Sample ADVERSE EVENT REVIEW TEMPLATE FOR FALLS

Please read the Adverse Event Review Protocol before initiating this review
This can be found on the NHS Lothian intranet under:
Healthcare > A-Z > Risk Management > Adverse Event Review Protocol

This template should be used for review of all Significant Adverse Events (SAE) resulting in major harm or death and for RIDDOR-reportable adverse events. Please save the template securely on your NHS shared drive as you work through the review.

The guidance information in the boxes is for guidance and should be deleted when you enter your review information. Once completed, update the document control details (within the footer) and attach the latest version into the relevant Datix adverse event as ‘Draft’.

Please note also that there must be no person-identifiable information in this report - apart from the names of the review team and who it was reported to – instead please say patient A, ward B, doctor C etc. Please also avoid abbreviations, acronyms and jargon wherever possible.

For more details see Falls SAE Guidance

The examples in the template below was extracted from a cross-section of real significant adverse event reviews and are used as an example of the level of detail required and general good practice

Datix ID Number

| Summary adverse event description and outcome: |
| Summarise the highlights of the investigation of the incident stating as briefly as possible the findings and the end result of the adverse event. |
| Include a description of the staffing and skill mix, any patient assessment, department pressures and any communication with family. |

The adverse event
Patient had a witnessed fall while in Ward A. The patient was reviewed by the medical staff and an X-ray showed a fracture of the left Neck of Femur. The patient was transferred to Ward X to await surgery.

Background
The patient had chronic deterioration, having had previous falls and increased back pain. There was urge urinary incontinence and hypotension. Three-hourly care rounding was taking place. The patient had a falls risk noted. The 4AT identified confusion; medication was reviewed and Nefropam discontinued, resulting in decreased confusion. Analgesia was given and SEWS score was recorded as 1. Patient had been asleep in a chair and rose to go to the toilet on awakening. She was using a wheeled Zimmer, at the time of the fall. The Band 4 nurse witnessed the fall from the other side of the room.

Staffing at the time of the adverse event
Due to a shift change the ward was one Band 2 short. There were four nursing staff on duty (two Band 5, one Band 4 and one Student Nurse).

Contact with family
The patient’s husband was advised by telephone of the adverse event and regarding his wife’s transfer Ward X and he later came into the ward to discuss his wife’s care with the Charge Nurse. Subsequent daily contact took place either by phone or in person and he stated that he was satisfied that his wife was ‘in good hands’. He stated that it had often been his wife’s habit to rise quickly from dozing in a chair to go to the toilet.

The review
The review report was completed within 2 weeks of the adverse event. Recommendations were discussed with the staff of ward A initially then shared with the other wards in the unit. Learning points included ensuring that the call bell was always within patient’s reach and increasing the frequency of care rounding to two-hourly. These will be shared at the next Charge Nurse meeting and the Quality Improvement Team meeting.

<p>| Description of Review Team | Time period of review: | Reported to |</p>
<table>
<thead>
<tr>
<th>Names and Designation</th>
<th>Start</th>
<th>Finish</th>
<th>Include both the name of the person who commissioned the review and to whom the review was reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>J. Smith CNM</td>
<td>Record start date of incident review</td>
<td>Record date of report completion</td>
<td></td>
</tr>
<tr>
<td>R Right Consultant Physician</td>
<td>Record date of report completion</td>
<td>Include both the name of the person who commissioned the review and to whom the review was reported</td>
<td></td>
</tr>
</tbody>
</table>

**Adverse event date:** Enter the date of the actual incident as per DATIX entry

**Adverse event type:** Refer to DATIX adverse event form – slip, trip or fall -Adverse event coding

**Location of Adverse event:** Enter exact location as recorded in DATIX

**Actual effect on patient/staff/please specify:** e.g. fractured Neck of Femur

**Scope and level of review**

- e.g. internal department review, led by CNM with the involvement of a multi-disciplinary team using information from clinical ward staff and health records OR review led by Associate Nurse Director conducted external to department with a specialty medical consultant from another Health Board using information from clinical team, police, social work and health records

*The review should include - medical and nursing care documented inclusive of, standard and content of documentation in relation to both falls prevention and any measures taken pre and post fall (look in unitary patient record, electronic patient record, nursing care plans, care rounding sheets etc).*

**Involvement and support of patient and relatives in response to Adverse event**

Document what was done to ensure that the patient is informed of the situation and reassured throughout the whole episode of care.

With the patient’s consent, and where appropriate, involve relatives, next of kin and carers in the review. Record that consent was given - or that it was not.

What plans are in place to ensure that all people affected by the adverse event get the opportunity to suggest questions to the review team that they would like to be considered and receive appropriate information about the outcome of the review?

- e.g. Following the incident the nursing staff ensured that the patient was kept comfortable and given adequate pain relief. Nursing staff contacted patient’s husband and informed him of the fall and the x-ray results and explained that at this time it is probable that his wife would be transferred to Ward X. Nursing staff spoke with the patient’s husband when they were in visiting later that day and advised that the ward was waiting for confirmation from ward X about when a bed would be available. Patient’s husband was informed of the transfer to Ward X.

In addition note any communication and follow up support provided to family beyond the event

- e.g. Patient’s husband spoke with nursing staff daily either on the phone or in person and was met on 3 occasions by Dr A to provide support after the adverse event. He was told that the review would take place and what it would entail. He was told that if he had any questions at this, or at a later time, he could call the lead reviewer and was given contact details. He did not raise any particular issues that he wanted to add into the review but was keen to see the final report.

**Detection of Adverse event (who, what, when & how)**

Who identified the adverse event? What was the date and time? How was the adverse event noticed? What immediate action was taken?

**Chronology of Adverse event (dates & times of key events/actions, use separate**
Use the tabular timeline in the adverse event review protocol (Section D).
It is important to note the time, date and the discipline of staff involved.
Attach the tabular timeline as a table or outline in the format below: e.g

### 27.4.14 17:15hrs
**Medical** – Reviewed by medical consultant, plan for OT and Physio. Requested MSU and bladder scan, falls checklist and E+S Blood pressure and seek MDT review.

**Nursing** – Bladder scan pre and post void within normal limits. MSU obtained at doctor’s request.

### 28.4.14. 11.55hrs

### 28.4.14. 13.40hrs
**Physiotherapist** – Assessed patient: Encourage mobility with walking stuck under supervision. Balance exercise and gait re-education.

### 29.4.14. 15:30hrs
**Physiotherapist** – Reviewed. Plan – continue with stick, continue gait re-education and balance education.

### 30.4.14. 14.30hrs
**Physiotherapist** – Assessed for mobility and was using a walking stick. However patient lost balance twice and there was inappropriate use of stick at one point. Reduced safety awareness and unfocussed when using the stick.
Plan – try patient with wheeled Zimmer under supervision, continue with gait re-education and balance exercise.

### 2.5.14. approx 19.30hrs
Care rounding had taken place 20 minutes previously and was documented. However patient was asleep in a chair at the time. When patient awoke she rose out of the chair quickly and headed to the toilet without requesting help and slipped before reaching the toilet. Patient was wearing appropriate slippers and was mobilising with Zimmer.
Call bell was not used to request help getting to and from toilet.

### Care & Service Delivery problems that led to the Adverse event
Care & Service Delivery problems can arise in the delivery in the process of care, usually actions or omissions by members of staff. (see adverse event review protocol section E)
For example, no clear escalation process for deteriorating patients, incomplete documentation, changes in care plan not adequately communicated at handover, new staff member unclear on aspects of care rounding, falls assessment carried out but not acted upon, staff did not attend training on (topic) etc.

*There will not always be any care or service delivery problems, so please just state that there are none if none have been identified, rather than leaving the section blank.
Sometimes care or service delivery problems are identified but have no direct impact on the adverse event. Please record these but state that they had no direct impact.*

### Contributory factors, e.g. patient/ staff, task/ technology, individual/ team, environment
Contribution Factors Guidance

Contributory factors are those associated with each Care episode /Service Delivery problem that has been identified. (see adverse event review protocol section F)

For example, if it was noted that the last care rounding was more than the specified number of hours ago, you would need to look at the staffing levels and activity on the ward at the time of the adverse event. If it had been completed at the right time, was it noted that the patient was asleep? If she was awake, did the nurse engage the patient in the process or just complete the documentation without any discussion? If missed training was identified as being relevant to the adverse event, you would need to explore further - appropriateness of training, type of training...
being delivered, availability of training, competence issues and supervision, reason why the training was missed.

If analysis tools are used e.g. Fishbone, 5 WHYs, change analysis, please insert these here or append at the end of the template.

During the review it is important that all possible contributory factors have been considered

<table>
<thead>
<tr>
<th>FACTOR TYPE</th>
<th>Examples of contributory influencing factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Focus</td>
<td>Chronic long term physical health problems. Previous falls in ward and tendency to rise quickly from dozing.</td>
</tr>
<tr>
<td>Task and Technology factors</td>
<td>Three hourly care-rounding in place but not always engaging the patient.</td>
</tr>
<tr>
<td>Individual (staff) factors</td>
<td>Nurse in the ward area was at the other side of the room attending to a patient who was in distress. Staffing levels on the day were less than usual. Handwriting in notes difficult to read.</td>
</tr>
<tr>
<td>Team factors</td>
<td>No (documented) evidence of recent team discussion regarding patient's mobility. Team short staffed at the time of the adverse event.</td>
</tr>
<tr>
<td>Work Environmental factors</td>
<td>Multiple sets of notes. Electric heater being used as ward was cold.</td>
</tr>
<tr>
<td>Organisational and Management factors</td>
<td>(e.g. Delay in letter typing – up to one month from dictation ).</td>
</tr>
<tr>
<td>Institutional Context factors</td>
<td>None noted</td>
</tr>
</tbody>
</table>

Key issues

Key issues identified by the review team e.g. ward staff failed to recognise deterioration in patient and escalate appropriately; patient choice and non-compliance.

It would then be appropriate that this risk is identified in any action/improvement plan

Lessons learned

Refer to key Issues as above.

E.g. there is a need to have a clearer local protocol in place for identifying deteriorating patients in this ward and appropriately escalating concerns relating to falls, identifying the need for regular documentation audits to ensure that information is recorded accurately and effectively and ensuring that care rounding is done with patient engagement.

Please also note good practice here.

Recommendations

Should:

- naturally follow from contributory factors, key issues and lesson learned
- be listed in priority order
- be strong and advocate actions

E.g. develop, test and implement a protocol for identifying deteriorating patients and escalating appropriately; ensure all staff trained in use.

Improvement plan

Sets out how NHS Lothian will improve systems by addressing recommendations. This should be documented using the improvement plan summary template at the end of this document.

The improvement plan should be discussed with the relevant service. Evidence of implementation of the plan will be the responsibility of the service rather than the Review Team and should be noted in Datix.
Arrangements for shared learning – where, when & by whom

Document agreed arrangements e.g. Completed and approved template to be shared with clinical team at team meetings, CNM to feedback to individuals, report to be shared with operational management group/ QIT members.

Consider sharing outwith NHS Lothian - ensure that staff who are outwith the direct service are informed of any actions required and the completion timescales.

Author: ** Don’t forget to put in this detail **  

Date:

For SAE, the adverse event must not be closed on Datix until this report has completed the formal governance approval process. This will be done at the end of the process by Clinical Governance & Risk Management Support Team staff.

This sign-off process can be found on the NHS Lothian intranet under: Healthcare > A-Z > Risk Management > SAE Sign-off process

**SIGNED OFF BY (IF SIGNIFICANT ADVERSE EVENT)** should be completed prior to submitting for final approval and sign off

| H&SCP Director / General Manager / * please refer to local guidance for named person(s) | Signed:  
|  | Date:  
| Acute Nurse / Medical Director / H&SCP Clinical Director / Chief Nurse * please refer to local guidance for named person(s) | Signed:  
|  | Date:  

**FINAL APPROVAL**

| NHS Board Medical Director | Signed:  
|  | Date:  
| NHS Board Nurse Director | Signed:  
|  | Date:  

Please ensure that the Improvement Plan Summary on the following page is completed
<table>
<thead>
<tr>
<th>Contributory Factors</th>
<th>Issues linked to contributing factors</th>
<th>Actions to Address Factors</th>
<th>Level of Recommendation (Individual, Team, Service Directorate, Organisation)</th>
<th>By Whom</th>
<th>By When</th>
<th>Resource Requirements</th>
<th>Evidence of Completion</th>
<th>Completion Sign-off</th>
</tr>
</thead>
</table>
| As identified on your fishbone, including notes. | Care & Service delivery problems. Something happened that should not have happened or something that should have happened did not. | Think about how we can improve the identified system weakness. Consider:  
- Improvements to protocol guidelines etc  
- Innovative ideas for improvements | Select from above the list | Give titles / designation | Timescale need to be achievable  
Discuss with staff in the by whom column | Discuss with people named in ‘by whom’ staff column | Refer to actions to address factors – agree key milestones in the planning phase of action plan. Proof of completion is vital | Improvement Plan actions signed of relevant Service Senior Manager |

**Improvement plan example**

| Two sets of case notes offer difficulties with continuity of care | Vital information was missed | Need for one system for all staff to record in. | Directorate | ...... ......  
(named individual) Title | By end March 2016 | None at present | Will record data / progress and present at core senior management team in April |