The sure in reassurance – Nick Moor

Understanding how organisations 'know what they know'

As John Humphries once said: "reassurance is not worth the paper it is not written on".

After many serious incidents in healthcare it has become something of a cliché for senior management to say that '*lessons will be learned'.* The reciprocal question at the heart of this statement, is, however, "*how will we know they have been?"* (particularly where patients and their families are concerned).

As specialist investigators we have undertaken many assurance reviews after the 'learning' has taken place (following an internal or an external investigation). It is not uncommon that we find the action plan for implementation has been 'RAG rated' as 'green' and all actions reported to have been completed by the organisation concerned. The governance surrounding action completion is often fragile, with verbal reports frequently being accepted in relation to progress. Action tables are often updated in response to this 'reassurance' rather than the actual assurance that comes with hard evidence of implementation. We often find that when the team or organisation are pressed for a validated position on action completion, the assurance is lacking in any real depth or breadth.

Investigation findings often question the lack of professional curiosity applied by practitioners. Frequently, this might be due to staff not asking the awkward question or failing to corroborate statements given by service users or patients. Sadly, we find the same lack of professional curiosity can be applied to the internal oversight of investigations when accepting reassurance from senior managers that actions have all been completed. We are sure that there is an expectation applied that busy professionals are being honest, and their word can be accepted. However, for the very serious nature of the cases we often review, we ask, is that really enough?

Often, there has indeed been a flurry of activity in response to an investigation action plan; the problem is that frequently this is not the action which was expected or required to meet the recommendation. It is almost as if the adage that "*something must be done, this is something, therefore let us do this"* is being applied in lieu of real organisation learning. How do we know that lessons have been learned when all we accept are green RAG ratings and verbal reassurance? And what does *evidence of assurance* mean?

Take the example of a recommendation that "a policy must be revised". So that we can be assured of the action's completion we would need to see that:

- discussion had taken place to cover the relevant sections of the policy and we could identify who had been involved in those discussions and when they took place;
- we can review the revised version of the policy with clear identification of the changes;
- this policy had been through the relevant subcommittees and was officially ratified and dated; and
- the change in the policy had been actively brought to the right people's attention so they knew about the changes (i.e. not just an email reminding people to read it but actual meetings and training sessions where changes to practice were discussed).

In order to be assured of the embeddedness of the action we need to see evidence that the policy is in place and being used with positive impact. To evaluate this, we might choose to discuss how practice had changed with a group of staff or clinicians and check this feedback with the revised policy. Another approach might be for the organisation to evidence the change in practice through clinical audit so they themselves were assured that the changes to practice are now embedded.

Lastly, to demonstrate the change is delivering sustained impact we might expect to see a re-audit of cases six months or so later where the intended consequence of the change could be quantified, such as a reduction in harms occurring, or a reduction in admissions for the condition involved.

On many occasions we have found that organisations have not used the key themes arising from incident investigations and recommendations to direct next year's clinical audit programme or objective setting parameters. And, because *change is the new normal*, and staff are very busy, in a year's time there will be new issues which supersede last year's problems, which results in a focus on process and not outcome management. It is essential then, that action plan completion is always embedded within a solid foundation of available evidence. Wouldn't you want to be able to say with conviction, "*lessons **have** been learned, and this is exactly how I know*".

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