RPET
The Resilient Performance Enhancement Toolkit

Axel Ros and Erik Hollnagel

THE JÖNKÖPING ACADEMY
FOR IMPROVEMENT OF HEALTH AND WELFARE

How do organisations learn

Safety-I

- From understanding accidents and incidents
- Accidents > incidents
- Major accidents > minor incidents
- Episodic learning based on events

”…the thought that the cure of a given troublesome condition depends primarily upon knowledge of its cause and the elimination, or at least mitigation, of that cause, ….upon ability to apply a known remedy.” *Heinrich, 1931*

How do organisations learn

Work that goes well is not the result of the effective elimination of hazards and risk but represents ”an ongoing condition in which problems are momentarily under control due to compensating changes”, *Weick, 1987*

Safety-II

Learning from everything that happens

Failures - - - successes

Non-events as well as events

Continuous and based on work-as-done

Continuous learning

Learning based on accidents (Safety-I) is not continuous.

Organisational support for reporting and analysis, rather than for learning.

Learning is more effective if continuous as an integral part of work.

Learning of what goes well (Safety-II):

- need not wait for an ”event”, because something happens all the time
- is part of the thoroughness of the present that is necessary for the efficiency of the future

Learning from work that goes well

- Learning should take place when work takes place
- Learning should take place where work takes place (on all levels of an organisation)
- Learning should be by and for the people who are part of the work

It´s all about understanding work-as-done

Seemingly simple but maybe problematic

since this way of learning is unfamiliar to most

Events and non-events

- Events are ”visible”, hence easy to learn from

- Non-events – when nothing happens
  - not visible
  - no terminology
  - no methods to analyse and understand

The learning process
Knowing what to look for

- How people recognise changes to conditions / situations
- How people handle unexpected situations
- How people recognise patterns over time

- From discovery to recognition

How people recognise changes to conditions / situations

Topics that might help the discussion

- Situations where something surprising or unexpected happened
- Mismatches between demands (work pressure) and resources.
- Obvious variability or change in routines, either by yourself or by others.
- Situations that somehow felt different from the usual.
- Situations where the preparations / plans had to be revised or adjusted.

How people handle unexpected situations

Topics that might help the discussion

- Situations where it was necessary to make goal trade-offs or change priorities
- Situations that required a change to the order of actions or operations.
- Examples where work was delegated to others or where others lent a helping hand.
- Situations where something had to be delayed or postponed.
- Examples of shortcuts or alternative ways to do things.

How people recognise patterns over time

Topics that might help the discussion

- Give examples of recurrent situations that they have become part of the daily or weekly routines.
- How are recurrent situations used in the preparation for work – including training?
- Is there a reasonable balance between routine and non-routine situations in your work?
- How is experience with recurrent situations captured, analysed, and used for learning?
- Do you informally discuss your experiences from recurrent situations with colleagues?

Keeping track of the learning process

For accidents and incidents (Safety-I) there are established practices

For work that goes well (Safety-II) there are no established practices/tradition

- A need for a tool that support Safety-II learning

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A tool for that supports daily conversations about work-as-done, documentation of those conversations, and organisational learning based on those conversations.

A concept that can be used on paper

Soft-ware is under development

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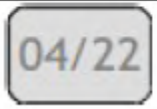
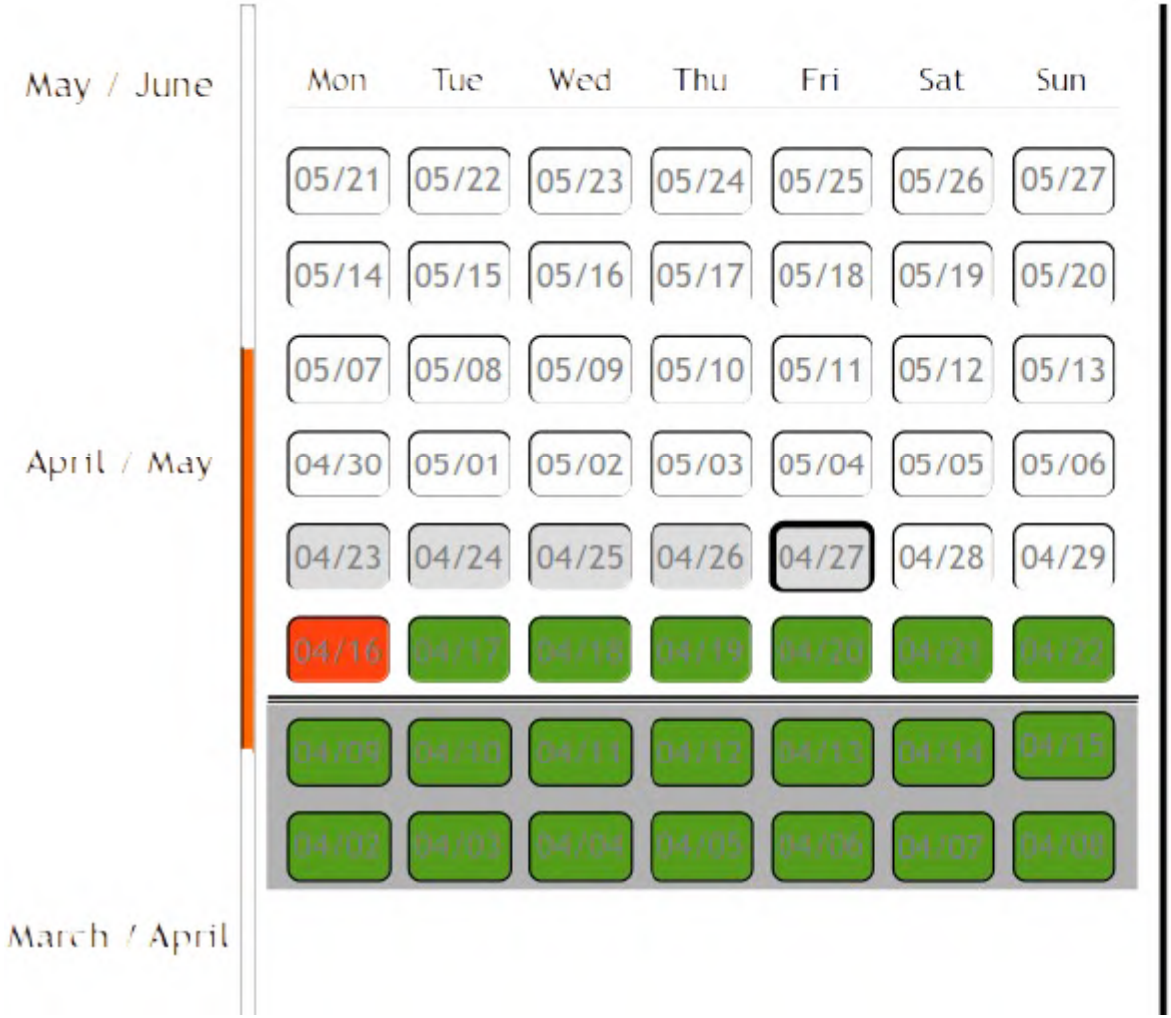
How different types of days can be presented

Icon	Interpretation
	A day coming: An upcoming or future day that has not yet occurred. It is represented by an empty rounded box. The numbers indicate the month and day (e.g., April 22).
	A day gone: A day that has passed but which has not yet been discussed. It is represented by a grey rounded box.
	A day discussed: A day that has passed and which has been discussed at the workplace. It is represented by a green rounded box. Since the day has been discussed at the very least an attempt to learn has been made.
	A safety related event: A day where a safety related event (accident, incident, ...) has been reported. It is represented by a red rounded box. If it is necessary to indicate the severity or category of the reported event, different hues can be used.
	A lesson learnt: A reportable safety event that has been discussed and where lessons have been learnt. It is represented by a red rounded box with a green perimeter (or a green rounded box with a red centre).

How progress can be represented



Friday 27-Apr-2018

Status ▾	No safety related events. Not discussed.

Here is some text about the day ...

Here are some links to documents about this day that have been uploaded.

Document title 1

Document title 2

NICU Jönköping RPET experience

- The Neonatal Intensive Care Unit at the County hospital Ryhov in Jönköping, Sweden
- NICU's in Sweden on all university hospitals and some county hospitals
- Neonatal intensive care is Sweden is under pressure
- Typical daily and seasonal variability in demand

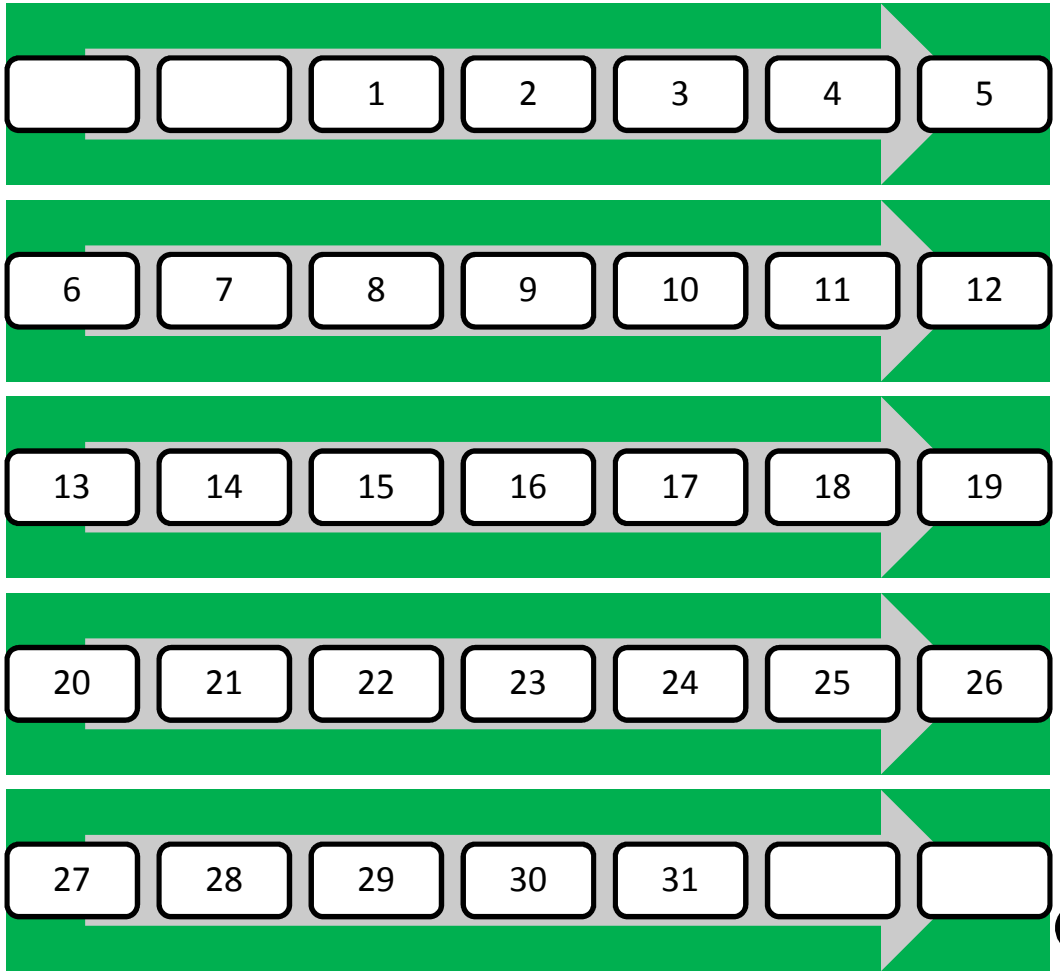
- 16 beds
- 60 nurses and assistant nurses, 6 doctors
- Typical dayshift 10 staff, 3 doctors

NICU Jönköping RPET experience

- Started in October 2019
- Project led by a patient safety officer
  project group staff at the NICU
  management support
  but staff ownership
- On-going evaluation aiming at scientific paper
- Safety climate measurements, before and during
- Interviews

May 2019

Gröna linjen – reflektion för lärande



- What did we do today to help work go fluently?
- What made things happen? Why?

- This months focus:……
- How did we manage this today? How – and what did we do?

- Did we have any situation that we did not manage very well? What happened? How did we discover this?

Mark with a colour:

No meeting, no reflection.

We met, but didn't find anything to reflect over.

We met, and did reflect

We had an event that did not go well (red), and had a reflective learning in the meeting (red and green)

Daily learning

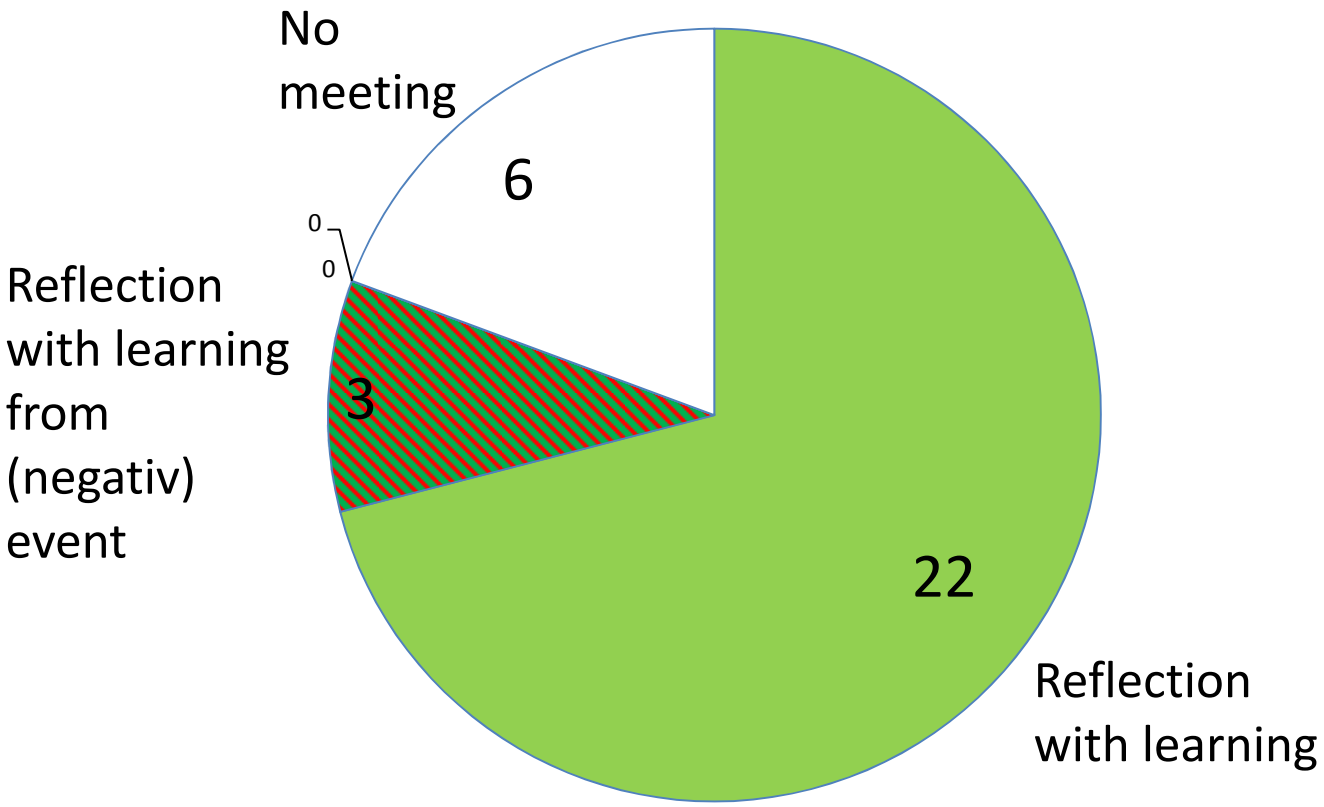
- Daily short meeting in the afternoon, all available staff on duty are supposed to participate, led by any one in the staff
- Questions aid the conversations
  They have been developed over time
- Documentation with colour-coding of the day and short notes
- Paper documentation

Learning from patterns over time

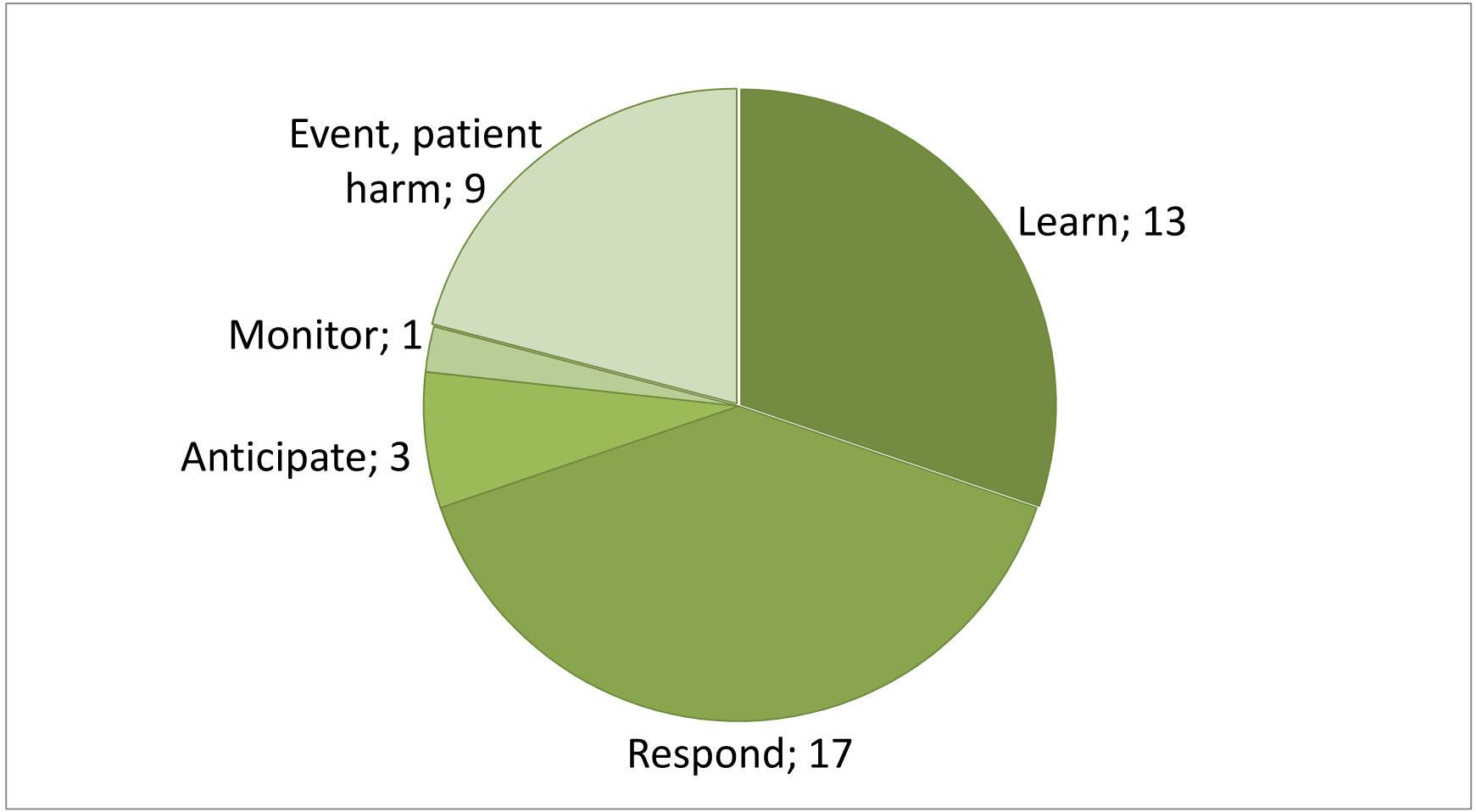
- A meeting every second week, all available staff on duty are supposed to participate, and local management, led patient safety officer
- Based on the colour-coded passed days and short notes and overall impressions and ideas
- Questions aid the conversations
- Documentation classified according to
  - the potentials of resilient performance
    to respond, to monitor, to anticipate, and to learn
  - and if there was a (negative) event, patient harm

How days are classified

March 2019



What was discussed
March 2019



NICU staff RPET experience

What has been appreciated

- Positive response with staff
- A simple and cheap means to continuously focus on learning from a positive perspective
- A new view to patient safety
- Exciting to try theories about resilience in practise

NICU staff RPET experience

Challenges (for the project team)

- To capture and improve from what turns up in the conversations
- To get everyone involved – project team, all staff, management
- To bear the responsibility that what is discussed really leads to improvement and is taken care of at the appropriate level
- To formulate questions for the reflections that capture what we are looking for
- Still more is said when we have had a (negative) event, it takes time to change focus