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Patient Safety Incident Response Framework (PSIRF) – Impact on Investigations of Transfusion Incidents

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Delivering excellent, accessible healthcare

An Associated University Hospital of
Brighton and Sussex Medical School

Introduction to PSIRF

- The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
- The PSIRF replaces the Serious Incident Framework (2015), removing the classification of 'Serious Incidents'.
- The PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

Patient Safety Incident Response Framework

Compassionate engagement and involvement of those affected by patient safety incidents	Application of a range of system-based approaches to learning from patient safety incidents	Considered and proportionate responses to patient safety incidents	Supportive oversight focused on strengthening response system functioning and improvement

Healthcare is under

HUGE PRESSURE

Adequate workload level

Responsibility to voice queries

By empowering people to speak up and use their skills and knowledge to act safely,

Key Aspects of PSIRF in Transfusion Practice

- **System-based approach**
- **Learning and Improvement**
- **Compassionate engagement**
- **Data-driven approach**
- **No additional resources**
- **Collaboration**

This does not replace existing requirements for investigating Serious Adverse Events and Serious Adverse Reactions related to transfusion

Patient Story

Old Framework v New Framework

- Chronological Timeline
- Time Person Grid
- Change/Barrier Analysis
- Cause and Effect
- Contributory Factors
- Five Whys
- Fishbone
- SI / RCA Report

- Timeline Mapping
- After Action Review
- Swarm Huddle
- Walkthrough Analysis
- MDT Review
- Horizon Scanning
- Thematic Review
- SEIPS
- PSII

Learning Response Toolkit

- **Patient Safety Incident Investigations (PSII)** –

An in-depth review, this tool is used when there has been serious harm to a patient or patients.

See next slide

Executive summary

Notes on writing the executive summary

To be completed **after the main report has been written.**

Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan. Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions. NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

PSII file name: Use local naming convention. Always include the version number and/or document status

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After Action Review (AAR)

Attendees:					
Date:		**Ward:**		**Incident number:**	

What was supposed to happen?	**What did happen?**
Why was there a difference?	**What can we learn from this?**

Learning Response Toolkit

- **Patient Safety Incident Investigations (PSII)** –

An in-depth review, this tool is used when there has been serious harm to a patient or patients.

- **After Action Review (AAR)** –

A structured, facilitated discussion of an event.

- **Swarm Huddle** –

A Swarm Huddle is designed to happen as soon as possible after an incident occurs.

See next slide

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SWARM

Patient Name	NHS Number	Date & Ward

ABOUT THE INCIDENT
1. What did the staff and patient say happened? What else was going on at this time?
2. What went well and what did not go well?
3. Why do we think this happened? (use lens of the SEIPS framework)
4. Where else in the organisation is the learning from this event relevant?
5. Identify immediate safety actions for the patient and team
6. Describe Next Steps and any escalation?

WALKTHROUGH ANALYSIS TEMPLATE						
Task Matrix - Process						
Incident Reference: **Incident Reported Category:** **Incident Summary:** xxxxx						
Patient Name:						
NHS Number:						
Date of Incident:						
Completion of Walkthrough analysis by:						
Date of Review:						
	Who performs	**Goal(s) of task**	**Frequency**	**How performed**	**When performed**	**Notes**
Task 1 Brief Title/summary of Task						
Task 2 Brief Title/summary of Task						
Task 3 Brief Title/summary of Task						

Learning Response Toolkit

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- **MDT Review** – An in-depth process of review with multiple disciplines to identify learning
- **Horizon Scanning** – Supports a forward look at potential or current safety themes and issues. The themes explored using the Horizon Scanning Tool can be identified from a range of sources.
- **Thematic Review** – Can identify patterns in data to help answer questions, show links or identify issues.
- **Clinical Case Review** – A structured, in-depth review of all aspects of the clinical care and pathway. The review is completed by a nominated clinician.

Systems Based Model - SEIPS

Tools & Technology

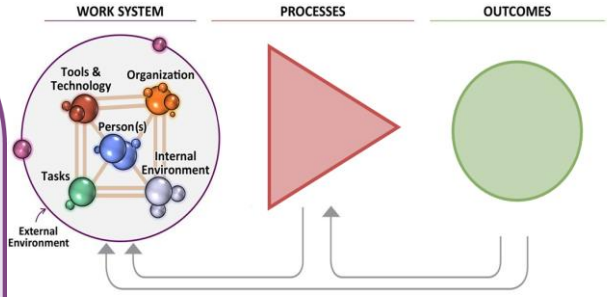
Organisation

Tasks

Person

Internal environment

External environment



Desired Outcomes

System Performance:

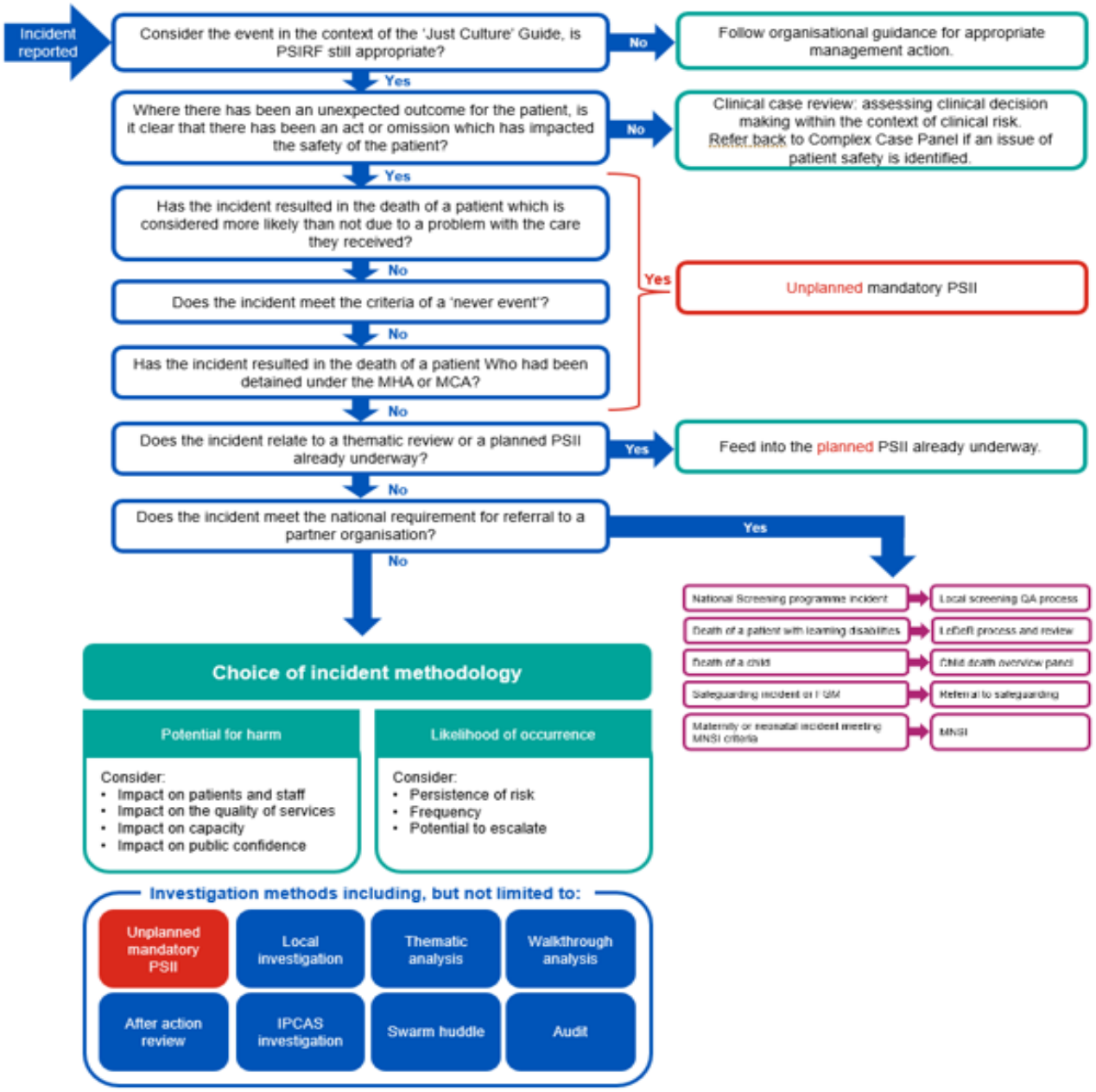
Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

POLLS Word Cloud

- Thinking back to the patient story about excessive time to transfuse, what are the concerns that you want to explore?


Incident reported
Consider the event in the context of the 'Just Culture' Guide, is PSIRF still appropriate?
No
Follow organisational guidance for appropriate management action.
Yes
Where there has been an unexpected outcome for the patient, is it clear that there has been an act or omission which has impacted the safety of the patient?
No
Clinical case review: assessing clinical decision making within the context of clinical risk. Refer back to Complex Case Panel if an issue of patient safety is identified.
Yes
Has the incident resulted in the death of a patient which is considered more likely than not due to a problem with the care they received?
No
Does the incident meet the criteria of a 'never event'?
No
Has the incident resulted in the death of a patient Who had been detained under the MHA or MCA?
Yes
Unplanned mandatory PSII
No
Does the incident relate to a thematic review or a planned PSII already underway?
Yes
Feed into the planned PSII already underway.
No
Does the incident meet the national requirement for referral to a partner organisation?
Yes
National Screening programme incident
Local screening QA process
Death of a patient with learning disabilities
LeDeR process and review
Death of a child
Child death overview panel
Safeguarding incident or I QM
Referral to safeguarding
Maternity or neonatal incident meeting MNSI criteria
MNSI
No
Choice of incident methodology
Potential for harm
Consider:
• Impact on patients and staff
• Impact on the quality of services
• Impact on capacity
• Impact on public confidence
Likelihood of occurrence
Consider:
• Persistence of risk
• Frequency
• Potential to escalate
Investigation methods including, but not limited to:
Unplanned mandatory PSII
Local investigation
Thematic analysis
Walkthrough analysis
After action review
IPCAS investigation
Swarm huddle
Audit

SEIPS in Action

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Tools & Technology

-Paper-based blood collection documentation system

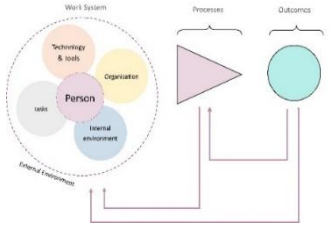
-Exploration of opportunity for electronic system

Tasks

-Nurse checked rate and followed doctors' orders

-Junior doctor acted on senior instruction

-Nurse sited new cannula but did not check authorisation chart or re-check transfusion



Organisation

-Training in place for all aspects of the process to support junior doctor

-Exploration of opportunity for electronic system

-Staff competency assessed on all aspects of the process

- Prevention of 4-hour authorisation on EPR system

Person(S)

-Patient Hb 71 and Iron deficient
-Consultant not specific – no formal TACO checklist
-Junior doctor lack of knowledge/training/acted on senior instruction
-Patient left the ward
-Nurse was focused on getting the blood transfusion completed
-No one thought about extended transfusion until night shift handover

Desired Outcomes:

- Ensure that patient receives the correct treatment they require within the optimum timeframe

System Performance:

- There were potential gaps in the process as the **xxxx**

Human Wellbeing:

- Staff working in the departments are working in stressful high paced environment.

External environment

- Request to add to medical school training via placement students

Internal environment

-Nursing Assistant rushed

-Staff working under pressure

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Many thanks for your time.

Questions?