

# Rewiring medication safety: The PSIRF prescription for system learning

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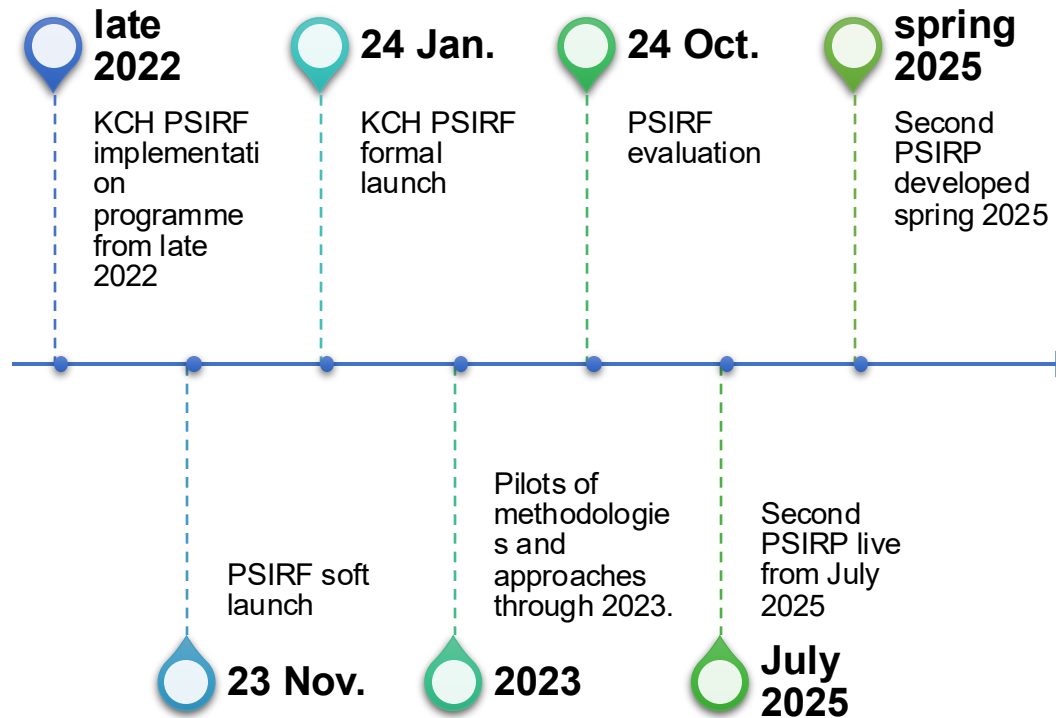
COMPASSIONATE ENGAGEMENT & INVOLVEMENT OF  
THOSE AFFECTED BY PATIENT SAFETY INCIDENTS

APPLICATION OF A RANGE OF SYSTEM BASED APPROACHES  
TO LEARNING FROM PATIENT SAFETY INCIDENTS

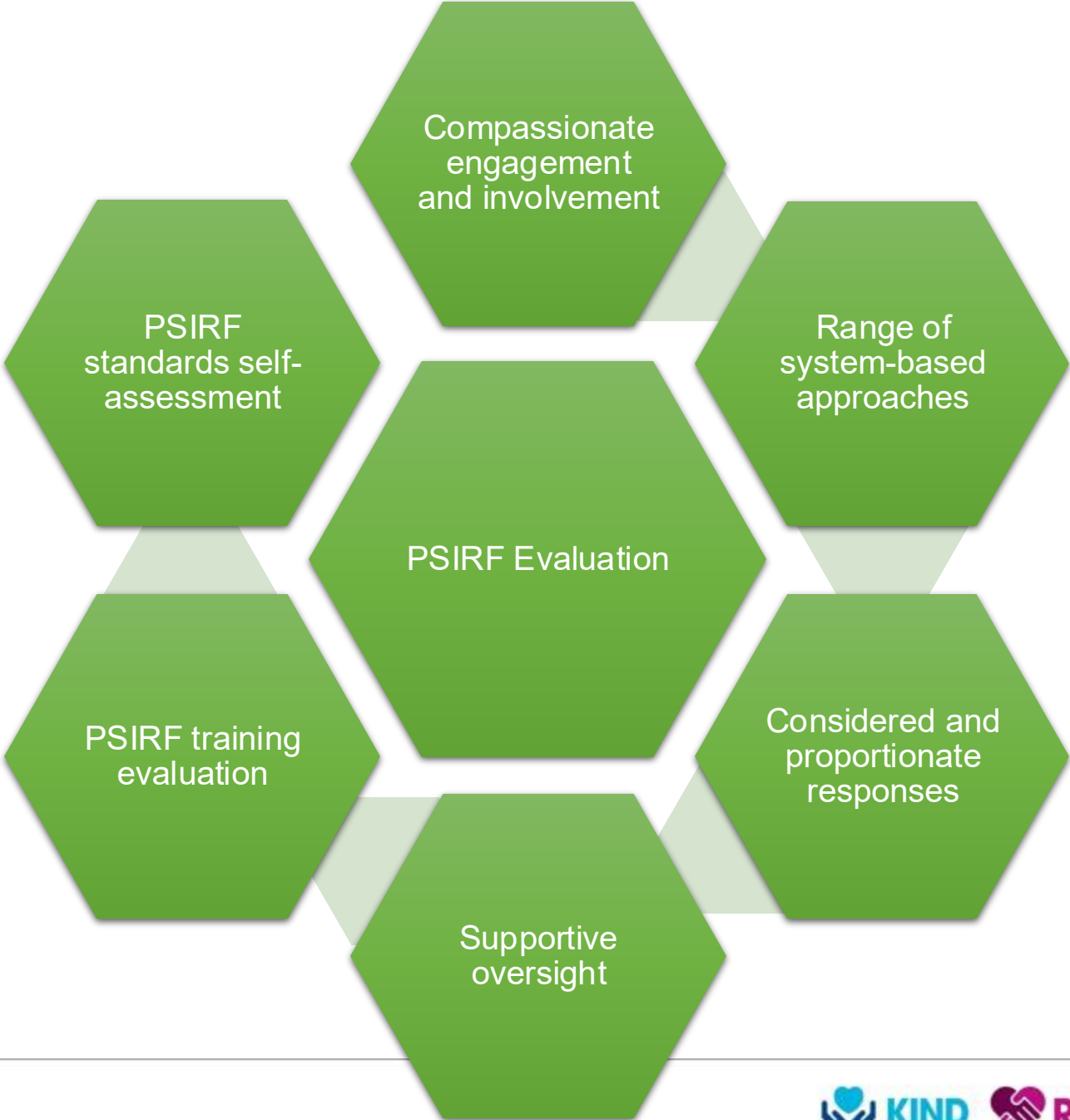
CONSIDERED AND PROPORTIONATE RESPONSES  
TO PATIENT SAFETY INCIDENTS

SUPPORTIVE OVERSIGHT FOCUSED ON STRENGTHENING  
RESPONSE SYSTEM FUNCTIONING AND IMPROVEMENT

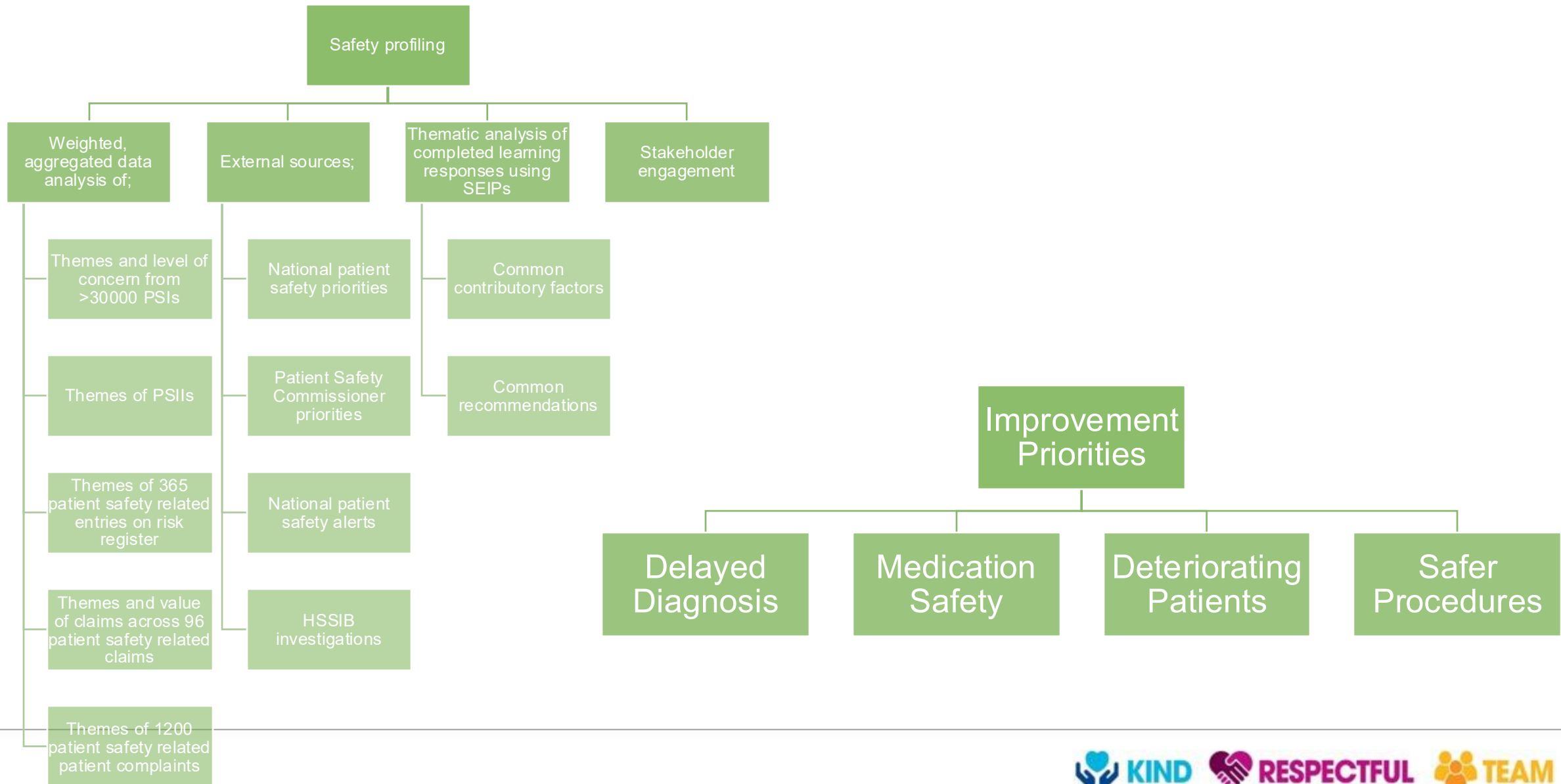
# Background KCH and PSIRF



# PSIRF Evaluation



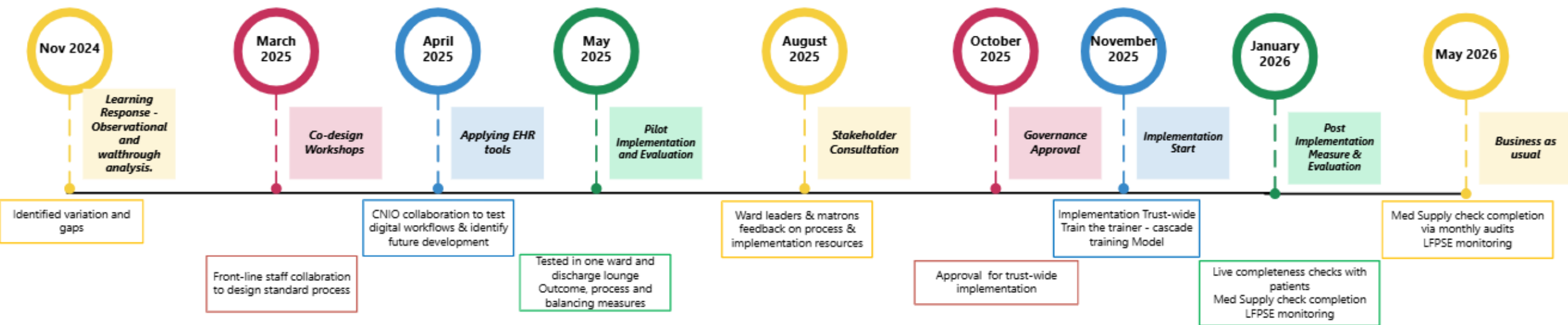
# Updating PSIRP



# Medication Safety PSIRP 2025/6

Improvement priority & group	Definition	Rationale for prioritisation	Known contributory factors	Current improvement focus
<b>Medication Safety</b>  <b>Medication Safety Committee</b>	Medication safety relates to the systems in place to enable the safe prescription, dispensing and administration of medications.	The highest reported theme in patient safety incident reporting (c. 4500 in the period), including 83 resulting in significant harm.	There are multiple system barriers which can lead to delays or omissions of critical medicines.	Implementation of tools and prompts to reduce delays and omissions of administration of time critical medicines
		The second highest volume of patient safety incidents reported with the highest level of concern.		Quality improvement project focused on prescribing omissions & delays of critical medicines
		A theme in two patient safety incident investigations commissioned.	There are practice variations and system vulnerabilities contributing to increased opiate use in the community after care in hospital	Trust achieves opiate stewardship standards in Anaesthesia Clinical Services Accreditation and Guidelines for the Provision of Anaesthetic Services (Royal College of Anaesthetics)
		The theme with the highest number of learning responses commissioned (120+).		Opiate stewardship projects initially focused on patients discharged from maternity and day procedure units
		Rated 16 on the Trust's risk register (joint 2 <sup>nd</sup> highest patient safety risk).	There are system vulnerabilities in how anticoagulation is managed for patients awaiting procedures	Implementation of recommendations from HSSIB report
		The most common theme in national patient safety alerts in 2024.	There are practice variations and system vulnerabilities contributing to patients going home with the wrong medicines at discharge	Implementation of co-designed workflow for provision of medicines to patients at discharge
National (NHS England) patient safety improvement priority.				
The theme with the second highest number of safety related patient complaints.				

# Discharge Medicine Supply



# Time Critical Medicines: reducing delays & omissions



# Key messages

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Multi-disciplinary **collaboration** is as important in safety practice as clinical practice

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The Patient Safety Strategy and PSIRF provide a **common language** for medication safety and patient safety teams

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**Triangulation** of a range of insights provides shared understanding of medication safety risks and where medications fit in the organisation's safety profile

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A successful PSIRP takes **time and iteration**. It is focused on priority risks that resonate with patients and clinicians and has defined **measurable outcomes**

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# THANK YOU

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