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NHS
Sandwell and West Birmingham
NHS Trust

Organisation Wide Learning

Patient Safety Incident Response Framework (PSIRF) July 2023 Issue 11

Welcome to July's 2023 edition of welearn. #welearnWednesday

This last 12 months, each Month we have presented **key learning themes** from local **serious incidents, investigations, complaints, litigation, or coroner cases.**

The learning may not have had a direct link to your area of work. However, the learning has provided an opportunity to reflect on some of the wider issues for you to consider of which we are seeking some impact such as reduction in Never Events.

This Month we are introducing you to the new Patient Safety Framework that will go live the end of 2023 into early 2024

Introducing the Patient Safety Incident Response Framework PSIRF

#welearnWednesday

Farewell 'serious incidents', hello PSIRF: a new era dawns for patient safety

THE PSIRF MAIN AIMS

1 - Compassionate engagement and involvement of those affected by patient safety

2 - Application of a range of system-based approaches to learning from patient safety

3 - Considered and proportionate responses to patient safety incidents

4 - Supportive oversight focused on strengthening response system functioning

What is PSIRF ?

What are the changes to the current Serious Incident Framework ?

PSIRF does not prescribe what to investigate. There is no distinction made between ‘patient safety incidents’ and ‘Serious Incidents’. As such it **removes the ‘Serious Incidents’ classification** and the threshold for it.

PSIRF embeds patient safety incident response within a **wider system of improvement.**

Prompts a **significant cultural** shift towards systematic patient safety management

Notably **cultural change will be key for successful application**, with behaviors exhibited from Board to Floor, to establish effective and compassionate patient safety reporting, with systems in place for continuous learning, and quality improvement underpinned by openness and transparency of a **Just culture.**

What are the Nationally defined Incidents we must investigate ?

There are **Must Do Investigations and Reports** that will continue:

- Maternity and neonatal incidents
- Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding Incidents
- Incidents in Screening Program
- Never Events
- deaths of patients in custody, in prison or on probation (health care awarded)

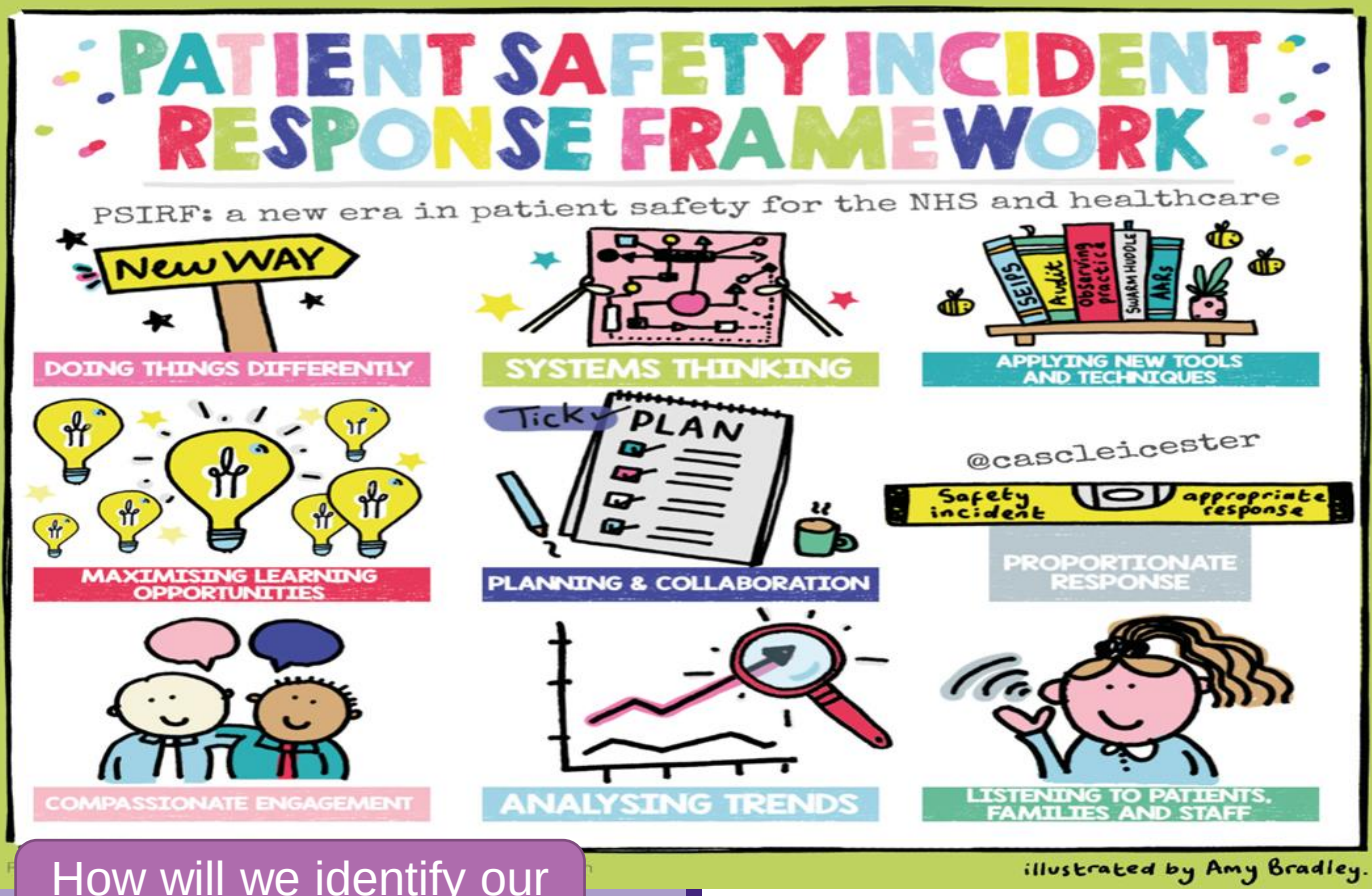
How do we know the locally defined incidents requiring a local PSII ?

Pre-defined Patient Safety Investigations:

There will be 4 Themes that have been identified for robust investigation using the SEIPS method and for sustainable Quality Improvement (see over).

Emergent Patient Safety Incidents:

An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or our organisation, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.



How will we identify our Themes?

The use of **inductive** and **deductive** approaches:

An inductive approach involves allowing the data to determine our Themes i.e. current focus on Sis RIs, litigation, complaints.

A deductive approach involves coming to the data with some preconceived themes that we expect to find based on theory or existing knowledge: the detail written into safeguard reports, from FTSU or from patient complaints.

We will look to utilising coding in the narrative of complaints and the wording in RIs to identify Themes via coding.

What are LIKELY to be our Trust Themes (predefined)?

1. Medication Management
2. Vulnerable Adult
3. Transfer and Discharge
4. Pressure Ulcers

How is the PSIRF approach different to RCA?

PSIRF recognizes that outcomes result from interactions between **multiple factors not one single root cause.**

Does not distinguish between care and service delivery problems – **explores contributory factors** (including 'individual acts') in the context of the whole system

Tools explore interacting contributory factors rather a single linear pathway. **Applying the Systems Engineering Initiative Patient Safety model (SEIPS)**

SEIPS replaces the contributory factors classification framework .

Examining the components of a system (e.g., tasks, tools and technology, people, the environment and the wider organisation) and understanding how they influence each other and contribute to patient safety.

Patient safety 'emerges' from interactions and not from a single component, such as the actions of people.

Insufficient to look at one component in isolation (e.g., the people involved)

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The Patient Safety team are hosting awareness sessions

The sessions will include:

- How the new process will differ from the current Patient Safety Framework
- What we will and won't investigate
- What his means for Duty of Candour and communicating the change with patients
- How we will involve patients as patient safety partners
- How we will investigate SEIPS Method
- What our Focused Themes will be and how may you may be involved

Dates will be out on the Intranet from August

To book on a session or for more information please email

swbtr.RiskManagement@nhs.net.N