

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

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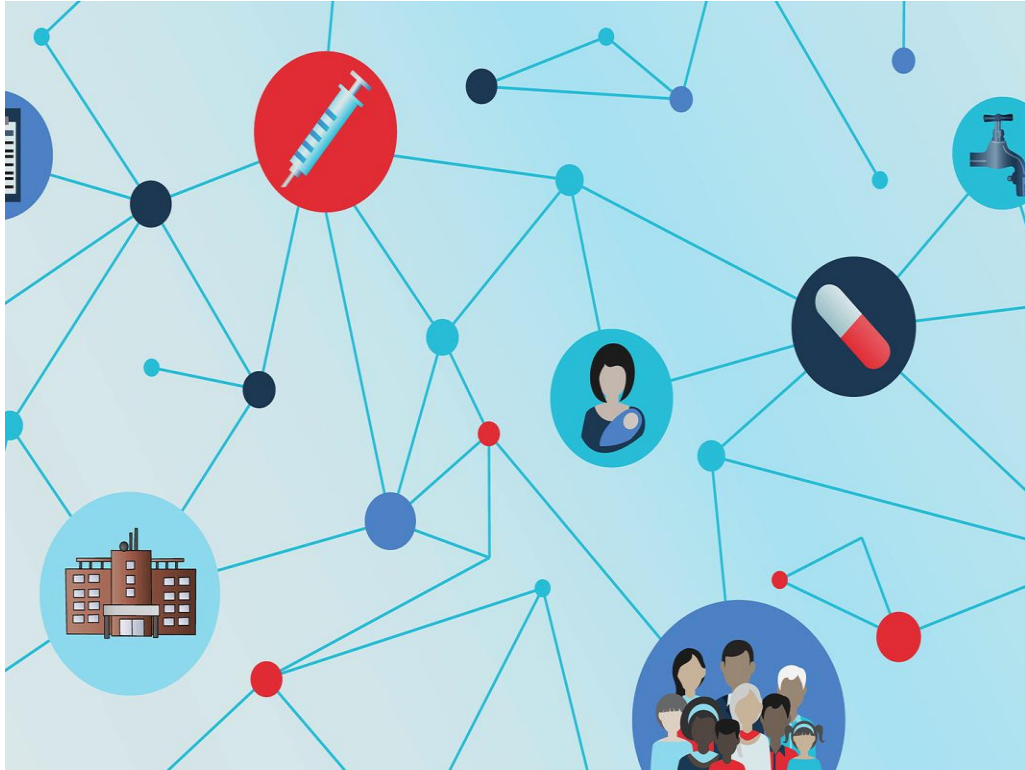
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14/03/2025

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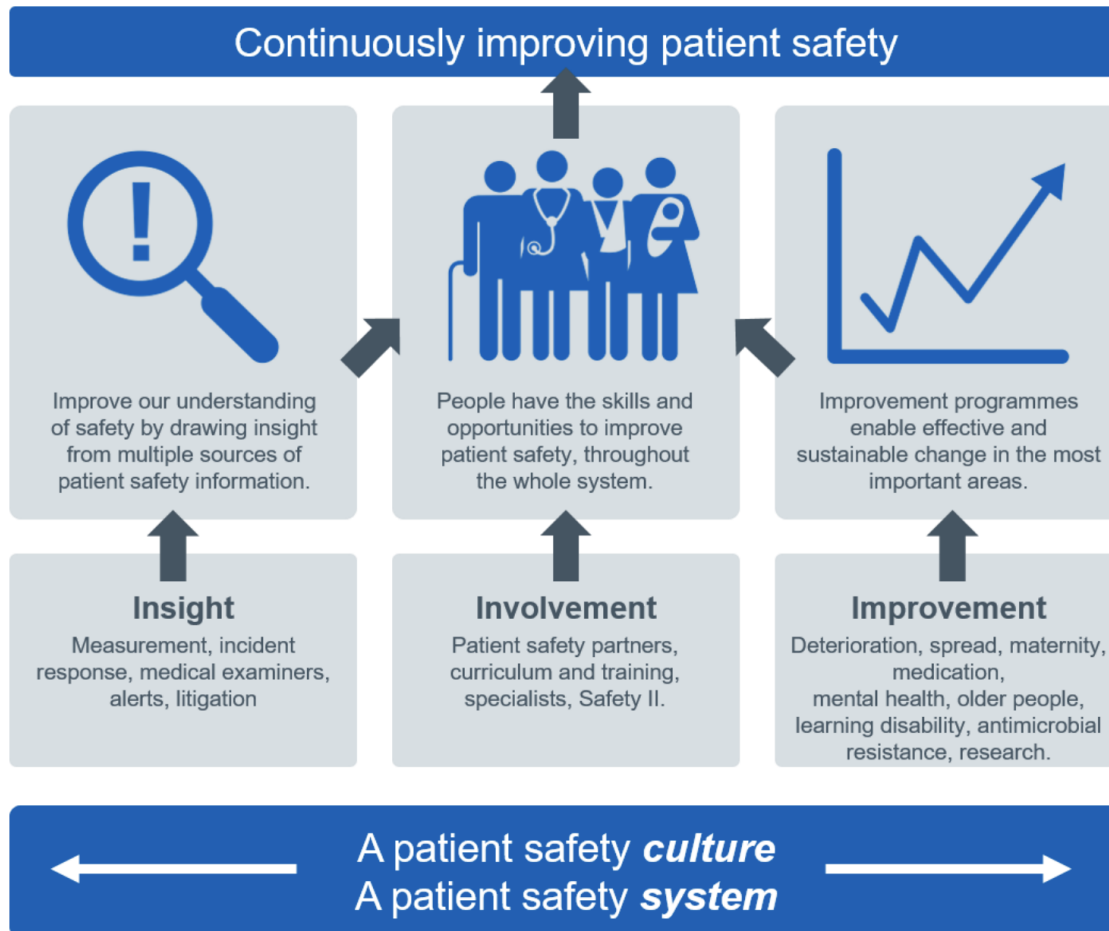


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# Presentation overview

- 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

## Patient Safety Incident Response Framework 2020

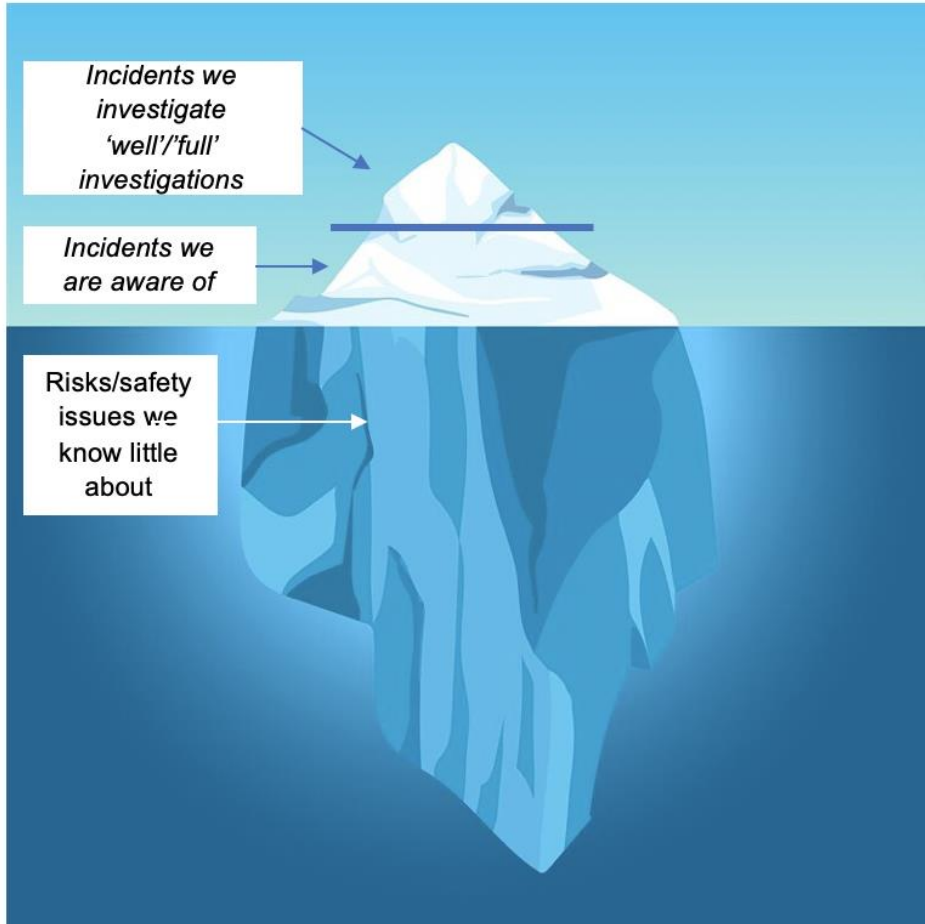
An introductory framework for implementation by nationally appointed early adopters

March 2020

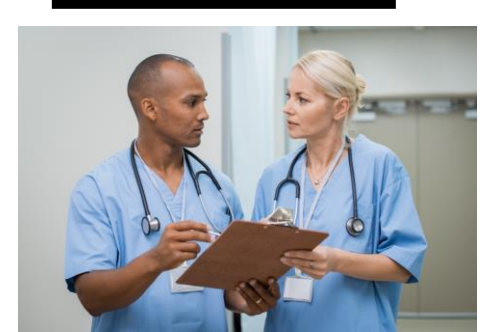
**The PSIRF will NOT replace other statutory requirements for investigation e.g. learning from deaths / incidents reported to HSIB**

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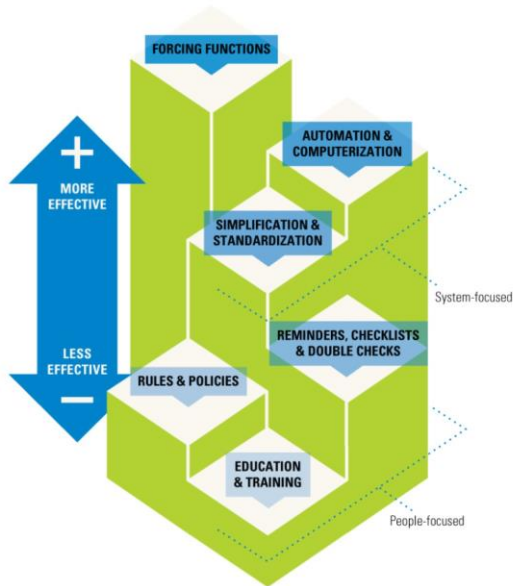
# Approaches to safety



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



The Hierarchy of Intervention Effectiveness



# 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/bmjopen-2021-001541

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

II approach.<sup>5</sup> 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 better for staff, patients and their families
- Provide an extra pair of eyes and ears for the shift leadership team on both shifts and areas for action
- Provide spot fixes as appropriate and in consultation with the Matrons and shift team

**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





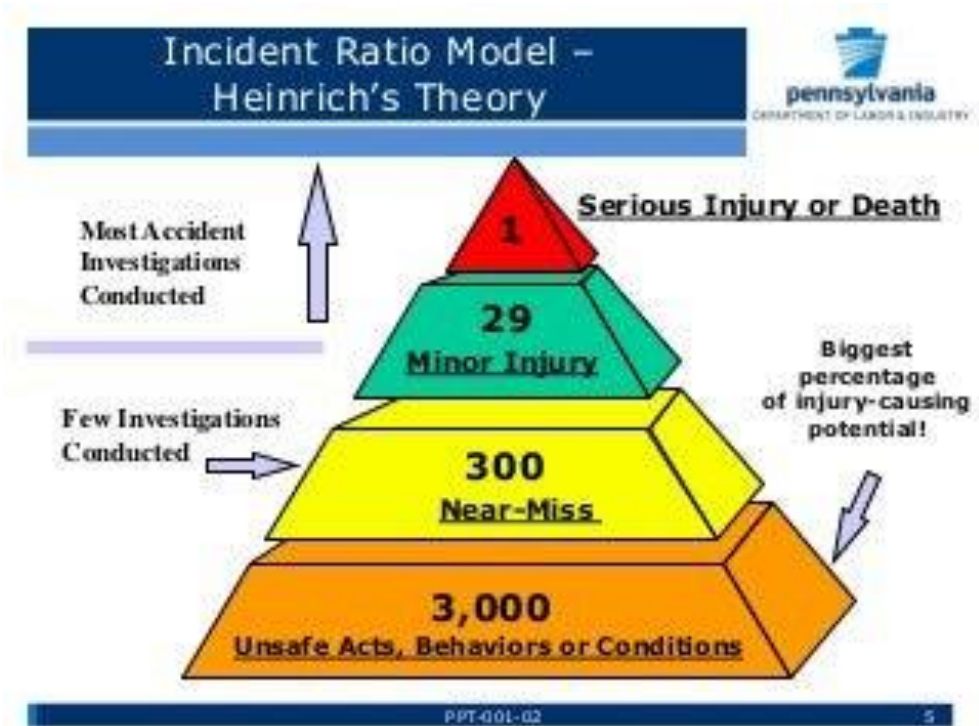
# What are our barriers to implementing?

- 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



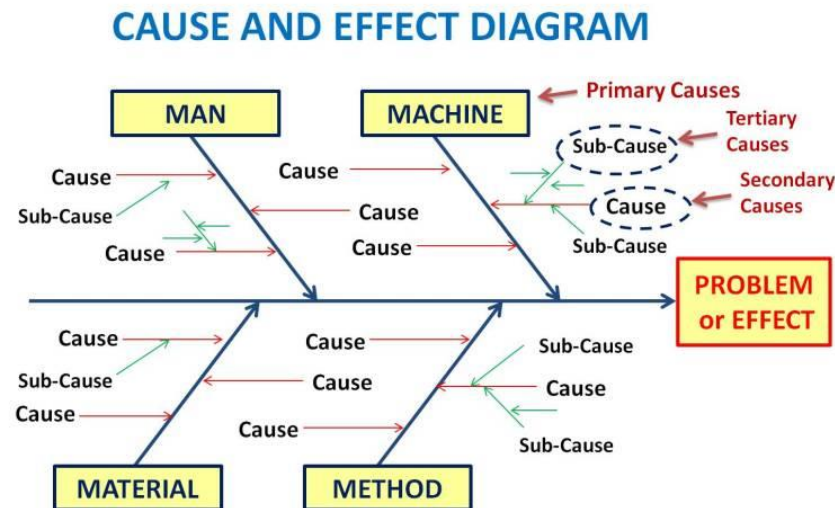
## A focus on harm

- 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

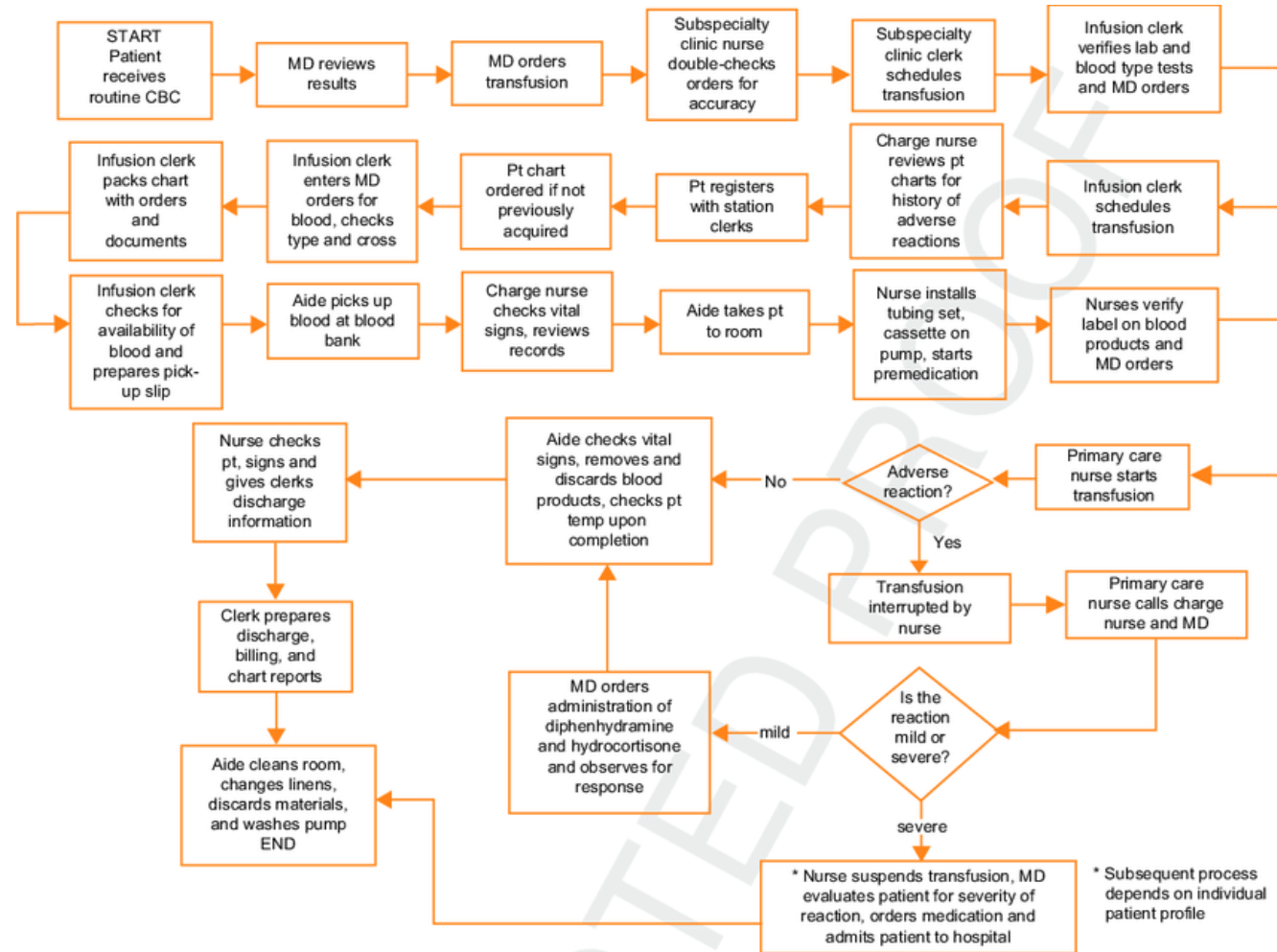
- SIF hasn't allowed for complexity being included in the analysis
- 5 Whys/Fishbone rely on the ability for all 'cause' to be mapped



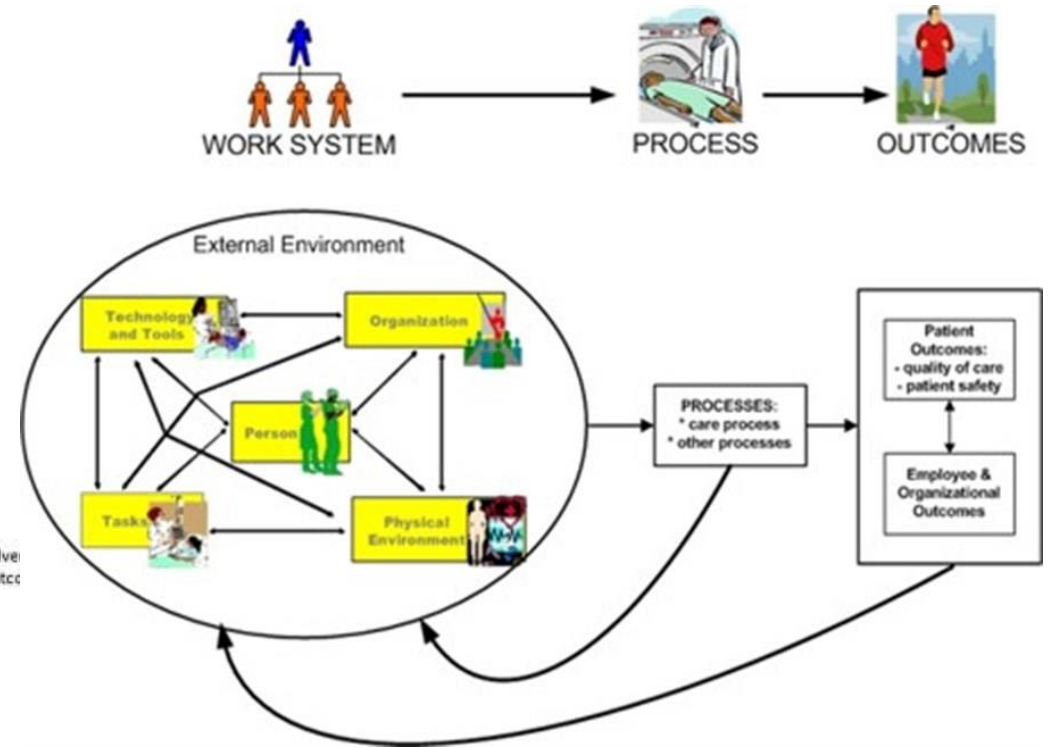
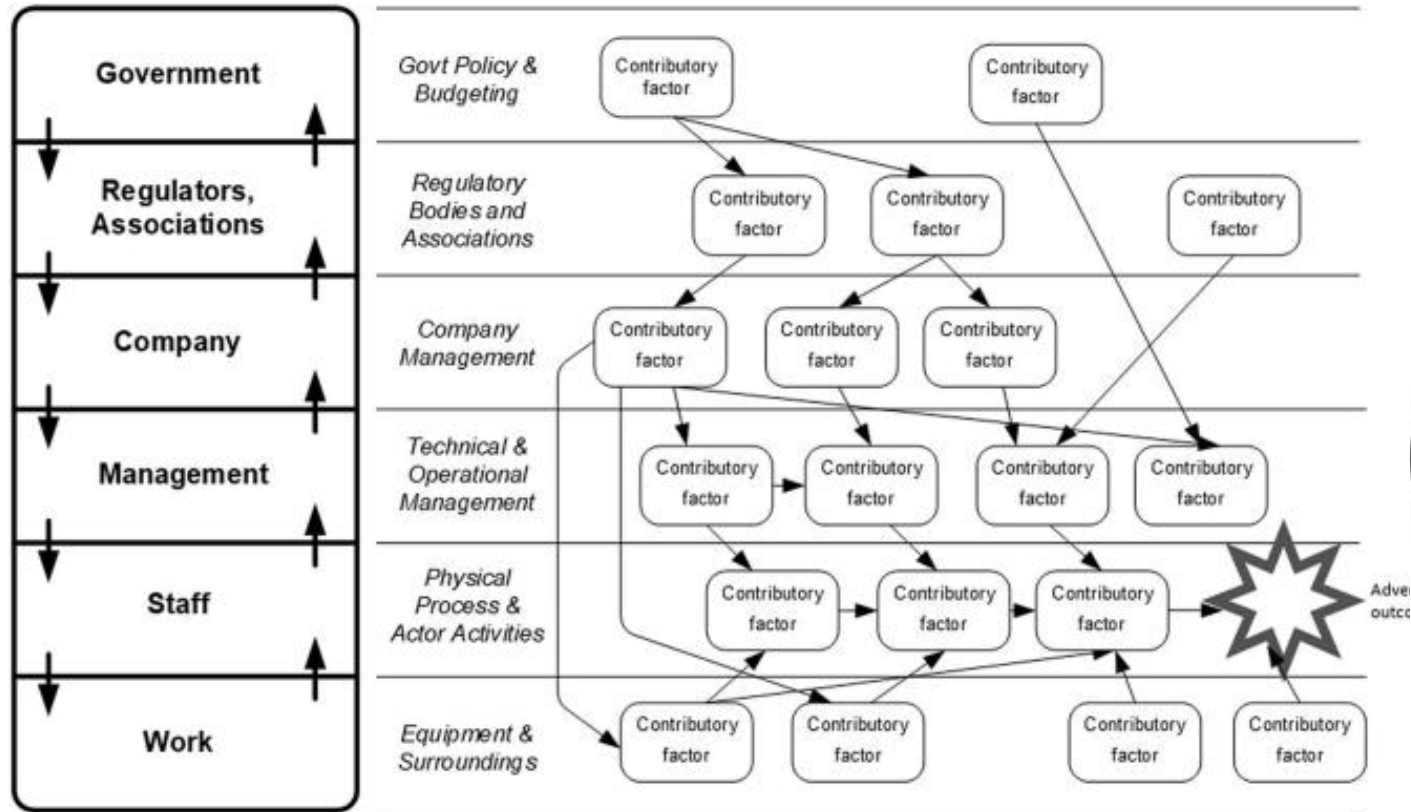
## Serious Incident Framework

Supporting learning to prevent recurrence

# Complexity in patient safety incident investigation



# Different tools to aid appreciation of complexity

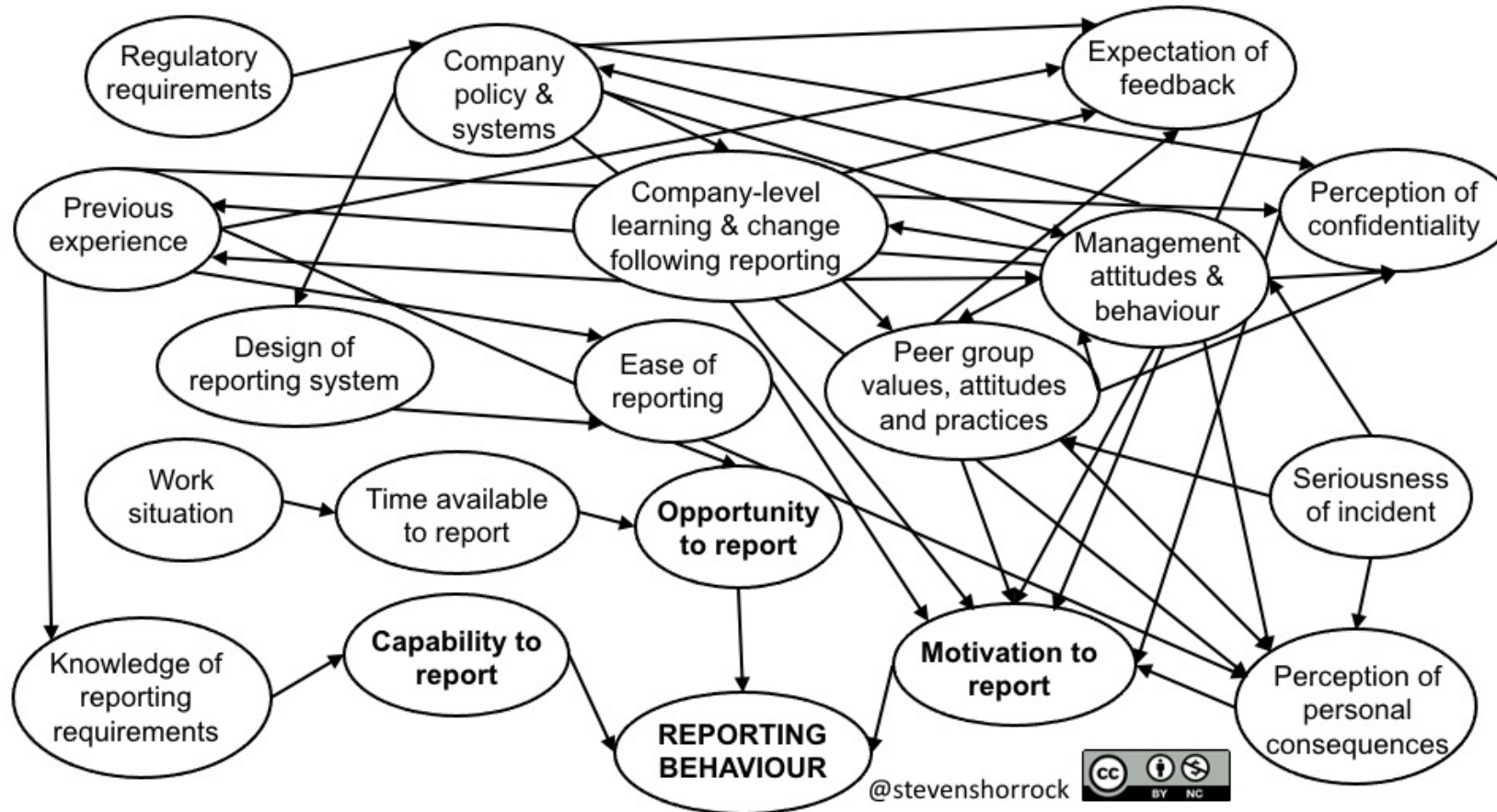


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# Sole tool – RCA. Why do we need to move?

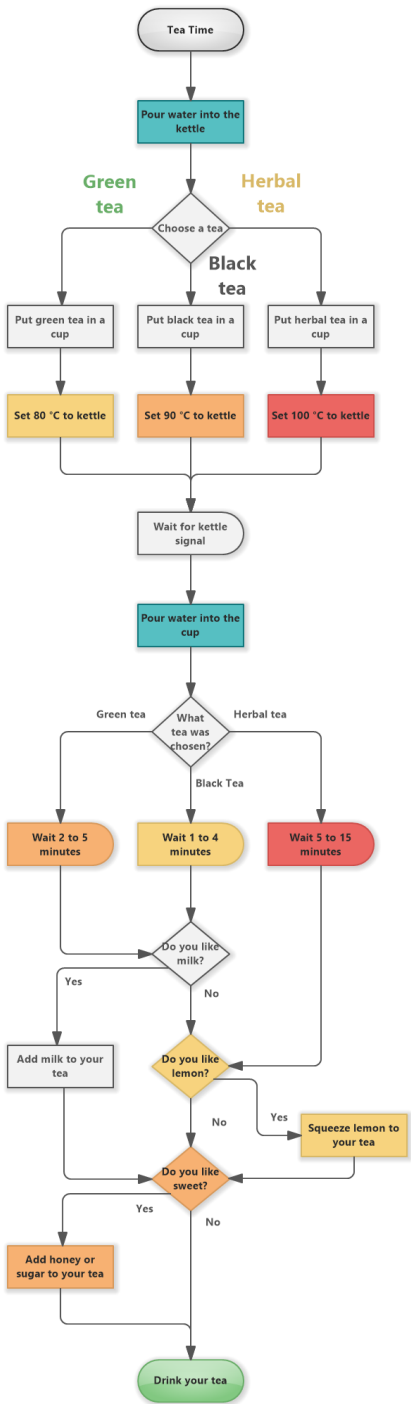
- PSIRF asks organisations to move away from reductionist methods towards more system focused methods
- Key challenge in PSIRF implementation is this move from RCAs and ‘root causes’ to consideration of the system
- A massive part of ‘systems thinking’ in investigations is shifting mindsets
- Investigation 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?

# Low reporting rates – the reality



# Complexity in patient safety incident investigation

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# Approaches to safety



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

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# Sole tool - RCA

## THE PROBLEM WITH...

### The problem with root cause analysis

Mohammad Farhad Peerally,<sup>1</sup> Susan Carr,<sup>2</sup> Justin Waring,<sup>3</sup>  
Mary Dixon-Woods<sup>1</sup>

- 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

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# What is in our toolbox?



# Incident Tools

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



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**Thank you for listening!**

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