A Qualitative Study of Factors Contributing to Serious Incidents in an NHS Psychiatry Service for Adults with Learning Disability

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Introduction

People with learning disabilities experience significant healthcare disparities and preventable harm. In-depth analysis of contributors to healthcare-related adverse events for this cohort is lacking. Serious incident investigation reports contain rich data, but learning is often confined to individual cases and lessons learnt are mainly shared with those who are involved in the incidents.

Aims

This study aimed to explore factors contributing to serious incidents involving people with learning disabilities receiving mental healthcare in an adult NHS mental health service and analyse recurring themes using a human factors framework.

Method

Thirty anonymised serious incident reports from the adult learning disability service of an NHS mental health Trust, between 2014-2023 were analysed using the Yorkshire Contributory Factors Framework (figure 1) , followed by reflexive thematic analysis to elicit patterns across factors. This qualitative approach enabled nuanced themes to emerge from the data.

Open coding (1/3) using inductive approach

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Content analysis using Yorkshire contributory factors framework

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Reflexive thematic analysis

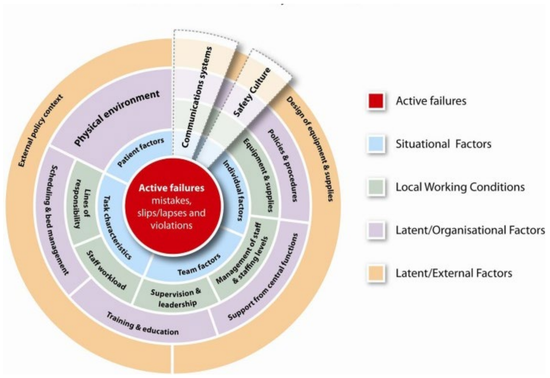


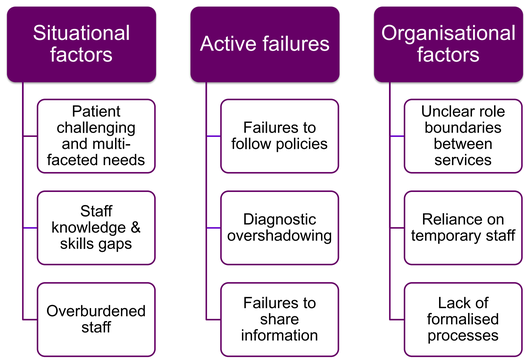
Figure 1 – Yorkshire Contributory Factors Framework (Lawton et al. 2011)

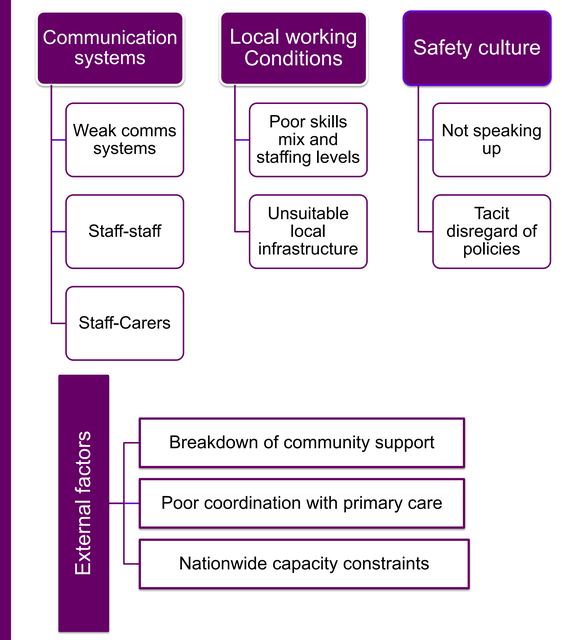
Results

- 63% were no/ low harm events
- 606 contributory factors across all domains

Contributory factors based on the Yorkshire Contributory Factors Framework	Number of serious incidents (n, %)	Number of instances across all incidents (n, %)
Situational failures	28, 93%	187, 31%
Active failures	29, 97%	109, 18%
Organisational factors	27, 90%	107, 18%
Communication systems	23, 77%	75, 12%
Local Working conditions	22, 73%	62, 10%
Safety culture	22, 73%	51, 8%
External factors	15, 50%	15, 2%

Table 1 – Frequencies of contributory factors across incidents





Conclusion

- Multiple factors at sharp and blunt ends of care affect safety.
- Multiple problems are systemically engrained.
- Better investigations important to generate learning

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