Shared learning from incidents: A qualitative study into the perceived value of an external chair on incident investigation committees

Published as: de Kam, D., K. Grit and R. Bal (2019). Shared learning from incidents: A qualitative study into the perceived value of an external chair on incident investigation committees. Safety Science, 120, 57–66.

ABSTRACT

Despite continued calls to learn from patient safety incidents and a tradition of incident investigations in healthcare, there is discussion about if and how learning from incidents occurs. In this article, we study a policy change in the Netherlands that aims to encourage organisations to learn more from incidents. Dutch healthcare organisations investigate their own incidents. Recently, the Dutch government decided that when an incident leads to the death of a client in elderly or disabled care, an external chair should head the investigation committee. Thinking of learning as social, participative practice, we asked how and under what conditions an external chair might help organisations learn from incidents. We adopted a qualitative research design. We asked healthcare inspectors to assess 20 incident investigation reports by committees with (10) and without an external chair (10), using what we learned in follow-up interviews and a focus group. We interviewed investigation committee chairs, professionals involved in incidents, quality advisers and directors of four healthcare organisations (n=15) to study how they investigated incidents with external chairs. We also interviewed external chairs, healthcare inspectors and other stakeholders (n=15). Our respondents valued external chairs' methodological expertise and experience in investigating incidents. The external chair's outsider's position enables critical, impartial inquiry. Besides helping organisations identify root causes of an incident, both external chairs and organisations learn from investigating an incident. Our article contributes to literature on (shared) learning from incidents by envisioning of the external chair as fostering a social and participative form of shared learning.

INTRODUCTION

Although learning from patient safety incidents and designing reporting systems that facilitate learning have been a top priority in healthcare since *To Err is Human* (Howell et al., 2017; Kohn et al., 1999; Macrae, 2016), it remains unclear whether the widespread adoption of incident reporting has truly made healthcare safer (Howell et al., 2017; Mitchell et al., 2016; Shojania and Thomas, 2013; Stavropoulou et al., 2015). Healthcare organisations face a wide range of increasingly well-documented challenges in the attempt to learn from incidents (Anderson and Kodate, 2015; Hibbert et al., 2018; Howell et al., 2017; Macrae, 2016; Mitchell et al., 2016; Peerally et al., 2016). These challenges range from using findings of the analysis of singular incidents as driver for learning at deeper levels or failing to provide feedback to staff after incident investigations (Macrae, 2016; Peerally et al., 2016). Despite such challenges, the belief that reporting and investigating incidents offers important learning opportunities to improve the safety of care practices is not abandoned (Le Coze, 2013). Rather, there is a call for "more sophisticated infrastructures for investigation, learning and sharing, to ensure that safety incidents are routinely transformed into systemwide improvements" (Macrae, 2016, p. 74).

In the Netherlands, the discussion on the need to learn from incidents and the question of how to do so, is equally dominant (De Bruijn, 2007; Inspectorate, 2016a; Leistikow et al., 2017). The national regulator that monitors quality and safety of care, the Dutch Health and Youth Care Inspectorate (Inspectorate), features prominently in this discussion. The Inspectorate maintains that healthcare organisations should learn from incidents (Inspectorate, 2016a; Leistikow et al., 2017). To that end, healthcare organisations are required to report all serious incidents to the Inspectorate, investigate incidents and report back on their findings. The Inspectorate reviews how healthcare organisations investigated serious incidents with a scoring instrument that aims to "[quantify the] quality of the learning process" (Leistikow et al., 2017, p. 2). Key to the Inspectorate's pedagogy is the conviction that healthcare organisations learn more from investigating their own incidents than if the Inspectorate, or any other external body, conducts the investigation (Inspectorate, 2016a; Kok et al., 2019; Leistikow et al., 2017). This notion is in line with literature that proposes "learning should be as close as possible to the shop floor and the actual workers to be involved" (Lukic et al., 2010, p. 430).

Recently, this conviction was challenged. When national media reported on healthcare organisations trying to conceal incidents (Kuiken, 2015; Van Es, 2013), politicians called for more independent investigations. They questioned both the trust the Inspectorate puts in healthcare organisations to investigate their incidents openly and properly as well as the idea that organisations would learn less if their incidents were investigated by an external party (Dutch House of Representatives, 2015). Following discussions with the Inspectorate, the Dutch Ministry of Health decided that an external

chair should head the investigation committee if a serious incident led to the death of a client in elderly and disabled care organisations (Dutch Ministry of Health, 2015). Appointing an external chair strikes a balance between having an investigation conducted by a team comprised of employees or by a fully independent, external team or agency. It is a compromise between the Inspectorate's emphasis on 'internal' investigations and the government's call for 'external' review. Allowing healthcare organisations to conduct their own investigations, the Inspectorate stimulates organisations to take 'active responsibility'; organisations can acknowledge responsibility for an incident and commit to work at preventing the occurrence of future incidents, rather than being passively held responsible for an incident (Braithwaite and Roche, 2000). Although an external chair brings an independent perspective on an organisation, organisations are still themselves responsible and accountable for the incident investigation.

The idea of appointing an external chair is inspired by the practice of Dutch prisons, where it is customary for investigations into the death of an inmate to be headed by a director of a different prison, ensuring an independent investigation (Dutch Ministry of Health, 2015). Elderly and disabled care were targeted specifically because whereas hospitals have improved in investigating and learning from incidents (Leistikow et al., 2017), it was claimed elderly and disabled care organisations have not (Dutch Ministry of Health, 2015). It was believed elderly and disabled care would stand to learn most from external chairs (Dutch Ministry of Health, 2015). External chairs were thought to be most needed in cases of serious incidents leading to the death of a client, although the Ministry stated no reason for this (Dutch Ministry of Health, 2015). An external chair should have no ties to the healthcare organisation that enlists the help of that chair, but no other criteria of eligibility are prescribed by the Inspectorate. In a letter addressed to the professional association of the Dutch disabled care sector, wherein the Inspectorate describes what it expects of organisations in this new way of working, the Inspectorate writes: "Appointing an external chair is the responsibility of the healthcare organisation. The healthcare organisation has to consider what skills [the external chair] should possess and how these skills fit the specific incident and the expertise of the investigation committee." (Inspectorate, 2015b) It is up to the organisation, in other words, to decide what a capable external chair is. In Dutch healthcare policy, it is common that healthcare organisations are provided room to adapt policies, while also making them responsible for doing so in a fitting way (van de Bovenkamp et al., 2014). Equally, the Inspectorate did not specify the role or responsibilities of an external chair (Inspectorate, 2015b). The Ministry claimed that appointing an external chair to head the investigation would bolster impartiality and "strengthen the capacity to learn [from incidents] and limit chances of recurrence" (Dutch Ministry of Health, 2015, p. 3). The Inspectorate also "expects organisations to learn more from mistakes by appointing an external chair" (Inspectorate, 2015c, p. Online press statement). It is unclear, however, what constitutes

an external chair's impartiality, how it might contribute to an investigation and why or how an external chair might help organisations learn from incidents.

Our aim

In this article, we study what the obligation to appoint an external chair accomplished. Our article is no 'classic' programme theory evaluation, intent on testing whether the policy's stated objectives—improved learning from incidents so that future incidents might be prevented—are realised in practice. Rather, we recognise that policy is "characteristically ambiguous" and that a policy's effects, intended or unintended, stated or unstated, are shaped by and valued within complex, local practices (Jones, 2018, p. 264). Our article, in that sense, is an attempt at "more broadly conceived [research]", advancing "a more general orientation to what is being accomplished, whether organization is moving in a fruitful direction and the conditions that support this" (Jones, 2018, p. 266). Having said that, our focus is not without demarcations as we attend, broadly, to the relationship between enlisting the help of an external chair in investigating incidents and learning from incidents. We think of learning as "a complex social and participative process that involves people actively reflecting on and reorganising shared knowledge, technologies and practices" (Macrae, 2016, p. 74). In doing so, we adopt a constructivist perspective on learning (Le Coze, 2013) and propose that learning is a social, participative activity, accomplished in and through practice (Drupsteen and Guldenmund, 2014; Le Coze, 2013; Lukic et al., 2010; Macrae, 2016). In this article, we are interested in *how* external chairs might help organisations learn from incidents and under what conditions, since this can help us define mechanisms for stimulating learning from incidents. We hope to contribute to literature that envisions learning from incidents as a social, participatory practice by reflecting on how enlisting external chairs, as organisational outsiders, might enable shared learning from incidents. For our article's key findings, see box 1.

Serious incidents in the Netherlands

A serious incident (*calamiteit* in Dutch) is defined in Dutch law as an unintended and unexpected event, related to the quality of care and having caused death or serious harm to the patient. Organisations are legally required to report serious incidents to the Inspectorate (Inspectorate, 2016b). After having reported a serious incident to the Inspectorate, healthcare organisations are granted eight weeks within which they are expected to investigate the incident and report their findings to the Inspectorate.

While what constitutes serious incidents in elderly and disabled care varies—as are the ways in which organisations report on their investigations of serious incidents—it might be helpful to share examples of serious incidents we encountered in our research and how organisations report on these incidents. We describe two 'typical incidents'

Box 1: Key findings

- While the possibility of learning from incidents is questioned in the literature, our research found that the figure of the external chair helps organisations better identify root causes.
- External chairs are valued for their 'fresh perspective'; external chairs are both familiar with the care practices of the organisations they investigate incidents in, yet unfamiliar with and untied to these organisations. This puts external chairs in a position to develop a critical perspective on the organisation and its practices.
- Using an external chair in investigating incidents is situated between internal investigations and external review. While internal investigations typically emphasise the need to locally embed the learning process and external reviews argue for the need for critical, impartial inquiries, our research suggests that appointing an external chair can do both. Members of the organisation are still involved and invested in investigating and learning from a local incident, while the external chair strengthens an impartial, critical inquiry.
- Using an external chair can prompt a form of participative shared learning, wherein the organisation learns from investigating an incident with the help of an external chair, but wherein the external chair learns too.

in elderly and disabled care, given the challenges that providing care to elderly and disabled people presents.

In elderly care, fall-related serious incidents comprises a particular type of incident that is well-known, can severely impact clients and are challenging to fully prevent (Nurmi and Lüthje, 2002). In one incident, a nurse had just dressed a 90-year old woman, who sat on the side of her bed (that was lowered given the earlier identified risk of falling as assessed by staff) and just as the nurse turned to transfer the woman to her wheelchair using a lift, the woman fell forward, out of bed, hitting her head on the floor. Two days after falling out of bed, the woman passed away.

People with intellectual disabilities are prone to suffer from dysphagia (swallowing disorders) and dysphagia-related serious incidents, where people choke while eating, are not uncommon in disabled care (Hemsley et al., 2015). In one incident, a 68-year old man with an intellectual disability, a diagnosed mental disorder and compulsive behaviour, who was known to want to eat a lot and too fast, choked while eating bread. Despite the efforts of staff, who were quick to perform the Heimlich manoeuvre and resuscitation efforts by emergency personnel, the man died.

The incident investigation typically follows a particular order—that corresponds to the root cause analysis methodology abbreviated as PRISMA (*Prevention and Recovery Information System for Monitoring and Analysis*), that the Inspectorate supports and that

is often adopted by organisations. A description of the incident itself is preceded by a description of the client and the care the client received at the organisation. Following that, events preceding the incident (e.g. previous falls of a patient or actions taken by the organisation to prevent falls, like lowering the bed), the incident itself and events after the incident (e.g. aftercare provided to family) are reconstructed. The level of detail of such reconstructions varies; some reports reconstruct events as they unfolded hourly or daily—with reconstructions of events running for multiple pages—while others are quite concise. Following the PRISMA methodology, investigations target organisational (e.g. does the organisation have a policy on re-assessing clients with an intellectual disability on choking risks, if a client has been assessed some years before?), technical (e.g. did technology or equipment, like computer systems or lifts, contribute to the incident?) and human factors (e.g. did staff notice the choking client and did they take appropriate actions?) that might have contributed to the incident. In the elderly care incident, the report concluded that while the incident could not have been prevented, the anticoagulants the woman had been administered—the usage of which was not periodically reassessed due to organisational changes—might have exacerbated the effect of the fall. In the disabled care incident, the report equally found that the organisation and staff had done much to prevent such incidents (the food was cut into small enough pieces, in line with the speech-language pathologist's recommendations), but also noted that staff struggled to open the emergency briefcase of the doctor when asked to, because they were unaware which of the multiple keys attached to the case would open it. The right key was labelled afterwards. In line with the identified contributing factors, recommendations are formulated according to SMART-criteria (e.g. developing and implementing a policy to re-assess risks of choking for clients with an intellectual disability annually).

The investigation committee typically consists of 3-5 people that, in line with the scoring instrument used by the Inspectorate (see box 2, item 1), is multidisciplinary, featuring physicians or medical specialists, nurses, managers and quality advisers. The committee determines who it needs to speak to in order to be able to reconstruct the incident, such as professionals directly involved in the care for the client and those present at the time of the incident. The committee might also speak to external experts (e.g. a speech-language pathologist in case of dysphagia-related incidents). The 20 reviewed incident reports range from 5 to 29 pages, averaging 15 pages in length. Prior to the need to appoint external chairs, it is good to note, quality advisers or medical directors typically acted as internal chairs of investigation committees. Organisations made sure that internal chairs did not work at, or were overtly familiar with the departments where the incident occurred. Staff that took up the role of internal chair were trained in incident investigation methodologies.

Box 2: Scoring instrument to assess the quality of incident investigations

Process

1 Is the investigating committee multidisciplinary?
2 Were any members of investigating committee involved in the incident?
3 Is the method for analysis specified? (e.g., root cause analysis (RCA))
4 Was input sought from all personnel directly involved?
5 Was input sought from other staff with knowledge about the care process?
6 Was input sought from the patient/relatives?

Reconstruction

7 Does the description of the event give a complete picture of the relevant 'scenes'?

Analysis

8 Has the question 'why' been asked extensively enough to analyse the underlying cause and effect?
9 Have the investigators searched relevant scientific literature?
10 Does the report state whether applicable guidelines/protocols were followed?
11 Was external expertise consulted?
12 Does the report state whether the medical indication for the provided care was correct?

Conclusions

13 Does the report identify root causes?
14 Do the root causes fit the reconstruction and analysis?
15 Are contributing factors considered and/or identified?
16 Are contributing factors, not under the control of the healthcare organisation, considered and/or identified?

Recommendations

17 Does the report document recommendations for improving processes and systems?
18 Do these corrective actions address the identified root causes?
19 Have the corrective actions been formalised? (e.g., Specific, Measurable, Attainable, Realistic and Time-Sensitive (SMART))
20 Does the healthcare organisation have an evaluation plan to determine if the recommendations are implemented?
21 Does the healthcare organisation have an evaluation plan to determine the effect of the recommendations?

Aftercare

22 Is the aftercare for the patient/relatives described?
23 Is the aftercare for the professionals involved described?
24 Has the report been shared with the patient/relatives?

Reaction of the board of the healthcare organisation

25 Is the reaction of the board adequate?

METHODS

Data collection

In order to understand what the obligation to appoint an external chair might accomplish, we opted for a qualitative research approach. To gain an initial understanding of how external chairs might help organisations learn from incidents, we asked five healthcare inspectors from the Inspectorate ('inspectors' hereafter) to individually score a random selection of incident investigation reports predating (n=10) and following the policy change (n=10). Both batches contained five elderly care and five disabled care reports from various healthcare organisations. The inspectors scored the reports with the instrument the Inspectorate uses to assess the quality of incident investigations (Leistikow et al., 2017). This instrument contains 25 'yes or no' items (see box 2). If all items are 'yes', the report scores 100%. We took the average of the scores awarded by all inspectors. Our aim of asking inspectors to assess the included incident investigation reports was to explore and understand, with inspectors, how reports predating and postdating the policy change might differ. We did not statistically test for differences between the reports predating and postdating the policy change and draw no causal inferences about the relationship between the presence of an external chair and the quality of the incident investigation (report). Rather, the inspectors' assessment of these reports served as starting point for inquiring what involving an external chair in incident investigations might mean in terms of learning from incidents. Therefore, following the scoring phase, we held a 2.5-hour focus group with three inspectors and conducted individual interviews with the remaining two inspectors, whose busy schedules prevented them from joining a focus group. In both focus group and interviews, we discussed why the inspectors scored reports the way they did.

In consultation with the Inspectorate, we selected four healthcare organisations (two elderly care and two disabled care organisations, spread throughout the country and varying in size) that had recently reported fatal incidents. In the Netherlands, the disabled care sector encapsulates organisations that cater to people with intellectual or learning as well as physical challenges. The two disabled care organisations we studied serviced people with intellectual challenges (see table 1). In one elderly and one disabled care organisation, the serious incident occurred just before the policy change, so that external chair involvement was not required, whereas the other incidents did involve external chairs.

The Inspectorate introduced us to all four organisations. We emailed their CEOs, detailing the objective of our study and requesting their participation. All approached organisations agreed to participate. Within these four organisations we interviewed (external or internal) chairs of the investigation committees, healthcare professionals involved in the incident, quality advisers and members of the board of directors (total

Table 1: Characteristics of studied organisations

Organisation	Number of clients	Number of staff	Investigation headed by
Elderly care organisation A	<1000	<1000	Internal chair
Elderly care organisation B	7500 – 10.000	5000 – 7500	External chair
Disabled care organisation C	2500 – 5000	2500 – 5000	External chair
Disabled care organisation D	1000 - 2500	2500 – 5000	Internal chair

All organisations operate regionally and cater to people on various locations throughout the region, that range in size from larger, multi-storied facilities that house more than 60 clients, residential homes that house a handful of clients, to clients that live in their own home and receive care there. Publicly available annual reports were consulted to provide the organizational characteristics provided here. However, to ensure the anonymity of the studied organisations, links to these documents will not be provided and the number of clients and staff reported were rounded off.

n=15). Prior to the interviews, the Inspectorate provided us with the incident reports of the four organisations and in the interviews, the incidents served as a case that allowed us to discuss incident investigation practices. These interviews allowed us to study how incidents were investigated and how the involvement of the external chair was organised and valued. While the incidents we discussed in organisations A and D were investigated with internal chairs, respondents also talked about incident investigations that they had since conducted with the help of external chairs. The four incident reports from the organisations were not part of the 20 reports scored by inspectors. To understand the (un)intended and perceived effects of the policy, as well as how the policy came about, we interviewed representatives of professional associations in elderly and disabled care (n=4), healthcare inspectors (n=7), politicians (n=2), an experienced external chair (n=1) and a director of a prison (n=1). Interviews were structured through interview guides that were prepared by the first (DdK) and second author (KG). The interview guides were tailored to respondent's positions and experience and adjusted given what we had learned from previous interviews.

Data analysis

In all, we conducted 30 interviews that lasted 61 minutes on average. With the respondents' consent, both the focus group and interviews were recorded and transcribed verbatim. The transcripts were analysed and inductively coded with the aim to identify themes (Green and Thorogood, 2018). DdK first coded the transcribed material, generating a wide range of codes. Following that, all authors discussed the codes that were then clustered and identified as emerging themes. We identified five (interrelated) main themes: the selection of external chairs, the role of external chairs, the value of external chairs, difficulties in involving external chairs and learning from investigating incidents with external chairs. The presentation of our findings will be structured in line with these themes.

FINDINGS

In the first year after the policy change, elderly and disabled care organisations reported 289 serious incidents that caused the death of a client. Most incidents (256) were reported in elderly care (Inspectorate, 2016c).

Scoring the incident investigation reports

Table 2 lists the average scores for the 20 incident investigation reports we asked inspectors to score, as well as the standard deviation (SD) per group of clustered reports.

Keeping in mind that we did not statistically test for differences, we want to make three tentative observations on how the inspectors assessed the investigations reports. We explored these further in the follow-up interviews and focus group. First, the ten reports before the policy change averaged 59.7, while the ten reports after the policy change averaged 77.0. Second, inspectors scored elderly care reports lower (52.6) on average than disabled care reports (66.8) before the policy change. After it, the difference between elderly care (75.9) and disabled care (78.1) is almost negligible. Finally, it is striking that after the policy change, no report is scored as low as any of the reports predating the policy change (29.3 and 33.0 in elderly and 38.0 in disabled care). The standard deviation of the scored reports before and after the policy change decreased (from 20.6 overall to 8.1).

Table 2: Scored investigation reports

Elderly care reports before policy change		Disabled care reports before policy change	
Report 1	69.0	Report 6	73.3
Report 2	52.3	Report 7	64.0
Report 3	79.3	Report 8	68.7
Report 4	29.3	Report 9	90.0
Report 5	33.0	Report 10	38.0
Average reports before change	52.6 (SD 21.8)	Average reports before change	66.8 (SD 18.9)
Average elderly and disabled care reports predating the policy change			59.7 (SD 20.6)

Elderly care reports after policy change		Disabled care reports after policy change	
Report 11	84.0	Report 16	81.0
Report 12	70.3	Report 17	68.7
Report 13	69.3	Report 18	67.3
Report 14	82.7	Report 19	83.0
Report 15	73.3	Report 20	90.3
Average reports after change	75.9 (SD 7.0)	Average reports after change	78.1 (SD 9.8)
Average elderly and disabled care reports after the policy change			77.0 (SD 8.1)

The inspectors' take on the incident investigation reports

In the follow-up interviews and focus group, we asked inspectors how they scored the reports and what they thought accounts for their scores.

Inspectors noted that post-policy change reports adequately addressed the process and analysis items of the investigation (see box 2). Understanding what happened is key, they argued, as the rest of the report builds upon that.

> What happened has to be clear (…) so I can tell if the root causes are properly identified. This is where it starts; it determines the next steps and whether or not these steps make sense. (Inspector, disabled care 6)

When asked why inspectors scored post-policy change reports higher than the predating reports, most inspectors argued that this is at least partly due to external chairs. One inspector noted that involving an external chair ensures a certain level of quality in investigating and reporting on incidents, snuffing out the 'really bad' reports (Focus group inspectors), which is in line with the scores in Table 2. Another inspector stated that, with external chairs, more investigations identify root causes.

> We see better reports in elderly care [when an external chair is involved]. Most investigations can identify root causes better. Before, we saw organisations stopping [analysis] too early and we'd say: 'If only you'd asked more questions'. So, the medication got swapped. [The organisation said,] 'The professional didn't follow protocol', period. 'So what do we do? We will better implement protocols'. But we don't know why she didn't follow protocol. Was it a busy nightshift? Did she have problems at home? Did she not feel well? [Such] root causes (…) weren't addressed [well] enough in earlier investigations. (Inspector, elderly care 2)

Inspectors were hesitant to attribute the improvement in reports solely to the external chair though. Inspectors noted that organisations might have become better in investigating incidents over time and recounted that in the past the Inspectorate had stressed the need to properly investigate incidents. Since 2014, the Inspectorate provides organisations that report an incident with a guideline that specifies what the Inspectorate expects of the investigation. This guideline overlaps considerably with the scoring instrument the Inspectorate uses to assess investigation reports (Inspectorate, 2016d). In outlining conditions known to contribute to thorough incident investigations, the Inspectorate hoped healthcare organisations would invest and improve upon their investigative practices (Kok et al., 2019; Leistikow et al., 2017). The external chair is part of wider efforts aimed at stimulating learning from incidents.

Below, we go on to discuss how the four healthcare organisations we studied organise and value the involvement of external chairs. The five themes we identified—the selection of external chairs, the role of external chairs, the value of external chairs, difficulties in involving external chairs and learning from investigating incidents with external chairs—order our findings.

Selecting an external chair

The obligation to appoint an external chair to head the investigation committee required organisations to arrange a way of recruiting them. All four organisations contacted other organisations to set up pools of people that can act as external chairs.

> When the policy came into effect, we agreed with other directors in the region that we would provide each other with external chairs. (Executive director, elderly care B)

> We looked for an organisation with a certain vision on transparency, trust, quality and safety (...) and agreed to exchange external chairs. (Executive director, disabled care D)

Organisations can hire external chairs from firms that offer experienced investigators, but the cost involved can rise to € 25,000, so that exchanging external chairs is also seen as cost-savings measure. When it comes to what an external chair should bring to the table, directors agreed that chairs should be competent, experienced investigators.

> We specified certain criteria, related to their knowledge and experience. We don't want an external chair to be someone conducting their first incident investigation. (Executive director, elderly care B)

Asked what a director expects of an external chair, he said:

> To get to the bottom of [the incident]. To be a thorn in our side. To not settle for it if our team says 'We couldn't have avoided it'. To look past that and analyse [what happened] critically. (Executive director, disabled care D)

The external chairs we interviewed are trained, considerably experienced investigators of incidents in healthcare settings. One external chair, not in a pool set up by the organisations we studied, used to be a family physician, worked for the Ministry of Health and the Inspectorate. In the past two years he conducted 25–30 investigations as chair.

Another external chair has investigated incidents since 2010 as an expert in disability care and as external chair since 2015.

In addition to expertise, external chairs should be familiar with the context and type of care the organisations deliver, directors told us. Directors look for external chairs that 'know our world'. While one director told us she hired a former judge, other organisations use external chairs with healthcare backgrounds. Related to this is the question if an external chair should have specific incident-related expertise. One organisation reported having positive experience with a psychiatrist investigating an incident related to psychopharmaceuticals and the onset of dementia in an intellectually disabled patient, but the external chair was not selected *because* he was a psychiatrist. It seems that organisations do not select external chairs on their case-specific expertise; the fit between an incident and the external chair's background is coincidental. Respondents explained they can and do recruit external members if they lack case-specific expertise.

The role of an external chair

The role of an external chair is not predefined in policy and is negotiated in light of the question what an external chair might contribute to an investigation. The organisation and the external chair have to agree on the external chair's responsibilities with each investigation.

> If you asked me, "What should an external chair do or pay attention to?", I'm not sure I could tell you. I'd say I'm responsible for conducting the investigation in a good way, within the time limits we face. This is important, because especially when a patient dies, these investigations can drag on for ages and it's so hard on family members when it does. (…) But especially, [an external chair] has to be impartial, that's key. And know the methodology. (External chair 3)

Without being able to fall back on a prescribed role or pre-structured responsibilities, external chairs and organisations have to think about what it means to be impartial.

> I was just asked to head an investigation in an organisation I had earlier worked as external chair. I couldn't do it, because I was on holiday, but it really made me wonder if I wanted to do it. Because although it was not at the same location, I have conducted an investigation [in that organisation] before. How impartial am I then? We have to assess that among ourselves (…) but it helps, in these cases, to know if I [as external chair] am there to see things are not swept under the rug, to bolster the quality of the investigation or to ensure the independence of the investigation. (External chair 3)

Whether external chairs should participate in the interviews conducted for the investigation was a recurring question for many of our respondents and for external chairs and directors in particular. A medical director remarked that as external chair, he is adamant about participating in interviews because doing so "[lets] me get a better picture of the incident" (Medical director, disabled care D). Another external chair addressed the tendency to curtail the external chair's role because of the time it takes to arrange thorough involvement from the start.

> The external chair would jumpstart the investigation and determine who to interview but would then back off [and] other people would do the interviews. [But] I've always done interviews; that's how I like being involved. (External chair 1)

According to a board member, an external chair should interview at least some "key people" (Executive director, elderly care B). Directors as well as external chairs agreed that the external chair's responsibility ends when it comes to designing and implementing improvements.

> When the report is done, I'm done too. Responsibility for improvement lies with the organisation, not me. (External chair 1)

We will revisit this proposed link between reporting on and investigating an incident and improving.

The perceived value of an external chair

Quality advisers, directors and healthcare professionals valued the 'fresh perspective' an external chair brings. With the critical perspective of an outsider, external chairs can question things people in the organisation take for granted. However, an external chairs' fresh perspective is equally rooted in a familiarity with elderly and disabled care, so that external chairs also know where to look.

> By appointing an external chair, (…) you open the door to people from other organisations with different backgrounds, to see if the way you see things makes sense [to an outsider]. It always leads to questions you wouldn't ask yourself. (External chair 3)

> I'm no better than anyone else, but I look at things from a detached, less emotional perspective. [After an investigation] we discussed the report with the organisation and they asked me if I'd like to come to the meeting with the parent [to share

> the report's findings]. So I did. The parent objected to our conclusions, which I thought was valid [and] I noticed that people from the organisation were like "Yeah, but…" We concluded that the anaesthesiologist had "acted professionally" during a cardiopulmonary resuscitation, [but] the parent disagreed. Listening to her, I thought "You're right". The anaesthesiologist had acted professionally in her medical expertise but she had not communicated professionally with the patient's representative. So I get why our assessment of "acting professionally" upset [that parent]. I said, "You're right, ma'am." (…) I noticed that as an outsider, I wasn't uncomfortable to admit [the parent was right]. (External chair 1)

Taking the parent's perspective seriously is hard for people in the organisation because it questions if the anaesthesiologist's actions were up to professional standards. The parent's objections prompted a defensive response ("Yeah but…"). Acknowledging the parent's objections was easier for the external chair, who was able to critically challenge and reframe what acting professionally meant. Respondents valued the external chair's impartiality, both in terms of the image the appointment conveys—external chairs are said to help counter suspicions of conflict of interest—and in how that impartiality can impact an investigation.

> The external chair addressed issues that we felt were important too, but were hard for us to address about our own organisation. Because the external chair felt they were important, it strengthened our conviction that these issues had to be in the report. (Quality advisers, elderly care A)

One external chair noted that it was easier for him to defend the committee's findings to a board of directors, "because I'm not in a hierarchical relationship with these people" (External chair 1). The independent position and impartiality of the external chair permits a critical perspective that is challenging for people within the organisation to adopt.

In line with the expected competencies, directors valued the expertise and experience external chairs have with investigating incidents.

> [External chairs conduct] methodically thorough [investigations], with an open mind and fresh perspective (…) and interview people in a professional, neutral manner. (Executive director, disabled care C).

Another respondent claimed 'the why question'—that seeks to uncover factors that help explain why an incident occurred—is pivotal and that the external chair is in a unique position (as well-trained, external investigator) to ask that question.

> When it came to the root causes of the incident, [the external chair asked us]: 'Why is that the root cause? What are your reasons for assuming that?' [He helped] us critically assess and sharpen our methodology. (Medical director, disabled care D)

Difficulties in involving an external chair

Time constraints are a difficulty for organisations. After reporting a serious incident, organisations have eight weeks to investigate the incident and report to the Inspectorate. Because they felt pressed for time, two quality advisers started their investigation without an external chair.

> We'd already done a lot. We'd done the interviews and written them up. But the external chair wanted to talk to some people again, (…) because he was uncomfortable with relying solely on our accounts. (Quality advisers, elderly care A)

Given the time frame for conducting an investigation, some professional groups are overrepresented in the organisations' pools of external chairs (quality advisers), while others are underrepresented (professionals and managers).

> The pool consists mostly of policymakers and quality advisers. We have only one physician. Sometimes you think, a GP would be a good fit, but they just don't have the time. (Quality adviser, disabled care C)

The same goes for managers, who never seem to be available (External chair 3). A lack of available external chairs from diverse backgrounds might limit organisations attempting to find the right person for the job.

Learning from investigating incidents with external chairs

When asked directly if they learn *more* from incident investigations with an external chair, directors and quality advisers hesitated. They reported that earlier investigations, conducted by internal teams, were already of high quality and generated valuable opportunities to improve. At the same time, respondents acknowledged that external chairs aided the investigation process—in helping investigation teams critically reflect on root causes or by neutrally interviewing personnel. We found various ways in which organisations can learn from external chairs, given how learning is conceptualised in multiple ways and happens at different moments in time.

First of all, external chairs, directors and quality advisers alike emphasised that learning from incidents means following up and implementing recommendations from the investigation report. As such, learning happens beyond the confines of the investigation.

> Really, learning and improved quality of care reside in following up recommendations from the incident report. (…) Possibly, [external chairs] formulate better recommendations, given [their] impartiality and fresh perspective. (Executive director, disabled care C)

While external chairs might contribute to a good investigation that comes to inform an organisation's learning process, learning starts, or continues, after the external chair leaves the organisation. In this sense, as we saw in an earlier quote, the responsibility for improvement is impressed upon the organisation and not attributable to the external chair.

Secondly, learning can also occur during the investigation, as one external chair pointed out, when we think of learning as the ability to reflect on and improve care practices.

> People were already reflecting [on their practices] in the interviews [and] made improvements during the investigation. I feel I contribute to learning in that way. (External chair 3)

Here learning is an activity not separated from but part of the process of investigating an incident.

Thirdly, already hinted at by the executive director cited earlier, external chairs frequently reported that organisations can benefit and learn from their ability to conduct incident investigations capably. The reports the Inspectorate received following the obligation to appoint an external chair, which inspectors scored more favourably, seem to corroborate this. Given that a thorough investigation can clear a path for appropriate recommendations and improved care practices in the future, learning how to conduct such investigations better helps learning both during and after incident investigations.

Finally, respondents think of learning as possessing a two-way directionality. The policy documents of the Ministry of Health present a one-directional perspective on learning, claiming that organisations can learn from external chairs. But external chairs and healthcare professionals reported that learning from incident investigations is reciprocal.

> For me, the value of being an external chair is being able to learn from cases elsewhere. (…) I've seen quite a few cases where I went back [to my own organisation] thinking, "This could've happened here too. We need to do something about this." So, it really has value, we share knowledge in an interesting way, even if it was not intended as such. (External chair 3)

> I think both organisations can learn from [investigating incidents with external chairs]. Although the incident did not occur at [name organisation], they can also come to realise that there are opportunities for improvement. For both sides, investigating an incident together is useful, I think. (Nurse, disabled care C)

One quality adviser talked of "cross-fertilisation", where external chairs go back to their own organisation with an increased awareness of potential risks (Quality adviser, disabled care C). Other quality advisers were happy that setting up pools of external chairs helped create a platform—that they felt they lacked before—where advisers from various organisations now talk about trying to deliver safe care and can learn from one another (Quality advisers, elderly care B). Learning in that sense becomes collaborative across organisational boundaries.

DISCUSSION

Inspectors scored incident reports more favourably after the policy change. In follow-up interviews, inspectors claimed that external chairs help organisations come to a better understanding of why an incident occurred, leading to better scores. The value of an external chair, we found in subsequent interviews, stems (in part) from their outsider's position. Our respondents valued the fresh perspective an external chair brings to an incident and the organisation where the incident occurred. External chairs are said to pose different questions and enlisting the help of an external chair is a way for an organisation to subject itself and its care practices to the scrutiny of an outsider unfamiliar with the specific organisation. Yet, chairs also have to be familiar with providing everyday care to elderly or intellectually challenged people to be of added value. External chairs strike a balance between distance (the external chair has to be 'foreign' enough) and proximity (the external chair has to be familiar with care practices in elderly and disabled care, knowing where to look). From this position, having expertise in conducting incident investigations and in being familiar with but untied to the organisation an external chair works in, external chairs are in a good position to 1) identify blind spots and ask questions that people familiar with the organisation would not think or dare of asking, 2) develop a critical perspective on the organisation, and 3) pose questions neutrally to healthcare professionals about incidents. This position, our respondents seem to suggest, comprises of and weaves together particular conditions (being able to function outside of the organisational hierarchy) as well as individual skills (being able to interview healthcare professionals and critically analyse incidents).

Revisiting the idea of learning as "a complex social and participative process that involves people actively reflecting on and reorganising shared knowledge, technologies

and practices" (Macrae, 2016, p. 74), external chairs stimulate various forms of learning. External chairs can help organisations identify root causes and capably conduct incident investigations, allowing fitting recommendations for improvement to be implemented. Also, external chairs can foster learning during the investigation, as healthcare professionals start reflecting on their practices during an interview or when professionals are asked to rethink what it means to act professionally. Being a relative outsider—knowledgeable about care practices in the sector, from outside the organisation—the external chair is not external to this learning process, but participates in it. The process of investigating an incident, more so than the report the investigation culminates in, is valuable for both the organisation and the external chair. The external chair and the organisation's insiders on the investigation team co-create knowledge about the incident. This knowledge travels bi-directionally; learning is reciprocal as external chairs take valuable insights back to their own organisation and future investigations elsewhere, while it seeps into the organisation where the incident occurred. We can conceptually think of external chairs as 'knowledge brokers': "persons or organizations that facilitate the creation, sharing, and use of knowledge" (Meyer, 2010, p. 119) that are typically envisioned as moving knowledge from one world or field to another (Meyer, 2010; Schlierf and Meyer, 2013). But knowledge brokers do not just move knowledge from one domain to the next, as if knowledge were a pre-packed, bounded entity. Knowledge brokers are mediators who, as they move knowledge, translate it and create new forms of knowledge. For Meyer, knowledge brokers possess a 'double peripherality', as they are "partially connected to the two worlds they bridge" (Meyer, 2010, p. 122). External chairs can be said to occupy such a position, where an external chair's double peripherality stems from the familiarity of the external chair with the type of care provided (knowing where to look) and being unfamiliar with the organisation wherein the incident occurred (allowing for a fresh, critical perspective).

We can think of the need for elderly and disabled care organisations to appoint an external chair to investigate serious incidents as a politically informed regulatory intervention and, as noted earlier, a compromise between the Inspectorate's emphasis on internal investigations and the government's call for external review. The Inspectorate, nor the Ministry of Health, formalised or specified what a capable external chair is and where an external chairs' responsibilities lie (and end), but instead, advanced that an external chair might help organisations investigate and learn from incidents, leaving it up to organisations and external chairs to work out how this might happen in practice. In line with a 'soft regulatory' approach, the Inspectorate provided room for organisations and external chairs to adapt this intervention to their needs (Levay and Waks, 2009). While the Inspectorate, explicitly and openly, expects healthcare providers to be intrinsically motivated to do the right things, putting trust at the heart of the Inspectorate's regulatory relationships with healthcare organisations (Inspectorate, 2016a;

Kok et al., 2019), the obligation to appoint an external chair came about as politicians called into question the trust awarded healthcare organisations, stressing the need for external review. In light of the well-established responsive regulation framework (Ayres and Braithwaite, 1992), that proposes "that enforcement strategies should be arranged in a hierarchy or 'regulatory pyramid,' with more cooperative strategies deployed at the base of the pyramid and progressively more punitive approaches used only if and when cooperative strategies fail" (Nielsen and Parker, 2009, p. 378), external chairs offer the Inspectorate an enforcement strategy situated between asking organisations to conduct their own investigations and calling for an external investigation or conducting one themselves.

Vaughan notes that in thinking about regulators and regulatees, and regulatory effectiveness, the notions of autonomy and interdependence can prove insightful (Vaughan, 1990). She characterises organisations as autonomous entities that are, to some extent, distinct and insulated from other organisations and not easy to access. Regulators, to perform their regulatory tasks, however, depend upon access to be able to gather and interpret information on an organisation to be able to adequately monitor it. To that end, "regulators attempt to penetrate organizational boundaries by periodic site visits and/or by requiring the regulated organization to furnish information to them" (Vaughan, 1990, p. 228). But still, the regulators' perspective is partial. As a result, Vaughan notes, regulators become dependent on the regulated organisations to provide them with information, rendering organisational compliance pivotal, possibly leading to regulatory capture (Bardach and Kagan, 1982). We might say that in the relationship between care organisations and the regulator, the external chair occupies an intermediary position. External chairs penetrate organisational boundaries and partake in information gathering practices that aid the monitoring practices of the Inspectorate. The external chair grants the Inspectorate the perspective of a potentially critical outsider, while not having to intervene or visit themselves. For organisations, opening its doors and having their care practices subjected to scrutiny from an outsider might be more acceptable when this outsider is familiar with the care practices and self-selected by the organisation. Having said that, just as regulatory capture poses a risk for regulators, the same may hold for external chairs—as suggested by the external chair who wondered if doing multiple investigations in the same organisations might compromise her impartiality. Given this question of impartiality or some of the concerns respondents voiced about the ability to recruit capable external chairs given the time frame for investigating incidents, the Inspectorate would do well to continue to monitor how these practices develop and potentially curbing some (e.g. organisations recruiting the same external chair repeatedly) while stimulating other practices.

Although we studied a Dutch case, we believe our findings are relevant internationally. The mechanisms explaining why involving an external chair in incident investi-

gations leads to learning have a more general value. The external chair might foster participative shared learning between organisations on a local or regional level and can complement instruments that promote learning across and between organisations nationally, like patient safety alerts (Lankshear et al., 2008; Rhodes et al., 2008) or public inquiries (Black and Mays, 2013; Francis, 2013; Walshe and Offen, 2001). Using trained external chairs is one way to professionalise incident investigations (Anderson and Kodate, 2015; Peerally et al., 2016) while keeping the learning process close to the organisation where the incident occurred. Ramanujan and Goodman propose that learning from incidents depends on a range of temporally ordered activities (of which investigating an incident is just one) that need to foster a shared understanding of what contributed to an incident (2011). Investigating an incident with the help of an external chair still locally embeds the learning process within an organisation and can contribute to creating this shared understanding. "Simply identifying a solution is part of event analysis, but does not entail learning," Ramanujan and Goodman warn (2011, p. 85). Other studies report that when it comes to shared learning from incidents, too often this takes the form of the one-way distribution of 'lessons learned' that are disconnected from the practices wherein this learning is constructed and used (Drupsteen and Guldenmund, 2014; Macrae, 2016). The value of an external chair on incident investigation committees suggests that shared learning from incidents can also take a different, social and participative form. We hypothesise that the value of an external chair over external investigations like public inquiries resides in the balance it strikes between bringing in a critical, external perspective and locally embedding the learning process. Future research into the role and value of the external chair in incident investigations might look into how external chairs participate in and contribute to "social processes of inquiry, investigation and improvement that unfold around incidents" (Macrae, 2016, p. 74), allowing for situated, shared and participative learning. Additionally, further research might study if investigations into incidents with external chairs lead to more effective and sustainable recommendations (Hibbert et al., 2018; Kellogg et al., 2016) and their implementation into practice.

Like the policy itself, how the policy encourages particular practices of incident investigation is dynamic and contingent. While the effects of the policy spill over its intended, stated objectives (allowing for reciprocal, shared learning, rather than one-directional learning), these are also mediated by other organisational and institutional structures. Healthcare organisations are required to investigate and report on an incident within eight weeks and thus need to ensure to involvement of a capable external chair within that time frame. Such structures shape the practices of selecting an external chair; capable external chairs need to be available too. Practices of investigating patient safety incidents with the help of external chairs are consistently developed further. To our knowledge, this is the first explorative study into the perceived value of such practices to

date and further research is called for. Our study has some limitations. For one, the data we collected at four healthcare organisations centres on the occurrence and investigations of singular incidents. Also, we did not follow organisations over a longer period, so we cannot comment on how the perceived value of repeatedly involving external chairs in incident investigations changes over time. Equally, we were unable to research incident investigation practices for the same organisations prior to and after the policy change; while the policy of needing to enlist external chairs in the investigation of serious incidents was adopted in October 2015, our research, that set out to evaluate what happened as organisations conducted investigations into incidents with help of external chairs, started in 2016, which meant we were not able to analyse incident investigations before the start of the policy. The number of incident reports scored by the inspectors do not permit us to assert with certainty that organisations learn more from incidents when conducting investigations with an external chair. Nonetheless, the scored reports, combined with the conducted interviews do convey a compelling account of how external chairs might contribute to shared learning from incident investigations.

CONCLUSIONS

Our findings suggest that trained external chairs can help healthcare organisations better identify root causes of serious incidents. External chairs who strike a balance between distance from the organisation and proximity to the specific care processes can facilitate learning processes during and after incident investigations in healthcare organisations. Moreover, they facilitate learning across organisational boundaries as they travel between healthcare organisations. An investigation committee that consists of an external chair as well as people from within the organisation is a promising combination that facilitates a shared learning process through which not just the people from the organisation concerned can improve, but others elsewhere can as well.