



THE UNIVERSITY OF  
NEW SOUTH WALES



CENTRE FOR CLINICAL GOVERNANCE RESEARCH

# EVALUATION OF THE SAFETY IMPROVEMENT PROGRAM IN NEW SOUTH WALES: STUDY NO 7(b)



REPORT ON RCA FOCUS GROUPS

***The Centre for Clinical Governance Research in Health undertakes strategic research, evaluations and research-based projects of national and international standing with a core interest to investigate health sector issues of policy, culture, systems, governance and leadership.***

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1. Safety Improvement Program (N.S.W.) - Evaluation.
2. I. Iedema II. Jorm, C. III. University of New South Wales. Centre for Clinical Governance Research in Health.

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## 1 ABBREVIATIONS AND DEFINITIONS

### 1.1 Abbreviations

<b>AHS</b>	Area Health Service
<b>CCGR</b>	Centre for Clinical Governance Research at University of NSW
<b>CEC</b>	Clinical Excellence Commission
<b>DOH</b>	NSW Department of Health
<b>IIMS</b>	Incident Information Management System
<b>RCA</b>	Root Cause Analysis
<b>RIB</b>	Reportable Incident Brief
<b>SIP</b>	Safety Improvement Program
<b>SAC</b>	Severity Assessment Code

### 1.2 Definitions

<b>Clinical Practice Improvement</b>	A combination of tools, techniques, skills and attributes designed to enhance care inputs, structures, cultures, processes, outputs or outcomes.
<b>Culture</b>	The configuration of attitudes, values, beliefs, meanings, behaviours and practices which together can be seen to be definitive of 'what people are' or 'where people come from'. Culture can be seen as a 'state' or something people possess, while it appears more fruitful to regard it as performance and also a process.
<b>Ethnography</b>	A research technique used for describing what human beings do in selected settings, usually comprising 'participant observation', field notes, narrative accounts, interviews, and other qualitative research methods.
<b>Evaluation</b>	The systematic examination of a policy, program or project aimed at assessing its merit, value, worth, relevance or contribution.
<b>Formative Evaluation</b>	Evaluation conducted during a course of a policy's, program's or project's life.
<b>Innovation</b>	The rate, propensity, capacity and effectiveness in adopting new ideas, practices or behaviours.
<b>Organisational Culture</b>	The collective set of relationships in organisations that differentiate one group from another in terms of dress, attitudes, values, behaviours, beliefs, language and shared meaning.
<b>Summative Evaluation</b>	Evaluation conducted at the end of a policy's, program's or project's life.
<b>Triangulation</b>	A multi-method research or evaluation design which adduces converging or diverging evidence drawn from pluralist sources to illuminate an object of inquiry.

## 2 EXECUTIVE SUMMARY

This report presents the results of the second part of study 7 in the evaluation of the Safety Improvement Program (SIP) in NSW. *Report on RCA Focus Groups*, provides a unique insight into the experiences of health professionals who have participated in RCA teams. Focus groups were held with three professional groups (nurses, allied health and medical staff). The focus groups centred on exploring people's experiences with doing RCAs in their organisation. The report sets out the detailed issues raised by each of the professional groups, before providing a summary of challenges, advantages and innovative solutions. They each had views in common and differed on other fronts. Each of the groups proposed innovations to enhance the RCA process or the contexts in which the process is enacted.

The main advantage of doing RCAs was seen to be contact with other professionals from across the hospital, and being able to discuss clinical practice details with them. The main challenges were perceived to centre on people's emotional worries and moral concerns about being involved in exploring clinical error; the uncertain legal status of RCAs and the information they generate; the unsatisfying ways in which recommendations are currently handled, and the limited impact of RCAs on persistent problems that do not directly or visibly cause errors, but that produce significant risks for clinicians working in specific areas of the hospital. Some innovative ideas were proposed, which target the procedural and formal definition of the RCA process and the organisational structures needed for ensuring RCA outcomes are acted upon.

### 3 INTRODUCTION

#### 3.1 Overview

The NSW Department of Health (DOH) and the Clinical Excellence Commission (CEC) have commissioned the Centre for Clinical Governance Research (CCGR) at University of New South Wales to conduct a formal evaluation of the Safety Improvement Program (SIP). This is a program to enhance safety in New South Wales. The DOH has commissioned this evaluation as part of its knowledge management program in safety and quality under CCGR’s contract to Develop and Evaluate a Knowledge Management Program for Quality Branch. The CEC is interested in the extent to which the SIP will make health care in NSW safer and better under CCGR’s contract to conduct a Research and Evaluation Program into Safety and Quality.

The Evaluation Protocol for this project noted: “SIP is a comprehensive safety program introduced to the NSW health system in 2002. It aims to improve patient safety by focussing on health care incident management. The objectives of SIP are:

- To make health care safer through constantly correcting system vulnerabilities by understanding why errors occur.
- To develop a culture where health care incidents are identified, reported, investigated, analysed and acted upon in a supported environment.
- To implement an information system that assists health care workers to achieve the first component.”

The overall evaluation of SIP takes the form of 12 inter-related studies (Table 1). This report documents the outcomes of study 7(b). It provides the results from three focus groups conduct with health services staff who had been involved in conducting RCAs. This component of the evaluation was conducted by Dr Rick Iedema and Dr Christine Jorm.

**TABLE 1: Evaluation Studies**

STUDY	TITLE	COMMENTS, ACTIONS AND TIMEFRAMES	LED BY/TEAM
<b>Study #1</b>	Literature Review	<ul style="list-style-type: none"> <li>• National and international literature on patient safety and RCA processes</li> <li>• Appraisal of the evaluation process through the extant literature</li> </ul>	Jeffrey Braithwaite, Peter Nugus, Jo Travaglia
<b>Study #2</b>	Review of education and training program	<ul style="list-style-type: none"> <li>• 2 a) Triangulated review of educational value of RCA program</li> <li>• 2b) Meta-analysis of SIP training program evaluation forms</li> </ul>	Jo Travaglia, Mary Westbrook, Peter Nugus, Rick Iedema, Debbi Long, Nadine Mallock

<b>Study #3</b>	Achievements of aims and objectives and stakeholder satisfaction	<ul style="list-style-type: none"> <li>• Questionnaire to all course participants</li> <li>• Review of course evaluations</li> </ul>	Mary Westbrook, Nadine Mallock
<b>Study #4</b>	Ongoing applicability of training to participants	<ul style="list-style-type: none"> <li>• Questionnaire to all course participants</li> <li>• Survey of international SIP programs to benchmark the current program in an international context</li> </ul>	Nadine Mallock, Mary Westbrook, Jeffrey Braithwaite,
<b>Study #5</b>	Satisfaction of Faculty members	<ul style="list-style-type: none"> <li>• Detailed interviews with faculty staff</li> </ul>	Debbi Long
<b>Study #6</b>	Program outcomes at local, area and state levels	<ul style="list-style-type: none"> <li>• Review of RCA data submitted to the DOH</li> <li>• Questionnaire to all course participants</li> <li>• Interviews with key stakeholders</li> </ul>	Jo Travaglia , Jeffrey Braithwaite, Mary Westbrook, Nadine Mallock, Marjorie Pawsey
<b>Study #7</b>	Lessons learnt	<ul style="list-style-type: none"> <li>• 7 a) In-depth observation and review of RCAs in situ</li> <li>• 7 b) Focus groups</li> </ul>	Rick Iedema, Rowena Forsyth, Christine Jorm , Peter Nugus
<b>Study #8</b>	Return on investment	<ul style="list-style-type: none"> <li>• Questionnaire to all course participants</li> <li>• Interviews with key stakeholders</li> </ul>	Jeffrey Braithwaite, Jo Travaglia, Mary Westbrook, Nadine Mallock
<b>Study #9</b>	Effectiveness of SIP Committee	<ul style="list-style-type: none"> <li>• Observation of Steering Committee</li> <li>• Review of outcomes</li> </ul>	Nadine Mallock, Jeffrey Braithwaite
<b>Study #10</b>	Management of RIB process	<ul style="list-style-type: none"> <li>• Focus group</li> <li>• DOH data</li> <li>• Interviews with key stakeholders</li> </ul>	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey
<b>Study #11</b>	Reporting processes	<ul style="list-style-type: none"> <li>• Focus group</li> <li>• DOH data</li> <li>• Interviews with key stakeholders</li> </ul>	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey
<b>Study #12</b>	Branch functions and actions	<ul style="list-style-type: none"> <li>• Focus group</li> <li>• DOH data</li> <li>• Interviews with key stakeholders</li> </ul>	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey

### 3.2 About this report

This report sets out findings derived from three focus groups held at a Sydney Teaching Hospital during March and April 2005, involving nurses, allied health staff and doctors respectively. The focus groups centred on exploring people's experiences with doing RCAs in their organisation. The report sets out the detailed issues raised by each of the professional groups, before providing a summary of challenges, advantages and innovative solutions.

In brief, the main advantage of doing RCAs was seen to be contact with other professional from across the hospital, and being able to discuss clinical practice details with them. The main challenges were perceived to centre on people's emotional worries and moral concerns about being involved in exploring clinical error; the uncertain legal status of RCAs and the information they generate; the unsatisfying ways in which recommendations are currently handled, and the limited impact of RCAs on persistent problems that do not directly or visibly cause errors, but that produce significant risks for clinicians working in specific areas of the hospital. Some innovative ideas were proposed, which target the procedural and formal definition of the RCA process and the organisational structures needed for ensuring RCA outcomes get acted on.

The report lists the findings from the nurses' focus group, the allied health focus and the doctors' focus group, before offering a conclusion and listing the main proposals put forward.

## 4 METHODS

Our methods included conducting focus groups on site, with three groups - nurses, allied health and medical staff. The groups were held in March and April 2005, in one Sydney teaching hospital.

A focus group schedule was designed by the evaluator, who used it to guide the structured focus group process, which was audio-taped with the agreement of the participants. Group participants were recruited internally, and all had had experience participating in multi-disciplinary RCAs. They were allocated to discipline specific groups in order for the evaluators to gauge differences in experiences of RCAs between professional groups. Each focus group lasted approximately one hour.

## 5 FINDINGS

### 5.1 Focus Group Data 1: Nurses

Nursing staff involved in the focus group identified a number of challenges associated with the RCA process. These are summarised in Table 2 below.

**TABLE 2: Challenges to RCA Process Identified by Nursing Staff**

CHALLENGE	COMMENTS
General	RCA is “a huge learning process”.
Difficulty of using SAC to decide to do an RCA	SAC is an unreliable indicator of whether to do an RCA or not: “a SAC of 3 or 4 is often well worthy of an RCA, while deaths are often unavoidable and self-evident in their cause”.
Legal uncertainty	Difficult to balance ‘no blame’ against ‘blame’; Coroner may come in and subpoena RCA information, putting investigators as well as investigated in a difficult and uncertain position; at times too there have been contradictions between RCA findings (targeting circumstances of error) and the Coroner’s findings (targeting cause of death only in a very narrow way), leading to tensions around the meaning and importance of RCAs; Lack of clarity about legal status of RCA investigations: are they privileged or not?
Emotional-moral worries	Many people are threatened by the process; difficult to understand it’s ‘a systems thing’ because it’s the individual that’s reviewed; people may have committed an error and experience genuine distress, but “what can they do if they are at the end of a second shift, 23 hours on the job and something goes wrong”: “the last person to touch the patient is not necessarily the guilty one”.
Difficulty of SAC-ing incidents	Difficulty deciding/agreeing what goes to an RCA; difficulty of deciding how ‘near’ a ‘near miss’ has to be to be a ‘near miss’.
RCA Practice Variation	Clinicians are conscious of variation in RCA practices across hospitals, which irks them.
What happens to the recommendations?	Who manages the recommendations? Who owns the recommendations? Trouble here is the tension between RCA as bureaucratic audit versus RCA as learning process: does the RCA end when the recommendations are filed? Can’t be just a bureaucratic process, because without ownership the process would not produce meaningful outcomes; it all hangs on commitment and interest in learning; without that, the process loses its appeal for many people; RCA team members need progress reports to confirm for them that their work was not for nothing; “The learning really only occurs in the team, other than that there is no dissemination of information, so there is a huge gap”.

CHALLENGE	COMMENTS
Political sensitivities	Difficulty of wording RCA recommendations – political sensitivity; Difficulty of deciding what is ‘the truth’: someone “totally denied the information she gave the day before”.
Logistics	Difficulty of team assembling and having meetings: people are often away or too busy; clinicians need to be resourced to do RCA's, they need backfill.

The same group also identified a positive factor affecting RCA process (Table 3 below). The group also proffered a number of innovations or ideas for the improvement of the process (table 4).

**TABLE 3: Positive factor Identified by Nursing Staff**

FACTOR	COMMENTS
Cross-organisational communication	RCAs engender cross-organizational learning, because they make team members think about “how would we do this kind of work?”

**TABLE 4: Innovations Identified by Nursing Staff**

INNOVATION	COMMENTS
Involve those who are being investigated early on	Difficulty of wording RCA recommendations: solution – ask those involved, ‘how would you word this?’
Appoint RCA experts	RCAs need master team leaders or experts in the organization who are recognized for their RCA skills and experience.
Publicise RCA recommendations	A Safety Newsletter summarizing ‘new learnings’.
Evaluation of RCA processes	We should measure practice improvement following RCAs.

## 5.2 Focus Group Data 2: Allied Health

Allied health staff provided a perspective on the challenges they saw as inherent in the RCA process. These are summarised in table 5 below.

**TABLE 5: Challenges to RCA Process Identified by Allied Health Staff**

CHALLENGE	COMMENTS
Uncertain status of RCA process in the legal context:	Tension between 'in-house' versus Coroner's demands for information; there is uncertainty here, the DOH is still working on this and RCA information is still not protected, main tension is that while RCA hides identifying information the Coroner reveals identifying info; some people see RCA as having to stop as soon as criminality is recognized to be in play which the police deals with; while RCA is ostensibly about systems learning the RCA investigation is still not protected from police investigation.
Logistics is a problem	Constituting teams is hard because senior clinicians are often overloaded and "I wouldn't really be able to nominate anyone in my team, we don't have people with the right experience to say what could have been done", "Most RCA team members will have had some responsibility above their actual job"; average of 8 to 10 hours per SAC.
Consumers	"I wouldn't feel comfortable, you'd need to get to the nitty-gritty and it's often too technical", "they may find it hard to interview staff", "it wouldn't work if they were cold", while consumer representatives that are currently holding positions on hospital committees might suit, because they are not 'cold'.
Emotional-moral burden	Interviewing colleagues about death, "raising with them what they'd gone through", "at the end [one clinician] said he wouldn't do it again".
Information sparsity	" ... you're looking for information that is not in the notes", "why was this drug prescribed in the first instance, and you may not find anything anywhere", finding such info would enable you to understand better what happened subsequently; "there are always some bits that you don't know the answer to, but I've never walked out of an RCA where I felt that I didn't know what happened", "sometimes all clinicians involved in an incident write down straight away what they saw as having happened, that was very useful", "but you wouldn't have the build-up information", "we already have a fairly strong culture to report".
Managing and realising recommendations	"...follow-up is a disaster".

The Allied Health group were able to identify three factors which they felt positively affected the RCA process. These we provided in Table 6 below.

**TABLE 6: Positive factor Identified by Allied Health Staff**

FACTOR	COMMENTS
Cross-organisational communication is good	Working with others you don't normally spend time with "is really good", "people generally have an amazing amount of goodwill" although "only certain people ... say yes to be on an RCA team".
SAC rating is not seen as a problem	No experience of major disagreements about SAC decisions re incidents: expertise called in to decide, and management checks (and sometimes upgrades ratings).
Politics is not a major interfering factor	"I've never been discouraged from investigating an incident"; people sometimes need time to decide about whether to participate or not; by allowing nurses to interview nurses and doctors doctors you can get to the bottom of things more we obviate people being dishonest, outsiders would not be able to push questions as far as colleagues; ongoing issues often addressed by means of RCAs.

The group also identified three possible innovations which they felt could contribute to the RCA process. Table 7 summarises these.

**TABLE 7: Innovations Identified by Allied Health Staff**

FACTOR	COMMENTS
Importance of pre-planning	We'll sit down with those involved as we start to write up our recommendations, but this used to cause delays, now [she] is good at pre-planning meetings to avoid things from dragging on.
Who asks what questions needs to be worked out carefully	This depends on what information you're seeking, sometimes you need same-profession questioners, while other times you need naïve questioners to get past established assumptions.
RCA team preparation is important	The team goes through the kinds of questions that need to be asked, rather than going off and asking all sorts of unnecessary questions; 'red herrings': interesting issues but not related to the event, earlier RCAs were just too detailed with branchings going everywhere; preparation weeds out unnecessary questions, distinguishing main causes from marginal ones; hypotheses about what happened tend to develop early: "your natural instinct is to try and solve", "sometimes we write such hypotheses down and put them aside"; "something we work backwards as well, with this result, what would have to have happened?"

### 5.3 Focus Group Data 3: Medical staff

The final focus group was held with medical staff from a number of hospital departments, including mental health, emergency and geriatrics. This group identified a similar series of challenges. These challenges are presented in Table 8, below.

**TABLE 8: Challenges to RCA Process Identified by Medical Staff**

CHALLENGE	COMMENTS
Emotional issues	People “are very very anxious, very very anxious”, particularly being in SWSAHS and with the scrutiny they fear from people.
Legal uncertainty	There is “still all this uncertainty about the legal status of RCA ... if someone decided to go the HCCC with RCA information that would be the end of RCAs”.
The process of doing RCAs	Sometimes investigations go off track, and “RCA questions are not seen as relevant by those involved”; You have no time for extensive investigation, so you pick and choose who to talk to, but generally there is no feeling that there was not enough information gathered; The RCA training emphasises one-on-one interviewing, which can be problematic; Problems: stronger views get more attention, and “you get people protecting themselves”.
Handling and actioning recommendations	<ol style="list-style-type: none"> <li>1. <i>The need to finalise recommendations and action them:</i> Delaying decisions about whether and to what extent to realise RCA recommendations leaves people uncertain about what they did and about what will happen to them: While waiting for recommendations to be ratified and actioned, “people feel their heads are on the chopping block”, so recommendations cannot just be handed in and left with management to decide what to do in their own time; there are people anxiously awaiting what will happen to them; “it’s supposed to be the CEO signs off and that something will happen;</li> <li>2. <i>The problem of management-clinician disconnect:</i> “don’t send them [RCA recommendations] up to us!”</li> </ol>
Limits of RCA as organizational change process:	<ol style="list-style-type: none"> <li>1. <i>RCAs can’t conjure up resources:</i> System changes are desperately needed and no RCA can do anything about that because it’ll cost money; RCAs can’t do anything about the most dangerous parts of the system: ED, mental health, geriatrics – due to entrenched resource allocation patterns within the hospital and the Area; DOH gives money to the Area to do things and it then has no control over whether something happens; it needs to place a person in Area to make sure it’s plans are carried through, but currently this disconnect works politically because the politicians can claim that they’re doing the right things but that there are others stalling what they’re doing, and because they do not need to confront the real costs of change and reform that would come into play,</li> </ol>

CHALLENGE	COMMENTS
	<p>were their reforms implemented fully; despite guidelines and good ideas because of the volume of expectation and lack of resources you end up micro-managing and ignoring grand guidelines and protocols and learned solutions; “any RCA would have something in it about ‘this cannot be changed’ and relate back to the system being stretched”.</p> <p>2. <i>RCA</i>s have no influence over things that are not actually wrong but that are inappropriate: offering too many MRIs does not have an adverse outcome but it’s soaking up resources unnecessarily; “what they should be doing is use the CEC to redistribute resources in ways that are rational”; “RCAs deal with the small problems that are left over.... Is there a point in dealing with the small problems ...?”; “It is difficult for me to put my hand up and continue to do RCAs”; RCAs are signed off because often recommendations are made that are too minor to worry anyone, i.e. they are too weak and polite, and not ‘big picture’ enough; “Without the system change RCA is a waste of time”; “if we did this interview in a year’s time, nothing will have changed, but if you did this in cardiology ...” (implying that cardiology is well-off and its RCAs lead to resourced changes); “Your whole hierarchy of risk management is gone because there is not enough staff to monitor up and coming clinicians, I cannot get agreement on how to recruit people”; “I’ve got a patient who I cannot get seen because the right people aren’t there or on holidays”, so the patient stays in bed for an extra two weeks, and you’ll get false economy.</p> <p>3. <i>RCA</i>s have had little effect on clinical practice: “I haven’t actually seen any changes ... I know there was certainly goodwill ... but has anything changed I don’t think so”; “‘Something happens’ is part my existence”; it all looks good on paper but “there are so few things you can fix so it’s not worth trying”; I needed an MRI and the following Thursday nothing had happened and I was told, you shouldn’t rely on your intern to organise this ... Are you going to ring up and scream at the radiology department every time?”; Triage in radiology is hopeless and needs to be fixed but there’s no money; “One of the hospitals had difficulty intubating a patient and you know the outcome, you can see the outcome of the RCA, there will be recommendations that you need a lot of money for to change things, or you’ll close, neither of which is acceptable to do, so you find something you can tweak at the edges and you’re better off”; “We did an RCA at [an hospital] and I’m still asking a year later about what happened”.</p>

The medical group identified four positive factors of RCAs, based on their involvement in a number of RCA teams. These are presented in table 9.

**TABLE 9: Positive factors Identified by Medical Staff**

FACTOR	COMMENTS
Enthusiasm	“People are more than happy to talk” .
Better documentation	“we’re better at reporting”, “we went in hoping that this would be a solution”
The importance of ‘local’ clinical insight	“It might always sound as if we’re on about money but if you look at what people are doing on the ground there are a lot of ideas”.
The importance of communicating across the organisation	Cross-pollinating: “it’s useful for the hospital for people to get out of their silos ... the chance of a surgeon and a respiratory clinician to cross paths would be remote”.

Table 10 provides an outline of possible improvements to the RCA process. These were identified by medical staff.

**TABLE 10: Innovations Identified by Medical Staff**

INNOVATION	COMMENTS
Involve the investigated	Build feedback in from the beginning of the RCA investigation.
Appoint directors of clinical governance	What needs to happen is someone a director of clinical governance needs to be appointed who has decision-making power, and who can make difficult decisions. You don’t need an RCA to say that if you’re psychotic you’ll lose and it stuff happens; at RPA they’ll have people out there in two hours because they’ve got enough staff; out there you have a ‘Mussolini’ who was able to rationalise what resources were needed where; if you did that here, you would not need as many RCAs, you would not have as many systems problems as we do.
Do pro-active mapping of practices and required resources	“This clinical governance person would know you would get patients entering a system and what resources are needed to make the system work safely”.
Engage in appropriate risk management:	A good system would identify the main risks, identify what needs to be done and what it costs, and decide on what can be done to benefit the greatest numbers of people, rather than maintain spending patterns that privilege ‘boutique’ aspects of care and that ignore current problems and risk areas while “they allow these people to do MRIs for the stupidest reasons”.

INNOVATION	COMMENTS
Use RCA as feedback system complementing pro-active mapping	A good risk management system would be pro-active, with RCA as a feedback system; failing such combination of planning and feedback, RCAs are a waste of time.

## 6 DISCUSSION

The three professional groups interviewed spoke about challenges, benefits and innovative approaches to doing RCAs. We summarise each of these in turn below.

### 6.1 Main challenges

1. Emotional-moral burden on investigators and investigated
2. SAC ratings an unreliable indicator as to whether to do RCAs or not
3. Logistical problems to do with making time and finding the right people
4. Uncertainty about the legal status of RCA investigative materials and processes
5. Concern that RCA recommendations be framed in narrow, do-able, 'realistic' terms, without addressing larger scale issues and problems
6. Uncertainty about whose responsibility it is to make sure RCA recommendations are acted on
7. Lack of clarity about management's role in negotiating and realising RCA outcomes.

### 6.2 Main benefits

1. Cross-organisational communication and learning
2. RCA as 'no blame' feedback mechanism, targeting systems problems.

### 6.3 Some professional differences

While for the nurses the emotional, moral as well as political aspects of doing RCAs were a major burden, this was not experienced in the same way by Allied Health staff. For medical staff the emotional problems were largely restricted to the problem of recommendations not being followed up and actioned, such that their impact on staff remained unclear. While for the nurses there were some problems of deciding on the SAC rating of critical incidents and on whether to do an RCA on the basis of those ratings, these were not major issues for allied health staff.

For medical staff, the issue of SAC ratings and decisions as to whether to do an RCA were subordinate to the problem that RCA is not a mechanism that is able to address persistent resource allocation problems in the system or address issues that do not result in critical incidents, but cause major risks in other areas. For medical staff, therefore, RCAs were only a small part of a much bigger problem, to do with a general lack of an over-arching view of the system, especially a lack of a clear view on what resources are needed where to benefit the greatest number of people, without favouring those areas of care that are able to attract attention and thus resources perhaps on spurious grounds.

## **6.4 Proposed innovations**

Staff proposed a range of innovations to improve the RCA process in their organisation. These are summarised below.

### **Innovations to the RCA investigative process**

1. Pre-plan RCA investigations and prepare team members; that is, gather chronological information from the medical record and other sources and think through possible scenarios and file early 'hypotheses' away;
2. Involve those who are being investigated early on; instead of rigidly separating the investigation and interviewing processes from the recommendation feedback mechanism, RCA investigations were seen to work better by involving those investigated early on in exploring ways of framing issues and causes, ways of thinking about problems and about how to investigate them, and ways of formulating recommendations.

### **Innovation to legitimate RCAs**

- Appoint RCA experts in the organisation
- Publicise RCA recommendations in a newsletter
- Engage in post hoc evaluation of RCA processes.

### **Innovations to enhance organisation-wide risk management**

- Appoint directors of clinical governance
- Pro-actively map clinical practices and appropriately allocate resources
- Use RCA as feedback system complementing pro-active mapping.

## 7 CONCLUSION

Participants in the focus groups reflected that RCAs constitute an important and necessary device for providing feedback about processes that make up the system. However, there are problems to be resolved around the legal, logistical and managerial dimensions of RCA inputs and outcomes.

## 8 REFERENCES

Centre for Clinical Governance Research in Health (2004). *Protocol: evaluation of the Safety Improvement Program*. Kensington: Centre for Clinical Governance Research, University of NSW.

Iedema, R., Braithwaite, J., Jorm, C.M., Nugus, P., & Whelan, A. (in press). Clinical governance: complexities and promises. In P. Stanton, E. Willis, & S. Young (Eds.), *Health care reform and industrial change in Australia: lessons, challenges and implications*. Basingstoke: Palgrave Macmillan.

NSW Health (2004). *Department brief for SIP evaluation*. North Sydney: NSW Department of Health.

NSW Health Quality and Safety Branch (2003). *Reportable Incident Briefs to the NSW Department of Health*. North Sydney: NSW Department of Health. Circular No. 2003/ 88 (File No. 03/ 11299).

9 APPENDIX

9.1 Appendix 1: Focus group questions

TABLE 11: Focus Group Questions

FOCUS GROUP STAGING	QUESTIONS
Introduction	<ol style="list-style-type: none"> <li>1. Generally speaking, have you enjoyed being involved in RCA teams?</li> <li>2. How many RCA's have each of you been involved in?</li> </ol>
Problems arising from RCAs	<ol style="list-style-type: none"> <li>3. Have you or your team encountered incidents about which you were uncertain whether to do an RCA on them?</li> <li>4. Have you or your team encountered incidents which you found hard to draw conclusions from?</li> <li>5. Some teams have had trouble with separating performance management from system change issues. What is your experience?</li> <li>6. Some teams have had trouble with separating organisational politics from organisational learning. What is your experience?</li> <li>7. How often do you face moral-personal dilemmas when doing RCAs?</li> <li>8. Are you ever worried that any of your (team's) recommendations might lead to lasting difficulties for yourself with other staff?</li> </ol>
Overall assessment	<ol style="list-style-type: none"> <li>9. Overall, how useful do you think RCAs are in your hospital?</li> </ol>
Potential strategies	<ol style="list-style-type: none"> <li>10. What strategies could you recommend to colleagues to help them cope with problems and difficulties arising during RCAs?</li> </ol>