Safeguarding - the strategic reflective phase for DSLs.

- **Current good practice asks that we are:**

- Professionally curious/professionally vigilant
- Non – assumptive
- Forensic
- Non biased

- As uncomfortable as it can be some of the best practice learning comes from applying all of these attitudes on a daily basis and particularly when an incident , safeguarding issue , accident , issue has arisen .
- It can be very uncomfortable- it should be honest and a basis for learning
- It should involve everyone on the team at some point
- It should be inherent in foster carer practice

Safeguarding for Leaders :

- Reflection , learning, planning and development-

Are you satisfied that you and the carers have a clear lessons learned culture in place ?

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Aims of session 3

- For the leader to be able to take a strategic view within the service/ organisation re. safeguarding in all aspects this underpinned by an understanding of risk

- To understand the structure and impact that a robust safeguarding CULTURE brings.

- To further develop your capacity to carry out and identify key learning and changes using approaches to incident analysis – large or small.

Root Cause. A **root cause** is a factor that caused a nonconformance and should be permanently eliminated through process improvement. **Root cause analysis** is a collective term that describes a wide range of approaches, tools, and techniques used to uncover **causes** of problems.

Sounds dire !!! Can't you tell it came from the car industry!
Rephrased it means that:-

-**Root cause analysis** is an approach for identifying the underlying causes of an incident so that the most effective solutions can be identified and implemented.

The 5 Whys?

By repeatedly asking the question “Why” (five is a good rule of thumb), you can peel away the layers of symptoms which can lead to the root cause of a problem. Very often the ostensible reason for a problem will lead you to another question. Although this technique is called “5 Whys,” you may find that you will need to ask the question fewer or more times than five before you find the issue related to a problem.

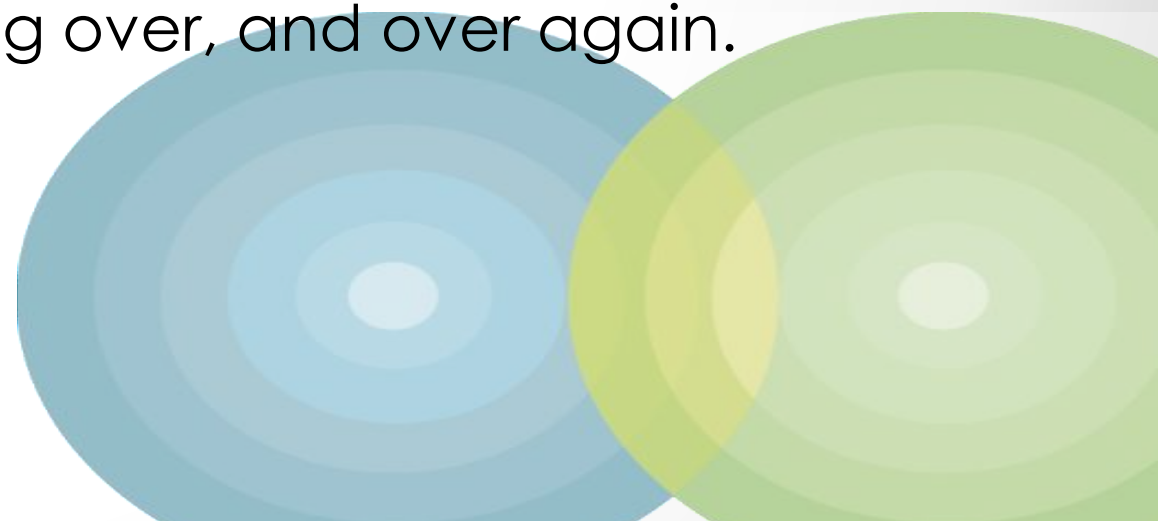
It is easily completed by a team who can often identify the sequence of events or issues and find the root cause themselves. This is always a good outcome if the issue lay within the team.

"If you don't ask the right questions, you don't get the right answers. A question asked in the right way often points to its own answer. Asking questions is the ABC of diagnosis. Only the inquiring mind solves problems." – Edward Hodnett

- *Be – curious , non assumptive , open.*
- *Make it safe for the team / foster carers*
- *Clear boundaries*
- *IS THIS THE CULTURE IN PLACE ?*

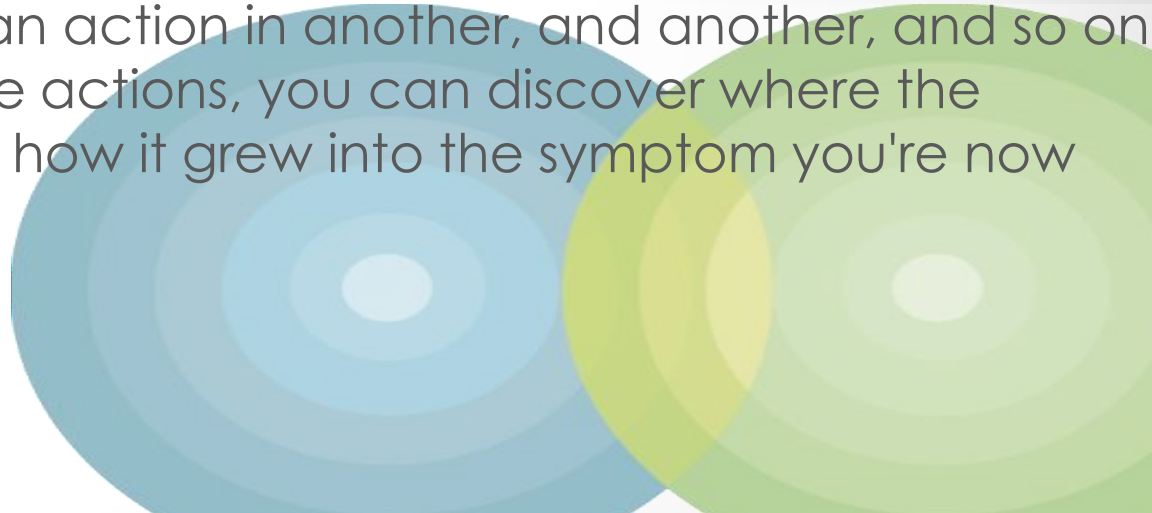
Tracing a Problem to its Origins-

- What do you do when you have a problem/incident/ accident / pattern at work?
- Do you jump straight in and treat the symptoms, or do you stop to consider whether there's actually a deeper problem that needs your attention?
- If you only fix the symptoms – what you see on the surface – the problem will almost certainly return, and need fixing over, and over again.



Tracing a Problem to its Origins

- Root Cause Analysis (RCA) is a popular and often-used technique that helps people answer the question of why the problem occurred in the first place. It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can:
- Determine what happened.
- Determine why it happened.
- Work out what to do to reduce the likelihood that it will happen again.
- RCA assumes that systems and events are interrelated. An action in one area triggers an action in another, and another, and so on. By tracing back these actions, you can discover where the problem started and how it grew into the symptom you're now facing.



You'll usually find **three** basic types of causes:

* **Physical causes** – Tangible, material items failed in some way

* **Human causes** – People did something wrong, or did not do something that was needed. Human causes typically lead to physical causes

* **Organisational causes** – A system, process, or policy that people use to make decisions or do their work is faulty

Step approach

- RCA assumes that systems and events are interrelated. An action in one area triggers an action in another, and another, and so on. By tracing back these actions, you can discover where the problem started and how it grew into the symptom you're now facing.

- **Step One: Define the Problem**

What do you see happening?

What are the specific symptoms?

- **Step Two: Collect Data**

What proof do you have that the problem exists?

How long has the problem existed?

What is the impact of the problem?

** There is no point looking for solutions until the problem is identified**

Step approach continued……

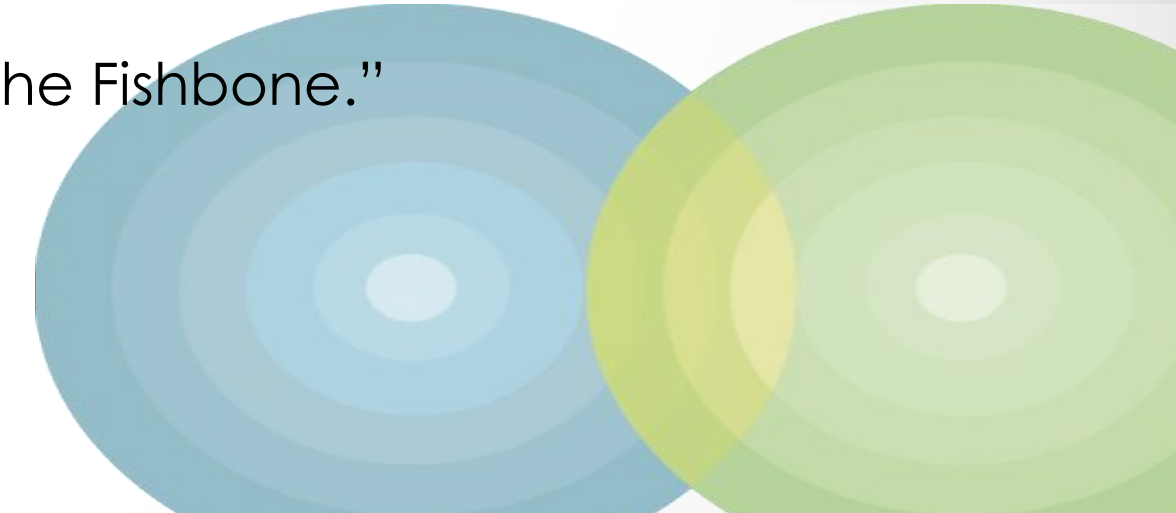
- **Step Three: Identify Possible Causal Factors**
- What sequence of events leads to the problem?
- What conditions allow the problem to occur?
- What other problems surround the occurrence of the central problem?
- During this stage, identify as many causal factors as possible. Too often, people identify one or two factors and then stop, but that's not sufficient. With RCA, you don't want to simply treat the most obvious causes – you want to dig deeper.
- DIG!!

Use the 5 whys??

Use Ishikara Cause and effect diagrams- aka "The Fishbone."

Ask "so what?"

Work with the team



Step approach continued.....

- **Step Four: Identify the Root Cause(s)**
- Why does the cause factor exist?
- What is the real reason the problem occurred?

- **Step Five: Recommend and Implement Solutions**
- What can you do to prevent the problem from happening again?
- How will the solution be implemented?
- Who will be responsible for it?
- What are the risks of implementing the solution?
- Analyse your cause-and-effect process, and identify the changes needed for various systems. It's also important that you plan ahead to predict the effects of your solution. This way, you can spot potential failures before they happen.

Follow on.....or starting point- useful for the DSL

- **Failure Mode and Effects Analysis (FMEA)**

Spotting Problems Before a Solution Is Implemented

Asking the question - "What Could Go Wrong?“ This is particularly useful where high levels of risk are involved. You can use this when considering a high risk placement – you identify what could go wrong and then look at the risk profile generated. Are these risks you can reasonably, safely mitigate?

- **Impact Analysis**

Identifying the Full Consequences of Change. while doing the TRCA and identifying changes to made take a little time to think things through.

If we do this how will it impact on…..? Avoid confusion and disruption later on and the “I wish I had thought of that moment.”

Ishikawa or Fishbone model of cause and effect

- According to **Ishikawa**, quality improvement is a continuous process, and it can always be taken one step further. With his cause-and-effect diagram (also called the "**Ishikawa**" or "fishbone" diagram) this management leader made significant and specific advancements in quality improvement.
- It is best used with your team/ group

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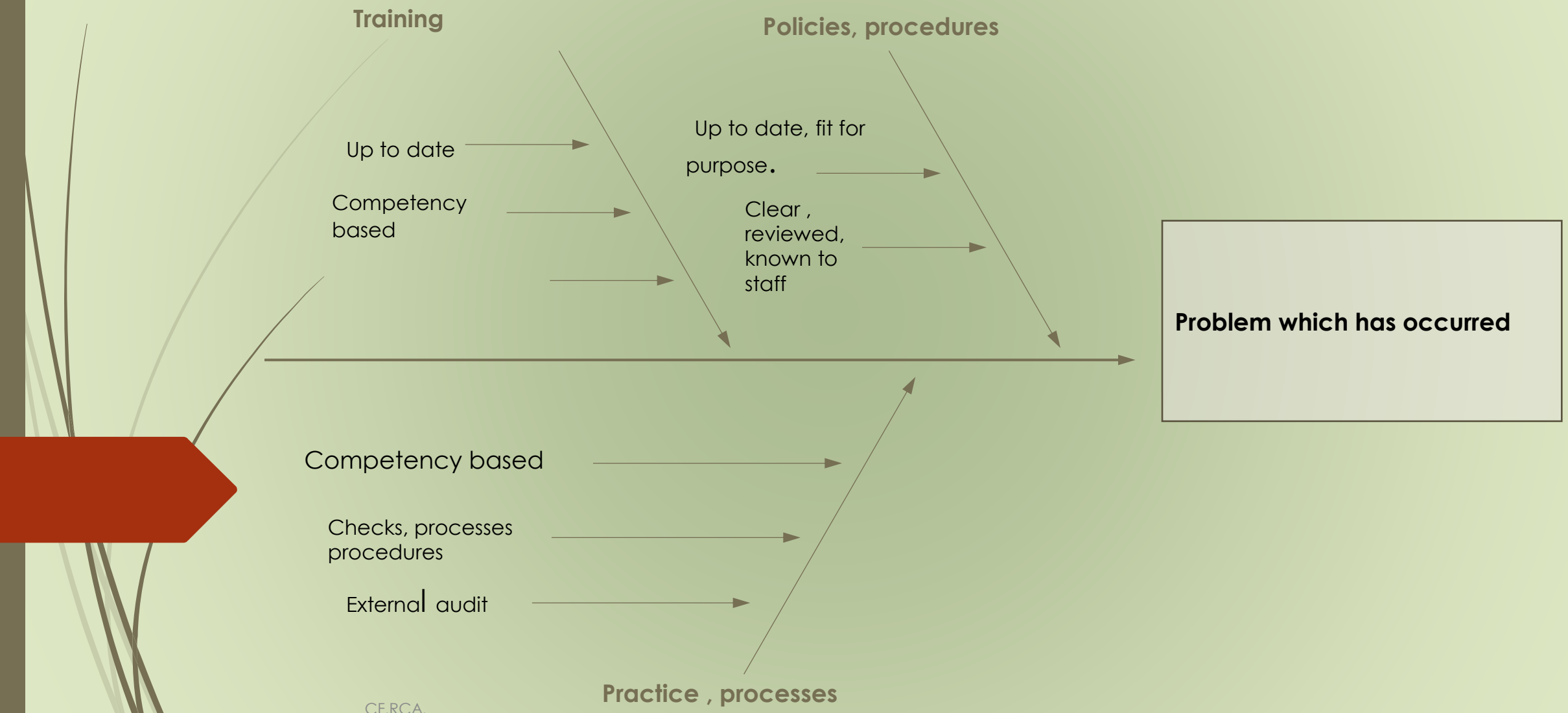
- Ensure everyone feels safe
- Identify the problem which has occurred
- Brainstorm everything that should be in place so that the issue should not have arisen.
- Look at your headings- was everything in place as it should have been ? Did everything happen as it should have?
- IF NOT –WHY NOT? USE THE 5 WHYS. IDENTIFY THE ROOT CAUSE.

Root cause analysis- from problem-example



Other factors to consider

- Equipment
- People in the broader sense- e.g family
- Visitors
- Other professionals
- Environment
- Health and safety
- Safeguarding

What can you use it for?

- Patterns and issues arising from anything!
- Repeated errors – at any stage in the process
- Pattern of increased numbers of notifications
- New processes you want to introduce
- Equipment failure
- Accidents
- Supervision
- Appraisal

- Use it with an impact assessment
- Staff turnover
- Foster carer turnover
- Patterns of staff issues arising
- After a key incident , allegation , complaint , serious case review
- Worries about low level concerns

Now the uncomfortable bit in any RCA for the leader-

- **You cannot assume** . You have to :
- THINK THE UNTHINKABLE-
- Could it be deliberate
- Could it be malicious
- Could someone have fabricated illness – think Beverley Allitt, Sheffield Hospital cases.
- Brainstorm it all.

Next steps when your plan is in place

- MONITOR
- MONITOR and MONITOR ! Especially when your plan is a consequence of a serious incident
- Don't let it drift
- "Tweak" it if it needs to be done.
- Is it working?
- If not , why not? Get people together and ask the question.

Consider:: any other frameworks and regs as needed e.g:

1.. Education inspection framework
2. KCSIE 2024
3. Adult safeguarding frameworks

WHEN USED REGULARLY YOU CAN AVOID ELEMENTS OF CRISIS STRESS…..