Management of adverse events

Learning and Improvement Report

March 2013
Background and context

In June 2012, we published a report called: *The Management of Significant Adverse Events in NHS Ayrshire & Arran* (2012). The report provides an in-depth analysis of NHS Ayrshire & Arran’s adverse event management arrangements and outlines a number of recommendations and issues that the NHS board should act on. The report also contains recommendations for other NHS boards in Scotland and learning points for NHSScotland as a whole.

Immediately following the publication of our report, the Cabinet Secretary for Health, Wellbeing and Cities Strategy asked Healthcare Improvement Scotland to carry out a rolling programme of reviews across NHS boards.

Our reviews focus on the six key recommendations for NHS boards (numbers 18–23) (See Annex A) from the NHS Ayrshire & Arran report. The purpose of the reviews is to assess how investigation of adverse events is being used by NHS boards to drive learning and improvement in order to reduce the risk of these events occurring again. The NHS boards that have completed the full review process so far are: NHS Western Isles, NHS Forth Valley, NHS Fife and The State Hospitals Board for Scotland.

This report provides a summary of our findings across all four reviews and identifies areas of learning that are applicable across NHSScotland. More detail is available from the individual NHS board reports which can be downloaded from our website.

www.healthcareimprovementscotland.org

Areas of good practice

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

- A range of staff reporting and recording adverse events on an electronic reporting system, including GPs and practice staff.

- 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 recently changed its incident reporting procedures in response to staff comments to automatically provide feedback to the staff member reporting the incident. Timely feedback has helped to encourage a reporting culture in the organisation.

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

- Wide ranging and positive staff engagement, particularly in reporting and feedback.

- A bespoke dynamic database to track recommendations and actions and monitor their implementation.

The State Hospital Board 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 incident reporting and for incident review methodologies.

• A simplified, responsive governance structure which has resulted in improved Board assurance and executive oversight of serious incidents.

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

• 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 introduced an overarching ‘reducing harm’ action plan to take an organisation-wide approach to focussing 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.

Learning points for NHSScotland

The following learning points have been identified from the first four completed review visits and apply across NHSScotland. These learning points have been listed under the headings relating to the six NHS board recommendations within the NHS Ayrshire & Arran report.

Engaging with stakeholders

• Most policies lacked guidance on how to involve stakeholders and there were significant inconsistencies in practice. The Institute for Healthcare Improvement paper: Respectful Management of Serious Clinical Adverse Events¹, outlines key elements that organisations should consider to ensure key stakeholders are engaged in the response to the adverse event.

• Staff engagement in adverse event management was found to be high when they received meaningful feedback following the reporting of adverse events.

Staff knowledge and training

• A pool of trained staff across the organisation with skills specific for adverse event review ensures competency is maintained and appropriate numbers of staff have up-to-date training.

Roles and responsibilities

• Identification of a senior manager with responsibility for adverse event management across the organisation can provide the overview and ownership for the process and for the implementation of improvement actions.

• Regular governance arrangement reviews can ensure that roles and responsibilities for escalation and decision-making are clearly defined and allow appropriate and timely progression of actions resulting from adverse events.

Information management
• Regular reports generated from local integrated information management systems can inform adverse event review, improve timely progression of actions, and support the identification of learning points across the organisation.

Risk-based, informed and transparent decision-making
• Standardised grading of events across an organisation is a challenge. The regular review of event grading linked to organisational training programmes should improve consistency of response, escalation and reporting.

• Linking complaints and incidents within an integrated risk management system allows governance groups to make informed decisions about areas of concern across the whole organisation.

Timely management, learning, dissemination and implementation
• Regular monitoring and reporting of recommendations and actions arising from adverse events, through defined governance structures, should allow learning points to be shared and implemented across the organisation in a timely manner.

• Sharing of learning is not an end in itself; it must lead to real measurable improvements.

Next steps

NHSScotland should consider these points while continuing to implement the NHS Ayrshire & Arran report recommendations 18-23.

The NHS boards that we have reviewed have developed improvement plans to address:
• recommendations 18-23 from the NHS Ayrshire & Arran report, and
• their board-specific recommendations identified through their review.

Each NHS board’s review report is available on our website: www.healthcareimprovementscotland.org.uk

As the review programme progresses, we will continue to provide feedback on our findings to the wider NHSScotland. We will use this information to inform and shape the national approach to adverse event management which will promote good practice and support NHS boards to improve their local arrangements.
Annex A

Extract from: The *management of significant adverse events in NHS Ayrshire & Arran – June 2012* (Recommendations 18-23 for NHS boards)

Full document available at [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

- There should be an active and planned approach to involvement and engagement of key stakeholders, including patients, family and carers.
- Staff should have suitable training, knowledge and understanding to be involved and contribute to the full management of adverse events, including the implementation of actions relating to learning, change and improvement.
- All members of staff should have a clear understanding of their roles and responsibilities regarding adverse events and that clear lines of accountability are defined and reflective of the organisation’s governance structure.
- Document control and related information systems should be suitably integrated and robust to provide a complete audit trail of adverse event management from the incident occurring to evidencing change and improvement. These systems should allow ongoing thematic learning from adverse events.
- Decisions relating to the management of adverse events should be risk based, informed and transparent to allow an appropriate level of scrutiny and assurance.
- The management of adverse events should be undertaken in a timely manner and thematic learning should be appropriately disseminated and acted upon throughout the organisation.
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB
Phone: 0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow G1 2NP
Phone: 0141 225 6999

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.