



CONSEQUENCE

A Two Day Workshop In to Root Cause Analysis and Incident Investigation In Primary Care Trusts

Introduction

This workshop has been designed for those persons within Primary Care who are expected to lead the development of Significant Event Audit (SEA) and Root Cause Analysis within their department, discipline, or Health Centre. The two-day programme allows participants to undertake a full causal analysis of a primary care event, and to be cognizant of the issues they need to consider when developing further the systems that may already have in place for SEA.

Programme

08.45 Registration

09.15 Introduction to the workshops aims and objectives

09.30 Basic Introduction to Human Error Theory

10.15 Adverse Event reporting and Significant Event Auditing (SEA)

11.00 Refreshments

11.15 Risk assessment of incidents and near miss events (to include practical application)

12.00 Introduction to the Root Cause Analysis Investigation / Review

13.00 Lunch

13.30 Developing the SEA process to allow more focused causal analysis of concerns and problems

14.15 Prioritising the safety and quality issues to be explored (Nominal Group Technique)

14.45 Bringing a mixed groups of professionals together and facilitating a RCA

15.15 Refreshments

15.35 Small group exercise

- Participants are presented with a list of issues that have been put forward for discussion at the next Significant Event Audit Meeting to prioritise

16.35 Opportunity for final questions, sharing of the experience of the day.

- Facilitator compiles aggregate prioritised list that represents the groups priorities for discussion/exploration.

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17.00 Close

Day 2 Continued

08.45 Registration and Refreshments

09.15 Exploring Problems and Issues to find the real causes

- Barrier Analysis
- The Five Why's Technique
- Fishbone Diagram
- Influencing and Causal Factors

11.00 Refreshments

11.20 Facilitated group work

- Analysing the problems prioritised yesterday using one or more of the RCA techniques

13.00 Lunch

13.45 Testing the effectiveness of proposed improvement strategies

- Pro-active Barrier Analysis

14.45 Generating a report and action plan that can be shared within the practice, and with others within the PCT

15.15 The summary

An opportunity to ask final questions

15.30 Coffee and Close

Objectives

To enable participants to:

- ✓ Have a good understanding of human error and event causation theory
- ✓ Understand the purpose of the Significant Event Audit (SEA); how to set up a significant event audit
- ✓ Explore the tension between information retention and information sharing
- ✓ Clarify the meaning of 'adverse event'
- ✓ Have a clearer picture of the contextual application of risk assessment when applied to significant events
- ✓ Appreciate how Root Cause Analysis tools and techniques can be applied in the Primary Care setting to support the SEA process
- ✓ Facilitate participants through a Primary Care Case Study identifying the 'significant events', the underlying causal factors and the root causes

Style of Delivery

This workshop is highly interactive to maximise the participant's confidence to experiment with and implement the RCA tools and techniques in practice. The delivery also employs a number of effective consensus building techniques during the practical exercises that participants will be able to utilise in practice.

Required of Participants

All participants are asked to bring at least one example of a significant event they were involved in or raised via their existing SEA or incident reporting processes, or a quality or safety problem that they are currently aware of but have not raised via their SEA or incident/risk reporting systems

Note: it is preferable if these incidents are of moderate to low severity, or were near miss events

"Effective safety and quality improvements within your control"