Learning summary guidance

General information

The Adverse Events Community of Practice website has been set up to support NHS boards to share learning for improvement following adverse events reviews. The longer term aim is to widen the scope to sharing learning from other patient safety sources, such as complaints and claims, across both health and social care. To begin with we are testing the approach with the Learning from Adverse Events Network which has agreed to start using a learning summary template, based on an approach already being used by some NHS boards.

We are asking NHS boards to use the learning summary template to share learning about:

- service improvements following recommendations and actions that have come from reviews with potential national application
- improvements in the management of adverse events e.g. in relation to the process of reporting, reviewing and learning from adverse events, and
- risk awareness notices.

Service improvements with potential for local application

A template for sharing learning locally which review teams can use to summarise individual events and the learning points identified during the review has also been developed. We recommend that the local learning summaries are shared with staff, patients, families and carers and are published on the NHS board’s intranet and website along with the review report. This template features the same categories as the national sharing learning from service improvements template; these can be used or removed as felt appropriate.

There may be occasions where a trend of similar adverse events occur, the individual learning summaries may not be relevant to share nationally, however a learning summary of the collated learning points may be useful to share.

The templates and completed learning summaries can be found on the 'sharing learning' page of the Community of Practice.

Service improvements with potential for national application

A template has been developed in order to be able to share service improvements which have resulted from adverse events reviews. These learning points will have the potential for application across other NHS boards.

To provide clarity on the sort of national learning points that we are aiming to share, the Community of Practice Action Group has developed criteria outlining the forms of learning points which would be useful to share.

Systemic failings:

These are reviews that identify a failure of more than one element or component in a whole system designed to deliver a service or a particular outcome for patients. Examples of such learning include:
- Lost patient records due to a failure in the electronic health record system (EHRS) leading to failure/delay in treatment. Case example - a patient lives on the border between two health boards, which have separate EHRS's. She has a scan in one, and a clinic appointment the next week in the other. The clinic doctor prescribes a medication, harmful to her, which they would not have done if they had known she had received a scan with that result.

- The theatre where a specimen was taken was on a different site to the pathology lab where it is analysed. The specimen never arrived and it was several weeks before the clinician noticed there was no result for the patient. After the specimen leaves the theatre there is no method of tracing what happened to it. As well as a delayed diagnosis the patient was required to return for a repeat biopsy to diagnose the condition.

📅 Significant, preventable and avoidable personal harm:

These are reviews that identify an explicit significant service failure that led to personal harm that was preventable. Examples of such learning include:

- A patient required a blood transfusion. The blood track system for electronic release of the blood was not working so a paper system was used. The nurse involved was not familiar with the paper system and mis-interpreted the information on the list of units of blood in the fridge. She took the wrong blood out of the fridge. At the bedside she checked the unit against a request slip (for another patient) instead of the patient’s name band. She administered the wrong blood to the patient.

- A patient was to receive an operative procedure to refashion a wound scar. The site marking pointed in the direction of the wound. However the operator assumed the mark was pointing to a large mole near the wound and removed this instead. The error was not realised until the patient awoke from general anaesthetic and required to return to theatre for the correct procedure.

📅 Precedent or unusual events:

These are reviews that identify an issue that has rarely been picked up through an adverse event review or other safety mechanisms. Examples of such learning include:

- An issue that has arisen due to the introduction of a new product or technique. This seems to work in a research setting but the implementation of this in clinical practice is less successful. Case example - a hip joint ‘glue’ wasn’t prepared sufficiently in advance of operations, leading to a high failure rate of the joints. All the correct products were used, and the glue seemed satisfactory as it was used, but as the exact method wasn’t followed, the product didn’t work as planned.

- A disposable metal suction catheter designed for removing fatty tissue has a blue plastic ring that can be slid up and down the catheter so the surgeon can determine the depth required for the catheter. In the unit this was used they did not know this was the purpose of the ring and did not use it for this. In fact it usually sat at the user end of the catheter and the staff were unaware that is could move. During an operation the ring came right off the end and was retained in the wound. The staff did not notice it was missing and it was not counted as it was not known that it could come away from the instrument. The patient could feel the ring under the skin and returned to have it removed. Following this event the NHS board did not purchase this product but chose an alternative one without the ring.
Significant, not well known learning:

These are reviews that have led to learning outcomes that have not been previously identified, either because they relate to a precedent or unusual event or because the adverse event review has involved looking at the event in a new and different way. Examples of such learning include:

- A patient was given chlorpromazine (a sedative) rather than chlorpheniramine. These were stacked in the drug trolley with the labels partially obscured by the next box. This made it possible to select the wrong box, more easily than when the boxes were clearly separate. The manufacturers were asked to add the name in more than one location, so that it would be visible even if part of the box was obscured.

- The patient's weight and height was taken at a pre assessment clinic as part of the routine details collected. Following review it appears that on occasion staff were asking the patient this information without checking and it was not correct. The weight and height were being used to calculate chemotherapy doses and these doses turned out to be incorrect for the patient's body mass. Patients were underdosed. The system was changed so this information was double checked on admission before treatment commenced.

Unusual recommendations with strong evidence of improvement:

Where the review team have identified a new solution to a problem that has not been arrived at previously, where there is strong evidence of its effectiveness. An example of such learning includes:

- A trauma patient in the Emergency Department was in urgent need for blood products. There appeared to be a delay in receiving what was being requested. The investigation discovered there was confusion regarding who was asking for what and what the patient had already received. Due to the nature of the case medical staff were shouting at anyone passing to get blood products and too many people were involved in the process which caused confusion. A new system was introduced where they have a dedicated phone in the department just for arranging blood products. The task of coordinating the blood is given to one member of staff who will liaise with the lab and the porter. They will also keep track of what has been given and the stage of availability of other products.

Improvements in the management of adverse events

We would also like to share learning points in relation to the management of adverse events. These will be about improvements surrounding the review process itself such as the process of reporting, reviewing and learning from adverse events. An example of such learning includes:

An NHS board found that incidents were recorded on Datix with a serious outcome such as death or significant harm that were actually not avoidable such as a known complication or the patient outcome was related to the patient's condition (e.g., died in CT following major trauma from road traffic accident). In order to filter these out from incidents which should have been avoided and therefore require investigation to reveal learning a 'severity 4/5 review template' was developed. This template is used for any incident that is not going straight to a significant adverse event review but has a serious outcome which has been coded a 4 (major injuries, long term incapacity) or 5 (death) using the NHS Scotland Core Risk Assessment Matrix. The document is two sides of A4 and also records the reason why a full review is not required which allows the decision-
making process to be captured. If, following this severity 4/5 review, the decision is to progress to a significant adverse event review, the template can be used as the rapid alert and the decision of why it is an significant adverse event review is recorded.

Risk awareness notices

We would like to share adverse events which present an immediate risk with other services and to inform them of the corrective action taken. A risk awareness notice has been developed which can be used both locally and nationally to share immediate risk.

Categories

Two short lists of categories have been developed in order to catalogue each learning summary. For service improvements:

- Anaesthetic practice
- Clinical/information governance
- Communication
- Facilities
- Infection control
- Medical devices/equipment
- Medication
- Moving and handling
- Obstetrics
- Other (please specify)
- Patient observations
- Radiation/imaging
- Self-harming behaviour/suicide
- Slips, trips and falls
- Theatre processes
- Transfusion
- Treatment problem

For improvements in the management of adverse events, the following list has been developed:

- Risk assessment
- Reporting
- Categorisation
- Levels of review
- Review techniques
- Patient, family and carer engagement
Staff engagement
Report writing
Action planning
Governance
Sharing learning points
Other (please specify)

Please select the most relevant category on the drop-down list on the learning summary to identify the learning points outlined on the summary. If there is not a good fit with the categories provided, please specify a category which you think fits best in the space below. We will regularly review the ‘other categories’ submitted and update the core lists as required.

Key words
In order to support searching for relevant learning summaries, please add key words, we suggest 3-5 for which you feel are most relevant to the learning summary.

Naming convention
Please use the following naming convention when naming the learning summary and risk awareness notice documents:

Learning summary: category-key words-date of upload (e.g. clinical/information governance - record keeping - 01 January 2015).
Risk awareness notice: subject of notice - date of upload (e.g. labelling of specimens - 01 January 2015).