

# Patient Safety Incident Response Policy and Plan

## Purpose

This policy is about how the Stroke Association will **improve** the **safety** of those affected by a safety **incident**.

A safety incident could be:

- Complaints
- Safeguarding
- Health and safety
- Data breach

The **Patient Safety Incident Response Framework** was developed by NHS England.

Anyone **delivering services** funded by the NHS needs to use the **Framework**.

The **Patient Safety Incident Response Framework** is also known as **PSIRF**.

Four **key aims** are:

1. **Engagement** and involvement of those affected,
2. **Learning** from incidents,
3. **Effective responses** to incidents and issues,
4. Making **improvements**.

## **Our safety culture**

- Open and honest.
- **Share** our **knowledge** and insight.
- Better **understand experiences**.
- Understand the **communities** we work with.

Our **organisational values** are:

- We are human.
- We believe in better.
- We give our all.
- We say it how it is.

These **values support** our **safety** culture.

We promote a fair evaluation of staff actions.

## **Engaging and involving stroke survivors, families and staff following a safety incident**

Safety incidents can have an impact **on stroke survivors**, their families, and carers.

Getting **involvement** right with stroke survivors and families in how we respond to incidents is **crucial**.

It will **support improving** our services.

We want to be **open** and **honest** with stroke survivors, families, and carers because it is the right thing to do.

We plan to create **procedures** that **support stroke survivors**, families, and carers to be **involved**.

## **Patient safety incident response planning**

We will explore **all safety incidents**. Not just the most serious ones.

This will help us to provide **an effective response**.

We will **set up** a **Learning Group**.

This group will explore the **data**.

We will use it to learn and make **improvements**.

## **Resources and training to support a patient safety incident response**

**Training** will be available to **staff** who deliver our commissioned services.

Staff in **specialist roles** will complete **external training**.

## **Responding to safety incidents**

All **staff** are **responsible** for **reporting** any potential or actual safety incident.

They will **follow** the **relevant process**.

Most incidents will **only require review** within the local commissioned service.

Where the **opportunity** for **learning** and **improvement** is significant, we will discuss it at the **Learning Group**.

The Learning Group will consider **all incidents** for learning and determine when a Patient Safety Incident Investigation is needed.

Our **Beneficiary Quality Oversight Group** will have **oversight**.

They will **report back** to the **Board of Trustees**.

Actions for learning must be **started as soon as possible** after the safety incident is identified.

This should be **completed within one to three months**.

Following review of safety incidents, we will identify areas for **improvement**.

We will also create a **safety improvement plan**.

## **Complaints and appeals**

We are committed to dealing with any complaints **quickly** and **effectively**.

You can **read more** in our [Complaints Policy](#).

## **Our patient safety incident response plan**

We have produced a **plan**.

This includes **key stages** for us to achieve.

Our plan includes actions to address **health inequalities**.

We have identified the following **areas of improvement**:

- **Training**

- Engagement
- Systems
- Involvement
- Culture
- Acting on Learning

If you have any **questions** contact the Product and Performance Team at [ProductManagement@stroke.org.uk](mailto:ProductManagement@stroke.org.uk)