

A decorative graphic on the left side of the slide. It features a large, semi-circular shape composed of many overlapping, semi-transparent triangles in various shades of orange and brown. To the right of this shape, there are several green geometric elements: a solid green circle at the top left, a green line forming a right-angled corner at the top right, and a green line forming a right-angled corner at the bottom left. At the bottom center, there are three short, curved green lines above a solid orange circle.

Patient Safety Incident Management in the UK

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Objectives to Cover

- Patient Safety and Incident Management timeline
- What is a patient safety incident
- Key players
- Reporting, supporting, investigating and learning
- Future direction of incident management

Pre 1999

1952 Establishment of national Confidential Enquiry into Maternal Deaths

1955 First guidance from the Ministry of Health to NHS hospitals on the reporting of accidents and untoward occurrences (HM(55)66).

1961 Joint Memorandum by the MDU, RCN, and National Council of Nursing, 'Safeguards against wrong operations'.

1963 Joint Memorandum by the MDU, RCN, and National Council of Nurses, 'Safeguards against failure to remove swabs etc., from patients'

1972 Guidance to hospitals on the prevention of surgical accidents (HM(72)37)

1999-2009

1999- Health Select Committee considers the handling of adverse incidents and occurrences in the NHS. The London Protocol

2000 - Department of Health report, *An Organisation with a Memory*, estimates that 850,000 patients (around 1 in 10) admitted to NHS hospitals encounter an adverse health event.

2001 - Establishment of the National Patient Safety Agency (NPSA)

Publication of Kennedy Report into Children's heart surgery Bristol Royal Infirmary

Department of Health report *Building a Safer NHS for Patients: Implementing An Organisation With A Memory*

Establishment of the Shipman Inquiry.

2002 - NPSA 1st patient safety alert, on preventing accidental overdose of intravenous potassium.

2003 - Establishment of National Reporting and Learning System (NRLS)

2005 - NPSA alert and guidance on Being Open: Communicating Patient Safety Incidents with Patients and their Carers

2008 Mid Staffordshire Enquiry

2009 to date

2009 Establishment of the CQC

2010 Francis Report into Mid Staffordshire

2012 NPSA abolished – fx transferred to NHSE

2013 Serious Incident Framework

2014 Duty of Candour legislation

2015 Morecombe investigation report

2016 establishment of NHSI

National Guardian Office and the Freedom to Speak – up Guardian

2017 Establishment Healthcare Safety Investigation Branch HSIB

2018 Gosport Report - prescription and administration of drugs such as diamorphine

2019 Publication of the NHS Patient Safety Strategy which includes the Patient Safety Incident Response Framework (awaiting the implementation of the latter)

2020 Report of the Independent Inquiry into the Issues Raised by Paterson

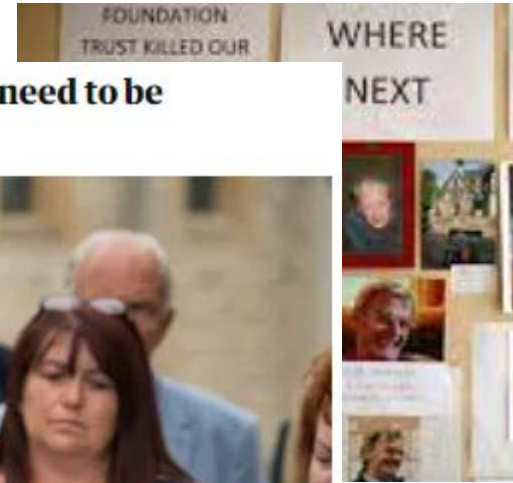
2020 First Do No Harm: The Report of the Independent Medicines and Medical Devices Safety Review (Cumberlege report)

2020 Interim Ockendon report into maternity services at Shrewsbury and Telford Hospitals NHS

2021 Medical Examiner role



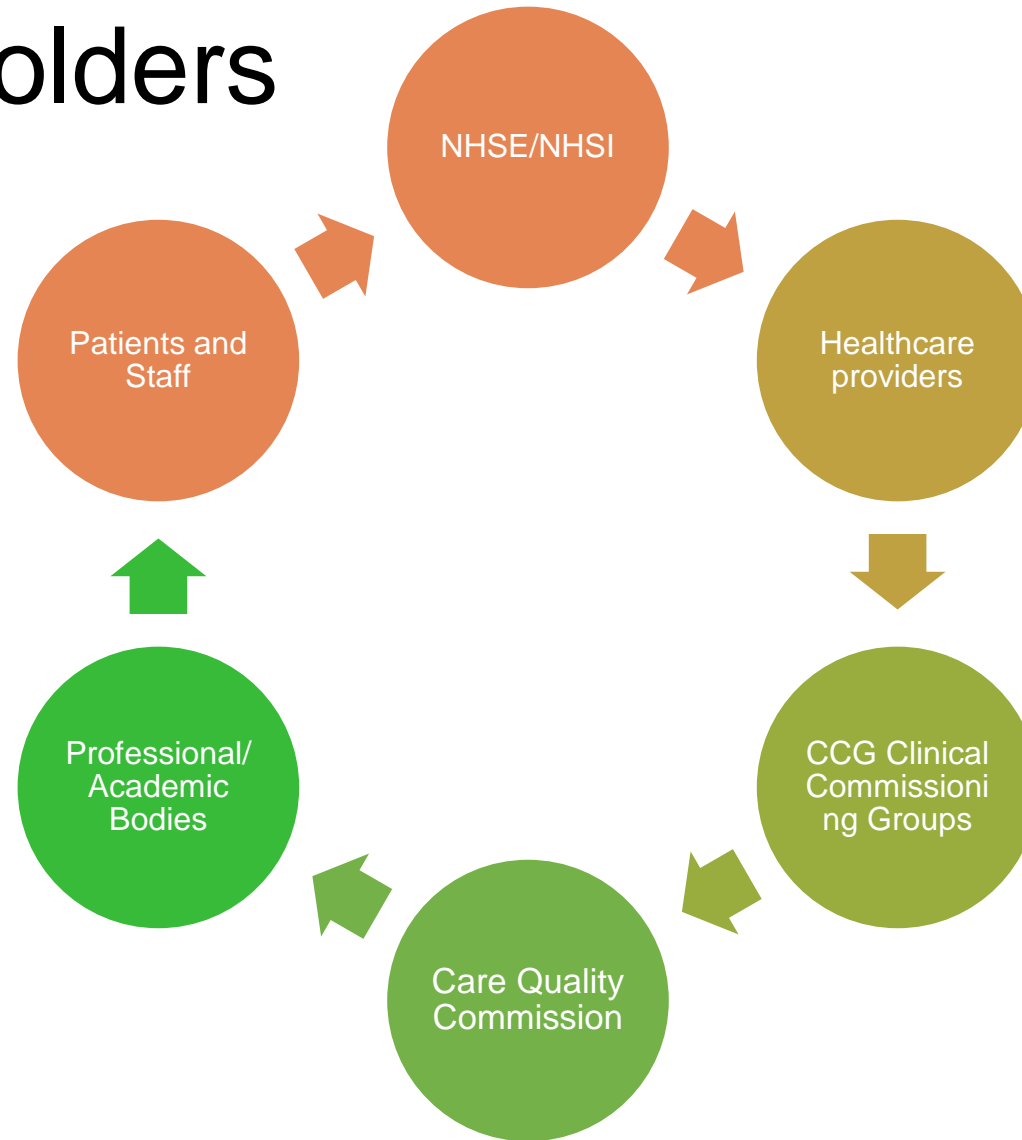
shameful, unforgivable actions need to be
court'



▲ Bridget Reeves (centre) speaks to the n
Independent Panel's report. Photograph: I



Key Stakeholders



Patient Safety Incident – NHSE/NHSI

- “Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe”. National Patient Safety Strategy 2019
- The number of incidents reported in England from **April 2020 to March 2021 was 2,109,057**, and represent a decrease of 6.1% compared to **April 2019 to March 2020 (2,246,622)**. Most incidents are reported as causing no harm (69.3%) or low harm (27.1%). Fewer than 4% of incidents reported caused higher degrees of harm. (NHS NRLS national patient safety incident reports: commentary Sept 2021)



Reporting

Supporting

Investigating

Learning





NRLS
 RESEARCH AND
 DEVELOPMENT
 NIHR Patient Safety Translational Research
 Centre at Imperial
 College London and Imperial College
 Healthcare NHS Trust

Reporting a Patient Safety Incident

Mostly electronic incident reporting in England which is beneficial for timely reporting, data analysis and good governance

Once this is submitted on the local incident management system it will create an automatic email that is sent to various leads responsible for that area

DESCRIPTION:

=====

An incident happened.

IMMEDIATE ACTION TAKEN:

=====

This is what I did in the short term to solve the problem.

Use this link [http://\[\]live/index.php?action=showuaincident&recordid=123456](http://[]live/index.php?action=showuaincident&recordid=123456) to view & approve it.

Incidents are triaged

All Incidents and Near Misses should be graded based on the actual 'Level of Harm', or 'Potential Level of Harm'

The ratings in order of severity are:

GREEN → **YELLOW** → **AMBER** → **RED**

Incident grading guides how incidents should be escalated, resourced and investigated and also ensures the Trust meets its reporting requirements (e.g. to NHS England, Commissioners, etc.)

Serious Incident Framework 2015

Acts and/or omission occurring as part of NHS funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user; or serious harm

Actual or alleged abuse where... healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS funded care

All Never Events

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following screening, security, IG, activation of Major Incident Plan etc.

Where there is loss of confidence in the service (i.e. prolonged media coverage)

Level of Harm	Example
Minor Harm	Defined as any event or circumstance resulting in extra observation or minor treatment and caused minimal harm, to one or more persons. E.g. Graze or small cut sustained
Moderate Harm	Semi-permanent harm (1 month – 1 year) including a return to surgery, an unplanned re-admission, a prolonged episode of care (4-15days), cancelling of treatment, or transfer to another area such as intensive care as a result of an incident, fractured wrist or pubic rami, prolonged period of psychological trauma. The suggested time scale for 'prolonged' is 28 days.
Major Harm	Permanent lessening of bodily functions; including sensory, motor, physiologic or intellectual. Long term incapacity/disability. Increase length of stay >15 days.
Death (directly caused)	Unexpected death as a result of an act or omission in the context of health care delivery.

Never Event – Always Red/SI

- A type of serious incident, that is **wholly preventable**, where guidance or safety recommendations that provide strong systematic protective barriers **are available at a national level, and should** have been implemented by all healthcare providers

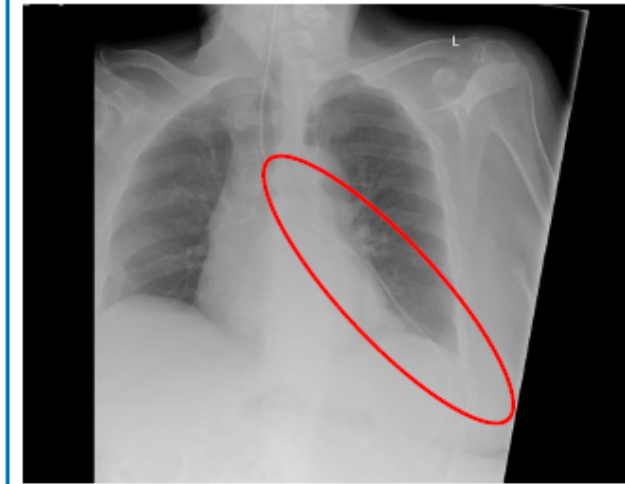
Is the NGT correctly placed before you commence feeding?

What happened?

80 year old lady admitted via ED at PRUH with diagnoses of acute kidney injury (AKI) and cellulitis / sepsis. Minimal oral intake so an NG tube was inserted. When pH testing of the aspirate did not confirm correct position an x-ray was performed. The x-ray was misinterpreted by a junior doctor as showing NGT in the stomach. Feeding was commenced.

The patient deteriorated over the next 24 hours and was put onto an end of life care pathway and died shortly thereafter.

The chest x-ray was reported the day after her death – the NGT was reported as having perforated the lung and the tip lay in the left posterior costophrenic recess .



What did the investigation find?

- The CT1 had received no formal training or assessment of competence with respect to interpretation of NGT position with x-ray checks. There was no robust Trust-wide training and competency programme which appeared to address this issue
- The CT1 reviewed x-ray in the early hours of Saturday morning. There was no out-of-hours reporting of plain film x-ray at PRUH at the time. Therefore a potential safety net (radiology reporting) was not available in this case

List of 15 current NE's as per the Never Event Framework 2018

Wrong site surgery

Wrong implant/prosthesis

Retained foreign object post procedure
Medication

Mis-selection of a strong potassium solution

Administration of medication by the wrong route

Overdose of insulin due to abbreviations or incorrect device

Overdose of methotrexate for non-cancer treatment

Mis-selection of high strength midazolam during conscious sedation

Failure to install functional collapsible shower or curtain rails

Falls from poorly restricted windows

Chest or neck entrapment in bed rails

Transfusion or transplantation of ABO-incompatible blood components or organs

Misplaced naso- or oro-gastric tubes

Scalding of patients

Unintentional connection of a patient requiring oxygen to an air flowmeter

Supporting patients and their family

Saying sorry and explaining what went wrong – Duty of Candour – Pflicht zur Offenheit

- Statutory duty effective from November 2014
- Applies when a notifiable incident has directly led to **moderate or severe harm or death and includes psychological harm**
- Candour requires that a conversation be held (as soon as practicable) between patient or relative & their consultant which includes:
 - An apology;
 - A factual account of what happened;
 - What further action will be taken (eg. Investigation report)
- The conversation must be documented and followed up in writing
- The patient/relative should be invited to contribute to the review
- Findings must be shared with the patient/relative
- Candour Guardian as support but not standard

Local Staff Survey at NHS Trust 2019 – Duty of Candour

132 people responded, including 95 consultants.

- 117 of those had spoken to a patient or relative about an adverse incident where there was moderate harm or more (a 'candour case').
- Of 132 respondents, only 5 felt that the initial Duty of Candour conversation had 'not gone well'. And in general, patients and families were grateful for openness and apology.
- In 11 cases, the patient or family were confused by the need for the meeting, and in 2 they did not feel it was the right time for the conversation.
- When it came to sharing the outcome of investigations with patients/families, feedback was generally positive. 6 People felt it had not gone well.

Overall the survey showed good engagement with an awareness of the Duty of Candour; that we can reassure clinicians that apology and openness is welcomed by patients and families the vast majority of the time.

Supporting Staff

The six recognised stages associated with staff reaction in the aftermath of an adverse event



Chaos
Error recognised
How/When

Intrusive reflections
Haunted re-enactments of event

Restoring personal integrity
Managing gossip
Fear

Enduring the inquisition
Realisation of seriousness
Who can I talk to?

Obtaining emotional first aid
Seeking personal and professional support

Moving on
- Dropping out (leaving profession)
- Surviving (coping)
- Thriving (learns from the event)

The Second Victim

Wu, Dr Albert, John Hopkins University, Adverse Events and the Second Victim, On-line Power Point Presentation.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patients. Qual Saf Health Care. 2009; 18(5):325-330.

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between two stages about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action arising out of an individual safety assessment must be taken to ensure a safe and secure working environment.

The actions of staff involved in an incident should not automatically be treated using the just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response from members of staff involved in an incident will and should differ according to the circumstances to avoid an error ever made. As well as protecting staff from undue blame, using the guide helps protect patients by ensuring the measures to limit future patient safety events are individualised.

Please note:

- A just culture guide is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- A just culture guide can be used as any part of an investigation, but the guide may need to be revisited as more information becomes available.
- A just culture guide does not replace an HR action and should be used in conjunction with organisational policy.
- The guide can only be used to label an action for failure to act through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes Recommendation: Follow organisational guidance for appropriate management action. This could include contact with regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Where investigation is still needed to understand these and why patients were not protected from the actions of the individual. **DO NOT PROCEED**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes Recommendation: Follow organisational substance abuse or staff guidance. Where investigation is still needed to understand substance abuse, follow organisational substance abuse action.

2b. Are there indications of physical ill health?

Yes Recommendation: Follow organisational guidance for health issues affecting staff, which is likely to include suspension until referred. Where investigation is still needed to understand ill health, follow organisational management and adjustment action.

2c. Are there indications of mental ill health?

Yes Recommendation: Follow organisational guidance for health issues affecting staff, which is likely to include suspension until referred. Where investigation is still needed to understand ill health, follow organisational management and adjustment action.

If No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/inaction in question?

If No to any Recommendation: Action arising out of the individual's inability to be appropriate for patient safety incident investigation should include the wider actions needed to improve safety for future patients. These actions may include, but are not limited to, the individual. **DO NOT PROCEED**

3b. Were the protocols/accepted practice workable and in routine use?

If Yes to any Recommendation: Action arising out of the individual's inability to be appropriate for patient safety incident investigation should include the wider actions needed to improve safety for future patients. These actions may include, but are not limited to, the individual. **DO NOT PROCEED**

3c. Did the individual knowingly depart from these protocols?

If Yes to any Recommendation: Action arising out of the individual's inability to be appropriate for patient safety incident investigation should include the wider actions needed to improve safety for future patients. These actions may include, but are not limited to, the individual. **DO NOT PROCEED**

If Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

If Yes to any Recommendation: Action arising out of the individual's inability to be appropriate for patient safety incident investigation should include the wider actions needed to improve safety for future patients. These actions may include, but are not limited to, the individual. **DO NOT PROCEED**

4b. Was the individual missed out when relevant training was provided to their peer group?

If Yes to any Recommendation: Action arising out of the individual's inability to be appropriate for patient safety incident investigation should include the wider actions needed to improve safety for future patients. These actions may include, but are not limited to, the individual. **DO NOT PROCEED**

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any Recommendation: Action arising out of the individual's inability to be appropriate for patient safety incident investigation should include the wider actions needed to improve safety for future patients. These actions may include, but are not limited to, the individual. **DO NOT PROCEED**

If No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes Recommendation: Action directed at the individual may not be appropriate. Follow organisational guidance, which is likely to include serious HR action or other degree of mitigation applied. The patient safety incident investigation should include the wider actions needed to improve safety for future patients. **DO NOT PROCEED**

If No Recommendation: Follow organisational guidance for appropriate management action. This could include individual training, performance management, competency assessment, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted. Staff suspension and disciplinary processes. The patient safety incident investigation should include the wider actions needed to improve safety for future patients. **DO NOT PROCEED**

ASSIST ME MODEL (a tool for managers and staff)

- **A** ACKNOWLEDGE with empathy the event and the impact on the member of staff
- **S** SORRY - express regret for their experience
- **S** STORY – allow time and space for them to recount what happened using active listening skills/SHARE personal experience
- **I** INQUIRE – encourage questions/INFORMATION – provide answers/information
- **S** SUPPORTS and SOLUTIONS (provide information on emotional and practical supports available)
- **T** TRAVEL – providing continued support and reassurance going forward and throughout the investigation/review process and open disclosure process
- **M** MAINTAIN contact/MONITOR progress/MOVING forward
- **E** END – reaching a stage of closure from the event./EVALUATE

[staff-guide-supporting-staff-following-an-adverse-event.pdf](#)
[\(hse.ie\)](#)

Learning from Incidents



July 2018

medications omissions

300 med omissions incidents reported in 2018

AVAILABLE 24/7
Code 6 omissions (drug not available) should not occur without first consulting medical team / pharmacist.

10 of these caused significant harm to the patient

IN HOURS
If meds are not on ward (stock cupboards, POD locker) etc., obtain via ward pharmacist. Ensure any newly prescribed meds are identified and ordered before next dose is due.

OUT OF HOURS
1. Other wards - search 'Location of stock on wards' guide on pharmacy Kwik! page.
2. On call pharmacist (via receptionists through switchboard).
3. Emergency Drug Cupboard.

1 death

Insulin omitted - patient went into DKA.
Desomorphin omitted - patient developed hypernatraemia.
Fluocortisone omitted - patient developed hyperkalaemia.
Encorperin omitted - patient developed a PE.

Antibiotics omitted for 3 days - patient developed septicaemia and died.

MEDICATIONS OMISSIONS (FOR ANY REASON) SHOULD ALSO BE:
1. DISCUSSED WITH PRESCRIBING MEDICAL TEAM TO IDENTIFY WHETHER A) OR TO DELAY THE DOSE AND B) CONSIDER DIFFERENT MEDS/ROUTE.
2. WELL DOCUMENTED.
3. HANDED OVER



Patient Identification Name Bands



Every child is required to wear a patient ID band at all times.

This is to keep them safe and ensure that they receive only the investigations, medication and interventions that are intended for them.

You can expect;

- Your child's name band to be checked before every intervention.
- Two nurses to check your child's identity when they are given a drug.

If you do not see your child's identity being checked, please feel that you can challenge the staff about this.

If you notice that your child is not wearing a name band please inform a member of nursing staff and they will issue your child with a new one.

Ask us if we've checked ID



Friends and family – how are we doing

	Benchmark (%)	Score (%)
Respect and dignity	94	
Involvement in decisions	85	
Kindness and understanding	94	
Controlling pain	93	
Involvement in discharge	75	

How are we improving patient experience

-
-
-

Themes of complaints and learning

-
-
-

Achievements and Greatix

-
-
-

Monthly Quality Update

Top three incident categories



What are we doing to prevent medication incidents

-
-
-

What are we doing to prevent falls incidents

-
-
-

What are we doing to prevent pressure ulcer & wound incidents

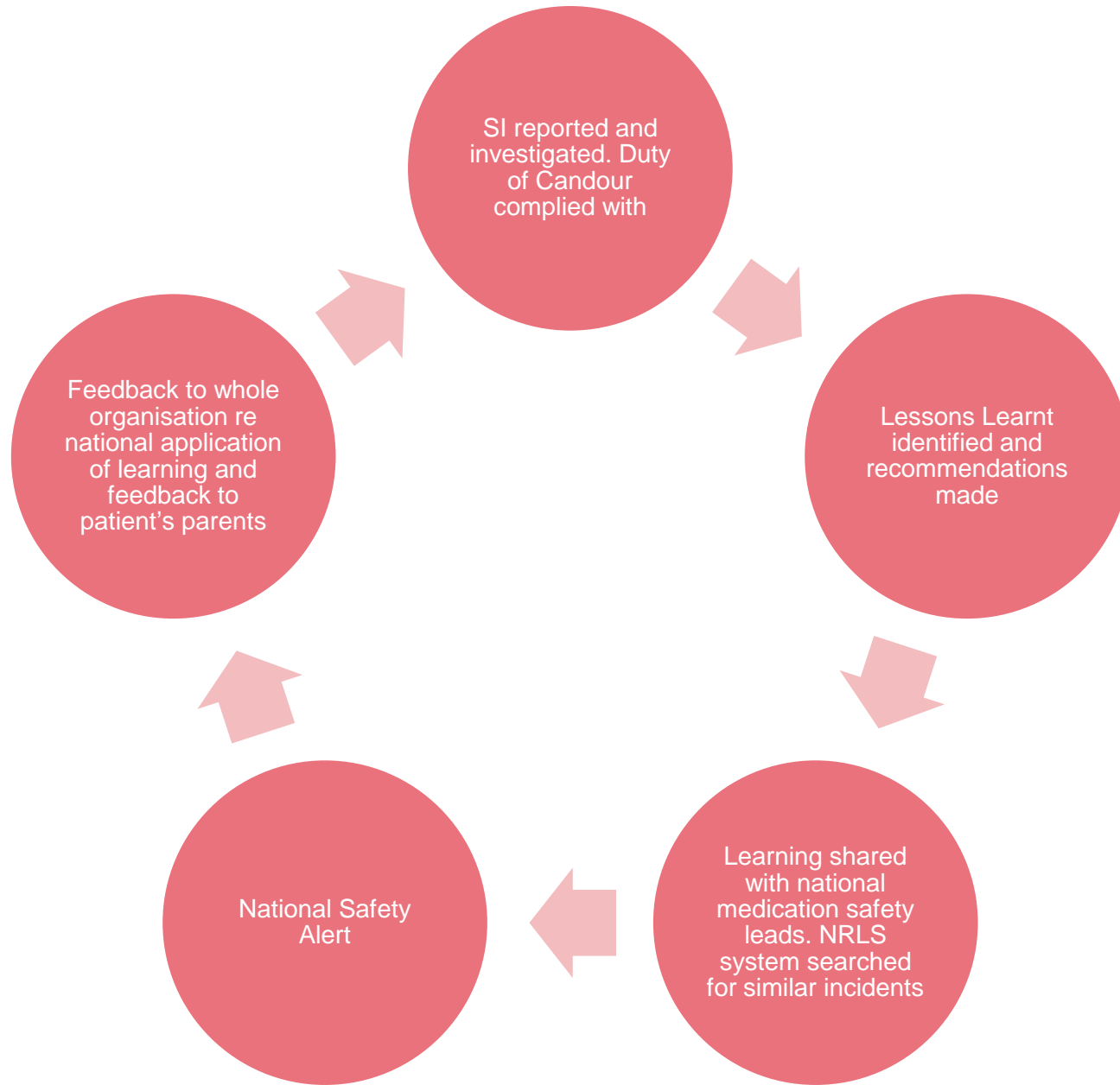
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Learning from incidents

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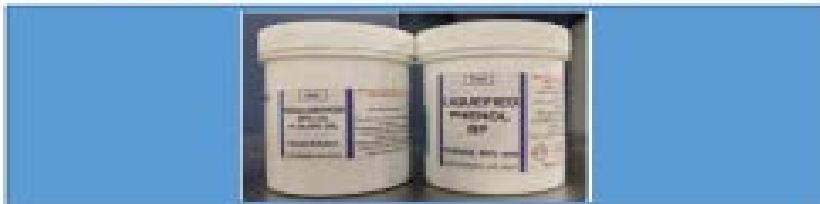
Actions to address Care Group's top three risks

-
-
-



Local Learning making a National Difference

A paediatric patient with a history of focal onset, drug resistant epilepsy required rectal paraldehyde at home, administered by his parents. He was receiving treatment at home as per his care plan (usually 20ml paraldehyde rectally). His parents noticed the medication smelt different to normal (paraldehyde has a distinct smell) and realised the medication administered was 7ml liquefied phenol 80% weight/weight (w/w) instead of 10ml paraldehyde 50% volume/volume (v/v) in olive oil; liquefied phenol had been erroneously dispensed instead of paraldehyde by Pharmacy. The patient was seen and treated at ED. The patient had surgical follow-up but did not suffer internal damage.



Similar packaging & close proximity storage of medicines/products – are key risks in medication safety.

- In this incident, the packaging was very similar (image above) and both were stored in the 'flamesable cupboard'. Other learning points that were identified:
- Procurement of similar presentation phenol and paraldehyde
- At the time, there was no automated dispensing robot in the Pharmacy
- On investigation, it was found that there had been one similar incident reported. There was no harm reported as the dispensing error was recognised before it could be administered.

The incident led to a rapid response by our staff. Phenol was immediately removed from the Trust and an alternative procured after the incident was reported. Learning from this incident was shared anonymously with the national medicine safety leads. The national team subsequently reviewed reported incidents on the national reporting system across England over a 5-year period and identified 30 further incidents including:

- + Harm from use: e.g. referral of a child to a specialised burns unit for treatment of burns to the lower leg sustained when liquefied phenol 80% spilled from a bottle during treatment for toenail avulsion.
- + Mis-selection: e.g. administration of unlicensed liquefied phenol 80% instead of licensed oily phenol 5% injection during a procedure to remove a rectal polyp

A National Patient Safety Alert NatPSA/2021/008/NHSPS was issued in August of this year requiring all NHS care providers to identify where liquefied phenol 80% is used and update procedures/guidelines to substitute use for a safer, suitable alternative. This ask and action is mandated.

Therefore – thank you for reporting and keep up the good work around sharing lessons learnt

Reported
Investigated
Cand
mplyed



Elimination of bottles of Liquefied phenol 80%

Date of issue: 25 August 2021 Reference no: NatPSA/2021/008/NHSPS

This alert is for action by: All acute trusts, trusts providing community services, and organisations providing podiatry services, including where these are provided by general practices.

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards). In acute trusts, the executive lead should be supported by clinical leads in pharmacy, podiatry and surgery.

Explanation of identified safety issue:

Phenol, a caustic compound used for its antimicrobial, anaesthetic, and antipruritic properties, is highly toxic and corrosive. It can cause burns, severe tissue injury and is rapidly and well absorbed causing systemic toxicity.¹

'High strength' phenol is available in different preparations:

- Bottles of liquefied phenol 80% (typically 7mL or larger): these can be ordered via pharmacy departments as an unlicensed pharmacy Specials product² or by clinical teams directly from wholesalers.
- Phenol swab packs: these contain an ampoule of phenol 89% with a cotton bud applicator attached (licensed as a medical device).

Current prescribing and supply data shows that the main use of 'high strength' liquefied phenol is in podiatry and orthopaedic foot surgery for destroying the nail matrix. This data also suggests some limited use in other clinical areas where it is no longer recommended.

Review of incidents identified a report where liquefied phenol 80% was administered to a child instead of the prescribed paraldehyde rectal enema,³ used to treat status epilepticus. The patient required emergency admission to hospital and intensive treatment to minimise the corrosive effects of phenol on their intestinal tissue.

Subsequent review of reported incidents over a 5-year period identified 30 further incidents including:

- Harm from use: eg referral of a child to a specialised burns unit for treatment of burns to the lower leg sustained when liquefied phenol 80% spilled from a bottle during treatment for toenail avulsion.
- Mis-selection: eg administration of unlicensed liquefied phenol 80% instead of licensed oily phenol 5% injection during a procedure to remove a rectal polyp.

Oily phenol 5% injection, an analgesic sclerosing agent², is licensed for the treatment of haemorrhoids; it does not need to be eliminated as part of this Alert.

Actions required

Actions to be completed as soon as possible and no later than 25 Feb 2022

1. Identify where liquefied phenol 80% is used and update procedures/guidelines to substitute use for a safer, suitable alternative.
2. Ensure clinical areas have stock of agreed safer alternatives and then remove bottles of liquefied phenol 80% from clinical areas, and update stock lists.
3. Amend electronic prescribing systems to ensure liquefied phenol 80% cannot be prescribed.
4. Amend current purchasing systems, and introduce ongoing controls on purchasing, to ensure liquefied phenol 80% cannot be purchased inadvertently via the pharmacy department or any alternative purchasing route.

Professional guidance includes:

Chemical ablation of nail matrix: The Royal College of Podiatry⁴, British Orthopaedic Association and British Society for Children's Orthopaedic Surgery do not support use of bottles of liquefied phenol 80% and advise use of licensed phenol impregnated swabs.

Pilonidal sinus: The Association of Coloproctology Great Britain & Ireland do not support the use of bottles of liquefied phenol 80% and advise use of safer, suitable alternatives.

Anaesthesia of tympanic membrane: British Society of Otolaryngology do not support the use of bottles of liquefied phenol 80% and advise use of safer, suitable alternatives.

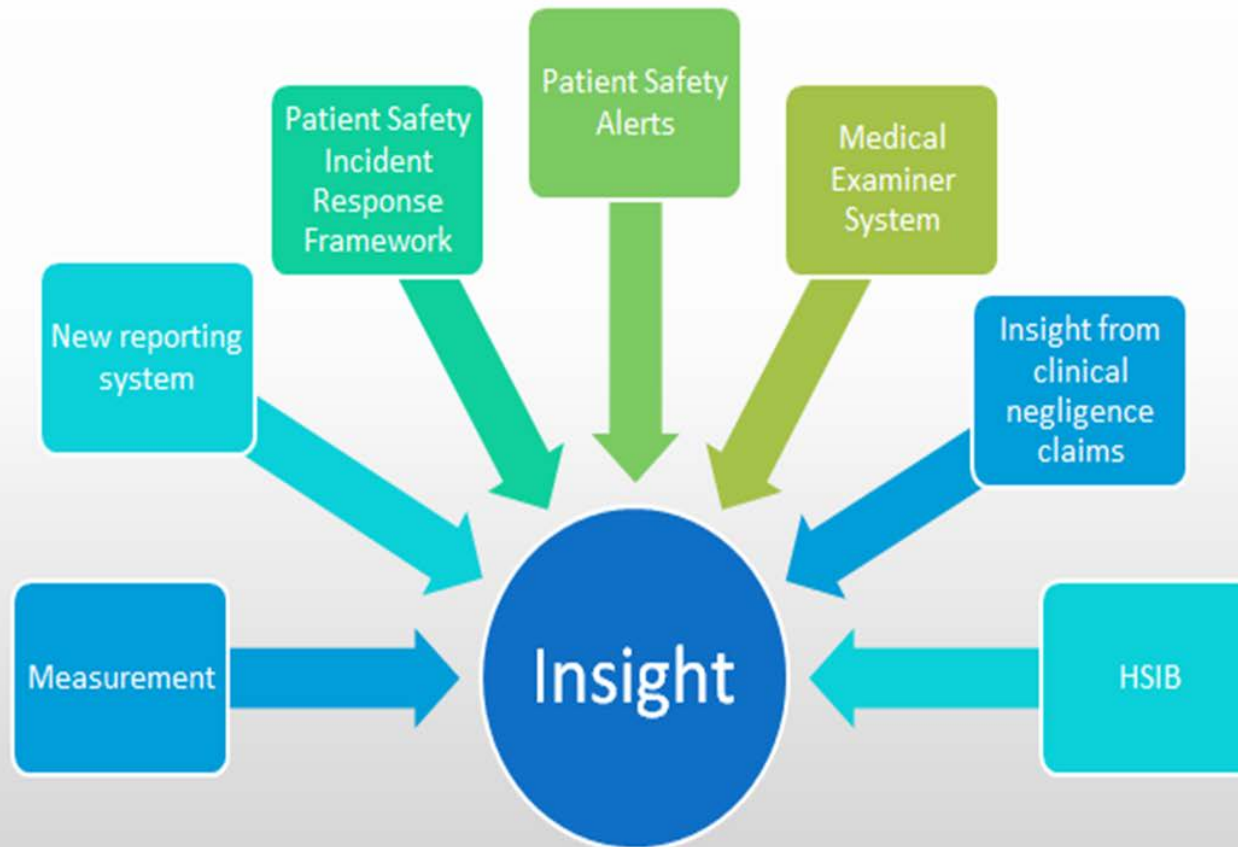
Genital molluscum infection: British Association for Sexual Health and HIV does not support the use of phenol.⁵

Pros and Cons of Current System

- Improved culture around openness and transparency
- High reporting of incidents
- Infrastructure in place to support the process
- Embedded in the system
- National learning shared
- Adverse events occur in up to 10% of all acute admissions in all modern health systems, and this rate has not altered for more than 50 years
Braithwaite, J., Wears, R. and Hollnagel, E. (2015), Resilient health care: turning patient safety on its head. International Journal for Quality in Health Care, 27, 418–420
- Resource intensive
- Quantity v Quality
- Investigations linked to harm too often
- Blurred lines re remit and other investigations
- None standardised training

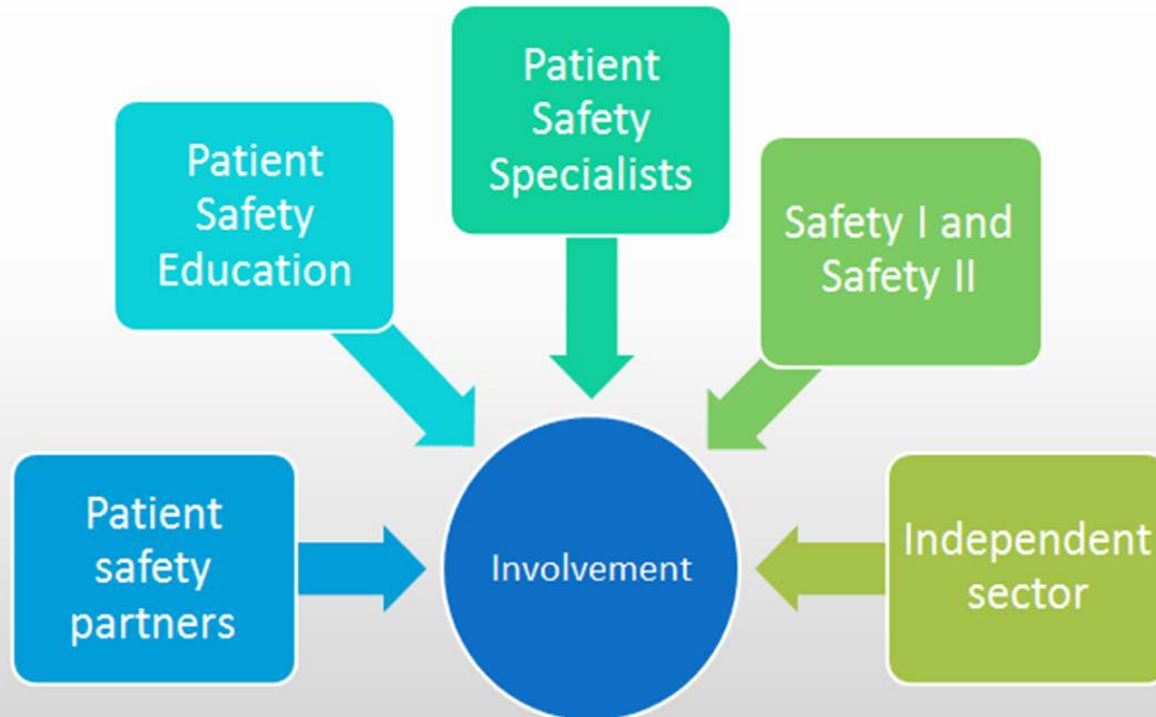
Patient Safety Strategy 2019

“Safer Culture, Safer Systems, Safer Patients”



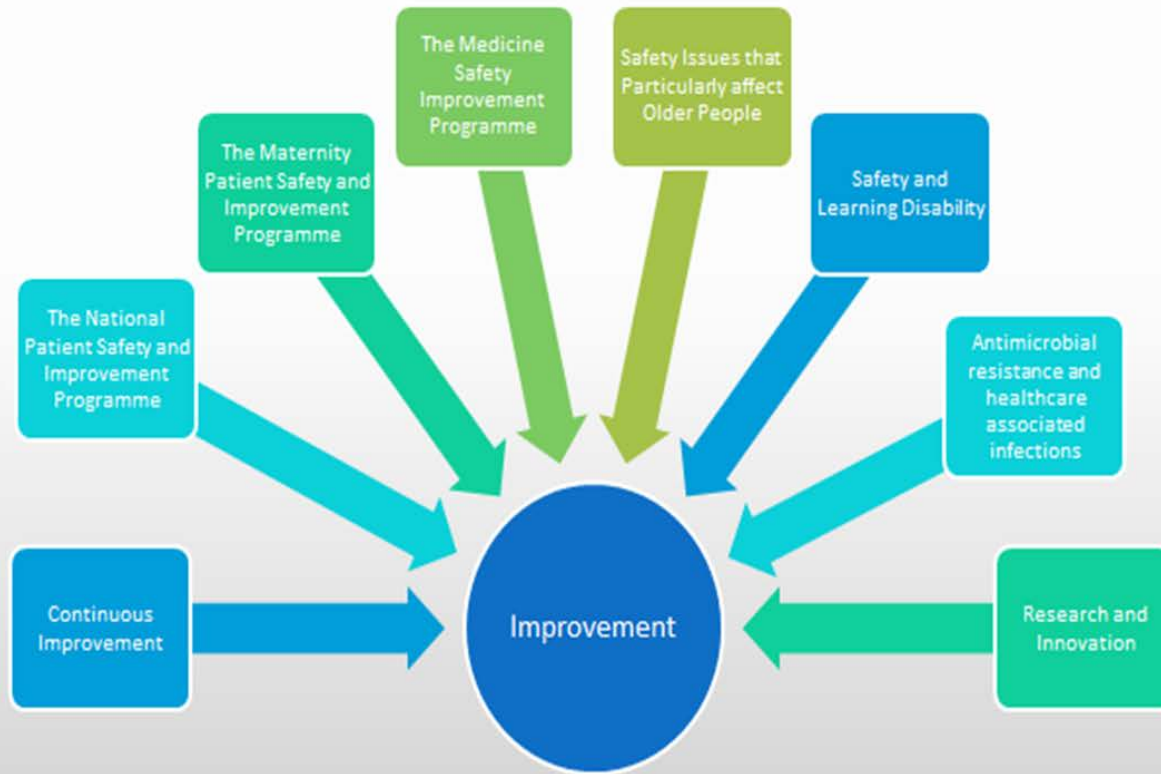
Patient Safety Strategy 2019

"Safer Culture, Safer Systems, Safer Patients"



Patient Safety Strategy 2019

“Safer Culture, Safer Systems, Safer Patients”



Patient Safety Incident Response Framework

- Currently being rolled out in pilot sites
- **Organisations should base their annual budget for PSII on their anticipated level of investigation activity but build flexibility into this because some demand-led/reactive activity will continue.** However, their PSIRPs must base and describe the planned PSII activity on past incident reporting data. Organisations should agree their PSIRP with their lead commissioner and monitor it annually.
- **Where an incident is of a relatively well understood type** – resources are better directed at improvement rather than repeat investigation.
- **Where the systems-based, interconnected contributory and causal factors of an incident are still not well understood,** a PSII may be needed to fully understand why it occurred.
- **Organisational leaders also must determine which categories of incident are priorities locally and require a PSII.** They should do this by reviewing past incident data (from the last three to five years where available) to identify those incidents representing the most significant risks. **This list must be set out in the PSIRP,** reviewed every two years and adapted as new risks emerge or diminish locally.
- **Organisations must also initiate a PSII for incidents which signify an unexpected level of risk and/or potential for learning and improvement but fall outside the predetermined national and local priorities.** These will be determined on a case-by case basis by key members of the patient safety team or equivalent responsible for reviewing patient safety incident reports and initiating relevant action through PSII leads. This process must not become a bureaucratic and burdensome panel assessment of each incident report. Instead, staff trained and experienced in patient safety should be empowered to determine the most appropriate action based on the available evidence, including that from clinical and patient/family/carer input.

DIFFERENCE TO SI FRAMEWORK

Investigator expertise, experience, time and authority: the framework clarifies that investigations must be led by those trained and experienced in patient safety incident investigation (PSII), with the authority to act autonomously and with dedicated time and resource.

Investigation timeframe: timeframes are more flexible and set in consultation with the patient and/or family. They should average three months and never exceed six.

Terminology: 'systems-based PSII' replaces the term root cause analysis (RCA). A systems-based approach means breaking down a complex arrangement into simple units to assist understanding of the complexity, interactive nature and interdependence of the various external and internal factors.

Governance and oversight: this is strengthened, with commissioners and local system leaders assuring plans and co-ordinating investigations spanning multiple settings. Provider boards now sign off PSII quality and safety improvements.


Incident Investigation Training under the PSIRF

Training for Lead Investigators


- Attended a theory and practical PSII training course which:
 - – follows and promotes this PSIRF or its predecessor, the Serious Incident Framework
 - – runs for a minimum of two days
 - – follows and endorses current NHS PSII guidance
 - – teaches recognised good practice approach(es) to systems-based PSII
 - – includes modules on human factors, just culture and Duty of Candour
 - – covers effective improvement/solution generation and implementation
 - – promotes the use of NHS PSII tools and templates
- Should have conducted a full PSII within 12 months of training
- Should consider completing advanced training within three years of the initial two-day course to advance their skills in the above and in complex safety investigations spanning different care or organisational boundaries; engaging patients and staff in PSII; incident analysis; improvement science; and PSII report

Training for those overseeing, supervising or reviewing PSII

- Attended a theory and practical PSII training course which:
 - – follows and promotes this PSIRF or its predecessor, the Serious Incident Framework
 - – follows and endorses current NHS PSII guidance
 - – runs for a minimum of two-days
 - – teaches recognised, good practice approach(es) to systems-based PSII
 - – includes modules on human factors, just culture, Duty of Candour and 'being open'
 - – covers effective improvement/solution generation and implementation
 - – promotes the use of NHS PSII tools and templates
- attended a one-day PSII oversight course
- attended training in coaching, feedback and delivery of learning
- conducted a full PSII within 12 months of training
- considered completing advanced training within three years of the initial twoday course to advance their skills in the above, complex PSII spanning different care or organisational boundaries; engaging patients and staff in investigations; incident analysis; improvement science and PSII reports



The end – Q&A?



With thanks
Lorraine