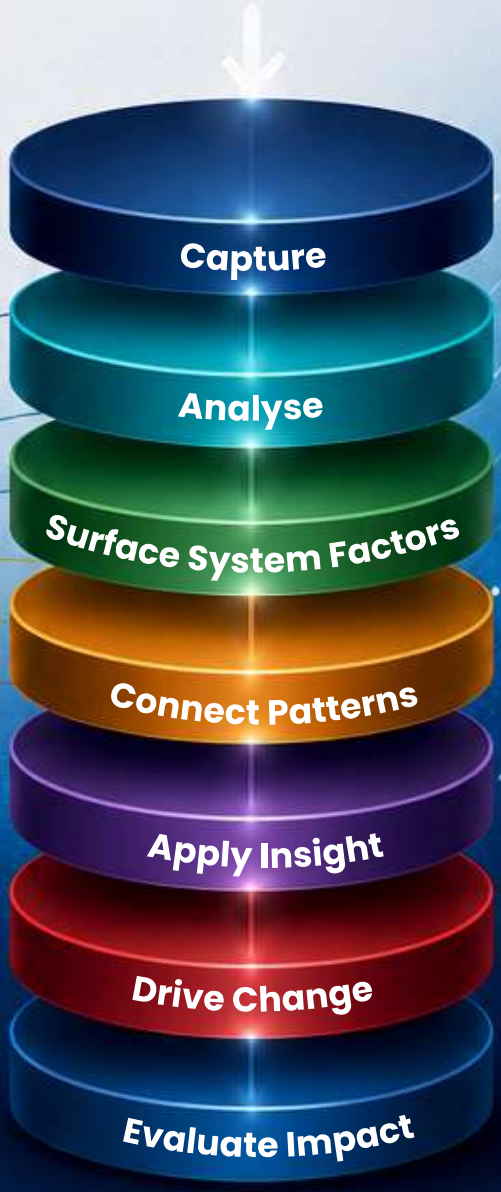
# CASCADE

## From Incident to Insight

***A Practitioner Workbook and Implementation Guide for Learning from Patient Safety Incidents***

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**CASCADE: From Incident to Insight — Toolkit & Implementation Guide**

CASCADE™ is a proprietary patient safety learning framework developed by Aderonke Opawande.



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# ABOUT THIS GUIDE

## Who This Workbook Is For

- Nurses and clinicians involved in patient safety incidents
- Patient safety and governance leads
- Clinical educators and quality improvement teams
- Care home and community healthcare leaders

## What You Will Be Able To Do

- Use CASCADE to structure patient safety learning
- Identify system factors beyond individual error
- Connect repeated incident themes across time and settings
- Convert insight into specific actions with owners and deadlines
- Evaluate whether learning has reduced risk
- Apply CASCADE retrospectively and prospectively

## HOW TO USE THIS WORKBOOK

This workbook is designed to help clinicians, patient safety leads, educators and healthcare teams apply CASCADE in real-world settings. You can read it from start to finish, use individual chapters during incident reviews, or apply the templates during team learning sessions.

CASCADE works best when used actively. Read, reflect, complete the tools, discuss the patterns and return to the Evaluate Impact stage after actions have been implemented.

## USING THIS WORKBOOK FOR CPD

This workbook can support reflective learning, patient safety discussion, quality improvement planning and professional development. Readers may use completed reflections, action plans and learning summaries as evidence for local CPD or revalidation portfolios, subject to their regulator's requirements and employer policies.

***Case study note:***
The case studies in this workbook are fictional and designed for learning. Any similarity to real events is coincidental. They should not replace local policy, clinical judgement, statutory reporting duties or organisational governance processes.


CHAPTER 1:

# WHY WE MUST LEARN DIFFERENTLY

*The gap between reporting and learning is costing lives.*

Every healthcare system in the world has an incident reporting system. The WHO estimates that across high-income countries, between 1 in 10 and 1 in 25 hospital admissions results in an adverse event, and the vast majority of those events are preventable. Yet the incidents keep happening. The same themes recur. The same harms repeat.

The problem is not that we are not reporting. The problem is that reporting without structured learning is the organisational equivalent of filing without reading. Data goes in. Insight does not come out.

This is not a knowledge gap. It is a method gap. Healthcare systems do not lack data, they lack a structured, repeatable way to turn that data into change. CASCADE is that method.

### The Global Evidence

WHO patient safety data indicate that around **1 in every 10 patients** is harmed in healthcare, and more than **3 million deaths** occur annually due to unsafe care. In low- and middle-income countries, unsafe care in hospitals is associated with an estimated **134 million adverse** events and around **2.6 million deaths** each year.

The global cost associated with medication errors has been estimated at US$42 billion annually (WHO, 2017).

Most of these events share one feature: they had predecessors. Someone reported something similar before. The events were not unpredictable, they were unlearned.

## THE INCIDENT REPORTING TRAP

Incident reporting was designed to create a learning record. In practice, it has become, in many organisations, a compliance record. Staff report because they must, not because they believe anything will change. HSSIB's 2025 report on investigating under PSIRF highlighted the need to strengthen how NHS organisations support staff to conduct system-based investigations and translate investigation activity into learning and improvement.

This is not a UK problem. The Joint Commission in the United States, the Australian Commission on Safety and Quality in Health Care, and WHO's Global Patient Safety Challenge all identify the same failure mode: organisations that report well but learn poorly. The Joint Commission's Sentinel Event Policy explains how it works with healthcare organisations after serious patient safety events to protect patients, improve systems and prevent further harm. The Joint Commission defines a sentinel event as a patient safety event that results in death, permanent harm or severe temporary harm.

## WHAT LEARNING MEANS

Learning, in the patient safety context, is not reading a report. It is the durable change in system behaviour that reduces the probability of the same harm occurring again. By that definition, most incident reviews do not produce learning, they produce documentation.

### The Three Markers of Real Learning

- A specific, identifiable change in system design, process, or behaviour
- A mechanism for verifying that the change was implemented
- Evidence that the change reduced the risk of recurrence

CASCADE offers a structured method for closing this gap. It gives individuals, teams, and organisations a repeatable process for moving from incident data to genuine insight, and from insight to embedded change.