**Abstract: Supporting Staff and Families during an Incident Investigation**

A patient’s family has been told that their loved one is going to die due to a medication error.

The family have to deal with a terminal diagnosis, with the death of their loved one, and process that this may or may not have been avoidable.

Their grief is overwhelmingly shadowed by their anger and they cannot get closure without getting answers first.

At the same time, the member of staff is completely devastated that they have caused the error that has led to the deterioration and eventual death.

Depending on the culture within the organisation, the member of staff may undergo a competence investigation, be removed from their job, be reported to their regulator, or be supported while the incident is reviewed.

A systems-based analysis would identify care delivery failures and service delivery failures, help to identify root causes for these failures, and would be supported with a SMART action plan to put systems in place that make it difficult for an error to reach the patient.

Any individual related issues identified, are dealt with in other ways, such as retraining, professional development, non-clinical support, or HR processes in an organisation that focuses on systems rather than individuals but practices a culture of accountability over a no-blame culture.

**Learning objectives:**

1) Understanding of the different types of cultures within organisations.

2) Understanding of systems-based analysis.

3) Support for staff involved in incidents.

4) Supporting patients/families through incidents.