Root Cause Analysis

The recognised system-based method for conducting an investigation is known as Root Cause Analysis (RCA) and this will be applied to a Serious Incident investigation in line with the national framework.

Other specialists may be involved in an investigation or they may request to be made aware of the outcome; this could include colleagues from within the Safeguarding team, Patient Experience team, or the Inquest team. We may also request an opinion/view from our colleagues in neighbouring hospitals.

The Trust also undertakes other types of investigations, which may be used when the patient safety incident does not meet the Serious Incident criteria of the national framework, or used alongside:

- Mortality Screening – Structured Judgement Reviews (Learning from Deaths Framework)
- Mortality & Morbidity Reviews*
- Cardiac Arrest Reviews
- Safeguarding Vulnerable Adult/Child Case Reviews
- Local Reviews

Each will have their own robust process to extract the outcome and learning.

*Mortality – subject to death; Morbidity – incidence of ill health

Timeframes

The national timeframe for completing a Serious Incident investigation is within 60 working days. Your named contact will keep you informed of any delays during the investigation process, as under certain circumstances extensions to this timeframe may be applied.

Your named contact is:
Contact telephone number:
Contact e-mail:

We Value Your Views On Our Service

If you wish to comment on the care which you, your relative or friend has received, we will be pleased to hear from you. Please speak to the person in charge of the ward, clinic or service in the first instance or ask them to contact the PALS Team. If you wish to contact them directly, telephone on **01983 534850**.

Alternatively you may prefer to write to:

Chief Executive
Isle Of Wight NHS Trust
St Mary's Hospital
Newport, Isle of Wight, PO30 5TG

You can also share any concerns you have about our services with the Care Quality Commission (CQC) on **03000 61 61 61** or at **enquiries@cqc.org.uk**

All NHS sites are no smoking areas.

If you would like help and advice to stop smoking please call: Freephone 0800 169 0 169 to talk to the NHS Smoking Helpline.

QG/SI/01

NHS
Isle of Wight
NHS Trust

Patient Information Leaflet

Serious Incidents
(Patient Safety Incidents)

Information for patients and their family / carers

Produced by:
Quality Governance

Date: April 2019
Review due: April 2022

SMOKEFREE
Isle of Wight

If you are unable to read this leaflet because English is not your first language, please ask someone who speaks English to telephone PALS on 01983 534850 for further information and help.

Polish:

Jeśli nie jesteś w stanie przeczytać tej ulotki bo angielski nie jest pierwszym językiem, poproś kogoś, kto mówi po angielsku, o kontakt telefoniczny z (PALS 01983 534850) aby uzyskać więcej informacji i pomoc

Russian:

Если вы не можете прочитать этот буклет на английском языке потому что не является первым языке, пожалуйста, попросите кого-нибудь, кто говорит на английском языке для телефонного (PALS 01983 534850) для получения дополнительной информации и помощи

Turkish:

Eğer İngilizce ana diliniz değilse, çünkü bu broşürü okumak için yapamıyorsanız, daha fazla bilgi için 01983 534850 üzerinde PALS telefon İngilizce bilen birine sormak ve yardım lütfen

Bulgarian:

Ако не сте в състояние да прочетете тази листовка, тъй като английският не е първи език, попитайте някой, който говори английски, за да телефонирам (PALS на 01983 534850) за повече информация и помощ

Czech:

Pokud nejste schopni přečíst tuto příbalovou informaci, protože angličtina není vaším rodným jazykem, zeptejte se někoho, kdo mluví anglicky na telefonní PALS na 01983 534850 pro další informace a pomoc

Bengali:

আপনি ইংরজেি আপনার প্রথম ভাষা না থাকার কারণে এই লফিলটে পড়তে অক্ষম হন, তাহলে আরও তথ্যরে জন্য 01983 534850 নভেগিশেন PALS টলেফিে ান ইংরজেি কথা কউে জজ্ঞিাসা করুন এবং সাহায্য করুন

If you require this leaflet in another language, large print or another format, please contact the PALS Team, telephone **01983 534850**, who will advise you.

Patient Safety Incidents

Every day more than a million people are treated safely in the NHS. Occasionally, things can go wrong or an unexpected event occurs. These are known as **patient safety incidents**. A patient safety incident is usually any event that has resulted in harm to a patient or service user. A patient safety incident could also include a near-miss event – when harm was narrowly avoided.

Not all safety incidents are the result of an error. For example, there may be occasions when a patient responds unexpectedly to treatments or interventions. It is only by undertaking a thorough investigation that lessons can be learnt about what has happened and why.

This leaflet explains the process and how you/your relatives/carers can be part of the investigation.

How will I know if something has gone wrong?

The Isle of Wight NHS Trust is committed to being open and honest at all times. In the NHS, this is known as **Duty of Candour**. If it is believed that something untoward has occurred during your care, you will be informed promptly, offered an apology and the circumstances explained to you.

The details of this conversation will be put in writing to you shortly after the event.

What should I do if I think a mistake has been made?

If you, your relatives or carers think that a mistake has happened, please immediately tell the team caring for you, so they can correct any mistakes and provide any immediate treatment that may be required.

What happens if I have been harmed?

The first priority if you have suffered harm during your care is for staff to take immediate action to ensure appropriate treatment is given and to prevent further harm.

The incident that has occurred will be subject to a robust review. This will be managed under the Serious Incident Framework **(https://improvement.nhs.uk/resources/serious-incident-framework/)** or investigated and managed locally. Whether an incident is managed under the Serious Incident Framework will be dependent upon the circumstances, such as whether the incident was avoidable and whether it meets the specific criteria for reporting under the national framework. Regardless of whether the incident is reviewed locally or under the framework you can be assured that a robust review will be undertaken, with a view to learning from the lessons identified.

The ultimate aim is to learn for the future and become a safer hospital. This Trust wishes our patients to be treated in a safe environment and be protected from avoidable harm.

Serious incidents managed under the **Serious Incident national framework** are reported to NHS England, the Isle of Wight Clinical Commissioning Group and the Care Quality Commission who all have a role in monitoring the quality of the NHS care provided.

The outcome and learning from any incident review will be shared at the Isle of Wight Trust's Patient Safety Sub-Committee, as well as within individual services where the incident occurred, to encourage wider shared learning.

How will I be involved in the investigation?

You will be asked if you have any questions or concerns that you would like the investigation to include. You will be given the name of a lead contact with whom you can discuss any concerns or questions relating to the incident.

If you would like to receive a copy of the investigation report and its outcomes, arrangements will be made for you and/or your family to meet with a member of the team to explain the findings and share the report with you.