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Foreword

Care will never be risk free, but we can minimise these risks in order to provide high quality care for the people of Scotland.

Learning from adverse events is crucial to continually improve person-centred, safe and effective delivery of care. This will contribute to the national health and wellbeing outcome that people who use health and social care services are safe from harm.

“The best way to reduce harm ... is to embrace wholeheartedly a culture of learning.”


NHS boards have made a number of improvements to their processes for managing and learning from adverse events. This learning and improvement summary report outlines some of the areas of good practice that have been shared over the last year. It also provides some specific examples of improvements that have been made following adverse event reviews that have led to an improved quality of care for people. Additionally, the report provides an update on the national programme of work that is aimed at supporting local implementation of the national framework for learning from adverse events.

Supporting cultural change is at the heart of this work. We all want to achieve a positive safety culture that is open, just and informed, in which reporting and learning from error is the norm. Achieving cultural change is challenging and will take time, but we are seeing positive changes with learning summaries beginning to be shared nationally through the adverse events community of practice website\(^1\). This is increasing the opportunities to actively learn from each other and put improvements into practice.

This report highlights only a sample of the work that NHS boards and Healthcare Improvement Scotland have carried out over the past year. We hope you will find it of interest reading about the improvements that have been achieved across Scotland.

David Farquharson
Chair of the Adverse Events Programme Board
Medical Director
NHS Lothian

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Healthcare Improvement Scotland

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\(^1\) [http://www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx](http://www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx)
Background and introduction

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 event².

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 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. In April 2015, we published the second edition of: Learning from adverse events through reporting and review: A national framework for NHSScotland³.

This summary report provides an overview of areas of good practice and challenges identified by NHS boards in implementing the national framework and sharing learning from adverse events. It features specific examples of the differences that have been made by NHS boards as part of their ongoing work to improve the management of adverse events. An update on the national programme of work that is aimed at supporting local implementation of the national framework for learning from adverse events is also included.

Adverse event reviews

Between autumn 2012 and spring 2014, Healthcare Improvement Scotland 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.

The review reports for each NHS board are available on our website⁴ and all NHS boards developed improvement plans to address the recommendations from their review. The recommendations focused on involvement of patients, families and staff, having reliable processes and documentation, and consistently sharing learning and demonstrating improvements.

The reviews highlighted areas of good practice; however, 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

⁴ www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/adverse_events_review_reports.aspx
for NHSScotland, which we published in September 2013. We committed to review and update the framework as our programme of implementation support developed. A refreshed framework was published in April 2015 taking into account the information, guidance and tools that had been developed (further details described below).

The national approach is not intended to prescribe a management system, but provides a framework to support standardised processes for managing adverse events across all care settings in Scotland. Consistent definitions and a standardised approach aims to ensure a robust and reliable process and maximise the opportunities for organisations to share and actively learn from each other, so that they can put improvements into practice.

**Progress meetings**

We met with all NHS boards in the autumn of 2014 to discuss and learn from their experiences of implementing the national framework. Between the end of September 2015 and the beginning of November 2015, we held a further series of progress meetings with NHS boards to understand how they are continuing to implement the national framework. Discussions were also focused on sharing information and ideas and getting feedback on the national programme to ensure we are focusing our resources on areas that will add value.

We met with all 19 patient-facing NHS boards as listed below:

- NHS 24
- NHS Ayrshire & Arran
- NHS Borders
- NHS Dumfries & Galloway
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS National Services Scotland
- NHS National Waiting Times Centre
- NHS Orkney
- NHS Shetland
- NHS Tayside
- NHS Western Isles
- Scottish Ambulance Service
- The State Hospitals Board for Scotland

This summary report shares the learning from areas of good practice and quality improvements being taken forward by NHS boards in the management of adverse events, identified through progress meetings or updates from NHS boards during 2015.
Areas of good practice

We identified many areas of good practice in the management of adverse events and some examples of these are listed later in this section. These do not apply to all the NHS boards reviewed, but are highlighted as examples of good practice. The rest of this section provides more detail about the areas of good practice across the following themes:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Specific areas of focus</th>
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| Sharing learning       | • A range of mechanisms used to share learning from adverse events within NHS boards.  
                          • Use of the national learning summary template (based on the learning summary template originally developed by the Scottish Ambulance Service) to share key learning points either locally or at national level.  
                          • Sharing approaches to adverse event management with stakeholders.  |
| Patient, family or carer engagement | • Engaging and involving the patient, family or carer, and maintaining a focus on the care delivery from their perspective.                          |
| Staff engagement and support | • Clinical engagement and local ownership.  
                          • Staff training and awareness raising initiatives.  
                          • Communication and support for staff. |
| Tools, guidance and processes | • Examples of how NHS boards are developing, implementing and adapting tools, guidance and processes to improve the management and monitoring of adverse events. |
| Governance and overview | • Examples of improved practices to support the overview and governance of adverse events.                                                             |
| Quality improvement    | • Examples of quality improvement initiatives to help prevent or reduce the number of adverse events.                                                       |
Sharing learning

The progress meetings highlighted good practice for sharing learning from adverse events, including a range of communication mechanisms, the use of the learning summary template and the sharing of approaches with stakeholders.

- A range of mechanisms used to share learning from adverse events within NHS boards.

**NHS 24** supports individual learning by reviewing the effectiveness of communication mechanisms, such as safety huddles, ‘hot topics’, e-learning, managerial feedback to staff and the visibility of staff noticeboards.

**NHS Borders** nursing staff are required to bring examples of patient feedback and relevant complaints or adverse events to their appraisal sessions, to support individual reflection and learning, and identify any development needs.

**NHS Dumfries & Galloway** uses a learning blog to promote learning from adverse events to staff, facilitated by the communications department. The NHS board is working on collating summary points from the learning blog for sharing with staff through leaflets, flyers, staff noticeboards and at team meetings.

**NHS Fife** holds inter-specialty clinical governance meeting every 3 months which has evolved from being a uni-disciplinary event to one which is open to all clinical professionals. The programme includes case presentations which share the learning and improvements from significant adverse event reviews.

**NHS Forth Valley** cascades learning from significant adverse events to relevant directorates and asks them to record what is being done in their area in response to the learning points, or to confirm that no action is required. Specialised groups review medication safety-related events including themes and actions required. Individual directorates nominate a lead reviewer to present the findings and learning to the directorate and for cascading through clinical leads.

**NHS Grampian** holds a shared learning session every 3 months aimed at all levels of staff, where each division is asked to present their recent significant adverse events for discussion.

**NHS Lothian** feeds adverse event review learning points directly into relevant improvement programmes for action as required.

**NHS National Services Scotland** shares learning from adverse events across relevant strategic business units.

**NHS Tayside** shares learning from adverse events through weekly clinical risk management meetings, a monthly ‘getting it right’ newsletter, and by considering significant adverse event learning summaries within the performance review process.

**The State Hospitals Board for Scotland** publishes all adverse event reports in a redacted format on the staff intranet.
• Use of the national learning summary template to share key learning points either locally or at national level.

<table>
<thead>
<tr>
<th>NHS Grampian’s</th>
<th>Risk management advisor for patient safety meets with divisional general managers each month and discusses with them the completed learning summaries uploaded to the national community of practice website.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Shetland</td>
<td>Has added the learning summary template to their adverse events reporting system to encourage use by staff.</td>
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<tr>
<td>NHS Forth Valley</td>
<td>Has shared learning points from ombudsman reports and a significant events newsletter for GPs through the adverse events community of practice website: <a href="http://www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx">www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx</a></td>
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• Sharing approaches to adverse event management with stakeholders.

| NHS Forth Valley | Has shared learning points from ombudsman reports and a significant events newsletter for GPs through the adverse events community of practice website: [www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx](http://www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx) |
| NHS Greater Glasgow and Clyde | Has been sharing its approach to training clinicians on how to undertake adverse event reviews with other NHS boards. |
| NHS Highland | Has shared the national framework for adverse events with Argyll and Bute Council to enable them to consider the implications for the integration of health and social care. |
| In NHS Lothian, council colleagues participate in team training for adverse event review in mental health services and plans are in place to test joint council/health reviews for suicide. |
| NHS Shetland | Has shared the learning summary template with Shetland Islands Council as part of health and social care integration discussions for sharing learning from adverse events. |

**Improvement example - Medicine Sick Day Rules cards**

**What happened**

There were a number of adverse events in NHS Highland which involved patients continuing particular ongoing medications while ill which led to dehydration and serious renal failure.

These included an older person who was admitted to hospital following a fracture. During
the patient’s stay, clinicians noted a previously unknown cognitive impairment. The patient was prescribed perindopril (to support stroke prevention) and continued on metformin for type 2 diabetes. In the context of dehydration, perindopril can accelerate the development of acute renal failure. Metformin accumulates to excess in renal failure and can then cause life-threatening lactic acidosis. The patient had poor fluid intake and was given intravenous fluids. The patient was transferred to a community hospital as an intermediate step to returning home. There were challenges in maintaining adequate hydration as the patient regularly declined oral fluids and removed a subcutaneous fluid line on several occasions. The patient was returned to the acute hospital when their condition acutely deteriorated due to acute kidney injury and lactic acidosis, a condition from which the patient died shortly after arrival. This event was caused by the continuation of the prescribed medication in the presence of inadequate fluid intake over several days.

What the adverse event review revealed

The reviews carried out by the NHS board and the Procurator Fiscal identified issues around:

- review of the patient’s medication following poor food and fluid intake, and
- recognition of the deteriorating condition and timely decision to transfer back to the acute hospital.

The reviews also identified areas of good practice around:

- staff attempts to raise the patient’s fluid intake
- a multidisciplinary approach to the patient’s care, and
- a person-centred discharge and transfer process.

What actions were taken following the adverse event review

A number of improvements have been put in place to address the recommendations made by the review as outlined below.

- Development and promotion of a medicines and dehydration briefing note. This outlines staff responsibilities to share patient ‘Medicine Sick Day Rules’ information cards setting out which medications to temporarily stop taking during illness as they can result in dehydration. These medications include:
  - ACE inhibitors: medicine names ending in ‘pril’.
  - ARBs: medicine names ending in ‘sartan’
  - NSAIDs: anti-inflammatory pain killers
  - diuretics: often called ‘water pills’, and
  - metformin: diabetes medication.

- Development of patient and clinician information leaflets to accompany the card. The patient information leaflet outlines what actions to take if they develop an illness that causes dehydration. The clinician leaflet explains why there is a need for this initiative and what it will involve.

- Assignment of a pharmacist to the particular hospital on a part-time basis who will be responsible for:
- medicines reconciliation on admission
- attending consultant weekly ward rounds
- hospital discharge letters, and
- pharmaceutical support and advice to medical and nursing staff.

**What difference has been made**

The Medicine Sick Day Rules card and information leaflets have been widely circulated across the country through community pharmacists, GP practices and hospitals. They have proven a useful resource for patients, carers and health professionals. The card promotes better management of long-term conditions through safer, more effective and person-centred use of medicines. It helps to raise awareness of potential harms if patients continue to take certain widely prescribed medicines whilst suffering from a dehydrating illness. An example of this is highlighted in the following quote from a patient.

“As a heart failure patient, that means I have a number of medications to maintain my condition. These medications can have important and serious side-effects. When picking up a prescription the pharmacist gave me a little card. This was a sick day rule card and this told me what to do should sickness and diarrhoea ever occur again. As chance would have it, sometime later I had another episode of sickness and diarrhoea, and I remembered the card I had been given. As a heart failure patient, I had it drilled into me that whatever happens I must always take my heart tablets. But I decided to follow the instructions on the card. I stopped the ACE inhibitors, I stopped the diuretics, and this time after a couple of days, rather than escalate out of control, the problem began to resolve itself. So that little card made a big difference. It meant I didn’t have to go into hospital and my family didn’t have to visit me in hospital.”

The Medicine Sick Day Rules card was launched nationally in conjunction with the Scottish Patient Safety Programme at the NHSScotland national event in June 2015. Copies of the cards and information leaflets were provided to delegates at the event. The card and information leaflets have since been widely circulated across the country and can be downloaded from the primary care section of the SPSP website:

www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/medicine-sick-day-rules-card

A video describing how the medicine sick day rules cards have been used in NHS Highland is also available.

**Improvement example - patient fall in an acute hospital ward**

**What happened**

A patient fell in an acute hospital ward and sustained a head injury and subsequently died in hospital.

**What the adverse event review revealed**

- Vital information supplied by the family was not taken into consideration in care planning.
- Additional nursing and specialist staff were needed on the ward to look after patients.
- Staff required support in what was a very busy ward environment.

5 [www.youtube.com/watch?v=9cqaXI0508k](https://www.youtube.com/watch?v=9cqaXI0508k)
The design of ensuite doors was poor as they could only be opened outwards which raised the risk of falls, particularly for patients using zimmer frames.

What actions were taken following the adverse event review

- The patient's relative was given the opportunity to meet with the service manager and they worked through a number of issues with the support of the patient relations team. A meeting was held between the patient’s relative and relevant nurses and doctors to discuss what improvements could be introduced. When the patient’s relative felt listened to and could see that action was being taken, she became more interested in helping to identify improvements.
- Improvements were introduced to the ward, including additional nursing and specialist staff, volunteers to support patients with Alzheimer’s, a new sitting room for patients and the installation of specially designed doors to enable patients to open them in both directions.
- The patient’s relative shared her experience at NHS Fife’s Board meeting, a falls event and at a national conference. Staff joined her to share their perspective.
- A two-part video featuring the relative’s story was co-produced with NHS Education for Scotland (NES)⁶ to support NHS Fife’s corporate induction for new staff. The video underlines the need to listen to and learn from patients, families and carers and makes the vital connection between the organisation’s vision and values and people’s lived experience.

What difference has been made

- Bringing the patient’s relative back to the ward to see the success of the implemented changes and allowing her to share her story has been very powerful.
- The patient’s relative has supported the development of learning materials for a case study which will be used by NES, so other people can learn from the adverse event and its associated improvement work.
- The patient’s relative is now a patient representative on the hospital’s falls group and the integration of health and social care group.

The patient’s relative highlighted the benefits of the changes made:
“I went back to go around the ward and see all that had been done, maybe 3 or 4 months after it had happened. Even walking through the front door it was a totally different atmosphere. There’s not a battered in atmosphere, everybody is confident and wanting to improve, there’s volunteers on the doors and people meet you. The whole thing is an absolute culture change and I so want to get it out into the public domain that things are on the up.”

Feedback indicates that the video has had a profound effect on staff attending the NHS board’s corporate induction.

Patient, family or carer engagement

The progress meetings highlighted good practice for engaging and involving the patient, family or carer, and maintaining a focus on the care delivery from their perspective.

**NHS Borders** has captured patient stories on a DVD for staff training and the chief executive is sponsoring work to help staff have a ‘listening’ conversation with the patient, family or carer. Patients have joined quality improvement initiatives, such as the frailty group, to help redesign the care pathway.

**NHS Fife** involved a family member to create a sense of urgency around the key organisational priority of falls (identified through adverse events data). The patient’s relative initially shared her experience at a Board meeting and has since told the story at a local falls event and a national conference. This story has been captured by video which is now used as part of corporate induction and national resources (see improvement example above).

**NHS Forth Valley** generally invites the patient, family or carer to take part in the adverse event review process at an early stage, so that any concerns can be identified and addressed promptly.

In **NHS Grampian**, it is now mandatory for staff to offer the patient, family or carer the opportunity to become involved in the review process for all category 1 reviews (adverse events that may have contributed to or resulted in permanent harm). Feedback advisors also attend feedback meetings with the patient, family or carer, by phone or face to face, to encourage early resolution, and to ask them “What is it you want from the process?”

**NHS Greater Glasgow and Clyde** has produced a flow chart illustrating how the complaints process runs alongside the adverse events review process. A main point of contact is given to the patient, family or carer for adverse events which had previously been part of the complaints process.

In **NHS Lothian**, the chief executive chairs the Patient Experience Group. The NHS board carried out a pilot of the ‘Being Open’ approach within maternity services. The pilot made a significant improvement to the culture within maternity and neonatal services at the Royal Infirmary of Edinburgh with staff feeling more confident and supported to talk openly with patients and their families following unwelcome or unexpected events. This has been appreciated by both staff and patients.

**The State Hospitals Board for Scotland** responds quickly to questions raised by patients during leadership walkrounds, so that any concerns can be addressed before they become significant issues.

**NHS 24** has agreed a process, for implementation in summer 2016, for recording the rationale for contacting the patient, family or carer as part of the review process, alongside who is responsible for making contact. Where it is not appropriate to make contact, the rationale for this will be recorded.
### Improvement example – offering to meet with relatives or carers for patients admitted to an acute mental health ward

**What happened**

NHS Lanarkshire received notification about the suicide of a former inpatient of one of its mental health units who had recently moved to England. As the person had recently been an inpatient and was known to the community mental health team, NHS Lanarkshire decided to carry out a review of the patient's involvement with its services whilst in its care. The review used the Healthcare Improvement Scotland suicide template.

**What the adverse event review revealed**

The review recommended that relatives or carers are offered a meeting with the primary or associate nurse within 72 hours of a patient being admitted to an acute mental health ward, with the patient's consent. Staff must clearly explain the purpose of meeting with the relatives or carers. This is in keeping with the Scottish Patient Safety Programme agenda within NHS Lanarkshire and is a process that was already in place within one of its acute inpatient areas. To date, there has been no occasion within the inpatient area where a patient has refused to give consent for contact to be made.

**What difference is being made**

The recommendation is being implemented within all NHS Lanarkshire acute mental health wards. The meeting allows staff to gain more background information from the family or carer’s perspective and provides an opportunity for the NHS board to offer support to them.

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### Improvement example – involving the patient’s family in the adverse event review

**What happened**

NHS Grampian became increasingly aware that a patient or family’s perception of an adverse event could be different from the perceptions of the healthcare professionals involved or the adverse event review team. While the Being Open guidance advises organisations to keep families informed at every stage of the adverse event review process, it does not mention involving families in the actual review. The NHS board felt that this did not reflect a person-centred approach and used an example adverse event case to test a new approach. The adverse event featured a patient who had passed away in hospital following admission after sustaining a head injury. Staff, experienced in the collection and use of patient stories for improvement, talked to the patient’s relative to help understand how the event unfolded.

**What the adverse event review revealed**

The patient story compiled from the conversation was read out at the beginning of the review panel meeting where all the evidence relating to the event was considered. This ensured that the review panel understood the patient as a person rather than a case study. It also helped the panel to understand the impact of the death on the deceased’s family.

A timeline was created which included the family’s understanding of what had happened. Evidence within the timeline was colour coded to indicate whether the information came from documented records, staff statements or from the relative’s story. As a result, the review team was able to consider all the evidence from all the different sources before drawing conclusions about what had happened and why. As a result of this test of change, the following recommendations were agreed:
Learnin

• appropriately experienced staff should review adverse events to determine if a patient or carer story should form part of the review
• consent should be sought from patients, carers or families to use their experiences and stories as part of an adverse event review, and
• as a more person-centred approach to adverse event reviews supports the Duty of Candour, this should become normal practice.

What difference has been made
The review team was clear that the adverse event review was enhanced by the inclusion of the family story as an integral part of the review and that additional learning was identified because of this more person-centred approach.

Improvement example – patient or family involvement in action planning

What happened
The Scottish Ambulance Service applied the national framework for the management of adverse events not only to new adverse events but also to some events which were within the previous review process at that time. This was to ensure an in-depth review was conducted and that appropriate learning had been identified. This included a significant adverse event review of a patient who died from brain injuries sustained after a fall, several days after the paramedic accident and emergency unit and GP had attended the patient at home, and following earlier discharge from hospital after treatment for a head injury related to a previous fall. The Procurator Fiscal was involved as were several other agencies.

What the adverse event review revealed
The Service involved a member of the deceased patient’s family throughout the review process and provided them with a draft copy of the review for comment before final sign-off. The family felt that once the review recommendations were implemented they might prevent the same adverse event happening to someone else. However, a family member expressed concern about the timescales identified within the action plan for each of the recommendations. As a result, the Service reviewed the action plan and amended the timescales for completion of actions. This process allowed the reviewer to build a relationship which led to the family member becoming a patient representative for the Service.

What difference has been made
• The family were engaged and listened to during the significant adverse event review process and had input to the recommendations and action plan.
• Improved timescales were included in the action plan in response to the family’s input, to ensure recommendations were implemented in good time to help prevent a similar adverse event occurring.
• By engaging and listening to the family during the significant adverse event review process, a positive relationship was built between the family and the Service. This led to a family member becoming a patient representative for the NHS board and providing their valuable experience and perspective to other issues.
Staff engagement and support

The progress meetings revealed good work across the NHS boards to improve the engagement and support for staff involved in adverse events. This included improved clinical engagement, local ownership, communication and training for staff.

- Clinical engagement and local ownership

**NHS Ayrshire & Arran** considers the use of language when developing guidance tools to ensure it promotes an open and supportive culture. Clinicians are given the opportunity to lead on reviews to enable local ownership.

**NHS Borders** reviews all deaths in hospital and other mortality reviews such as children and stillbirths. If a harm-related event is identified that is not part of an adverse events process, the mortality and morbidity group is asked to review it and provide feedback. The NHS board is working with a group of medical staff, nursing staff and clinical service managers to increase the profile of clinical risk.

In **NHS Dumfries & Galloway**, the adverse events process is devolved and owned by individual directorates who discuss risk triage and what actions need to be taken at a local level.

**NHS Forth Valley** has adapted its electronic reporting system for clinical staff to make it more relevant and easier to use. It is also testing links with mortality and morbidity meetings for cardiac arrests and critical care, using local audit tools.

**NHS Grampian** is leading national work to better link mortality and morbidity meetings with adverse events. Medical staff are now recording more mortality and morbidity activity on the electronic reporting system which provides a wealth of information. The NHS board has adapted some of its processes to encourage medical staff to report adverse events and is featuring human factors within learning and ‘train the trainer’ sessions.

**NHS Lothian** has produced standards for mortality and morbidity meetings setting out criteria, such as which deaths should be discussed at the meetings and who should attend. This has been led by clinicians to ensure it is fully adopted.

The **NHS National Waiting Times Centre** reviewed the transplant service cardiologists’ mortality and morbidity meetings, which are held every 3 months. To support early capture and correction of error, it has been agreed that clinicians discuss events which went wrong or had gone very well, at their weekly multidisciplinary team meetings.

**NHS Orkney** is establishing links with **NHS Highland** to provide a medical education role aligned to medical staff development and placement experience.

**NHS Tayside** has developed specialty-specific modules, including a mortality and morbidity module, on its electronic reporting system.
- **Staff training and awareness raising initiatives**

**NHS 24** provided scenario-based training sessions for line managers to coach them to be more confident in supporting staff involved in adverse events. The training was well-received and has had a positive impact.

**NHS Ayrshire & Arran** is implementing the Care Behaviours Assurance System using tools from NHS Education for Scotland’s compassionate connections programme: [www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/maternity-care/about-us/current-projects/compassionate-connections.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/maternity-care/about-us/current-projects/compassionate-connections.aspx). This includes initiatives such as ‘Go Shadow’ where staff are encouraged to view the system as a patient, at least one day a year, to better understand the patient or service user perspective and to help manage difficult conversations when things go wrong.

**NHS Fife** implemented a revised corporate induction session in January 2016 which focuses on the experience of a patient’s family following an adverse event. The story provides a platform for discussion with staff and the opportunity to promote good quality and safety in healthcare.

**NHS Forth Valley** held a Health and Safety week in October 2015 to highlight health and safety issues and demonstrate the adverse events system and processes to staff.

**NHS Lanarkshire** has a human factors group, chaired by the medical director, as part of the Scottish Patient Safety Programme. The NHS board provides human factors skill-based team training through medical education. A human factors video is also available on the intranet for all staff to view.

**NHS Lothian** has been undertaking intensive work with clinicians through training and providing expertise. Training for adverse event reviews is now delivered to clinical teams and this has been effective in improving service-based processes for significant adverse event reviews.

The **NHS National Waiting Times Centre** is rolling out human factors training to all staff which includes specific de-briefing techniques.

**NHS Tayside** uses a variety of methods to train staff and raise awareness of adverse events. For example, adverse event management roadshows for all staff, reporting system training for verifiers, awareness sessions, risk management workshops, root cause analysis training, reviewer training workshops and learnPro modules.
• **Communication and support for staff**

Several **NHS boards** have a hospital safety huddle each day in their main hospitals. This provides an opportunity to engage with staff and talk about risk, adverse events and safety issues in real time. **NHS Borders** videoed some of their hospital safety huddle meetings for later discussion to determine if anything in the huddle could be improved. Theatres in the **NHS National Waiting Times Centre** are looking into holding quick huddles or debriefs after normal activities to make it routine practice, rather than in response to an adverse event or near miss.

**NHS Fife** completed a ‘second victim’ project to evaluate the support provided to staff who may be suffering trauma following an adverse event. This was to establish what was in place to support staff, to identify gaps and consider any improvements that could be implemented in the future. The aim is to minimise impact, respond appropriately to staff and establish a resilient culture.

**NHS Lanarkshire** has used the national framework guidance to develop a leaflet to provide information and support to staff involved in, or affected by, a significant adverse event. The NHS board has also developed a learnPro module to educate staff about significant adverse event reviews, and produced an information leaflet for patients and their carers.

**NHS Western Isles** has a key performance indicator for feedback to staff. Providing feedback to staff is a mandatory field on the electronic reporting system and requires managers to record how they communicated with staff.
Tools, guidance and processes

The progress meetings provided examples of how NHS boards are developing, implementing and adapting tools, guidance and processes to improve services and support the management and monitoring of adverse events.

**NHS Ayrshire & Arran** recently held a successful cross-agency adverse event review meeting involving health, social care and other stakeholders and tested the draft national guidance for multi-board reviews.

**NHS Forth Valley** added questionnaires and tools for pressure ulcers to the electronic reporting system for staff to complete (as a mini review). Managers discuss the completed forms with staff, including any learning or further detail required. There has been good feedback from charge nurses that they like the real-time feedback.

Following an internal audit, **NHS Grampian** is encouraging staff to record the start and completion dates of reviews on the electronic reporting system. Adverse event reviews are considered to be open if the completion date has not been recorded. The NHS board is piloting a ‘light’ version of the electronic reporting system for primary care to better meet the needs of GPs.

**NHS Greater Glasgow and Clyde** has started a process of evaluating significant adverse event reviews, looking at whether patients were informed at the time of the event, if they were involved in the review process, the quality of the review and the length of time taken. **NHS Tayside** has also undertaken an evaluation of the adverse events process from the patient, family and staff perspective.

**NHS Highland** has produced an adverse events resource toolkit to support operational units, especially managers. The toolkit is based on resources published on the national adverse events community of practice website. Access to these resources has reduced the amount of work required to create new resources and increased standardisation.

**NHS Lanarkshire** has improved the adverse event review report writing style to reduce the amount of information which could be personally identifiable. This avoids the need for significant redaction later in the process.

In **NHS Lothian**, templates have been developed and are being tested within adverse event reviews of falls and pressure ulcers. The templates include triggers to guide reviewers who are not frequently involved in adverse event reviews.

In **NHS Orkney**, GPs feed into the electronic reporting system and governance processes. Completed significant event analysis forms are attached to the system.

**NHS Tayside** has compiled a library of good practice from different services. This is currently held within a spreadsheet and the NHS board is considering how to make it more interactive. The NHS board has also developed a template for mortality and morbidity meetings to consistently capture information and reduce variation.
**Improvement example – improved chemotherapy drug processes and guidance**

**What happened**

Extravasation is the term used to describe the inappropriate or accidental infiltration of an intravenous medicine into the subcutaneous tissue or subdermal tissues surrounding the administration site. Organisations have policies and guidelines for the prevention and management of extravasation. This includes guidelines specific to systemic anticancer therapy (SACT) as a number of these treatments (described as 'vesicants') can cause significant damage to tissue if there is leakage. Specific techniques are used to minimise the risk of extravasation. In the event of an extravasation occurring, staff, are trained to take immediate actions appropriate for the medicine concerned, to minimise the risk of tissue damage.

Following the implementation of the West of Scotland Cancer Network (WoSCAN) extravasation policy and guidelines, it was agreed that, as these are relatively rare, adverse events involving extravasation of SACT would be collated and reviewed regionally by a network subgroup on an ongoing basis to support shared learning across the constituent NHS boards. The initial review collated and analysed information on all such events reported in 2012: a total of 59 events across the network were identified during that period.

**What the adverse event review revealed**

The regional review of extravasation events highlighted issues relating to the following.

- Infusions of a specific group of vesicants accounted for 11 (28%) of the events reported. Further review attributed the high rate seen to the use of a very small gauge cannula normally used in children.
- Challenges with the practical use of an antidote, DMSO, which is an unlicensed medicine.
- Appropriate categorisation of extravasation and capturing outcomes.
- A further issue with the referral pathway for plastic surgery review was flagged in relation to an event in 2013.

Recommendations for improvement on these points were incorporated into an action plan for the network subgroup.

**What actions were taken following the adverse event review**

In response to these issues a number of actions were progressed.

- Guidance on appropriate selection of adult cannulation products. The smallest gauge cannula device possible is recommended (RCN 2010 Standards for Infusion Therapy), which will preserve vein integrity, cause least pain to the patient and which will accommodate prescribed therapy.
- Identifying an alternative DMSO preparation which is more suitable for patient self-administration.
- Review of the report form to support better capture of outcomes.
- Formalising the referral pathway for plastic surgery advice and intervention.

Extravasation leads in the NHS boards of the network also took forward local actions to improve follow-up of patients.
Learning was shared with the nurse education team to ensure the regional SACT administration course incorporated learning from the review, in particular cannulation products.

The extravasation guideline was reviewed and the learning from this regional audit helped to inform improvements to the guideline.

**What difference has been made**

- An audit was undertaken of extravasation events reported across WoSCAN for the period January to June 2013. The audit revealed that the change in practice of selection of appropriate gauge of cannula resulted in a decrease in reported events specific to this issue from 11 in 2012 to two in the first 6 months of 2013.
- An alternative DMSO preparation was identified and a clinical risk assessment completed. A prescription template, handling instructions for staff and a patient information leaflet were developed to optimise compliance with the management guidelines.
- The report form was revised and, following a pilot, has now been implemented which is expected to improve information available on contributory factors and follow-up of patients.
- Units delivering SACT across the four NHS boards in the network now have a clear pathway for urgent plastic surgery advice.
- The improvements have been reflected in the revised WoSCAN SACT extravasation guidelines, published in 2015: [www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx](http://www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx)

WoSCAN will continue to review extravasation events to identify learning and improvement.
Improvement example – bespoke reporting system and process for blood sciences

What happened

NHS Tayside’s blood sciences department was using three different reporting systems for adverse events which involved several duplicated and time-consuming steps for the staff involved. The complexity of the system was acting as a barrier for staff to report adverse events due to the time required to complete a record. The system also permitted the adverse event handler to opt out of providing feedback to staff who originally reported the event on the system. In addition, the process was not supporting:

- medical laboratory compliance with the United Kingdom Accreditation Service (UKAS) International Organization for Standardization (ISO) 15189, and
- the requirement set by the Medicines and Healthcare products Regulatory Agency (MHRA) to have a full audit trail of an adverse event in one location rather than spread across various systems.

The department recognised the need to have a reporting process as a ‘continual loop’ from identifying an adverse event to the continual improvement and prevention of future or repeat events.

What actions were taken to rectify the problem

In 2015, the blood sciences department moved to reporting their adverse events using a bespoke electronic reporting system and specific verifying forms. Staff now only use one reporting system.

What difference has been made

- The new bespoke blood sciences electronic reporting system is now UKAS ISO 15189 and MHRA compliant.
- The system has removed repetitive steps and added mandatory fields so that handlers cannot opt out of providing feedback to staff who reported the adverse event.
- It includes discipline-specific categories to allow easier trend analysis of where adverse events are occurring.
- It includes root cause sections to allow trend analysis of the root causes of adverse events.
- Reports can be quickly and easily compiled.
- It has led to increased and more effective reporting of adverse events by staff compared to the old process.

Creating a bespoke adverse event management system has enabled the blood sciences department to improve the reporting culture and to use corrective action to prevent recurrences. It is important that the system was compliant with mandatory MHRA regulation and best practice UKAS accreditation, giving the department a mark of quality for the diagnostic service delivered in NHS Tayside. This bespoke system has enabled the department to increase diagnostic effectiveness and ensure that a safe, person-centred service is provided at the right time, every time.
Governance and overview

In the progress meetings, NHS boards highlighted examples of improved practices to support the management and governance of adverse events, as outlined below.

**NHS Fife** introduced a system of performance reviews in June 2015 which includes an adverse event component as part of the supporting data pack. The data provides a picture of the number, type and severity of adverse events over time. The process facilitates discussion and the effective management of adverse events at an operational and strategic level. It also provides an ideal opportunity to identify trends and risks and to agree appropriate actions.

**NHS Grampian** holds a weekly quality huddle meeting, including representatives from the acute sector, clinical governance and health and safety. The group reviews all major and extreme adverse events, assesses them for appropriate grading and identifies who should undertake the review. The group also looks at review outputs and action plans.

In **NHS Highland**, a ratification group (a subgroup of the clinical governance and risk group), reviews all significant adverse event review reports and identifies arising themes. The NHS board carries out thematic reviews as required.

**NHS Tayside** holds performance review meetings on a 9-week cycle to look at all aspects of governance and any emerging risks within a particular directorate, supported by a core data set. The meetings are led by the service and chaired by the relevant director. The meetings include clinical and management representation from all areas within the directorate.

**NHS Western Isles** has introduced a key performance indicator around the use of the risk matrix to monitor whether staff are using it appropriately.

The **Scottish Ambulance Service** is testing a quality assurance toolkit, including an approval checklist, for signing off an adverse event review.
Quality improvement

NHS boards provided the following examples of quality improvement initiatives to help prevent or reduce the number of adverse events.

**NHS Borders** is testing the Charles Vincent framework: "A framework for measuring and monitoring safety (April 2014)", including decision making and how staff talk about safety: [www.health.org.uk/publication/framework-measuring-and-monitoring-safety](http://www.health.org.uk/publication/framework-measuring-and-monitoring-safety). Service thematic reports are compiled for high volume adverse events, such as patient falls, and used to target improvement work. Two improvement facilitators are being recruited to work with clinical teams to support changes in practice around patient falls and pressure ulcers. The NHS board also uses a contributory factors framework and took a human factors approach when developing the Scottish Patient Safety Programme care bundle for theatres.

**NHS Dumfries & Galloway** is integrating adverse events work with safety and improvement work. The adverse events management process takes a proactive approach to risk, recognising where things have gone wrong, learning from it and feeding learning into the safety and improvement programmes.

**NHS Fife** has combined data on adverse events and the Scottish Patient Safety Programme driver diagrams into an overarching ‘reducing harm action plan’. This provides an evidence-based picture to help determine where improvement work should be focused. The NHS board is testing an actions module on its electronic reporting system to capture actions from significant adverse event reviews, rapid event investigations and Scottish Public Services Ombudsman reports.

**NHS Greater Glasgow and Clyde** uses data from adverse events to drive improvement, such as reviewing a series of lower grade specimen-related adverse events, to understand what was going wrong in the process and what improvements are required to prevent re-occurrence. The NHS board produces a risk awareness notice when a trend of adverse events is identified.

**NHS Lanarkshire** aggregated data from primary care following the introduction of the Trigger Tool (a tool to measure patient harm caused by healthcare) to GPs.

**NHS National Services Scotland** is reporting more near misses and trying to categorise the risk rather than the outcome, to ensure staff focus on what was learned rather than what happened.

**NHS Orkney** moved the inspection element from leadership ward walkrounds into the infection control walkrounds. The leadership walkrounds, which include non-executive directors, are now focused on patient safety conversations and areas of concern. This change of focus has been well received by staff and there is more transparency in how issues are fed upwards to the Board. NHS Orkney has seen a significant shift in culture over the last 3 years.

The **Scottish Ambulance Service** looks at all adverse event and complaint data to build up a picture and help identify where focused work is required. It is also looking at key themes supported by a prioritisation matrix, to identify if a similar event happened before and whether the responding actions had the expected impact.
# Improvement example – multiple falls in a community hospital care of the elderly ward

## What happened

Within a 2-week period, four patients fell and sustained fractures in an NHS Fife community hospital care of the elderly ward.

## What the adverse event review revealed

The significant adverse event reviews for all four falls identified:

- a lack of insight into falls management
- lack of a clear systematic approach to falls prevention at ward level
- lack of consistent falls risk assessment in all cases, and
- no clear care planning for the risk of falls.

The reviews also identified learning around communication, monitoring performance, staff development, training and nurse leadership. Recommendations for improvement on these points were incorporated into an action plan for the ward.

## What actions were taken following the adverse event review

A structured approach to monitoring the ward performance was introduced. This featured the senior charge nurse and the lead nurse regularly reviewing the ward profile data, which includes information on clinical quality indicators, Scottish Patient Safety Programme, workforce planning and patient feedback, including complaints and compliments.

An in-depth review of the electronic reporting system’s falls data was undertaken to identify patterns. This revealed a high number of falls during night hours with the majority of the patients who fell having dementia and/or delirium. It also identified high risk areas within the ward environment. NHS Fife carried out improvement work around staff vigilance, assessment of patient placement within the ward and the location of the staff work station. These changes led to a significant reduction in the number of falls.

Data analysis also identified that many patient falls were happening when the patient was at the end of their rehabilitation period. Structured multidisciplinary ward rounds now use information on white boards to ensure patients are on the right discharge pathway and are not delayed. This has had a positive effect.

Following a review of processes for safety briefs and ward handovers, an electronic safety brief and handover was developed. This supports staff to share consistent information about patients and specifically those at risk of falling.

## What difference has been made

- There has been a significant improvement in staff knowledge and skills in the assessment and management of patients at risk of falling.
- There is now a systematic approach to prevention and management of falls which has empowered staff to do the right thing at the right time.
- The changes have led to a significant reduction in the number of patient falls within the ward.
- The changes have had a positive impact on patient discharge pathways and timelines.
### Improvement example – referral process to the Intensive Home Treatment Team

#### What happened

In 2011, a GP contacted the Intensive Home Treatment Team (IHTT) to refer a patient following a consultation earlier that day. The team informed the GP that the patient did not meet its criteria for referral as the GP did not think the patient required admission to hospital. It advised the GP to contact the sector senior psychiatrist for an urgent outpatient appointment. The patient was charged with murdering their partner the following day.

#### What the adverse event review revealed

Reviews carried out by NHS Forth Valley and the Procurator Fiscal identified:

- the IHTT referral process was complex and GPs were unclear about where to refer, or that they could request same day assessments, and
- improved systems were required to ensure information provided in telephone communications by GPs were accurately relayed to the community mental health team.

The reviews also identified key learning for staff, across both primary and secondary care settings and highlighted areas of good practice shown by professionals involved, such as effective family liaison by the GP.

#### What actions were taken following the adverse event review

Following a service improvement day, the IHTT service altered its remit to agree to see same-day emergency referrals even if they do not require admission to hospital, and changed its telephone triage questionnaire. There was also an internal awareness-raising initiative for mental health staff covering both existing and new processes. The new arrangements will be evaluated on an ongoing basis and will include obtaining feedback from referrers.

A single point of access protocol has been developed for the Psychiatric Emergency Hub. There is a single telephone number for all same-day emergency referrals, both in and out of hours, for use by GPs and the acute hospital. This means the referrer no longer needs to remember when (day and time) certain aspects of the service are in operation or the separate telephone numbers (for the IHTT liaison or duty doctor). An engagement event was held which 30–40 GPs attended.

A pathway for GP referral to adult mental services was developed to provide clarification as to the type of referral, for example routine, urgent, emergency or requires detention. This pathway also sets out timescales in which the patient should be assessed.

#### What difference has been made

- Same-day emergency assessments can now be requested for patients who are assessed as not requiring admission to hospital, improving patient care.
- A single telephone number is now available for all same-day emergency referrals, and pathways and protocols are in place to support a consistent approach to referral which has improved the referral process.
Challenges

NHS boards identified a variety of challenges with the management, monitoring and sharing of learning from adverse events. Some of the more common challenges are listed below under identified themes of capacity, stakeholder engagement, sharing learning, governance and overview and quality improvement.

Many of these are the same challenges that were known when the national framework was being developed in 2013. This is not to say that progress has not been made, but rather emphasises the complexity and long-term nature of the task to transform the culture to an open learning one. Much work has taken place in recent years to foster an open learning culture, and the national approach to learning from adverse events has contributed to this. However, there are a number of barriers to moving to an open learning culture when there is still a defensive approach used for claims and litigation to protect organisational liability. Additionally, the ever increasing interest from the media and wider public for identifying who is to blame fuels a defensive, blame culture where individuals working within the service are afraid of being open about failures to protect their careers. It has been well reported that only by combating the blame culture in the NHS will transparency and meaningful change take place. Learning from adverse events is one contributor to changing that culture.

Capacity

- Having capacity to undertake adverse event reviews. Due to clinical or other commitments, adverse event reviews can become person dependent, can result in delays and can lead to a focus on the process rather than on identifying the key learning points and improvement required.
- Meeting adverse event review timescales outlined within the national framework can be difficult, particularly for events which involve the Procurator Fiscal.
- Having sufficiently trained staff in critical review and analysis, interview techniques and human factors, and maintaining review skills for those staff who only occasionally take part in adverse event reviews.

Stakeholder engagement

- Providing meaningful and timely support to patients, family and carers.
- Providing support to staff involved in adverse events (recognising that they are ‘second victims’); involving all staff in adverse event processes and encouraging local ownership.
- Staff feeling confident to have conversations with patients, family and carers about adverse events.

Sharing learning

- Understanding and reflecting relevant background information and situational context in thematic adverse event reviews, review reports and learning summaries to ensure the information supports improvement.
- Understanding and sharing lessons learned and promoting a systematic approach to sharing learning.
Governance and overview

- Capacity to monitor actions arising from adverse event reviews and ensuring actions are taken.
- Capacity to evaluate if actions taken following adverse event reviews result in changes that are improvements.
- Prioritising which areas to focus on when there are a number of identified themes and issues around adverse events.
- Ensuring the Statutory Duty of Candour for Health and Social Care Services\(^7\) is implemented in a way that builds on existing adverse event processes and does not create a system that is built around rigidly monitoring and counting disclosable events.

Consistency

- Ensuring consistency in the quality of adverse event reviews and reports, and developing expertise in operational units to support a standardised approach.
- Supporting an open culture around adverse events in the face of the defensive legal approach used for claims and litigation.
- Inconsistent or lack of reporting of adverse events from primary care and variable use of the NHS board’s reporting and governance systems by GPs.
- The integration of health and social care given the varying governance arrangements, process, culture and terminology used across the different stakeholder organisations.

\(^7\) [www.gov.scot/Publications/2015/05/8235](http://www.gov.scot/Publications/2015/05/8235)
National support for implementation and improvement

Following publication of the first version of the national framework for learning from adverse events in 2013, Healthcare Improvement Scotland established a national programme to support implementation, focusing on activities that would add most value at a national level. An update on this national work is outlined below. More information on all of our work including guidance and tools that have been developed, can be found on the adverse events community of practice website\(^8\).

**Managed community of practice and network**

Healthcare Improvement Scotland has developed a managed community of practice to support sharing of good practice and key learning points from adverse event reviews nationally. The community of practice includes both a website with a virtual network of members and complementary network meetings. The network meets twice a year.

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 number of learning summaries shared on the community of practice website has been monitored as an indicator that learning points are being shared nationally. The number of unique page views of the sharing learning page on the community of practice website has also been monitored as an indicator that the shared learning summaries are being accessed.

In 2015, 14 learning summaries were shared with a total of 735 unique page views of the sharing learning page on the community of practice website. 2015 was the first complete year of using this mechanism to share learning points following adverse event reviews. We first began sharing learning summaries in September 2014 and a total of four learning summaries were shared in 2014. Between January 2016 and April 2016, seven learning summaries were shared and there have been 413 unique page views. Charts 1 and 2 below display this information, and while we need to collect more data to be certain, it seems there is a positive shift in the number of people accessing the learning summaries.

\(^8\) [www.knowledge.scot.nhs.uk/adverse-events.aspx](http://www.knowledge.scot.nhs.uk/adverse-events.aspx)
Chart 1: Learning summaries uploaded to the Community of Practice website

Learning summaries uploaded to the Community of Practice website

Chart 2: Unique views of the sharing learning page

Unique views of the sharing learning page

The community of practice website will be continuously developed, monitored and improved to meet the needs of the network.
Being open

“Being open about what happened and discussing patient safety events promptly, fully and compassionately can help patients and professionals cope better with the after-effects”⁹. All NHS boards in Scotland have faced challenges in implementing the ‘Being Open’ principles which relate to communicating with patients and their families.

Healthcare Improvement Scotland has been working to develop a package to support NHS boards in implementing the ‘Being open’ principles to ensure a consistent approach to engaging with patients, families and carers.

There are two strands to this work:

- the principles within the National Patient Safety Agency (NPSA): Being Open Framework (2009) have been developed into a guidance document for NHSScotland¹⁰, and
- a 12-month pilot within NHS Lothian to support staff in implementing the principles of ‘Being Open’ when an adverse event happens.

The ‘Being Open’ guidance document 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.

The NHS Lothian pilot project tested how we can support implementation of the principles of ‘Being Open’. The pilot took place in the inpatient maternity and neonatal service at the Royal Infirmary of Edinburgh and ran until June 2015.

The aim of this pilot was to improve communication with patients about adverse events – from when the event happens until the end of the review process. NHS Lothian worked 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
- communications training for staff.

The testing pack developed by NHS Lothian, including a communications toolkit, is also available on the community of practice website. A short video explaining the project has also been developed for the Institute for Healthcare Improvement/BMJ Quality Forum 2016¹¹.

NHS Lothian is discussing with another NHS board how this process can be tested in another maternity unit before being spread more widely. NHS Lothian is also looking at testing this

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⁹ Being Open, NPSA, 2009  [www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726](http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726)

¹⁰ [www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058625/20150113%20Being%20Open%201.0.pdf](http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058625/20150113%20Being%20Open%201.0.pdf)

¹¹ [www.youtube.com/watch?v=0I7JDZjgDA&list=PLVdY5G6w32Njli1bxx4-G7lbeS-H6Zluiz&index=25](http://www.youtube.com/watch?v=0I7JDZjgDA&list=PLVdY5G6w32Njli1bxx4-G7lbeS-H6Zluiz&index=25)
process in another clinical area. The results of this pilot are also informing how the statutory duty of candour will be implemented in Scotland.

**Standardised report writing**

To enable appropriate learning to be shared, whilst safeguarding patient, family and staff confidentiality, Healthcare Improvement Scotland has developed a standard approach to writing adverse event review reports\(^\text{12}\). 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.

**Learning summaries**

Although it is our aim for NHS boards to write adverse event review reports in a way that can be shared and others can learn from the event, not everyone will have the time to read a full report. A one-page template\(^\text{13}\) has been developed with NHS boards to summarise what happened, what went well, what if anything we could improve, and what we have learned.

A short-life working group is currently developing guidance on how we might more clearly define what should be shared nationally and when a learning summary should be shared. The guidance will also include reference to how NHSScotland might consistently respond to Freedom of Information requests for adverse event review reports. This aims to ensure that learning points are shared to improve the quality of care provided, but also to openly share outputs from significant adverse event reviews with the public.

**Sharing learning points from death investigations identified by the Procurator Fiscal**

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 continuing to refine this process. We 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. To date we have shared the learning from eight death reviews\(^\text{14}\).

\(^\text{12}\) [www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058632/20150112%20Data%20Redaction%20and%20Standardised%20Reports.pdf](http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058632/20150112%20Data%20Redaction%20and%20Standardised%20Reports.pdf)


Multi-agency review

There will be occasions where an adverse event review has the potential to involve more than one organisation. At the outset of the review process, consideration should be given to whether a collaborative approach is needed. The lead organisation (where the adverse event was reported) should contact the other organisation(s) and agree the scale of the involvement (from providing information or documentation to being part of the review team). A single point of contact for the patient, service user, family or carer should be clearly defined at the outset. A multidisciplinary review team with experience relevant to the different components of the care system being reviewed should also be agreed at the outset. We have developed guidance\textsuperscript{15} to support a consistent approach to collaborative reviews which is currently being tested by NHS boards.

Non-executive directors network

We have established a non-executive directors network to support non-executive directors in their role of challenging executives and providing assurance to the Board that care is being delivered that is person-centred, safe and effective. The first network meeting was in August 2014 and has now met four times. Feedback has been positive with non-executive directors welcoming the opportunity to meet to share good practice and discuss challenges and potential solutions.

The network developed a safety checklist\textsuperscript{16} which was published by Scottish Government in 2015 as part of a suite of resources to support non-executive directors. The safety checklist poses a number of questions to support staff to think about the questions to ask and the answers to expect when discussing safety within their organisation. The checklist was originally developed to support non-executive directors in their role but could be used by any member of staff.

Reducing Suicide Risk: Mental health team discussion framework

In 2013, the National Confidential Inquiry into Suicide and Homicide (NCISH) published a safer mental health services toolkit. It is intended to be used as a basis for self-assessment by mental health services in England and Wales. In early 2014, the Scottish Government asked Healthcare Improvement Scotland’s Suicide Reporting and Learning System (SRLS) to develop a similar document for use in Scotland. The framework was produced in collaboration between the SRLS Community of Practice, the Scottish Patient Safety Programme in Mental Health (SPSP-MH), the Mental Welfare Commission for Scotland and Scottish Government.

When a suicide takes place, NHS boards need to understand what happened and learn from any lessons identified. The lessons learnt are important to improve services and help staff recognise where risk exists. Suicide reviews are the way that NHS boards, and their mental health services, analyse what happened and recognise where anything can be done to make things safer for other people at risk. All NHS boards are required to report to the SRLS team any suspected suicide of a person who has been in touch with mental health services 12 months prior to death. The SRLS aims to assist NHS boards to improve the way that suicide reviews are carried out and reduce risk.

\textsuperscript{15} \url{www.knowledge.scot.nhs.uk/adverse-events/adverse-events-toolkit.aspx}
\textsuperscript{16} \url{www.gov.scot/Publications/2015/11/9455}
These reviews produce many detailed learning points and recommendations that provide strong themes and messages about how we can improve the way we work together. The framework is largely based on the information we receive from these suicide reviews, supplemented by the NCISH toolkit.

The purpose of the framework is to help mental health multidisciplinary teams and managers develop a habit of coming together to think about risk and how to reduce it in the work that they do. The framework does not give specific guidance on risk assessment and management. It has been designed to promote discussion between members of multidisciplinary teams, to make sure there is a common understanding of knowledge, practice and attitudes towards the way that individual patient care is organised and managed.

The framework was published on 29 May 2015 and is available from the suicide review community of practice at: [www.knowledge.scot.nhs.uk/suicidereviews.aspx](http://www.knowledge.scot.nhs.uk/suicidereviews.aspx).

**Suicide Reporting and Learning System briefing papers**

Key themes identified from suicide review reports submitted to the SRLS are highlighted in our twice yearly briefing papers\(^{17}\).

Sustaining change is the theme of our recently published: *Briefing Paper for Community of Practice – February 2016* (February 2016)\(^{18}\). In this edition, we aggregated learning themes from suicide reviews submitted during the reporting period 1 May–31 December 2015 and focused on supporting mental health services’ approaches to recurring improvement themes. To help services to prioritise change areas, we set out the specific issues we identified under six key quality improvement themes:

- transitions of care
- risk management
- effective management of safe therapeutic observation practices
- medicines management
- family involvement, and
- life factors or contributory social factors.

We also provided links to related resources available on the suicide reviews community of practice at: [www.knowledge.scot.nhs.uk/suicidereviews.aspx](http://www.knowledge.scot.nhs.uk/suicidereviews.aspx).

**Development of an educational framework for adverse events management**

An education short-life working group is currently developing an overarching, evidence-based educational framework. This will support the management of adverse events, identify existing materials which address these outcomes and highlight any gaps which may exist. The group aims to design and create content and produce educational materials to meet these gaps.

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\(^{17}\) [www.knowledge.scot.nhs.uk/suicidereviews/other-resources/briefing-papers.aspx](http://www.knowledge.scot.nhs.uk/suicidereviews/other-resources/briefing-papers.aspx)

\(^{18}\) [www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4072155/414ec9ba-3b5b-4634-9a65-aa39551039b5.pdf](http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4072155/414ec9ba-3b5b-4634-9a65-aa39551039b5.pdf)
Conclusion and next steps

This learning and improvement report highlights some of the work that NHS boards and Healthcare Improvement Scotland are doing to improve services for the people of Scotland. There is much good practice taking place across Scotland and we are seeing benefits for patients, service users and staff from learning from adverse events and putting improvements into practice.

This report also provides an overview of the challenges that NHS boards are continuing to face, particularly around:

- having the capacity and capability to carry out effective adverse event reviews
- providing support to those involved in an adverse event (patients, family, carers and staff)
- ensuring review recommendations are translated into practical actions that lead to improvements
- identifying and sharing key learning points widely, and
- working with colleagues in primary care, secondary care and social care to move towards a more consistent approach.

At a national level, the challenge remains how we collate, analyse and learn from adverse events across Scotland, and how we look to integrate other data, such as from complaints and claims, in order to inform improvements. The Suicide Reporting and Learning System briefing papers provide a good example of how themes can be collated nationally and shared to support improved service delivery.

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 will continue to work with relevant teams to integrate this work more fully with the Scottish Patient Safety Programme, Morbidity and Mortality reviews, and the measurement and monitoring of patient safety.

We will continue to work with health and care providers across Scotland to improve how adverse events are managed and to continue to develop a positive safety culture that is open, just and informed, in which reporting and learning from error is the norm.