Learning Event Analysis (formerly SEAs)
Outline

• What is a learning event analysis (LEA)
• Why do LEA’s?
• What makes a good LEA?
• A look at human factors that contribute to a LEA.
• Consider System changes to avoid errors
• The impact of evidence based health care & templates
• Group Work
Definition

A significant event.

Also known as untoward or critical incident, is any unintended or unexpected event, which could or did lead to harm of one or more patients.

This includes incidents which did not cause harm, but could have done, or where the event should have been prevented.

RCGP
Background of LEAs

• Evolved from Critical Incident Reviews in hospitals

• Required by the GMC where a patient could have or did come to harm.

• A focus on quality and safety.

• A key part of the NHS complaints procedure.

• An essential standard for CQC compliance.

• Required by individual GPs for appraisal and revalidation.
Why Learning Event Analyses 1

A way of formally analysing incidents that may have implications for patient care.

Learning from what went wrong or right should help improve clinical practice.

To analyse events that highlight sub-optimal care or methods of practice that could be improved to enhance the quality and safety of health care.
Why LEAs 2

Focus is on understanding, analysing and redesigning the systems we work in and, how we as individuals interact with them to learn how to reduce the risks of future significant events.

Prevention: Without undertaking a systems-based analysis to understand why an event happened and ensure that an action plan for improvement is developed and implemented, it’s likely that the same thing will happen to someone else.

Facing up to problems: Brushing our mistakes under the carpet or dealing with them superficially is a missed opportunity for professional learning and improving patient care.
Process of LEA

Incidents identified
- unexpected deaths
- delayed or missed diagnoses
- medication errors
- communication failures

Reporting
- an established method for reporting
- an easy to use system
- confidentiality

LEA Discussions
- case analysis by the whole team
- Examine the underlying systems
- Honest, non-judgemental, no fault way.

Act on the incident
- prioritise changes
- Identify training and skills required
- Amend protocols/policies
Seven Practical Steps for an effective LEA

1. Awareness and Prioritisation of a Significant Event
2. Information Gathering
3. The Team-based Meeting
4. Investigation and Analysis of the Significant Event
5. Agree, Implement and Monitor Change
6. Write-It-Up
7. Report, Share and Review learning from significant events
The LEA Meeting

Protected time for team discussion, not just a casual conversation over coffee or in the corridor!

Ask reflect and record:

- What Happened?
- Why did it happen?
- What has been learned?
- What needs to be changed or actioned?

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Analysis of incidents can usually identify them to be the result of the interaction between, **people**, the **environment** in which they work of the **activity** which they are undertaking.
Benefits of an effective LEA

• Reflecting on interesting or complex cases.
• Identifying individual or practice training needs.
• Facilitating implementation of change and improvement.
• Contributing to the management of risk in the practice
• Enhancing the safety of patient care and local safety culture
Primary care has a poor track record of acknowledging significant events. There is a tendency to discuss them informally and superficially with trusted colleagues. This affects the chances of making the necessary improvements in practice systems to minimise the risk of the event recurring. Making a mistake and being part of a significant event can also have an emotional impact on the healthcare professionals involved. Or the tendency is to be very selective over what incidents are chosen because of personal feelings of guilt or embarrassment or fear of punishment or ridicule.
Awareness of Human Factors helps

- Understand why healthcare staff make errors and in particular, which ‘systems factors’ threaten the safety of your patients
- Improve the safety culture of teams and organisations
- Enhance teamwork and improve communication between healthcare staff
- Improve the design of healthcare systems and equipment
- Identify ‘what went wrong’ and predict ‘what could go wrong’
- http://qualitysafety.bmj.com/content/22/10/802.full
Addressing Human factors

• Creating a workplace environment where patient safety is paramount begins with the understanding of Human Error.

• Human beings make mistakes everyday – it is part of being human, it is a fact of life.

• In our personal and working lives we all make mistakes in the things we do, or forget to do, but the impact of these is often non existent, minor or merely creates inconvenience.

• However, in healthcare there is always the underlying chance that the consequences could be harmful.

• It is this awareness that often prevents such incidents as we purposefully heighten our attention and vigilance when we encounter situations or tasks we perceive to be risky.
## Human Factors Myth or Fact

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
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<tbody>
<tr>
<td>Human factors is about eliminating human error</td>
<td>Human factors is about designing systems that are resilient to unanticipated events</td>
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<tr>
<td>Human factors addresses problems by teaching people to modify their behaviour.</td>
<td>Human factors addresses problems by modifying the design of the system to better aid people.</td>
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<td>Human factors is focused only on individuals.</td>
<td>Human factors work ranges from the individual to the organisational level.</td>
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<td>Human factors consists of a limited set of principles that can be learnt during brief training</td>
<td>Human factors is a scientific discipline that requires years of training; most human factors professionals hold relevant graduate degrees</td>
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System Approach

Examples of systems approaches to accommodate human fallibilities, include:

• Automate systems where possible and appropriate (e.g. IT mail merges to invite patients with chronic diseases to the practice for clinical review or phone text alerts for appointments).

• ‘Forcing functions’ should be added where appropriate (e.g. adding reminders and ‘double clicks’ to confirm doses, dosing intervals and durations of high-risk medications – although these can sometimes be counter-productive)

• Standardise systems to reduce reliance on memory (e.g. Following Clinical Protocols)
System Approach 2

• Checklists used prior to operations improve teamwork and avoid errors.
• Primary care examples include systematically checking the contents of the emergency bag and use of controlled drugs.
• Minimise staff interruptions and distractions. (e.g. Unnecessary interruptions during a consultation with a patient)
• Add redundancies (e.g. ‘double checks’ when administering MMR vaccinations).
Clinical practice is now dominated by guidelines and templates.

Evidence Based Healthcare is the application of research findings to inform individual clinical decisions.

EBHC has been held up a Quality Standard of best clinical care.

However, there is a tension – both philosophical and practical – between the average result form a population study and the circumstances and needs of an individual patient.
Evidence Based Healthcare Risks

• The volume of clinical guidelines, has become unmanageable

• Statistically significant benefits may be marginal in clinical practice

• Inflexible rules and technology driven prompts may produce care that is management driven rather than patient centred

• Evidence based guidelines often map poorly to complex multimorbidity.
EBHC & the individual

• Use of evidence in clinical decision making is situational and contextual.
• The unique individual patient. Not abstracted truths from distant research studies, must be the starting point for clinical practice.
• Systemic reviews are generally placed above narrative reviews in an assumed hierarchy of secondary research evidence.
• Narrative reviews provide interpretation and critique. Their key contribution is deepening understanding.

Trisha Greenhaulgh
Get the balance right

Evidence Based Health Care

Anecdote

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Summary

- LEA – why, who and how.
- Human factors in safety
- Guidelines & policies in clinical quality
- System approaches in safety and quality
- The balanced use of EBHC and templates.
3 Interactions to each SEA

- Activity
  - complexity
  - Guidelines
  - Policies
  - Equipment

- LEA

- People
  - Individuals
  - Team
  - Patients

- Environment
  - Work setting
  - Communication
  - Training

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Group Work

Spend 15 minutes on your table discussing, and prepare to feedback:

• How are LEAs used in your CCG/locality?
• What key learning was identified?
• How difficult/easy was it to implement change supported from LEAs?
• What else is left to do, what's next?
“We cannot change the human condition, but we can change the conditions under which humans work.” Reason (2000) Reason J. Human error: models and management. BMJ 2000;320:768e70.

Too often when mistakes happen, individuals are blamed and little attempt is made to explore and address the underlying systemic causes that lead to errors (Russ et al., 2013) Russ AL et al., (2013). The science of human factors: separating fact from fiction. BMJ Quality & Safety