‘Deep Dive’ Reviews:
A different way of learning from incident reports

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Introduction
Incidents relating to Organ Donation and Transplantation are hugely diverse and often complex and multifactorial. It was found that some reports that were ‘investigated’ in the traditional sense highlighted no real learning or solutions, simply increased workload for all, and potentially took individuals away from clinical care for no benefit; an unsatisfactory outcome for all. To be more effective, it was agreed to explore a new method of reviewing certain types of incident reports.

Method
Learning from other areas, the concepts of both ‘deep dives’ and ‘thematic reviews’ have been developed for certain reports.

The overarching aim of each deep dive is to strengthen current processes and highlight areas that need further focus. Details and facts are still collated, however by stepping back from the individuals involved it takes away any ability to blame as the focus is on the wider learning: the ‘why’ and ‘what’ rather than the ‘who’.

Due to the nature of Organ Donation and Transplantation it was agreed that for the deep dives to be of benefit, all key stakeholders needed to be involved. Each deep dive is led by ODT Clinical Governance and has a representative from Commissioning, NORS/care clinician input, SNOs and Hub Operations; this is crucial as the aim is to ensure things are seen through the eyes of all those involved. Expertise from others, such as the Lead Nurse - Recipient Coordination, are also sort where needed.

A deep dive occurs every two months and the cases are mapped through bringing out key questions, further ‘diving’, suggestions to strengthen practice or processes and recommendations to take forward.

Results and Discussion
So far there have been 4 ‘deep dives’. The learning from these has far exceeded, not only what would have been gained from the previous way of reviewing, but also the expectations of those involved.

There have been a number of significant actions taken forward and some of the findings have been truly unexpected, highlighting the benefits of the change.

Recurrent reports with similar themes are now used by the ODT Clinical Governance Team as an alert that neither the root nor the common causes are being identified. The early findings suggest that the concept of investigating a small number of reports, in-depth, and in a proactive way, will be significantly beneficial for all, patients, donor families and staff.

References

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