Gaining insight from pressure ulcers - human factors and linking with PSIRF

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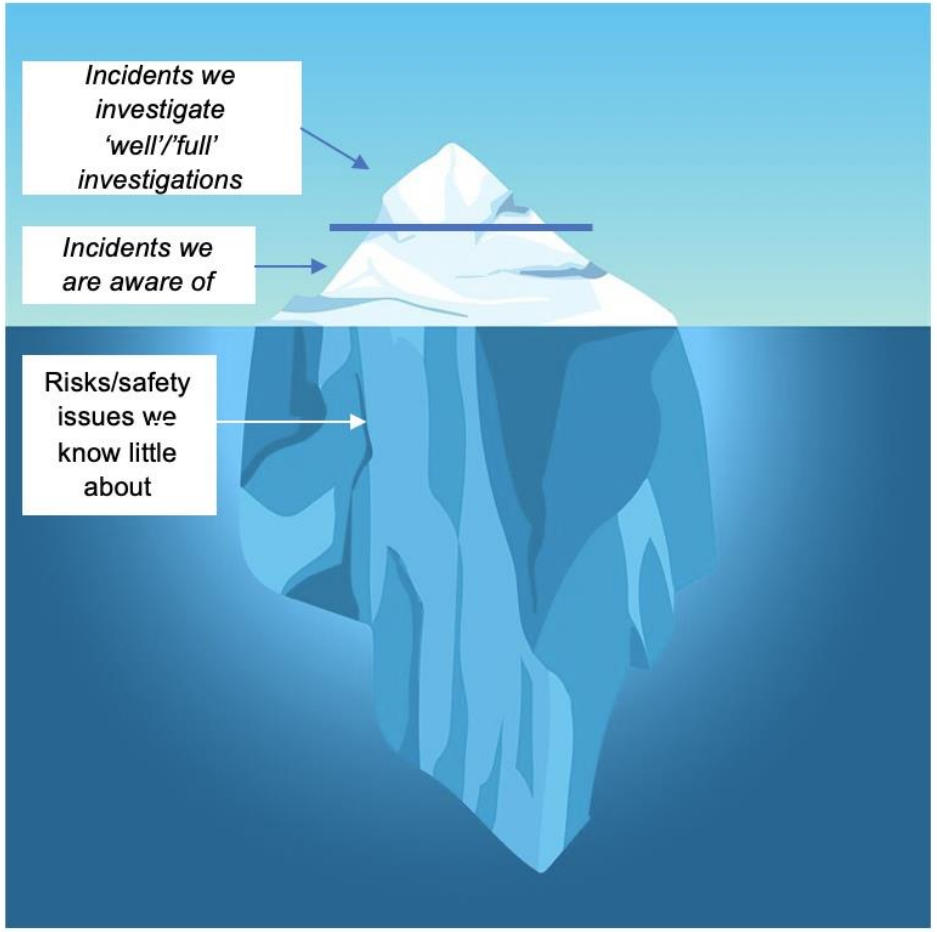
Patient Safety Incident Response Framework (PSIRF) (2022)

- 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*

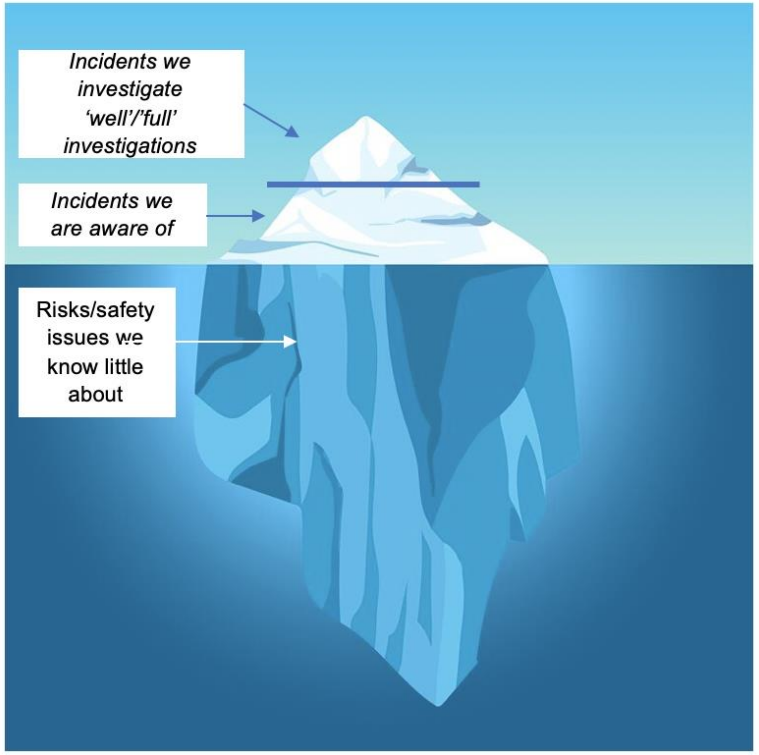
The PSIRF will NOT replace other statutory requirements for investigation e.g. learning from deaths / incidents reported to HSIB

Approaches to safety

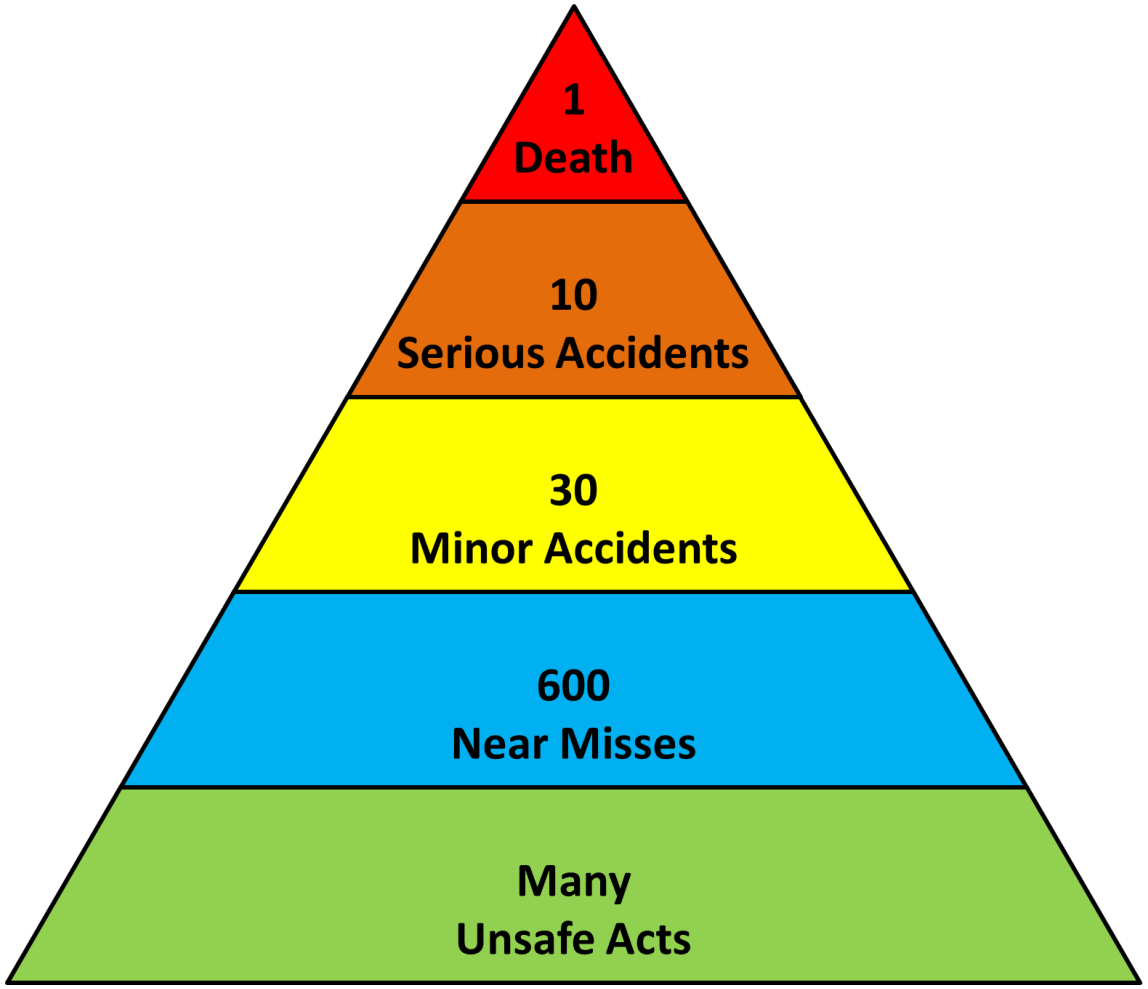


Safety science

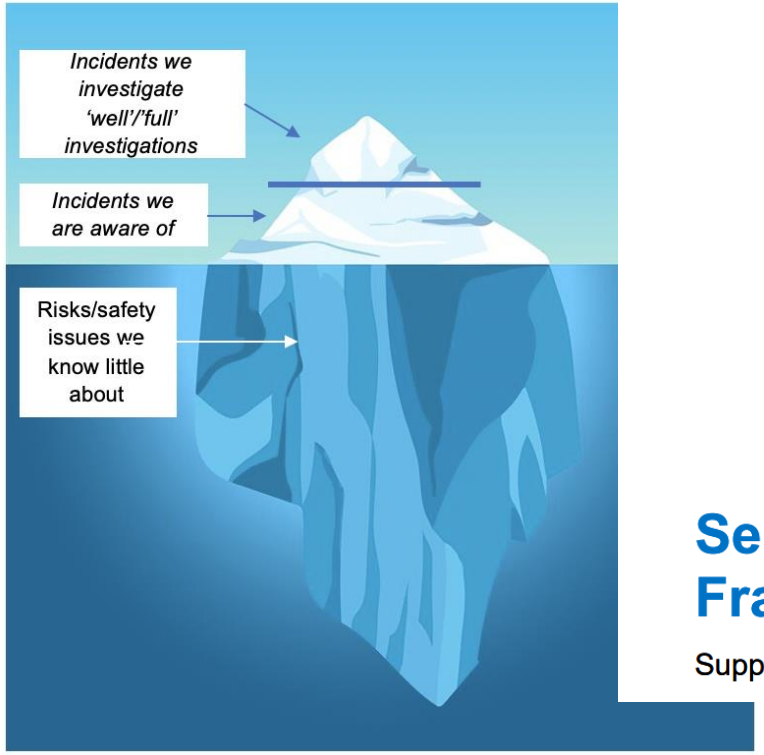
- Heinrich’s Accident Triangle & Bird’s triangle
- Direct relationship between the ‘tip’ and the ‘bottom’



Heinrich's Accident Triangle



Safety science

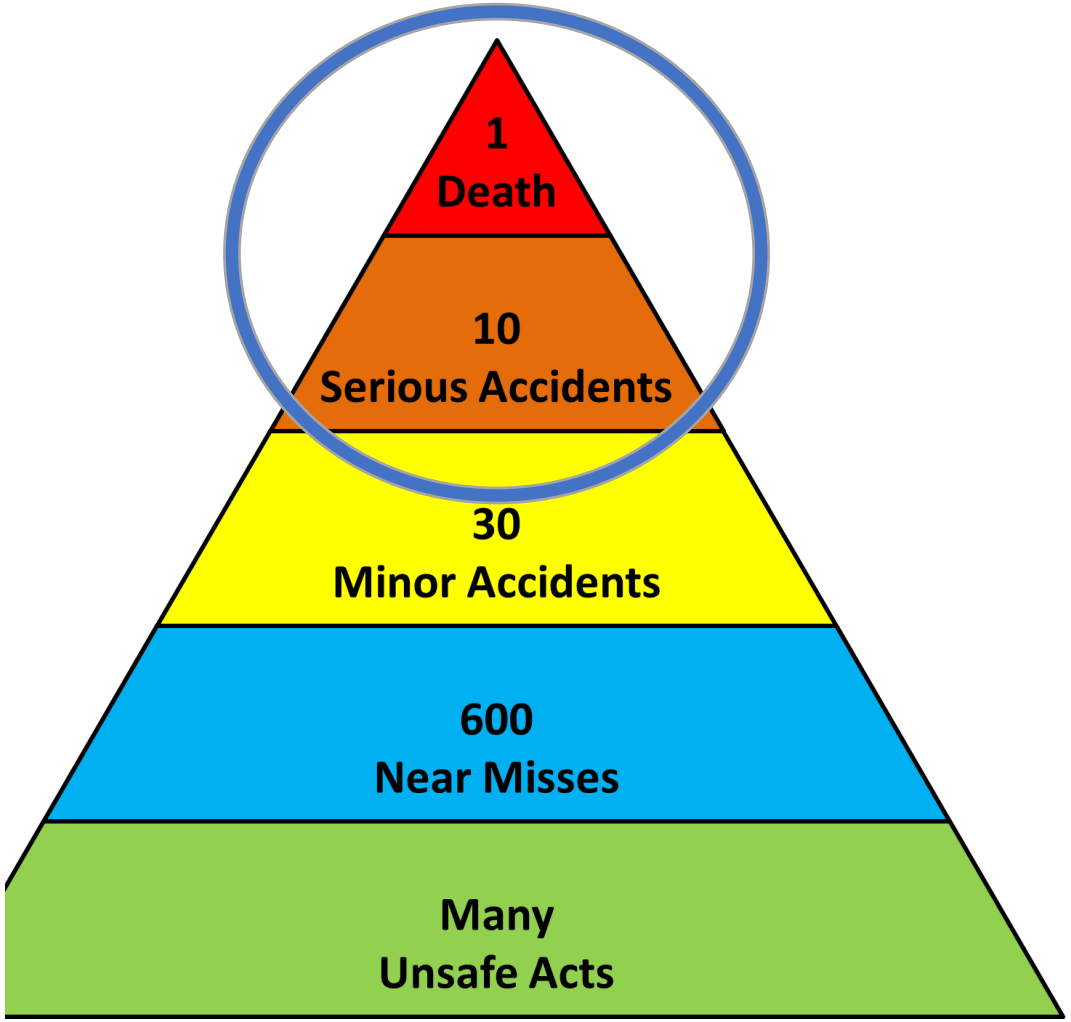


NHS England

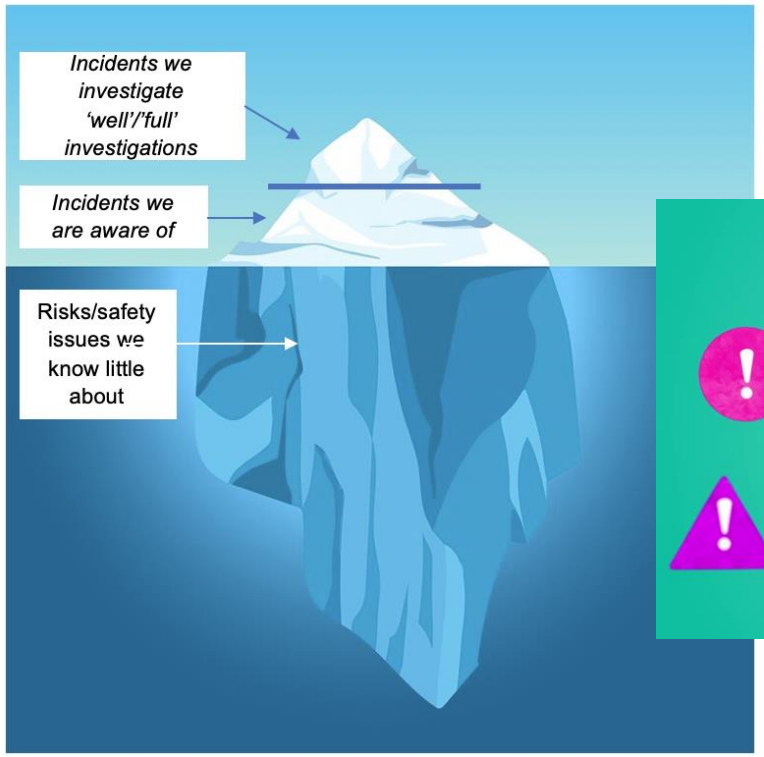
Serious Incident Framework

Supporting learning to prevent recurrence

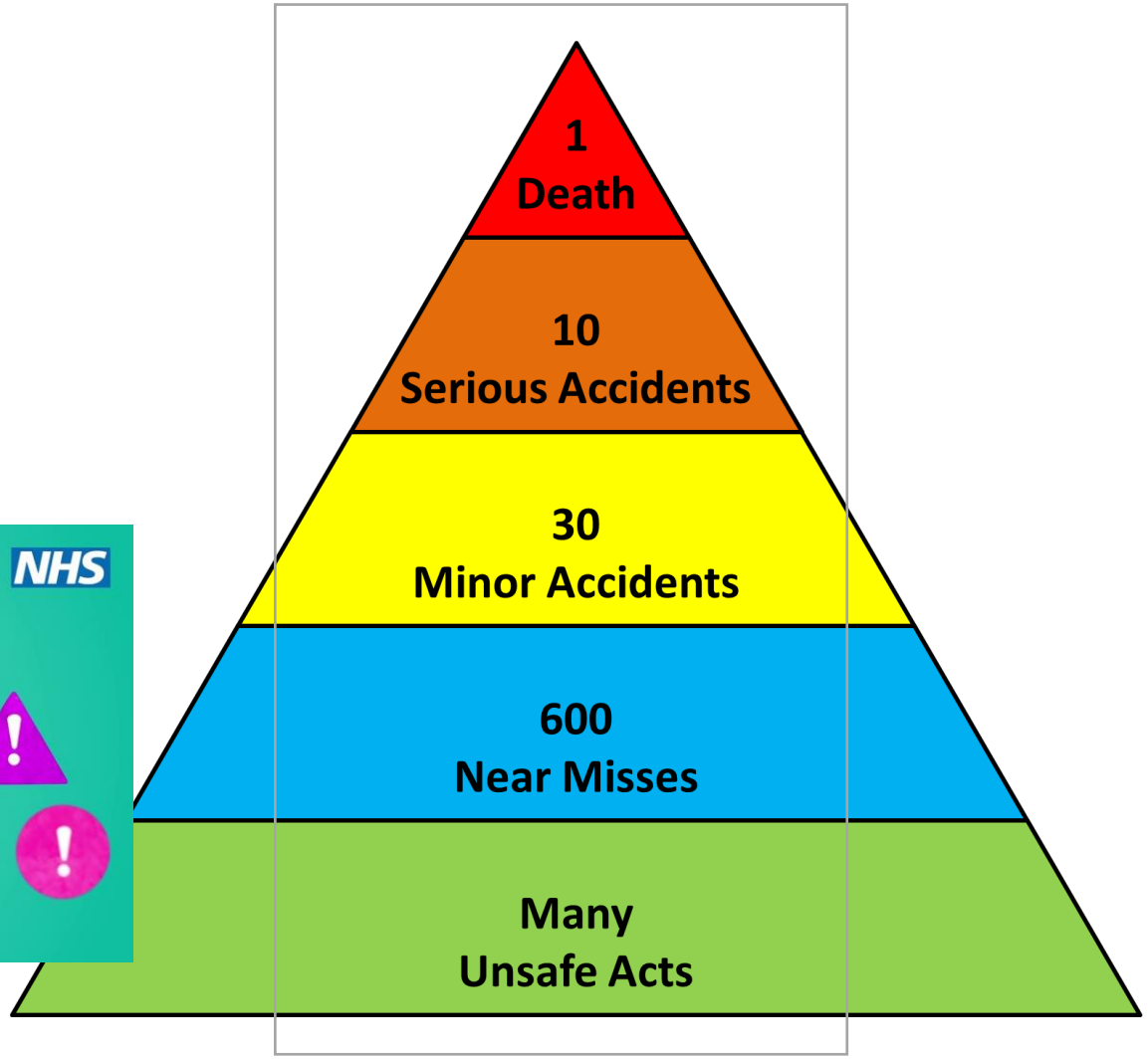
Heinrich's Accident Triangle



Safety science

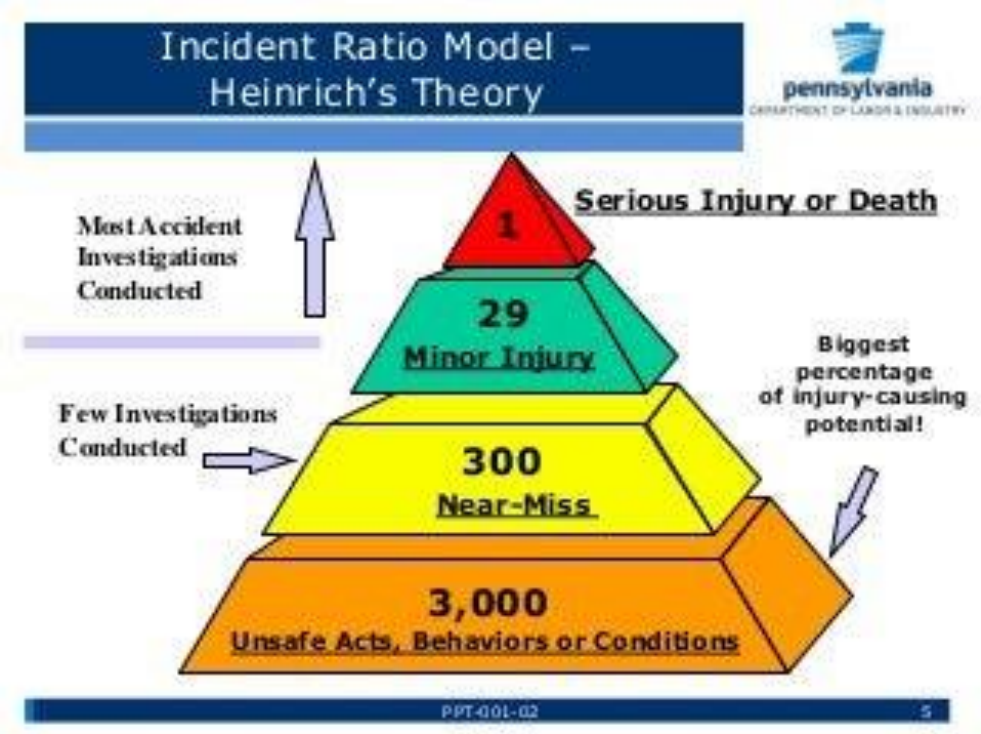


Heinrich's Accident Triangle



A focus on harm

- SI has guided us towards harm as the way to sieve through incidents
- Research shows that isn't always correct
- SI Framework encouraged us to focus just on those meeting high harm levels
- Theming together incidents to look at portfolios versus isolated incidents



Incident Tools

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

Open access Quality improvement report

BMJ Open Quality

Thematic reviews of patient safety incidents as a tool for systems thinking: a quality improvement report

Samantha Machen

To cite: Machen S. Thematic reviews of patient safety incidents as a tool for systems thinking: a quality improvement report. *BMJ Open Quality* 2023;**12**:e002020. doi:10.1136/bmjoq-2022-002020

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjoq-2022-002020).

Received 20 June 2022
Accepted 12 April 2023

ABSTRACT

Ensuring organisations learn from patient safety incidents is a key aim for healthcare organisations. The role that human factors and systems thinking can have to enable organisations learn from incidents is well acknowledged. A systems approach can help organisations focus less on individual fallibility and more on setting up resilient and safe systems. Investigation of incidents has previously been rooted in reductionist methodologies, for example, seeking to find the 'root cause' to individual incidents. While healthcare has embraced, in some contexts, the option for system-based methodologies—for example, SEIPS and Accimaps—these methodologies and frameworks still operate from a single incident perspective. It has long been acknowledged that healthcare organisations should focus on near misses and low harms with the same emphasis as incidents resulting in high harm. However, logistically, investigating all incidents in the same way is difficult. This paper puts forward an argument for themed reviews of patient safety incidents and provides an illustrative template for theming incidents using a human factors classification tool. This allows groups of incidents relating to the same portfolio, for example, medication errors, falls, pressure ulcer, diagnostic error, to be analysed at the same time and result in recommendations based on a larger sample size of incidents and based on a systems approach. This paper will present extracts of the themed review template trialled and argues that thematic reviews, in this context, allowed for a better understanding of the system of safety around the mismanagement of the deteriorating patient.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Previous research relating to investigation into patient safety incidents has identified the need for systems-based investigation versus person-focused investigation to ensure improvement to systems of safety. Currently, there is no way to group incidents together to theme incidents through a validated systems lens.

WHAT THIS STUDY ADDS

⇒ This improvement report presents a worked example of how a thematic review template would be used and compares findings and recommendations based on the themed review template versus individual investigations. The template provides the opportunity for investigator(s) to aggregate incidents and guide investigators to provide more system-focused findings and recommendations.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

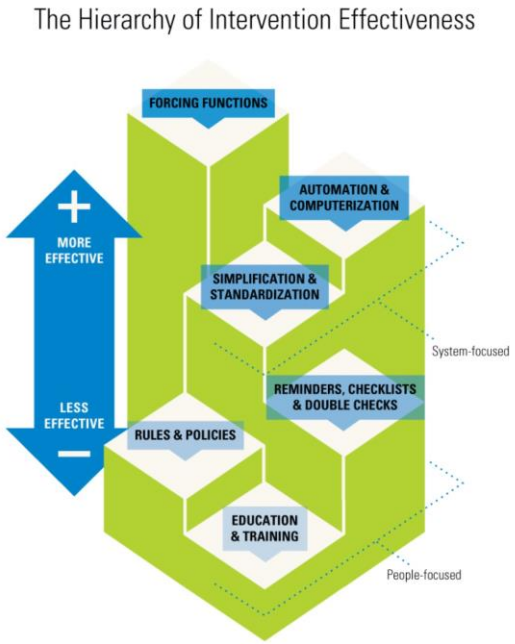
⇒ This thematic review paper is the first documented attempt to provide a template for patient safety practitioners to group together patient safety events and guide investigators towards a focus on systems of safety and not individuals. This addresses a key gap in safety science literature and poses the emergent method of investigating using thematic reviews can be useful in helping appreciate context and safety issues from a systems lens.

Thematic reviews

- Thematic reviews as a key part of PSIRP
- Clustering groups of incidents together to look at key themes
- Key requisite is a defining matrix to apply to all incidents
- All incidents – not based on harm
- Supplemented by local insight / work as done information
- Example: PPH, Lost to follow up cases, deteriorating patient, falls

Thematic reviews of pressure ulcers – an example

- SI framework meant ‘full’ investigations of pressure ulcers when severe harm or above
- Is there a difference between a lower category PU versus a PU with a higher category grading
- The outcome (having a PU) be the same, but the omissions may be different
- Thematic reviews can focus on omissions over a number of cases
- Identify controls or system barriers to error and assess all incidents as to whether these things happened or were omitted
- E.g. of controls: PU risk assessment/controls put into place as a result of the risk assessment/mobility assessment/equipment/turning schedules/regularity of checking skin integrity

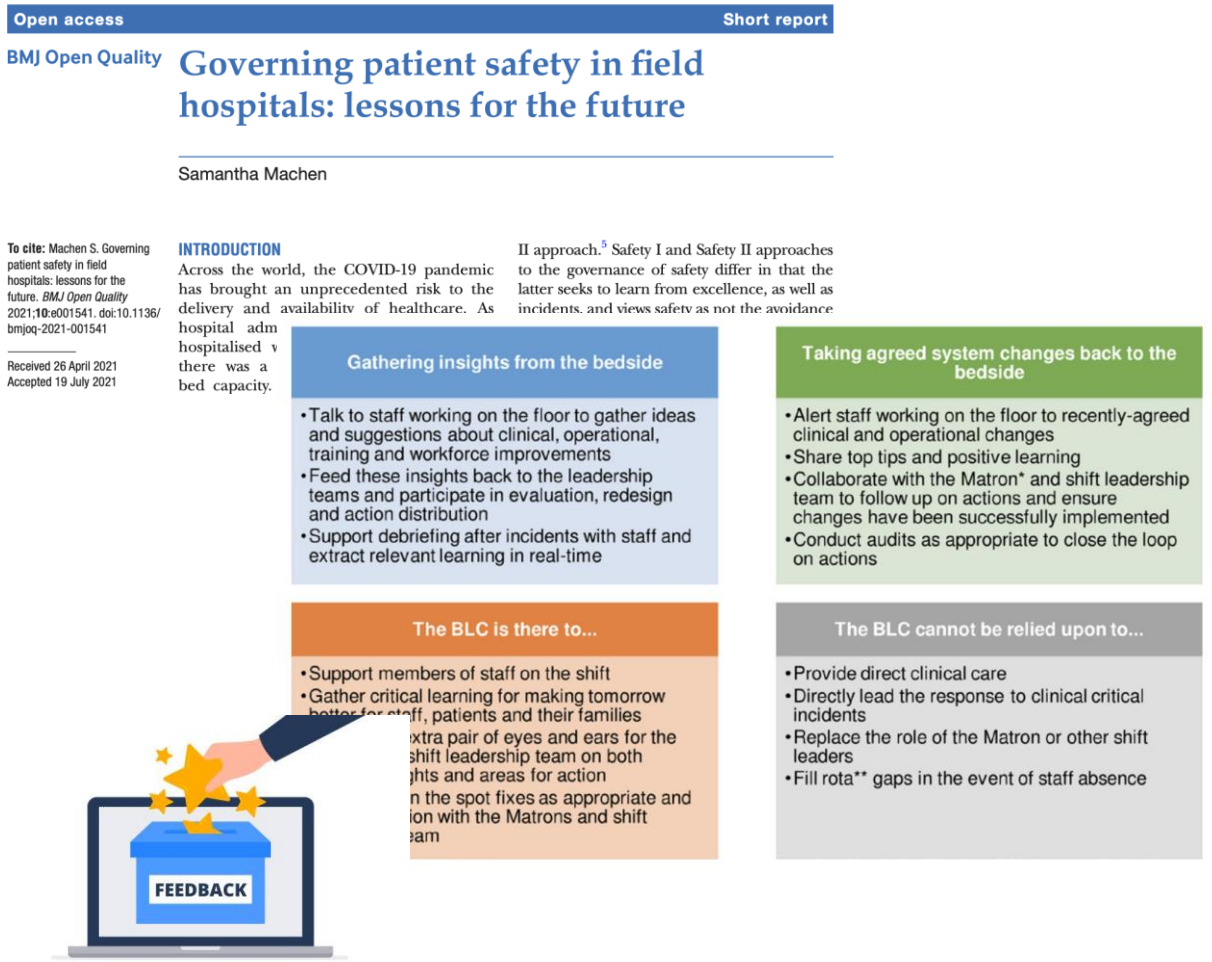


Improvement

- 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

Samantha Machen

To cite: Machen S. Governing patient safety in field hospitals: lessons for the future. *BMJ Open Quality* 2021;**10**:e001541. doi:10.1136/bmjoq-2021-001541

Received 26 April 2021
Accepted 19 July 2021

INTRODUCTION

Across the world, the COVID-19 pandemic has brought an unprecedented risk to the delivery and availability of healthcare. As hospital adm hospitalised v 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 incidents, and views safety as not the avoidance

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
- eam

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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