**‘Improving Safety and Reducing Error (ISREE)**

**Learning from endoscopy patient safety incidents case template**

Section A: Case synopsis

[*Insert anonymised case synopsis. 300 words approx*]

Section B: Categorisation1

*[Optional: Categorise PSIs by severity and theme]*

Please consider the patient safety incidents from the case and write these in below. Each should be categorised by severity (mild, moderate and severe) based on the actual or potential impact to the patient and adherence to clinical guidance, as well as by the following themes1: (*If you do not know how to categorise these incidents then JAG can complete this section for you*)

**Categorical theme**

1. Oxygen monitoring
2. Distractors and Time Management
3. Non-Technical Skills and training
4. Documentation and reporting errors
5. Technical skills and equipment
6. Sedation intravenous access and monitoring
7. Drug errors
8. Consent
9. Histology and sampling errors

|  |  |  |
| --- | --- | --- |
| **PSI** | **Theme** | **Severity** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| *Add additional rows as necessary*  |  |  |

Reference

1. Matharoo et al ‘A Prospective Study of Patient Safety Incidents in gastrointestinal endoscopy’. Endoscopy International Open 2016;04: E83-E89

Section C: Learning Points

*[Bullet point learning points as relevant for the individual / team / unit / organisation]*