

Clinical governance in action

TRAIL: a model to promote active learning from adverse events

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ABSTRACT

This article describes TRAIL, a model developed within Leicestershire Partnership NHS Trust's City Adult Mental Health Services to facilitate incident reporting and active learning from adverse events. In common with other similar trusts, Leicestershire Partnership NHS Trust has successfully implemented a risk management strategy that has encouraged staff to report adverse events, but this does not guarantee that all staff are aware of why incidents should be reported, and the challenge to move away from the 'blame culture' of old has remained real. As a service, we identified the need to move to the next

stage of development that involves learning lessons from these events and engaging staff within clinical services in identifying changes required within their team practices. The TRAIL model has provided the service with a framework for identifying the lessons that could be shared more widely and raising awareness of individual and team responsibilities for maintaining safer services.

Keywords: adverse events, learning lessons, mental health, patient safety

Introduction

The clinical governance agenda has provided the NHS with a greater focus on patient safety than ever before. It has helped NHS organisations develop clearer lines of accountability, strengthen risk management functions and improve methods of assessing clinical quality. Every day more than a million people are treated safely and successfully in the NHS. But the evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional staff are. And when things go wrong, patients are at risk of harm:¹

- it is estimated that around 10% of patients admitted to NHS hospitals have experienced a patient safety incident, and that up to half of these incidents could have been prevented¹
- every year, around 1150 people who have been in recent contact with mental health services commit suicide²
- the NHS pays out around £400 million in settlement of clinical negligence claims.²

For the staff involved, these incidents can be distressing and demoralising. Findings in the US, Australia,

New Zealand and Denmark have suggested similar error rates. Although most of the research to date has focused on incident rates in acute care, many of the underlying contributory factors also apply to other healthcare settings.

The Department of Health asserts that one of the NHS's serious deficits has been an inability to recognise that the causes of failures in standards of care in one part of the NHS may be the way in which risk can be reduced for patients elsewhere.³ The Bristol Inquiry concluded that every effort should be made to create an open and non-punitive environment in which it is safe to report.⁴ It was with these two principles in mind that the TRAIL model was developed.

Learning the lessons in practice

Leicestershire Partnership NHS Trust's City Adult Mental Health Services is a large and diverse service that was formed following a reorganisation in 2002. It provides a range of clinical services including acute

inpatient care, community mental health teams, rehabilitation and psychological therapies for common mental health problems within primary care. The varied and dispersed nature of the services provided has meant that bringing staff together to improve practice has been a challenge, however, significant progress has been made in developing clinical governance structures. A service clinical governance committee meets monthly, and a network of clinical implementation teams ensure that clinical governance is on the agenda for clinicians within all specialties. The clinical governance committee is actively involved in reviewing incident reports and monitoring the implementation of resulting action points. The committee receives and interprets regular reports on incidents, adverse events, service user comments and complaints that incorporate quantitative and qualitative data.

The trust has a well-established process for reporting incidents, but thresholds for reporting vary greatly across the organisation. The service has identified that there is a need for managers in all areas to review reportable incidents trends and ensure that staff within their teams are reporting appropriately. We recognise that a high level of reporting of patient safety incidents is a sign of an open and fair culture where staff learn from things that go wrong. The experience from other sectors, such as the aviation industry, shows clearly that as reporting levels rise the number of serious incidents begins to decline.⁵ Incidents within the service are investigated using a root cause analysis approach, a problem-solving process that is triggered by serious or unusual patient occurrences.⁶ Rather than blaming or finding fault with individuals, the approach focuses on discovering and addressing the underlying systems that directly or indirectly led to the incident. When a patient safety incident occurs, the important issue is not who is to blame for the incident but to explore how and why it happened and what can be done to prevent recurrence.⁷

What is TRAIL?

An Organisation with a Memory, a report on patient safety in the NHS, made the important distinction between 'passive learning' (where lessons are identified and not put into practice) and 'active learning' (where those lessons are embedded into an organisation's culture and practices).² To be effective, the analysis of patient safety incidents should lead to a local action plan to ensure that lessons are applied throughout the organisation. The impact of these action plans should then be measured over time, as part of a core clinical governance activity review programme. Communicating the results of these action plans to staff will also

help to boost confidence in the incident reporting process. Lugon points out that such systems will only be successful if they are owned by clinical teams, and if those teams are empowered to reflect and learn from experiences and to act accordingly.⁸ Communication is a prime responsibility of healthcare organisations, she argues, and they should ensure that the lessons from one team are spread to the whole organisation.

The TRAIL model advocates a five-stage process to support teams to consider what they can do locally to improve patient safety.

The five stages of the TRAIL process are:

- *talk*: create a regular opportunity for open discussion about incidents and adverse events within your team
- *reflect*: take time as a team to reflect on the key themes identified and the implications for your clinical practice
- *act*: consider simple changes in working practices to reduce the likelihood of things going wrong
- *improve*: develop your team's focus on reportable incidents and awareness of safety issues
- *learn*: ensure that all staff know when and how to report an incident, and disseminate learning from other teams and services.

Promoting TRAIL and changing the culture

A newsletter-style TRAIL bulletin is produced on a quarterly basis and it aims to raise awareness of the importance of reporting processes, provide feedback on incidents that have been reported, and disseminate learning points that have been identified from investigations. The document is intended to stimulate discussion, learning and service improvement within teams. It has been purposely produced in an easy-to-read format that incorporates short vignettes about real incidents that have occurred across the service. Following each vignette the key learning points are clearly identified. The vignettes are anonymous and care is taken to ensure that good practice and the positive findings of investigations are stressed. The vignettes address systems and organisational failures rather than individual errors or omissions, and care is taken to ensure that individual staff or teams will feel supported if they are able to recognise themselves in the case studies. Over recent months they have been extended to include vignettes drawn from complaints investigation findings. The bulletins also regularly include articles encouraging staff to report by explaining the process and the benefits to patient care, and clearly outlining what types of incident should be reported.

Reviewing the impact of TRAIL

To ensure that all staff have access to it, each edition of TRAIL is circulated widely via the internal email system. Team managers take responsibility for ensuring that time is allocated within each clinical service to discuss and reflect on the issues highlighted in each issue. The team manager is asked to complete a feedback questionnaire that is included in each issue and return it to the clinical governance department. The feedback questionnaire gives clinicians and managers an opportunity to summarise what action they have taken as a result of TRAIL and which of the issues highlighted have been of most relevance to them. The purpose of this feedback questionnaire is to provide a method of evaluating the success of TRAIL in meeting the above aims and ensuring that all teams are using it effectively.

Our reportable incident investigations aim to identify what each incident tells us about the system in which we work. Unfortunately staff often feel that the aim of an investigation is to identify the poor practice that caused it or, worse, to identify who is to blame. The confidential nature of investigations has meant that in the past it has been difficult to share findings, and TRAIL has therefore proved to be an effective catalyst for culture change and raising awareness of the aims and benefits of root cause analysis. Patient safety incidents are now regularly on the agenda for discussion amongst all clinical teams, and the service has plans to audit the effectiveness of the work undertaken to date. Staff have proved to be genuinely interested to hear about and reflect on adverse events that have occurred in other parts of the organisation; each TRAIL bulletin has generated a significant amount of constructive feedback about work that individual teams have progressed in order to ensure that errors are less likely to be replicated. There are plans to extend the use of the TRAIL model across other services within the trust, and this will allow valuable sharing of issues within all clinical specialties.

Examples of TRAIL vignettes (for confidentiality reasons, these vignettes are fictional)

Relatives warn that patient should not be allowed time off the ward

A male inpatient on Section 3 of the Mental Health Act asked nursing staff for permission to leave the ward for a couple of hours. He was later found in the grounds of

the hospital having made a serious attempt to take his own life. Following medical treatment, he was returned to the ward unharmed. An investigation found that the patient's family was very unhappy that he had been able to leave the ward. His mother had visited the ward the day before and expressed concern to a member of staff that her son remained suicidal and should not be allowed to be on his own or leave the ward. It transpired that this piece of information had not been effectively passed on to other members of the multidisciplinary team, and that there was a lack of clarity regarding leave arrangements for this patient.

Learning point:

Arrangements for patients to have leave or time off the ward should be agreed and clearly recorded by the multidisciplinary team.

Learning point:

Staff should be aware of the need to communicate effectively with patients' friends and family and ensure that any risk issues highlighted are reflected in the risk assessment and care planning process.

Complaint highlights the need for staff to check patient identity

The healthcare records of two women with similar names who lived in the same street recently caused confusion for clinicians. One woman had an initial contact with one of the trust's mental health practitioners. The mental health practitioner was given the wrong records by staff within the referring acute trust, and did not check the woman's date of birth or other identifiers. The error came to light when the wrong woman was contacted with follow-up information, which was of a particularly sensitive nature.

Learning point:

This incident highlights the need for all staff to check the full name, date of birth and address of all patients who use our services. This is relevant even when patients are well known to the staff caring for them.

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CONFLICTS OF INTEREST

None.

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Received 8 April 2005

Accepted 25 May 2005

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