Patient Safety Incident Investigation (PSII) Report

PSII file name: **XXXX**

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

Distribution list

Name	Position

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

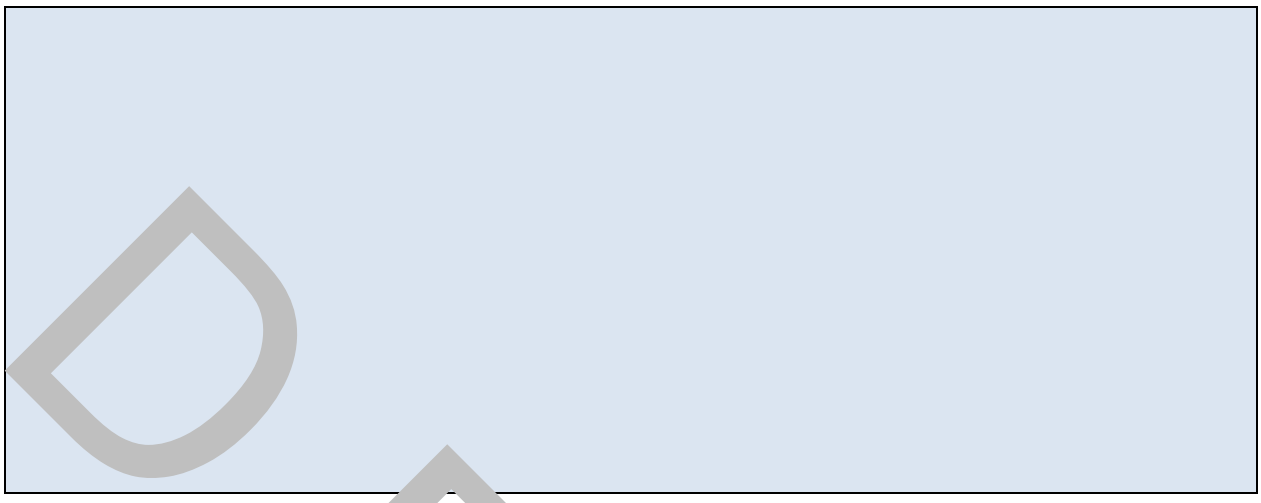
PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement



Executive summary

Incident overview

Summary of key findings

Summary of areas for improvement and safety actions

Contents

Background and context

Description of the patient safety incident

Investigation approach

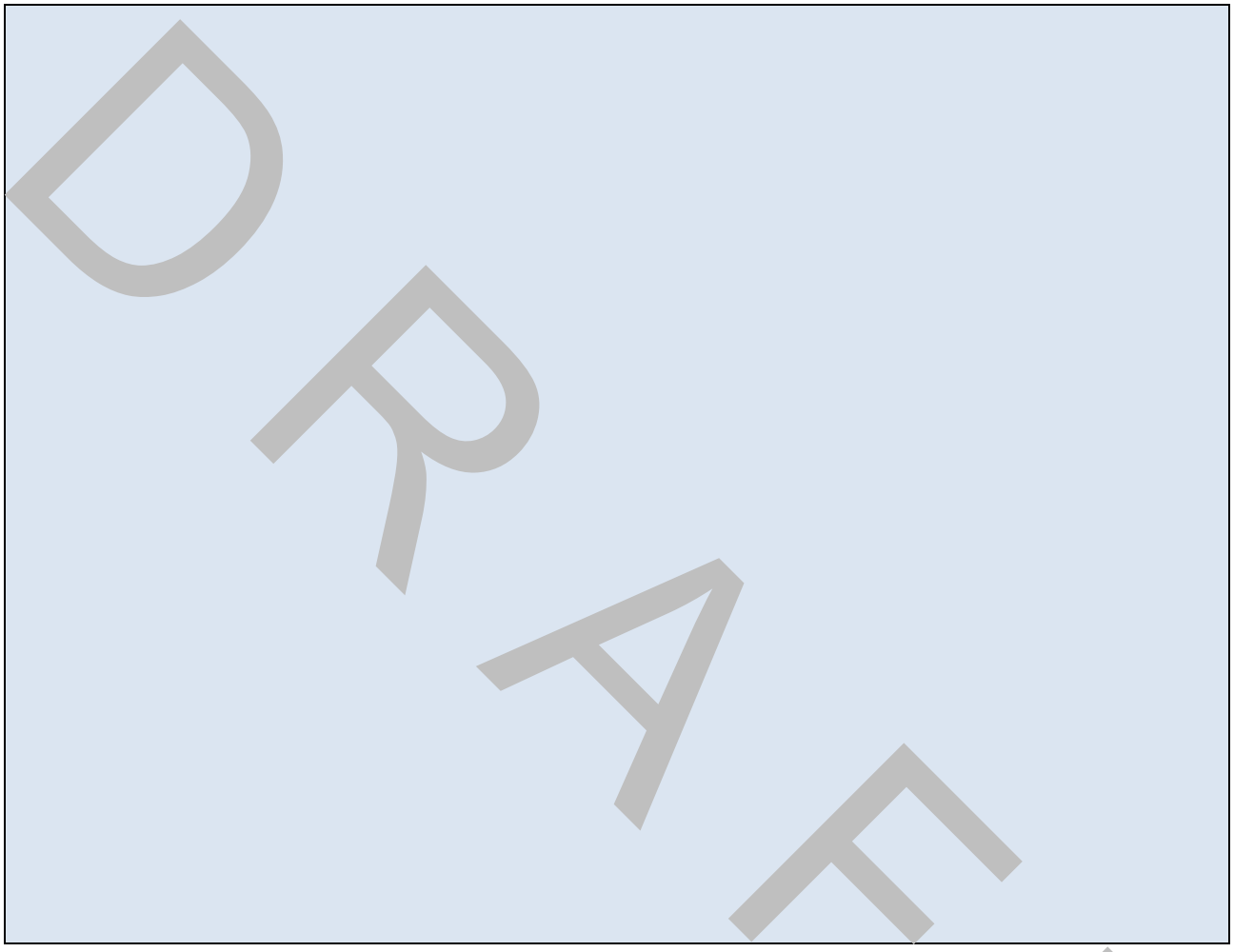
Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissi[illegible]/convenor:			
[illegible]vestiga[illegible]n lead:			

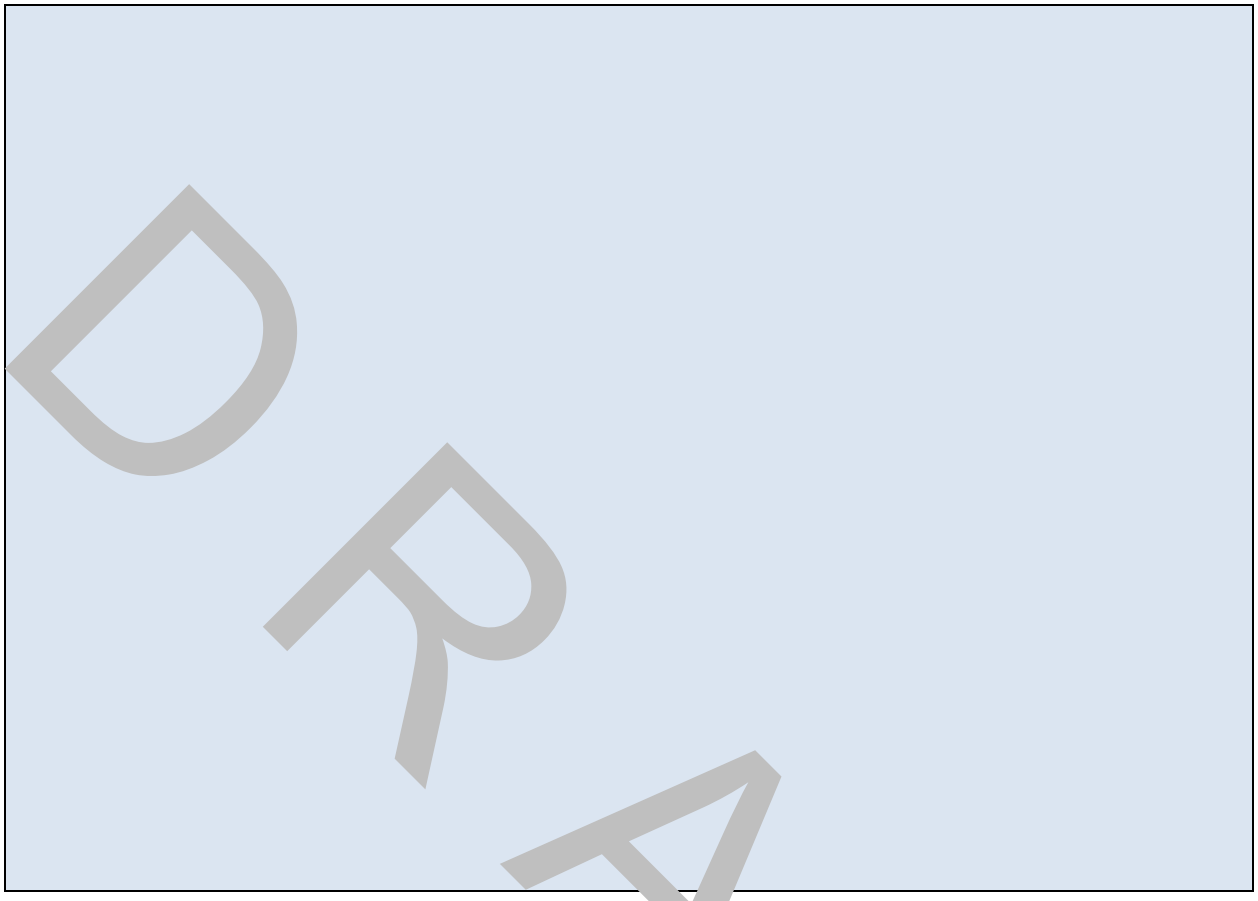
S[illegible]mmary of i[illegible]vestigation process

Terms or reference

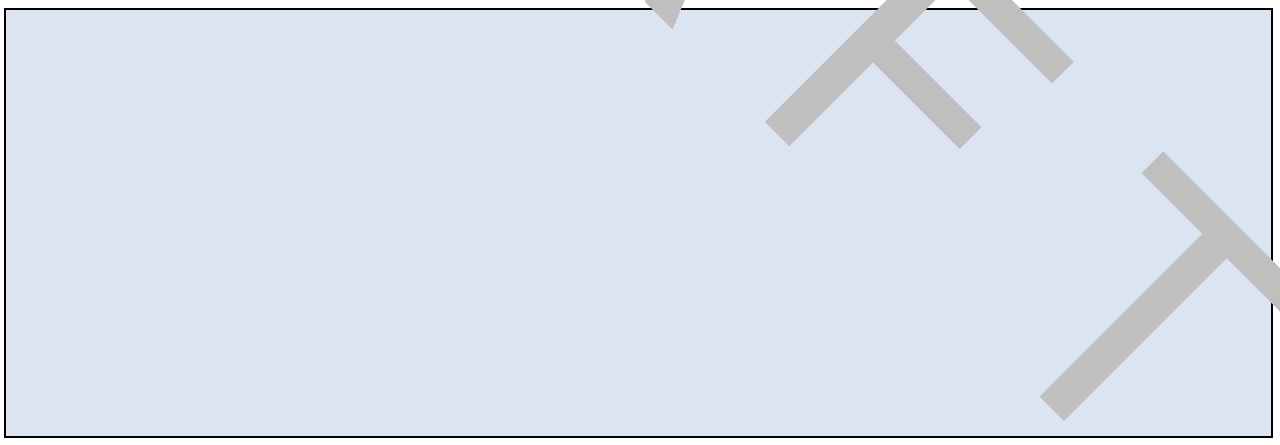
Information gathering



Findings



Summary of findings, areas for improvement and safety actions



Safety action summary table

Area for improvement:								
	Safety action description *(SMART)*	**Safety action owner** *(role, directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.								
2.								
…								

Area for Improvement:								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.								
…								

Appendices

References

Tools and Technolo

Organisation

Tasks

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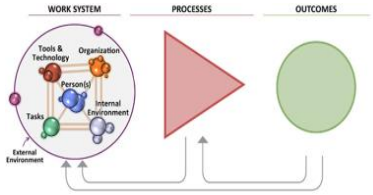
Internal Environment

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?