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

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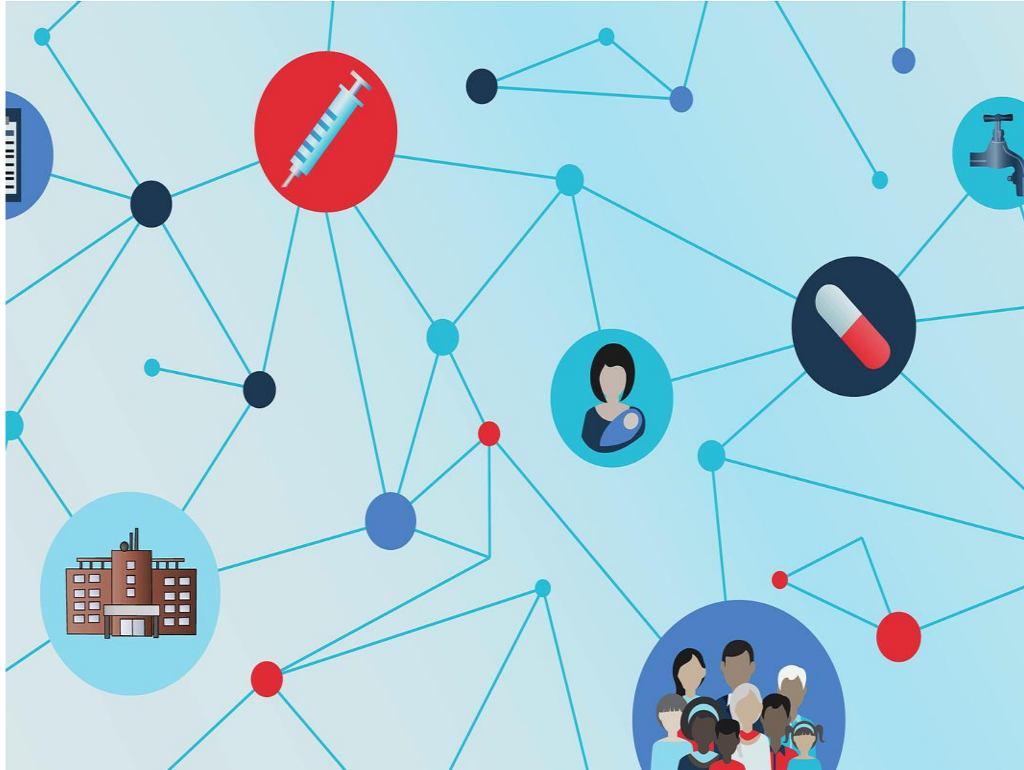
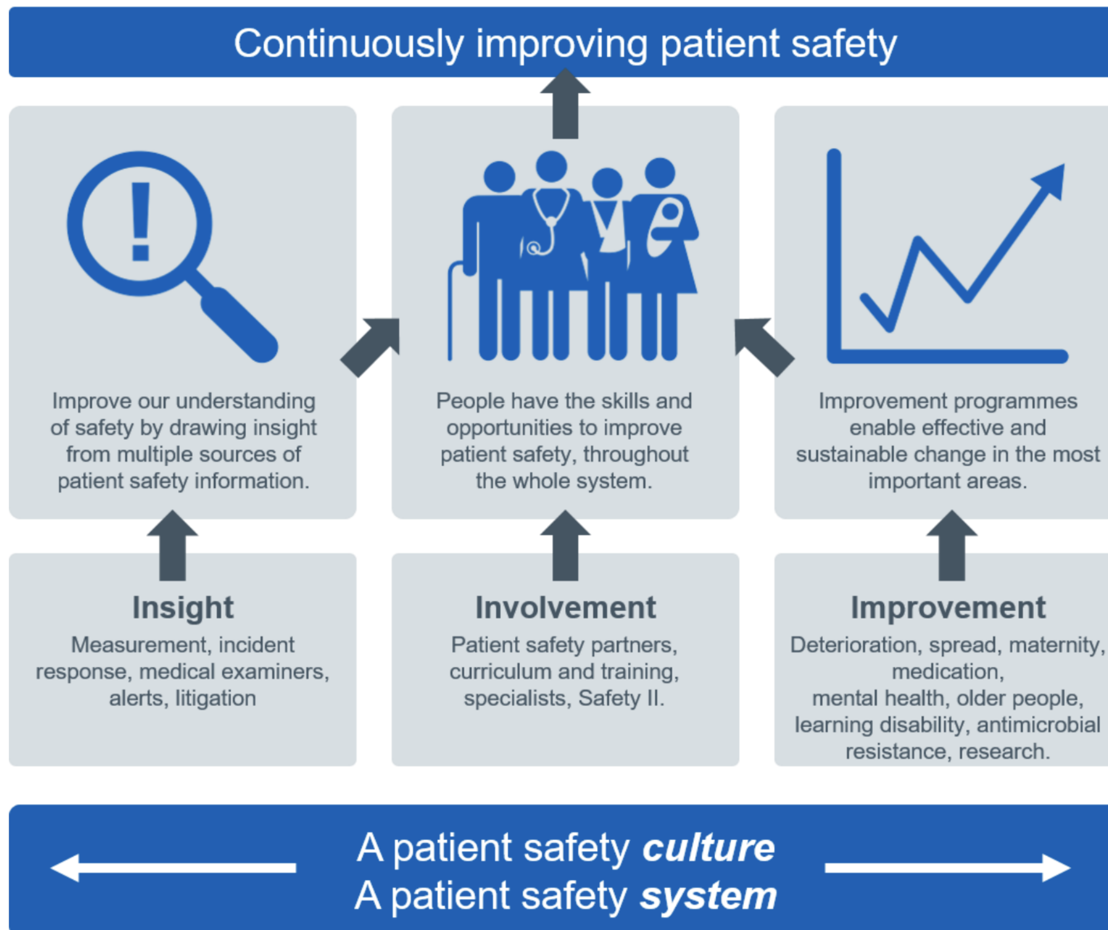


Presentation overview

- 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*

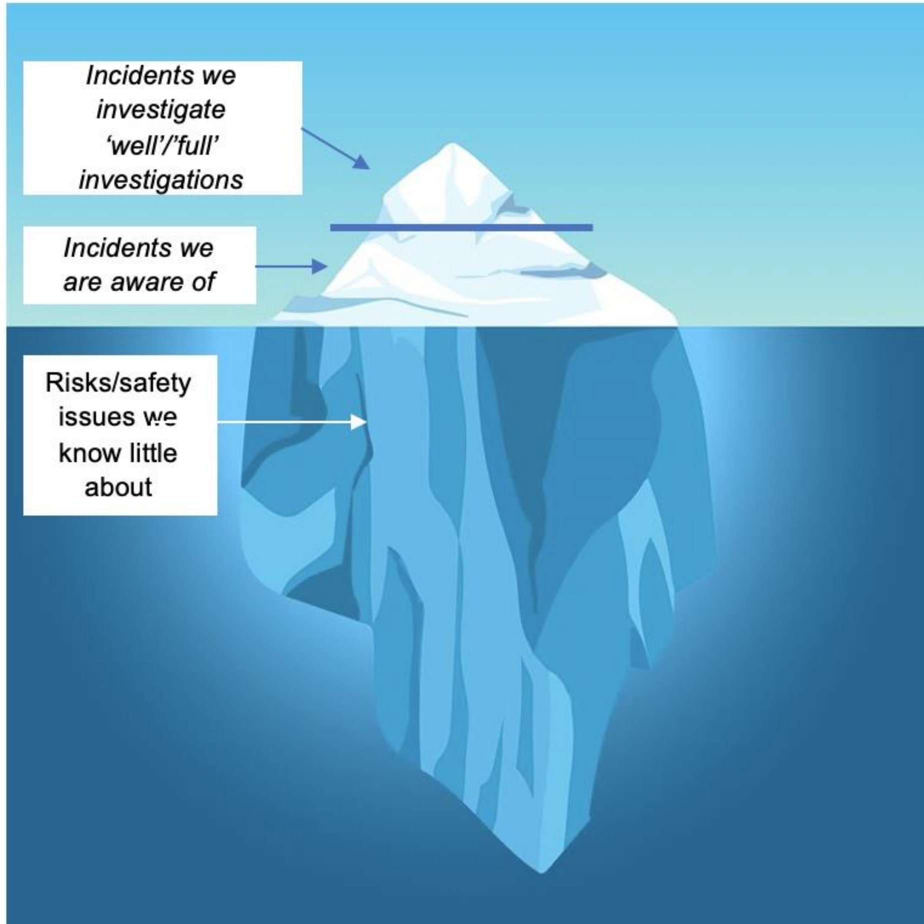
Patient Safety Incident Response Framework 2020

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

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

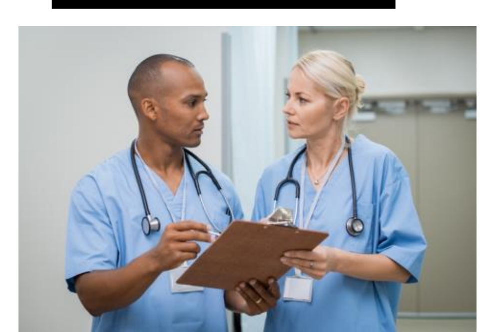
Innovative medicine
Trauma centres

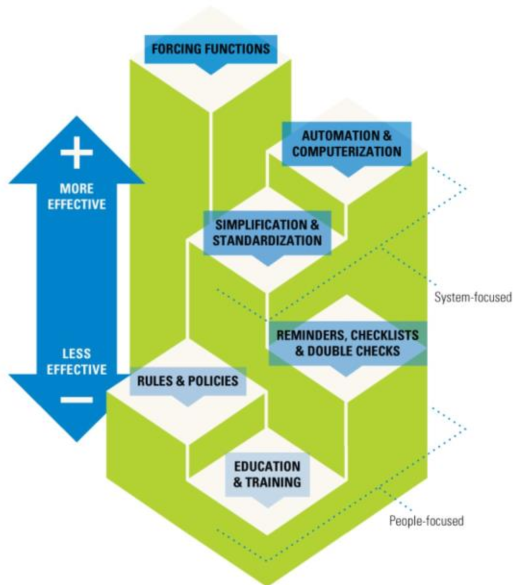
Scheduled surgery
Chronic care

Anaesthesiology
ASA1

Radiotherapy
Blood transfusion

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



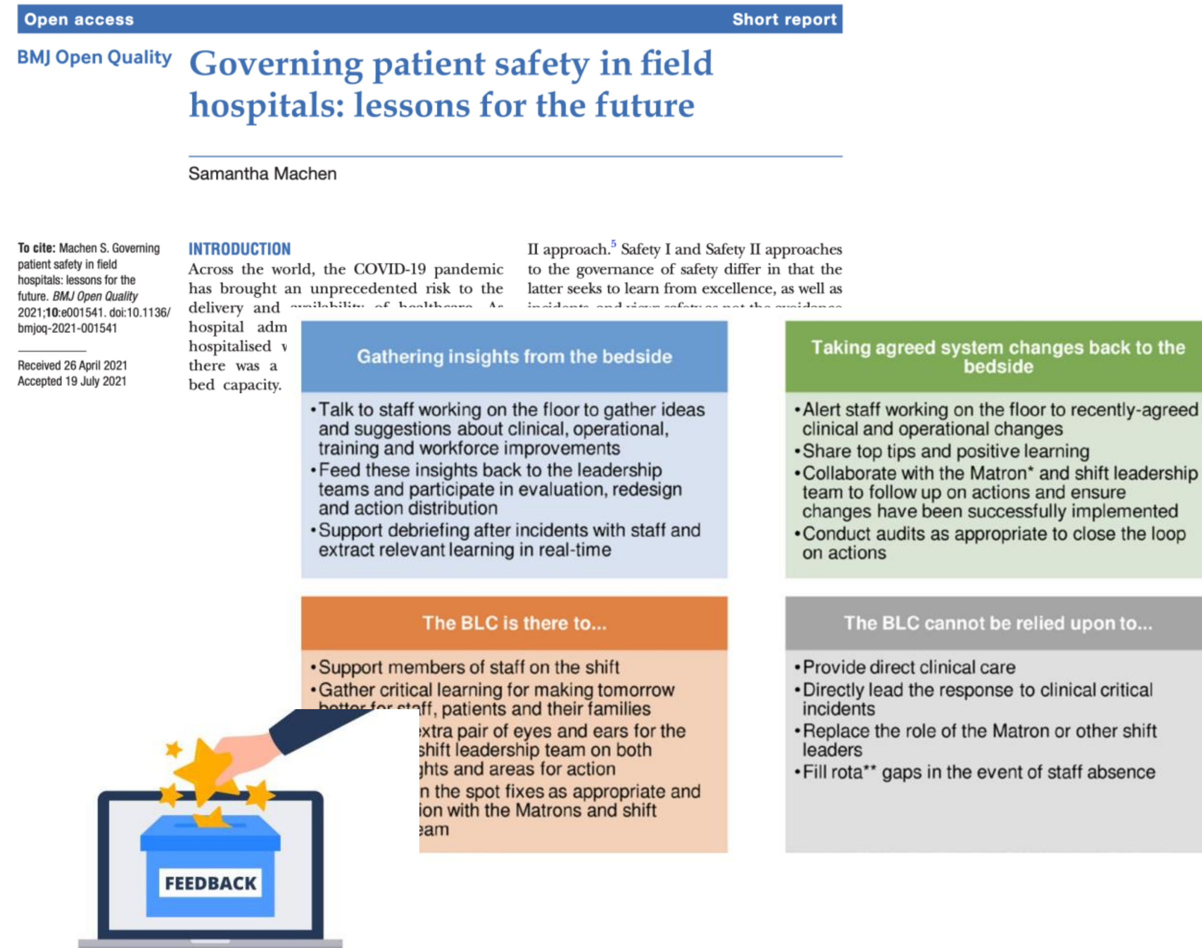


Improvement

- 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)

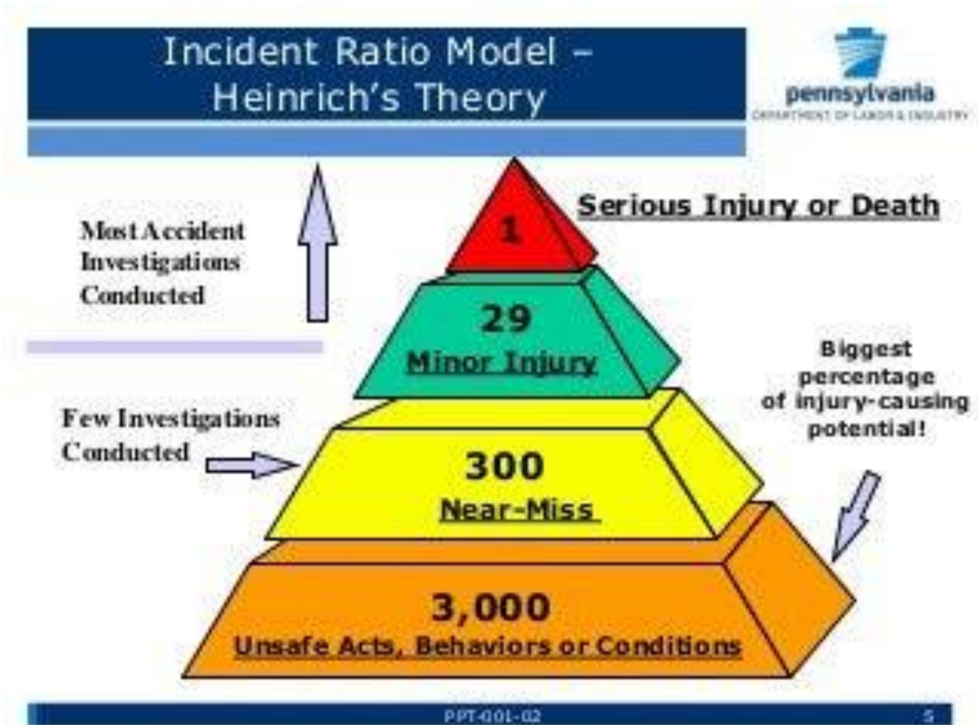


What are our barriers to implementing?

- 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

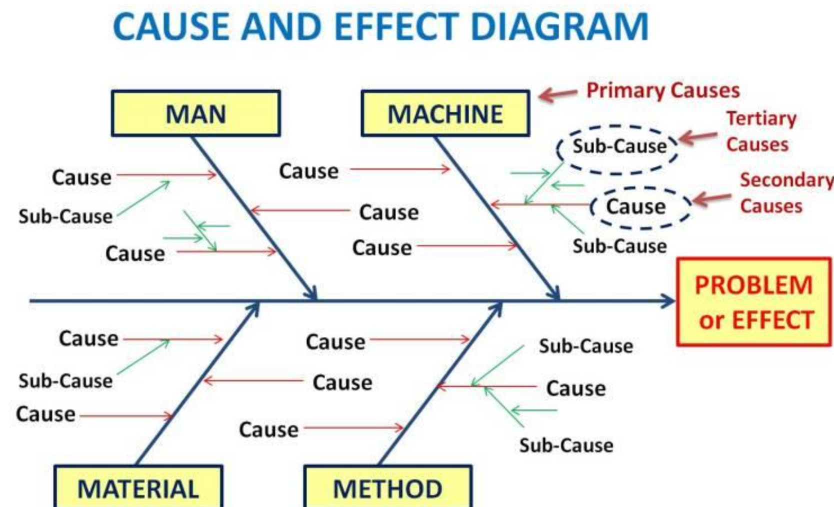
- SI has guided us towards harm as the way to sieve through incidents
- Research shows that isn't always correct
- SI Framework encouraged us to focus just on those meeting high harm levels
- Theming together incidents to look at portfolios versus isolated incidents



NHS England

7+ years of reductionist thinking

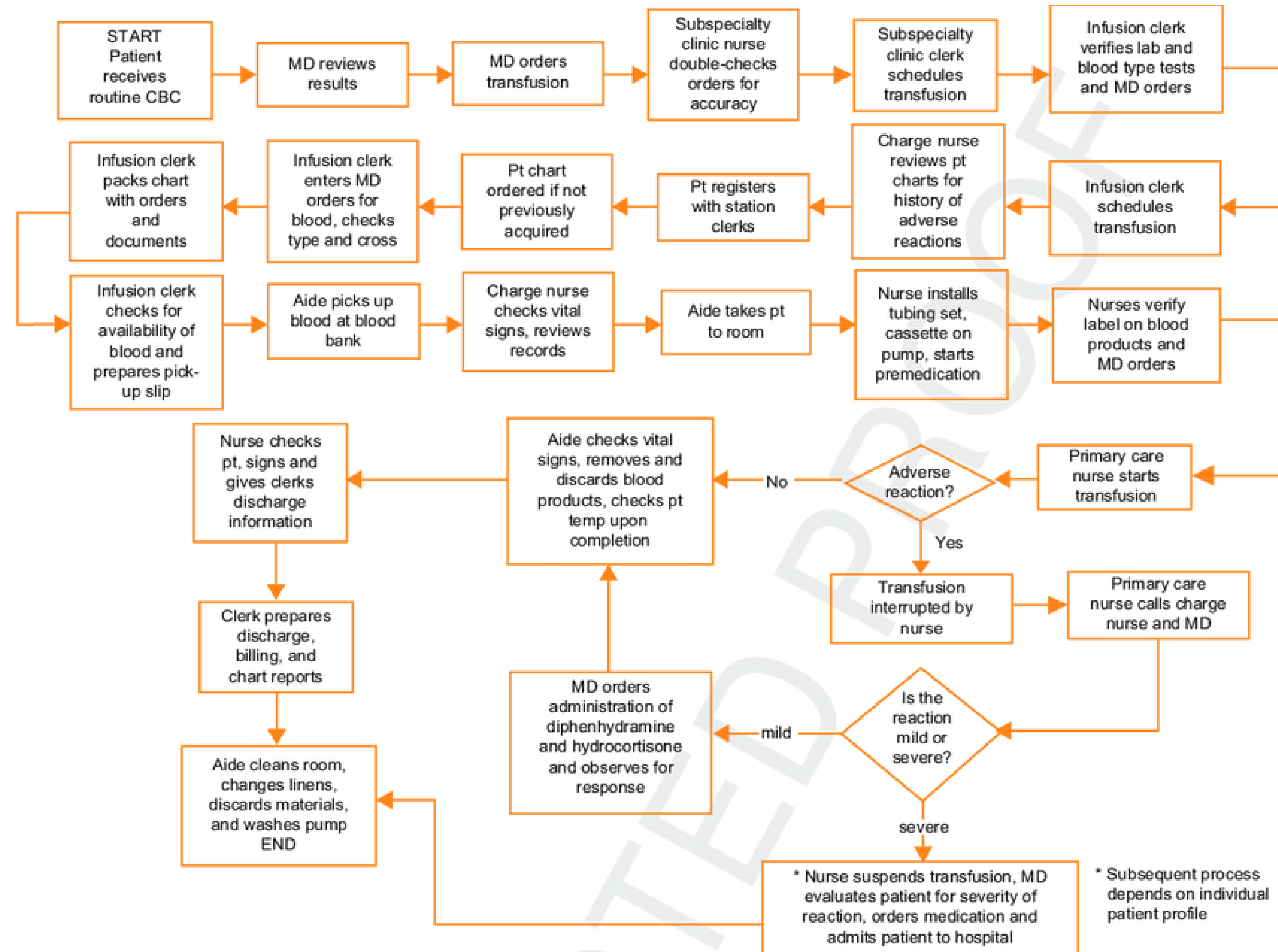
- SIF hasn't allowed for complexity being included in the analysis
- 5 Whys/Fishbone rely on the ability for all 'cause' to be mapped



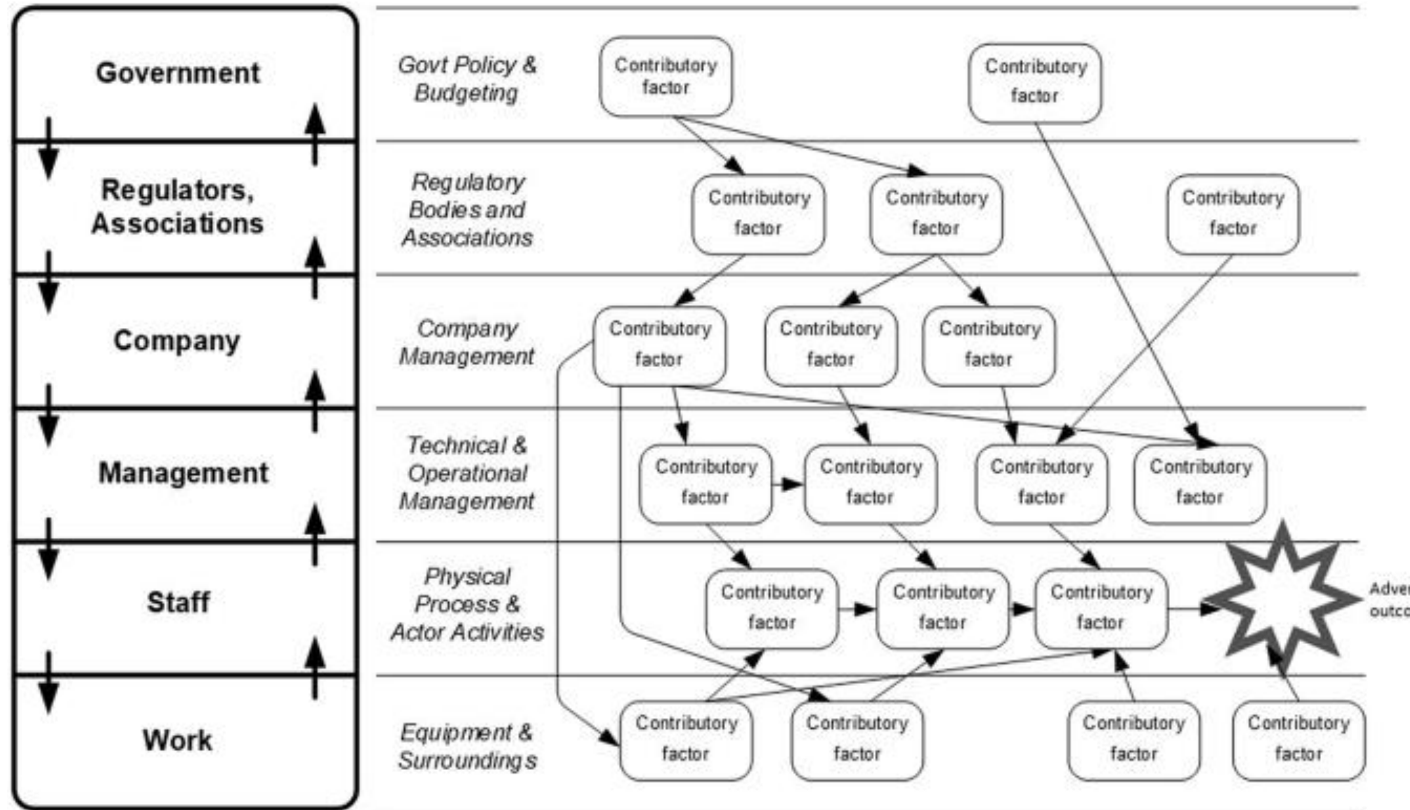
Serious Incident Framework

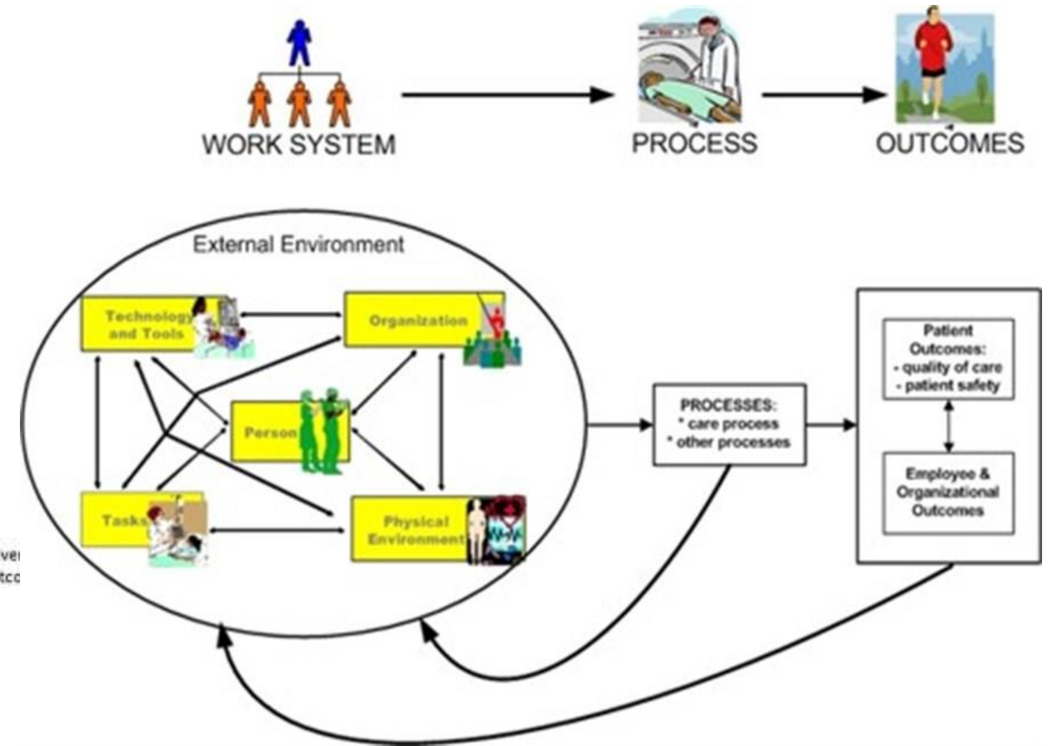
Supporting learning to prevent recurrence

Complexity in patient safety incident investigation



Different tools to aid appreciation of complexity

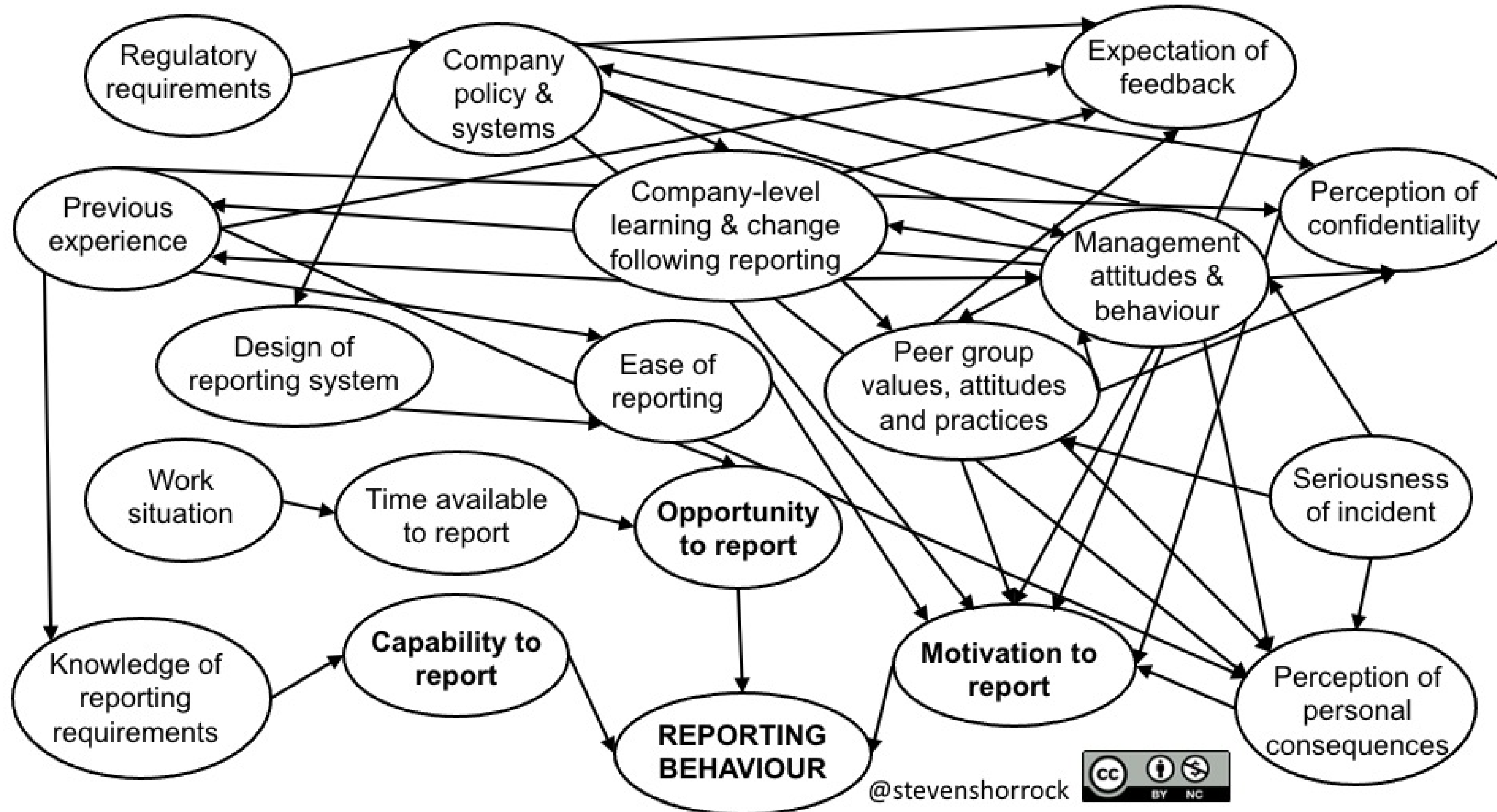


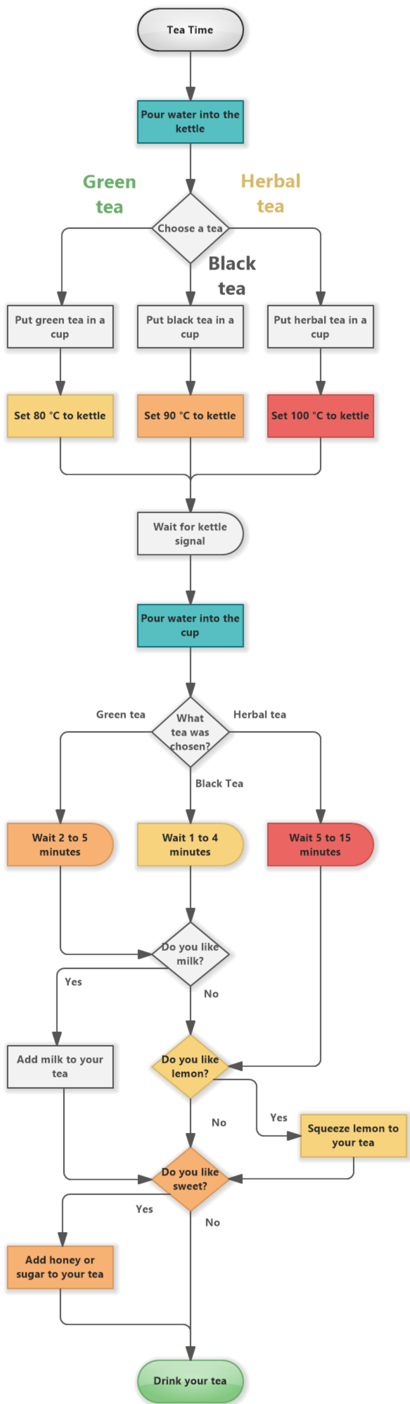


Sole tool – RCA. Why do we need to move?

- 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

Approaches to safety

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

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

What is in our toolbox?

Incident Tools

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

Thank you for listening!

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