Starship Clinical Excellence

Understanding and Learning from Patient Safety Event

Process Activity	Improve clinical services through identifying, understanding and sharing learning from patient safety events, including good catches.
Supporting Documents	Starship Clinical Excellence Programme 2015 Starship Clinical Excellence: Service Mortality and Morbidity Review Process Starship Clinical Excellence: Service Level Clinical Excellence Requirements
Process Description	The efficient and effective review of patient safety events and good catches, using a multiservice/multidisciplinary process, to identify system failures and inform quality improvement activities with escalation as needed.

Review Process	
Responsibility	Establish need for review

Service Leaders	• Initial identification of events for further review
	  • Assess any unexpected event that causes patient harm
	  • Assign Severity Assessment Code (SAC) score or Always Report and Review category
	• If unsure, can be discussed with line manager and also:
	  • Service Clinical Excellence lead
	  • Child Health Medical/Nurse Director/Leader, Safe Care
	  • At Weekly Clinical Safety Meeting
	  • At Fortnightly Safe Care Meeting

	SAC 1 / 2 & Always Report and Review Events
Director /Nurse Director /Leader, Safe Care in consultation with service leaders and facilitated by Quality Department staff	• Identify and confirm review participants ensuring relevant services and professions are represented • Complete SAC Huddle Document • Identify staff member to develop initial timeline
Quality Department staff	• Facilitate the review according to the Adverse Event Review Committee (AERC) organisational process. A range of methodologies can be used (e.g. Root Cause Analysis, London Protocol, Case Review) • Circulate the final report
Review team	• Participate in review process • Present final report at the Service Clinical Excellence meeting
Service Clinical Excellence Lead	• Recommendations are assigned to an individual and entered into the Service Clinical Excellence Action Register • Include a brief summary as part of the Service Clinical Excellence group activity on the report to Child Health Clinical Excellence Governance Committee
Service Leaders & Service Clinical Excellence Lead	• Monitor progress with the development and implementation of action plans for service learning and improvement to meet the recommendations

Leader, Safe Care Programme	• Table /discuss the final report at a Safe Care Meeting. The recommendations are noted and feedback sought from service on progress • Follow up on any opportunities for directorate wide learning and improvement
	All other patient safety event reviews
Service Leaders	• Identify and confirm review team members and lead, ensuring relevant services and professions are represented • Monitor progress of review
Review team	• Complete the review process within 3-4 months of the event • Present the final report at the Service Clinical Excellence meeting • Attach the final report to the Datix file NOTE: Grade 3 or 4 Healthcare Associated Pressure Injury (HAPI) and SAC 2 Fall reviews will be presented at a Safe Care Meeting prior to AERC subcommittee meeting. Following the AERC subcommittee meeting, the final report is presented at the Service Clinical Excellence Meeting.
Service Clinical Excellence Lead	• The recommendations are assigned to an individual and entered into the Service Clinical Excellence Action Register • Include a brief summary as part of the Service Clinical Excellence group activity on the report to Child Health Clinical Excellence Governance Committee • Attach a copy of the report to the Datix record • Save the report to a secure service clinical excellence folder and where there are opportunities for directorate learning and improvement send a copy of the final report to the Leader of the Safe Care Programme.
Service Leaders & Service Clinical Excellence Lead	• Monitor progress with the development and implementation of action plans for service learning and improvement to meet the recommendations
Leader, Safe Care Programme	• Table /discuss final report at a Safe Care Meeting ± Child Health Patient Deterioration Governance meeting. • Follow-up on opportunities for directorate wide learning and improvement • Coordinate presentation of Learning from Patient Safety Events at the Paediatric Grand Round
Resources	
Review Templates	SAC Score Decision Huddle.docx TOR -Clinical Case Review (29.10.18).d Timeline - Patient Safety Event (29.10. Clinical Case Review Form (29.10.18).doc Service Mortality Review Form (29.10. PICU_PCCS Morbidty and Mortality Review HA-PI Case Review Child Health (16.10.1

Understanding and Learning from Patient Safety Event

Further Information	Quality Department Reportable Events webpage Starship Clinical Excellence and Starship Safe Care webpage Health Quality & Safety Commission | Adverse Events webpage

Descriptors	
After Critical Event (ACE) Review	Feedback offered on potential system and process improvement. If no further review is required, the feedback should be included at Service Clinical Excellence meeting.
Always report and review	A list of events from the Health Quality & Safety Commission which must always be reviewed and reported irrespective of SAC score.
Complaint process	Feedback from family members may indicate a patient safety event which has not been previously identified. The Nurse Unit Manager (NUM) or Service Clinical Director (SCD) to submit a Datix and consider the need for case review alongside of the complaint response process.
Datix incidents	All Datix submissions require some form of follow-up. The assigned Severity Assessment Code (SAC) will guide the type of review if required.
Datix SAC 1 or 2	A SAC score of 1 or 2 will require formal review by nominated clinical staff and facilitated by Quality department staff.
Datix SAC 3 or 4	Followed-up by the assigned 'responsible manager'.
Deteriorating Patient Feedback	Feedback offered on the recognition and response system. If no further review is required, the feedback should be included at Service Clinical Excellence meeting
Clinical Case Review	All ward cardiopulmonary arrests and significant unanticipated harm will be reviewed at the relevant clinical service meeting. The service /directorate may also identify an individual or a collation of SAC 3 or 4 Datix submissions where further review will provide learning and practice improvement.
Good Catch	An unexpected event that could have been harmful but was avoided through active intervention or detected early before patient harm occurred. May be reported in Datix or via other processes to the Service Clinical Excellence Committee.
Mortality	All inpatient deaths (unless immediately meeting SAC 1 or 2 criteria) will be reviewed at the relevant clinical service meeting. Where multiple services are involved, a separate review process may be required and the report presented at all relevant clinical service meetings. Where an associated patient safety event is identified the formal SAC 1or 2 process should be undertaken instead.
Patient safety event	Any unexpected event which causes patient harm.
Pressure Injury & Falls with harm	All Grade 3 & 4 Healthcare Associated Pressure Injury (HAPI) and SAC 2 Falls are reviewed by the service according to the AERC subcommittee process.

Starship Clinical Excellence

Understanding and Learning from Patient Safety Event