

**Learning Response Review and Improvement Tool**

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| **Report details:** | **ID**:  | **Title**:  |
| Development of this tool was informed by a research study which identified ‘traps to avoid’ in safety investigations and report writing. The tool was originally developed by NHS Scotland. It has been further refined in collaboration with HSSIB (previously HSIB) and NHS England after being piloted in approximately 20 NHS Trusts and healthcare organisations in England. The content validity of the tool is currently being assessed. |
| **How to use this tool** | The tool is intended to be used by:**1** Those writing learning response reports following a patient safety incident or complaint, to inform the development of the written report.**2** Peer reviewers of written reports to provide constructive feedback on the quality of reports and to learn from the approach of others.  |

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| **Area of review** (Descriptor) | **Rating scale**(Please insert ‘X’ in the applicable box) | **Comments/examples of text quotes**Add comments to clarify your ratings, this may be things that can be improved or content that you thought worked well and should be used in other reports |
| 1 | **People affected by incidents are meaningfully engaged and involved**The report demonstrates evidence that all those affected by the incident such as staff, patients, families and carers have been actively listened to and emotionally supported where required (i.e. interviews and perspectives of those affected are included in the report). | Goodevidence

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| 2 | **The systems approach is applied**The report demonstrates consideration of system-based performance influencing factors (e.g. task complexity, technology, work procedures, workplace design, information transfer, clinical condition of patient, stress, fatigue, culture, leadership/management, policy/regulation) and how these interacted to contribute to the incident in question. | Goodevidence

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| 3 | **‘Human Error’ is considered as a symptom of a system problem**‘Human error’ or similar (e.g. nurse error, medical error, loss of situation awareness) is not concluded to be the ‘cause’ of the incident. Instead, multiple contributory factors which influenced the event are explored. | Goodevidence

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| 4 | **Blame language is avoided** Language does NOT directly or indirectly infer blame of individuals, teams, departments, or organisations and/or focus on human failure (i.e. the nurse failed to follow policy; the doctor lost situation awareness). | Goodevidence

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| 5 | **Local rationality is considered** The report clearly explains why the decisions and actions taken by individuals involved felt right at the time (i.e. the situation and context faced by those individuals is explored and described). | Goodevidence

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| 6 | **Counterfactual reasoning is avoided**The report focuses on what happened and understanding why an incident happened. The report does not make a judgement on what people, departments or organisations ‘could’ or ‘should’ have done during or before the incident. | Goodevidence

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| 7 | **Safety actions/recommendations are systems-focussed, evidence based and developed collaboratively**Safety actions/recommendations proposed:**•** have been developed collaboratively with relevant staff/stakeholders and with consideration of wider organisation priorities and improvement work **•** focus on system elements (IT, equipment, care processes/pathways) not individuals**•** are specific, robust and actionable i.e. they don’t add to ‘safety clutter’ **•** are accompanied by a plan to monitor progress over time **•** are demonstrably linked to the evidence and findings in the report. | Goodevidence

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| 8 | **The written report is clear and easy to read.**The report is concise, written in plain English and uses inclusive language i.e. it is written to ‘inform rather than impress’. | Goodevidence

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| 9 | **General comments**Is there anything else that can be improved or content that you thought worked well and should be used in other reports? |