Lessons Learned
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Introduction

One of the primary promises of BETA HEART is that organizations will not only develop a process for rapid identification and response to harm events, but also that HEART organizations will analyze what contributes to harm events, learn from that analysis and take action to prevent reoccurrence. This is what we know to be most important to patients, families and our valued workforce. When an incident occurs within a complex healthcare system, the cause is rarely singular. More often, untoward outcomes or “adverse events” have multiple causality. This is also true of “near misses” which are incidents that could have had a detrimental outcome, but stopped short of completion. For that reason, we encourage HEART participants to learn from and share lessons learned from both actual and near miss events.

After an actual or near miss event occurs or patient is harmed, the contributing factors are identified and the appropriate corrective action is taken, it is imperative upon organizations to share what was learned from the event analysis broadly with staff so that there is clear understanding of efforts taken that supports prevention of future error. The process for doing so is often referred to as “Sharing of Lessons Learned”.

The following chapter is intended to provide guidance and examples of how to develop a process for telling the story of what occurred, and sharing of lessons learned as a result.

What Are “Lessons Learned”?  

In the purest definition, lessons learned is merely information gained through experience. The experience is the event that occurred and the process of analyzing the adverse or harm events either through a collaborative case review / RCA, or in some situations, closed claims reviews. Using the information learned and developing a process to tell the story of what contributed to harm, and actions taken to prevent reoccurrence help staff begin to appreciate vulnerabilities within systems as well as in how we as human’s interface with our environment. The sharing of lessons learned help to diminish the fear associated with discussing errors while reinforcing a culture of shared accountability and organizational learning. When experiences of previous incidents are translated into preventive measures, an organization progresses
toward becoming a learning organization, one that actively creates, captures, transfers, and mobilizes knowledge to enable it to adapt to the changing healthcare environment that is a foundational piece for creating a culture of safety.

Identifying and Selecting Lessons Learned

At a minimum, organizations should identify and share lessons learned from the following:

- Sentinel events
- Significant events resulting in harm
- HEART events (defined as an event resulting in physical, emotional or financial harm to a patient; or any event where, from the patient/family perspective, a delay in reporting or communication with them may impede effective event review or cause more harm)
- Closed claims events that have resulted in performance improvement activities
- Near miss events where opportunities for improvement have been identified and implemented

Telling the Story

Sometimes the hardest part is getting started and understanding what about the event or story is important to communicate and then once it is determined what should be communicated, how the story should be told. When sharing lessons learned, it is important to protect both patient and employee safety. To the extent possible, the case should be deidentified so that protected health information is not inadvertently released, and involved staff do not feel targeted. Sharing lessons learned is dependent upon staff feeling safe and a part of an organization that values learning. It is the event itself, factors that contributed to harm, the lessons learned from the analysis and the actions taken that are important to communicate. The story should encourage staff to ask the question, “could this happen here in my unit?” “Could I make a similar mistake and if so, what can we as a discipline or department do to prevent this from occurring?” An example of information that can be shared includes the following:

- Patient demographics and clinical background (if pertinent)
- Setting, time of day/shift, day of week (if pertinent)
• Description of event
• Impact to the patient
• Impact to involved clinician or others that may have been impacted
• Process for learning of what contributed to event
• Activity or error that contributed to event
• Equipment (if involved in event)
• Medications (if involved in event)
• Any human factors or system design issues that contributed
• From a just culture standpoint, if human error is there a system design component that contributed?
• If at-risk behavior, was the behavior influenced by the environment?
• Actions taken or recommendations made as a result of the above learning
• Opportunity for staff to ask/consider if this event could occur in the current environment
• Any additional learning that could be suggested

Mechanism for Sharing Lessons Learned

Sharing lessons learned can occur via a variety of communication routes. Lessons can be “pushed,” i.e. newsletters, alerts, units staff meetings or “pulled” as in a facility online search engine. While written communications are helpful in an effort to reach all staff, verbal sharing of lessons learned offer the opportunity for interactive discussion and Q/A, often which identify related vulnerabilities. This allows for greater learning. All in all, care must be taken so that the information is not reduced to nothing more than another electronic file stored away in a shared drive. The following are examples of some best practices:

• As an organization, dedicate a quarterly interdisciplinary patient safety meeting to an individual case presentation. Be attentive to human factors and system design as they impact the event. A practical tool for developing this type of approach is attached in the resource section.
• Review lessons learned for 10-15 minutes in regularly scheduled staff and committee meetings i.e. unit/departmental meetings, medical staff meetings, quality council, environment of care etc.
• Commit to maximizing the productive aspects of previous experiences and minimizing repeat mistakes through sharing lessons learned.

• Introduce a safety moment(s) at the beginning of daily rounds and every meeting; incorporate lessons learned and great catches as part of the safety moment.

• Select one day a week dedicated to a lesson learned. Communicate broadly. Develop a process for rewarding staff who are able to articulate what was learned that week.

• Reward staff for identifying and contributing to learning opportunities.

Examples and Resources

The following are a few examples of types of events that can easily result in lessons learned followed by links to strategies and tools for communicating lessons:

• Surgical specimen was missed and never reached pathology as a result of a failed post-surgery team debrief
• Patient misidentification as result of documentation in the wrong medical record
• Misreading of glucometer as a result of device design flaw


Joint Commission Journal on Patient Safety; A Practical Tool to Learn from Defects in Patient Care; February, 2006 http://www.jointcommissionjournal.com/article/S1553-7250(06)32014-4/pdf

Brigham and Women’s “Just Culture” event review can be found here: http://www.brighamandwomensfaulkner.org/about-us/general-information/bwfh-news/Just-Culture-at-Work-Collaborative-Case-Review-provides-the-structure-for-open-and-honest-communication-in-the-OR.aspx

MedStar Health in Maryland utilizes online videos to share lessons learned: Annie’s Story: How a System’s Approach Can Change Safety Culture and be accessed here: https://www.youtube.com/watch?v=zeldVu-3DpM
References


6. CHPSO Lessons Learned: http://www.chpso.org/lessons-learned

7. ASPAN (American Society of Paranesthesia Nurses/Lessons Learned / Best Practice Standards: http://www.aspan.org/Clinical-Practice/Safety-in-Practice/Lessons-Learned
People make errors. Errors can cause accidents. In healthcare, errors and accidents result in patient harm and sometimes even death. For decades, in healthcare, the organizational response to human error has been—seek out the responsible party and punish them. This punitive approach has never proven effective in solving the underlying problem.

People function within systems designed by organizations and, while an individual may be at fault, frequently, so is the system. Punishing people without changing the system only perpetuates the problem. The framework of a just culture ensures balanced accountability for both individuals and the organization responsible for designing and improving the systems in the work environment.

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**Case Scenario: Response to Human Error**

**Scenario:** Medication A and B both come in the same type of vials with red caps. They are stocked next to each other in dispensing bins. At the end of a very busy night shift, the pharmacy technician mistakes Medication A for Medication B and, in error, places it into a patient’s administration bin. The nurse notices the error before administering the medication. She reports the error. The technician, who has a sterling record, is very upset that it happened.

If this incident occurred in a Just Culture, what should be the response?

a) The incident should be investigated and the pharmacy technician should immediately be put on probation or fired.

b) The incident should be investigated and the pharmacy technician should be consoled, as this was human error with added systemic issues.
Just Culture: An Introduction

Just Culture Coalition (left to right): Sandra Howard, RN (Nurse Manager, 4 West), Dr. Peter Kelp, M.D. (General Medicine), Thuy Hai, RN (Nurse Manager, ED), Kevin Hoy, RRT (Respiratory Therapy), Kim Daniels (Patient Experience)

A patient care system is obligated to collect productive investigative data that can be analyzed and acted upon to improve patient safety. This process is not possible unless members of the organization remain vigilant and mindful and maintain continuous surveillance. Similarly, people within the organization must believe that they are obligated to report errors. However, medical institutions cannot afford a blame-free culture: Some errors do warrant disciplinary action. Finding a balance between the extremes of punishment and blamelessness is the goal of developing a just culture.

A just culture balances the need for an open and honest reporting environment with the end of a quality learning environment and culture. While the organization has a duty and responsibility to employees (and ultimately to patients), all employees are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to system design and management of the behavioral choices of all employees.

To hear more about management of these choices, everyone is invited to an introduction to Just Culture governance. There are both day and night sessions. Please check the main website for announcements or email justculture@pbc.org for date, time and location.


Answer to Patient Safety Question:
Investigate the incident and Console the employee