Being Human
in Healthcare Ltd

Patient Safety Event Recorded

Compassionate Engagement
Respond to the needs of those affected
Ensure Duty of Candour is upheld if required

PSIRP review

Choose appropriate response from PSIRP
Assessment to determine response
Look for problems in care requiring exploration
Structured judgement review, e.g. case record or note review

Improvement Response Pathway
Incident type & contributory factors well understood & reflected in safety action improvement work

Check
Stakeholders satisfied, contributory factors being addressed & no individual learning response required

Learning Response Pathway
contributory factors not well understood, minimal improvement activity underway. Unexpected incident not accounted for in PSIRP

Undertake proportionate response as per PSIRP

Incident where National or regulatory requirement for PSII exists *

MDT | AAR | Swarm | PSII | ToR

Systematic Safety Management
Review learning response & improvement response outputs, including potential safety actions, contributory factors & triangulate with other data

Where applicable, generate safety actions based on insight gathered from learning responses & prioritise

Maintain oversight of implementation and monitoring of safety actions

Consider using horizon scan & thematic review

All responses must
Understand everyday work
Gather information
Engage with staff affected (where agreed engage with patients & families)

Consider Using
Observation, walk through, Interview & link analysis guides & timeline mapping, work system scan tools & thematic review

PSII
Report writing

Use a collaborative approach to
Carry out any immediate safety actions if required

Identify areas that require strengthening or dampening down and check against current improvement work

Define areas for improvement

If applicable generate potential safety actions

Consider using safety action development guide (HFIX, iFACES) & SHARE debrief tool

*Locally-led PSII Mandated - for example, learning from deaths criteria, deaths of patients under MHA or MCA linked to problems in care, never event criteria, MHRA (see appendix A, guide to responding proportionately to patient safety incidents)