Systems Analysis
Guidance for Services
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Introduction

The HSE Incident Management Framework (2018) sets out three levels of review (comprehensive, concise and aggregate) and the approaches to review available for each level. With the exception of After Action Review\(^1\) (AAR), all approaches to review should be undertaken using a systems analysis methodology.

So what is a system analysis methodology and how is this beneficial for reviewing incidents? To answer these questions it is important to understand:

a) What is a system?

b) What is systems thinking?

c) How the system and systems thinking relate to patient safety.

d) Models explaining systems errors or accidents

e) What is systems analysis?

a) What is a system?

A system is defined as a set of things working together as parts of a mechanism or an interconnecting network; a complex whole.\(^2\) Systems thinking is not new and is a theory that has been around for some time. It is largely influenced by the work of an American academic, Peter Senge.

Senge defines a system as 'a perceived whole, whose elements hang together because they continually affect each other over time and work towards a common purpose.'\(^3\) According to Senge, life teaches us to be systems thinkers as we are part of systems in all aspects of our lives. On a personal level, families are systems and in our professional lives, the teams and organisations that we work in are systems.

The HSE and HSE funded services are complex organisations or in other words, complex systems where people and technology work together to provide health and social services to the population of Ireland. This system is made up of a diverse range of complex services provided by multi-disciplinary staff and administrative and management functions; these functions ‘hang together’ to deliver the organisational goals and targets set out in the Corporate Plan and other organisational plans. Elements of the system within the health and social care settings might include:

- Service users: individuals and families who use services.
- Staff members: the people providing the services.
- Services: the separate services provided and the individual tasks performed to deliver them.
- Teams: local and national teams where individual staff members work.
- Management: the overall organisational/management structure.
- Equipment: the technology and equipment used to carry out tasks associated with service provision.
- External environment: legislation, regulators, standards, political etc.

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\(^1\) An after action review is a facilitated discussion analysing what happened, why and what can be done better.

\(^2\) https://en.oxforddictionaries.com/definition/system

b) What is systems thinking?

In a world of increasingly complex problems, systems thinking allows us to understand how elements of a system fit together so that we understand how to make changes to improve the system. It is a way of thinking that encourages reflection. Reflection is necessary as it opens people up to thinking together to collaboratively solve any problems. Systems thinking supports us to take a big picture view rather than trying to understand problems individually or in isolation.

Systems thinking is a way of thinking about and a language for describing and understanding the forces and interrelationships that shape the behaviour of systems. This discipline helps us to see how to change systems more effectively.4

Systems thinking is useful for:
- Complex problems that involve helping people to see the big picture and not just their individual part of it.
- Recurring problems or those that have been made worse by past attempts to fix them.
- Issues where an action affects (or is affected by) the environment surrounding the issue
- Problems where solutions aren’t obvious.

Using systems thinking allows you to get a better understanding of the real causes of the complex behaviours that occur in systems so you can try to predict them and ultimately adjust their outcomes.

c) How the system and systems thinking relate to patient safety

When seeking to make health and social care services safer, a good place to start is by analysing the elements of the system to identify where improvements can be made. A systems view of health care recognises that we need to move from ‘silos’ to an appreciation that in order to be effective, each element of the system must recognise its dependence or influence on other elements so that the performance of the system as a whole is strengthened. In the same way, individual team members must recognise their dependence and influence on other team members.

All the components in systems are interrelated and interact with each other. These complex interactions can lead to positive or negative outcomes. Positive outcomes happen when the system is working well. In a health and social care setting, this might mean that staff are using evidence based approaches and working in line with national policy and legislation to provide services. In turn, service users benefit by living fulfilled lives and being as healthy as they can.5 However, a negative outcome might mean a particular intervention or approach hasn’t worked and this may have consequences for the service user, sometimes fatal consequences. In cases where a reported incident has resulted in a negative outcome, we need to look at the system to see if there are any improvements that we can make to prevent or minimise the risk of further adverse outcomes.

Factors in the wider system, often outside the control of the health and social care delivery system, also influence the work and function of these services. These are commonly political, environmental, and sociological factors which influence the manner in which health and social care services are required to operate. Changes in one part of the system can have a positive or negative effect on another part. For example, changes made in the political arena such as budget allocations or legislative change can affect service provision.

4 http://www.thwink.org/sustain/glossary/SystemsThinking.htm
5 http://www.hse.ie/eng/services/publications/corporateplan/
d) Swiss cheese model of accident causation

A British psychologist, James Reason, has developed a model to help explain how incidents or accidents happen from a systems perspective. This model is commonly referred to as the Swiss cheese model.

This model explains that systems have many layers of defence. Some of these are engineered (e.g. alarms or physical barriers). Others rely on people and others again depend on procedures and administrative controls. This model proposes that failures, such as patient safety incidents, are rarely caused by isolated errors at the point of care delivery. Instead it is a combination of factors which taken together conspire to create an environment where incidents can occur.6

Figure 2: Swiss cheese model

HAZARDS

Some holes due to active failures

Other holes due to latent conditions

Incident

SUCCESSIVE LAYERS OF DEFENSES

On the whole, the defences we put in place to prevent incidents occurring are effective. However, in complex systems like healthcare there are always weaknesses which mean that adverse events/incidents will occur. In this model, the weaknesses are depicted as the holes in slices of Swiss cheese. The presence of holes in any one slice does not normally cause a bad outcome but this can happen when the holes in lots of layers line up to allow the opportunity for error.

The holes in defences arise for two reasons: active failures and latent conditions. Active failures are unsafe acts (e.g. mistakes, slips, deviation from policy) carried out by people who are in direct contact with service users – people at the ‘sharp end’ of the system. For example, this might be the nurse who gave the patient the incorrect drug or the surgeon who performed the wrong procedure.

On the other hand, latent conditions are underlying factors or organisational influences which contribute to error. These are at the blunt end and refer to the many layers of the health system that don’t have direct contact with service users. They can include policy makers, management and manufacturers of equipment or technology and other people and forces which affect how health and social care services are delivered. According to Reason, latent conditions can include time pressures, staffing deficits, fatigue, inexperience and poorly maintained equipment.7 Latent conditions can create long lasting holes or weaknesses in the system increasing the risk of error. They can also lie dormant for a while until they combine with active failures to trigger opportunities for error. Unlike active errors, they can be identified and remedied before an adverse event occurs. Understanding this leads to proactive management of risk.

6 See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1298298/ and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/

7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/
If we followed a more traditional approach to incident review by focusing on the actions of an individual (i.e. person approach to review), we would focus on the person at the sharp end. This approach aims to ‘fix’ the people rather than the system within which they operate. However, this type of approach reinforces a blame culture and fails to address weaknesses in the system that would seek to reduce the risk of a similar incident occurring in the future. The weakness remaining in the system would serve to facilitate similar errors to occur involving other staff members as far as from being random, errors tend to fall into recurrent patterns. A useful analogy is to think about road safety and accident black spots. The focus in these situations isn’t on individual cars or drivers rather it is on other measures that need to be put in place. These measures might include prominent signage warning motorists and improvements about the road surface. There may also be national campaigns to reduce speed and ensure all vehicles meet certain safety requirements in an effort to reduce the number of road traffic accidents. In this way there is a whole system of road safety that includes safe vehicles and safe road users.

e) What is systems analysis?

The HSE’s Incident Management Framework defines systems analysis as:

A methodical review of an incident which involves collection of data from the literature, records (general records in the case of non-clinical incidents and healthcare records in the case of clinical incidents), individual interviews with those involved where the incident occurred and analysis of this data to establish the chronology of events that led up to the incident, identifying the key causal factors that the reviewers considered had an effect on the eventual harm, the contributory factors, and recommended control actions to address the contributory factors to prevent future harm arising as far as is reasonably practicable. The principles of systems analysis can be applied using a comprehensive, concise or aggregate approach.

A systems analysis approach is useful as it ensures that the system as a whole is reviewed not just the incident in isolation so that all of the factors that contributed to the incident occurring in the first place are established. A common patient safety incident can illustrate why a systems analysis approach is useful. A recent HIQA report suggests that there could be as many as three million medication errors in Irish public hospitals every year. Giving the wrong drug to a patient can lead to devastating consequences for the service user but also for the staff member concerned. If we respond to this incident by looking at the incident in isolation and telling the nurse who gave the patient the wrong drug to be more careful next time, we won’t see what other factors contributed to this error. However, if we expand our view to look at the system rather than just the individual we will be able to see the bigger picture. For example, we will see other contributory factors which might include prescribing or dispensing errors and/or staffing deficits. We need to understand a system before we can change it. This ‘big picture’ thinking is the reason that health care organisations use a systems approach to make services safer.

This guidance has been prepared to support staff undertaking incident reviews using a systems analysis approach. It provides information on systems analysis and aims to help you to carry out a methodical, systemic review whether you are working alone or as part of a review team or panel, and whether you are doing a concise, comprehensive or aggregate review. The guidance will support your review to be methodical by outlining the steps to follow in order to gather information, analyse it and generate recommendations. It will support your review to be systemic by guiding you to consider all aspects of the system rather than just focusing on the point of occurrence of the incident. This means that the outcome of your review will facilitate systemic improvements rather than focusing solely on the incident or staff member involved.

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Steps for reviewing incidents using a systems analysis approach

The approach set out is based on research using a systems approach in healthcare. This research advocates replacing blame and finding fault with individuals with a more structured, reflective approach which uses clinical experience and expertise as part of the process. This type of approach:

- Supports reviewers to look beyond single acts or omissions as immediate reasons for an adverse event and identify the multiple factors or series of events that contributed.
- Is structured and systematic which helps to ensure that reviews are carried out consistently.
- Promotes a greater climate of openness facilitating systemic improvements rather than assigning blame.

The accompanying Incident Management Framework – Guidance provides detail on the levels and approaches to reviews that can be done under the Incident Management Framework (see Incident Management Framework – Guidance, Section 8 page 39. Irrespective of the level and approach to review chosen, with the exception of After Action Review, all reviews carried out under Step 5 (Review and Analysis) of the Incident Management Framework must be carried out using the six step system analysis approach outlined below.

The six steps in the systems analysis approach are:

1. Step 1 – Organise the review and gather the data/information
2. Step 2 – Determine the incident chronology
3. Step 3 – Identify the key causal factors (KCFs) and incidental findings (IFs)
4. Step 4 – Identify the contributory factors (CFs)
5. Step 5 – Make recommendations
6. Step 6 – Prepare a report and submit it to the person requesting the review.

The Incident Management Framework in Step 4 and Step 5 contain detail of the decision making process for reviews, the commissioning of reviews and the review and analysis process. The Incident Management Framework – Guidance also contains guidance which will assist the establishment and conduct of reviews i.e. the role of the Serious Incident Management Team (SIMT), approaches to review, fair procedures, terms of reference, developing recommendations and the report governance approval process along with templates for reports. This guidance is therefore designed to be read in conjunction with these documents.

Though this guidance is set out in a sequential manner it is important to remember that in practice you might have to go back and forth between the steps when gathering and analysing information. You may also find gaps in your analysis and need to gather additional information.

In the aftermath of an incident open disclosure will have taken place with the service user/family. If the plan for review is available at the time of making the open disclosure the service must outline this plan and seek the involvement of the service user/family in the process. If the plan is not available at the time of the open disclosure meeting the service should confirm that they are carrying out a preliminary assessment to inform the next steps and that a further meeting will be organised to outline this plan.

http://qualitysafety.bmj.com/content/21/5/369
Whilst the service has an obligation to review any incident that has caused harm, it is best practice to seek the consent of the service user/family in relation to accessing the data required to conduct the review e.g. the service user’s healthcare record. This should be carried out at the meeting where the plan for review is discussed with them.

**Step 1 Organise the review and gather the data/information**

The first stage in step 1 (i.e. organise the review) refers to the commissioning process whereby appropriate reviewers are identified, terms of reference developed and confirmation is provided that liaison persons are in place to provide support to persons affected i.e. service users/families and staff. Please refer to pages 22-25 of the Incident Management Framework and the Incident Management Framework – Guidance, Sections 9 and 10 for information about this process.

The next stage in Step 1 is to gather the data/information. There are many sources of information that you can use when using a systems approach to review an incident. Your understanding of what happened will be informed by the information that you gather and your subsequent analysis of this. It is important to gather information on the four levels of healthcare. Figure 1 show these as four nested levels including: (1) The patient/service user (2) The care team including professional care providers (e.g. members of the clinical and wider care team, family members and others). (3) The organisation (e.g. hospital, clinic, nursing home, etc.) that supports the work of care teams by providing infrastructure and complementary resources and (4) The environment within which that team works (e.g. political/economic/regulatory).

**Figure 3: Four levels of healthcare**

Gathering information at the patient or service user level might rely on medical records, as it may not be possible or appropriate to meet the service user (e.g. if they are acutely ill as a result of the incident). In these cases, reviewers can engage with the service user’s next of kin. This meeting provides reviewers with an opportunity to hear the perspective of the service user/family and identify what questions they would like to see the review address. This also provides an opportunity to outline the process to be undertaken, the likely timeframe and the opportunities for them to provide further input (e.g. a meeting to discuss the draft report). Don’t forget to factor in that service users/families might need support when engaging with reviewers. You can advise service users that they can bring a family member or friend or other trusted person such as a patient advocate.

Other information at the care level will include engaging with staff, the healthcare record, documentation about the incident (this might include incident report forms and staff recollections – see Incident Management Framework – Guidance, Section 4) and relevant policies and standards in place at the time.

Examples of information sources:

- Patient – medical record/patient file/meeting(s)
- Care team – meetings with family/staff and/or line managers and administrative decision makers. Review any written recollection of events written by staff, the incident report form and documentation related to the incident.
- Organisation – policies and procedures/operational plan organisation structural and governance arrangements
- Environment – national policy, clinical guidelines, legislation/regulatory standards and inspection reports

You may also need to consider information from the literature regarding the evidence base and/or best practice.

**Step 2 Determine the incident chronology**

Once you have gathered information, it is time to establish a chronology of events. The chronology is simply you setting down the information in the sequence that you understand the events to have occurred.

A chronology can be documented in a simple tabular form as outlined in table 1 (please see Appendix 3 on page 58 of Incident Management Framework – Guidance).

**Table 1: Example of tabular chronology**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Source</th>
<th>What happened?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 January</td>
<td>14.20</td>
<td>Medical record.</td>
<td>Patient A presented to XX Hospital Emergency Department complaining of shortness of breath.</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 January</td>
<td>14.40</td>
<td>Medical record/engagement with Staff Nurse A</td>
<td>S/he was triaged as serious but stable and allocated to see a doctor within an hour.</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This simple chronology is provided as an example. Reviewers should note that all information about service users and staff in review reports must be anonymised (please see page 59 of Incident Management Framework – Guidance for information about pseudoanonymisation and codes). Remember to include sufficient detail about staff members such as profession, grade, clinical speciality and team name.

It is useful to have a basic chronology prepared from available documentation before engaging with staff so that you can use the engagement to confirm your understanding of what happened and to address any gaps in the chronology that might exist. As you add more information, the chronology will become more detailed and will be drawn from a number of sources.

It is important to remember that the purpose of engaging with staff is to gain further understanding of what happened. These meetings are not about attributing blame or reviewing people’s performance. There are other processes that address performance or competence issues; the purpose of reviewing the incident using a systems analysis approach is to generate learning to promote safety and system improvement.

Staff may wish to bring a colleague (not one who was involved in the incident or who had line management responsibility) or other support person. However, the move to a less adversarial approach to reviewing incidents will hopefully mean that staff will feel confident to meet directly with the reviewers in the knowledge that it is the system and not them that is the subject of the review.

When data has been gathered, the reviewer(s) can move on to analyse the data.
**Step 3 & Step 4 Analyse the data (to identify the key causal factors, contributory factors and incidental findings)**

Using systems analysis to review safety incidents recognises that there are usually multiple factors that taken together contribute to the outcome; no single factor is more important than the other in a systems analysis.

Analysing the data involves a combination of Step 3 (identify the key causal factors and incidental findings) and Step 4 (identify the contributory factors). Therefore, this guidance deals with them together as they are mutually dependant steps. In practice, the process can require reviewers to work in a more discursive way to agree these, rather than working sequentially.

Steps 3 and 4 involve reviewing and developing an understanding of the information that you have gathered in order to identify any system deficiencies that may have contributed to the occurrence of the incident.

Analysing the data seeks to:
1. Identify the key causal factor(s)
2. Identify the contributory factors
3. Identify any incidental findings

Key causal factors, contributory factors and incidental findings are defined below.

- **Key causal factor(s):** Issue(s) that arise in the process of delivering and managing health and social care services which the review team considers had an effect on the eventual harm.

- **Contributory factor(s):** Circumstance(s), action(s) or influence(s) which are thought to have played a part in the origin or development of an incident or to increase the risk of an incident.

- **Incidental Finding(s):** Issue(s) that arose in the process of delivering and managing health services identified during the course of a review which the reviewers consider did not impact on the outcomes but which serve to identify issues for system improvement e.g. issues relating to documentation, communications etc.

The Incident Management Framework recommends the use of the Yorkshire Contributory Factors Framework (YCFF) to help reviewers to identify key causal factors, contributory factors and incidental factors (see Incident Management Framework – Guidance, Section 11, page 65).

The YCFF is shown in Figure 4 and depicts the contributory factors domains as a series of concentric circles. Active failures (mistakes, slips/lapses and violations) are at the centre while the outer circle represents the external policy context. This diagram helps to illustrate the domains and their proximity to the active failure which is in the centre.

The YCFF is useful when analysing incidents as reviewers often have a tendency to focus primarily on the proximal causes of the incident or those closest to it (e.g. active failures and situational factors) and less on distal causes such as the working conditions and latent factors and how these contributed to the incident. If not addressed, these distal factors can result in further incidents and affect patient safety.
The underlying aim of this tool is not to ignore individual accountability for unsafe care but to try to develop a more sophisticated understanding of the factors that cause incidents. These factors can then be addressed through changes in systems, structures and local working conditions. Finding the true causes of patient safety incidents offers an opportunity to address systemic flaws effectively for the benefit of all our future service users.

By reviewing the information gathered and considering the chronology or sequence of events, the reviewers may be in a position to quickly identify and agree what the key causal factors, contributory factors and incidental findings are. However, this is not always the case and reviewers may need to spend time reflecting on what happened and come to an agreement on the key causal factors and contributory factors, if any.

Key causal factors can be related to service management and delivery and may relate to actions, omissions or decisions of staff and managers in services where harm has occurred. These might include mistakes, such as administering the wrong drug, lapses of judgement, forgetting to carry out a procedure, failures to correctly interpret or act on test results. Several key causal factors might be involved in one patient safety incident.

Once the reviewers agree the key causal factor(s) they look to at the wider organisational context to consider what factors contributed to the key casual factor occurring. These are known as the contributory factors. These are factors which influence staff performance and which may affect service user outcomes.

If the review concludes that there aren’t any key causal factors, the evidence to support this finding should be included in the report.

Throughout the process, reviewers must take care to act with integrity and to review incidents without any undue bias. For example, it is important that reviewers’ conclusions about what happened and why it happened are not unduly influenced by their knowledge of the adverse outcome (outcome bias). As well as outcome bias, reviewers need to be aware of hindsight bias. This happens when the people reviewing the incident minimise any uncertainty faced by the staff involved in patient safety incidents. Anyone involved in the retrospective analysis of patient safety incidents needs to be able to consider what happened in the context of any complexities and uncertainties facing the staff at the time of the incident. There may have been human factors at play at the time that informed staff decision making. These factors may be described in staff written recollections or discussed with staff at engagement meetings. It might be helpful
for reviewers to focus on seeking to understand why a staff member’s actions made sense at the time rather than focusing on what they may have done wrong.

In their 2009 report, the World Health Organisation (WHO) defined human factors as ‘environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way that can affect health and safety’. The report states that a simple way to view human factors is to think about three things – the job, the person and the organisation – and the impact that these have on people’s health and safety related behaviour. Human factors science aims to identify what aspects of work are challenging or make a ‘wrong action’ seem reasonable in context.

Once reviewers have identified those aspects of the system that contributed to the incident they can move to the next stage, which is making recommendations to support staff to provide safer services.

**Step 5 Make recommendations**

An essential part of the systems analysis review process is generating recommendations that will reduce or prevent the risk of future harm from whatever contributory factors have been identified.

When making recommendations is important to deal with identified system deficiencies; these are where the longer terms safety solutions lie.

Recommendations should be linked to key causal and contributory factors and should be SMART (specific, measurable, achievable, realistic and time-bound). See Incident Management Framework – Guidance, Section 12, page 70 for further guidance regarding developing recommendations.

Try to ensure that recommendations are broad enough to address a wide population group i.e. the system, rather than the individual that was harmed. The system could be a unit, a department, a site or the organisation.

There are generally different ways to address a problem and not all will have the same impact in terms of improving patient safety. Reviewers may find it useful to refer to the hierarchy of controls when making recommendations.

This is a well-known concept in risk whereby the strongest recommendation is to eliminate the risk entirely by putting in place solutions which engineer out the problem rather than those which are dependent on the actions and behaviour of individuals.

Figure 5 illustrates the hierarchy of controls from the most effective to the least effective. When making recommendations about safety, reviewers might recommend that a particular practice stops (i.e. eliminating the risk) or they might recommend actions aimed at minimising further risk (i.e. limiting the number of models of a particular device, use of checklists or training and education for staff).

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13 [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3786617/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3786617/)
Recommendations relating to the top of the hierarchy are considered the most effective but they are often the most difficult to implement in terms of resources. Lower level recommendations are considered easier to implement but may not have as much of an impact on safety.

Whilst the above hierarchy is a useful tool it should not be slavishly applied in the context of patient/service user safety\textsuperscript{14}. Health and social care unlike other industries is uniquely complex and reliant on human behaviour, interactions and knowledge. Assessment of risk controls should be based on the findings of empirical research and good theory about how to make improvements in health and social care and therefore if it may be that controls of an administrative type e.g. training and education, which when implemented through a robust change model or use of implementation science, may be appropriate. Remember that the people involved when something goes wrong are often the ones that will have the best solutions for improving the system. It is therefore a good idea to get ideas about recommendations from:

- Service users and/or families
- Frontline staff
- Managers

You can ask people for suggestions for recommendations when you engage with them during the review process and/or meet service providers, management and/or policy makers to help you develop recommendations or refine them after you have drafted them.

A collaborative approach to developing recommendations is useful for a number of reasons. It allows reviewers access to local and expert knowledge and increases the likelihood that findings and recommendations will not be affected by any reviewer bias. Consulting relevant stakeholders before finalising recommendations also ensures that everyone understands what is intended in the recommendation increasing their feasibility. Finally, it ensures buy in from the people who have to implement them.

You may need to gather additional information to formulate recommendations. Other sources might include publications, consulting experts who can provide information on best practice and/or looking at similar services in other countries.
Step 6 Write the report

The quality of the report generated as a consequence of the process is critical both from the perspective of those affected by the incident and also the service within which the incident occurred (see Incident Management Framework – Guidance, Section 8, Approaches to Incident Review Pages 50-51 and the report template on pages 52-59). The report provides an opportunity to set out the information gathered, the analysis and the recommendations made in a structured and concise way and provides a primary mechanism for sharing learning with those affected, the service and other services. As there are three key audiences for the report i.e. service users/families, staff participating in the review process and the service, the report must be written in a manner which is concise and accessible.

The draft report should be finalised in the context of the Governance Approval Process for Finalising Review Reports (Section 13 of the Incident Management Framework – Guidance).

Conclusion

The aim of any review is to identify system deficiencies, develop recommendations and make changes to improve the system where possible. Systems analysis allows us to understand how a system works and how its different elements interact. Adopting a systems approach allows a shift from blaming individuals to learning how to improve or make the system safer. Effective incident management allows us to adopt a proactive approach to incident prevention by using the learning derived from the review of incidents to make services safer for those both accessing and working in health and social care.

Closing the loop on the incident by ensuring that any recommendations identified as required to improve safety are implemented is critical. It is the responsibility of the review commissioner to ensure that any recommendations made are translated into actions to improve the quality and safety of services.