Deciding investigation responses – opportunities for learning and proportionality

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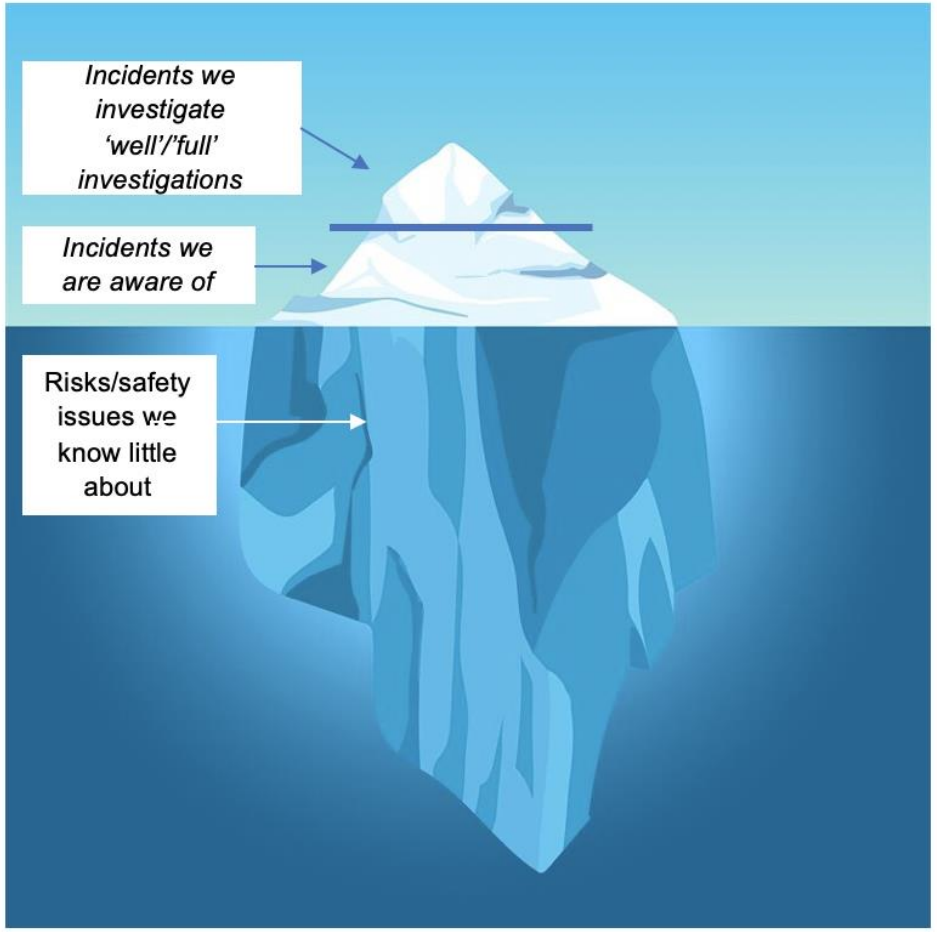
Patient Safety Incident Response Framework (PSIRF) (2022)

- Guide for how NHS should develop culture, behaviours, and systems to respond to safety incidents and risks
- Replaces Serious Incident Framework (SIF)
- How does it differ from SIF?
  - ***Broader scope*** *– moving away from reactivity and towards proactivity.*
  - *Range of* ***tools*** *suggested*
  - ***System-wide approach*** *to incidents*
  - ***Not guided by harm*** *caused to patient*
  - *Focus on* ***quality of investigation*** *rather than quantity as a proxy for assurance*
  - ***Supporting staff*** *involved in incidents*
  - ***RCA no longer used*** *as preferred methodology*
  - *Proportionate responses to patient safety incidents*

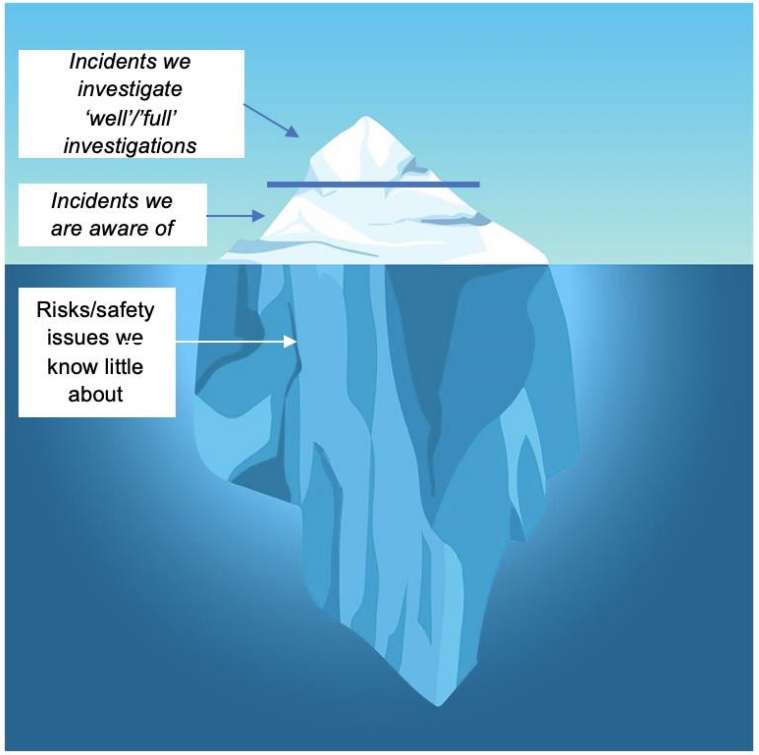
The PSIRF will NOT replace other statutory requirements for investigation e.g. learning from deaths / incidents reported to HSIB

Approaches to safety

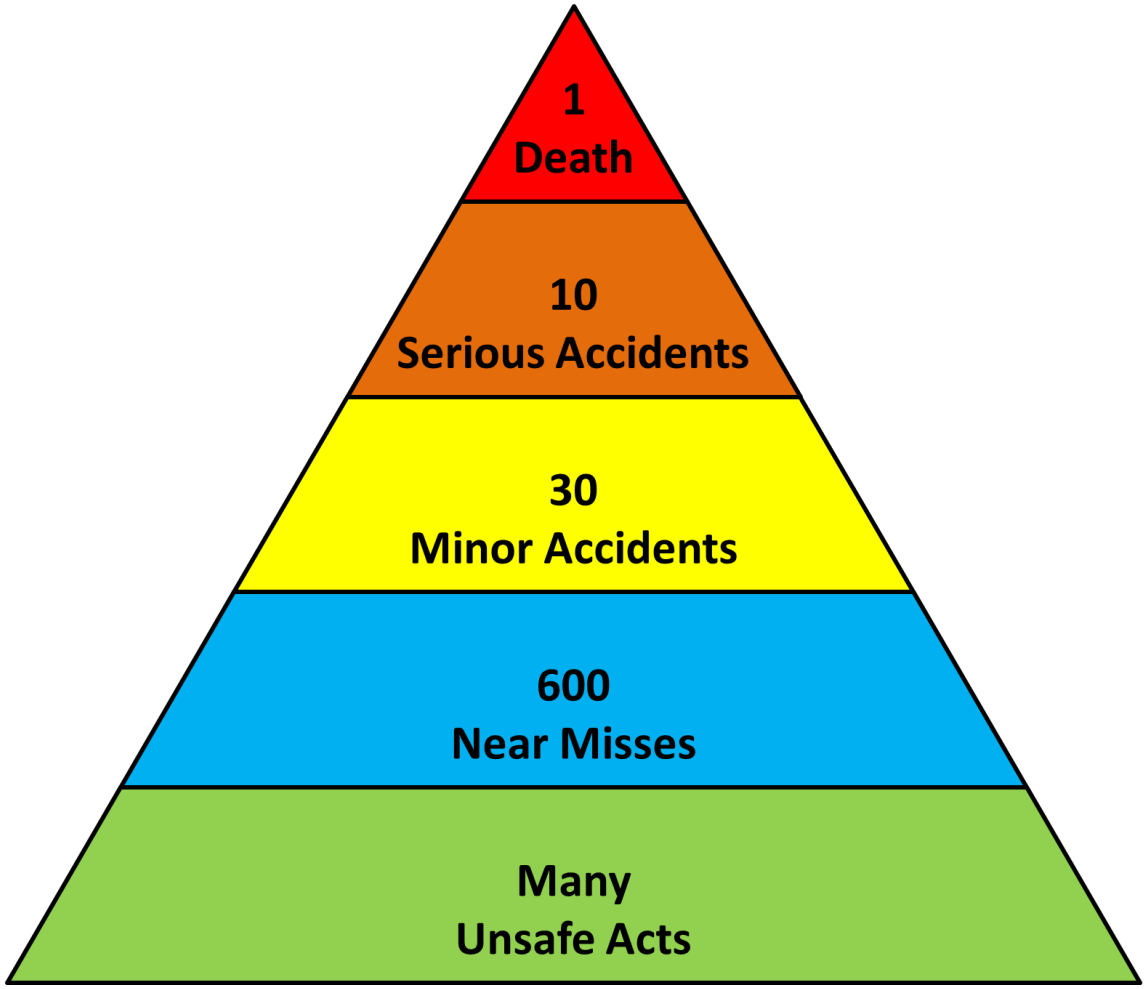


Safety science

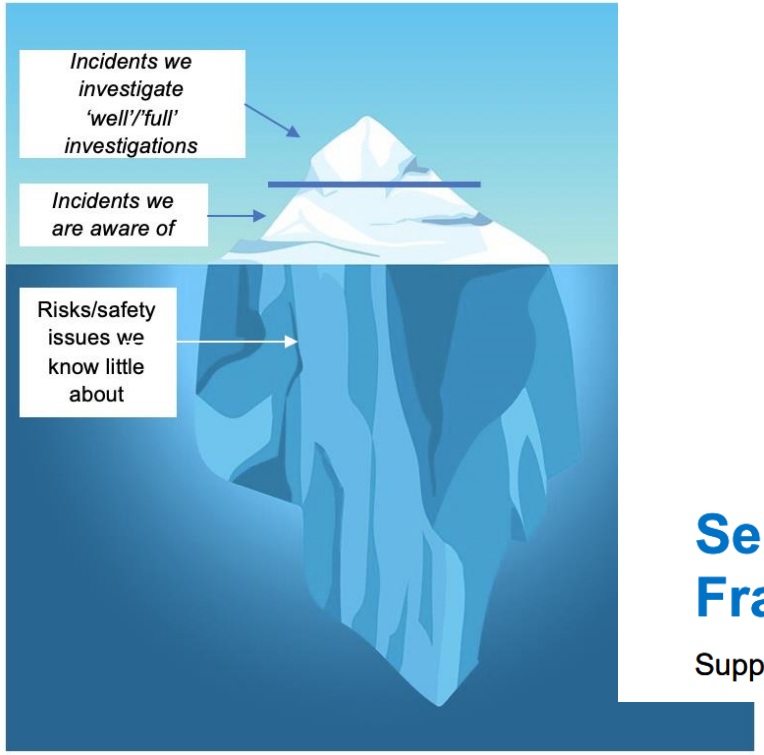
- Heinrich’s Accident Triangle & Bird’s triangle
- Direct relationship between the ‘tip’ and the ‘bottom’



Heinrich's Accident Triangle



Safety science

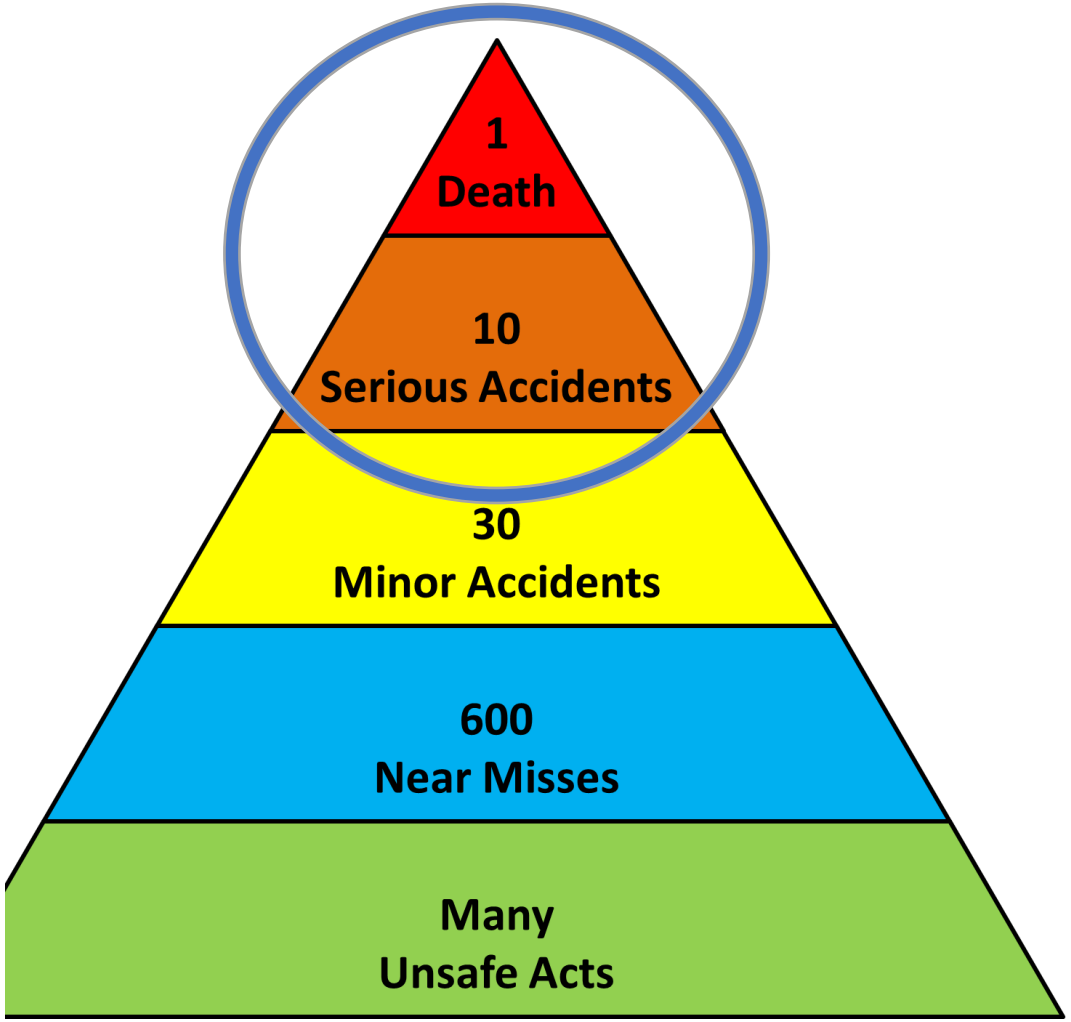


NHS England

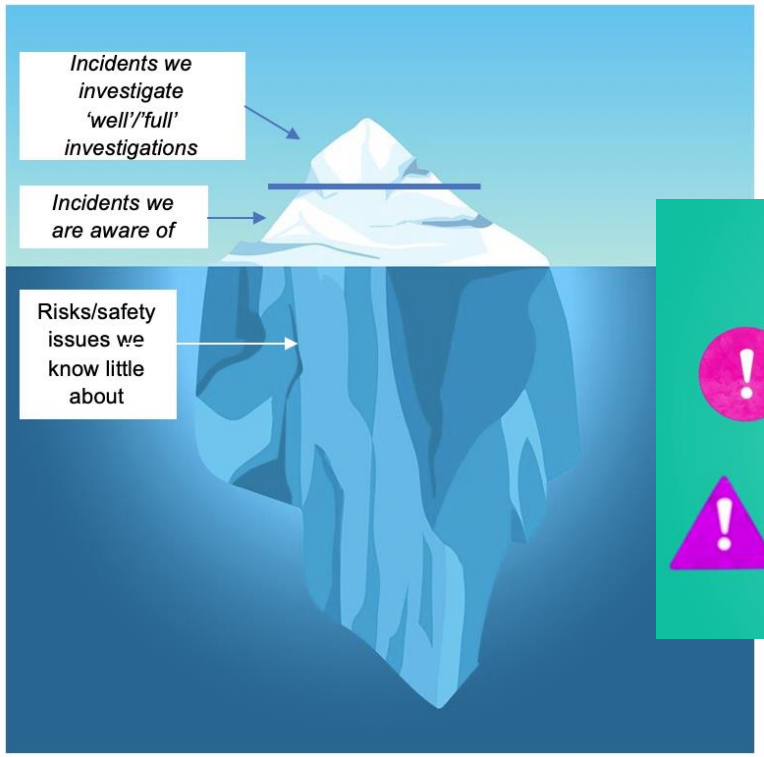
Serious Incident Framework

Supporting learning to prevent recurrence

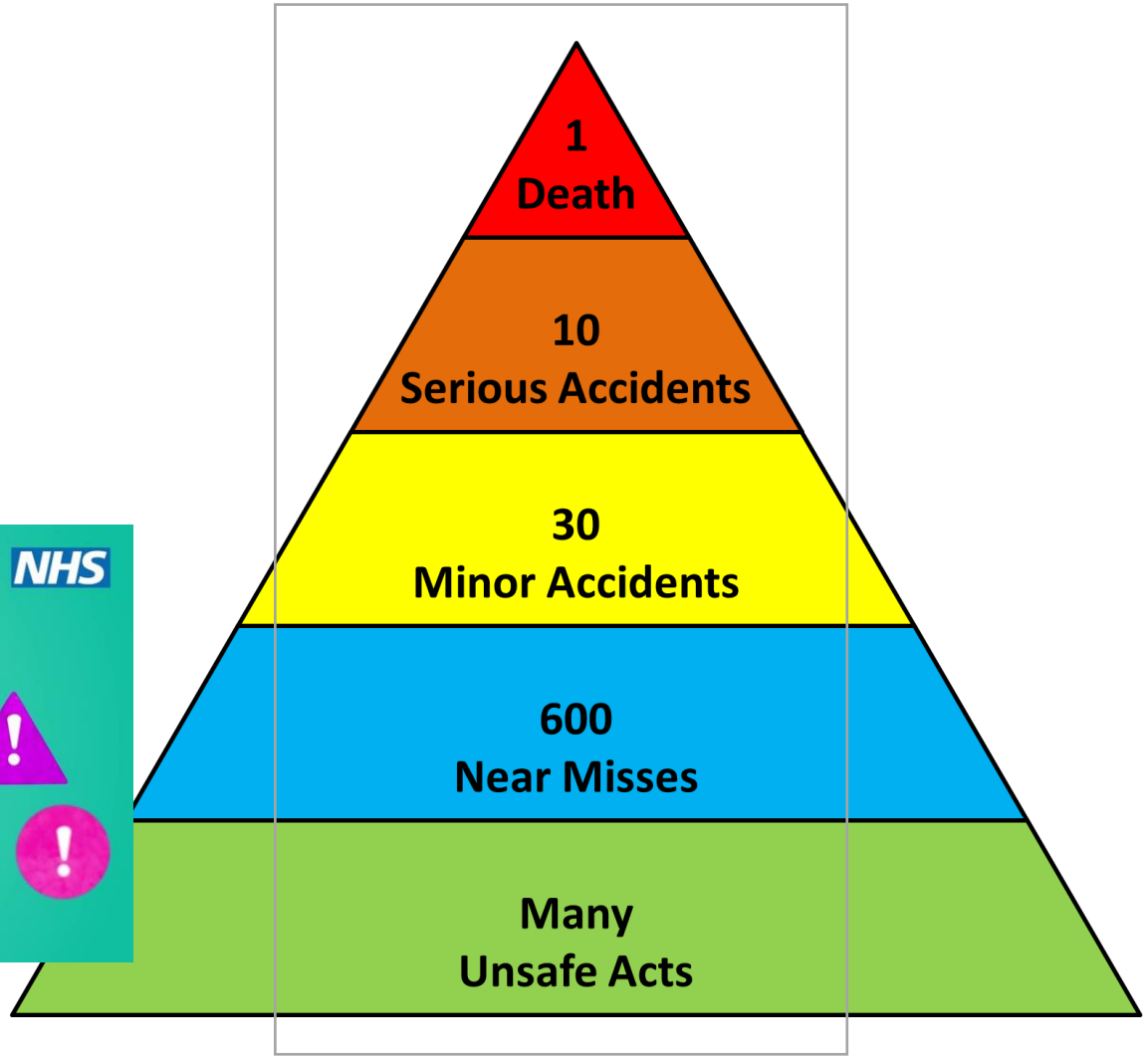
Heinrich's Accident Triangle



Safety science



Heinrich's Accident Triangle



Incident Tools

- ‘Full investigations’ (PSII)
- System based investigations
- Thematic reviews
- After Action Reviews
- Rapid Review
- ‘Hot’ Debriefs

Investigation outputs

- Report
- Notes written onto a proforma
- System mapping (e.g., SEIPS)
- Insights from individual staff members

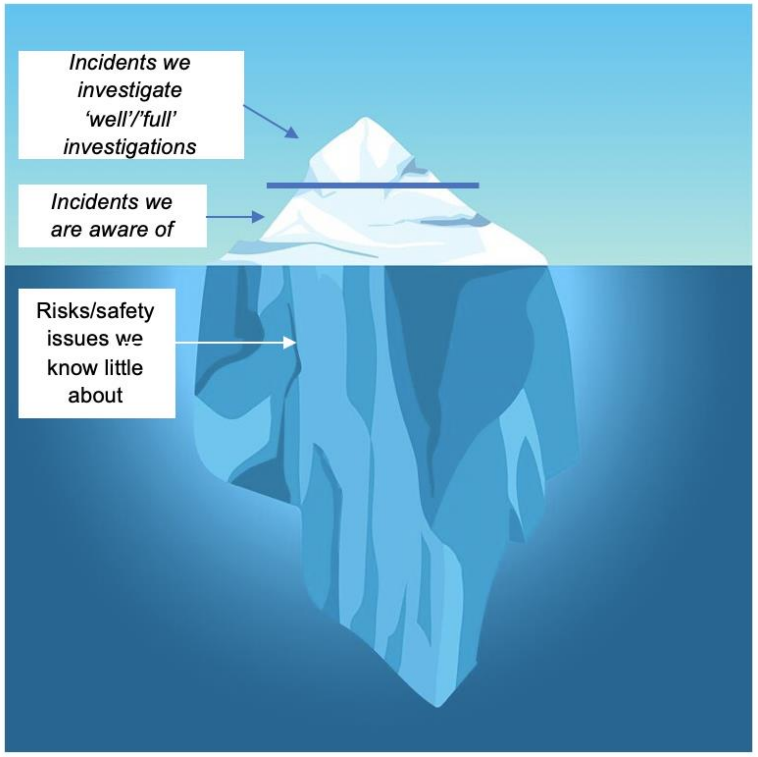
- *‘Full investigations’ (PSII)*
- *System based investigations*
- *Thematic reviews*
- *After Action Reviews*
- *Rapid Review*
- *‘Hot’ Debriefs*

Which tools for which incidents? Activity

- Assessing why patients are falling - a cluster of 10 falls
- Delayed diagnosis which resulted in a death
- Dose omissions
- Individual medication error
- Near miss in surgery – wrong lens selected but not implanted
- Reflections post a difficult airway (successful outcome)

Ultra adaptive Embracing risk	High reliability Managing risk	Ultra safe Avoiding risk
Context: Taking risks is the essence of the profession: Deep sea fishing, military in war time, drilling industry, rare cancer, treatment of trauma. **Safety model: Power to experts** to rely on personal resilience, expertise and technology to survive and prosper in adverse conditions. **Training:** through peer-to-peer learning shadowing, acquiring professional experience. knowing one's own limitations.	**Context: Risk is not sought out but is inherent in the profession:** Marine, shipping, oil Industry, fire-fighters, elective surgery. **Safety model: Power to the group** to organise itself, provide mutual protection, apply procedures, adapt, and make sense of the environment. **Training in teams** to prepare and rehearse flexible routines for the management of hazards.	**Context: Risk is excluded as far as possible:** Civil aviation, nuclear Industry, public transport, food industry, medical laboratory, blood transfusion. **Safety model: Power to regulators and supervision** of the system to avoid exposing front-line actors to unnecessary risks. **Training in teams** to apply procedures for both routine operations and emergencies.
Priority to adaptation and recovery strategies	**Priority to procedure and adaptation strategies**	**Priority to prevention strategies**
Innovative medicine **Trauma centres**	**Scheduled surgery** **Chronic care**	**Anaesthesiology** **ASA1**	**Radiotherapy** **Blood transfusion**

Charles Vincent & Rene Amalberti *'Safer Healthcare – Strategies for the Real World'*

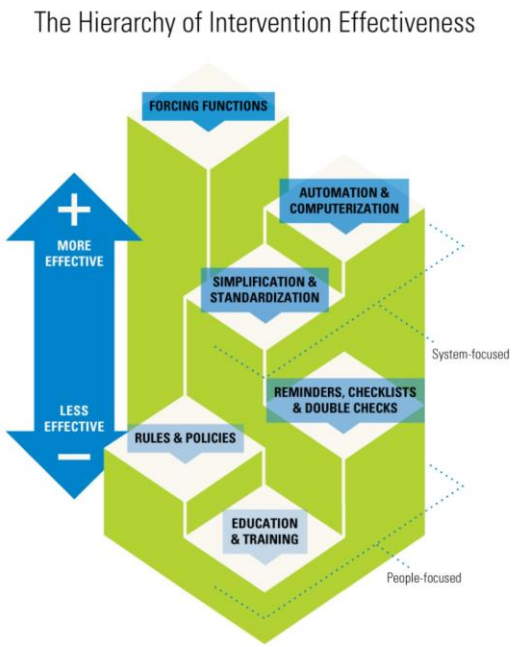


Proportionality in PSIRF

- Learning is key within incident investigation
- Proportionality doesn't always relate to the harm of an incident
- Opportunity cost of commissioning continued reports

Key questions to ask:

1. What is the potential learning with this incident?
2. Is there more depth to a problem we are unaware of?
3. What are the patient/family needs?
4. What is staff/patient insight telling you? Could high concern be cause for concern and signal a greater problem?

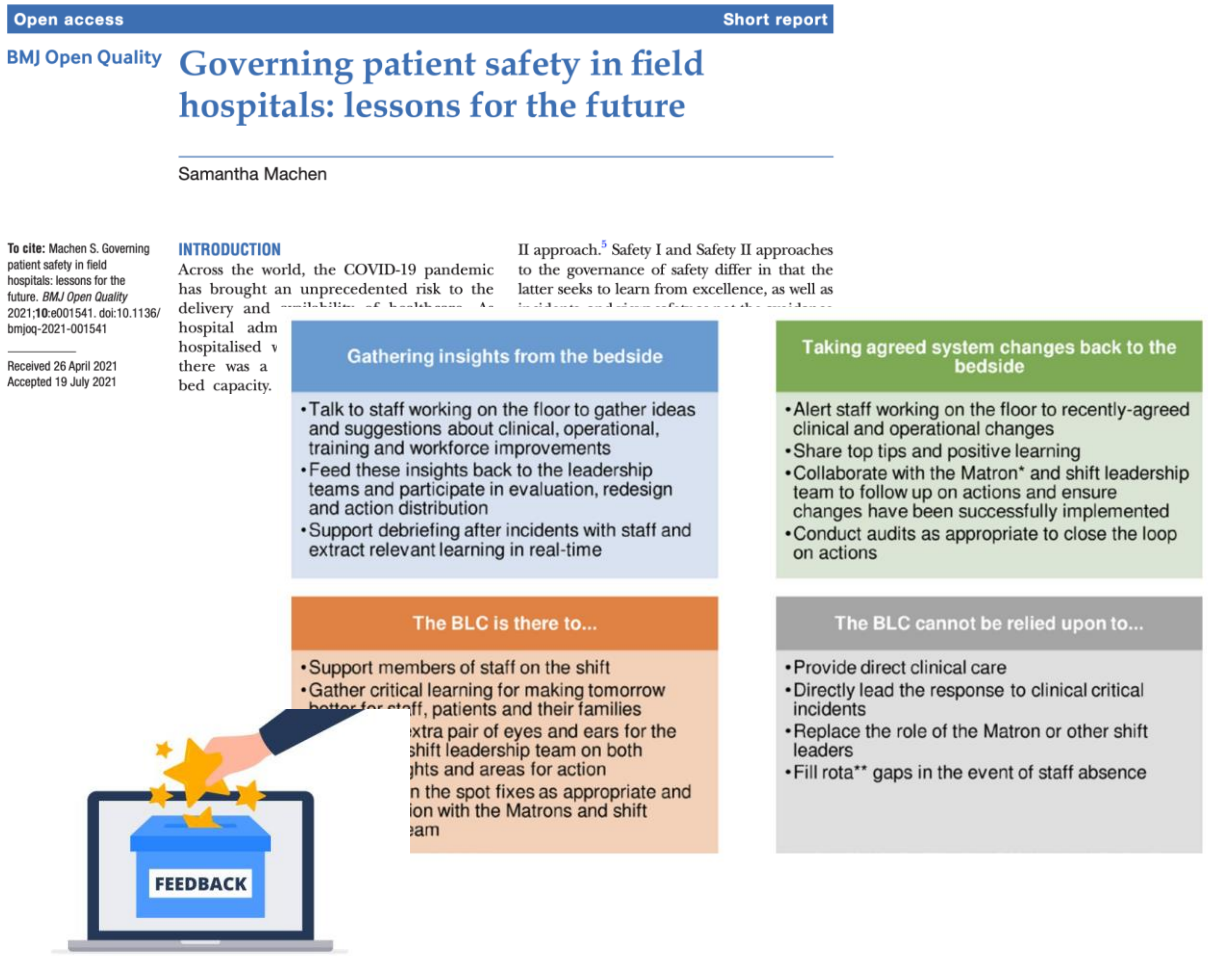


Improvement

- What do we do with safety insights?
- How is this aligned with safety science?

Strategies for improving insight

- Actively seeking work as done
- Questioning work as imagined
- Providing a safe and supportive platform for staff to identify common workarounds
- Collecting insights as routinely as Datix incidents
- Focusing on proactivity
- Following ‘hunches’/safety risks identified by those who have the best insight (staff/patients)



Open access Short report

BMJ Open Quality

Governing patient safety in field hospitals: lessons for the future

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INTRODUCTION

Across the world, the COVID-19 pandemic has brought an unprecedented risk to the delivery and
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there was a
bed capacity.

II approach.[5] Safety I and Safety II approaches to the governance of safety differ in that the latter seeks to learn from excellence, as well as

Gathering insights from the bedside

- Talk to staff working on the floor to gather ideas and suggestions about clinical, operational, training and workforce improvements
- Feed these insights back to the leadership teams and participate in evaluation, redesign and action distribution
- Support debriefing after incidents with staff and extract relevant learning in real-time

Taking agreed system changes back to the bedside

- Alert staff working on the floor to recently-agreed clinical and operational changes
- Share top tips and positive learning
- Collaborate with the Matron* and shift leadership team to follow up on actions and ensure changes have been successfully implemented
- Conduct audits as appropriate to close the loop on actions

The BLC is there to...

- Support members of staff on the shift
- Gather critical learning for making tomorrow
  ff, patients and their families
  xtra pair of eyes and ears for the
  hift leadership team on both
  hts and areas for action
  n the spot fixes as appropriate and
  ion with the Matrons and shift
  am

The BLC cannot be relied upon to...

- Provide direct clinical care
- Directly lead the response to clinical critical incidents
- Replace the role of the Matron or other shift leaders
- Fill rota** gaps in the event of staff absence

What are our barriers to implementing?

- Years of focus on harm
- Years of reductionist thinking
- Years of sole methods being used – training gaps
- Approach to safety
- Seemingly asking for more incidents to be reviewed
- Systemic system-based issues
- Wider system partners' engagement

Thank you for listening!

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