Overcoming Quality Issues in Illinois Critical Access Hospitals

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The Joint Commission

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The Joint Commission

Objectives

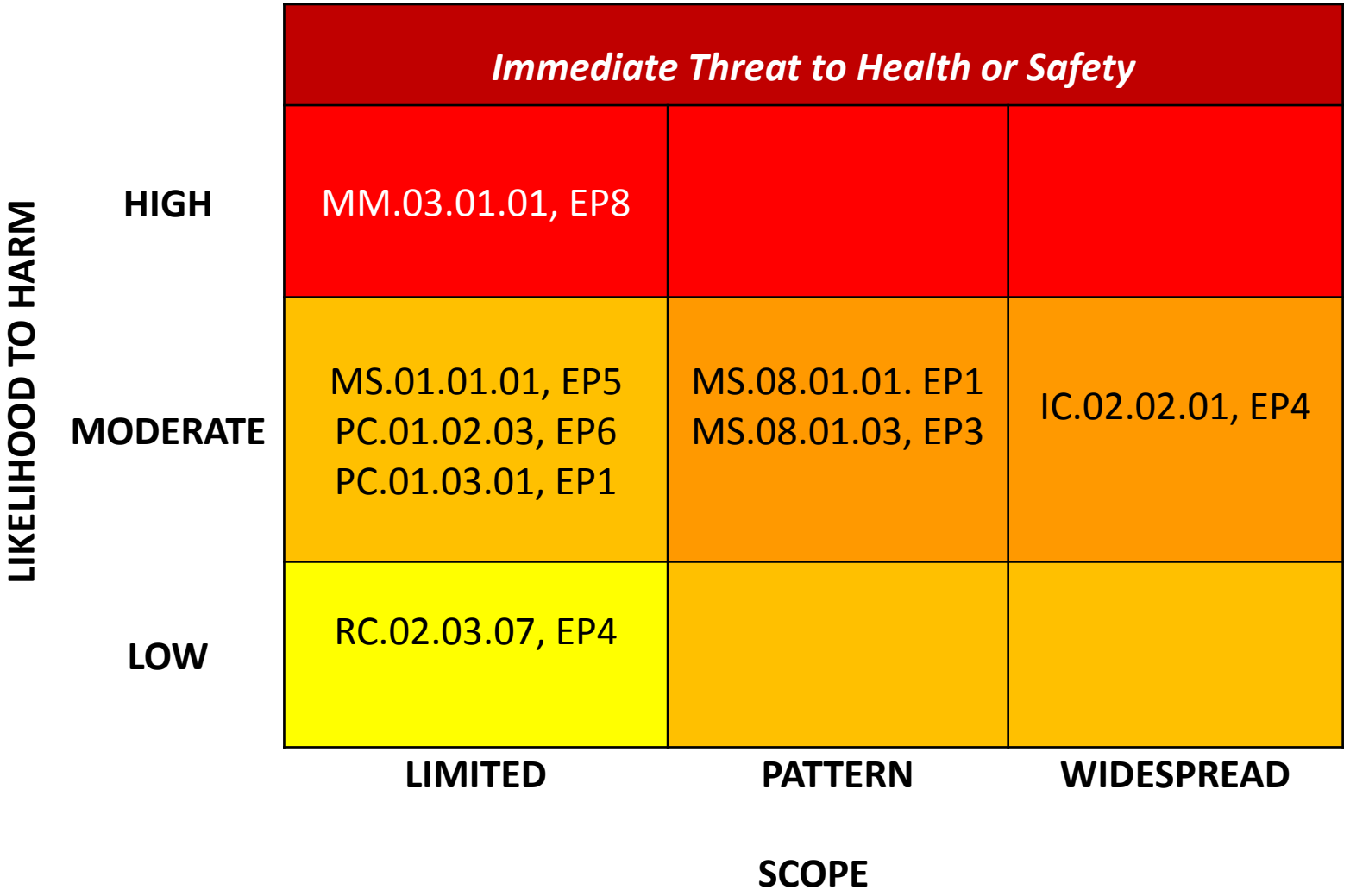
- Review emerging survey trends for critical access hospitals in the United States
- Compare survey trends to critical access hospitals in Illinois
- Provide resources and information to address quality and patient safety issues in critical access hospitals

The Joint Commission Today

- An improvement organization focused on improving health care for the public
- ***Evaluating*** and ***inspiring*** health care organizations to excel in providing safe and effective care of the highest quality and value
- Beyond accreditation: Creating and delivering effective solutions towards quality and safety improvements
- Continuously evaluating and improving everything we do using lean six sigma and change management methodologies
- Leading the way to zero harm: Creating a vision for high reliability in healthcare and providing a road map to get there

Our Assessments Focus On Identifying Areas of Risk

- Surveys identify areas for risk within an organization
- Risk areas depicted in visual matrix:
  - Communicates risk points
  - Prioritizes improvement efforts based on potential for harm
  - Can be used as an internal comparison tool across health systems



Aggregate *SAFER* Data

Critical Access Hospital Requirements for Improvement (RFI) distribution for surveys

01/01/2019 through 09/30/2019 (n=65)

Likelihood to Harm a Patient/Staff/Visitor	Immediate Threat to Health or Safety 0.0%			
HIGH	0.8%	1.1%	1.3%	3.20%
MODERATE	16.2%	7.7%	4.4%	28.3%
LOW	50.4%	12.4%	5.7%	68.5%
	67.4%	21.1%	11.5%	
	LIMITED	PATTERN	WIDESPREAD	

Scope

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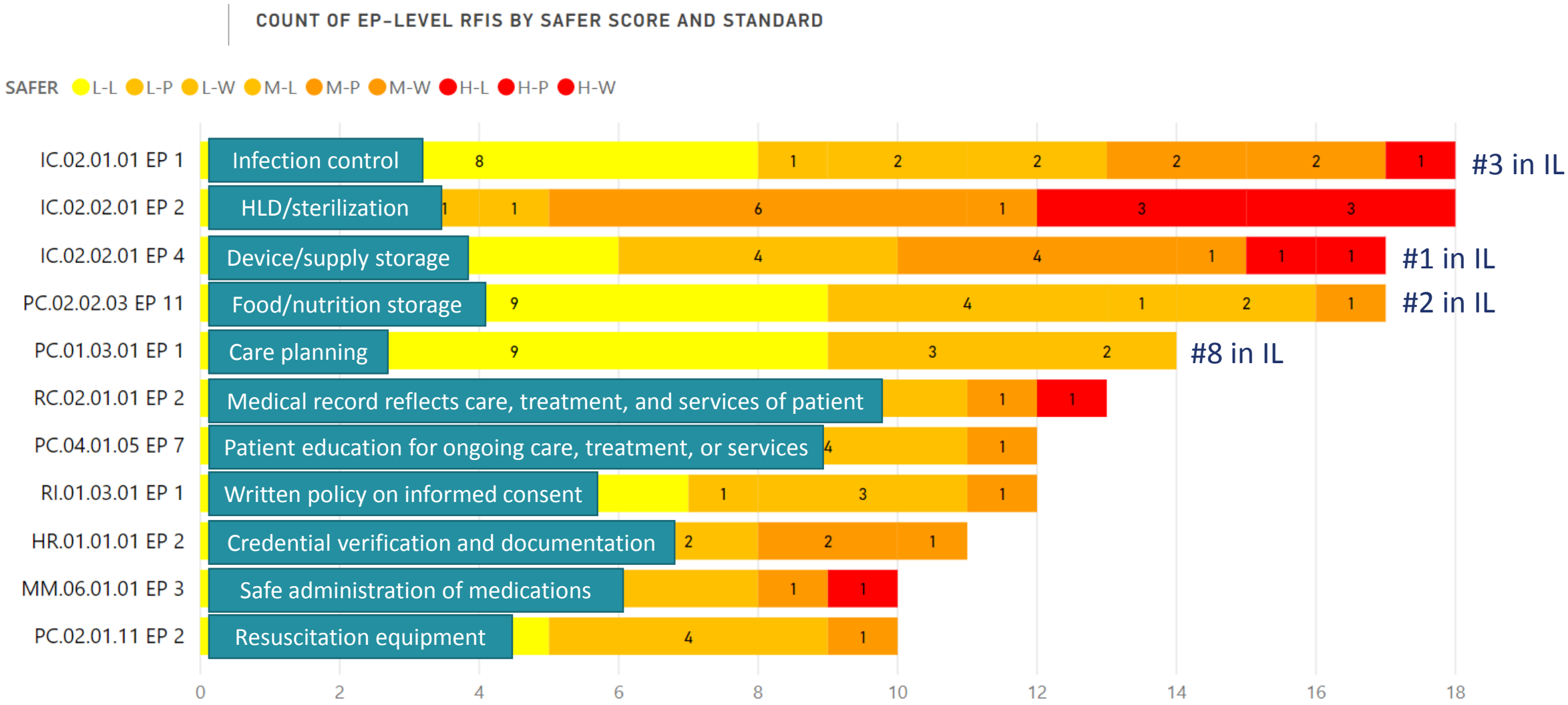
Most Frequently Cited Standards in Critical Access Hospitals

Most Frequently Cited Clinical Elements of Performance

Critical Access Hospital surveys from 01/01/2019 through 09/30/2019 (n=65)



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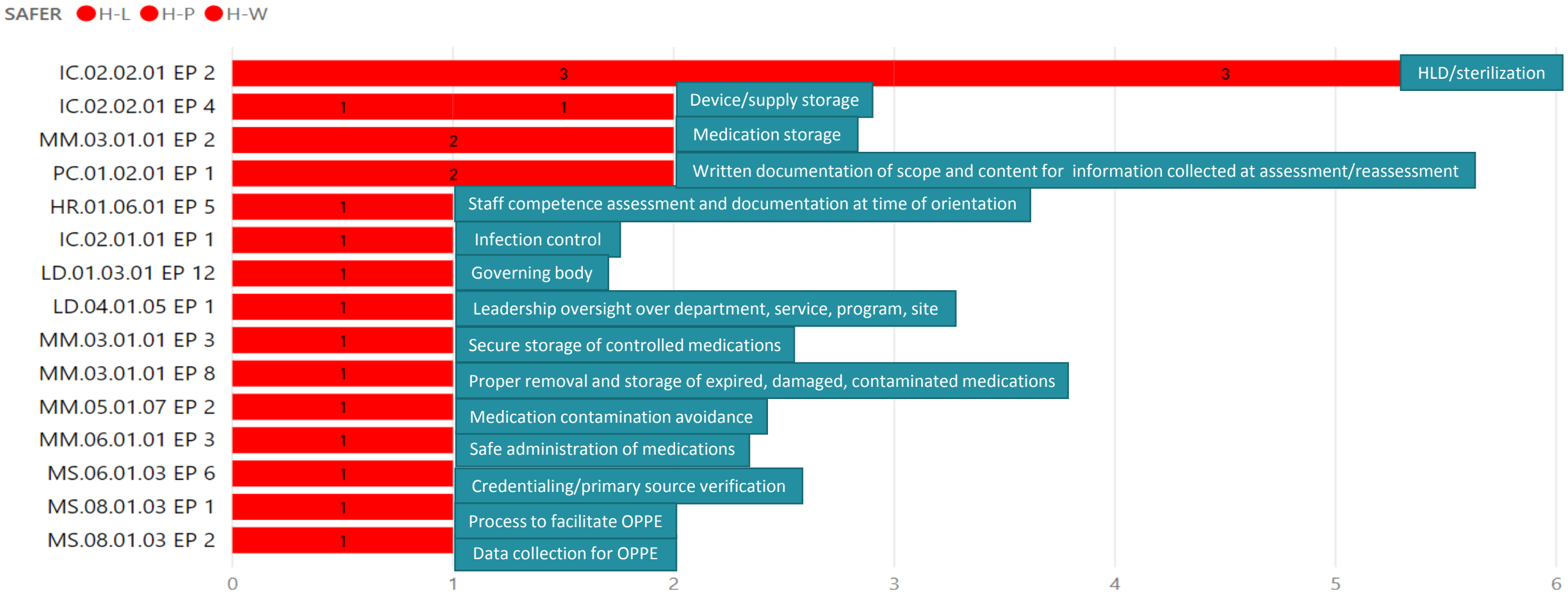
Note: Clinical EPs include all chapters in the Critical Access Hospital Accreditation manual except for the Environment of Care and Life Safety Code Chapters.

Most Frequently Cited High Likelihood to Harm Clinical EP's

Critical Access Hospitals surveys from 01/01/2019 through 09/30/2019 (n=65)

COUNT OF EP-LEVEL RFIS BY SAFER SCORE AND STANDARD



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Note: High Likelihood to harm is defined as harm could happen at any time and may directly lead to harm without the need for other significant circumstances or failures.

Top 10 Frequently Cited Clinical Standards and EP's Illinois Critical Access Hospitals

1.	IC.02.02.01, EP 4	Device/supply storage
2.	PC.02.02.03, EP 11	Food/nutrition storage
3.	IC.02.01.01, EP 1	Infection control
4.	MM.03.01.01, EP 6	Prevention of unauthorized individuals from obtaining medications
5.	MM.04.01.01, EP 13	Medication errors
6.	MM.06.01.01, EP 3	Proper administration of medications
7.	PC.01.02.03, EP 4	Physical exam within appropriate timeframe of procedure requiring anesthesia
8.	PC.01.03.01, EP 2	Care planning
9.	RC.01.01.01, EP 7	Dated medical entries
10.	RC.02.01.03, EP 7	Progress note entered in patient record prior to transferring after high-risk procedure

Most Frequently Cited Clinical EP's: Sample Observations

IC.02.01.01, EP 1 -The critical access hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

- The Ear Nose and Throat clinic performed high level disinfection. The area had not been included in the infection control risk assessment or plan and there was no infection control oversight.
- The vinyl covering was torn and frayed not allowing for proper cleaning.
- The facility was using sanitizer in the final rinse cycle of the dishwasher to provide disinfection. The sanitizer level was only being checked once daily and not at each time the dishwasher was drained and refilled for a different meal time washing per manufacturer's instructions.

Most Frequently Cited Clinical EP's: Sample Observations

IC.02.02.01, EP 2 – The critical access hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies

- Facility was not following manufacturer's instructions for use.
- Instruments were soaking in a sink that is used for hand hygiene.
- Staff were not following the correct process for high-level disinfection.
- Reusable laryngeal mask airway (LMA) are being used. The reusable LMA's have limited 40 uses or one-year reprocessing limit according to manufacturer. Staff were unaware of the manufacturer's recommendation, and were not monitoring the number of times that the LMA's were reprocessed.
- The Scope Buddy used in the cleaning process for endoscopes was not being cleaned at the end of the day per manufacturer's recommendations.

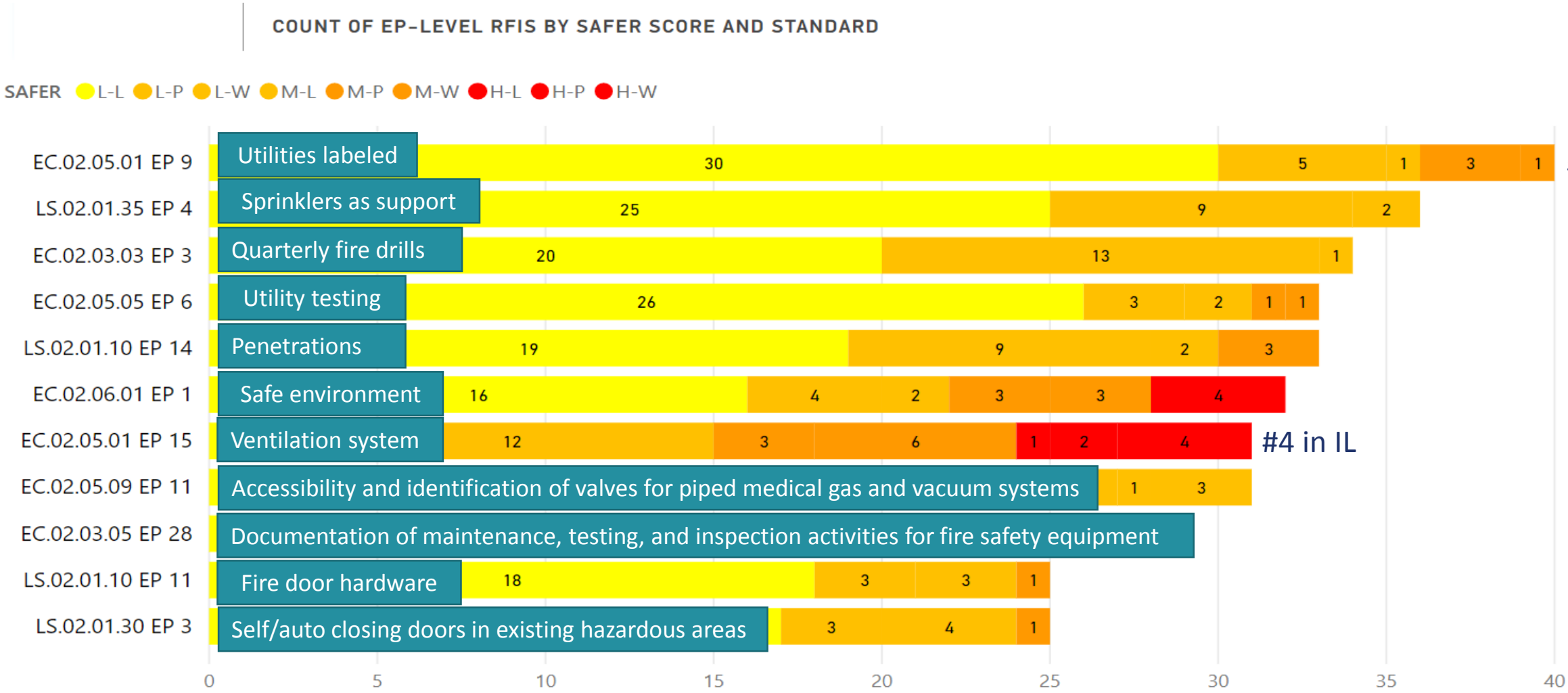
Most Frequently Cited Clinical EP's: Sample Observations

IC.02.02.01, EP 4 - The critical access hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

- OB delivery room had a vaginal probe that was not protected from contamination.
- The airway bags that are stored in the hospital owned ambulances contain six laryngoscope blades of various sizes, which were not protected from contamination.
- During a tour of the sterile storage room, it was noted that a rack with sterile instruments was stored less than two inches from an external wall. This is not consistent with AAMI guidelines, which the organization has adopted.
- Storing of scopes, the bronchoscopes, were observed hanging bent and the ends upward which did not follow manufacturer instructions for storage.

Most Frequently Cited Environment of Care & Life Safety EP's

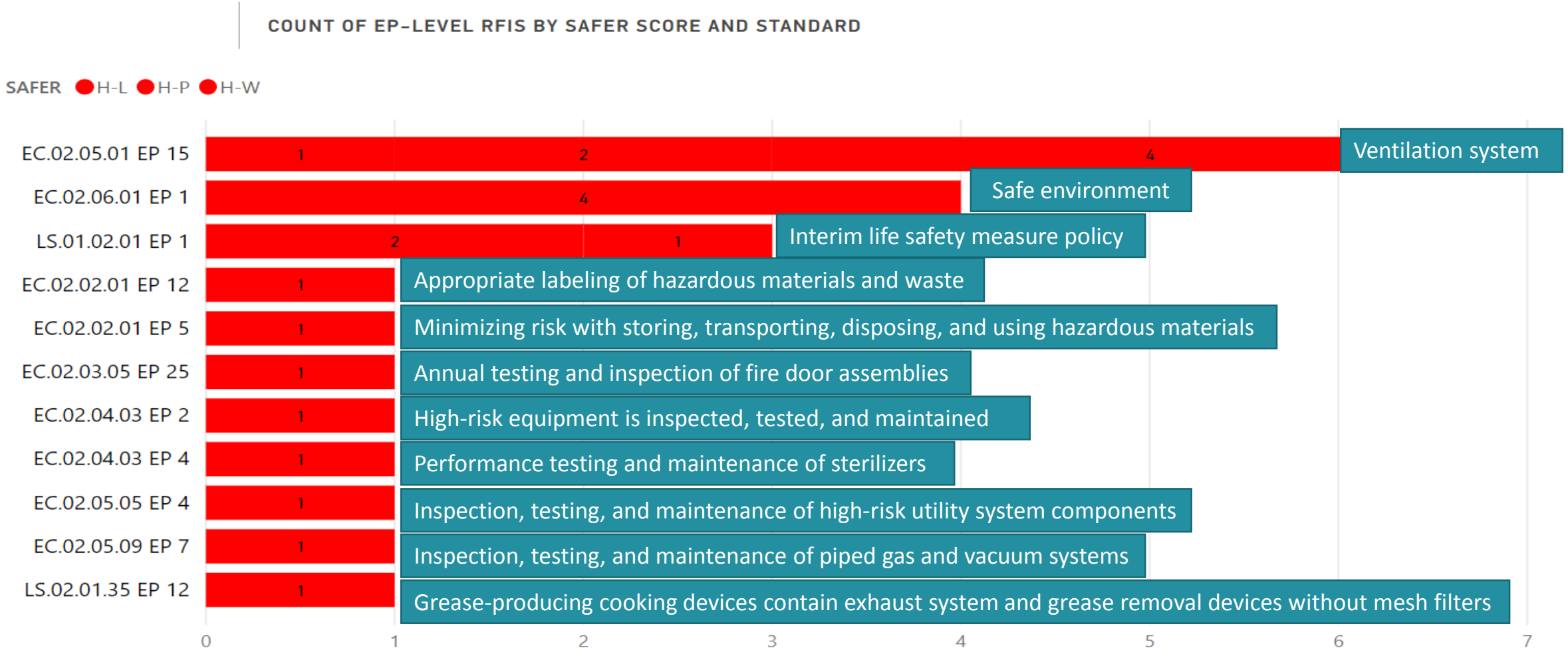
Critical Access Hospitals surveys from 01/01/2019 through 09/30/2019 (n=65)



Note: The Environment of Care and Life Safety Code chapters address general life safety design, building construction, and the physical environment.

Most Frequently Cited High Likelihood to Harm Environment of Care & Life Safety EP's

Critical Access Hospitals surveys from 01/01/2019 through 09/30/2019 (n=65)



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Top 10 Frequently Cited Environment of Care & Life Safety Standards and EP's – Illinois Critical Access Hospitals

1.	EC.02.04.03, EP 3	Non high-risk equipment is inspected, tested, and maintained
2.	EC.02.02.01, EP 5	Minimizing risk with storing, transporting, disposing, and using hazardous materials
3.	EC.02.03.03, EP 1	Quarterly fire drills, by shift, within all buildings identified as healthcare occupancy
4.	EC.02.05.01, EP 15	Ventilation system
5.	EC.02.05.01, EP 9	Utilities labeled
6.	EC.02.05.09, EP 12	Policy implementation for handling of all cylinders
7.	LS.02.01.34, EP 10	Fire alarm requirements
8.	LS.02.01.35, EP 6	18+ inches of space between top of storage and sprinkler deflector
9.	EC.02.02.01, EP 12	Appropriate labeling of hazardous materials and waste
10.	EC.02.03.01, EP 9	Written fire response plan with specific roles of staff defined

Most Frequently Cited Environment of Care & Life Safety EP's: Sample Observations

EC.02.05.01, EP 9 - The critical access hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

- Electrical Panel 42 had a circuit breaker that was on and not labeled.
- The circuit breaker that controls the main fire alarm control panel did not specifically state, "FIRE ALARM CIRCUIT" as required by NFPA 72 2010 section 10.5.5.2.2.
- In 3 of 6 Electrical panel checks panel number did not match the index and numerous numbers were missing on the breakers. Additionally, the some of the panel breaker numbers did not match the index.

Most Frequently Cited Environment of Care & Life Safety EP's: Sample Observations

LS.02.1.35, EP 4 - Approved automatic sprinkler systems piping is not used to support any other item.

- A wire was found using the sprinkler pipe as support.
- There was low voltage wiring and/or metal flex conduit lying on the fire sprinkler piping.
- Ceiling in front of the 2nd floor electrical closet there were cables and flexible conduit on the fire main.
- During ceiling inspection, conduit was observed using the sprinkler pipe for support, outside nursing station in acute care, 3 wires were observed using the sprinkler pipe as support.

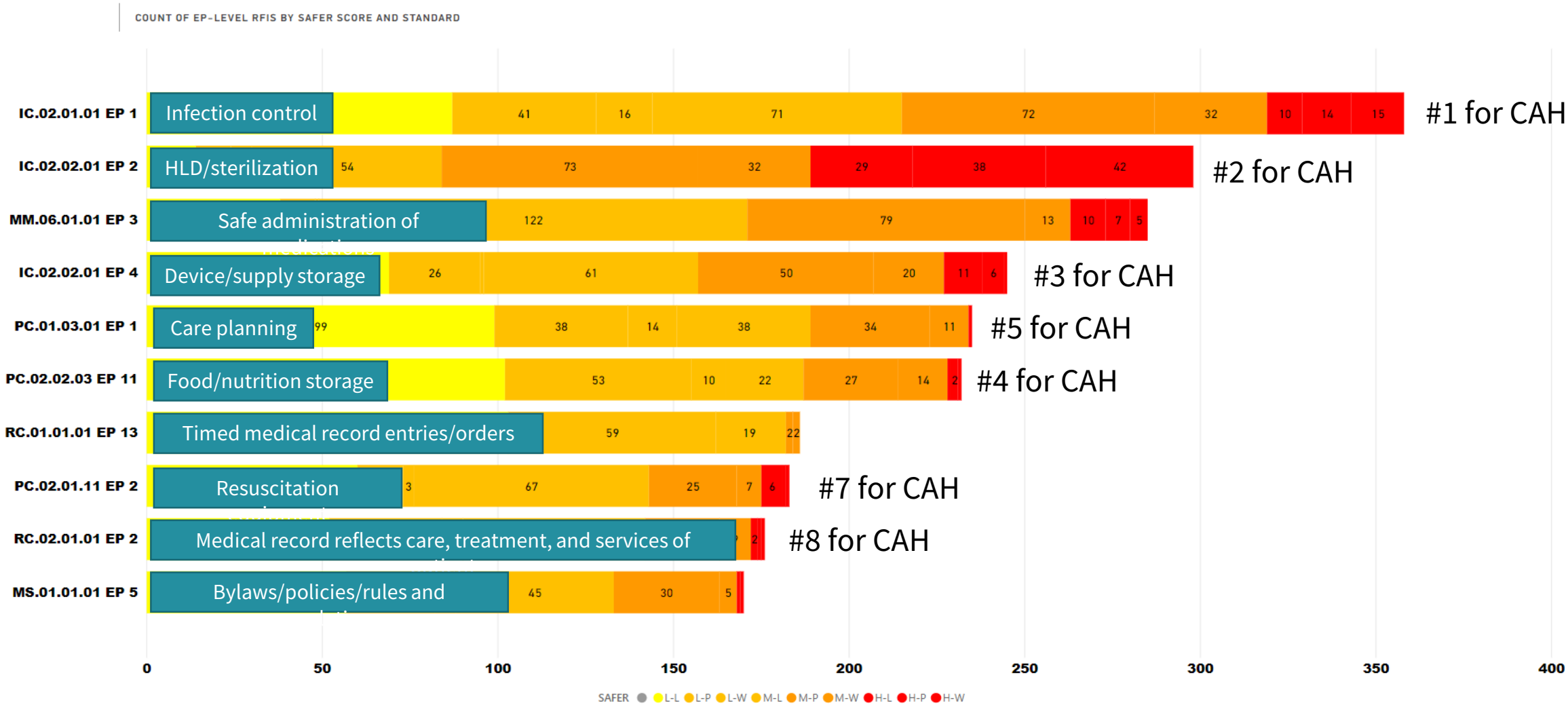
Most Frequently Cited Environment of Care & Life Safety EP's: Sample Observations

EC.02.05.05, EP 6 – The critical access hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note: Scheduled maintenance activities for non-high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the critical access hospital AEM program.

- Observed on building tour, an electrical shut off panel was blocked in Imaging X-ray. This finding was observed during survey activity but corrected onsite prior to the surveyor's departure.
- An open electrical Junction box was observed above the ceiling on the first floor by the nurses station.
- It was observed that there were combustible materials stored within 12 inches of two transformers in the engineering area. It was observed that an electrical junction box was open in the liquid oxygen yard enclosure.

Top 10 Most Frequently Cited Clinical Elements of Performance (EPs)

Comparing General Acute Care Hospitals to Critical Access Hospitals (CAH)



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Note: Clinical EPs include all chapters in the Hospital Accreditation manual except for the Environment of Care and Life Safety Code Chapters.

Quality and Safety Improvement Tools

Methods to Address Quality and Patient Safety Issues

Accreditation Activities

- Standards and survey processes
- R3 Reports
- SIG/FAQs
- Continuous Customer Engagement

Risk Reduction

- Sentinel Event Alerts
- Sentinel event review process
- Complaint analysis
- Topic specific portals
- Case examples

Education and Publications

- Published books and journals
- Seminars/webinars/conferences

Communication

- Joint Commission Online
- Website postings and news releases
- Quick Safety Alerts/advisories

Center for Transforming Healthcare

- Targeted Solutions Tools
- Center projects

Performance Measurement

- Pioneers in Quality™ portal
- Quality Check

Advocacy

- Washington, D.C. office
- Speak Up™ Campaigns

Collaboration with Professional Organizations

- Advisory Groups
- Expert Panels

Educational Resources

Evidence-based resource portals:

- Infection Prevention and Control
- Workplace Violence Prevention
- Suicide Prevention
- Physical Environment
- Emergency Management
- Transitions of Care

Addressing Patient Safety Issues – Behavioral Health/Inpatient Suicide

A complimentary publication of TheJoint Commission

Issue 18, Nov. 27, 2018
UPDATED May 6, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

Effective July 1, 2019, seven new and revised elements of performance (EPs) will be applicable to all Joint Commission-accredited hospitals and behavioral health care organizations. These new requirements are at National Patient Safety Goal (NPSG) 15.01.01 and are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide. Because there has been no improvement in suicide rates in the U.S., and since suicide is the 10th leading cause of death in the country, The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

Addressing Patient Safety Issues – Behavioral Health/Inpatient Suicide

Addressing Patient Safety Issues – Behavioral Health/Inpatient Suicide

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Case Example #3 – Part 1

Suicidal patient slips through the cracks

UPDATED: See added safety strategies on page 2

CASE EXAMPLE

A patient was brought to the emergency department (ED) via ambulance after being found unresponsive at home from an alcohol and drug overdose. The patient was given Narcan by the EMS prior to arrival and was able to participate during triage.

Upon the patient's arrival to the ED, a nurse performed a suicide screening using questions adapted for the organization's electronic medical record (EMR). Though the patient shared that he had recently lost his job and was having relationship issues, he assured the nurse that the overdose was an attempt to relax and sleep, and he denied suicidal ideation. The suicide screening was determined to be negative. While the patient's social stressors were documented in the nursing notes, they were not directly communicated to the ED physician.

The ED physician assessed the patient, noting a decrease in oxygen saturation, and consulted with the hospitalist. They decided to admit the patient to the medical floor for suspicion of aspiration pneumonia. This was the third overdose patient that shift for the ED physician, and after seeing the suicide screen as negative and hearing the patient's explanation, the physician believed the patient to have accidentally overdosed, so the physician focused on the medical aspects. Psychosocial factors were not communicated to the admitting hospitalist. Later, it was found that eight months prior, the patient had been admitted to a sister hospital for an overdose after a suicide attempt. This information was not accessed by either physician.

The patient was transferred to the medical-surgical unit. A hand-off between the ED and the receiving unit did not occur. An admission assessment and history/

The suicide screening process was driven by the EMR and did not trigger consideration for other at-risk behaviors or events. The process had become rote.

Previous admissions are cumbersome to access in the EMR.

The verbal report/hand-off with the receiving med-surg

The suicide screen was developed by the organization and was not evidence-based.

It was a busy time for the ED, limiting opportunity for verbal communication.

The inpatient suicide risk screening/assessment is accessed by a tab that the nurse must click to open and complete. As the suicide screen was negative in the ED, there was no other apparent information or prompt,

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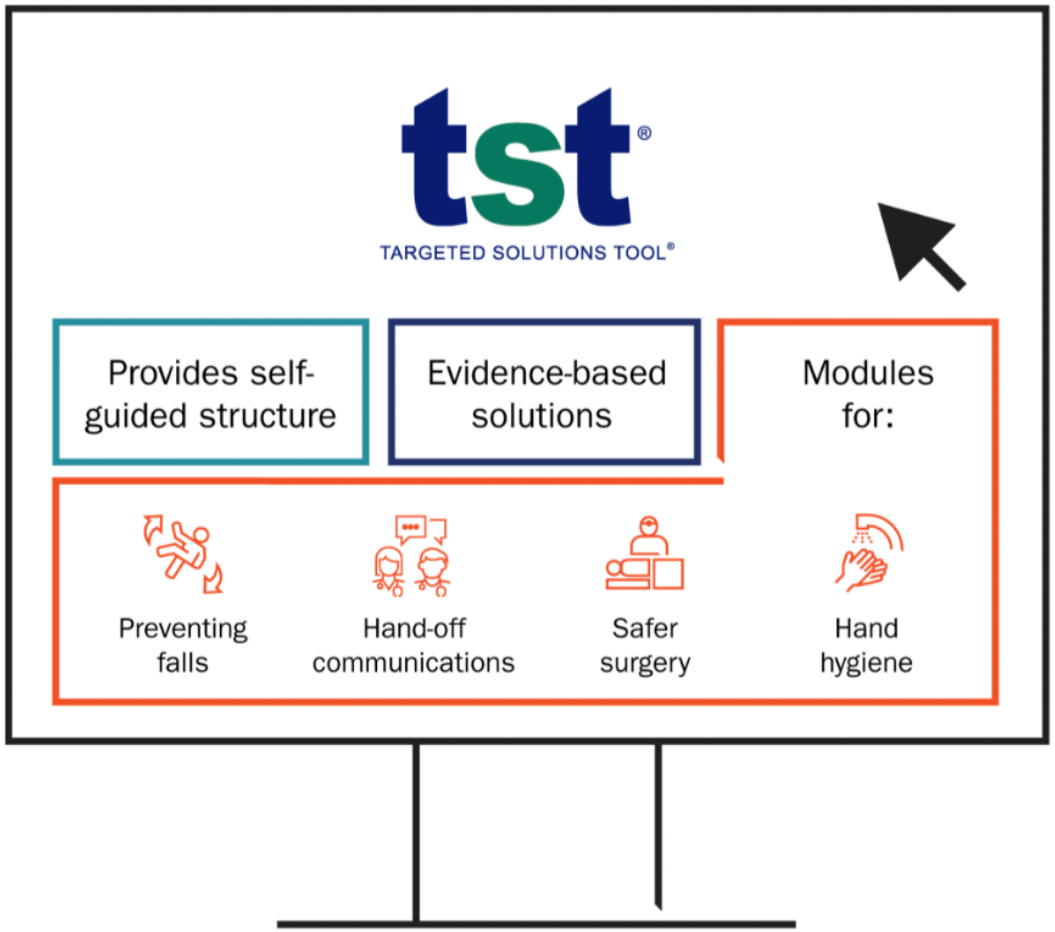
Quality and Patient Safety Solutions Tools

- Proven, highly effective improvement tools for persistent quality and safety issues:
  - Hand Hygiene
  - Safe Surgery
  - Hand-Off Communications
  - Preventing Falls
  - Sepsis
- Provides evidence-based solutions unique to your organization



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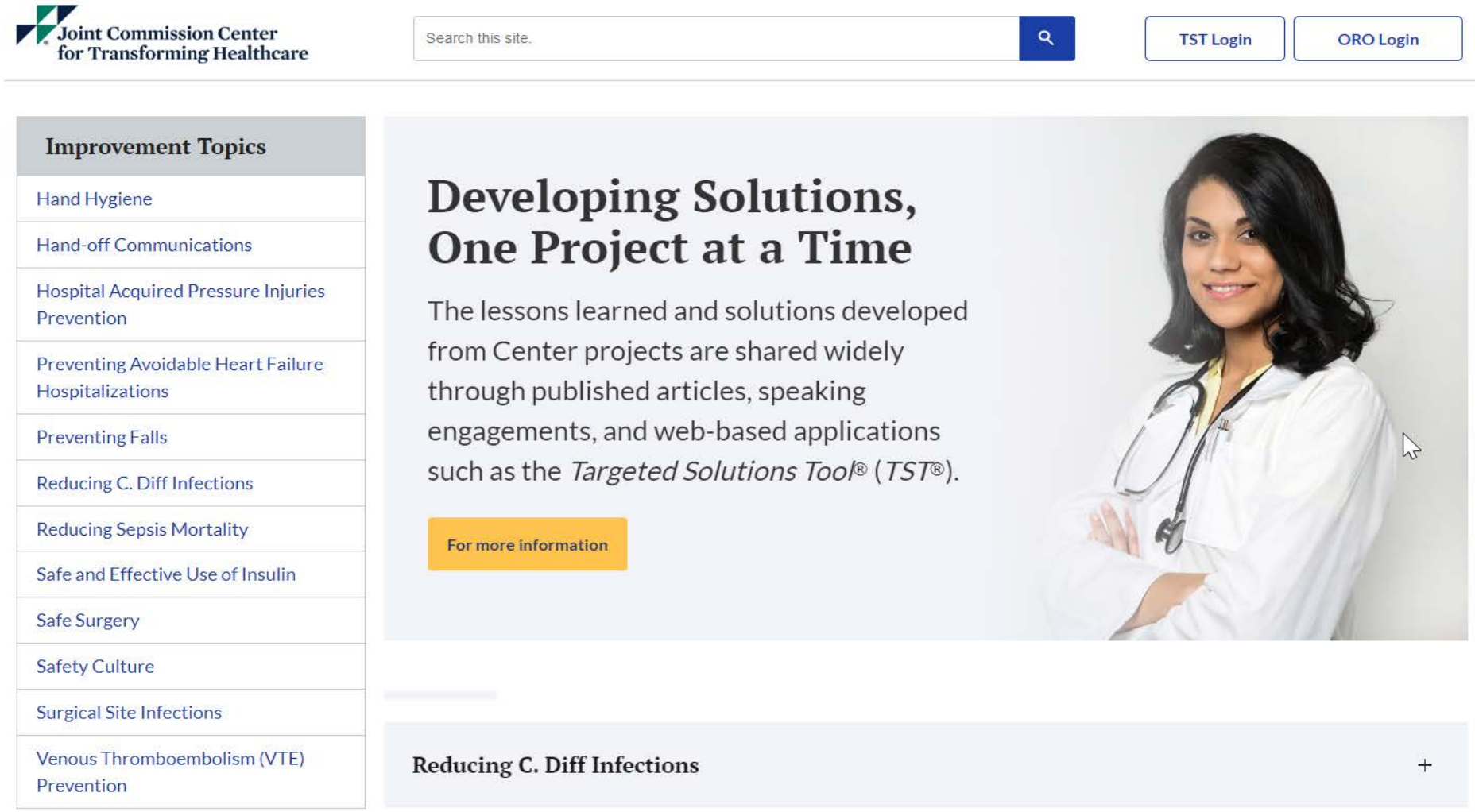
Quality and Safety Solutions



Resources to Aid in Prevention of Hospital-Acquired Conditions

HAC	The Joint Commission: Key Resources for Prevention	Cost per Occurrence*
CLABSI	• Infection Prevention & Control Portal • CLABSI Toolkit and Monograph on Website • National Patient Safety Goal (NPSG) #7 and Specific NPSG on CAUTI • Standards on Infection Control & Prevention • Performance Measures on Pneumonia • Targeted Solutions Tool on Hand Hygiene	$48,000 per CLABSI
CAUTI		$13,000 per CAUTI
Ventilator Associated Pneumonia		$47,000 per VAP
Surgical Site Infections	• Surgical Site Infection (SSI) Implementation Guide • Infection Prevention & Control Portal • Performance Measures on SCIP • Colorectal SSI Project on Center for Transforming Healthcare Website	$28,000 per SSI
Pressure Ulcers	• NPSG on Pressure Ulcers • Pressure Ulcers/Injuries Project on Center for Transforming Healthcare Website	$14,000 per pressure ulcer
Injuries from Falls	• Targeted Solutions Tool on Preventing Falls with Injury	$6,700 per fall with injury
Venous Thromboembolism	• Performance Measures on VTE • NPSG #3 – Improve the Safety of Using Medications • Center Project on VTE Prevention	$17,000 per VTE
Adverse Drug Events	• Medication Management Standards • NPSG #3 – Improve the Safety of Using Medications • Sentinel Event & Quick Safety Alerts	$5,700 per ADE
Preventable Readmissions	• Performance Measures on CHF • Standards on Discharge Planning and Care Coordination • Integrated Care Coordination • NPSG #2 – Effective Communication Among Caregivers • Transitions of Care Portal and White Papers • Center Project on CHF Readmissions • Targeted Solutions Tool on Handoff Communications	$14,000 per readmission

*Source: AHRQ 2017

Transforming Healthcare Into A Highly Reliable Industry

LEADING the way to 0

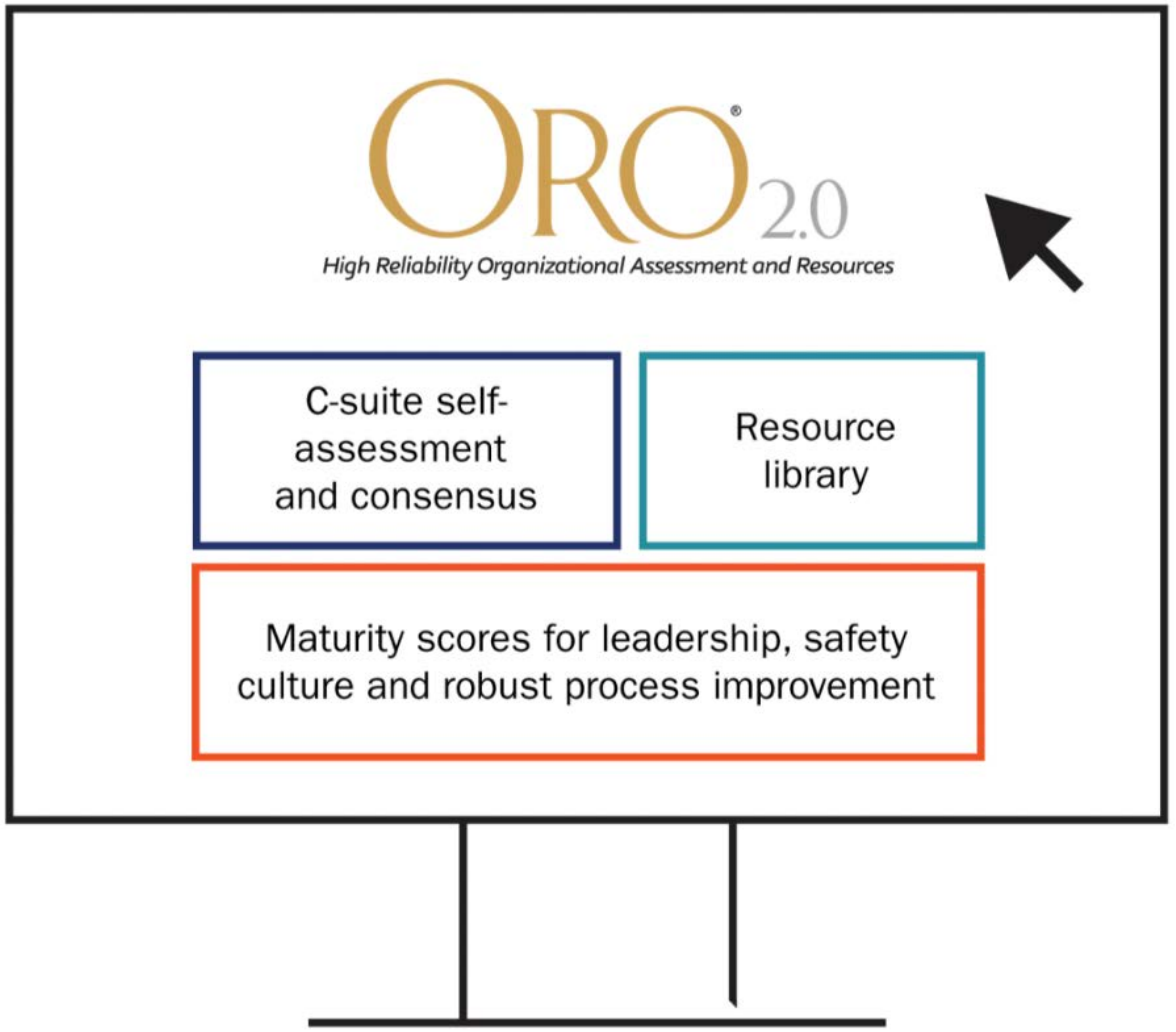
Ensure leadership is committed to a goal of zero harm

Develop and adopt a safety culture

Incorporate process improvement tools and methodologies in your work

High Reliability Assessment and Resources

- Self-assessment tool for hospitals
- Gauges an organization's maturity level (beginning, developing, advancing, approaching) towards high reliability
- Contains a resource Library with educational resources and change management strategies to assist organizations on high reliability journey



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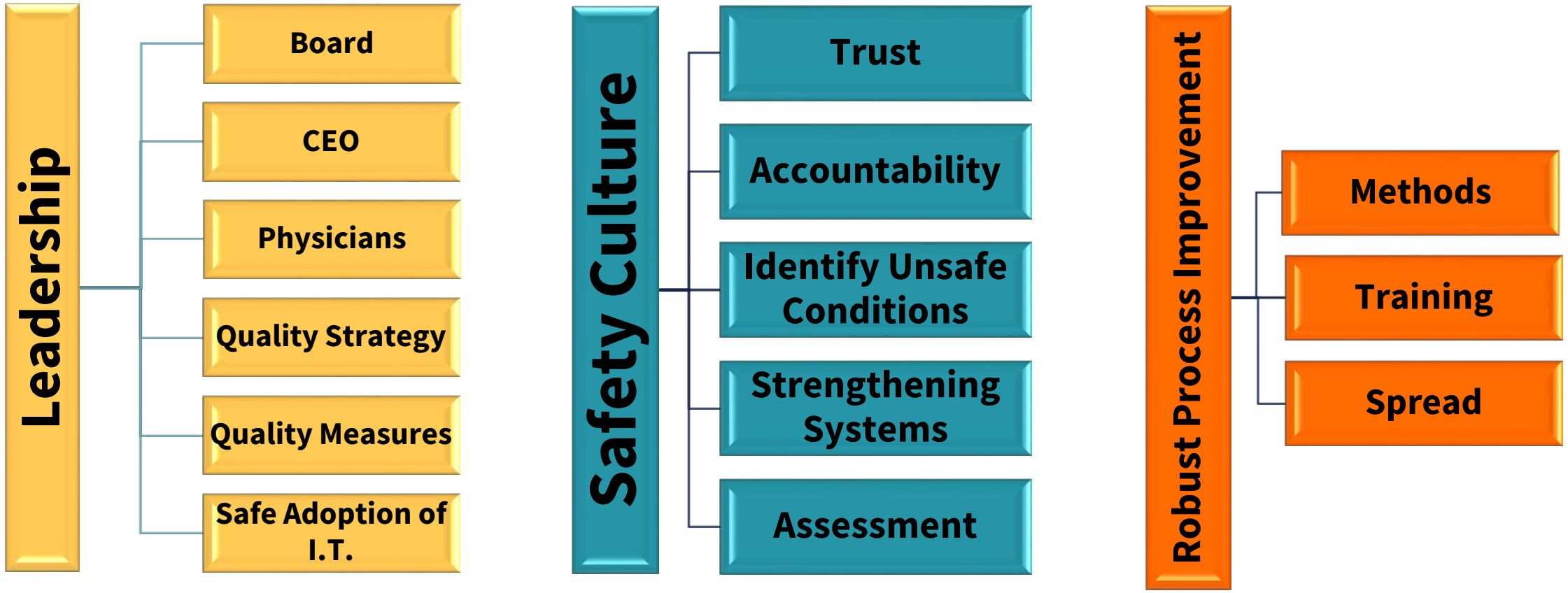
High Reliability Assessment Tool Components



Appendix

SAFER Matrix – Operational Definitions

SCOPE

Category	Definition	Further Guidance
LIMITED	Unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff	– An outlier. – Scope is isolated when one or a very limited number of patients are affected and/or one or a very limited number of staff are involved, and/or the deficiency occurs in a very limited number of locations.
PATTERN	Multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff	– Process Variation. – Scope is pattern when more than a very limited number of patients are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same patient(s) have been affected by repeated occurrences of the same deficient practice.
WIDESPREAD	Deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff	– Process Failure. – Scope is widespread when the deficiency affects most/all patients, is pervasive in the facility or represents systemic failure. Widespread scope refers to the entire organization, not just a subset of patients or one unit.

SAFER Matrix – Operational Definitions

LIKELIHOOD TO HARM

Category	Definition	Further Guidance
LOW	Harm could happen, but would be rare	– Undermines safety/quality or contributes to an unsafe environment, but very unlikely to directly contribute to harm. – It would be rare for any actual patient harm to occur as a result of the deficiency.
MODERATE	Harm could happen occasionally	– Could cause harm directly, but more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures. – If the deficiency continues, it would be possible that harm could occur but only in certain situations and/or patients.
HIGH	Harm could happen at any time	– Could directly lead to harm without the need for other significant circumstances or failures. – If the deficiency continues, it would be likely that harm could happen at any time to any patient (or did actually happen)

Preventative Resources for Emerging Healthcare Issues

Sentinel Event Alert

A complimentary publication of The Joint Commission

Issue 59, April 17, 2018

Physical and verbal violence against health care workers

"I've been bitten, kicked, punched, pushed, pinched, shoved, scratched, and spat upon," says Lisa Tenney, RN, of the Maryland Emergency Nurses Association. "I have been bullied and called very ugly names. I've had my life, the life of my unborn child, and of my other family members threatened, requiring security escort to my car."[1]

Situations such as these describe some of the types of violence directed toward health care workers. Workplace violence is not merely the heinous, violent events that make the news; it is also the everyday occurrences, such as verbal abuse, that are often overlooked. While this *Sentinel Event Alert* focuses on physical and verbal violence, there is a whole spectrum of overlapping behaviors that undermine a culture of safety, addressed in *Sentinel Event Alert* issues 40 and 57;[2,3] those types of behaviors will not be addressed in this alert. The focus of this alert is to help your organization recognize and acknowledge workplace violence directed against health care workers from patients and visitors, better prepare staff to handle violence, and more effectively address the aftermath.

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the

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Preventative Resources for Emerging Healthcare Issues

De-escalation in health care

Issue:

The need for using de-escalation techniques has become more prevalent as violence in health care settings increases. De-escalation is a first-line response to potential violence and aggression in health care settings.[1] The Centers for Disease Control and Prevention (CDC) has noted a rise in workplace violence, with the greatest increases of violence occurring against nurses and nursing assistants.[2] A three-year study in the *American Journal of Nursing* noted that 25 percent of nurses reported being assaulted by patients or the patient's family members. Statistically, higher rates of health care violence are reported to occur in the emergency department (ED), geriatric and psychiatric settings.[2]

The purpose of this Quick Safety is to present some de-escalation models[1] and interventions for managing aggressive and agitated patients in the ED and inpatient settings. There are many different de-escalation techniques; this Quick Safety is intended to guide health care professionals to resources for more information and training.

Resources for Emerging Healthcare Issues

Quick Safety

Issue 50 | July 2019

Developing resilience to combat nurse burnout

Issue:

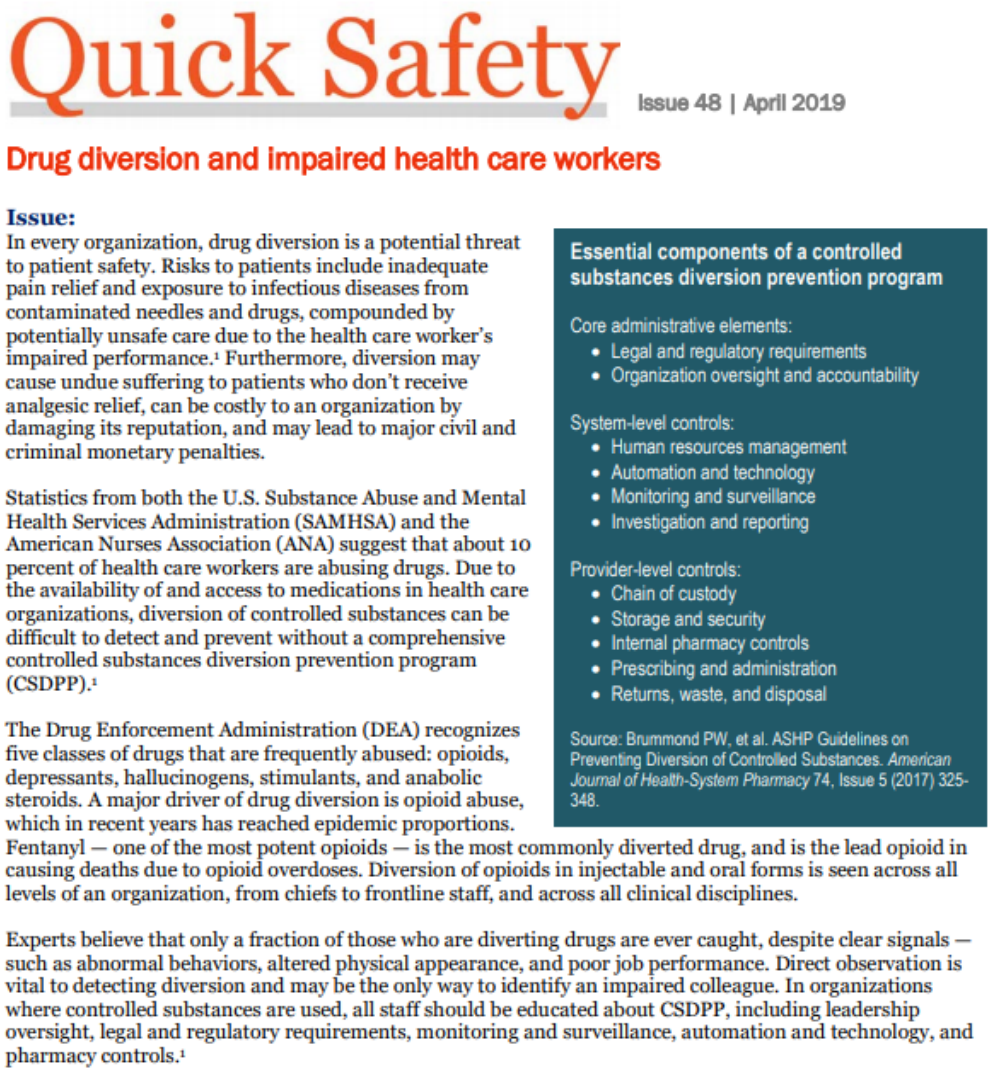
As the frontline caregivers in health care today, nurses accomplish a myriad of tasks and responsibilities, but often at high personal cost. The need to juggle competing priorities in often high-stress situations can result in feeling overwhelmed or burnout. The negative effect of these stressors can affect the ability of health care professionals to care for others.[1] Organizations have a responsibility to support nursing staff and address the causes of burnout. An emerging method to do this is by developing and fostering resilient environments and individuals.

Developing strategies for nurse resilience is a patient safety strategy, as burnout negatively affects the physical and emotional health of staff and contributes to rising costs.[2] It also has been shown to have a negative impact on patient satisfaction, worsen patient outcomes or increase rates of safety events, and increase mortality.[2] This impact is understandable given that nursing staff responsibilities include:

- Providing direct care in a highly complex environment.
- Overseeing and coordinating care and treatment provided to patients by others.
- Educating peers, patients and families.
- Supporting patients and families at critical and life-changing times.
- Advocating for the needs of patients and communities.
- Continuing personal development and staying abreast of changing practice and evolving science.
- Managing personal needs and work-life balance.

According to a national nursing engagement report released in April 2019, of the 2,000+ health care partners responding to the survey, 15.6% of all nurses self-reported feelings of burnout, with emergency room nurses being at a higher risk.[3]

Resources for Emerging Healthcare Issues



Quick Safety

Issue 48 | April 2019

Drug diversion and impaired health care workers

Issue:

In every organization, drug diversion is a potential threat to patient safety. Risks to patients include inadequate pain relief and exposure to infectious diseases from contaminated needles and drugs, compounded by potentially unsafe care due to the health care worker's impaired performance.[1] Furthermore, diversion may cause undue suffering to patients who don't receive analgesic relief, can be costly to an organization by damaging its reputation, and may lead to major civil and criminal monetary penalties.

Statistics from both the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Nurses Association (ANA) suggest that about 10 percent of health care workers are abusing drugs. Due to the availability of and access to medications in health care organizations, diversion of controlled substances can be difficult to detect and prevent without a comprehensive controlled substances diversion prevention program (CSDPP).[1]

Essential components of a controlled substances diversion prevention program

Core administrative elements:

- Legal and regulatory requirements
- Organization oversight and accountability

System-level controls:

- Human resources management
- Automation and technology
- Monitoring and surveillance
- Investigation and reporting

Provider-level controls:

- Chain of custody
- Storage and security
- Internal pharmacy controls
- Prescribing and administration
- Returns, waste, and disposal

Source: Brummond PW, et al. ASHP Guidelines on Preventing Diversion of Controlled Substances. *American Journal of Health-System Pharmacy* 74, Issue 5 (2017) 325-348.

The Drug Enforcement Administration (DEA) recognizes five classes of drugs that are frequently abused: opioids, depressants, hallucinogens, stimulants, and anabolic steroids. A major driver of drug diversion is opioid abuse, which in recent years has reached epidemic proportions. Fentanyl — one of the most potent opioids — is the most commonly diverted drug, and is the lead opioid in causing deaths due to opioid overdoses. Diversion of opioids in injectable and oral forms is seen across all levels of an organization, from chiefs to frontline staff, and across all clinical disciplines.

Experts believe that only a fraction of those who are diverting drugs are ever caught, despite clear signals — such as abnormal behaviors, altered physical appearance, and poor job performance. Direct observation is vital to detecting diversion and may be the only way to identify an impaired colleague. In organizations where controlled substances are used, all staff should be educated about CSDPP, including leadership oversight, legal and regulatory requirements, monitoring and surveillance, automation and technology, and pharmacy controls.[1]

Standards Compliance Resources

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Safety Culture Resources

The 4 Es of a Reporting Culture

1. Establish trust

- Leaders communicate their commitment to building trust and reporting through a safety culture.
- Governance supports leadership commitment to establishing trust.

2. Encourage reporting

- The organization's incident reporting system is accessible by all staff, easy to use, enables data analysis to be done in a timely fashion, and includes reports of close calls and hazardous conditions.
- The organization's recognition program includes a feedback loop so staff know that action is being taken to address or fix safety problems they have identified.
- The organization clearly defines what types of incidents should be reported. Staff may not recognize that a daily annoyance is actually an unsafe event or unsafe condition.

3. Eliminate fear of punishment

- Those who report human errors and at-risk behaviors are NOT punished, so that the organization can learn and make improvements.
- Those responsible for at-risk behaviors are coached, and those committing reckless acts are disciplined fairly and equitably, no matter the outcome of the reckless act.
- Senior leaders, unit leaders, physicians, nurses, and all other staff are held to the same standards.

4. Examine errors, close calls and hazardous conditions

- Data is used to identify error-prone situations, the frequency at which they occur, and their potential severity.
- Data also is used to identify successes of the staff and the system.
- Learnings are used to help determine what to address, to strengthen the protective processes within the system, and to help staff identify the factors that lead up to a situation and what to look out for in similar situations in the future.

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