Learning to be safer – Part 2

How to identify the learning from incidents and share the learning

What level of review needs to be carried out?

Managing, investigating and learning from serious incidents in healthcare requires a considerable amount of time and resource. Therefore it is important to prioritise and identify the most significant way to learn from incidents and prevent future harm. The levels of review will be identified in your organisational safety policy.

Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Therefore for incidents that caused moderate, severe harm or death, duty of candour will also apply. The guidance also applies in situations where the patient may yet suffer harm or distress as a result of something going wrong.

The point at which you realise that an error's been made is the trigger for the duty of candour to come into effect, not the point at which harm or distress is apparent.

The table below is intended to provide a guide as to appropriate actions but incidents should be considered on their own merits and the potential for learning.

In all incidents, but particularly those involving moderate, severe harm and death, it is important to identify any **second victims** who may be at risk and provide appropriate support.

Type of incident	Actions
Near miss, no or low harm incident Informal complaint/ concern raised through patient feedback	Report only Report and carry out concise internal investigation (SBAR) Identify theme from a number of incidents/ complaints and carry out a root cause analysis (RCA) Investigation and provide informal response to patient.
Incident causing moderate harm Formal complaint from patient or relative	**Duty of candour applies** Report and carry out comprehensive internal investigation (SEA) or enhanced SEA Report and provide complaint response to patient/ relative – this could be in the form of a telephone call, meeting with the family, or written response, depending on the level of the complaint and patient/ relative's preferred method of response Identify and support any potential second victims
Incident causing severe harm or death	**Duty of candour applies** **Report on NRLS and as Serious Incident Requiring Investigation (SIRI) on STEIS** Carry out multi-agency investigation (SIRI) Commission independent investigation Identify and support any potential second victims

North Bristol NHS Trust
NHS Bristol Clinical Commissioning Group
NHS England
West of England Academic Health Science Network
Published: November 2016

What is a Significant Event Analysis? (SEA)

The Royal College of General Practitioners (RCGP) state that significant events suitable for analysis are events where the practitioner can identify an opportunity for making improvements, either because the outcome was standard, or because there was a potential for an adverse outcome.

An SEA asks the following questions:

- What is the impact on those involved (patient, carer, family, GP, practice)? (**What is the actual impact of the event? How will we support staff involved in the event? How does Duty of Candour apply?)**
- The problems (**What happened**?) including lapses in care/acts/omissions that may have contributed towards an incident; and
- The contributory factors that led to the problems (**How did it happen**? **How could things have been different?**) taking into account the environmental and human factors; and
- The fundamental issues/root cause (**Why did it happen?)** that need to be addressed; and
- Enables the development of solutions which effectively address problems to reduce the likelihood of recurrence. (**What can we learn from what happened? What needs to change?)**

There are different formats and templates for completing an SEA. Topics for SEA can be drawn from incidents reported through a local reporting system, but can also be identified through **patient feedback** (complaints, concerns, comments and compliments). If there are a number of near miss or low harm incidents around the same topic or a particular theme these might be an area to consider taking more in depth look at through an SEA.

Practically the first step in carrying out an investigation is to create a **timeline of events**. Investigations should be done with the multi-disciplinary team involved in the incident.

Significant Event or Learning Event?

Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. **Learning from Excellence** is a different approach, which believes that studying excellence in healthcare can create new opportunities for learning and improving resilience and staff morale.[1]

Excellence reporting askes the following questions:

- Who achieved excellence?
- What did they do that was excellent?
- Name one thing we could do to develop excellence in this area.

In the same way that SEA is a deeper look into reported incidents, IRIS (reverse SIRI) is a way to take a more structured approach to look at an excellence report in more detail.

[1] http://learningfromexcellence.com/

How will we support staff involved in the incident?

There is increasing recognition that healthcare staff are often impacted by medical errors as **second victims** and experience many of the same emotions and/or feelings that the 'first victims' have.

These effects can disrupt their professional and personal lives, as well as their ability to deliver high-quality, safe care. Reactions typically fall into four basic categories: psychological and emotional, cognitive, physical, and behavioural.

Anxiety, depression, sleep disturbance, fear and worry are consistently reported by those involved in adverse events, as are shame, guilt, loss of self-confidence, and feelings of incompetence and worthlessness. The severity of these effects is related to the degree of harm to the patient and the clinician's experience of the investigation process; they are more pronounced with more serious incidents. The length of these symptoms can vary, and a few go onto suffer long-term consequences, and sadly some healthcare workers leave their profession and a few even commit suicide because of the experience.

Therefore when investigating an incident it is important to consider the effects that an incident can have on yourself and your colleagues in the practice team. Appropriate reassurance and support from colleagues and supervisors can help individuals cope ion these difficult situations. Debriefing after an incident occurs can be one way to deal with this in the moment. Awareness is crucial, as colleagues are often the first responders to a second victim. They can help by providing empathy and emotional support, and may be able to help meet information needs of a second victim who is struggling to understand what happened. Appropriate signposting to trained counsellors and professional treatment may be considered.

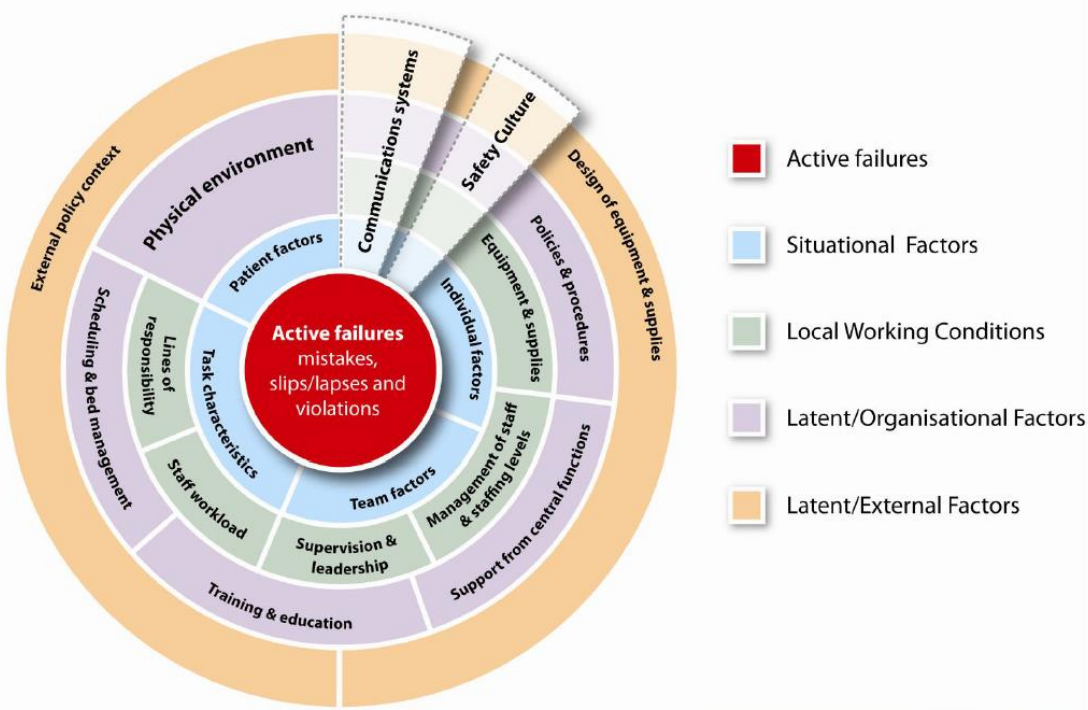
The Medically Induced Trauma Support Service (MITSS) have produced a useful guide on supporting colleagues.[2]

The **incident decision tree** is a tool developed by the NPSA to determine a fair and consistent course of action towards staff involved in patient safety incidents.[3] The approach does not seek to diminish health care professionals' individual accountability, but encourages key decision makers to consider systems and organisational issues in the management of error. It also helps identify appropriate actions to take to support individual staff members.

What contributory factors should we consider when investigating incidents?

The Yorkshire Contributory Factors Framework (YCFF) © Bradford Teaching Hospitals NHS Foundation Trust provides a model for **contributory factors** that act as "holes" in the Swiss Cheese. [4]

[2] http://www.mitsstools.org/how-to-support-a-colleague.html
[3] http://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf
[4] http://www.improvementacademy.org/documents/Projects/safety_incidents_framwork/Patient%20Safety%20Incident%20Investigation%20checklist.pdf



What actions will we take to prevent harm in future?

Brainstorming as a team will identify actions that could be taken to prevent harm in future. Map these actions against the contributory factors and then try and assess the impact that this solution could have on that contributory factor. The Yorkshire GPs at SEA training has identified changes and solutions as having different impacts on improving safety as follows:

Stronger	Moderate	Weaker
• Architectural/ physical plant or equipment changes • New device with usability testing before purchasing • Engineering controls (interlock/ forcing function) • Simplify the process and remove unnecessary steps • Standardise equipment or processes or care plans • Tangible involvement and action by leadership in support of Patient Safety	• Increase in staffing/ decrease in workload • Software enhancements/ modifications • Eliminate / reduce distractions • Checklist/ cognitive aids • Eliminate look and sound-a-likes • Enhanced documentation • Enhanced communication	• Double checks • Warnings and labels • New procedure/ policy/ training • Additional study/ analysis • Disciplinary action

How will we know that our actions have made a positive impact?

Using a **Quality Improvement** approach can help you test and measure the impact of changes to improve safety. For more information on the quality improvement approach visit http://www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/steps-in-the-improvement-journey/ or download our Guide to Quality Improvement http://www.weahsn.net/wp-content/uploads/A5-QI-Brochure.pdf