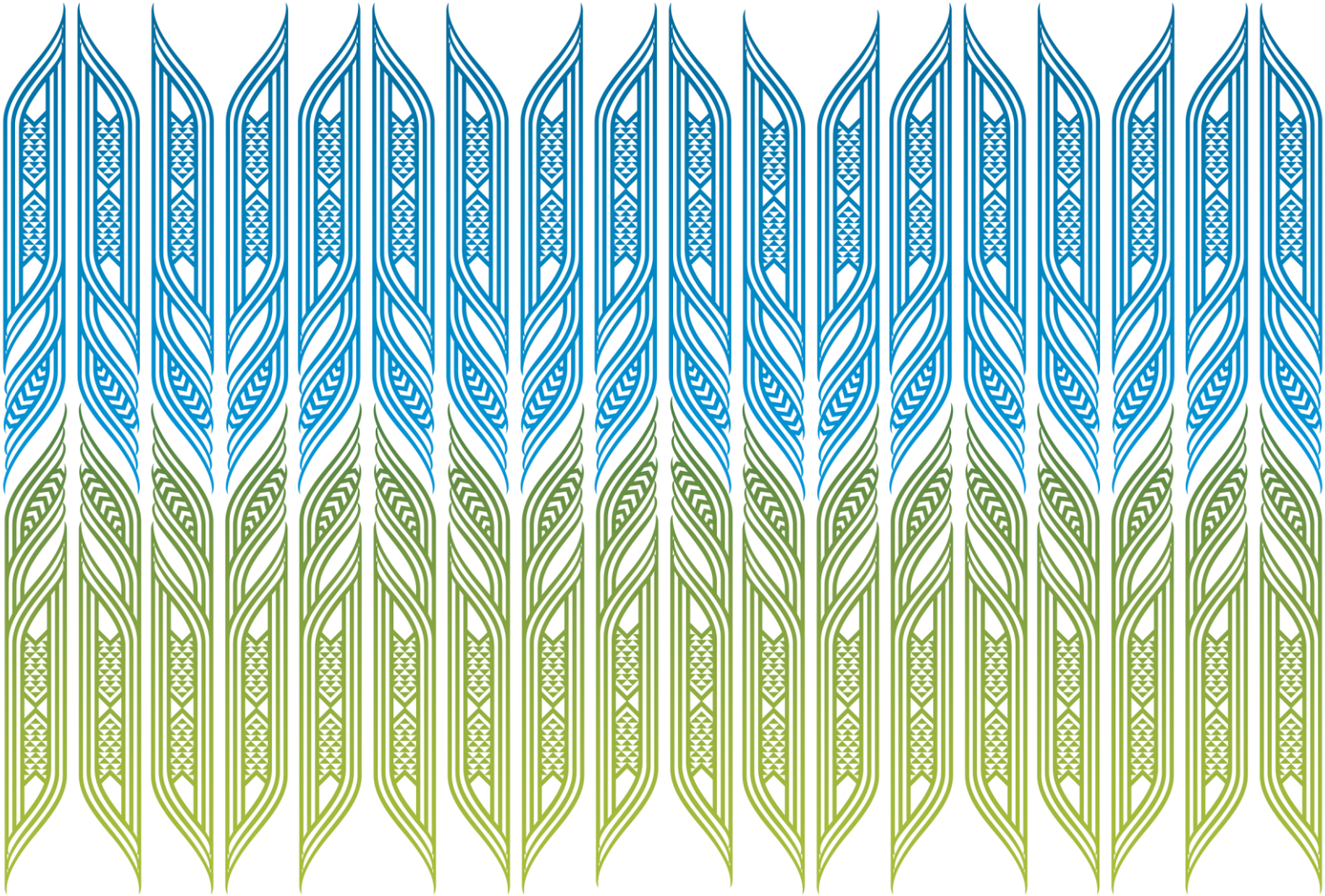
Te Tāhū Hauora
Health Quality & Safety Commission

Guide to doing a learning review

He aratohu arotake ako



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Te Kāwanatanga o Aotearoa
New Zealand Government

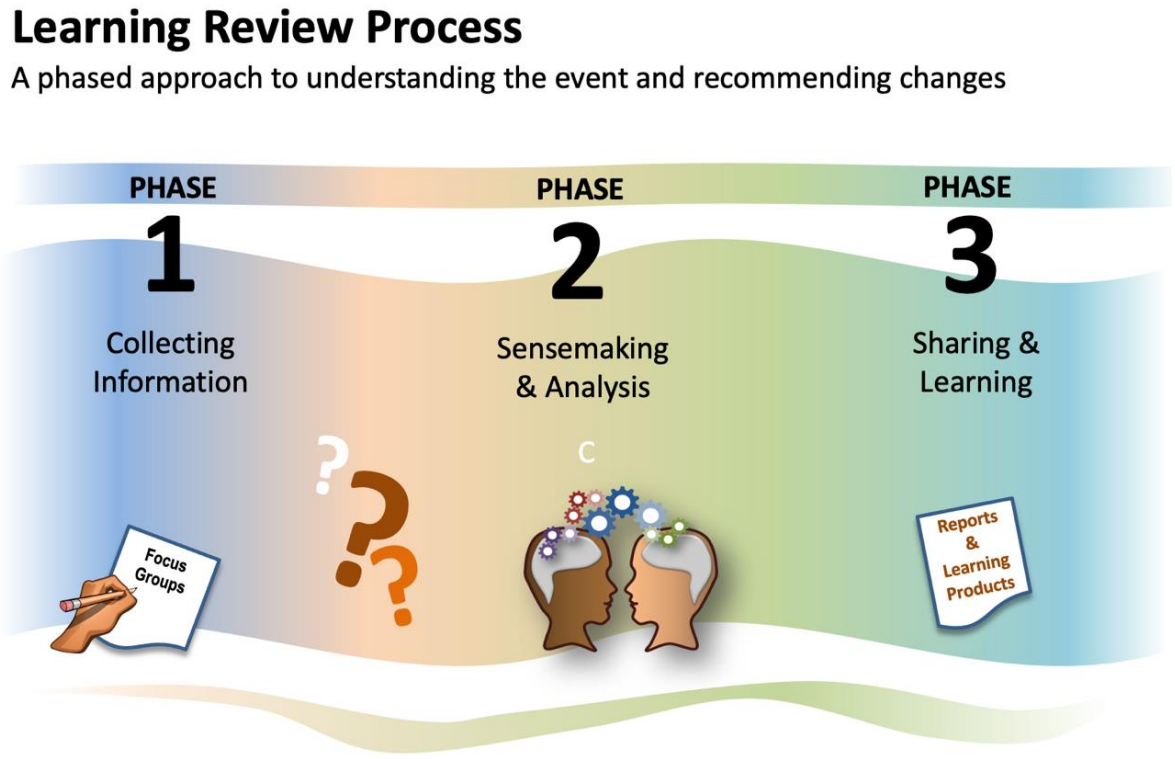
Introduction | He kupu whakataki

As stated in the revised National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023[1] (the policy), reporting must be accompanied by meaningful analysis that leads to system improvement. This guide aims to enable health providers to review harm by applying the learning review method. Te Tāhū Hauora Health Quality & Safety Commission prefers this method because it better reflects the complex sociotechnical system that is health care.

Reviews of harm offer the opportunity for:

- healing, by listening to, understanding and addressing the needs of all the people who are affected by a harmful event or experience
- learning how people usually create safety, and understanding how risk becomes difficult to manage
- improving, by ensuring what is learned is used to enhance system safety and consumer, whānau and health care workers' experiences.

Reviews should focus on improving health care systems for all; they do not look to blame individuals. Including blame or trying to determine whether an incident was preventable within a review designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.



Permission to use graphic granted by Dr Ivan Pupulidy February 2024.

[1] Te Tāhū Hauora Health Quality & Safety Commission. 2023. Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023. Wellington: Te Tāhū Hauora Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/national-adverse-event-policy-2023.

What a learning review is and how it differs from traditional methods

Learning reviews differ from traditional methods in their purpose, the way they are conducted and the focus of the learning opportunities.

The purpose of a learning review is to learn and improve, in a way that allows you, the reviewer, to understand the realities of everyday work to uncover how harm occurs, minimise risk in the system and support health care workers to do the right thing.

This approach, influenced by human factors, systems safety and resilient health care, differs from more traditional methods because it evaluates all the interactions within the system. The learning opportunities and actions for improvement focus on improving the whole 'system' (the way work is done in health care) rather than on individuals. Therefore, it is essential that, at the start of the review, all participants (consumers, whānau, health care workers) understand that the output of the review will be to identify changes that can be made to systems, not to apportion blame.

In this method, the reviewers are facilitators, not subject matter experts, and should come from outside the area where the event occurred.

Why it helps

Learning reviews recognise two important things: that we can't escape human error (even the most competent health care worker makes mistakes) and that errors are a product of the 'system' rather than just workers making mistakes. Learning reviews uncover how the system might have contributed to harm and, more importantly, how the system can be improved to minimise the risk of harm reoccurring.

This guide walks you through each step, showing how to conduct a learning review.

Step 1: Collecting information | Hīkoi 1: Te kohi mōhiohio

Before collecting any information, where required, complete a term of reference. Decide who your review facilitators will be, and note that it is preferable they are not subject matter experts. Do not read through all the clinical notes and other documentation before collecting information; this can lead to hindsight and outcome bias.

Getting people to tell their stories

Information collection begins with a conversation to establish how work is done in the health care setting where the harm occurred and what happened on the day of the event. It is about getting people (consumers, whānau and health care workers) to tell their stories – their descriptions and experience – not their explanations. Ask questions about what and how, not why. When conducting the interview discussions, review facilitators should have as little background knowledge of the harm as possible so that information is not collected as evidence to support preconceived theories about what happened (outcome bias).

Be sure to take a culturally responsive approach to these conversations at a time and place that suits those involved.

Conducting the interview

Who	Who should do the interviews	• The review team should preferably consist of facilitators who are not experts in the specialty area of practice. The number of facilitators will depend on the complexity of the review • The review facilitators should be regarded as independent and be able to record information quickly and accurately
	Who you should talk to	• The consumer who was affected by the event and their whānau. • The health care workers involved in the event, regardless of whether they were directly involved or witnessed the event unfolding • Managers or policy makers can help provide a clearer picture of differences between work as imagined[2] and how it was actually being done • Some reviews will cross 'boundaries', and it is important to consider the consumer's journey rather than just a specific location within which the harm occurred. For example, a review may include a community care provider, ambulance service and the emergency department
What	• The goal is to collect as much information as possible • Try to establish what 'normal' operational processes look like, including adaptations and work arounds • Leave the discussion of the event to towards the end, when the interviewee feels comfortable and has more of an understanding of the learning review process • When talking about the event, encourage people to tell you what happened from their perspective and to include all the detail they can. Start with simple questions and avoid assumptions. Ask about the days before the event to understand the different pressures and influences on the day • Build an understanding of the history of those involved in the event. Major personal and professional events that may have influenced the participant are an important part of their stories. Influencing factors can go back weeks or even further • Don't persuade, defend or interrupt. Be curious and non-judgmental. Your job is to listen	

[2] Basically, work as imagined is the work that we (ourselves and others) imagine takes place. See: Shorrock S. 2020. Humanistic systems. Proxies for work as done: 1. Work-as-imagined [Blog]. URL: humanisticsystems.com/2020/10/28/proxies-for-work-as-done-1-work-as-imagined

Where	• Ask the consumer and whānau where they would like to meet to discuss their experiences (this may be at home) and who they would like to support them. Ask what culturally appropriate tikanga would meet their needs • Ideally, meet the health care workers in their work setting. Being in a similar environment can help people remember and helps you understand things that are hard to describe with words alone
How	• Speak to health care workers individually and without managers present but with a support person if requested (consider appropriate tikanga with whānau) • Listen and write down the details that people remember. Work to make the discussions psychologically safe to encourage people to speak up • During this phase, it is important not to problem solve, generalise or draw conclusions
Timeframe	• There is no time limit (you may need to wait until the consumer/whānau are ready to share their story). • Get participants' contact details in case you need to clarify anything, and give them your contact information in case they remember more details they think are important

Once you have collected the information from the participants, review all other sources of information such as clinical documentation, policies, guidelines, equity data (including disability), audit data, workforce data and equipment and environmental data. Sometimes it is helpful to observe the actual environment where the harm occurred. If so, ensure you are there at a time that reflects the acuity of the situation. You may need access to a subject matter expert to help you interpret the data accurately.

It is important to consider human factors when gathering information to ensure you understand all the interactions and interconnections between people, the system and the context within which they work (ie, the relationships, tools, tasks, technology, culture and internal and external environment). The systems engineering initiative for patient safety (SEIPS) tool may help with this (available under the systems learning kete).

Examples of questions to help you collect information

An **observation** is made	*'The patient seemed a little off'*	Ask about the **cues** they picked up	What specifically made you think that? What were you experiencing at the time?
As **assessment** or judgement is made	*'The patient was deteriorating'*	Ask about **how** they arrived at that	How could you tell? What tipped you off?
A **choice** or decision is made	*'So, I decided to call the charge nurse'*	Ask about any **options** they considered	What brought you to that decision? Have you done this in the past?
'I **knew** …' is stated	*'I knew the patient had to be seen soon'*	Ask them **how** they knew that	How did you know? Was this like something that had happened in the past or something you had been told?
A **state of mind** is mentioned	*'It was really frustrating'*	Ask them about **external factors** present at the time	What else was going on to make you frustrated? When did you first notice feeling frustrated?
A **mental model** of normal operations is explained	*'Usually when I call, someone answers promptly'*	Ask them to tell you about **normal work**	What usually happens when the call is answered?
An **action** is explained	*'I kept ringing the number but no reply'*	Ask them about **alternatives**	Were there other ways to contact the charge nurse at the time?
Asking for **help** is mentioned	*'After 20 minutes, I put out a MET [medical emergency team] call'*	Ask them about the point at which they decided to **ask for help**	Was there a particular reason you made a MET call at that time? How did you know you had to make a MET call?

Examples of questions to consider in developing an understanding of conditions and pressures

- What was happening? Were the actions/decisions part of ‘everyday work’ (accepted practice or culture)?
- What were the criteria that health care workers used to prioritise work?
- What were the workers trying to achieve and why?
- What knowledge did the workers have, and how did they apply it?
- What were they looking at, listening to, feeling and thinking as the event unfolded? Where was their attention focused and why?
- How were they dealing with risk and hazards?
- What behaviours were rewarded, discouraged and measured in the workplace? How did these influence the actions and assessments of those involved?
- What were the previous hours/days/weeks like for those involved?
- What physical and environmental conditions influenced the event?
- How did the consumer and whānau perceive what was happening?

Building the story

The next step is to create a detailed narrative (story) that captures everyone’s perspectives. Don’t try to resolve differing accounts into a single narrative. Consider using an equity tool to evaluate for equity issues that arise from the information gathered. Supplement the story with an accurate description of the event site. Diagrams, policies, photographs and maps can all be useful. Use a subject matter expert if you need support to interpret some of the data.

What to do with the information you’ve collected

Decisions and actions	• Identify key decisions/actions. Don't try to differentiate between what is a decision and what was an action. It is likely that anything that people did was a combination of deliberation and intuition, thus somewhere on the spectrum between decision and action
Create an information map	• Create a network of influences map to build an image of the information • Avoid the desire to categorise your map at the beginning; just free flow all the ideas and information you have gathered using coloured sticky notes • Next, categorise the information. Let the categories develop from your sticky notes and arrange according to the themes you notice • In this way, interactions, interconnections, decisions/actions and contradictions can be depicted like a map. Information groupings should be allowed to emerge and change as the process develops. Often, emergent ideas become the most powerful learning opportunities • All the information around how work is every day is crucial to the story and enables readers to walk in the shoes of the key players

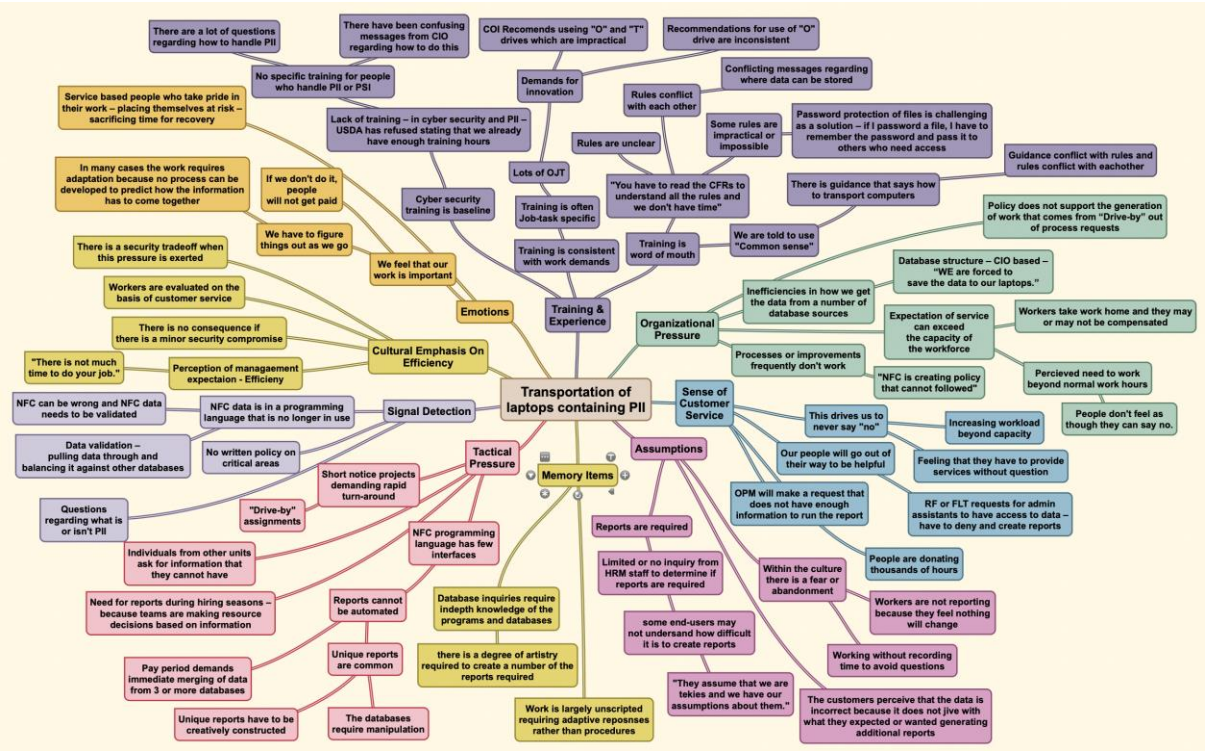
	• You can show the information map and pictures/drawings to the focus group in the next stage to help them understand the event and conditions that supported the decisions and actions
Identify key actions	• Identify key decisions/actions that stand out from the story • Avoid descriptions like 'the worker failed to follow procedures'. Instead, focus on actions as they appeared to the people in the situation • Don't get bogged down trying to decide whether an action was a deliberate decision. Avoid attempting to judge the intent of the worker
Identify key influences	• Identify key factors that have influenced people. Understanding the interactions between these factors is critical to the next phase, so the more detail, the greater the possibility of understanding the event

The 'network of influence' map

The network of influence map is a holistic visual process that facilitates the creation of a complex narrative and is central to the sensemaking phase.

There is no single way to create a map. We have used many physical and/or technical tools and methods to collect and view the conditions and influences that emerge around a complex event. Some examples include sticky notes on a wall or on a huge piece of paper (to keep for future reference), pieces of paper that are rearranged on the floor and many different versions of mind-mapping software. For example: [www.simplemind.eu.](http://www.simplemind.eu)

Example of a network of influence map



At a minimum, the mapping technique should give you the ability to track multiple thoughts and add, subtract or rearrange as necessary. Writing notes on a flip chart is not mapping, because you will have a hard time readjusting the elements as connections between data points emerge. Here are some mapping tips:

1. Work from the outside – in

To limit bias as much as possible, we strongly recommend that you do not begin with established categories. Place the main topic or question of the Learning Review in the centre of your map, then post the influences as they are discovered. Step back to gain a new perspective and look for related information. Titles for this aggregated data will become apparent as related or similar performance-influencing factors emerge. Further grouping and titles will emerge during team discussions and focus group dialogues.

2. Don't simply focus on causes

Looking for the 'cause' of the accident can easily lead to blame of individuals, which is a dead-end for learning from events. As Todd Conklin says, 'You can blame, or you can learn. You can't do both.' Instead, look for factors in the system of work that enabled the event to happen or that may have influenced people to do what they did.

3. Capturing actions and decisions

Gather information to facilitate sensemaking and analysis. Sensemaking applies to understanding why it made sense for someone to do what they did. Analysis is done to understand any technical or mechanical information relevant to the incident or event.

Determine key decisions and actions and place them in context by identifying performance-influencing factors and associating them with each decision/action. During this phase, the team should avoid problem-solving, generalising and drawing conclusions.

4. Think outside the time and place of the accident

It is easy to think that the important information happened close to the accident – either in time or in physical proximity. Many opportunities for systemic learning exist outside these parameters. Avoid using timelines as the sole source of information gathering, as these linear models can drive or shape lines of inquiry, rather than allowing understanding and relationships to emerge. Timelines do little to help us understand the context of the event.

5. Capture quotes

Direct quotes can provide the original perspective of a participant or witness. Leaving these intact allows people to speak in their own voices, which can help limit the bias of the Learning Review team members.

6. Move away from the accident to normal work

Accidents are often anomalies that will likely never happen in the exact same way again. Looking at the conditions that surround normal work procedures can give insight into places where systemic changes can be made. As Professor James Reason said, 'You cannot change the human condition, but you can change the conditions under which humans work.'

Example of developing a network of influence map

Write up the story	• Create the complex narrative of the event and the days before using the network of influence map and any other information gathered • The narrative should be written from the viewpoint of those involved, not of an outsider. It should show how the participants' decisions made sense to them based on information they had at the time • It is inevitable that people will have different perspectives and memories of what happened and why. Don't try to change their perceptions. Rather, capture these differences; they could help explain someone's state of mind and how that affected their decisions. It could also reflect issues with the 'system' that will be looked at in the next phase

Step 2: ‘Sensemaking’ | Hīkoi 2: He kupu whakamārama

‘Sensemaking’ uses focus groups and is about understanding why health care workers did what they did at the time.

- It removes the distorting effects of hindsight, which can make it easy to say what people should have done during an event.
- Understanding why people did what they did helps us come up with more useful learning opportunities and actions for improvement.
- ‘Sensemaking’ is done using focus groups of health care workers and independent consumers.

Focus groups – ask the experts

Focus groups should be made up of health care workers in the same roles as those involved in the event. These ‘experts in their field’ talk about what they usually do in scenarios similar to those surrounding the event and offer insights into how they decrease exposure to the risks. You can use their knowledge to create learning opportunities and actions for improvement that work. The people involved in the event should not be in the focus groups.

Focus groups can involve:

- **A team of health care workers in positions similar to those involved in the event.** The advantage of talking to a team is that often they will have a deeper understanding of the work.
- **Task-specific group.** You may decide to talk to a group of leaders and policy-makers.
- **Subject matter experts.** You could also speak to professional or academic specialists to help create innovative, practical solutions.
- **Independent consumers.** Including consumers provides a more complete understanding of sensemaking and ensures that recommendations are consumer and whānau oriented.

Ideally, focus groups should be conducted in a venue that is private and readily available onsite but away from distraction, particularly for clinicians. Use phone calls or virtual meetings for experts who cannot attend or are only required to provide specialist input.

Facilitation

Who	• Ideally, focus groups should have two facilitators: one to ask questions and one to take notes. Some facilitators like to record the session, but follow your local process and ask permission before using a digital recorder
How	• Explain what you know about the event by using the narrative developed in step 1, then open up the discussion for others to comment • It is important to remain objective and quiet and to listen. Do not share opinions but gently steer the conversation away from blaming

	individuals. If a facilitator is opinionated and judgmental, the conversation will close down
Protections	• Confidentiality is important to collect honest views and experiences. If you hear about unsafe practices, remain quiet and objective. The purpose of the review is to uncover things like this. It provides insight into how work is done and enables us to improve an area of the system we might not have known was vulnerable. Individual performance management should be undertaken outside of a review using a separate human resource process • Psychological safety is essential for participants to speak up, so beware of power dynamics within the group and steer conversations away from blame

Tips on running a focus group

Set expectations	• Counter the urge to find a single explanation for the event. Begin the focus group by setting an expectation of complexity • Assure members of confidentiality and establish a safe environment to share and discuss sensitive issues • Set the goals of the review and the rules for the group – such as avoiding language associated with blame
Present the story	• Present the narrative you prepared in step 1 and invite people to write down ideas for improvement that come up during the timeline reconstruction, so they can bring them up later. Also invite everyone to think about the lessons from the event
Discuss the influences	• Get the group to discuss the key influences on conditions that you identified in step 1. Identify the main factors that influenced what happened and use these as starting points for your focus group discussions. Typically, expect to have three or four factors to begin with

Dynamic inquiry	• Start the dynamic inquiry stage by asking people whether they've faced similar situations. Encourage them to describe their experiences:
	  ○ What did they do?
	  ○ Why do they think this happens?
	  ○ What would they recommend?
	  ○ Can a development in technology or systems fix this?
	• When you begin discussing the lessons, encourage everyone to speak up and not to censor themselves. This should be a brainstorming session
	• Step in when discussion focuses on people. Ask for technical or systems-related solutions
	• To avoid the discussion turning towards blame, steer clear of asking people why something happened and instead ask how. Do not ask whether they thought what someone did was right

Zooming in and zooming out

Zooming in: If someone says something is ‘common knowledge’, see whether that’s what the group thinks. Ask them why they think something was obvious or not.

Zooming out: Ask workers to step back from the day to day and think about when work is handed over from one person/team to another and the potential for misunderstanding is high. Do this by asking questions like: how much of this would be new information, how many of you would be aware of all the moving pieces here?

When discussing the learning and potential solutions in the focus group, be sure to consider their impact and how effective the potential solution will be for the problem you have identified within the context of the setting.

Step 3: Reporting and learning | Hīkoi 3: Te pūrongo me te akoranga

Reporting

Create a draft report exploring the key issues that emerged during the review. Share the draft report with the health care workers, consumer and whānau to get feedback on the learning opportunities and actions for improvement. The report should be less about error control strategies and more about managing the system and unravelling goal conflicts in the system – to create an environment where workers can be successful. The learning should describe weaknesses in the system, or within various levels of the system, that require intervention by management.

Once the learning opportunities have been decided, consider what the best solutions would be within the specific context of the area. Make sure the suggested actions account for the realities of work. All actions will need to be finalised through a governance process, implemented and evaluated for effectiveness. Quality improvement tools can be used to develop sustainable change that minimises the risk of unintended consequences.

When designing the actions for improvement, it can be useful to use a Human Factors user-centred design tool to ensure that the solution fits with work as done and considers all the interactions and interconnections within the system. This is where the SEIPS tool 2.0 may be helpful (tool available under the systems learning kete).

Potential learning opportunities

- Understanding the differences between the organisation’s and/or leadership’s promoted values (what we say we want) and values in practice (the perceived goals). This is often based on what the organisation and leadership measure, reward and punish.
- The value of individual performance diversity, or adaptation, and its contribution to this event. We must understand that adaptation is necessary to meet the challenges of dynamic or complex environments. No set of policies can fully anticipate all the potential scenarios the workforce will face; therefore, they will have to adapt to meet the unexpected.
- How did accountability function before the event, in terms of peer, hierarchical, upward and self-accountability?

- Structural incongruities or inconsistencies around rules, regulations, policies and procedures. For example, did the rules make sense; do they describe work as done?
- Was there confusion in roles and responsibilities?
- Were there indications of practical drift (the unintentional adaptation of routine behaviours from written procedure) or cultural pressures that were inconsistent with the promoted values of the organisation?
- Were there structural inconsistencies around communication of decisions down through the organisation, feedback up through the organisation and communication across the organisation?
- Was communication clear? How did the message sent compare with the message received?
- How did the design or culture of the system contribute to the event (eg, equipment, tasks, workload and capacity)?
- Describe how the physical environment contributed to the event (including workspace design, ergonomics, etc).

Closing the loop

Follow up with all participants to thank them for their involvement and demonstrate the implementation of any improvements. Seeing their ideas and commitment lead to improvements is critical for the success of future learning reviews. Ensure that improvements are evaluated to ensure they have created sustainable change.

Acknowledgement | He whakamihi

The learning review approach was developed by the United States Forest Service from work led by Ivan Pupulidy. The approach was first adapted in Aotearoa New Zealand for the forestry setting through an initiative by Scion published through Safetree New Zealand.[3] This version has been modified for health from the Scion documents and the learning review guide written by Ivan Pupulidy and Crista Vesel in 2023 with their express permission.

[3] Safetree. 2017. *Guide to Doing a Learning Review*. Wellington: Safetree. URL: safetree.nz/resources/guide-to-doing-a-learning-review