On 12 September 2017 Dr Farhad Peerally presented a very well received LIIPS seminar entitled ‘Bridging the gap between analysis and improvement following serious incident investigations in healthcare’.

Fifty eight people representing all LIIPS organisations plus NHS England, Derbyshire Healthcare NHS FT and local solicitors registered to attend. An opening exercise involved delegates identifying the first word to come to mind when thinking of incident investigations in healthcare (list included challenging, formulaic). Dr Peerally reviewed current practice of incident investigation in the UK starting by looking at the challenges facing the practice of incident investigation (RCA) in healthcare, the history of root cause analysis (RCA), quality of investigations, patient involvement and the gap between analysis and actions and the gap between recommendations and implementation.

Following a networking break the delegates were asked by table to identify solutions to allocated problems e.g. improving the quality of investigations, the RCA model based in linearity. Perspectives from other safety critical industries were then presented to inform how to improve actions following incident investigations in healthcare.
Two systemic models were presented including the STAMP model which was illustrated by a safety control structure for an insulin over prescription incident (from www.systemsthinkinglab.com). This illustration was based on collaborative work resulting from the LIIPS Medication Safety group. Many other factors were raised for consideration. Details available on the slides here. In summary need to: identify the right causes through the right model, identify the right solutions for the right causes, implement the right solutions, monitor the right solutions (in case they are the wrong solutions!) and then tell everyone concerned about the incident, the right causes, the right (and wrong) solutions.

Slides from the seminar are available here and include a reference list on the last slide.

**Seminar Aim**

Root Cause Analysis is a commonly used tool to investigate patient safety incidents in healthcare. Questions have however been asked of its effectiveness in producing improvement. This seminar will aim to synthesize the evidence on the effectiveness of incident investigations in healthcare, identify what can be learnt from practices in other safety critical industries and stimulate the audience to think of ways actions can be improved to sustain organisational learning and mitigate risk.
Speaker Biography

Dr Farhad Peerally (Leicester Medical School)

Dr Farhad Peerally is a Clinical Research Fellow with the SAPPHIRE group at the University of Leicester and a Gastroenterology registrar at the University Hospitals of Leicester. He is currently undertaking a Health Foundation funded doctoral study in the Department of Health Sciences investigating how action plans following root cause analysis of serious incidents in healthcare can be made more robust.

Further Reading

The following articles on RCAs may be of interest:

- Root-cause analysis: swatting at mosquitoes versus draining the swamp
- Our current approach to root cause analysis: is it contributing to our failure to improve patient safety?
- The problem with root cause analysis
- Reference list on the last slide here