Learning from adverse events

Learning and improvement summary

November 2014
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1 Background and context

It is internationally recognised that between 10–25% of episodes of healthcare (in general hospital, community hospital and general practice) are associated with an adverse event\(^1\).

It is important that there are robust and reliable processes in place to effectively manage adverse events, and that lessons are shared widely and used to support improvements in patient care and service delivery.

Healthcare Improvement Scotland has been working with NHS boards across NHSScotland to improve the effective management of, and learning from, adverse events.

This summary paper provides an overview of the work to date, including areas of good practice we have seen across NHSScotland and an update on the national activities that are aimed at supporting local implementation of the national framework for learning from adverse events.

Review programme

Between autumn 2012 and spring 2014, we visited every NHS board that provides services directly to patients to review their processes for managing adverse events. The reviews were aimed at supporting NHS boards to improve services by learning from adverse events, reducing the risk of these events happening again, and providing public assurance that NHS boards are effectively managing adverse events. Our reviews focused on the following six key areas:

- engaging with stakeholders
- staff knowledge and training
- roles and responsibilities
- information management
- risk-based, informed and transparent decision-making, and
- timely management, learning, dissemination and implementation.

The review reports for each NHS board are available on our website\(^2\).

We found areas of good practice (see Section 2), but we also found common areas across all NHS boards that should be improved in order to effectively manage adverse events. These included:

- involving patients, families and carers in the adverse event review process and documenting their involvement
- providing feedback to staff members about the review in a timely manner
- ensuring information from all stages of the adverse event review process, from initial report through to monitoring of actions, is consistently and reliably recorded, and
- consistently sharing learning and demonstrating improvements.

\(^1\) The Health Foundation (2011). Evidence scan: Levels of Harm (http://www.health.org.uk/publications/levels-of-harm/)

\(^2\) http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/adverse_events_review_reports.aspx
All NHS boards have improvement plans in place to address the recommendations from their review.

We also found substantial variation in the processes of managing adverse events across NHSScotland, making it difficult to share comparable information.

**National framework**

In early 2013, we carried out an extensive engagement and consultation exercise with NHS boards, clinicians, patients and a number of national groups and organisations to inform the development of a national approach to learning from adverse events. This feedback, alongside existing evidence and good practice from Scotland and internationally, was used to develop *Learning from adverse events through reporting and review: A national framework for NHSScotland*[^3], which we published in September 2013.

The national approach is not intended to prescribe a management system, but provides a framework to support NHS boards standardise processes of managing adverse events across all care settings in Scotland.

Consistent definitions and a standardised approach to adverse event management across NHSScotland aims to ensure a robust and reliable process and maximise the opportunities for NHS boards to share and actively learn from each other so that they can put improvements into practice.

The national framework:

- provides, for the first time, a national definition of an adverse event and guidance on the reporting categories that should be used to group adverse events
- provides the principles on which the national approach is based such as openness, a just and positive safety culture, accountability, teamwork, a systems approach and an emphasis on learning and promoting best practice.
- outlines the steps that should be taken to manage adverse events, and
- defines the roles and responsibilities necessary to support the effective management of adverse events.

The national approach seeks to ensure that no matter where an adverse event occurs in NHSScotland:

- the affected person receives the same high quality response
- any staff involved are treated in a consistent manner
- the event is reviewed in a similar way, and
- learning is shared and implemented across the organisation and NHSScotland to improve the quality of services.

Section 3 provides details of the key achievements to support the implementation of the framework over the past year.

2 Areas of good practice

We identified many areas of good practice in the management of adverse events and some examples of these are listed below. These do not apply to all the NHS boards reviewed, but are highlighted as themes of good practice.

- A range of staff reporting and recording adverse events on an electronic reporting system, including community and primary care staff.

**NHS Grampian** has undertaken a project to extend the use of Datix to independent GPs within Grampian and also plans to extend the availability of Datix to independent dentists and community pharmacy contractors. This will allow themes and learning to be identified across primary and secondary care.

**NHS Tayside** uses the DatixWeb system which is capable of capturing adverse event reports from all acute and community-based services including opticians, community pharmacies, community dental practices, health and social care services, schools and education facilities across Tayside.

- Developing leaflets to support staff and patients or families and carers involved in a significant adverse event review.

- Changes made to reporting systems and review documentation to explicitly record notification and involvement of the patient, family and carer in the review process or reasons for not involving them.

- Providing guidance for staff to support them through the reporting, review and action planning processes.

**NHS Ayrshire & Arran** has developed guidance and resource packs containing a variety of checklists and templates for undertaking a review and developing action plans to support a robust and consistent approach.

**NHS Greater Glasgow and Clyde** has produced a toolkit to guide reviewers through the review process. This provides information on tools and methods available to facilitate the review and an advice leaflet for the lead reviewer.

**NHS Lanarkshire** has updated and implemented its policy for the management of adverse events with the national framework categories for grading adverse events. It has also developed a handy pocket-sized guide for staff on the adverse event process which includes these categories. Staff have fed back that they find these grading categories easier to use.

**The Scottish Ambulance Service** uses hot debriefs immediately following a significant adverse event to gather quick learning points, look at what happened and what could have happened. Structured debriefs are used to gather information following a period of reflection after the event.
• An adverse event management system that is adapted in response to staff consultation.

**NHS Forth Valley** uses Safeguard as an integrated risk management system. It has changed its adverse event reporting procedures in response to staff comments to automatically provide feedback to the staff member reporting the adverse event. Timely feedback has helped to encourage a reporting culture in the organisation.

**NHS Lothian** has consulted with staff on how to improve the adverse event management system and made a number of changes to processes in response to staff feedback. These include developing a staff support booklet, training on writing reports and revision of the reporting form to make it more user-friendly.

• Making reporting easier by placing shortcuts to electronic reporting systems or forms on staff computers, providing web-based reporting using smart phones and tablets, and allowing reports to be made without logging on to the system.

• Senior management engagement and commitment to improving the adverse event management process.

• The use of patient stories at governance group meetings.

• Innovative approaches to encourage reporting by medical staff.

**NHS Forth Valley** and **NHS Tayside** have developed specialty-specific adverse event reporting systems to encourage reporting and review of adverse events.

**NHS Lothian** has piloted a system to encourage junior doctors to report adverse events.

• The use of an SBAR (Situation, Background, Action and Recommendations) format as part of the reporting system to support a consistent approach to reviews.

• Developing databases or systems to track recommendations and actions, and monitor their implementation.

**NHS Ayrshire & Arran** uses the Sharepoint system to support tracking and auditing of action plans. Alerts can be sent out as a reminder of timescales and senior staff can access action status reports to monitor progress.

**The State Hospitals Board for Scotland** has created a bespoke database through which the implementation of action plans is monitored and real-time updates generated and reported to relevant committees.

• A rolling programme of training for adverse event reporting and for adverse event review methodologies.
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- A simplified, responsive governance structure which has resulted in improved Board assurance and executive oversight of significant adverse events.

- An ‘open door’ culture from senior staff to support the adverse event management process.

- A range of approaches to support sharing information and learning from adverse event reviews.

**NHS Dumfries & Galloway** promotes learning from adverse events and complaints through twitter (@dglearn) and online blogs (dglearn.wordpress.com).

**National Services Scotland** has been undertaking work to support and promote a ‘just culture’ including workshops for staff and communications through the intranet and newsletters.

**NHS Highland** anonymises and uploads all of the reports from significant adverse event reviews carried out in Raigmore Hospital, Inverness, onto the NHS Highland intranet to promote openness and transparency and support the sharing of learning. It plans to extend this to include reports from all its operational units.

- Identification of organisation-wide themes to inform priority areas for improvement across the organisation, by analysis of adverse events, complaints and other sources of information.

**NHS Fife** has introduced an overarching ‘reducing harm’ action plan to take an organisation-wide approach to focusing on patient safety and quality improvement issues. Information is gathered from a number of sources such as adverse event reviews, complaints, medical and surgical profiles, morbidity and mortality data and Scottish Patient Safety Programme measures.

A number of other NHS boards have developed dashboards which link data from adverse events, complaints and claims. The data can be presented at ward, directorate and organisational level to look at emerging themes.

- Partnership working with other NHS boards to jointly consider adverse event reviews and share learning points.

**NHS 24** has established monthly regional meetings with partner NHS boards to discuss learning points from adverse events.

**NHS Western Isles** has linked with NHS Grampian and NHS Greater Glasgow and Clyde to work through a multi-NHS board review. They have established a single point of contact for the patient to be involved in the review process.
• Service improvements following adverse event reviews.

**NHS Borders** has invited a patient back to see the improvements that have been made following implementation of the adverse event review recommendations.

**NHS Fife** has put in place an increased level of frailty screening for over 65s following identification of falls as the top adverse event theme.

**NHS Greater Glasgow and Clyde** is currently evaluating the outcomes of adverse event reviews to determine if the implemented recommendations have resulted in improved quality of care.
3 National support for implementation and improvement

Following publication of the national framework for learning from adverse events, we established a national programme to support implementation focusing on activities that would add most value at a national level. We have made significant progress over the past year and some of these key achievements are outlined below.

We committed to review and update the framework as the programme progressed. A refreshed framework is currently being developed and will be published in early 2015 with the guidance and toolkits described below.

National collaborative learning event

In May 2014, we held a national collaborative learning event for NHS boards and stakeholders involved in learning from adverse events. The event provided a learning platform for:

- consulting on and shaping key deliverables: national reporting system; national and local measures;
- tools; learning strategies
- NHS boards to present and debate the successes and challenges of implementing the national framework and influence the next iteration
- master classes on key topics such as human factors and situational awareness
- launching the community of practice online resource, and
- high performing organisations to share their success methods.

The event was an opportunity to bring together NHSScotland and other stakeholders (such as Scotland’s Patient Association, Scottish Public Services Ombudsman, Academy of Royal Colleges and Faculties Scotland, Scottish Trade Unions Congress, Scottish Government) to learn from adverse events and improve the safety of Scotland’s healthcare system for everyone.

The outputs and learning from this event are being fed into the refresh of the national framework, in particular signposting good practice, supporting materials and information.

Being Open

“Being open about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals cope better with the after-effects”\(^4\). All NHS boards in Scotland have faced challenges in implementing the ‘Being Open’ principles which relate to communicating with patients and their families.

We have been working to develop a package to support NHS boards implement the ‘Being Open’ principles to ensure a consistent approach to engaging with patients, families and carers.

\(^4\) Being Open, NPSA, 2009 ([http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726](http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726))
There are two strands to this work:

- the principles within the National Patient Safety Agency (NPSA) Being Open Framework (2009) have been drafted into a guidance document for NHSScotland, and
- a 12-month pilot is under way within NHS Lothian and the National Waiting Times Centre to support staff in implementing the principles of ‘Being Open’ when an adverse event happens.

The draft ‘Being Open’ guidance paper\(^5\) presents a refresh of the NPSA Being Open framework to support a standardised approach to communicating and engaging with patients, families and carers when an adverse event happens. The information can be used to guide and inform local policy and procedures, and applies across all care settings within NHSScotland. The principles are written for patients, families and carers, but should be applied, when appropriate, to any adverse events (clinical or non-clinical) which cause harm to patients or staff.

This paper was issued for consultation to key stakeholders in July 2014 to facilitate further engagement and discussion ahead of publishing as guidance with the refreshed framework in 2015.

We are working with NHS Lothian on a pilot project to test how we can support implementing the principles of ‘Being Open’. The pilot is taking place in inpatient maternity and neonatal services at the Royal Infirmary of Edinburgh and will run until June 2015.

The aim of this pilot is to improve communication with patients about adverse events – from when the event happens until the end of the review process. NHS Lothian will work with staff in maternity and neonatal services to:

- develop and test processes for engaging with patients and families and ensuring that their ongoing support needs are identified, and
- develop and test communications training for staff.

Learning from the project will be shared locally and nationally. The learning and outcomes from the pilot will also provide case studies that can be used as practical examples of the ‘how’.

We are also working on developing national information leaflets for patients, families and carers and for staff which can be used as a tool to support implementation.

**Standardised report writing**

To enable appropriate learning to be shared, whilst safeguarding patient, family and staff confidentiality, we have developed and consulted on a standard approach to writing adverse event review reports\(^5\). This approach supports writing review reports in a format that minimises the need to redact patient or staff identifiable information so that information can be shared more freely.

We have set out:

- the recommended elements to include in an adverse event review report
- guiding principles for NHS boards to consider when writing reports and deciding what information could be meaningfully shared with patients, families, carers, staff, partner organisations or across NHSScotland, and
- a checklist of items to consider for redaction before sharing widely.

This standard approach would apply across all care settings within NHSScotland.

The feedback from the consultation exercise is being reviewed and the final guidance will be published as part of the refreshed framework toolkit.

**Systems mapping exercise**

A mapping exercise of existing systems and data used by all NHS boards to manage adverse events was undertaken in early 2014 [http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/adverse_events_consultation1.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/adverse_events_consultation1.aspx)

This was used to inform an options appraisal process on the potential for a national IT-led approach which would support the implementation of a national system to capture and share learning from adverse events.

Following extensive consultation throughout the year, it was agreed that a network of learning portals was the current preferred option for capturing and sharing learning and improvement nationally. We are now working with NHS boards to develop the national community of practice and adverse events learning network to support this (detail below).

However, the majority of participants in the options appraisal process indicated a preference to move to a standardised national IT approach for reporting of adverse events in the longer term. We are currently in discussions with NHS England about the redevelopment of England’s National Reporting and Learning System to understand any relevant lessons for Scotland.

**Managed community of practice**

A managed community of practice is being developed to support sharing of good practice and key learning points from adverse event reviews nationally. The community of practice includes both an online site[^6] with a virtual network of members and complementary network meetings. The network will meet twice a year, and the first meeting took place in October 2014.

The community of practice aims to:

- share key learning points from adverse event reviews and the resulting process or service improvements
- share review tools and methodologies

• support national discussion of key or topical issues
• develop a national network that provides peer support
• support national training by holding 'train the trainer sessions' for the network on key topics, and
• support the network to focus on specific events and use adverse event review reports to develop ‘safety cases’ as a structured tool for showing that the local risks to service delivery systems have been both identified and addressed.

The community of practice site will be continuously developed and improved to meet the needs of the network.

We have agreed with the Procurator Fiscal to share key learning points that apply nationally from the review of deaths reported to them and we are currently testing this process. We will use the community of practice along with other existing mechanisms, such as the Scottish Patient Safety Programme networks and managed clinical networks, to share these learning points.

**Clinical governance non-executive directors’ network**

The quality portfolio group (set up by NHS board chairs and holds commissioning powers for development needs identified by board chairs and chief executives) agreed earlier this year that Healthcare Improvement Scotland should establish a network of non-executive directors involved in clinical governance. The network will initially focus on supporting non-executive directors in their role of challenging executives and providing assurance to the Board that adverse events are being managed effectively.

The first network meeting was held in August 2014 and feedback has been extremely positive with non-executive directors welcoming this opportunity to meet to share good practice and discuss challenges and potential solutions. The network will meet twice a year with the next meeting scheduled for February 2015.
4 Challenges and next steps

Challenges ahead
An ever-changing landscape brings new challenges. Whilst the principles within the framework are defined, the context and circumstances in which they sit will change as new evidence, policy and legislation are introduced. Of particular consideration for us in the short term are the developments around the introduction of a statutory duty of candour, an offence of wilful neglect and no fault compensation and the implications of these for learning from adverse events.

We have taken a phased approach to implementing framework, with an initial focus on acute care and managed community services. The principles are intended to encompass all care settings and work is now required to embed the framework within primary care and social care services; the latter becoming increasingly important as we move towards health and social care integration in 2015.

It is also important that this work is not taken forward in isolation of other national programmes that share the same aims to improve the reliability of processes and reduce harm. We are working with relevant teams to integrate this work more fully with the Scottish Patient Safety Programme, Person-Centred Health and Care Collaborative and learning from the complaints and feedback programme.

Next steps
The refreshed framework is currently being developed and is planned for publication in early 2015. The principles within the framework will not change, and we will publish the tools and guidance that have been developed nationally. These will further support NHS boards to effectively manage and share learning from adverse events to improve the safety of Scotland’s healthcare system for everyone.
You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

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