

PSIRF Masterclass

Systems Approach to Learning from Patient Safety Incidents

Tuesday 14th January and Wednesday 15th January 2025
Tuesday 11th February and Wednesday 12th February 2025
Tuesday 11th March and Wednesday 12th March 2025
Tuesday 8th April and Wednesday 9th April 2025
Tuesday 13th May and Wednesday 14th May 2025
Tuesday 10th June and Wednesday 11th June 2025
Tuesday 15th July and Wednesday 16th July 2025
Tuesday 12th August and Wednesday 13th August 2025
Tuesday 16th September and Wednesday 17th September 2025
Tuesday 14th October and Wednesday 15th October 2025
Tuesday 11th November and Wednesday 12th November 2025
Tuesday 9th December and Wednesday 10th December 2025

Approved
NHS Framework
Provider for PSIRF
Training

Facilitated by:

Jo Perruzza

Former mental health nurse and clinician, clinical leader and senior manager in mental health provider organisations



**H HEALTHCARE
CONFERENCES UK**



Systems Approach to Learning from Patient Safety Incidents

10% card payments discount*
15% group booking discount**

OVERVIEW

Facere Melius are the only approved training supplier that worked closely with NHS England in developing tools and guidance to support PSIRF.

Training to support the development of core understanding and application of systems-based patient safety incident response throughout the healthcare system - in line with NHS guidance, based upon national and internationally recognised good practice.

This course covers the end-to-end systems-based patient safety incident response based upon the new NHS PSIRF and includes:

- purpose of patient safety incident response framework
- introduction to complex systems, system thinking and human factors
- restorative just and learning culture
- duty of candour
- involving staff in incident response
- involving patients, families and carers in incident response
- improvement science and developing system improvement plans
- general response techniques
- interviewing and asking questions
- conducting observations, understanding work as done
- systems frameworks
- response types
- patient safety investigation planning, analysis and report writing
- commissioning and oversight of an internal investigation
- a high-level overview of system-based response tools

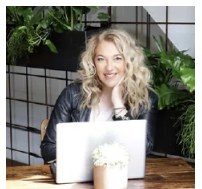
This course can also be delivered in house either in person or virtually for up to groups of 25 – please contact us for more information

WHO SHOULD ATTEND

Lead investigators; Executives, commissioning, and service leads for investigations; Investigators supporting or overseeing patient safety incident investigations

FACILIATOR

Jo Perruzza is a former mental health nurse and has been a clinician, a clinical leader and a senior manager in mental health provider organisations. With a passion for patient safety and an expert in psychological safety she brings experience of leading internal and external investigations.



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DAY 1 PROGRAMME

- 09.30 Welcome and introductions
- 09.45 Setting the scene for the 2-day workshop:
The Patient Safety Incident Response Framework:
Changing our approach to learning & improvement
- Aims of PSIRF
 - Patient Safety Incident Response Plan & Policy
 - Learning response leads
 - Oversight of PSIRF
 - Overview of national templates and guidance
- 10.45 Comfort break
- 10.55 Breakout group 1:
Gap analysis: Where are we now?
What changes will PSIRF entail for our organisation?
Optional: an update from your own organisations
- 11.30 Sessions three
Developing your Patient Safety Incident Response Plan
What does a good Patient Safety Incident Response Plan look like?
Safety one and Safety two
Scenario – Safety one and two in action
- 12.45 Lunch break
- 13.15 Session four
Introduction to complex systems, systems thinking, and human factors Part one
- 14.00 Comfort break
- 14.10 Complex systems, systems thinking, and human factors in investigation Part 2:
Introducing the Systems Engineering Initiative for Patient Safety (SEIPS framework)
- Breakout group 2: Learning through the lens of SEIPS
 - Breakout group 2 debrief
- 15.00 Session five
Sector Specific Case study 1: TBC
Group forum work: Supporting those affected
Just culture, the duty of candour: Part 1
- 15.50 Questions from Day one
- 16.00 Close

DAY 2 PROGRAMME

- 09.30 Recap from Day one
Restorative just and learning culture
Breakout group: supporting staff and families
Planning the learning response
- Choosing the Learning Response Lead & Team
 - Working with those affected (staff, patients, families and carers)
- 11.00 Comfort break
- 11.10 Understanding work as done
(cognitive interviewing, observations, walkthroughs and talk-throughs)
Group forum discussion of analysing work as done
- 12.10 Case study 1 continued.
Synthesis: event mapping, evaluating, and interpreting information using SEIPS.
Breakout group 4: Data synthesis for Case study 1
- 12.40 Lunch break
- 13.10 Improving and developing system-level improvement plans
- Safety actions and improvement plans
 - Writing a high-quality, compassionate summary of your findings
- 14.10 Comfort break
- 14.20 Other learning response tools:
- After Action Review
 - SWARM
 - SEIPS Work system explorer
 - Horizon scanning tool
 - Thematic analysis
 - MDT review
- 15.20 - 16.30 Closing questions

