

Learning the Lessons from Major Incidents

For years, our customers have said they wished APT did a course with this title. Well we do now.

A 3-day course for 6-15 people (2-day version also available).

Executive Summary:

In mental health and related areas there are a number of 'major incidents' that can occur, most notably to do with people losing their lives through suicide, violence or neglect, but also relating to sex offending and a whole range of serious but less tragic events. After a serious incident there often seem to be obvious 'oversights' or mistakes, although some of these can be put down to the wisdom of hindsight. This important course aims to equip managers to examine such incidents and to draw the real lessons from them, while also distinguishing those lessons from 'the wisdom of hindsight'. Vivaly, the course highlights the importance of 'free lessons' where serious consequences were avoided more by luck than by judgment. One of the major methods on the course is to learn the principles of analysis by examining major incidents from other areas – road traffic accidents and air crashes – and then to apply those same lessons to mental health and related areas.

The course covers the following:

Overview

- Human Error: "The notion of a root cause seems to be an over simplification. Usually there is a chain of events and a wide variety of contributory factors leading up to the eventual incident." Taylor-Adams and Vincent.
- Learning lessons needs to be quick, easy – and right: A Simple 5-step Process.
- Who Sets an Investigation in Motion?
- Don't underestimate the kitchen table.
- Team or solo investigations?
- Keeping Other People Involved.
- Learning the Lessons: The 4 Key Principles.

How to investigate

- Naive investigators imagine that incidents choose themselves. In fact some of the best lessons are learned by opting to examine 'near misses'.
- Sometimes it's chosen for you, other times you can choose it. Always be the latter; that's what differentiates a learning organisation from others.
- How do you investigate a 'near miss'? Nothing happened, after all!

- A key ability in learning individuals: being able to spot incidents that were "almost a near-miss"!

Finding out about the incident

- Good Information is Vital. As the old saying goes: 'Garbage in, garbage out.'
- The four key sources of information.
- In interviewing people, your Attitude is Key.
- Open Questions and Requests.
- Requests for Opinions.
- Leading Questions, e.g. the 'forced choice' question, are not OK.
- 'Transparent questions' are perfectly legitimate to ask – how and why.
- Closed Questions are important and under-rated.

Writing a clear account of the incident

- Without a clear, accurate account of what happened, anything that follows is undermined. This involves (a) getting good information and (b) setting it down clearly.
- The two ways: A narrative account and a time line.

Identifying what would have prevented the incident

- Catastrophic Incidents usually occur as a result of a sequence of small events that accumulate to create a more serious situation.
- Catchpole, K.(2009).
- Develop "If only ..." statements.

Identifying Recommendations

- Blaming individuals is emotionally more satisfying than carefully thinking through recommendations that will be to the organisation's benefit. After Reason, J.(2000).
- Examples of 'system' recommendations.
- Will Your Recommendation really Improve Matters Overall?
- Permanent-ising Your Recommendations.
- Rules for making sound judgments.

Continued Overleaf

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- Traps to avoid: The risky shift. The omnipotence trap. The ‘appointed expert’ trap. The ‘someone must be to blame’ trap. The scapegoating trap. The plausibility trap. The hindsight trap.
- Important concepts to bear in mind in writing your recommendations. This course aims to introduce you to the nature of anger and how it may relate to an underlying problem such as depression.

Delegates' Feedback

Average presentation rating: **93%**



Average relevance rating: **95%**



Written Feedback:

“Fantastic, very relevant ... would recommend it for all clinical managers.”