From a clinical to a whole of systems approach to reviewing adverse events

Nathan Farrow, Manager Incident Response Team
<table>
<thead>
<tr>
<th>Clinical thinking</th>
<th>Systems thinking</th>
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<tr>
<td>Human error is the root cause of accidents</td>
<td>Human error is a symptom of problems residing in the system</td>
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<td>Healthcare professionals are socialised to strive for error-free practice</td>
<td>Human error is inevitable and systems will fail</td>
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<td>Error is often perceived as a failure of character</td>
<td>Professionals behaviour is affected by the context in which it occurs</td>
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<td>Medico legal landscape and focus on individual accountability results in a culture of blame</td>
<td>A just culture is built on mutual trust and considers the accountability of both systems and individuals</td>
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<td>Health professional training encourages prompt recognition of symptoms and rapid diagnostic decision making</td>
<td>Investigators need to resist the need for closure, challenge bias and embrace complexity</td>
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<td>After an accident, safety is primarily improved by retraining individuals involved</td>
<td>We cannot change humans but we can change the system within which they work</td>
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Good investigation principles to help improve surgical safety

1. Keep focus on learning
2. Manage your bias

To err is human
To cover up is unforgivable
To fail to learn is inexcusable
- Sir Liam Donaldson
Good investigation principles to help improve surgical safety

3. Keep focus on system improvement
4. Use a just culture lens

Why did it make sense to them at the time to do what they did?

Is it possible that a similar person with similar experience and training in a similar situation and circumstances would do the same thing?
5. Collaborate and engage to improve safety

• **Review teams**
  - multi-disciplinary
  - independent person external to health service
  - consumer representative
  - qualified safety or human factors professionals

• **Engagement with other stakeholders and staff**
  - Feel heard, included, inform the outcome
  - Understand work-as-done rather than work-as-imagined
  - Understand how and when people make trade-offs to balance and help achieve system goals
Developments in incident review and learning at Safer Care Victoria

- Incident analysis training
  - Focus on good incident review process
  - Broaden to 3 incident analysis methods
    - RCA, London Protocol and Accimap
  - Cognitive interviewing and managing cognitive bias
  - Human Factors and systems safety
  - On-line learning management system
Developments in incident review and learning at Safer Care Victoria

- Consumer role in incident reviews
  - Co-designed approach
  - Interviewing consumers and their families
  - Consumers on incident review panels
  - Keeping open disclosure as a separate process.
Developments in incident review and learning at Safer Care Victoria

- Independent experts on all RCA review panels
  - ✔ PEER platform

- Mentorship and coaching in incident review
  - ✔ Incident Response Team
  - ✔ SCV Academy