# Case study

# The experience of managers:

# The how of organisational learning after patient incidents in a hospital

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# ABSTRACT

This case study describes the learning capability of a hospital after patient incidents. The theoretical framework is based on Carroll, Rudolph and Hatakenaka's model of four stages of organisational learning. Ten managers were interviewed and documents such as incident management policy, quality plans and incident reports were examined. The ten participants include five clinical managers who are responsible for investigating incidents and five unit managers who are responsible for signing off incident reports.

This study found that incident investigations generated valuable learning for the participants. Being the learning agent, they also appeared to influence and lead team learning and, to some extent, organisational learning. Most of the participants appeared to be practising between the constrained stage and the open stage of learning. This study uncovers the concepts of preparedness, perception and persistence. The application of these exemplary concepts has strengthened the learning capability of some participants and distinguishes them as practising at the open stage of learning. By employing these concepts, *The Hospital* can also gain leverage to progress from the constrained stage to the open stage of learning that supports a systems approach, advocates double-loop learning and facilitates the culture of safety.

This case study has found that *The Hospital* assumes a controlling-orientation to ensure staff's compliance with policies and procedures to prevent patient incidents. However, it also advocates a safety culture and attempts to promote learning from patient incidents. This impetus is inhibited by the obstacles in its incident management system, the weak

modes of transfer of learning and hindering organisational practices. Three propositions are offered to overcome these barriers. Firstly, revolutionise the incident management system to remove obstacles due to the rigid format of *Incident Forms*, the difficulty in retrieving information and the lack of feedback. Secondly, provide regular, safe, transparent and egalitarian forums for all staff to learn from patient incidents. Facilitated incident meetings have been shown to be more effective platforms for learning than a bureaucratic approach via policies, procedures, training and directive decisions delivered during departmental meetings or by written communications. Thirdly, attain a balance between controlling and learning to mitigate the effects of bureaucratic process and the silo phenomenon.

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# GLOSSARY

Terms and definitions used in this report are adopted from Reason (1992), Ministry of Health (2001), New Zealand Incident Management System (Communio, 2008) and the Incident Management Policy of *The Hospital* (*The DHB*, 2008, 2009b).

**Clinical manager** is the line manager to whom a staff reports directly.

**Department** denotes a service, team, ward or unit.

**Errors** include slips, mistakes and violations.

**Health professional** is a healthcare service provider that includes medical practitioners, nurses, midwives and allied health professionals.

**Incident / patient incident** is an event which could have, or did, result in unintended or unnecessary harm to a patient.

**Incident management** is a systemic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and acting to prevent recurrence or minimise harm.

**Investigation / incident investigation** is an inquiry to ascertain facts and identify causes of incidents.

**Minor incident** is an incident with minor or minimal consequence and the probability of recurrence being likely to highly unlikely.

**Moderate incident** is an incident with moderate consequence and the probability of recurrence being certain to highly unlikely.

**Near miss** is an event that could have had adverse consequences but did not and is indistinguishable from an actual incident in all but outcomes.

**Preventable incident** is an event that could have been anticipated but had occurred because of an error or systems failures.

**Reporting / incident reporting** is the completion of the incident form following the identification of an incident.

**Sentinel event** is an event in which unexpected death or serious harm to a patient occurred.

**Severity Assessment Code (SAC)** is a numerical score assigned to an incident, based on the consequence of the incident and the likelihood that it will occur. Incidents rating a SAC of 1 or 2 are considered extreme risk or high risk while a SAC of 3 or 4 are medium risk or low risk.

**Staff** is any person who works in a healthcare organisation. They include all employees at all levels.

**System** is a collection of components and relations between them. The components include human, such as staff; equipments, such as bed rails; technology, such as computers; and management policies and decisions.

**Systems failure / systems problem** is a fault, breakdown or dysfunction within an organisation's operations, processes or infrastructure.

**Unit manager** reports to the service manager or the general manager and is the person to whom the line manager or clinical manager reports.

# NOTES ON QUOTATIONS

Direct quotations from the participants' narratives are in *italics*. The identity of the participants is anonymised and referenced to their narratives is at the end of the text, for example: "*Patient safety is ...*" (*Manager A*).

The identity of health professionals and names of the departments, procedures or treatment are replaced by [text inserted], for example: [staff] means a health professional, health professionals or frontline staff.

Words or phrases emphasised by participants are in capital letters and is noted accordingly, as shown in the following example: *patient safety is IMPORTANT* [emphasised by participant].

Direct quotations of the participants are included in the discussion because they reflect and describe the perspectives and situational experiences of the participants (Kramp, 2004; Weiss, 1995).