Patient Safety Incident Investigation (PSII)

What to expect and how you can be involved

Patient Information factsheet

Why have I been given this booklet?

- We are sorry to hear that you, a family member, or someone you care for has been involved in a patient safety incident whilst under the care of the Whittington Health.
- It is important to us that we listen, understand and learn from your experience. The incident will be reviewed as part of a Patient Safety Incident Investigation (PSII). This booklet is designed to provide you with information about what to expect of this process and how you can take part in it, if you wish to do so.
- We understand that the investigation cannot change what has happened in your case, but the primary goal of a PSII is to help the Trust in understanding what happened. This is so that we can learn how things can be changed and improved to prevent it from happening again.
- Your involvement in this process is important, so that you can understand what happened and how we as a Trust are committed to change and improve.

What is a patient safety incident?

The definition of a patient safety incident is: **"Unintended or unexpected harm to people during the provision of health care. We aim to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm"** Patient Safety Incident Response Framework (PSIRF).

PSIRF is a framework followed by all NHS Trusts in England in how to identify and respond to patient safety incidents. If you would like to read more about PSIRF, you can find it here: **https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/**

What is a patient safety incident investigation?

- Patient safety incident investigations (PSII) take place to identify new opportunities for learning and improvement. The focus is on improving our healthcare system. A key aim is to provide a clear explanation of how an organisation's systems and processes have an impact on patient safety incidents.
- Whilst recognising that mistakes take place, these investigations would examine system factors, such as the technologies used and the work processes, involved

in each case. This allows the findings to be identified and analysed to help ensure improvements are made in the future.

- PSIIs start as soon as possible after an incident has taken place and these investigations can take several months to complete. However, some cases could last longer if required or needed.
- If an investigation identifies a high-level risk that requires immediate action, this will be implemented as soon as possible. Some actions for system improvement may not take place straight away but will take place on a later date once the new system is set-up.
- The investigation team follow the Duty of Candour (DoC) and involve patients, families and staff after a patient safety incident. This enables us to help identify the events that took place and how this resulted in a patient safety incident.
- Further information on Duty of Candour can be found here: **https://resolution.nhs.uk/resources/duty-of-candour-animation/** or visit the Care Quality Commission (CQC) website at: **https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour**
- PSIIs are led by a senior investigator who is trained to conduct and analyse the incident for learning. The investigation will follow the guidance set out in the Patient Safety Incident Response Framework (PSIRF) and in the national patient safety incident response standards.

What to expect?

Initial conversation

- As soon as possible after the incident, it will be discussed with you and an apology given. This is known as the 'Duty of Candour', which all hospitals legally need to follow to make sure they are being honest and open when things go wrong.
- We will send you a letter to explain the timelines of the incident. A written record will be kept of all meetings and communications.

Starting the investigation

- Once the Trust has identified that a patient safety incident investigation is the appropriate response, a lead investigator will be appointed. This will be a specially trained member of staff to lead the investigation, who was not involved in the care provided.
- They will conduct a detailed investigation to identify how it happened and the organisational factors that resulted in the patient safety incident.

Informing you of the investigation

- You will be contacted either by the investigation lead or an allocated person of contact and they will talk to you about the incident and the investigation process.

- They will explore your support needs and how you would like to be involved in the process including how and when you would like to be contacted.
- They can arrange for you to share your experience and provide any questions or concerns that you would like answered as part of the investigation. If any of your questions are outside the scope of the investigation, you will be directed towards the right people to answer this for you. They will keep you informed of progress and timescales as you prefer.
- Here is a list of ways you can get involved:
    - To share experience of the incident
    - To ask any questions that you would like looked at in the investigation
    - To see a copy of the draft report
    - To see a copy of the final report and the opportunity to discuss it.

Scale and scope of the investigation

- The scale of the investigation will depend on its complexity and whether your case is the only incident being reviewed as part of the investigation. In some cases, there may be more than one similar incident being investigated together.
- The scope of the investigation is set out in the 'Terms of Reference'. These act as a guide for those involved in the investigation. You will be made aware of what will be included and what questions need to be answered.

Gathering the information

- Relevant information will be gathered to answer the questions set out in the 'Terms of Reference'. This information will be used to understand exactly what happened and why.

Analysing the information

- After we have formed a clear picture of what happened, we will explore all the different factors that may have contributed to the incident.
- A systems-based method will be used to identify areas that need to be improved.
- Specialists (who have relevant knowledge and expertise) will support the lead.

Writing the report

- Once the lead investigator has written their findings, they will send it to relevant area/service leads for review. This ensures that the information is accurate, and actions are achievable.
- Your person of contact will contact you if you have requested for the draft report to be shared with you to check that the information is factually correct. The final report will be taken to our Trust Board for approval.

Closing the investigation

- At the end of the investigation, you will be offered the final report which provides the findings and conclusion of the investigation.

- We understand that this may be a difficult time, and we will offer you a meeting to discuss the findings and ask any questions you may have.

Opportunities for further involvement

- Once the investigation is complete, you may be able to get involved in sharing your experience to drive improvements. Please discuss with your person of contact if this is something you would be interested in.
- Hopefully, you will be able to move forward feeling reassured by the investigation outcome. Your valuable involvement will also help to reduce the risk of the same thing happening again.

What if I am not happy?

- If you are unhappy with the investigation firstly speak to your person of contact to see if the problem can be resolved.
- The investigation should have answered most (if not all) of your questions.

General Support Services

- You can find general support resources and information about local services at **www.mind.org.uk**.
- **www.samaritans.org**. Their support is available 24 hours a day, 7 days a week, 365 days of the year.
- **www.bereavementcare.uk**.
- For child bereavement - **https://www.childbereavementuk.org/about-our-helpline** or you can call 0800 028 8840
- **www.citizensadvice.org.uk**. You can also call an advisor on 0800 144 8848

Contact our service

If you have any further questions, please contact the team at whh-tr.patientsafetyteam@nhs.net

Contact our Trust

If you have a compliment, complaint or concern, please contact our Patient advice and liaison service (PALS) on **020 7288 5551** or **whh-tr.PALS@nhs.net**.

If you need a large print, audio or translated copy of this leaflet, please email **whh-tr.patient-information@nhs.net**. We will try our best to meet your needs.

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