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Supporting involvement after safety events in healthcare

Beyond disclosure:

How listening to, and learning with, patients and families during incident investigations can reduce further harm.

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Some background...

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ORIGINAL RESEARCH

OPEN ACCESS

What can patients tell us about the quality and safety of hospital care? Findings from a UK multicentre survey study

Jane K O'Hara,[1,2] Caroline Reynolds,[2] Sally M
Laura Sheard,[4] Claire Marsh,[2] Ian Watt,[5] Joh
Rebecca Lawton[2,7]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2017-006974).

[1]Leeds Institute of Medical Education, University of Leeds,

ABSTRACT

Background Patient safety measurement remains a global challenge. Patients are an important but neglected source of learning; however, little is known about what patients can add to our understanding of safety. We sought to understand the incidence and nature of patient-reported safety concerns in hospital.

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HSR Health Services Research

DOI: 10.1111/1475-6773.12593
PATIENT SAFETY & MEDICAL LIABILITY

Patients as Partners in Learning from Unexpected Events

Jason M. Etchegaray, Madelene J. Ottosen, Aitebureme Aigbe, Emily Sedlock, William M. Sage, Sigall K. Bell, Thomas H. Gallagher, and Eric J. Thomas

Importance. Patient safety experts believe that patients/family members should be involved in adverse event review. However, it is unclear how aware patients/family members are about the causes of adverse events they experienced.

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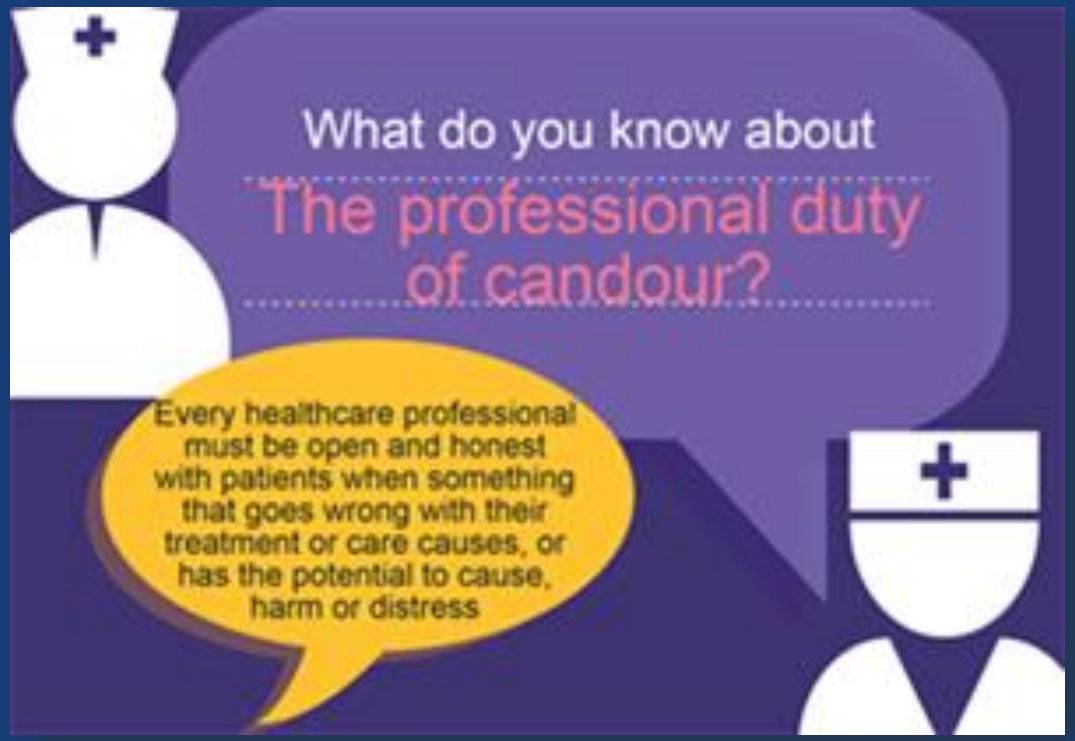

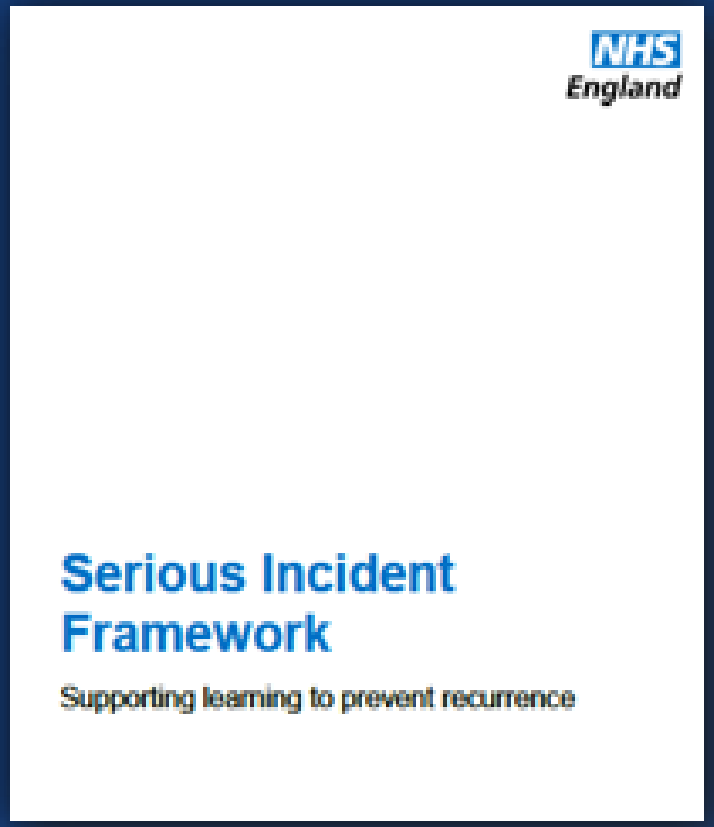

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2. Routinely involving patients and families in investigations

Only nine (12%) of the reports in the sample included clear evidence that the patient or their family had been involved in the investigation.

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‘Organisational learning’ is a key aim of investigations

Patients and families are **not routinely involved in investigations**

Missing a key perspective in understanding what went wrong

If we can involve patients and families, can we improve learning?

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What did we do?

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To ***develop*** and ***test*** new processes and guidance to support the better ***involvement of patients and families in serious incident investigations***

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NHS

NHS Trust

Incident/Serious Incident Repor Policy

This policy describes the process for r investigating and managing incidents a incidents.

Key Words:	RIDDOR Investigation
Version:	9
Adopted by:	Quality Assurance Commit
Date Adopted	25 July 2016

REVIEW ARTICLE

OPEN

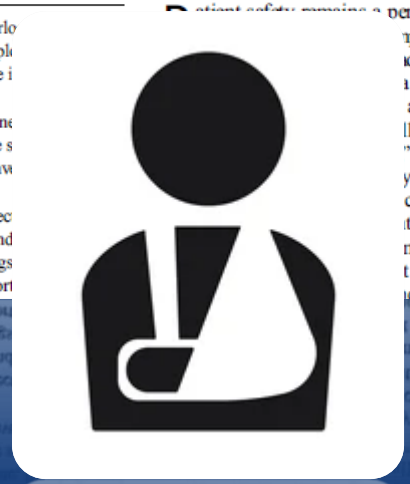
Patient and Family Involvement in Serious Incident Investigations From the Perspectives of Key Stakeholders: A Review of the Qualitative Evidence

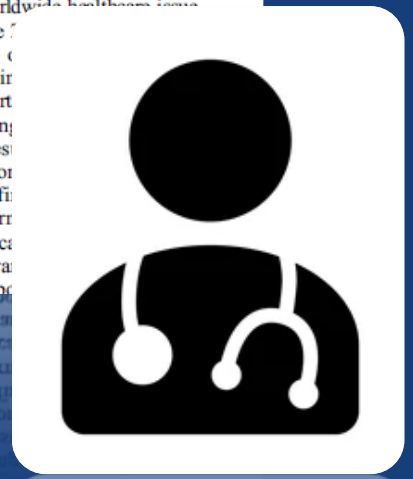
Lauren Ramsey, PhD, Siobhan McHugh, PhD,* Ruth Simms-Ellis, PhD,* Kayley Perfetto, MSc,† and Jane K. O'Hara, PhD*‡*

Objectives: Investigations of healthcare harm often overlo insights of patients and families. Our review aimed to expl tives of key stakeholders when patients and families were i ous incident investigations.

Methods: The authors searched three databases (Medlin CINAHL) and Connected Papers software for qualitative s patients and families were involved in serious incident inv no new articles were found.

Results: Twenty-seven papers were eligible. The perspec and families, healthcare professionals, nonclinical staff, and sought across acute, mental health and maternity settings and families valued being involved; however, it was import





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PRINCIPLES FOR
MEANINGFUL INVOLVEMENT

[VERSION 1.3]

Make apologies meaningful. Rather than offer excuses, demonstrate understanding and a commitment to learn what has happened and why.

Individualise your approach. Involvement should be flexible and adapt to changing needs. Set realistic expectations.

Be sensitive to timing. Investigations can feel like they're happening slowly, quickly or at insensitive times. Investigators need to manage time carefully.

Treat people with respect and compassion. Harm can happen through the experience of the investigation, and how people are treated within it.

Strive for equity. Investigations allow an organisation to learn, but if their agenda is prioritised over patients/staff, the process can feel discriminatory.

Provide guidance and clarity. Patients, families and even healthcare staff can all be confused by what an investigation actually entails.

Listen. If there is a true commitment to learning, then everyone involved should have the opportunity to share their experience.

Be collaborative and open. People who feel involved are less likely to need to seek other routes to be heard (e.g. complaints, litigation).

Respect humanity. Investigations should embrace and accommodate different human responses.

Accept subjectivity. Each individual will experience the same incident in different ways. No one truth should be prioritised over others.

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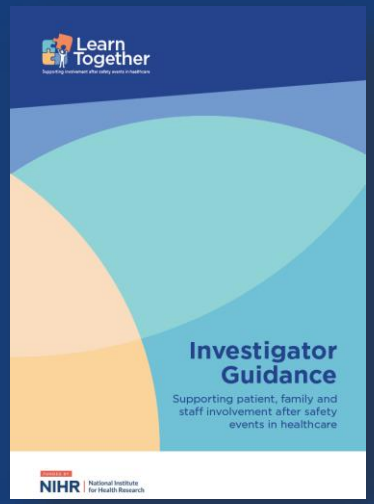
50+



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6m

What did we learn?

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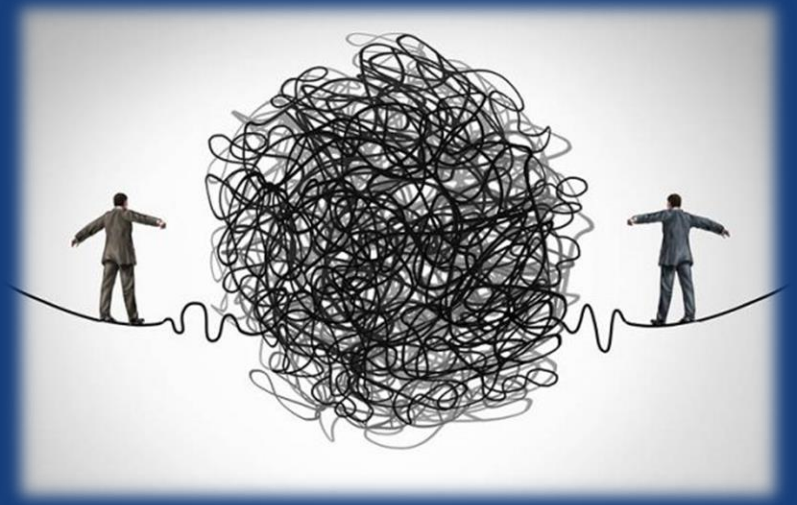

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Compounded harm is the harm that can be created ***after*** a safety incident, due to the processes that follow.

Received: 16 December 2021 | Revised: 6 February 2022 | Accepted: 5 March 2022

DOI: 10.1111/hex.13478

VIEWPOINT ARTICLE

WILEY

Humanizing harm: Using a restorative approach to heal and learn from adverse events

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Allison Kooijman MA, Patient Advocate[2] | Joanne Hughes Patient Advocate[3] |
Jane K. O'Hara PhD, Professor[4]

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Abstract

Background: Healthcare is not without risk. Despite two decades of policy focus and improvement efforts, the global incidence of harm remains stubbornly persistent,

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"I wrote a really carefully worded complaint letter. I put a lot of thought into it....I tried to make sure that the letter wasn't aggressive or pointing the finger... but when I got the response, ***I've often said that was the worst day of my life****."*

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"At one stage I was so upset by the whole thing I felt like taking legal action but I was very aware that the NHS is a very large organisation and, you know, it was little me against them.

I felt like I was in the boxing ring with my hands tied behind my back. ***And I felt desperate****."*

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Listening

Learning

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Can it be done?

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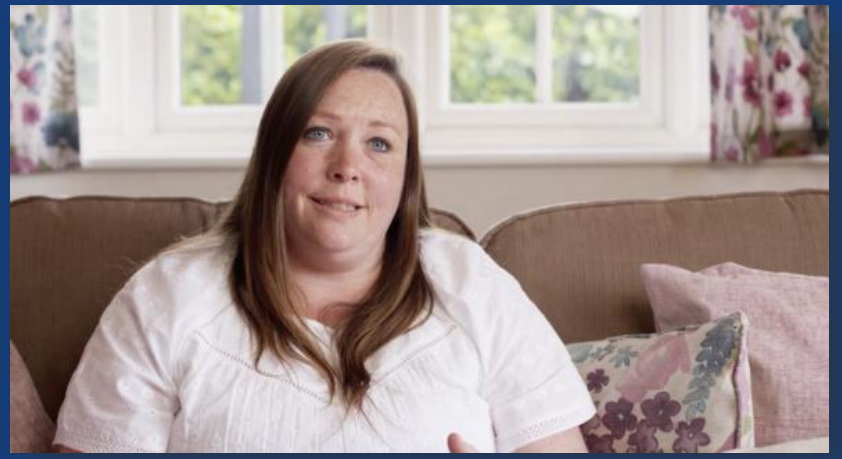

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Stage 1.

Understanding you and your needs

Stage 2.

Agreeing how you work together

Stage 3.

Giving and getting information

Stage 4.

Checking and finalising the report

Stage 5.

Next steps

LISTENING AND SUPPORTING

LEARNING

- National guidance
- Collaboration with NHSEI and HSIB
- Released August 2022
- *Revisions due 2024*

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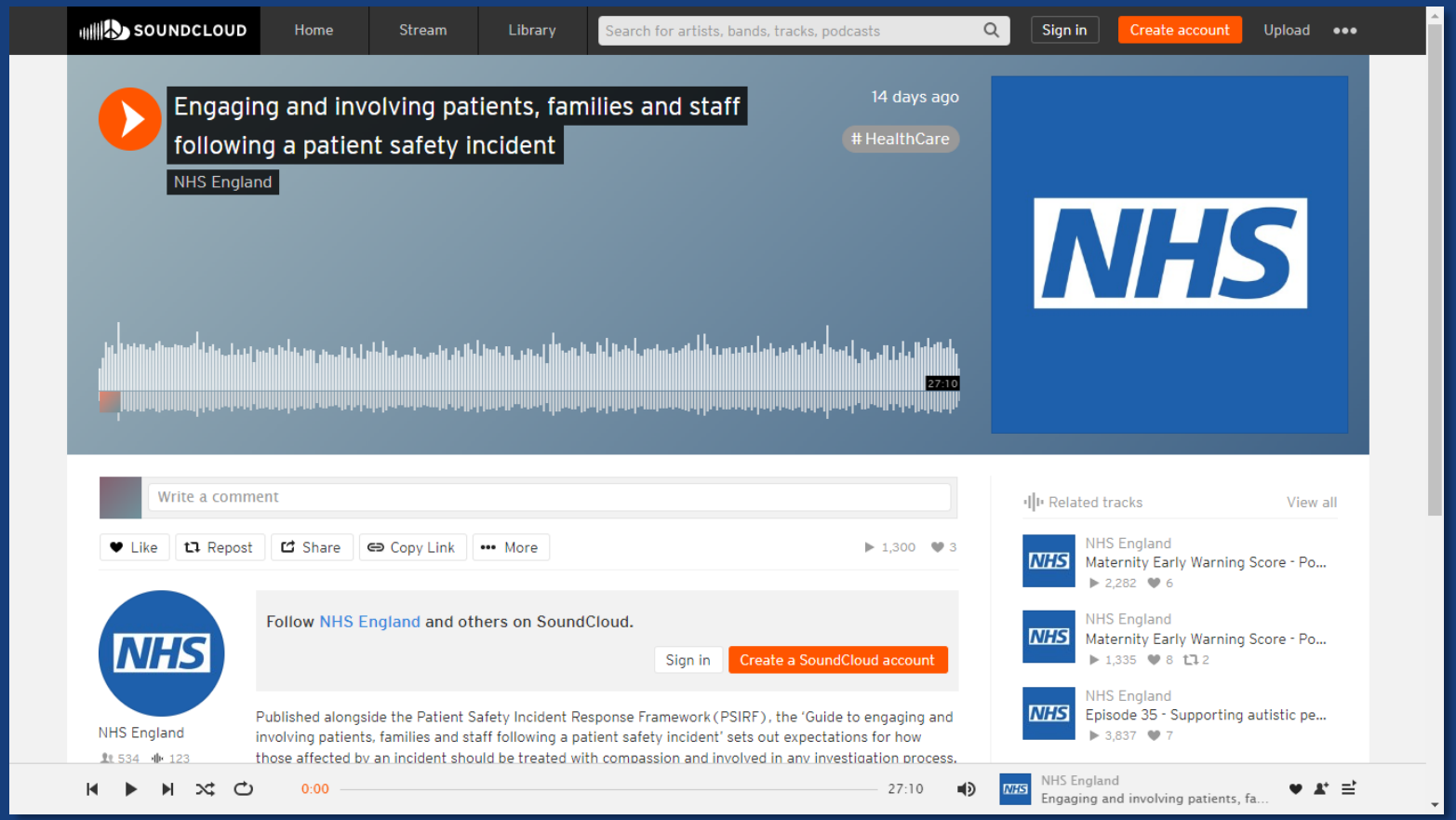

https://soundcloud.com/nhsengland/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident?utm_source=clipboard&utm_medium=text&utm_campaign=social_sharing

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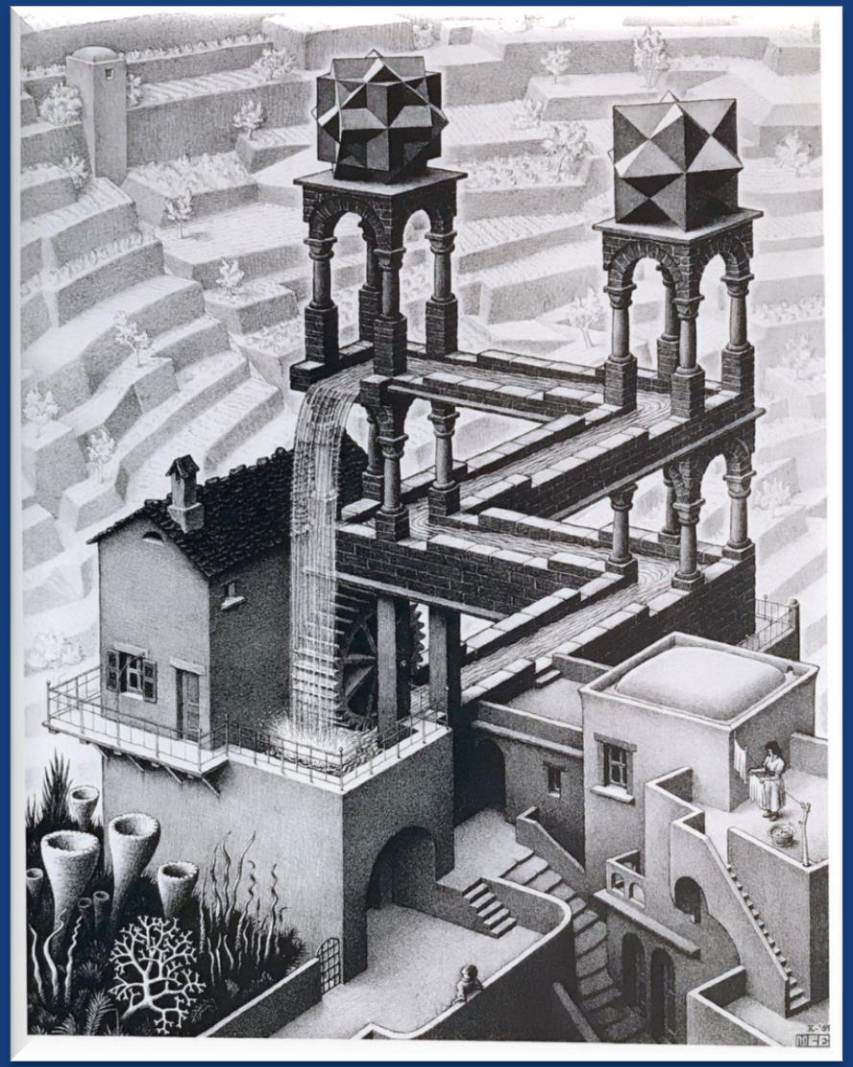


Is reducing compounded harm...

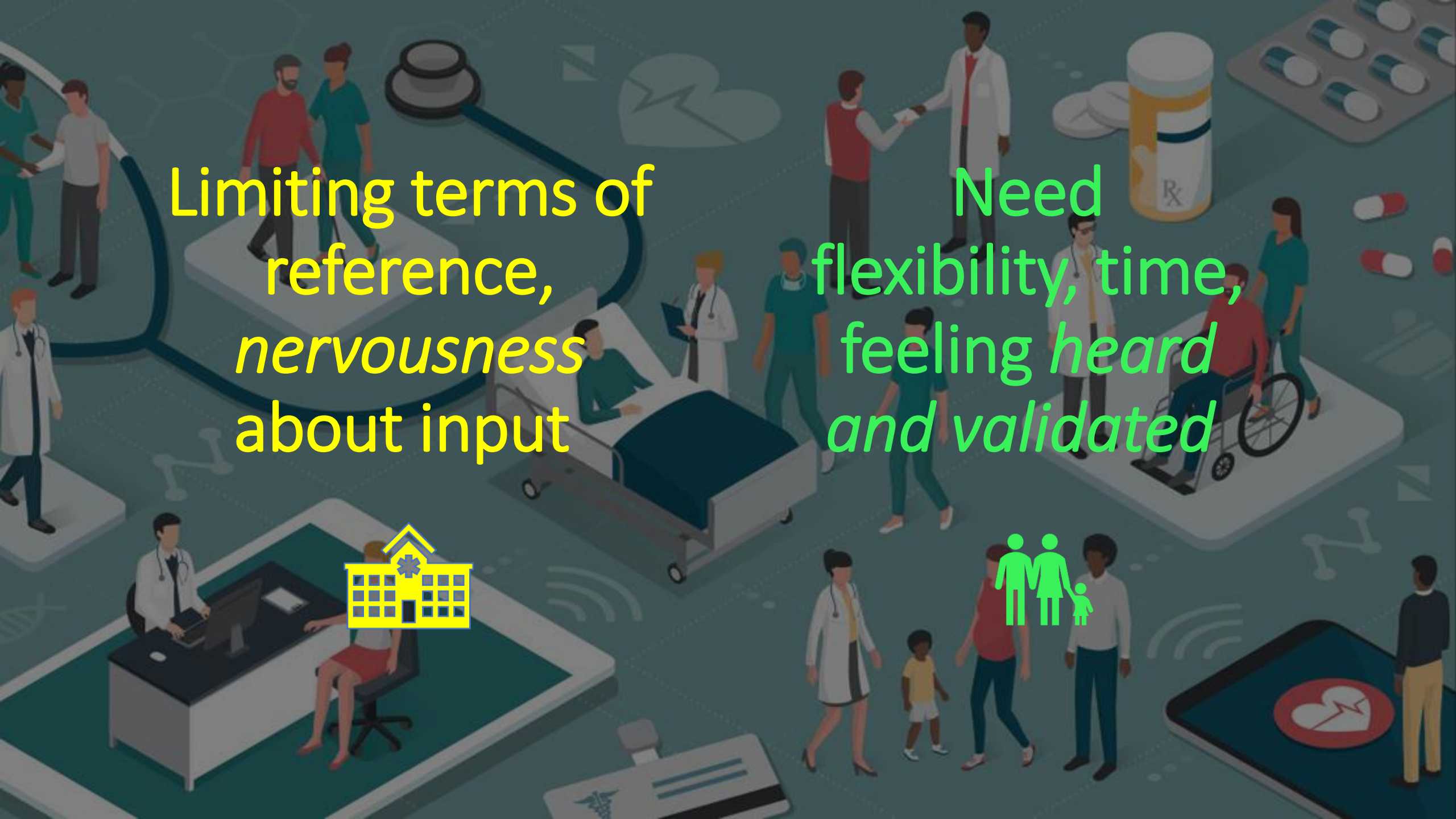
... deceptively simple?


Path to compounded harm may be paved with good intentions…

Focused on incidents with *greatest learning potential*

Want answers about *their experience*

Can rigid systems accommodate family-centred investigations?


Limiting terms of reference, *nervousness* about input
Need flexibility, time, feeling *heard and validated*

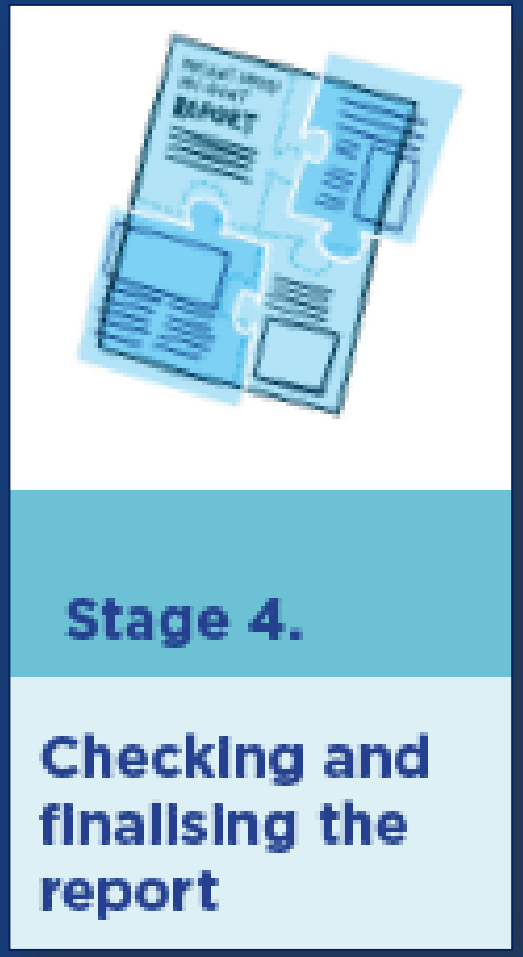
Stage 4.

Checking and finalising the report

Stage 4.

Checking and finalising the report

- Critical point of process
- Welcomed in principle, but nervousness about the practice
- *Does it put the organisational processes above needs of patients and families?*



- If investigations are to learn, patients and families *should* be able to see the report and amend inaccuracies

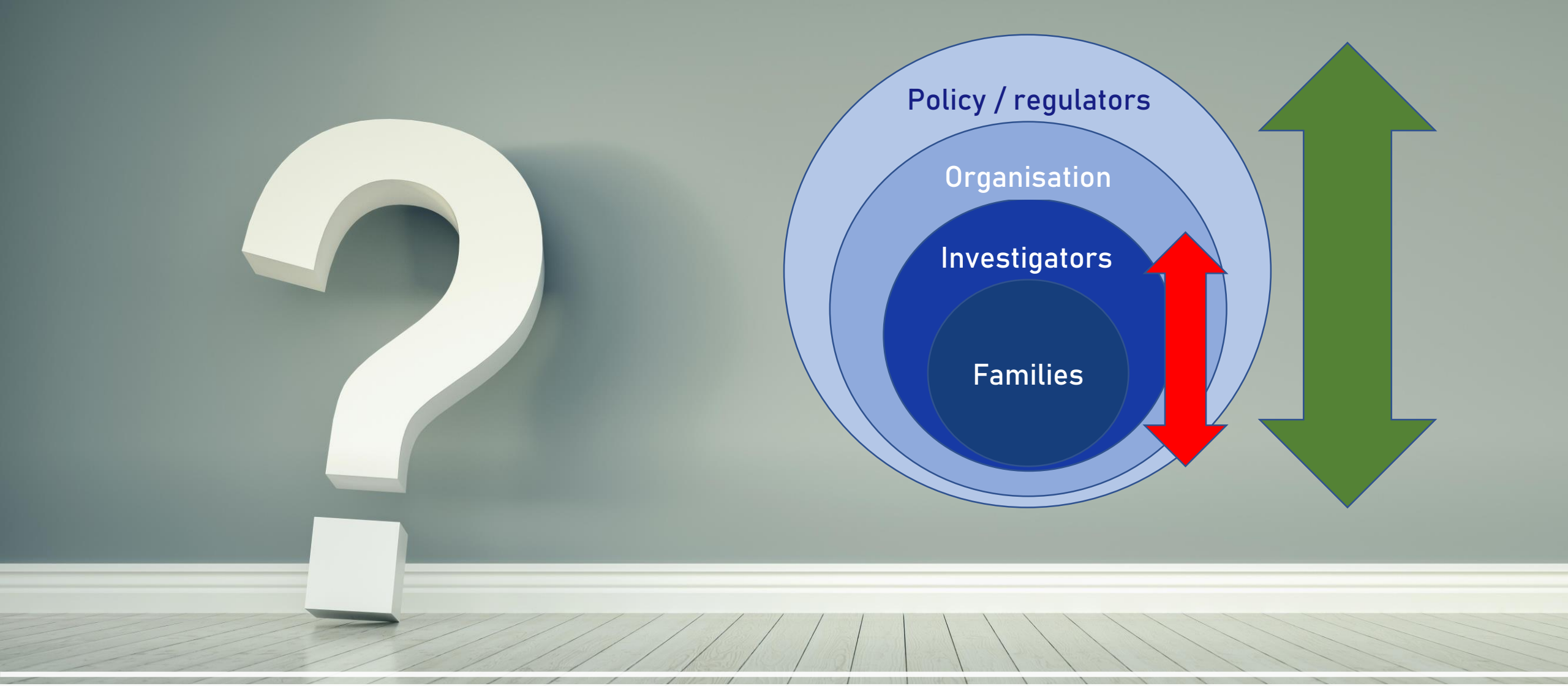
- But this can cause problems in terms of:
  - Timing in organisational processes
    - *Post clinical accuracy, pre governance sign off?*
  - The influence of competing pressures
    - *Reputational damage and the need to keep control of negative information?*

Stage 4.

Checking and finalising the report

What we learned

- *'Put your money where your mouth is' moment*
- It addresses 'other needs'
  - Dignifying the person
  - Making sure details are accurate
  - Supporting a sense of transparency and working together
- Pivotal point that impacts further processes?
- Needs to be *demonstrably* a point where things can still be changed



Even if *everyone wants something*, getting it embedded can be difficult…

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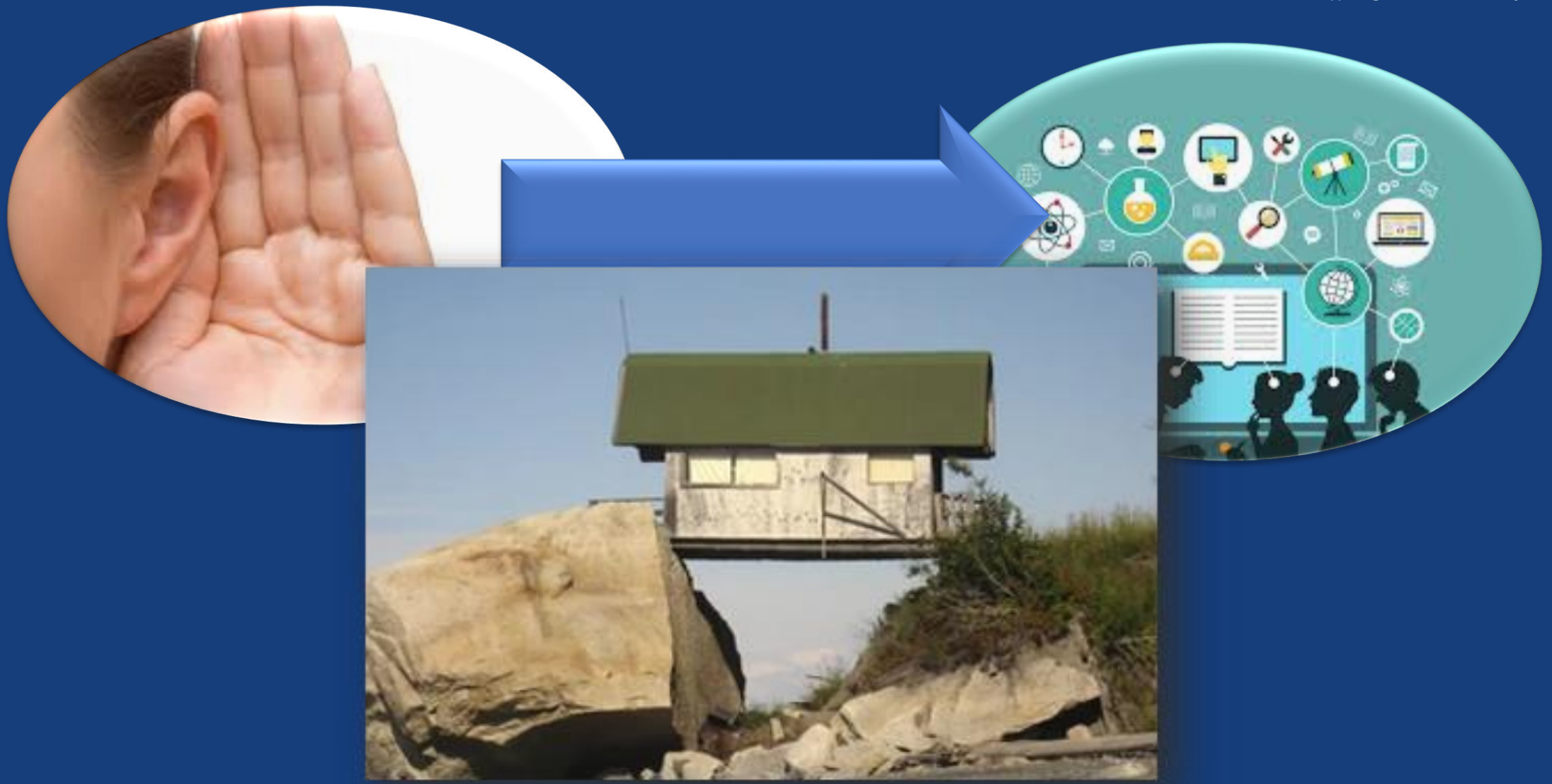

This project is funded by the NIHR HS&DR programme [18/10/02]. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Patients and families

Learn Together Research Team

Healthcare staff

Our partner NHS Trusts

NHS England and HSIB

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