GLOBAL AIR TRAINING

Safer Systems and Processes - Root Cause Analysis using a Human Factors Approach

2 Day Course Programme

Introduction

Patient care, like other technically complex and high risk services, is an interdependent process carried out by teams of individuals with advanced technical training who have varying roles and decision-making responsibilities. While technical training assures proficiency at specific tasks, it does not address the potential for error deriving from communication and decision making in dynamic environments.

In response to these challenges, the aviation industry has developed training focussed on effective team management known as Crew Resource Management (CRM). The concepts originated from NASA research that examined the role that human error plays in aircraft accidents. CRM training considers the role of human factors in high-stress, high-risk environments. During the past decade lessons from aviation's approach have been applied to the health care industry and its approaches to patient safety.

NHS organisations should have in place a holistic and integrated system covering management, reporting, analysis and learning from all adverse incidents involving patients, staff and others. The challenge is to change cultures and move towards a just, honest and open approach to incident reporting so that staff are involved and secure in sharing their experiences.

Healthcare and Social Care organisations and staff involved in service delivery should report when things go seriously wrong. However, an effective, systematic approach to risk assessment and management requires a proactive approach to identify what could go wrong and to capture and learn from 'Near Miss' events.

It is important for organisations and their staff to establish the underlying causes of adverse incidents, errors and near misses. Unless the causes of an adverse patient experience are properly understood lessons will not be learned and required changes will not be made to reduce the risk of harm to future patients.

This programme sets out the key requirements for Health and Social care organisations to manage, report, analyse and LEARN from ALL adverse patient incidents.

Root cause analysis provides a means of getting to the bottom of adverse incidents and seeking solutions to prevent or reduce the likelihood of reoccurrence.

This programme will provide participants with the skills and expertise to effectively apply the principles and learning from error management techniques to practice. A workshop approach is used to allow the participants to share information and experience.

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Programme Content

The two day facilitated learning sessions will cover:

- How to improve communication and interpersonal relationships within clinical teams
- How to support staff through the investigation process following an adverse patient safety incident
- How to address communication and public relations issues
- How to develop a robust risk assessment framework for patient safety incidents
- How to engage staff in error management
- How to undertake a root cause analysis using a human factors approach
- How to formulate resulting action plans
- How to identify the lessons learnt and select appropriate methods for dissemination
- How to address cultural change issues

All course participants will receive relevant handouts, including:

- Examples of good practice
- Exemplar proformas for adaptation and use in own work place
- A bibliography of recommended further reading, a list of useful websites and other resources

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Day One

09:15 *Registration and Coffee*

09:30 **Welcome and introduction**
Domestic arrangements
Syllabus and Programme objectives

09:45 **Patient Safety – the bigger picture**
Review of national reports and agencies
Statistical evidence & the case for change
The role of the NPSA in England

10:15 **Lessons learnt in Aviation**
Air safety developments
Principles, approaches & concepts
Aviation case-study

10:45 **SHEL – Human Factors Model**
What affects human performance?

11:00 *Morning refreshments*

11:15 **Human performance and limitations**
What causes us to make mistakes?

11:45 **Communication**
Dealing with the media and public relations
Skills & strategies to improve communication
Keeping staff informed

12:15 **Classifying Patient Safety Incidents**
Agreeing definitions and classifications
Review of local policies and procedures

12:30 *Lunch*

13:15 **Root Cause Analysis**
Definitions
Tools and models

15:00 *Afternoon refreshments*

15:15 **Health and Social Care Case-study –**
Gathering the evidence

17:00 *Close*

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Day Two

09:15 *Coffee and welcome*

09:30 **Review of Day One & Introduction to Day Two**

09:45 **Healthcare & Social Care Case-study continued**
Reviewing the evidence

10:30 **Root Cause Analysis**
Identifying causal factors
Mapping exercise
The Error Chain

11:15 *Morning refreshments*

11:30 **Feedback from Root Cause Analysis exercise**

12:00 **The causal report**
Agreeing the causal factors
Analysis of causal factors

12:45 *Lunch*

13:30 **Writing the Action Plan**
Agreeing action with roles and responsibilities
How to track progress

14:15 **Personal Lessons learned/transfer to the workplace**
Individual action planning

15:00 *Afternoon refreshments*

15:15 **Changing the culture, systems & processes**
Identifying methods to share experience and information
Opportunities for integration
Improving teamwork and interprofessional relationships

16:00 **Next steps**
Sharing lessons learnt
What will I do differently tomorrow?
What should the organisation do differently tomorrow?

16:30 **Programme review**

17:00 *Close*

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