Can we really learn from the past?

Chair: Claire Sweeney, Healthcare Improvement Scotland
Join the conversation on Twitter, follow #SPSPConf16 and remember to include it in your tweets.

Free wi-fi available
Wi-fi network: delegate
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<tr>
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## Agenda

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Shona Robison MSP – Cabinet Secretary Address
Prevent? Recognise? Respond?
Why recognise and respond to past events?

- Understand why things go wrong
- Understand why things go right

**AIM:** To design a system that supports people better and makes it easier to do the right thing more often!
The person or the system?

The person model

Who did it?
Who is to blame?

The system model

What happened?
How do we prevent it in the future?
Past harm
Has patient care been safe in the past?

Reliability
Are our clinical systems and processes reliable?

Safety measurement and monitoring

Integration and learning
Are we responding and improving?

Anticipation and preparedness
Will care be safe in the future?

Sensitivity to operations
Is care safe today?
New quality of care reviews

“The range and depth of knowledge and expertise that exists across the various functions within Healthcare Improvement Scotland affords an important strategic advantage and uniquely positions the organisation to place quality improvement at the heart of its approach to external scrutiny. I firmly believe that implementation of this new model will further drive and embed a culture of quality improvement across health services in Scotland that will lead the way in achieving sustainable and resilient healthcare.”

Tracey Cooper, Chief Executive of Public Health Wales and Design Panel Chair
“Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them.

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

**Aim:** Scotland has a consistent national approach to learning from adverse events through reporting and review, which supports service improvements and enhances the safety of our healthcare system for everyone.

“Care will never be risk free, but we can minimise these risks in order to provide high quality care for the people of Scotland. **Learning from adverse events is crucial to continually improve person-centred, safe and effective delivery of care.** Each of these events should be regarded as an opportunity to learn and to improve in order to increase the safety of our care system for everyone.

**“Supporting cultural change is at the heart of this work.** We all want to achieve a positive safety culture that is open, just and informed, in which reporting and learning from error is the norm. Achieving cultural change is challenging and will take time, but we are seeing positive changes with learning summaries beginning to be shared nationally through the adverse events community of practice website.”

David Farquharson, Chair of the Adverse Events Programme Board and Medical Director of NHS Lothian
Learning from adverse events

Helen Munro, Public Partner
Scottish Mortality and Morbidity Programme

Manoj Kumar, National Clinical Lead and Consultant Surgeon, NHS Grampian
‘The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.’

Dr. Lucian Leape
Professor, Harvard Medical School of Public Health

Testimony before Congress on Health Care Quality Improvement
ORGANIZATIONAL CULTURE

Why Organizations Don’t Learn

by Francesca Gino and Bradley Staats

FROM THE NOVEMBER 2015 ISSUE

#SPSConf16
PART 2

DUTY OF CANDOUR

Duty of candour procedure

21 Incident which activates duty of candour procedure
22 Duty of candour procedure
23 Apologies
24 Reporting and monitoring
25 Interpretation of Part 2

22 Duty of candour procedure

(1) The "duty of candour procedure" means the actions to be taken by the responsible person in accordance with regulations made by the Scottish Ministers.

(2) Regulations under subsection (1) may in particular make provision about—

(a) the notification to be given by the responsible person,
(b) the apology to be provided by the responsible person to the relevant person,
(c) the actions to be taken by the responsible person to offer and arrange a meeting with the relevant person, including asking the relevant person whether the relevant person wishes to receive an account of the incident as mentioned in section 21(2) or information about further steps taken,
(d) the actions which must be taken and following such a meeting,
(e) an account of the incident as mentioned in section 21(2), information about further steps taken and any other information to be provided by the responsible person,
(f) the form and manner in which information must be provided,
(g) the circumstances in which the responsible person is to make available, or provide information about, support to persons affected by the incident,
(h) the keeping of information by the responsible person,
(i) steps to be taken by the responsible person—
(1) to review the circumstances leading to the incident, and
(2) following such a review,
even if the relevant person has advised that the relevant person does not wish to receive an account of the incident as mentioned in section 21(2) or information about further steps taken,
(j) training to be undertaken by a responsible person,
(k) training, supervision and support to be provided by a responsible person to any person carrying out any part of the procedure on behalf of the responsible person,

(3) In this section "relevant person" means—
Can we really learn from the past?
Discussion

Thinking about what you have heard;
1) at your table agree an issue to discuss
2) put this issue in the centre of the framework
3) what information do you already collect to help you answer the question ‘how safe is our care?’ in relation to this issue?
4) have you identified any gaps?
Case studies – measurement and monitoring of safety

Mags Baird, NHS Borders

• QI methodology & project management approach to testing.

• The framework provided a structure to map inpatient stories, measures, documents being used at each stage of the frailty pathway to inform our improvement plan.

• The language of the framework is helping us to structure staff conversations around safety for older people, in hospital.

• The framework provided an evidenced based approach to measuring and monitoring safety at pathway level.

#SPSPCONF16
Case study – sick day medicine cards
Case studies – wrong site surgery

Wrongfooted

how failure of process and inadequate WHO checklist participation led to the wrong foot being operated on.

I would like to thank my medical director for the permission to talk about this openly, and widen the scope of learning beyond our hospital to a much bigger arena.

This happened on a routine orthopaedic operating list that not long ago.

The orthopaedic surgeon involved had a busy list booked with 6 patients on it. He didn’t have a registrar with him as he normally would have which made him later for the start of the list.

Total views: 14,927
story.com
host brewery place.blogspot.com
other

Failing to learn

20/10/13 09:46

Yesterday @TraumaGasDoc posted an incredibly powerful story, Wrongfooted, of a sequence of events that culminated in operating on a patient’s wrong foot. It is a must-read and I pay tribute to him and his medical director for publishing it. Clearly it struck a nerve and over 5,000 people visited the page within 24 hours.

I read it with an increasing sense of deja vu, sadness and even anger. The details aren’t important but essentially we also had a case in October 2012 where we had operated upon the wrong foot with a major contributing factor being that the patient had inadvertently placed a TED stocking on the limb which was due to be operated upon and thus covered up the pre-op surgical marking. The presence of a single stocking is a very powerful distractor from the loss obvious absence of a mark and this is a classic example of the complexity of surgery and the huge potential impact of ‘human factors’. Well-intentioned, highly respected and conscientious stuff collectively managed to do the wrong thing. The pre-op marking was done on the ward, the sign-in in the anaesthetic was carried out as was the time out before surgery.

Despite all of these, we managed to line up a series of holes in the ‘Swiss Cheese’ (for the original proposal of the Swiss Cheese model see this book by Prof James Reason) and the wrong foot was operated on.

I would like to think that we instigated an open, rapid and thorough investigation. Within a week we had a Grand Round about the case with the best attendance of ANY meeting that has occurred in the 12 years I have been at the Trust. Our excellent staff were shocked that this had happened and genuinely wanted to prevent a repeat. The involved surgeon gave
Learning summaries

Sharing national criteria: Systemic failures
Category: Theatre processes
If other, please specify:
Preventing: Retained surgical items
Learning summary key words: swab, retained, theatre, count, surgery

What happened?
Between 2008 and 2010 we noticed a number of significant incidents which involved retained items following surgery. This was more often a swab or pack (large swab) but also included disposable devices used intraoperatively. Each case was slightly different influenced by various contributory factors. We conducted a detailed review of the process for counting and keeping track of intraparative items which revealed some interesting information. Although all the hospitals had policies to follow that they felt were robust and had confidence in, there were some aspects of the process that were still dependent on each individual scrub nurse and how they chose to perform part of the task. The other revelation was that all the policies were different.

We discovered some safety critical elements of the process that if implemented would have prevented the cases we had experienced. A new SOP was written that incorporated all the learning from the review and was implemented across all the sites. This was not easy, as some hospitals had not had an event and felt their policy was safe so an education exercise was also rolled out with the policy to explain to the staff why the changes were necessary. Different equipment was also required to facilitate the method of counting we were advocating.

What went well?
The SOP has worked in stopping the kind of events (swab related) we had before. We have reduced retained item incidents in all our surgical theatre suites.
The method used for counting swabs provided a recurring saving for some hospitals.

What, if anything, could we improve?
We did not insist the SOP was speed to Obstetric Theatres – we are doing this now.

What have we learnt?
- Count swabs / packs in sets of 5.
- Display swabs / packs in an easy to identify format.
- Bag swabs / packs in sets of 5.
- One red string (which is round the new swabs) goes out with each set of 5.
- All swabs and packs must be counted and bagged in 5’s even at the end of the operation so no swabs are left on table / trolley etc.
- Dispatch count – everything that has been counted in, is now counted out – no loose swabs / packs etc.

If you have any comments about this or any similar adverse event please send them to hsc addButtonevents@hs.scot.nhs
Sharing learning introduction

Please use this area to share information related to the management of adverse events or service improvements resulting from an adverse event that NHSScotland colleagues may find useful.

Learning summary templates are available below. Guidance for completion is also available below.

To upload a document please send to your NHS board administrator (details listed below).

If you would like more information about any of the learning summaries or risk awareness notices, please get in touch with the adverse events team at hos.adverseevents@nhs.net.

Guidance for the completion of learning summaries

Letter from Programme Board to NHIS board Chief Executives to support development of learning summaries

Local learning summary template

National learning summary template - management of adverse events

National learning summary template - service improvements

NHIS board Community of Practice administrators

Risk awareness notice template

Sharing learning from the Procurator Fiscal

Healthcare Improvement Scotland has agreed with the Procurator Fiscal to share learning summaries from death investigations across NHSScotland. You can find these summaries below in the service improvement section.

Process for sharing learning from death investigations

National learning summaries - service improvements

Communication - CT scan learning session - April 2016
Communication - discharge letter, incorrect information, medicines - 10 July 2015
Communication - DNA, outpatient appointment, Community Mental Health Teams - 09 June 2015
Communication - result handling, locum consultant - 16 July 2015
Communication - theatre prosthesis learning summary - April 2015
Medication - clozapine, smoking, medication monitoring - 17 March 2015
Medication - dehydration, ACE inhibitor, Metformin - 24 June 2015
Medication - gentamicin - 18 April 2016
Medication - rivastigmine - 18 April 2016
Medication - atorvastatin - 18 April 2016
Other - diabetes - 04 September 2015
Other - mental health - community, same day referrals, single point of access protocol - 01 October 2014
Other - mental health - community, same day referrals, single point of access protocol - 01 October 2014 - supporting documentation 1
Other - mental health - community, same day referrals, single point of access protocol - 01 October 2014 - supporting documentation 2
Other - paediatrics, sub-conjunctival haemorrhage, child protection - 01 September 2014
Radiation imaging - amnion, CT scan - 22 January 2015
Self-harm, behaviour, autism - medication management, care coordination research - 19 April 2014

Case study – suicide reporting and learning system
Anna Wimberley
Discussion

• What will you do differently after today?

• What suggestions do you have for the national programmes?
Feedback and panel discussion

- **Craig White**, Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
- **Manoj Kumar**, National Clinical Lead and Consultant Surgeon, NHS Grampian
- **Jenny Long**, Senior Programme Manager, Healthcare Improvement Scotland
- **Jonathan Kirk**, National Clinical Lead, Measurement and Monitoring of Safety
- **Helen Munro**, Public Partner
Coming next

Shona Robison MSP – Cabinet Secretary Address

Pentland Suite Level 3