Policy for the Management of and Learning from Adverse Events

Co-ordinator:	Reviewer:	Approver:
Quality Governance and Risk Unit	GAPF Policies Subgroup	Grampian Area Partnership Forum (GAPF)

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The provisions of this policy, which was developed by a partnership group on behalf of Grampian Area Partnership Forum, apply equally to all employees of NHS Grampian except where specific exclusions have been identified.

NHS Grampian

Policy for the Management of and Learning from adverse events and Feedback

This document is also available in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on Aberdeen (01224) 551116 or (01224) 552245.

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NHS Grampian

Policy for the Management of and Learning from adverse events

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Policy for the Management of and Learning from adverse events

1.   Introduction

The following policy for staff in NHS Grampian reflects the definitions and principles outlined in the Healthcare Improvement Scotland (HIS) publication **Learning from adverse events through reporting and review: A national framework for NHS Scotland (2018).**

It is recognised that although NHS staff strive to deliver safe, effective and person centred care, adverse events (including duty of candour events) do occur. It is an aim of the national approach to learn from adverse events locally and nationally to make service improvements that enhance the safety of our healthcare for everyone (this includes the health, safety and wellbeing of staff and everyone entering NHS Grampian premises). Regardless of where an adverse event occurs the person/s affected should receive the same high quality response and any staff involved should be treated in a consistent manner.

NHS Grampian requires that all adverse events including near misses are recorded in the Risk Management Information System (Datix). This allows local management of the event by managers who are also responsible for initiating a review and escalating or fast-tracking adverse events to managers or topic specialists, as appropriate.

2.   Scope

This policy applies to all staff involved in the reporting and management of adverse events. It provides information to managers in order to assist them to fulfil their responsibilities and to ensure that information about adverse events is communicated effectively and lessons are learned from the subsequent reviews.

The scope covers:

•   Acute Services and Health and Social Care Partnerships and Hosted Mental Health Services;

•   Primary care (GP practices, dental practices, community pharmacies and optometrists);

•   Social care;

•   Employees and independent contractors;

•   Clinical and non-clinical events (including health and safety at work, information governance, adverse publicity and finance).

Where appropriate there may be concurrent reviews running independently, for such events, co-operation and co-ordination should be given.

3.   National Definitions

The following definitions are used within this policy:

An **adverse event** is defined as **an event that could have caused (near miss), or did result in, harm to people or groups of people**;

- **Harm** is defined as **an outcome with a negative effect.** Harm to a person or groups of people may result from worsening of a medical condition, the inherent risk of an investigation or treatment, system failure, provider performance issues, service disruption, financial loss or adverse publicity;

- **Near Miss** is an undesirable incident that by chance or intervention did not result in harm or loss;

- **People** are defined as; service users, patients, members of staff, carers, family members, visitors and contractors;

- **Groups of people** include any functional grouping of individuals such as an organisation. In this way, adverse events that result in, for example, reputational harm or financial harm are included.

A **statutory duty of candour adverse event** is defined as an unexpected or unintended adverse event or events which are not related to the natural course of someone's illness or underlying condition. To be a duty of candour event, the patient / service user need to have suffered **harm and / or care or service delivery issues**. Appendix One provides the statutory duty of candour flowchart)

Under the legislation, **harm** is defined as: death; permanent lessening of bodily, sensory, motor, physiologic or intellectual functions; increase in treatment; changes to the structure of the person's body; the shortening of the life expectancy of the person; impairment of sensory, motor or intellectual functions for at least 28 days; pain or psychological harm which has been, or is likely to last, for at least 28 days; treatment to prevent death or anything that would lead to one or more of the above outcomes.

Care and Service Delivery issues means: a different plan and / or delivery of care may have resulted in a different outcome though uncertainty regarding impact on patient outcome/event.

A different plan and / or delivery of care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how the case was managed had a direct impact on the level of harm

Public Protection is the term used to describe the joint commitment to preventing and managing the risk of serious harm to vulnerable individuals, families and communities.

An adult at risk is defined as a person aged 16 or over who is:

- Unable to safeguard his or her own well being, property, rights or other interests, and
- At risk of harm and

- Because she/he is affected by disability, mental disorder illness of physical or mental infirmity is more vulnerable to being harmed than adults who are not so affected.

An adult at risk under the legislation needs to meet all three of the above points.

The term child protection is referred to as preventing and responding to violence, exploitation and abuse against children.

Please see glossary of terms (Appendix Two) for all key terms used in the policy.

4.   Duties and responsibilities for managing adverse events

Staff

All staff are responsible for:

- Demonstrating leadership behaviours and actions that support a positive safety culture and commitment to being open;

- Maintaining a safe environment, safe systems of work and taking proactive measures to reduce the risk of an adverse event occurring and reporting adverse events including near misses e.g. on the Datix system;

- Supporting reasonable actions as required to reduce or eliminate risks associated with adverse events and duty of candour;

- Co-operating fully with adverse event and duty of candour review procedures;

- Implementing recommended actions and learning points;

- Attending training where applicable for their role;

- Understanding learning points and implementing recommended improvement actions;

- Engaging with patients, service users, families and carers, visitors and contractors.

The NHS Grampian Board

The Board is collectively responsible for ensuring the proper reporting, recording, review management and learning of all adverse events and duty of candour. The governance frameworks are utilised by the Board to seek assurance that all adverse events including duty of candour are managed in accordance with this policy.

- **Formulating strategy**: providing a clear vision and purpose that puts quality and safety at its heart including strategic aims for safety;

- **Ensuring accountability**: for delivering the strategy and seeking assurance that systems are robust, and for the organisation operating with openness, transparency and candour;

- **Shaping culture**: modelling and promoting values and standards of conduct for everyone.

The Board will seek assurance that systems in place support the effective management of adverse events.

The Board should be kept informed of serious and ongoing issues and recognise the links between staffing, quality outcomes, and health and safety.

A Board Director is formally designated to lead on and be responsible for health and safety and the management of adverse events, including responsibility for appropriate closure of adverse event reviews.

Governance Committees

Demonstrate leadership behaviours and actions that support a positive safety culture and commitment to being open.

Are responsible for assuring the Board that there are robust measures in place to record and manage adverse events, including meeting duty of candour requirements, and that learning and improvement have taken place to reduce the risk of recurrence.

Ensure preventative measures and processes are in place to effectively undertake risk assessment, identify potential harm and manage risks to an acceptable level. The aim being to minimise the likelihood of an event occurring and / or to the level of harm.

Ensure actions contained within improvement plans have been completed and contribute to organisational learning by sharing and adopting key learning points.

Have systems in place for their Senior Leadership Teams in accordance with their governance principles to receive regular briefings on the detail of significant issues, trends and other analysis on adverse events and duty of candour processes. This includes consideration of adverse events, duty of candour processes and associated information during Board meetings.

Ensure the Senior Leaderships Teams receive summary information, including the number of adverse event reviews open beyond recommended timescales, to help gain assurance that appropriate action has been, or is being, taken to safeguard patients, service users and staff in a timely manner, and to understand the impact on individual patients, service users and staff.

Integrated Joint Boards

Integration Joint Boards have an active role in the oversight of the operational activities that contribute to the achievement of their Strategic Plans. Each of the three Integration Joint Boards in Grampian are required to have supporting Committees, including a Clinical and Care Governance Committee.

NHS Grampian staff working in the three-Health and Social Care Partnerships that report to the respective Integration Joint Boards must adhere to this policy, and follow the NHS

Grampian reporting and investigation progress so that NHS Grampian as the accountable body for service delivery has sight of adverse events.

Joint Health and Social Care Investigations

Where adverse events involve health and social care, there will be agreement at the start of the process which the agency will lead the investigation. The requirement remains in that reporting and investigation process must adhere to the NHS Grampian process and timescales, which does not prejudice the parallel reporting that will be required through NHS Grampian and the relevant Local Authority.

Chief Executive

The Chief Executive demonstrates leadership behaviours and actions that support a positive safety culture and commitment to being open.

Creates a culture to support staff to safely express concerns and for these to be listened to, discussed and acted on as appropriate.

Is accountable to the Board for ensuring resources, policies and procedures are in place. The Chief Executive is also responsible for ensuring the effective reporting, recording, review and learning from adverse events and duty of candour. Also, that there are suitable and sufficient arrangements for the support of staff affected by adverse events.

The Chief Executive is ultimately accountable and takes an active interest in reading and signing all responses and delegates the authority to deliver NHS Grampian's adverse event and duty of candour management arrangements as specified in this policy:

Executive Directors

Executive Directors through line management structures will ensure that all staff within their Directorates are aware of this policy and that it is implemented effectively. They are responsible for ensuring that there are systems in place to monitor adverse events and duty of candour within their Directorates; and that they are reviewed appropriately with completed action plans and that improvements are made. Executive Directors are also responsible for facilitating the learning of lessons from adverse events and duty of candour through their normal lines of communication, they:

- Demonstrate leadership behaviours and actions that support a positive safety culture and commitment to being open;

- Have a role in determining adverse events review levels;

- Engage with patients, service users and families, including through duty of candour processes;

- Ensure staff support and training;

Non-executive Directors

Demonstrate leadership behaviours and actions that support a positive safety culture and commitment to being open.

Challenge executives and seek assurance that effective systems for reporting, managing, reviewing, learning and improvement from adverse events and duty of candour procedures are in place and working well within the organisation.

Senior Managers and Clinicians

Have responsibility for ensuring compliance with this policy. Specifically they are required to ensure:

- They demonstrate leadership behaviours and actions that support a positive safety culture and commitment to being open;

- They responsibly set an example and encourage openness and honesty in reporting adverse events and actively foster a culture of learning and improvement;

- Compliance with adverse event and duty of candour policies and procedures, including establishing Formalised Local Sector Performance Groups;

- Appropriate staff under their jurisdiction are given the necessary process information, instruction, training and supervision to enable them to carry out adverse event and duty of candour reviews;

- Review and management of adverse events and duty of candour. Within their areas of responsibility all adverse events and duty of candour are reported, graded, reviewed and actions taken to the level appropriate to the risk grading and that the information is documented;

- Local provision of support to staff affected by an adverse event and duty of candour;

- People affected are informed when an adverse event and duty of candour occurs and that they are notified of the Boards policy for management and review, as set out in this document;

- People affected are invited to participate in discussions to facilitate a positive outcome as part of the adverse event and duty of candour review process;

- Any modification to local procedures undertaken following the review are brought to the attention of their staff and any information, instruction or training required is given, and recorded;

- Where appropriate risk assessments are updated and communicated, consideration should also be given to updating risk registers;

- Learning from the adverse event and duty of candour review and analysis is shared with staff; and patients;

- The findings of reviews from adverse events and duty of candour are communicated through the management structures;

- Anonymised review reports and actions are provided to the appropriate forum to facilitate local learning;

- Where appropriate learning from the review is shared wider by utilising the Safety Alert Broadcast System (SABS) e.g. through Datix;

- Lessons learned following the review of an adverse event and duty of candour which may apply to areas outside of their remit are brought to the attention of all relevant managers within NHS Grampian for sharing learning;

- There are regular reviews of adverse events and duty of candour to analyse data, identify trends, and manage performance;

- Improvement plans are progressed and are followed up.

Line managers

Are responsible for ensuring:

- They demonstrate leadership behaviours and actions that support a positive safety culture and commitment to being open;

- They are aware of the processes for reporting, management and review of adverse events and duty of candour in their area of responsibility, including the updating and closing of adverse event reports once the review has been completed. This includes anonymising patient and staff details;

- Staff working in their area report adverse events and there are registered health care professionals available to advise whether an event triggers the duty of candour or health and safety professionals to advise whether external RIDDOR reporting is required;

- Staff working in their areas are aware of and comply with the reporting procedure and cooperate in any relevant review;

- Sufficient numbers of staff are trained and that staff do attend training to conduct adverse event reviews and follow the duty of candour procedure;

- The factual and timely management of information regarding adverse events and duty of candour is evidenced e.g. on the Datix system;

- Adverse events which come to their attention are graded appropriately and where required are reported to the appropriate Senior Manager;

- People affected have relevant details of the event and duty of candour and receive timely and adequate explanations from appropriate members of staff;

- Equipment suspected of contributing to the event is quarantined and that the scene is appropriately cordoned off;

- All relevant documentation is gathered, completed and securely stored (e.g. in Datix) including statements;

- Staff are suitably supported following an adverse event, referring to other support services as required e.g. Occupational Health Service (OHS), counselling services, Chaplains, etc. and advised to contact their Trade Union / professional body;

- Where staff are injured or suffer ill health as a result of an adverse event they follow guidance from the OHS;

- There are regular reviews of local adverse events to analyse data, identify trends and manage performance.

Occupational Health Service (OHS)

- OHS will support staff providing confidential care should this be required following an adverse event, and where necessary will contact managers identifying ways to support staff at work;

- They will remind staff of their responsibility to report adverse events when they attend the Occupational Health Service appointment e.g. following sharps injury.

Corporate Health and Safety Department

- Offers support to areas with follow up on risk assessment / risk assessment reviews;

- Offer topic specialist advice on health and safety matters.

Health and Safety Representatives

Demonstrate leadership behaviours and actions that support a positive safety culture and commitment to being open.

Health and Safety Representatives should be engaged and involved in adverse event reviews. They can assist and guide staff members through processes and ensure preventative and protective measures are put in place and are effective.

Representatives are suitably trained to support staff during the review process, they are also able to signpost to further support services, such as Partnership support and counselling services. Contact details are available via this e-mail link

5.   Risk - prevention and control - adverse events and duty of candour

Appendix Three – provides further information on adverse event including duty of candour prevention through NHS Grampian's Risk Management Strategy, Safety Alert Broadcast System and promotion of Positive Health and Safety Culture.

6.   Immediate actions following discovery of an adverse event

The first priority is always to ensure the needs of the people affected by the adverse event are attended to, including any urgent clinical care. A safe environment must be re-established, and the health, safety and welfare of all in the area secured, and further risk reduced. Care must be taken to preserve evidence, for example, isolate and label faulty equipment or medication, copy, retain and secure all documentation as this will facilitate review and learning.

There is also a requirement to inform senior staff immediately if a serious adverse event occurs to ensure that the level of harm is minimised, support is secured from other professionals, and staff involved in the event are supported. Staff involved in an adverse event should be kept informed and involved in any subsequent review. Staff may also be required to provide a statement depending upon their proximity to the adverse event.

When the adverse event (statutory duty of candour or otherwise) has resulted in serious harm or death to a patient or staff member it is essential that family members and carers are contacted. They must be kept informed according to their wishes and preferences. All staff are required to be honest and open with patients, their families and carers when a patient has been harmed following an event.

Where Statutory Duty of Candour is suspected to apply this involves acknowledging, apologising* and explaining what has gone wrong. The seniority of the member of staff who undertakes this role will depend on the severity and nature of the adverse event. When there is likely to be an ongoing review a member of staff must be nominated promptly to liaise with the patient, family of patients / staff and there is a requirement for them to document details following each communication e.g. in the notepad on Datix. A formal written apology must be sent to the patient / family and a copy uploaded to Datix.

*When staff offer an apology they are not accepting blame for causing the adverse event. They are acknowledging that the event has occurred and reassuring the people affected a review will be undertaken to establish the cause.

7.   Reporting an adverse event

Adverse events should be reported e.g. on Datix as soon as possible, and as a minimum within 24 hours of the incident occurring, or of it being identified. Guidance on how to report an event on Datix is available from the Quality Informatics intranet page Datix Reporting Guide. If an adverse event related to feedback has not been recorded on Datix, managers should record this retrospectively in order to utilise Datix as the repository for the review details.

In addition to reporting the adverse event on Datix, it is essential that the reporter informs their line manager at the first opportunity. Automated email alerts are sent via Datix to all relevant groups of people, and topic specialists, for information when an adverse event is reported.

It is essential that information recorded on the Datix report contains only factual information, and avoids making assumptions or stating opinions.

Managers are required to inform the Datix team to ensure their staff members have accounts and correct permissions on Datix, including removal if staff leave.

8.   Categorising event, grading risk and corresponding review levels

The response to each adverse event should be proportionate to its scale, complexity and opportunity for learning.

The NHS Scotland Core Risk Assessment Matricies (Appendix Four) are used to categorise adverse events. Such categorisation acts as a formal rule of thumb in determining the appropriate level of review.

Upon an adverse event being entered into the Datix system, it is initially reviewed by the Line Manager or First Approver for the area. They are responsible for making a judgement using their knowledge of the area to check and / or amend the entered 'severity' of the **actual outcome** event: negligible; minor; moderate; major or extreme. Figure 1 below demonstrates the formal rule of thumb to determine the required review level based upon the actual event outcome.

Consequence / Impact		
Negligible	**Minor** **Moderate**	**Major** **Extreme**
Review Level 3	Review Level 2	Review Level 1

Figure 1 – Actual Event Severity Review Levels.

However, it is known that some adverse events depending upon the nature of the event, person/s or equipment involved, service etc. may, if they occurred again, result in a different outcome. They have the potential to be more serious and can also provide a valuable source of learning to prevent recurrence. The aim is to prevent rather than react and not wait until harm occurs before making system improvements.

Therefore, 'risk' associated with the adverse event, should it occur again, is graded: low; medium; high or very high and should also be considered when determining the appropriate level of review.

After categorising the actual severity, the risk should also be graded. This considers how likely it is to recur together with what the potential consequence would be (consider the most feasible consequence rather than the worst possible consequence).

Figure 2 demonstrates the formal rule of thumb to determine the required review level based on graded risk.

Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost Certain				Very High	
Likely			High		Level 1
Possible		Medium		Level 2	

Consequence / Impact

Unlikely	Low	Level 3	
Rare	Level 3		

Figure 2 – Potential Risk Grading and Review Levels.

Using figures 1 and 2 assists in determining review levels. If an adverse event occurred which resulted in negligible harm, using Figure 1 demonstrates a Level 3 review is appropriate, however, if the same event, were to happen again had the potential to be more serious using Figure 2 will help determine an appropriate level of review. For example, Level 1 or 2 reviews could be conducted for a near miss where no harm actually resulted.

If a Review is to be downgraded, for example, an adverse event occurred which resulted in major harm, then using Figure 1, a Level 1 review would be appropriate. However, if due to the nature of the event itself, its rarity and / or less severe impact, by using Figure 2, then it is possible to downgrade the level of review to be undertaken.

In all cases the decision making process and reasons for raising or lowering the review level, whether based on actual event severity or potential risk grading, must be recorded fully and accurately in the Datix record by the responsible Manager. If a decision is taken not to proceed to a Level 1 Review following a Level 1 event (see figure 1) this must be fully documented and recorded. It may also transpire that only following full review, when all the circumstances of the event are revealed it is then downgraded following the review.

When categorising events, grading risks to determine review levels, it is important to note that Line Managers and First Reviewers must use the definitions in the NHS Scotland Core Risk Assessment Matrices and not rely on their subjective interpretation 5 x 5 matrix terms.

In addition to using the formal rules of thumb to determine appropriate adverse event review levels, any adverse event within healthcare may provide important opportunities for learning and the following decision points should be taken into account:

- Is the outcome a known complication of the disease / treatment / process?

- Are there unknowns surrounding the adverse event?

- Has there been any breach or deviation in policy or procedure?

- Is there learning to be gained / would you do anything differently next time?

- Is there concern regarding the event from the patient, family, staff or from management?

In relation to **statutory duty of candour events,** the review level may be either level 1 or 2. Statutory duty of candour events must be completed within 90 days, however, if a level 2 review has been commissioned this will required to be completed within 30 days.

Since the 1st of January 2020 all NHS Boards are to notify Healthcare Improvement Scotland where a Level 1 review has been commissioned for an adverse event with a major or extreme severity (regardless of whether severity was actual or potential harm). This is to move towards standardising terminology and definitions across Scotland. The data is

submitted monthly by the Quality Assurance and Improvement Team, following discussion at the Clinical Risk Meeting.

9. Review: team structure, method, output and timeframes

All adverse events are subject to review.

NHS Grampian Sectors and Health and Social Care Partnerships are responsible for development of their own governance for effective management and review of adverse events within their areas (see Section 12). To ensure consistency in the treatment and effective management of adverse events, NHS Grampian's overall requirements for each Review Level is provided below:

Review Level 1 – Significant adverse event Review

Review Team

- Level 1 Review Teams should include a Senior Manager / Consultant a full Review Team has a minimum 3 members;

- The **Commissioning Managers** are generally a Divisional General Manager / Divisional Clinical Director / Chief Nurse from the area where the event took place. However, where staff groups work geographically across the organisation this role may fall on affected staff's senior line managers;

- Commissioning manager/s firstly consider and agree the required level of review;

- Commissioning Manager appoints Review Lead and writes a Terms of Reference (ToR) with colleagues;

- Commissioning Manager is responsible for ensuring all staff involved in the event, and where appropriate, patients and families; receive a copy of the final report;

- Commissioning Manager is responsible for ensuring that any learning is shared across divisions and services and implemented;

- Where a patient is involved in the adverse event or if an employee is seriously injured the Commissioning Manager appoints a **Family Liaison Manager** (where existing relationships exist with families this role does not have to be within the Review Team).

- The Family Liaison Manager involves the family and provides feedback from the review – the named Family Liaison Officer should be recorded e.g. on Datix and should:

  o ensure that they are appraised of all facts;

  o agree how the patient / family will be communicated with and with what frequency;

- keep accurate records of all communications / discussions with patient / family uploaded e.g. in notepad on Datix;

- respond to requests from patient / family to meet with other staff in NHS Grampian in relation to the situation;

- provide updates for the patient / family on the progress of the review in an appropriate format;

- consider and act upon the potential contribution the patient / family can make to the review process;

- signpost the patient / family to external support as indicated by the situation.

- Commissioning Manager ensures the review team are suitably established and trained to conduct the review;

- Commissioning Manager considers involving the Health and Safety Representatives particularly in instances where staff members have been harmed, or staff need support;

- **Review Lead** may be a Senior Clinician / Manager / Head of Department from within or out with the Department and have experience of conducting reviews, they co-ordinate the review and report findings back to the Commissioning Manager;

- The Review Lead is responsible for uploading progress reported e.g. onto Datix as and when required;

- Where the adverse event involves external agencies (outside NHS Grampian or Independent Contractors) this should be escalated to the appropriate Executive Director to commission the review involving external agencies (see Appendix Five);

- Where the adverse event is likely to have serious implications or require external reporting, police involvement or may attract media attention it should be brought immediately to the attention of Senior Management who are responsible for escalating the information appropriately e.g. Corporate Communications, Head of Health and Safety.

- As a result of Post Mortem finding in cases of sudden or unexpected death, a police investigation is likely – all original case notes and other relevant documents will be requested and removed by the police.

- **Review team** members should be sufficiently removed from the event to avoid conflict of interest and maintain objectivity and are appointed by Commissioning Managers;

- The Review Team has authority to make recommendations based on the review findings and involves staff in identifying learning points;

- Review teams where appropriate should be multi-professional. A multi-professional team should include a professional with experience relevant to the event being reviewed;

- At least two team members should be trained in the use and implementation technique of the selected root cause analysis tool.

Method

- Use of validated root cause analysis tools e.g. fishbone, 5 why's or evidence of screening and clear rationale for not progressing to root cause analysis;

Output

- Review Team complete the report and include their recommendations in the appropriate review report template;

- Review Lead meets with the Commissioning Manager for both to agree and sign the report;

- Commissioning Manager / Senior Management produce an Improvement Action Plan based on the recommendations (where recommendations are not taken forward as part of the action plan the Commissioning Manager must provide a rationale on Datix). It is also best practice to ensure the review team receive timeous feedback regarding improvement actions.

- Full Report and Improvement Action Plan uploaded to Datix, and use made of the action tracker function in Datix;

    o Where completion of full report and improvement Action Plan is delayed, progress should be documented weekly e.g. in the Datix notepad;

- Shared learning of final review;

- Final Approver / Senior Manager signs the adverse event report and closes the event on Datix.

Review Level 2 – Local Management Team Review

Review Team

- Level 2 Review Teams should include a First Line / Middle Managers / Medics a full Review Team has a minimum 3 members;

- The **Commissioning Managers** are generally a First Line / Middle Managers / Clinicians from the area where the event took place. However, where staff groups work geographically across the organisation this role may fall on affected staff's senior line managers;

- The Commissioning Manager appoints the Review Team;

- Consideration should be given to involving staff members from outwith the service and taking a multi-professional approach.

- Commissioning Manager/s firstly consider and agrees the required level of review;

- Commissioning Manager appoints Review Lead and write a Terms of Reference (ToR);

- Commissioning Manager is responsible for ensuring that any learning is shared across divisions and services.

- If the event is **a statutory duty of candour** event the Commissioning Manager appoints a **Family Liaison Manager** as described in Level 1 above.

- **Review Lead** co-ordinates the review and report findings back to the Commissioning Manager;

- Review Lead has authority to make recommendations based on review findings and involves staff in identifying learning points;

- Review Lead is responsible for uploading progress reported e.g. onto Datix as and when required;

- Where the adverse event involves external agencies (outside NHS Grampian or Independent Contractors) this should be escalated to the appropriate Senior Management to commission the review involving external agencies (see Appendix Five);

- **Review team** members should be sufficiently removed from the event to avoid conflict of interest and maintain objectivity and are appointed by Commissioning Managers;

- Review teams where appropriate should be multi-professional. A multi-professional team should include a professional with experience relevant to the event being reviewed;

- Where the review method adopted involved the use of a root cause analysis tools at least one team member should be trained in the use and implementation technique of the selected root cause analysis tool.

Method

- The Review Team can use validated root cause analysis tools e.g. fishbone, 5 whys, **or**

- Meet to discuss the case and gathered evidence / facts in determining causation and implement measures to prevent recurrence;

Output

- Review Team complete the report and include their recommendations in the appropriate Review Report Template;

- Review Lead meets with Commissioning Manager for both to agree and sign the report;

- Commissioning Manager produces an Improvement Action Plan (based on the recommendations) (where recommendations are not taken forward as part of the action plan the Commissioning Manager must provide a rationale on Datix). It is also best practice to ensure the review team receive timeous feedback regarding improvement actions.

- Full Report and Improvement Action Plan uploaded to Datix, and use made of the action tracker function in Datix;

  o   Where completion of full report and improvement Action Plan is delayed, progress should be documented weekly e.g. in the Datix notepad;

- Shared learning of final review.

Review Level 3 – Local Review by Line Manager

Review Team

- Local Line Manager via formalised Localised Sector Governance Structures.

Method

Local Line Manager reviews event details with their team.

Output

- Review details uploaded e.g. on Datix and record immediate actions to establish safe environment and further actions taken to mitigate future risk (e.g. the Datix record is the adverse event report);

- Highlight any trends or themes to next direct Line Manager;

- Where trends or themes in adverse events are identified, a higher level review should be considered or escalated to local Senior Management;

- Final approver Local Manager closes the event on Datix;

- Shared learning of final review, through local Health and Safety Committees and / or other relevant groups.

Public Protection Reviews

In addition to internal reviews as described above a Public Protection adverse event review could be undertaken as a Significant Case Review, Multi Agency Case Review or Initial Case Review and would be reported on a multi agency basis to the respective Adult or Child Protection Committee where appropriate. Under any of these reviews health staff are duty bound to cooperate with the lead agency.

Timeframes

Table 1 demonstrates the associated timescales required for each review level. Where Level 1 or Level 2 reports are not completed within these timescales weekly progress should be recorded e.g. in the Datix notebook.

Review Level	Starts - Date Event Reported on Datix	
	All timescales in 'working' days	
Level 1	Commission review	≤ 10 days
	Commence, close the review and submit report for approval	≤ 90 of date of commission
	Final report approval	≤ 30 dates of report submission
	Develop an improvement action plan	≤ 10 days final report approval
Level 2	Commence, close the review and submit report for approval	≤ 30 days
	Final report approval	≤ 30 days of report submission
	Develop improvement action plan	≤ 10 days of final report approval
Level 3	Electronic e.g. Datix report approved and closed	≤ 10 days

Table 1 – Review Level and Corresponding Timeframes

10.   Accountability for health and safety: links with Human Resources / NPSA Incident Decision Tree

It is extremely rare for members of staff to deliberately cause harm, potentially resulting in disciplinary and / or criminal proceedings.

However, it is possible and Commissioning Managers are advised to use the NSPA Incident Decision Tree (Appendix Six) which assists in the assurance of a 'just culture' in invoking disciplinary / conduct processes if required.

Where such a process is activated this is **treated as separate** to the adverse event review and escalated through line management structures with the appropriate Human Resource policies.

General Support for Reviews

Support for undertaking a review should be sought initially from management and Clinical Leads. The Quality Improvement and Assurance Team (QAI) have staff available to support

the process, for more detail contact QAIT on ███████████ or e-mail
████████████████████████████

Specialist Support for Reviews

The Corporate Health and Safety Manager is available for advice and support regarding adverse events that involve staff and can be contacted on ███████████ or e-mail ████████████████████████ Additional advice and support can be gained from Specialist professionals e.g. Infection Control, Fire Safety, Health and Safety, Health and Safety Representatives and Medication Safety Advisor.

11.   Event review methodology and analysis

Managing and learning from when things go wrong is an integral component of risk management and supports risk prevention. This data can act as an early indicator that a system is not functioning effectively, and analysing trends can provide valuable insight into where improvements may be required.

The purpose of the review is to seek to understand what happened, why it happened and to recommend improvements and monitor the effectiveness of the systems and processes put in place to prevent future occurrences. NHS Grampian supports a structured process and encourages completion at the earliest opportunity. Depending on the complexity of the review, the team should choose the root cause analysis tool, implementation technique and templates to facilitate understanding the sequence or timeline leading to the event, identification of contributory factors, and root causes in a timely manner.

A supporting list of additional Root Cause Analysis (RCA) techniques (e.g. fish bone and 5 whys) and supporting guidance and templates can be found on the Quality Improvement Hub intranet site or via this link. Whichever tools and techniques are adopted, this should be clearly identified in the final adverse event report.

It should be remembered to share identified good practice and that although the aim is to rectify root causes, remedial action should also be taken where findings are discovered not directly related to event causation. In support of a just culture, consideration should also be given to human factors.

It should also be remembered that in relation to patient safety, not all adverse events will identify system failures and proper care may have been delivered, therefore a review may conclude appropriate care was given and the adverse event was unavoidable.

All Level 1 reviews must include two members of staff who have undertaken root cause analysis training as a minimum requirement, details of which can be found on Turas.

Whether conducting a Level 1, 2 or 3 review appropriate preventative actions cannot be implemented unless the causes of the event are understood. This involves reviewing what factors contributed to the event, and within those contributory factors, the identification of root causes, that is the fundamental reason/s for the occurrence of the event.

The review of each adverse event should be proportionate to its scale, complexity and opportunity for learning. Reviewing adverse events on an individual basis will not identify trends and themes within departments, sectors or across the organisation.

Therefore, as well as analysis being conducted for each event itself, in line with the Review Level guidance, Departments and Sectors are required to periodically and systematically take a holistic overview of all their adverse events, including those that did not result in harm, to identify emerging patterns or themes which may give rise to further risk.

Thus aiming for prevention rather than reaction and not waiting for harm to occur before making system improvements. Where emerging risks are identified preventative measures should be implemented within the Department / Sector or escalated to more Senior Management.

12. Formalised Local Sector Performance Monitoring

NHS Grampian's Sectors are responsible for having local performance monitoring mechanisms in place to consider and monitor adverse event review and duty of candour procedures. Such mechanisms should facilitate regular trend or thematic reviews to extract learning and support the development of organisational memory and continuous improvement with regard to health and safety.

This includes:

- Level of approval / sign off for Level 1, 2 and 3 reviews;

- Clarity of accountability and seniority of roles required for Level 1, 2 and 3 adverse events reviews within areas of responsibility;

- Clarity of escalation to more senior management;

- Monitoring Terms of Reference are met and those conducting Level 1 and 2 reviews are trained to do so;

- Monitoring effectiveness of actions / recommendations adopted;

- Embedding a periodic analysis of adverse events taking place in their sector to identify themes and emerging risk;

- Reporting frameworks and structures to ensure a holistic view is taken and all reviews are undertaken within the timeframes included in this policy;

- Method for sharing learning and learning summaries where appropriate

13. Action Planning and Effectiveness Monitoring

Those identified as responsible for implementing recommendations of an adverse event review, should record the reasoning, if unable to implement the recommendations

Formalised Local Sector Governance structures should include action monitoring to ensure recommendations are effective in preventing recurrence of the adverse event.

14.   Confidentiality

Reviews are carried out with a high degree of confidentiality; however staff and patients involved in the adverse event should be kept well informed of any review and subsequent learning and actions. Guidance on 'Openness and Honesty' is available at the following link and should be utilised in order to ensure that there is a consistent approach to engaging with patients and their families.

During the review process, confidential information relating to the event will be gathered, including information on service delivery, individual practice etc. The process should follow the principles of just culture. If the review team considers that there are any issues about the performance of an individual member of staff, this should be immediately referred to the Commissioning Manager and should not be part of the review.

ORGANISATIONAL DUTY OF CANDOUR PROCEDURE

Please note: the Duty of Candour procedure applies in addition to the NHS Grampian Policy for Management of and Learning from Adverse Events and Feedback and should be read in conjunction with that document.

Possible means of identifying events

| Clinical Claims | Complaints | Adverse events | Mortality & Morbidity cases | Whistleblowing |

Possible Duty of Candour Event Identified

Reviewed at ward/ specialty/service level*

DoC triggered?^   Yes / No / Unsure

* The act states that the decision should be based on the reasonable opinion of a registered health professional who was not involved in the event.

^ There may be circumstances where a situation develops or further information becomes available which means this decision should be overturned.

Reviewed at Divisional level*

DoC triggered? ^   Yes / No / Unsure

Reviewed at Sector level*

DoC triggered? ^   Yes / No

Organisational Duty of Candour does not apply but event reviewed as per NHSG Adverse Events policy

Duty of Candour Procedure starts

Duty of Candour procedure should be started within 1 month of event occurring. If it is not, an explanation must be provided to the relevant person.

Notification made to relevant person within 10 working days of procedure start date

10 working days

3 months

In addition to any apology provided at the time of the event, the relevant person must be offered a written apology and must be provided one if requested.

Meeting held with relevant person

Note of Meeting (within 10 working days of meeting)

Questions from relevant person used to inform review terms of reference

Carry out appropriate level of Review ~ (to be completed within 3 months of start date)

~ A minimum of a Level 2 review should be carried out for all events which trigger the Organisational Duty of Candour.

Final report (within 10 working days of request)

If there is uncertainty around whether the Duty should be triggered, the decision can be escalated as per local arrangements. The levels of escalation in this document are based on the structures within Acute and Mental Health but other reporting lines may be in place within your area.

V2 Mar 2018

Term	Definition
Adverse Event	An adverse event is defined as an event that could have caused, or did result in, harm to people or groups of people.
Harm – Adverse Event	An outcome with a negative effect. Harm to a person or groups of people may result from worsening of a medical condition, the inherent risk of an investigation or treatment, system failure, provider performance issues, service disruption, financial loss or adverse publicity.
Being Open Principles	Being open is about how healthcare staff communicate with patients and/or their carers following a patient safety adverse event. We need to be honest and use a consistent approach to communication with patients, their carers, family and staff following an adverse event.
Consequence	The outcome or impact of an event. Most predictable consequence to the individual or organisation where the circumstances in question occur.
Datix	Datix is the integrated Risk Management Information System that is used by NHS Grampian to record, manage and extract learning from patient and staff safety adverse events. It also holds the Organisation's Risk Registers and is used to distribute Safety Alerts.
Groups of people	Includes any functional grouping of individuals such as an organisation.
Human Factors	Scientific discipline, simply put is a way to think about 3 aspects: the job, the individual and the organisation and how they impact people's health and safety related behaviour.
First approver	Manager who carries out initial review of adverse event reported on Datix, often a Senior Charge Nurse or equivalent / deputy. Full details of the role of a first approver can be found on the ▮▮▮▮▮▮▮
Final Approver	Manager with responsibility for providing support and feedback to the first approver in terms of encouraging the building of a reporting and learning culture *and* to ensure the quality of the data in Datix. Full details of the role of a final approver can be found on the ▮▮▮▮▮▮▮
Governance	The system by which NHS Grampian is directed and internally controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all areas of clinical, corporate and staff governance.
Likelihood	Description of probability or frequency.
Near Miss	An undesirable incident that by chance or design did not result in harm or loss.
People	Service users, patients, members of staff, carers, family members and contractors.

Risk Assessments	This is a proactive process in which information is collected about an event, process, organisation or service in order to identify where risk may exist and how well it is controlled. The information gathered allows an assessment of the consequence and likelihood of harm and actions to be taken if necessary.
Risk Registers	A database of risks that face NHS Grampian at any one time. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made. NHS Grampian Risk Registers are stored on Datix.
Root Cause Analysis (RCA)	Structured techniques to establish the true systematic causes of an event as opposed to its apparent causes.
Review	A formal assessment of something with the intention of instigating change if necessary.
Safety Alert Broadcast System (SABS)	The system that NHS Grampian uses to distribute risk control notices; National Patient Safety Alerts; Medicines and Healthcare Regulatory Agency Bulletins; and Shared Learning Notices electronically to staff for onward distribution. spacing
Severity	Most predictable consequence to the individual or organisation where the circumstances in question occur.
Statutory Duty of Candour	An unexpected or unintended adverse event or events which are not related to the natural course of someone's illness or underlying condition. To be a duty of candour event, the patients / service user need to have suffered harm and / or care or service delivery issues.
Harm - Statutory Duty of Candour	**harm** is defined as: death; permanent lessening of bodily, sensory, motor, physiologic or intellectual functions; increase in treatment; changes to the structure of the person's body; the shortening of the life expectancy of the person; impairment of sensory, motor or intellectual functions for at least 28 days; pain or psychological harm which has been, or is likely to last, for at least 28 days; treatment to prevent death or anything that would lead to one or more of the above outcomes
Care and Service Delivery issues – Statutory Duty of Candour Issues	a different plan and / or delivery of care may have resulted in a different outcome through uncertainty regarding impact on patient outcome / event
Terms of Reference	A formal written agreement that outlines a remit including the principles, scope and purpose of a review.
Public Protection	Is the term used to describe the joint commitment to preventing and managing the risk of serious harm to vulnerable individuals, families and communities. Public Protection is split into three key groups: • People at risk of harm; • people who pose a significant risk of harm to themselves (and potentially also to others); and

	• people who pose a risk to others (who have problems which make them a risk to themselves).

The NHS Grampian Board promotes preventative and protective measures to avoid, reduce and minimise the potential for harm arising and affecting all those who could be affected by the Board's activities: patients, service users, families, carers, staff members and third party workers (contractors).

To facilitate this the following documents instruct and guide all levels of staff of their role within the risk prevention / control framework:

Statement of Intent
Health and Safety Strategy
Health and Safety Policy
Risk Assessment Policy (under review at time of writing)

Further information can be found at:

Quality Assurance and Improvement Team
Corporate Health and Safety internet
Pubic Protection

However, risk prevention is not fool proof and events do occur. Every adverse event provide both the Board and individuals excellent opportunities for learning, making improvement and continually developing ways of working by sharing lessons within teams, departments, directorates, the board or nationally.

Learning opportunities are only successfully shared where there is a positive health and safety culture: where leadership behaviours promote working environments of openness and honesty where all those who could be affected: patients, service users, families, carers, staff members and third party (workers), feel supported before, during and after adverse events, where the focus is clearly on improving systems and not apportioning blame.

The NHS Grampian Safety Alerts Broadcast System is implemented to prevent recurrence of adverse events by organising and managing safety warnings, alerts and recalls issued by: the Medicines and Healthcare products Regulatory Agency; Safety Action Notices and Hazard Notices and alerts issued by Health Facilities Scotland; and notices issued by NHS England. Additionally, this procedure is the methodology for the distribution of Local Risk and Learning Notices.

Just

All are treated fairly, with empathy and consideration whether involved in or raising health and safety issues

Duty of candour followed organised open and apologise to those affected

Reporting

confidence in reporting systems, used to notify managers

no blame or punishment for reporting constructive timely feedback provided Reporting is easy

Leadership promotes open and fair environment

Informed

Learns from what has happened and shares key learning points

Analyses trends and develops action plans

Uses learning to promote positive health and safety culture

Learning

Organisation learns from past, identifies and mitigate future events because:

Committed to learning lessons Remembers lessons over time Shares key learning points more widely

Table 1 - Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome; long term effects –expect recovery >1wk.	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects.
Objectives/ Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff.	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim. Complex justified complaint.
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. Minor error due to ineffective training/implementation of training.	Late delivery of key objective/ service due to lack of staff. Moderate error due to ineffective training/ implementation of training. Ongoing problems with staffing levels	Uncertain delivery of key objective /service due to lack of staff. Major error due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. Critical error due to ineffective training / implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal financial loss (£<1k).	Minor organisational/ personal financial loss (£1-10k).	Significant organisational/ personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	• Can't believe this event would happen • Will only happen in exceptional circumstances.	• Not expected to happen, but definite potential exists • Unlikely to occur.	• May occur occasionally • Has happened before on occasions • Reasonable chance of occurring.	• Strong possibility that this could occur • Likely to occur.	This is expected to occur frequently/in most circumstances more likely to occur than not.

Version March 2013

Table 3 - Risk Matrix

Likelihood	Consequences/Impact				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

References: AS/NZS 4360:2004 'Making It Work' (2004)

Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

Work related Deaths, and Specified Injuries, Occupational Diseases and Dangerous Occurrences (relating to equipment and materials, electrically caused fire and explosion, biological agents, radiation generators and radiography) are reported to the Health and Safety Executive as set out in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

> Reports must be sent to the Executive within 10 or 15 days depending upon the AE categorisation under RIDDOR
> http://www.hse.gov.uk/riddor/reportable-incidents.htm
> http://www.legislation.gov.uk/uksi/2013/1471/contents/made

Events involving health, social care, estates and facilities equipment are reported to the Incident Reporting and Investigation Centre (IRIC) within Health Facilities Scotland as set out in CEL 43 (2009)

> http://www.hfs.scot.nhs.uk/services/incident-reporting-and-investigation-centre-iric/adverse-incidents-/

Events relating to blood are reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) as required by the UK Blood Safety and Quality Regulations 2005 and the EU Blood Safety Directive

> https://www.gov.uk/guidance/blood-authorisations-and-safety-reporting#report-a-serious-adverse-event-or-reaction-related-to-blood

Adverse drug reactions, defective medicines and counterfeit medicines via the Yellow Card Scheme to the MHRA

> https://yellowcard.mhra.gov.uk/the-yellow-card-scheme/

> Suicides of individuals in contact with mental health services are reported to Healthcare Improvement Scotland
> http://www.healthcareimprovementscotland.org/our_work/mental_health/suicide_reviews.aspx

Sudden deaths associated with medical or dental care are reported to the Procurator Fiscal
> http://www.copfs.gov.uk

Relevant information is reported to UK-wide national audits and enquiries managed by the Healthcare Quality Improvement Partnership (HQIP)
> https://www.hqip.org.uk/clinical-outcome-review-programmes/

Information governance events are reported to the eHealth Division within Scottish Government and the Information Commissioners Office
> https://ico.org.uk/for-organisations/health/

Ionising Radiation adverse events are reported to the Warranted Inspector for IRMER
> https://www.cqc.org.uk/guidance-providers/ionising-radiation/reporting-irmer-incidents
> http://www.legislation.gov.uk/uksi/2000/1059/contents/made

Serious crimes (homicides, serious assault, and serious sexual assault) by an individual who is receiving care from mental health or learning disability services are reported to the Mental Welfare Commission for Scotland
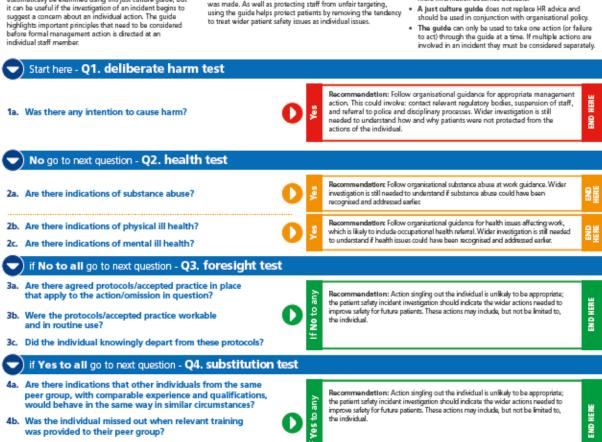> https://www.mwcscot.org.uk

NHS
Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should not automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:
- A just culture guide is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- A just culture guide can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- A just culture guide does not replace HR advice and should be used in conjunction with organisational policy.
- The guide can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes — Recommendation: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. | **END HERE**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes — Recommendation: Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. | **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes — Recommendation: Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. | **END HERE**

if No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If No to any — Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. | **END HERE**

if Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any — Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. | **END HERE**

if No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes — Recommendation: Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. | **END HERE**

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. | **END HERE**

improvement.nhs.uk   Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by: Academy of Medical Royal Colleges · avma action against medical accidents · CareQuality Commission · General Medical Council · National Guardian Freedom to Speak Up · Nursing & Midwifery Council · NHS England · Royal College of Nursing

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