HSIB

HEALTHCARE SAFETY
INVESTIGATION BRANCH

Emerging themes from HSIB investigations in Emergency Departments

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My background

Shoreham plane crash: Seven dead after Hawker Hunter hits cars

22 August 2015 | Sussex

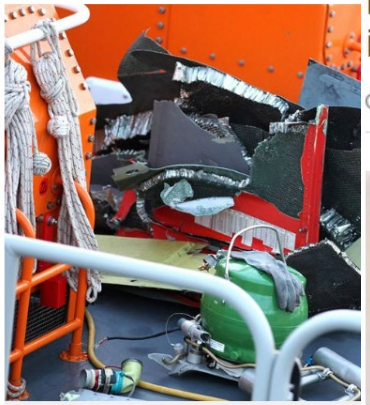
Share

RAF Tornado jet crash: One air crew member dead and two still missing after mid-air collision

A fourth crew member is in a serious but stable condition in hospital after the two warplanes plunged into the Moray Firth yesterday

SHARE

BY CHRIS HUGHES
15:24, 4 JUL 2012 | UPDATED 10:45, 11 OCT 2012



Wreckage: Part of the plane brought to shore on the Buckie lifeboa

NEWS

Red Arrows pilot Sean Cunningham 'died in 300ft ejection'

9 January 2014 | Lincolnshire

Share

Plane crash closes runway at RAF Linton-on-Ouse in North Yorkshire

Dan Bean

OTHER

Most popular | Most commented

Overview

- Brief introduction to the Healthcare Safety Investigation Branch (HSIB)
- Emerging themes from HSIB investigations conducted in ED
- Questions

HEALTHCARE SAFETY
INVESTIGATION BRANCH

Independent

Entirely separate from any operational, regulatory, financial, commissioning, improvement or performance management functions and established on a permanent institutional footing

Learning-focused

Acting solely to understand the underlying causes of patient safety issues in order to drive system-wide learning and improvement, without seeking to apportion blame

Expert

Staffed by experts in safety analysis, improvement science and human factors, with core expertise in the processes and practices of safety investigation

System-wide

Empowered to access, examine, investigate and issue recommendations to all organisations and individuals across the healthcare system, from top to bottom

Trusted

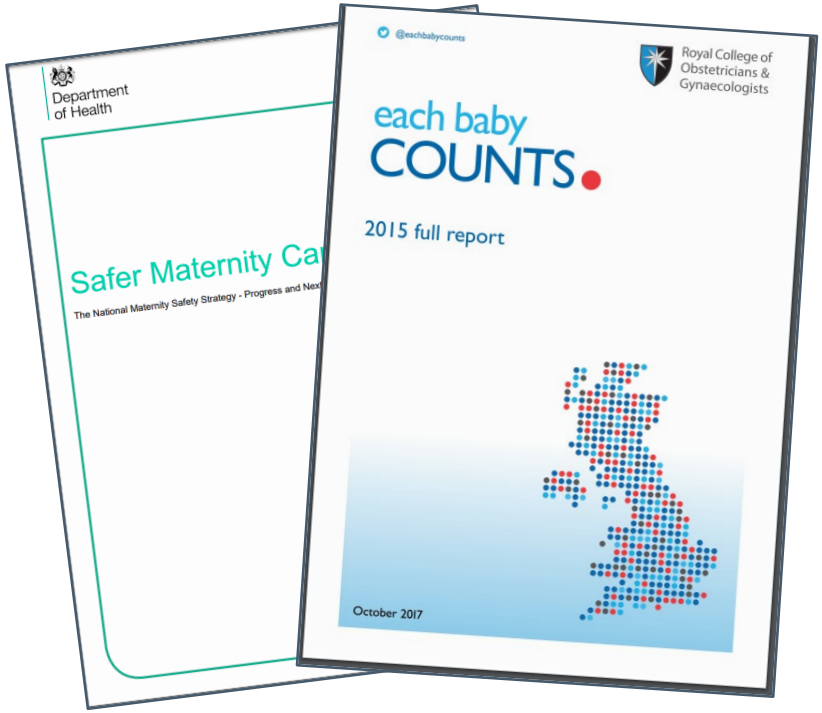
Viewed by patients, professionals and the public as legitimate, impartial and objective in the analysis of risk, the handling of data and the development of safety recommendations

National Investigations

- Encompasses any patient safety concern that occurred within NHS-funded care in England after 1 April 2017
- Decide what to investigate based on:
  - Outcome Impact
  - Systemic Risk
  - Learning potential
- Make safety recommendations at a national level

Maternity Investigations

- National Maternity Safety Strategy Nov 2017
- HSIB to undertake investigation of cases meeting EBC criteria (~1,000) & maternal deaths
- Replace local Trust Serious Incident Investigation
- Regional model
- Investigators seconded from Trusts
- Full national roll out completed in April 2019



Systems approach to investigation

"Systems thinking focuses more on the system rather than on human actions in order to learn how to redesign the system to reduce losses—where the system includes engineering design, construction, operations, management, and organizational structure."

Leveson, Stringfellow and Thomas

Why use a systems approach in investigation?

- Healthcare systems are complex and so you need to use an approach which embraces its complexity of interactions and interrelationships
- The vast majority of healthcare incidents have systemic factors that may have influenced the sequence of events
- Enables the investigation to look beyond ‘human error’
- By understanding the **factors which contribute** to human error it is possible for recommendations to be defined and targeted at the right place to reduce the risk of reoccurrence

HSIB investigations which involve ED

INVESTIGATION INTO THE PROVISION OF MENTAL HEALTH CARE TO PATIENTS PRESENTING AT THE EMERGENCY DEPARTMENT
I2017/006

Independent report by the Healthcare Safety Investigation Branch

November 2018 Edition

MANAGEMENT OF ACUTE ONSET TESTICULAR PAIN

Healthcare Safety Investigation I2018/011

September 2019 Edition

TRANSFER OF CRITICALLY ILL ADULTS

Healthcare Safety Investigation I2017/002A

January 2019 Edition

RECOGNISING AND RESPONDING TO CRITICALLY UNWELL PATIENTS
I2017/007

Independent report by the Healthcare Safety Investigation Branch

FAILURES IN COMMUNICATION OR FOLLOW-UP OF UNEXPECTED SIGNIFICANT RADIOLOGICAL FINDINGS
I2018/015

Independent report by the Healthcare Safety Investigation Branch

July 2019 Edition

UNDETECTED BUTTON AND COIN CELL BATTERY INGESTION IN CHILDREN
I2018/012

Independent report by the Healthcare Safety Investigation Branch

June 2019 Edition

Emerging themes from HSIB investigations in ED

Handover and transfer of clinical information

Guidance and standardisation

Misperception

Handover and transfer of clinical information

Distributed Situation Awareness

Distributed situation awareness considers how the system can be viewed, as a whole, by taking into account the information held by the actors, for example, medical records, people, and the way in which they interact.

Salmon, P.M., Stanton, N.A., Walker, G.H. Jenkins, D.P., and Rafferty, L. (2009). Is it really better to share? Distributed situation awareness and its implications for collaborative system design. Theoretical Issues in Ergonomics Science. 11, 58-83.

Guidance and standardisation

- **Volume of guidance from multiple sources**

Regulators and Organisations with Regulatory Influence

Oikonomou E, Carthey J, Macrae C, et al. Patient safety regulation in the NHS: mapping the regulatory landscape of healthcare. BMJ Open 2019;9:e028663. doi:10.1136/ bmjopen-2018-028663

Guidance and standardisation

- Volume of guidance from multiple sources
- Lack of standardisation
- Outdated guidance still in circulation

Misperception

‘Wellness bias’

The patient who ***does not*** appear critically unwell

Reports can be downloaded from:

https://www.hsib.org.uk/investigations-cases/

HSIB

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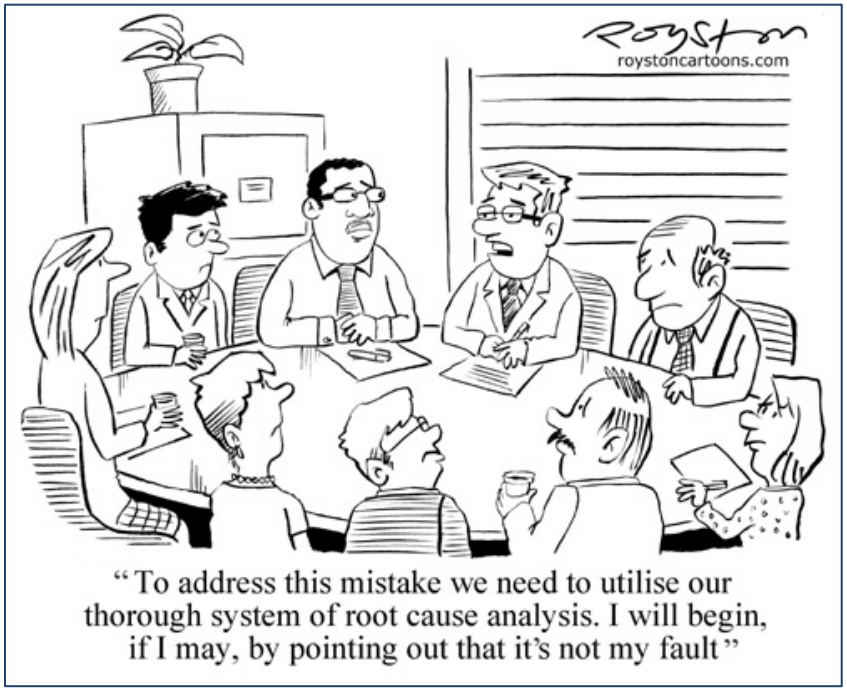

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