**What is SWARM?**

* A swarm is designed to start as soon as possible after a patient safety incident occurs (immediately or within 24 – 48 hrs).
* It is used to **identify learning** from patient safety incidents, enabling **insights** and **reflections** to be quickly sought and generate prompt learning by preventing:
* those affected forgetting key information because there is a time delay before their perspective on what happened is sought.
* fear, gossip and blame; by providing an opportunity to remind those involved that the aim following an incident is learning and improvement
* losing key information about what happened and ‘work as done’ because those affected leave the organisation where the incident occurred.
* This swarm tool integrates the **Systems Engineering Initiative for Patient Safety (SEIPS3)** framework and swarm approach to explore what happened and how it happened, in the context of how care was being delivered in the real world (i.e. work as done), in a post-incident ‘huddle’.
* The SEIPS Tool is available here: [Proportionate Response Tools](https://mynuffieldhealth.sharepoint.com/sites/quality-and-safety/QualityNew/SitePages/PSIRF%20-%20Proportionate%20Response%20Tools%20and%20Systems%20Investigations.aspx)

**When to use it?**

* Immediately after an incident, staff ‘swarm’ to the site in which the incident has occurred, to quickly analyse:

- what happened

- how it happened

- what needs to be done to reduce risk of it happening again.

**What are the steps to carrying out a swarm?**

An effective SEIPS swarm involves six steps – Please use the SEIPS Power Point Template is available at: [SEIPS Guidance and Template](https://mynuffieldhealth.sharepoint.com/:p:/r/sites/quality-and-safety/QualityNew/_layouts/15/Doc.aspx?sourcedoc=%7B065E37D1-23B3-48BE-BB7F-1FDCACF437F6%7D&file=SEIPS%20Template%20with%20Guidance%20updated%20Jan%202024.pptx&action=edit&mobileredirect=true&previoussessionid=aa8920cb-b727-2c3b-0744-ec40469fbbad);

1. **Introduce all participants** so everyone knows who each other’s name and their role in the swarm.
2. **Create a safe and ‘brave’ space** by reassuring participants that the purpose of the swarm is to identify what happened and why by exploring the systems and contexts in which patient care was being delivered (i.e. work as done).
3. **Replay the events** that led to the swarm.
4. **Explore what happened and why**, through the lens of the SEIPS framework.
5. **Identify where else** in the organisation the learning from the swarm may be relevant.
6. **Identify safety actions**, and where feasible, assign specific deliverables and completion dates to leads.

**Top Tips for Running a SWARM**

**During the Swarm**

**Do…**

* Try to include as many people in the swarm as possible relevant to the incident.
* Run the swarm as close to the area where the event happened wherever possible.
* **Use this form as a prompt and a conversation starter.** You don’t need to follow as a script.
* Create a safe space, welcome everyone and thank them for their time.
* Introduce all participants so everyone knows who each other’s name and their role in the swarm.
* Create a safe and ‘brave’ space by reassuring participants that the purpose of the swarm is to identify what happened. Encourage people to speak up and feel included, discourage blame language.
* Be clear on who is responsible for taking forward actions identified from the swarm.
* Be realistic when agreeing deadlines for completing actions.
* On completion, check that those who took part are okay. Thank everyone for their time, their honesty, and their contributions.

**On Completion**

**Do…**

* **Share the swarm document for review** to those in attendance. Include those who did not attend the swarm but were present at the incident- who may have not been able to attend. **Request for their review and to add any additional feedback**.
* Ensure that there is a process in place for feeding back the swarm.
* Review actions in a timely manner and **ensure that any key and urgent actions are prioritised**. Ensure that a follow-up is booked.
* Identify where else in the organisation the learning from the swarm may be relevant. Think other departments within the facility, regionally or across the business.

**N.B. If a handwritten template is completed during the SWARM, then it MUST BE UPLOADED to the Radar Adverse Event Record together with the typed version that is completed after the meeting. This ensures there is evidence that the information captured at the time has been accurately transcribed and cannot be questioned later.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Swarm Title** | | **Date of event:** | |
| **Radar reference: ADV** | | **Date of swarm:** | |
| **Site, department & location:** | | | |
| **Name** | **Job Title / Role** | **Name** | **Job Title / Role** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Is everyone here who needs to be here?**  If any key people are absent share the document later for review |  | | |
| **Current situation and causes:**  **What has happened?**  Include contributory factors with consideration of SEIPS- *Persons, Task, Tools and Technology, Internal and External environment, and Organisation.* |  | | |
| **What should have happened?** Highlight any gaps noted  Consider Organisational policy and national guidance |  | | |
| **Who has this impacted (patients/departments / staff) and how?** Do any staff require additional support/guidance? |  | | |
| **From reviewing this SWARM, what are the key learnings and critical success factors?** |  | | |
| **Good practice identified:** | | | |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |

**Key activity to make improvements and sustain success**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Area for quality improvement identified** | **Planned actions** | **Planned completion Date?** | **By whom?**  **(Name and role)** | **Actual completion date:** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

**Shared learning**

|  |
| --- |
| **How are you going to share the learning from this event? E.g. consider all staff alerts, whole team meetings, sharing within the PCN or at Place, with the ICB, professional or clinical networks and meetings.** |
|  |

**Follow up SWARM and review of actions**

|  |  |
| --- | --- |
| **Date booked for follow-up SWARM:** | |
| **Follow-up**   * **Please list those present at discussion** * **Have our initial actions worked? If not, what other actions do we need to take?** * **Have any questions raised by the patient been addressed? (where relevant)** |  |
|
| **Follow-up SWARM Completion date:** | |
| **SWARM Completion**  **What are the overall outcomes/results after final SWARM?** |  |

As the SWARM Facilitator, I confirm that I have shared the initial safety actions, completed the follow up SWARM and shared further safety actions generated during this.

**SWARM facilitator name and signature: Role: Date:**

**DCS name and Signature: Date:**

**PLEASE ENSURE THAT ON COMPLETION THIS FORM IS ADDED TO THE RADAR RECORD**