably reduced risk of repeat incidents.

Reports to the board will include:

- Patient safety incident reporting overview
- Findings from PSIIs and wider themes related to learning events
- Progress against the PSIRF and areas identified within this PSIRP
- Results from improvements following implementation of actions from PSII
- Results of surveys and/or feedback from patients/families/carers on their experiences
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents

Version Control

Date	Version	Author	Change Details
June 2009	1	Dixine Douis	Initial Document
June 2010	2	Dixine Douis	Minor Changes
Jan 2012	3	R Channing - Brown	Minor Changes
April 2013	3.1	Dixine Douis	Minor personnel changes
Nov 2013	4	Clare – Louise Nicholls	Minor Changes
April 2015	4.1	Clare – Louise Nicholls	Minor Changes
July 2015	4.2	Clare – Louise Nicholls	Addition of Caldicott Guardian Role
Sept 2015	4.3	Clare – Louise Nicholls	Inclusion of New Timescales
28.6.18	4.4	Clare-Louise Nicholls	Inclusion of the learning event portal, new learning event categories. Update learning event descriptors. Remove learning event form in appendices. Update reporting procedure to reflect use of the portal.
01.05.20	5	Sarah Pearce, Clare-Louise Nicholls	Updated Core values. Removed reference of DAC and replaced with LERIS Replaced updated IMP to include quality impact Job title/boards/groups updates Refresh insurance requirements post CNSGP Removal of change register pre-2018. Updated appendix 1 to new version. Update risk appendices in accordance with update risk management policy
28.03.22	6	Sarah Pearce	Changed reference from Incident to Learning events to reflect change in process. Added 5-point plan as appendix.
10/0/2023	6.1	Sarah Pearce	Changed SI definition to align with NHS England guidance
06/02/2024	6.2	Linda Meekhums	Extended the ‘being open’ information and add the original ‘being open’ policy as an appendix for future guidance.
13/11/2025	7.0	Rhys Hancock & Sarah Pearce	Full review and update to align with PSIRF

Appendix One – Learning Event Management Report

LERIS Reference:		**Target Date:**	
Location of the event:		**Closure Date:**	
Date & Time of the event:			
Service Areas disrupted:			
Duration of the event:			
Reported By: *(inc contact details)*			
Information Used: *(e.g. Records, call recordings, discussions)*			
Summary of the Event			
Initial Assessment of Risk *(Refer to Risk Management Policy)*			
	Severity	**Likelihood**	**Total**
Severity x Likelihood = Total			
Key Learning *(Consider patient, colleague, education, equipment, environment, organisational, and system factors)*			
Does this event need escalation to a higher-level review to draw effective systems learning?			
Action Plan *(Inc. immediate actions taken, planned actions, any continuity plans used, and third part contact and involvement in the review)*			
Action	Owner		Deadline
Residual Assessment of Risk *(Refer to Risk Management Policy)*			
	Severity	**Likelihood**	**Total**
Severity x Likelihood = Total			
Feedback Issues to Reporter *(Inc. By Whom, email/telephone, and a summary of the feedback)*			
Return this plan to brisdoc.governance@nhs.net			

Appendix Two – Cases Requiring PSII

National Priorities

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are:

- maternity and neonatal incidents:
- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme · all perinatal and maternal deaths must be referred to MBRRACE
- mental health-related homicides by persons in receipt of mental health services or within six months of their discharge
- must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)
- child deaths (Child death review statutory and operational guidance):
- incidents must be referred to child death panels for investigation
- deaths of persons with learning disabilities
- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme
- safeguarding incidents
- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation e. incidents in screening programmes:
- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)
- Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract:
- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

Nationally Defined Incidents for Local PSII

Nationally defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

- incidents that meet the criteria set in the Never Events list 2018
- incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan, or following reported concerns about care or service delivery.

- deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
- deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
- deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS
- suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

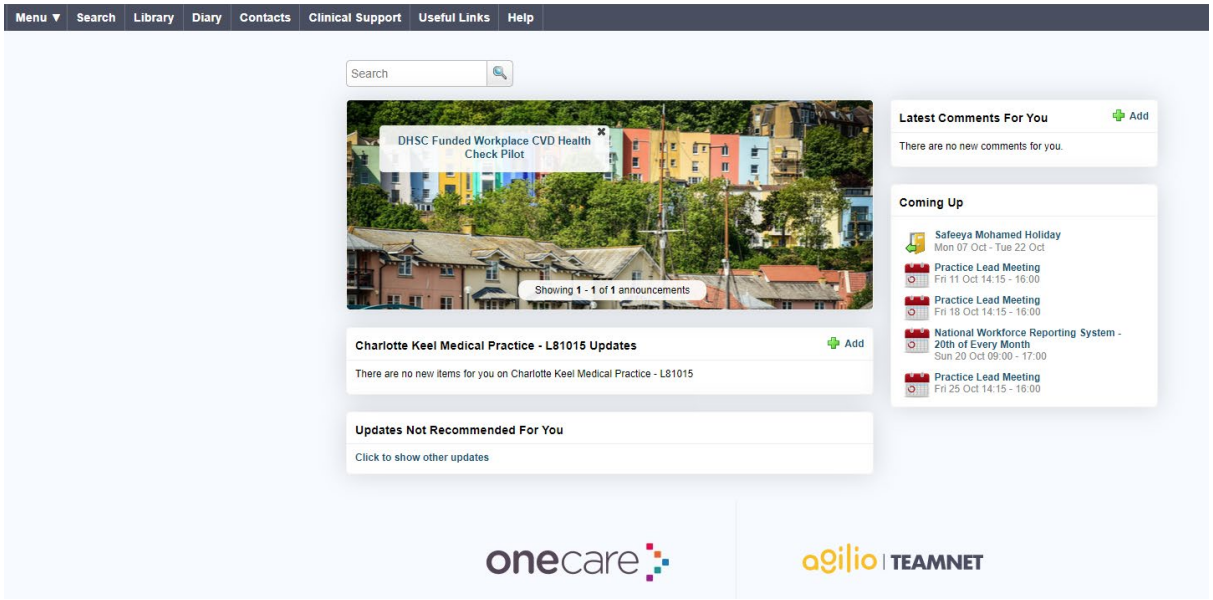
Locally defined incidents requiring PSII

Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII may have been set by the local system, these could include:

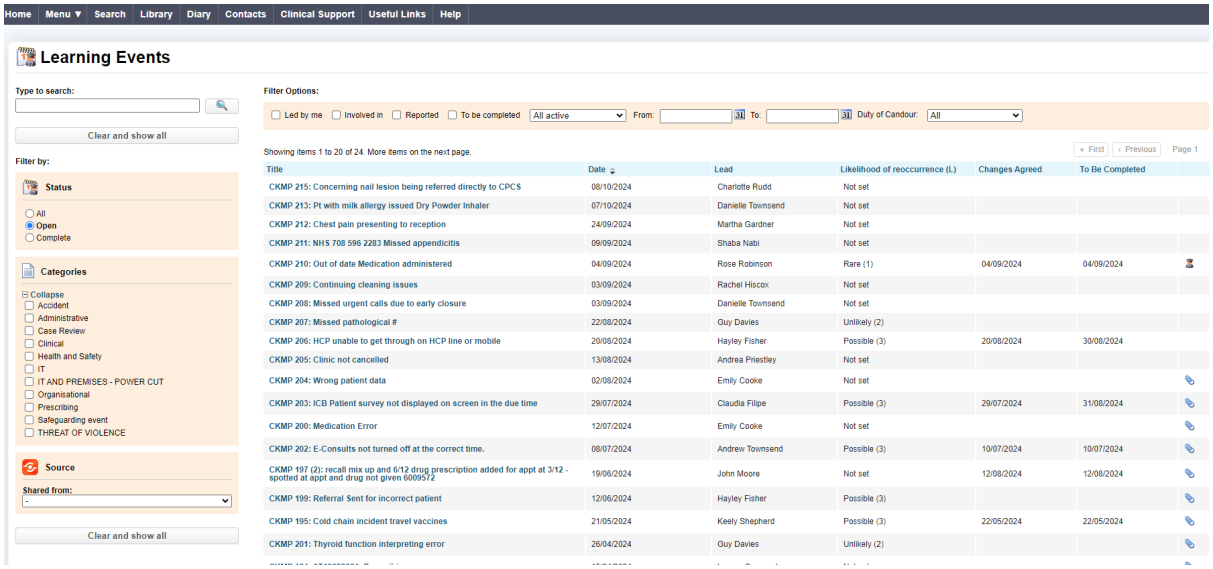
- Locally defined emergent patient safety incidents requiring PSII. An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.
- Locally predefined patient safety incidents requiring investigation. Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years) and agreed with the commissioning organisation(s) as a local priority.

Team Net Recording

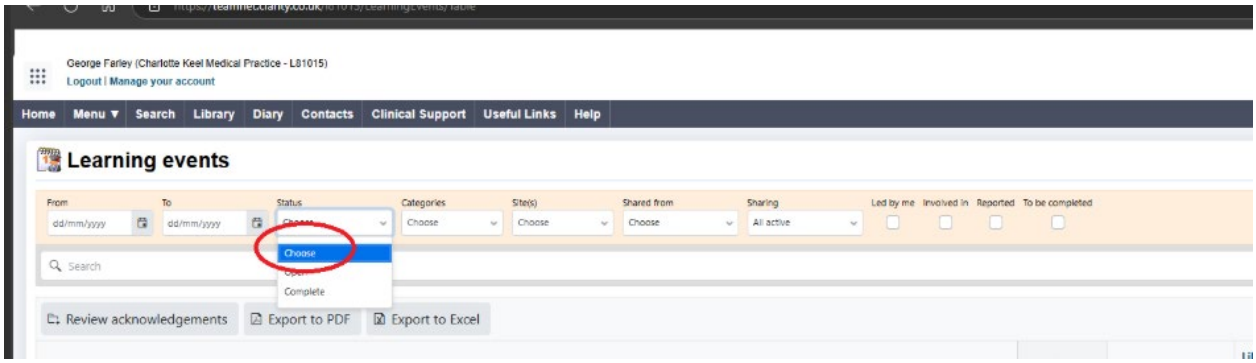
Open Team Net (An individual log in is required for this) https://agiliosoftware.com/login/



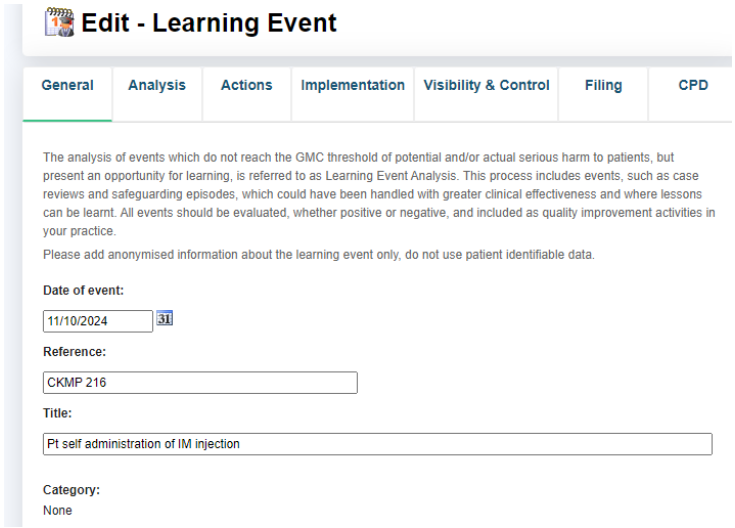
Select the following: Menu → Management → Learning Event



Take note of the last title number - If you click at the top to show you all of the Learning Events (not just the closed/open ones) as shown in the screenshot below, it will tell you what the next number will be.



Top right corner: ADD learning event



Reference: Enter “CKMP and Number”

Title – Learning event identifier

Click Analysis – complete as per boxes

Actions – add any actions with completion date – This will need updating when completed

Implementation - Any changes to practice agreed as result of LE. This will need updating when completed

Visibility and control – Choose anyone linked to Learning event – this allows them to view and reflect on LE.

Filing – please file under the following if appropriate – this links all the events and allows for audit of themes/current trends

- Safeguarding
- Medication
- Infection control

The LE are then added to the relevant meeting agenda for discussion

Appendix Three – PSII Template