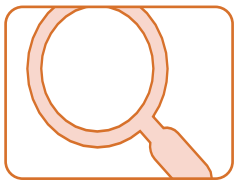
# SHOT Bite No.1(a):
## Investigating Incidents: a systems-based approach

SHOT Serious Hazards of Transfusion

February 2021



**Investigating incidents** is integral to providing a safe transfusion service and preventing patient harm. The quality and safety risk in the context of the patient should be central to all investigations. The 2019 Annual SHOT Report noted that 84.1% of all reports were the result of error, these can be avoided if systems support safe practice. Effective incident investigation processes can reduce error, improve practice and lead to safer systems. ***Learning from experiences can prevent harmful incidents from reoccurring- safety is enhanced by learning from all incidents.***

**Systems approach and just culture**: Incident investigations often are inadequate and fail to identify causes of failure or improvement actions to reduce recurrence. Introduced into SHOT reporting in 2017, the Human Factors Investigation Tool (HFIT) results have shown that investigations disproportionately blame individuals while system failures are overlooked. Re-training or supervising one individual will not fix the system or prevent recurrence of errors. To truly improve practice, provide safe processes and reduce risk a systems-based approach to investigating incidents is required. This SHOT Bite provides guidance and key messages for incorporating a 'systems-based' approach to investigation of incidents and moving to a 'just and learning' culture.

**Regulatory guidelines and standards** require that incidents, or non-conformances, are identified, investigated and that actions are taken to reduce the risk of recurrence: Good Practice Guidelines 2018 **(9.4)** include requirement for appropriate level of RCA and identification of CAPAs; **UKAS** ISO15189:2012 includes identification of the root causes, implementation of CAPA and review of the effectiveness of the actions; NHS England and NHS Improvement provide standardised tools and templates for patient safety incident investigations, guides to duty of candour and supporting a just culture and CQC regulation 12: safe care and treatment require that incidents are reviewed, thoroughly investigated by competent staff and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

**Performing an effective investigation:** What do you want to get out of the investigation? (**DISCOVER**):

**D**etermine the risk and harm if no harm on this occasion consider the future potential risk

**I**dentify any root cause(s), contributory and incidental findings (that did not impact on the incident but are symptomatic of systemic issues) – do not ignore ones that may be difficult to resolve, they still need review

**S**MART corrective/preventive actions (**Specific** – articulate and understandable, **Measurable** – verified that is solving the problem, reviewing the effectiveness of the action, **Achievable** – can be achieved within the resources and time frame, **Relevant** – related to the cause(s) of the incident, **Time bound** – time required to complete the actions)

**C**o-operation with the individual(s) involved and the wider team

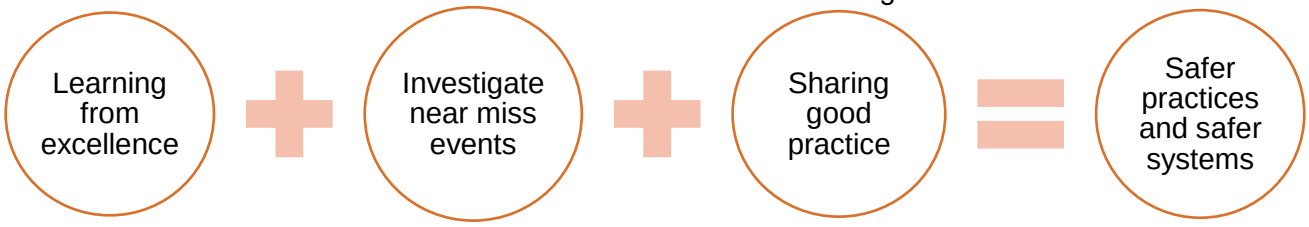
**O**btain an understanding and full review of the whole system, identify weakness in the system where improvements can be made

**V**alue any notable practice that occurred

**E**nsure that key learning points identified for sharing within the organisation

**R**eview of the effectiveness of the actions

**Every experience helps in improving systems:** Safety management should not only be reactive, but proactive as well. 'Near miss' does not mean 'no error' and hence 'no investigation'



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## DESIGN the investigation methodology and corrective/preventive interventions

**D**etermine the investigation team requirements (experts, objective, patient/family, investigation specialists)

**E**valuate relevant tools for use (incident decision tree, 5 whys, fishbone diagram, change grid analysis, tabular timeline, cause and effect chart, SHOT HFIT)

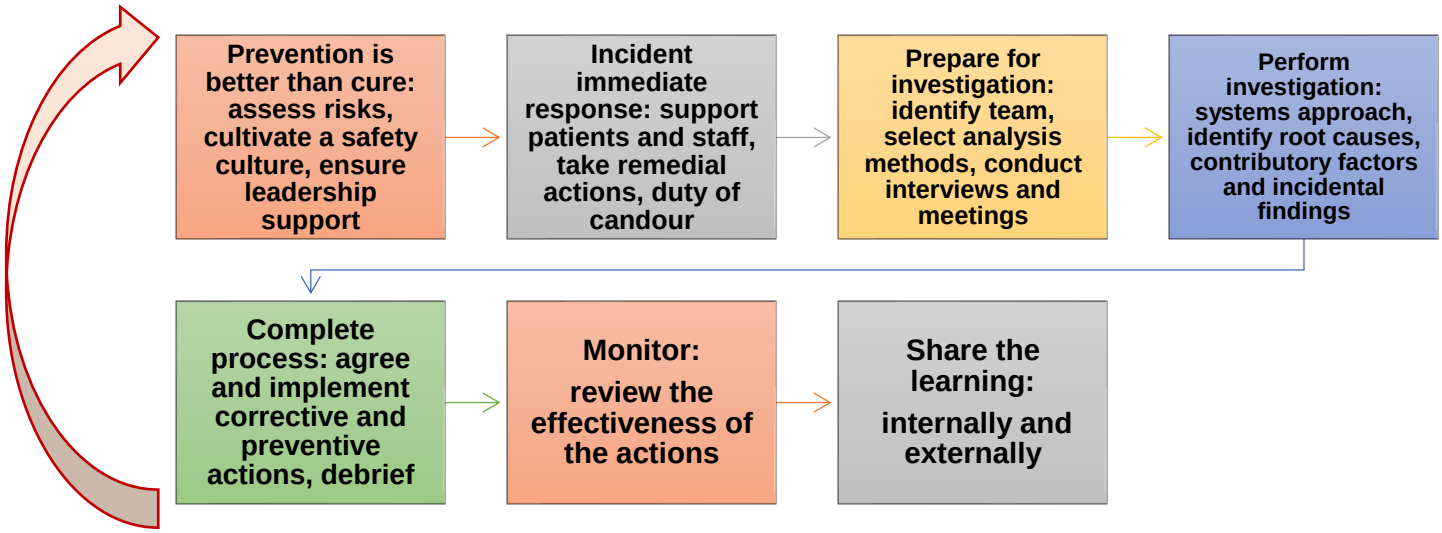
**S**ystems approach is vital to address all the relevant aspects. A just culture that supports a consistent, constructive and fair evaluation is necessary and never a blame culture

**I**ntervention effectiveness – systems focussed interventions are more effective and enable a long term change

**G**ather all the evidence and facts, triangulate, check and confirm

**N**otify external bodies (if relevant), staff line managers for support, risk management department

**Incident management is an ongoing process:** Incident analysis is part of the incident management continuum in every organisation and needs to be reviewed regularly




### Useful resources

NHSI The future of NHS patient safety investigation
Thebmjopinion Carl Macrae: Healthcare safety investigations must offer a safe space for learning
Nuffield Trust – Safety in health and social care
The Health Foundation – Continuous improvement of patient safety
BMJ Journals – Transforming concepts in patient safety: a progress report
The King's Fund: The risks to care quality and staff wellbeing of an NHS system under pressure
Introduction to Northern Ireland Adverse Incidents Centre (NIAIC)
Health Improvements Scotland: Learning from adverse events through reporting and review
Healthcare Safety Investigation Branch
SHOT Human Factors Investigation Toolkit
USA RCA$^2$ approach (root cause analysis and action)
https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf
https://forums.mhra.gov.uk/showthread.php?4150-Incident-reporting-presentation