Wirral Community Health and Care
NHS Foundation Trust

Information Leaflet

Responding to patient safety incidents

Information for patients and carers - Patient Safety Incident Response Framework (PSIRF)

Responding to patient safety incidents

More than a million people are treated safely in the NHS every day. Occasionally, things can go wrong, or an unexpected event occurs. These are known as patient safety incidents.

NHS England defines a patient safety incident as an **unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare**. There are a range of incidents for example a **no harm** incident could be a missed dose of medicine, a **near miss** for example could be where a clinician is about to treat a patient and new information is received which changes the treatment. This is classed as a near miss as the staff member only received the information by chance before carrying out the original agreed care or treatment.

In almost all cases, incidents occur because of problems in the system people work in, and not because individuals meant to cause harm. It is important that we learn from patient safety incidents, so that we can try and prevent them from happening again.

Wirral Community Health and Care NHS Foundation Trust will use the **Patient Safety Incident Response Framework (PSIRF)** which is the way that patient safety incidents are responded to and how patient safety investigations are undertaken in NHS funded care.

The Patient Safety Incident Response Framework (PSIRF) required our organisation to develop a **Patient Safety Incident Response Plan (PSIRP)** in agreement with Cheshire and Merseyside Integrated Care Board. The Patient Safety Incident Response Plan (PSIRP) supports the trust to identify our most significant patient safety risks and focus on these

risks to ensure they are fully investigated according to patient safety investigation standards. **Patient Safety Incident Response Policy and Plan - Wirral Community Health and Care NHS Foundation Trust (wchc.nhs.uk)**.

How will I know if a patient safety incident has occurred?

If it is believed that something has gone wrong during your care, that has caused you moderate or more severe harm, you will be told about this immediately. The Trust will always be open and honest about patient safety incidents that have occurred and will provide support, this is known as 'Duty of Candour'. You will receive an explanation of the circumstances around the incident and an apology from the Trust.

What if I think something has gone wrong or a patient safety incident has occurred?

Please tell the team caring for you immediately, they can provide treatment which may be required. A family, friend or carer can also act on your behalf. The care team will report the incident and it will be reviewed according to the PSIRP which will enable the Trust to learn from the incident.

What happens if I have been harmed?

We will treat you straight away. We will also ensure your support needs are met and listen to you. The incident will be recorded. We will give you the facts. We will say **Sorry**.

What if I am not happy with the information I receive and/or the response that is taken?

Please raise any concerns with a member of the team caring for you alternatively you can contact **wcnt.yourexperience@nhs.net**

What happens if someone has died?

The death of someone, even if expected, can be a very distressing and difficult time for family and loved ones. Dedicated support and information about how we review and investigate the care provided to those who have died, including information about a Coroner's inquest, is available via our information guide for bereaved families and through our bereavement service.

Further information on how to access further help and support is available via the following link: **www.cruse.org.uk /get-support/helpline/**. Alternatively, you can telephone for free 0808 808 1677 the helpline is open Monday, Wednesday, Thursday, Friday 9.30am - 5.00pm, Tuesday 1.00pm - 8.00pm. Saturday and Sunday closed.

What can I expect if I am involved in a patient safety incident investigation?

If you are involved in a patient safety incident investigation your dedicated point of contact person will arrange to meet with you. You can ask a friend or family member to join for support or to speak on your behalf if you do not feel able to do so. We will do all we can to support you.

Details of your dedicated contact will be provided to you. They will be available Monday to Friday from 9.00am to 5.00p.m. We are committed to supporting and involving patients and families to the extent they wish, and in accordance with patient safety investigation standards. If you would find it helpful your dedicated contact can provide you with a copy of the patient safety investigation standards and discuss them with you.

During the investigation we will ask you to help in several ways.

This includes:

- Telling us about any issues or concerns you have about the care and treatment provided
- Sharing questions, you would like answered
- Describing your experience and giving your account of what happened to help us establish the facts about the incident and how it happened
- Reviewing the draft investigation report
- Helping to inform recommendations and action for improvement
- Keeping us up to date with how you are feeling and whether there is more we can do to support you
- Providing feedback about your experience of the patient safety incident investigation

If you are happy to be involved, we will work with you to understand how we can support your involvement in each of these areas. If you wish to have support from an independent advocacy service, we can also discuss this with you.

Proposed time frames will be shared with you, and we will keep you updated throughout the investigation process. We endeavour to complete all investigations within 1 to 3 months. Once the investigation is complete, we will send you the draft report and arrange a meeting to discuss this with you.

Within the report, information may be anonymised. For example, it may use terms like **the patient**, or **the nurse**, rather than giving their names. This may appear insensitive but that is not the intention. This may be due to various reasons such as General Data Protection Regulation (GDPR).

The finished report will be signed off by the Clinical Risk Management Group (CRMG). Actions to reduce future risk may need to begin immediately.

We will continue to monitor improvement plans to determine whether the changes we are making are actively reducing risk and improving patient safety. This will be overseen by the Patient Safety Incident Response Framework Review and Oversight Group. We will continue to keep you updated with the progress being made.

You may want to tell us about your experience for us to work towards continuous improvement. Your dedicated named contact will ask you and any family members to complete a survey, they will go through this with you and provide necessary support if required. Information you provide will be used solely for the purposes of improving our services.

Information will be collected anonymously.

Contact details

If you have any queries or concerns about the content of this leaflet, please email:

wcnt.yourexperience@nhs.net

You can also share any concerns you have about our services with the Your Experience Team.

Department: Quality and Governance
Division: Corporate
Production date: October 2024
Review date: October 2025
Clinical Assurance Group Approved October 2025

If you would like this information in another format or language, please contact the Your Experience Team on freephone 0800 694 5530. Alternatively you can email wcnt.yourexperience@nhs.net