Learning from Patient Safety Incidents – Embedding PSIRF & the role of the investigator

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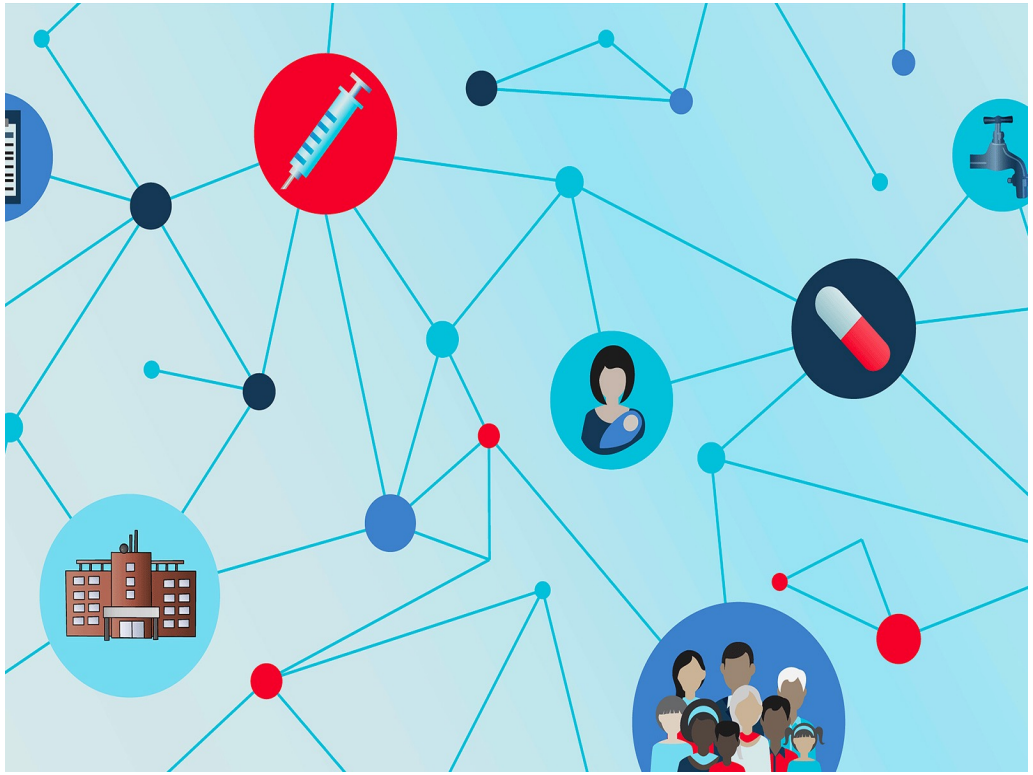
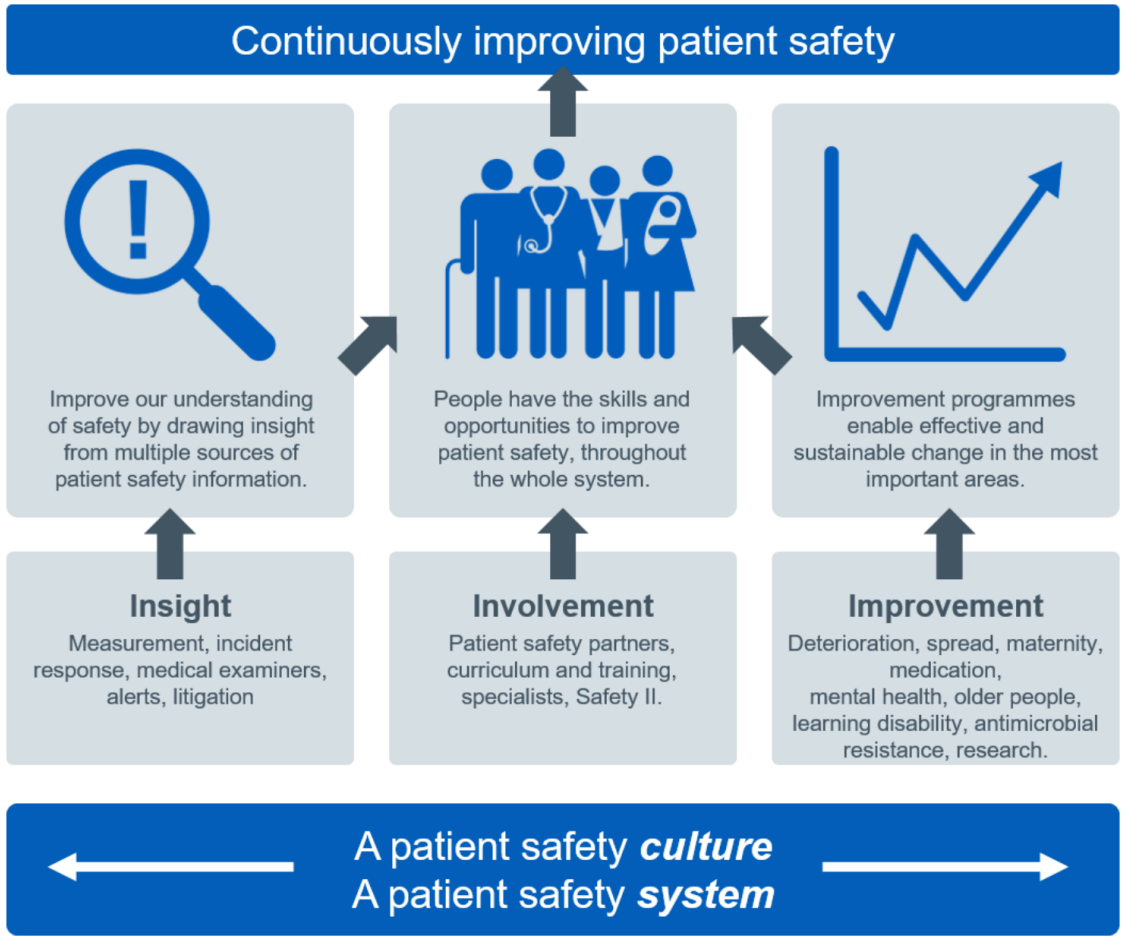


Presentation overview

- PSIRF – what is it and what does it aim to do?
- Why should we change?
- How will we change?
- What do we need to change?
- Embedding PSIRF and cultural barriers



Patient safety Strategy

- Increasing insight as a means for improvement
- Increasing involvement
- Improving from outputs of investigations

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*

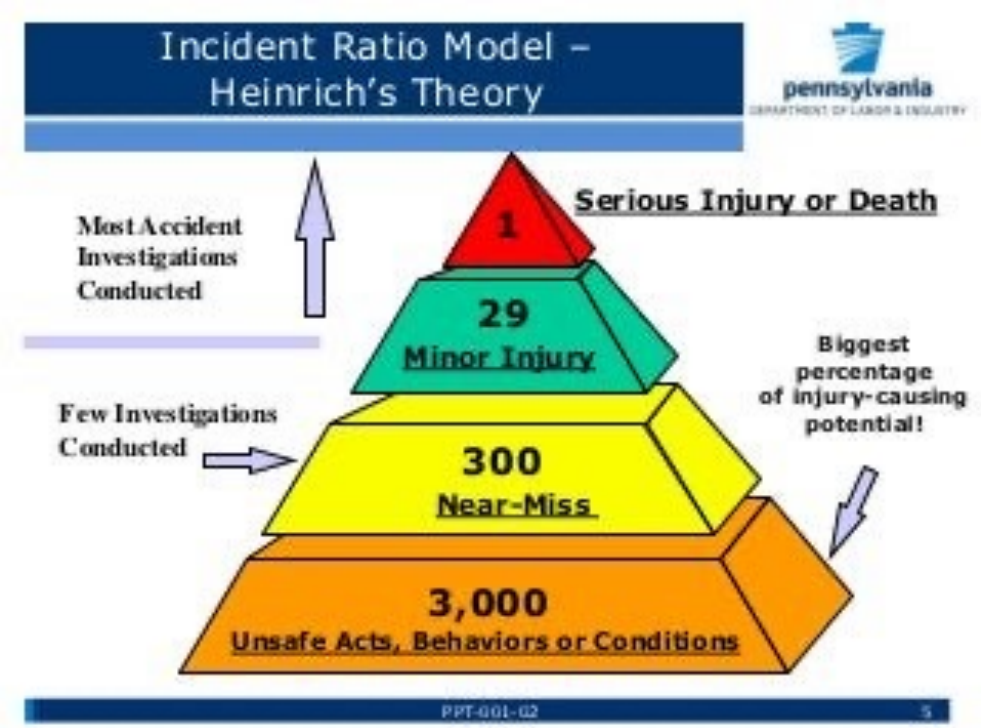
The PSIRF will NOT replace other statutory requirements for investigation e.g. learning from deaths / incidents reported to HSIB

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

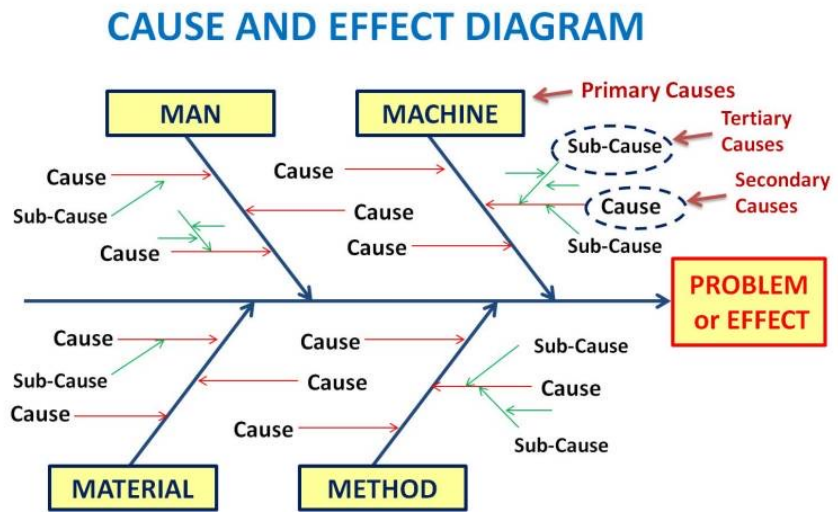
A focus on harm

- 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



7+ years of reductionist thinking

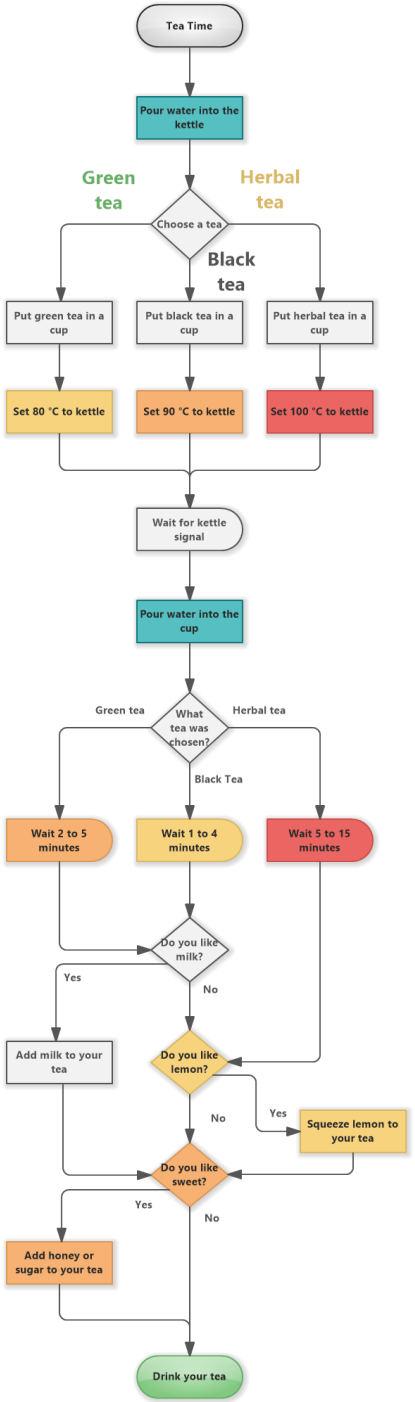
- SIF hasn't allowed for complexity being included in the analysis
- 5 Whys/Fishbone rely on the ability for all 'cause' to be mapped



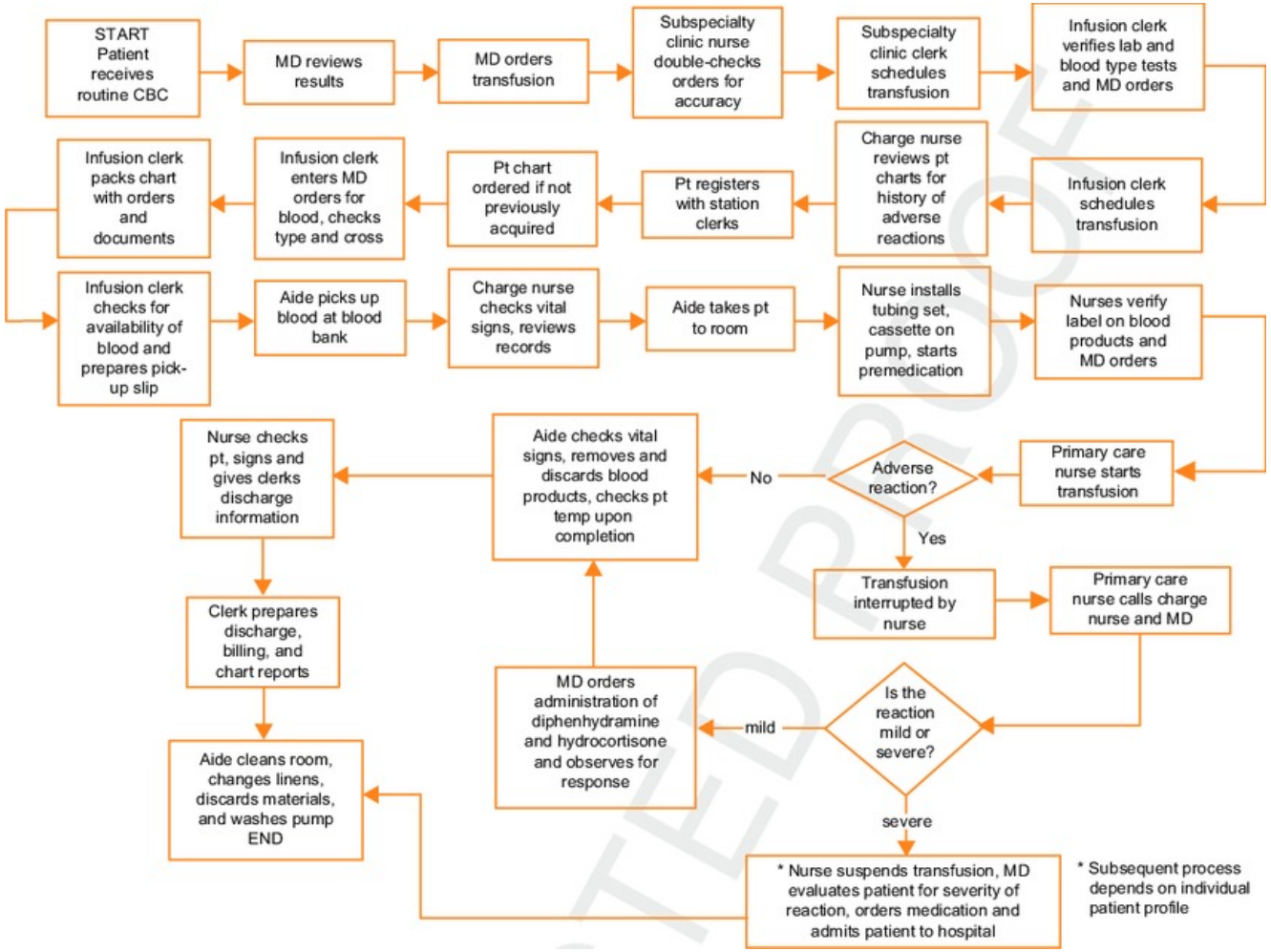
Serious Incident Framework

Supporting learning to prevent recurrence

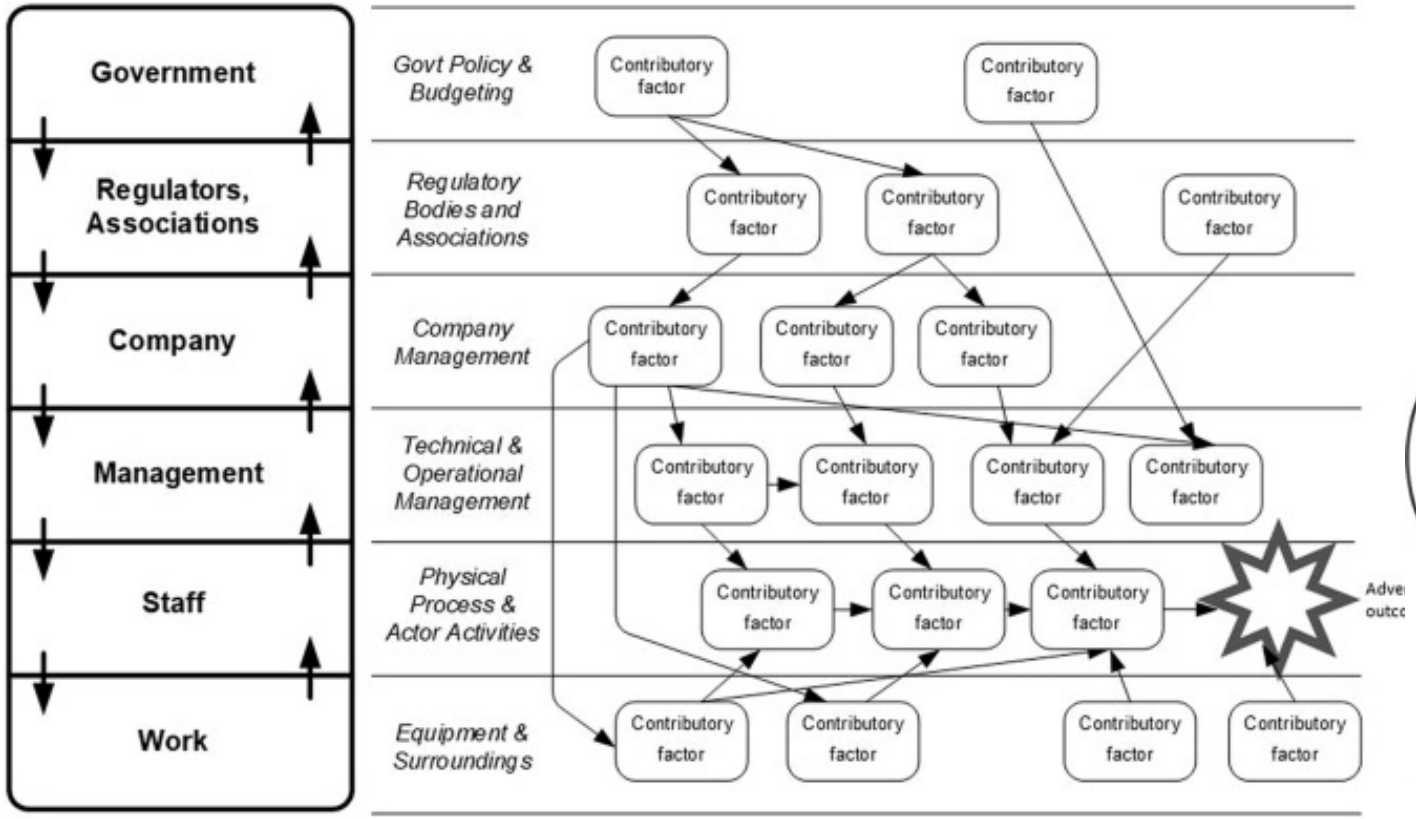
Complexity in patient safety incident investigation

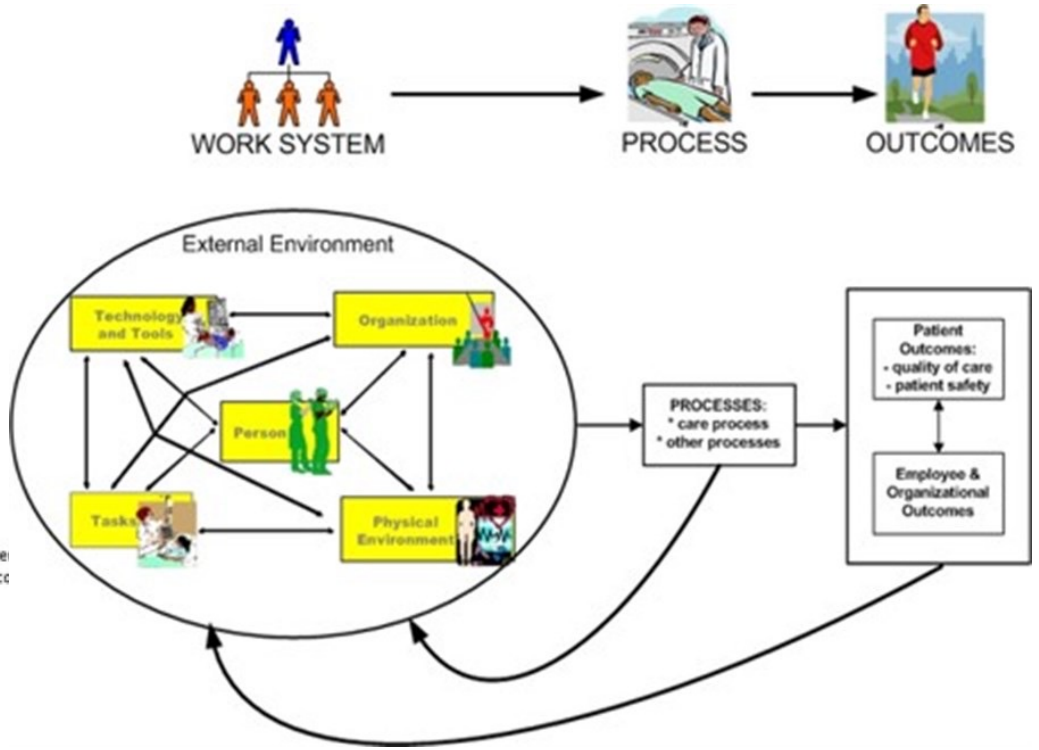


Complexity in patient safety incident investigation



Different tools to aid appreciation of complexity





Sole tool – RCA. Why do we need to move?

- PSIRF asks organisations to move away from reductionist methods towards more system focused methods
- Key challenge in PSIRF implementation is this move from RCAs and 'root causes' to consideration of the system
- A massive part of 'systems thinking' in investigations is shifting mindsets
- Investigation tools are just one part of the puzzle
- RCA as a tool for investigation is intrinsically linked with reductionist mindsets in healthcare currently
- So….why is RCA not the tool to take us towards systems thinking?

Sole tool - RCA


THE PROBLEM WITH...

The problem with root cause analysis

Mohammad Farhad Peerally,[1] Susan Carr,[2] Justin Waring,[3] Mary Dixon-Woods[1]

- The root
- Quality of the investigation
- Political hijack
- Poorly designed controls after RCA
- Poorly functioning feedback loops
- Disaggregated analysis
- Confusion about blame
- Too many hands

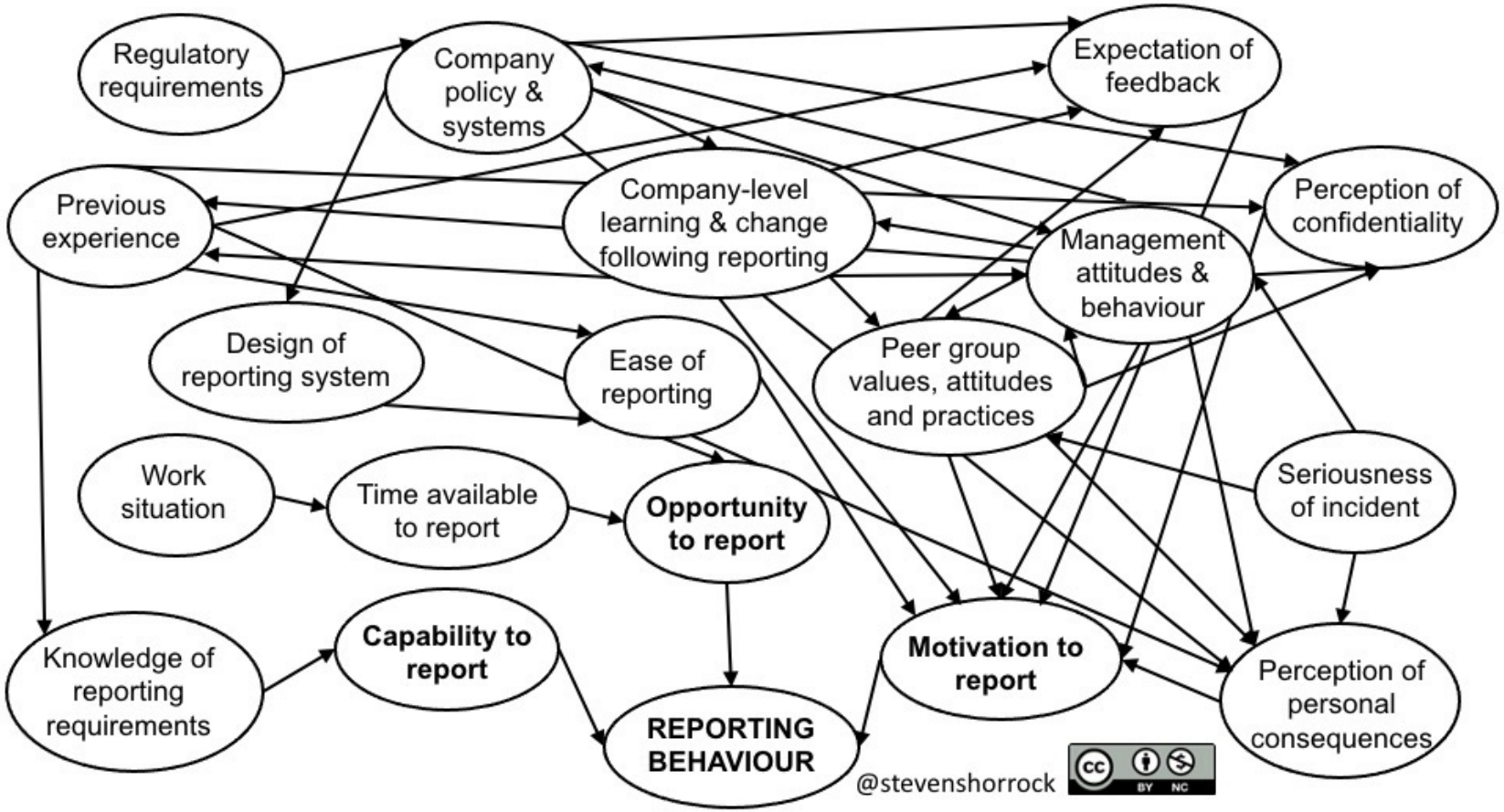
Looking for the ‘root’ cause

Individuals not aware of how or why to report incidents

Resulting in low reporting rates

Increase awareness and close the loop of reporting

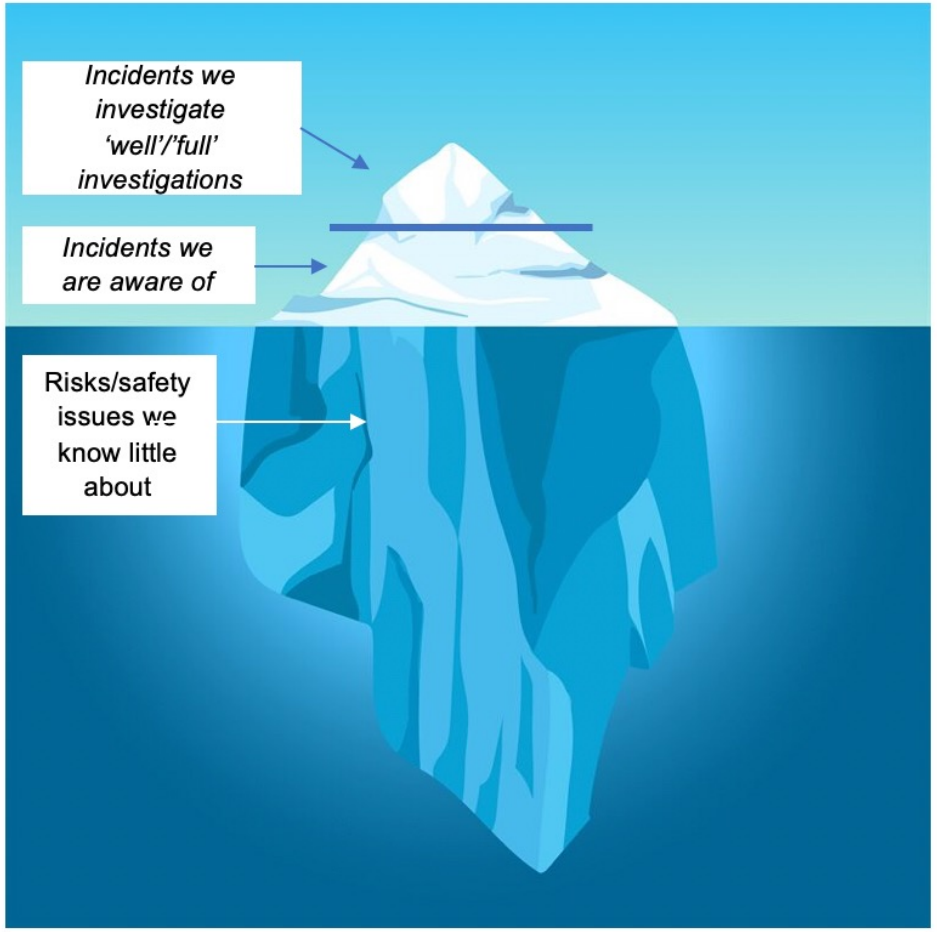
Low reporting rates – the reality



Approaches to safety

- Safety I vs Safety II
- Near misses/low and no harms
- Insights being acted upon
- Proactivity away from reactivity

Approaches to safety



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'*

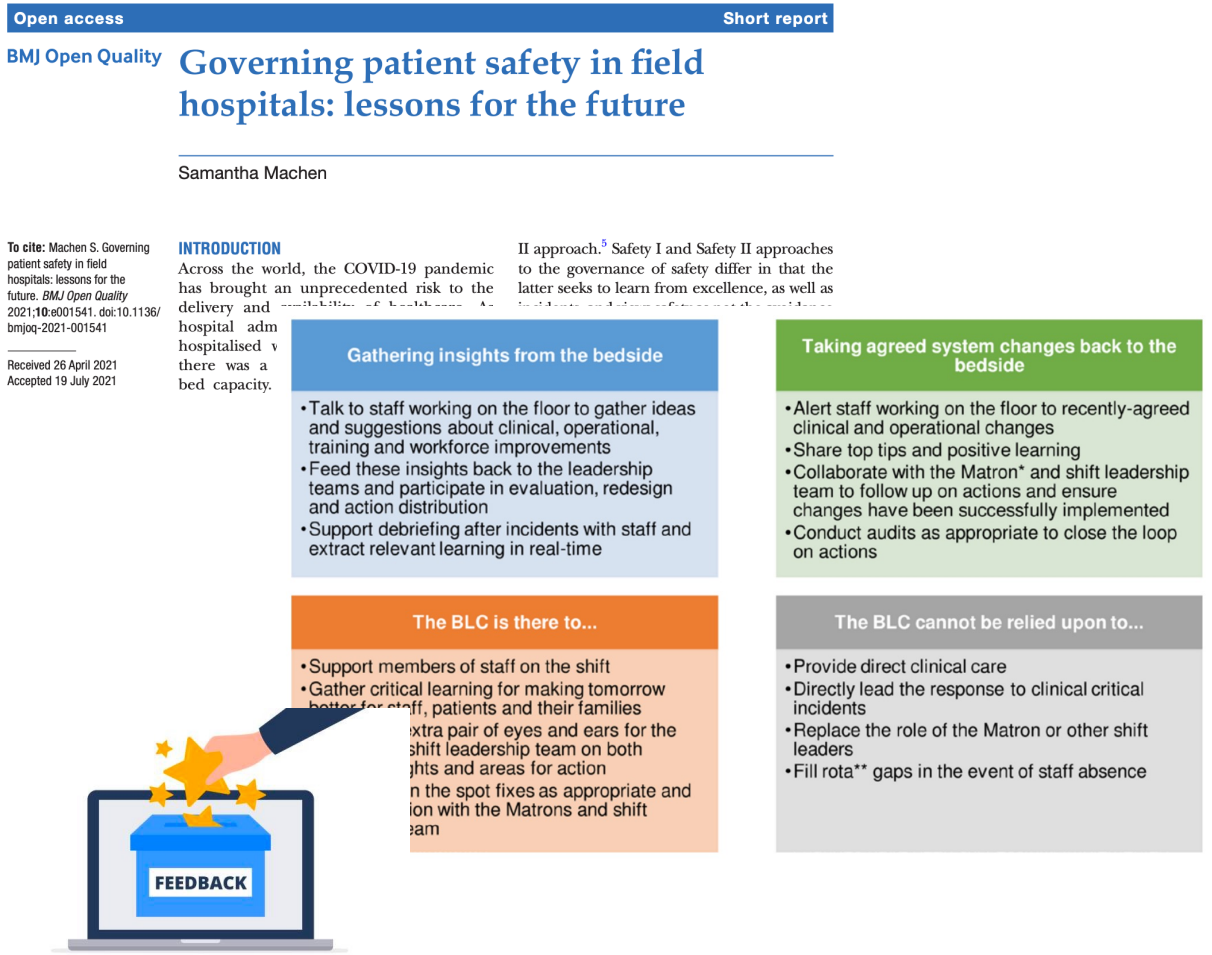
What is in our toolbox?

What is in our toolbox?

- After Action Reviews
- Thematic reviews
- Rapid reviews
- 'Full' investigations
- Insight visits
- 'Speaking up'-based improvement projects

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 [illegible] 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

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

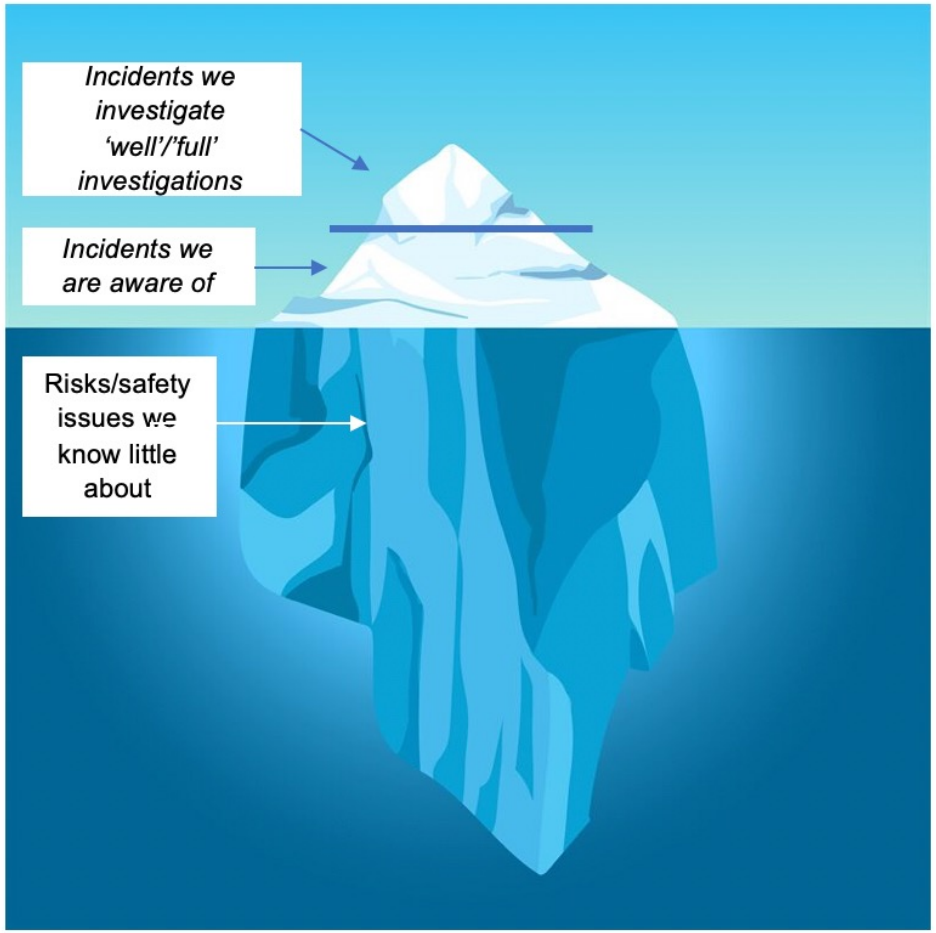
The BLC is there to...

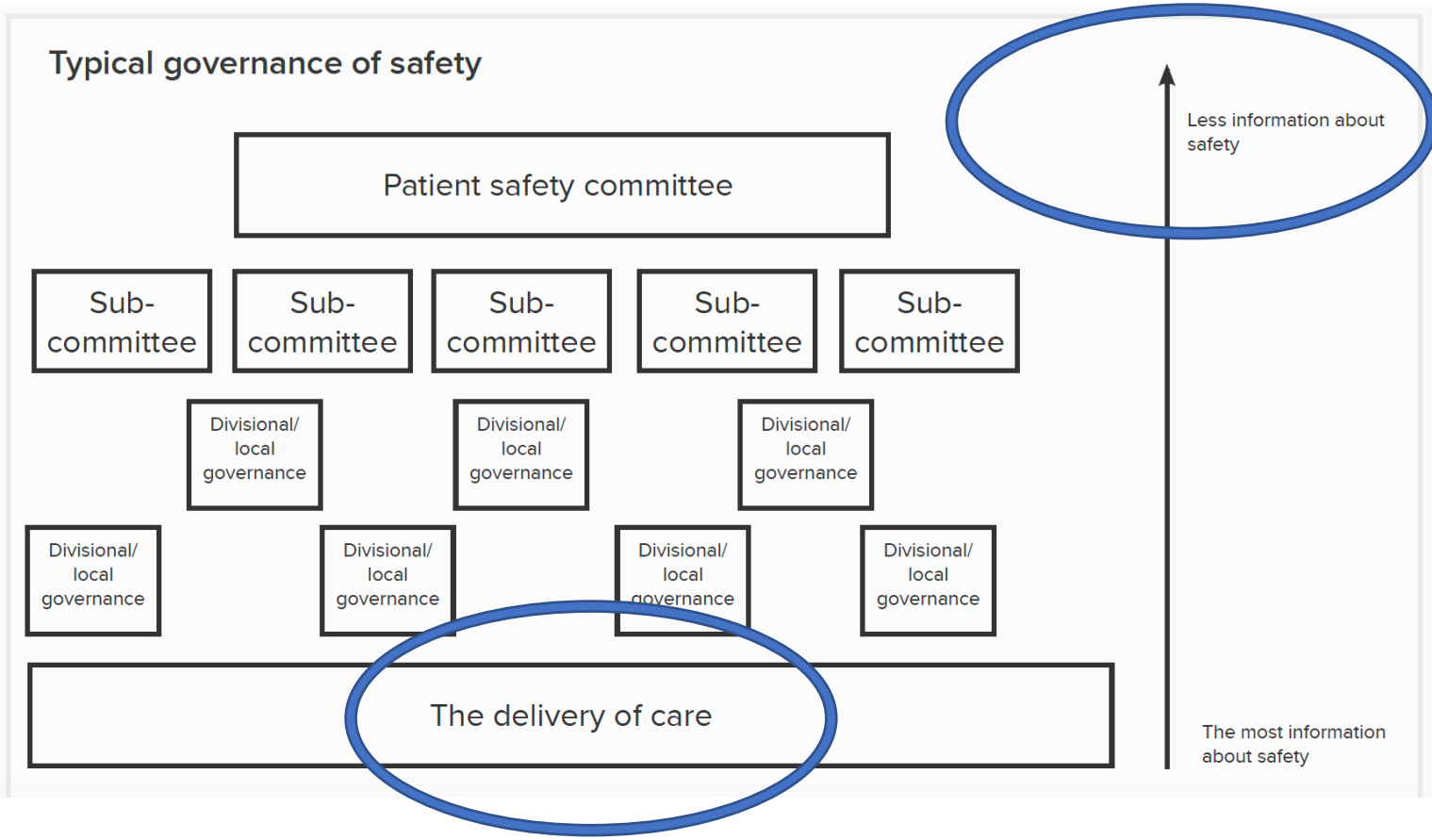
- Support members of staff on the shift
- Gather critical learning for making tomorrow [illegible]ff, patients and their families
- [illegible]xtra pair of eyes and ears for the [illegible]shift leadership team on both [illegible]hts and areas for action
- [illegible]n the spot fixes as appropriate and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

Involvement as a tool for improving safety





Strategies for improving involvement

- Changing semantics – staff want to do best by their patients, safety improvement allows this
- Active listening (even when it is hearing something that violates our work as imagined)
- Visibility and leadership
- Supporting staff – safety problems can feel overwhelming and downwards pressure doesn't help
- Seeing patient safety team as an extension of their team and on the same side

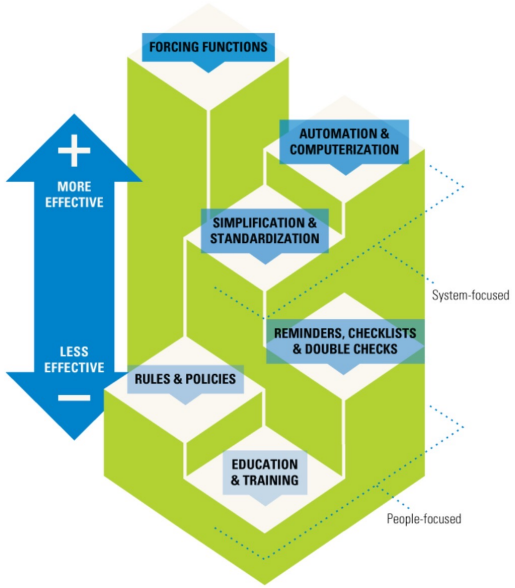
Revisiting Safety as a norm

- During multiple waves of Covid, ED staff concerned with understanding how safety was affected by poor staffing (proactivity)
- Not wanting to wait until something went wrong (reactivity)
- Ran weekly safety calls utilising both Safety I and Safety II theory
- Building on resilience and identifying context which may precipitate incidents/harm
- Picked up safety concerns by involving staff in a simple question – "how safe was your shift?
- Safety intelligence gets us closer to understanding safety culture/climate

Worth the Risk?
Double-Checking High Risk Medication Calculations

CorrectionalNurse.net

The Hierarchy of Intervention Effectiveness



Improvement

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

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Thank you for listening!

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