PE1604/B

NHS Ayrshire & Arran Letter of 11 October 2016

This proposal is that all patients who complete suicide when detained under the Mental Health (Care & Treatment) (Scotland) Act (MHA) should have a mandatory 'inquest style system'.

The Public Petitions committee requested clarification on the following points:

(i) **What measures are in place to provide protection for the health and safety of patients who are released from hospital or receiving care in the community under a Compulsory Treatment Order?**

Criteria for the use of the Care Programming approach includes detention under the Mental Health Act (MHA) which allows for multi-agency meeting where relevant risks can be considered and an appropriate care plan developed.

(ii) **How are investigations conducted in cases where a patient who was released from hospital or was receiving care in the community under a Compulsory Treatment Order completes suicide to ensure that lessons are learned to improve patient care in the future?**

All unexpected deaths, including suicides, are reported to the Adverse Event Review Group (AERG) and investigated in line with the standard operating procedure (Appendix 2). The AERG includes Senior Managers, the Associate Medical Director and Associate Nurse Director. All suicides are investigated and an Adverse Event Review is completed using a standard template (Appendix 3).

The review team would consist of a Consultant Psychiatrist and another professional, both from outside the clinical team involved. They would be expected to contact both the family and clinical team as well as reviewing case notes. The draft report would be reviewed by the AERG and any recommendations would be developed into an Action Plan by the relevant Service Managers. The AERG would monitor completion of the Action Plan and also forward the final report to relevant governance group and to NHS Health Improvement Scotland (HIS).

HIS develops good practice guidance on suicide reviews and receives copies of completed Adverse Event Reviews from which they identify shared learning.

(iii) **The Committee also heard evidence from the petitioner on the impact on families when a patient commits suicide and families' desire to be involved in the investigation process. What support is offered to families by your health board and how are families involved in the process in such a way that it is clear to them that the incident is being taken seriously and lessons learned from it?**

Families are involved routinely in all Mental Health Adverse Event reviews and other Significant Adverse Event Reviews (SAER) within NHS Ayrshire and Arran.

The terms of reference for the review team would be to meet with the family as part of the investigation and then to feedback the outcome to the Adverse Event Review to the family. Copies of the full Adverse Event Reviews are provided to families.

Other general comments on the petition

In addition to the local systems in place to investigate suicides of patients detained under the MHA there are already a number of external safeguards and mechanisms for external review.

All deaths of patients detained under the MHA are reported to the Mental Welfare Commission (MWC). The MWC has discretionary powers to investigate and would look closely at any suicide of a patient detained under the MHA. If required they have statutory powers to investigate.

The Health and Safety Executive also have powers to investigate and have investigated cases in Scotland where patients have completed suicide whilst detained under the MHA and also prosecuted Health Boards where failings have been identified.

Local Authorities also have a responsibility to investigate and can hold a Significant Case Review if the independent Chair deems this appropriate.

The Procurator Fiscal also has a responsibility to look at all deaths of patients detained under the MHA. The guidance on reporting deaths of patients detained under the Mental Health Act was only strengthened last year (see Appendix 4). The Procurator Fiscal would investigate all deaths and has discretionary powers to request independent reports and/or hold a Fatal Accident Inquiry (FAI). During this process they would take account of families' views but would also balance these with subject expert's views and whether a FAI would be in the public interest.

This would appear to be an appropriate level of scrutiny. Some families may be keen for a inquest-type system but other families would find a mandatory inquest system distressing (see Appendix 1) especially as the current system of Fatal Accident Inquiries can be delayed for years. Staff can also find the process difficult, as regardless of the intention, this can be experienced as an adversarial experience. The concern is that we would move from a learning organisation to one that is more defensive and less open to acknowledge issues at an early stage.

Therefore we would not be supportive of the petition, as we believe that the current legal safeguards, through mandatory reporting to the Mental Welfare Commission and the Procurator Fiscal, with discretionary powers to investigate, are proportionate and provide adequate safeguards .

Yours sincerely
Thelma Bowers
Head of Service, Mental Health
North Ayrshire Health & Social Care Partnership

Enc

1. Royal College of Psychiatrists in Scotland response to the Scottish Government Consultation on Proposals to Reform Fatal Accident Enquiries Legislation
2. Mental Health Service Adverse Event review Standard Operating Procedure (below)
3. Mental Health Service Adverse Event Review Report Template (below)
4. CMO(2015)20 Reporting Deaths to the Procurator Fiscal

Mental Health Services

Adverse Event Review Process Standard Operating Procedure

Version No:	Final - 1.0
Prepared By:	Derek T Barron, Associate Nurse Director
Effective From:	16/01/2014
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Lead Reviewer:	Derek T Barron, Associate Nurse Director

Dissemination Arrangements:

- Standard Operating Procedure Distribution List (as held by Clinical Documentation Steering Group)
- NHS Ayrshire and Arran Intranet - AthenA
- Others, as relevant

Standard Operating Procedure Content

1.0 Introduction

1.1 Purpose of the Standard Operating Procedure

The purpose of this Standard Operating Procedure is to:

- Ensure that all staff are aware of how incidents in Mental Health Services are appropriately reported, investigated and how the service learns from them
- Describe the Adverse Event Review Group (AERG) and its role in the adverse event reporting process
- Describe the reporting process for adverse events in Mental Health Services
- Describe what happens once an adverse event has been reported
- Support the organisation and staff to learn from incidents
- Support the organisation to take action following an incident to minimise or eradicate the risk of this happening again.

1.2 Scope of the Standard Operating Procedure

This Standard Operating Procedure applies to all staff within Mental Health Services.

1.3 Abbreviations

AER	- Adverse Event Review
AERG	- Adverse Event Review group
AMD	- Associate Medical Director
AND	- Associate Nurse Director
CGG	- Clinical Governance Group (Individual service groups)
CSM	- Clinical Services Manager
EMD	- Executive Medical Director
END	- Executive Nurse Director
HCD	- Healthcare Director
HCM	- Healthcare Manager
HQGSU	- Healthcare Quality and Governance Standards Unit
HIS	- Healthcare Improvement Scotland
GDG	- Governance and Development Group
SMT	- Service Management Team (CSM, Senior Nurse, Clinical Director)
MHS	- Mental Health Services
MWC	- Mental Welfare Commission
RCA	- Root Cause Analysis
RMO	- Responsible Medical Officer
SAER	- Significant Adverse Event Review
SBAR	- Situation Background Assessment Recommendation

1.4 Definition of an incident

There is no one single definition of ‘an incident’. In general terms we should consider an incident as an event that has led to or has the potential to lead to an unwanted outcome. All staff are expected to use their common sense and professional assessment in considering if an event is an incident that requires reporting through this system.

Incidents, that require review, happen on a regular basis. The purpose of the Mental Health Services Adverse Event Review process is to review each incident to consider what we can learn and where we can learn to prevent reoccurrence. The review process is not a punitive

process; it is a shared learning experience and will involve clinical and managerial staff in various aspects of reporting, reviewing and sharing.

Some obvious incidents include:

- Any and all deaths of service users, either as an inpatient or within community
- Incorrect medication – either prescribed, dispensed or administered
- An incidence of serious self harm – clinical and managerial staff are expected to use professional judgement in determining 'serious' – if in doubt, report it.

This list is deliberately short, it is not designed as exhaustive – the clear expectation is that our staff exercise a high degree of skill and knowledge in determining the reporting of incidents. As noted above, if in doubt, report it.

NB: All deaths of current service users (this includes all services users on caseload and where we have been informed of the death of service users who have been seen within the one year previous) should be reported on an SBAR Incident Form. Additionally all unexpected deaths should be reported on Datix. Expected deaths or deaths by natural causes do not require to be reported on Datix but should be reported to the AERG on the SBAR Incident Form (Appendix 4).

There are two reporting tools used within Mental Health Services: Datix and SBARs.

1.5 SBAR Reporting

The reporting of incidents within Mental Health Services is done on the SBAR Incident Form (Appendix 4). The SBAR (Situation, Background, Assessment and Review) format is an easy to remember mechanism that every service can use to report incidents that are requiring the AERGs attention.

The SBAR Incident Form consists of standardised prompt questions within four sections, to ensure that services are sharing appropriate information. It allows communication to be effective, reducing the need for repetition.

The tool helps staff anticipate the information required by the AERG and prompts staff to formulate information with the right level of detail.

(Paraphrased from:
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html)

1.6 Datix Reporting

Datix is an integral part of our adverse event process. Datix reports with a consequence score of major/extreme are automatically copied by the Datix team to the AERG mailbox, AND, AMD, HCD and HCMs.

Datix reports which are received though this process are reviewed by AERG to ensure:

a) they already know about the incident, and
b) that there is an accompanying SBAR where this is required.

Where there is insufficient information on Datix the AERG may request further information in the form of an SBAR.

The AERG will inform the CSM of the outcome of discussion and request that Datix is updated accordingly; the normal outcomes are likely to be:

- Request that any local review/investigation is completed and that the Datix incident is approved and closed.
- Ask the CSM to update the Datix to record that an AER report (Clinical Record Review or Adverse Event Review) has been commissioned.

Following completion of an AERG commissioned review the resultant report should be uploaded to Datix by the CSM.

1.7 Adverse Event Review Group (AERG)

The AERG is a sub group of the MHS Executive and the Governance and Development Group, it has accountability to the Executive Team and has dual lines of reporting to both. The AERG meet every Tuesday morning 09:30 – 12:00hrs. The AERG membership is:

- Associate Nurse Director
- Associate Medical Director
- Health Care Manager Mental Health and Offender Services
- Health Care Manager Mental Health Specialist Services

At the AERG meeting the following documents are considered:

A. All new SBAR Incident Forms.
B. All new Datix reports reported to AERG due to the consequence level.
C. All updated SBAR Incident Forms.
D. All new reports
   - Local (where requested)
   - Clinical Record (where commissioned)
   - Adverse Event Review (where commissioned.)
E. All updated reports received
F. All updated Action Plans (and supporting evidence).
G. Any other relevant information, as deemed appropriate by the AERG.

NB All Datix reports would, in normal circumstances, have a corresponding SBAR notification. In the case of a death or other significant event the SBAR notification would normally have a corresponding Datix.

Reporting an Incident

2.0 Action to be taken when incident occurs

When a serious incident occurs within a service a senior manager should be informed immediately. The service telephones the MHS Executive Admin Team to inform them that a 'serious' incident has occurred. *NB CSMs need to agree a process for this to happen in their service*.

The Executive Admin Team email the AERG informing them that an incident has occurred. The AERG decide on the appropriate immediate action, this may include direct contact with the area concerned, specific remedial action to be taken, information to be passed immediately to the END/EMD (this would normally be completed by AND/AMD). The HCM would normally inform the HCD of an incident occurring and action taken to ensure staff and service user safety as appropriate.

The Consultant (RMO) responsible for the care of the individual service user would be expected to inform the MWC as soon as practical of serious incidents causing harm for service users detained under legislation. Suicides would be reported to HIS by the AERG and no longer need to be reported to the MWC. *NB There may be situations where incidents involving non-detained service users should also be reported to the MWC e.g. act of homicide due to mental illness.*

Serious incidents involving 'Restricted Patients' and those treated as Restricted (e.g. transfers from prison) should be reported immediately to the Scottish Government by the Consultant/RMO in accordance with the memorandum of procedure. Out of hours this would be the consultant on call.

CSM (or nominated person) ensures that Datix is completed, and also completes and submits an SBAR Incident Form (Appendix 3) to the Executive Admin Team using the AERG mailbox aerg@aapct.scot.nhs.uk (available on global address list.). In addition to reporting this to AERG it may be a sensible time efficient process for services to upload the SBAR to Datix. This would normally be completed on the day of the incident or as soon as possible after the incident (but must be within 24hrs). CSM must ensure they have in place a system to process SBAR Incident Forms including factual accuracy, readability and identification *NB the name of the individual **must** be used, along with the CHI, on the SBAR. The Datix ID Number should be used in the SBAR Incident Form*.

> Datix ID Number
> The Datix system generates two numbers, one is called the ID number, the other the Reference number. Throughout the organisation the ID number is the universal identifier used. It is important that we use this number to accurately identify incidents and events.

The Executive Admin Team will read the SBAR and may seek immediate clarification if relevant information is not included on the SBAR e.g. name of person/incident, Datix ID number, service name etc. The Executive Admin Team circulate the SBAR to the AERG via email.

The Datix team automatically email the Executive Team (and AERG mailbox) with all Datix reports with a consequence score of four or more (major or extreme).

On a Tuesday morning all of the above information is discussed by the AERG.

Reporting an Incident

2.1 Out of Hours provision

Where an incident occurs out of hours then the service should contact the on call manager to inform them that a "serious" incident has occurred. The on call manager would decide on the appropriate immediate action, this may include further contact with the area concerned, specific remedial action to be taken, information to be passed immediately to the On Call Director.

At the first available opportunity the On Call Manager (or nominated person) ensures that Datix and an SBAR Incident Form are completed, and the SBAR is submitted to the AERG using the AERG mailbox aerg@aapct.scot.nhs.uk (available on global address list.).

The following day (Monday morning if incident occurred over weekend), the Executive Admin Team circulate the SBAR to the AERG via email.

3.0 Review of new SBAR Incident Forms

At the AERG meeting SBAR Incident form which have been submitted are reviewed specifically related to the following areas:

- Consider potential to inform HIS → notifications, if required, will be done by the AERG admin team on the HIS template using nhs.net to nhs.net email protocol
- Consider Child Protection issues
- Consider Adult Support and Protection issues (including Adults with Incapacity)
- Consider informing Scottish Government e.g. Restricted Patient Team
- Consider if MWC has been informed or requires to be informed (by RMO).

All new SBARs are discussed by the AERG; a range of outcomes are listed below:

3.1 Closed

The information has been considered, there is no further action required. The AERG will close the incident, (from an AERG perspective) and note this on the SBAR. This is logged onto our (AER) tracker system and sent to the CSM.

3.1.1 CSM, or nominated person, would include the updated and closed SBAR onto Datix and either continue their own investigations or close the Datix incident.

3.2 Further information is required

- Copy of local review is requested
- insufficient information on SBAR
- information does not appear to make sense
- awaiting cause of death information e.g. post-mortem results.

3.2.1 An email will be sent to the CSM requesting the additional information, this should (except for PM results) be emailed to AERG mailbox ahead of the following week's AERG.

3.2.2 This will be recorded on the AERG tracker system where it will continue until the situation is resolved/appropriate information provided.

3.2.3 On receipt of further info AERG may:

- Close the incident as per Number 1 above
- Create a Learning Note, then close the incident as per Number 1 above
- Go to stage 3, as explained below.

3.3 Commission a review

AERG can commission a Clinical Record Review or Adverse Event Review – please see Section 4.0 for further detail on this process.

3.4 Recommendation for SAER

AERG consider if the incident falls within the SAER categories and requires consideration for a Significant Adverse Event Review and/or reported to the END/EMD. Where appropriate AERG complete an SAER SBAR form notifying the END/EMD of the incident and the recommendation to:

- Commission an SAER, including rationale
- Not to commission an SAER, including rationale
- Not to commission an SAER until further information is gathered.

Where further information is required e.g. the outcome of Toxicology screening, this will be recorded on the tracker system for follow up. Once the information is received it will be forwarded to the END/EMD with a recommendation around any further action.

If an SAER is commissioned by the END/EMD no further MHS review will be commissioned. MHS will be asked to nominate one/two subject matter experts to the SAER review team.

Once an SAER is completed the creation and completion of the Action Plan will become the responsibility of MHS. A tracker system has been created to enable MHS to review and follow up actions, until such times as the actions are completed. Service Management Teams are responsible for the collation of evidence of completion within their service this must be forwarded to the AERG mailbox for central collation and sharing with the Healthcare Governance and Quality Assurance Team as requested.

NB only the Executive Admin Team, on behalf of the AERG, should be providing information outwith MHS to ensure there is a robust system of document control. If a request is made directly to individual services this should be referred to MHS Executive Office.

The Service SBAR is updated by the AERG administrator. This records the decision/recommendation of the AERG and actions required by the CSM. The CSM uploads the information to Datix and either continues their own investigation or closes the Datix incident.

NB it is not necessary that the CSM actions the above personally, however they are required to have in place a system across their services to ensure the procedure is followed.

Investigation of an Incident

4.0 Commission of review

The AERG may commission a review to consider the events leading up to the incident, decisions taken and actions followed. The purpose of the review is to fully consider the event and lessons that may be learnt and shared across services.

The Review Commissioning Form (Terms of Reference) document (Appendix 5) will be completed by the AERG and sent to the nominated chair, co-chair of the review and the Admin Co-ordinator for the area where the 'chair' or 'co-chair' is based. The Review Commissioning Form will also be sent to the CSM for their information.

4.1 Types of Review

There are two types of review that AERG would consider commissioning:

4.1.1 Clinical Record Review

This type of review will be undertaken by an external review team from where the incident happened, normally it will consist of two people – at least one of whom should be a clinician. In this context 'external' means someone not working directly within the service involved, however it will be the norm that they work within MHS in NHS A&A.

The Clinical Record Review is a review of all the clinical records (electronic and paper); it will include correspondence and any other relevant documentation.

It is not a routine requirement to engage directly with the clinicians involved in delivering care, when undertaking this type of review. However where this would add clarity it is not unreasonable to do so. The family would not normally be involved in this level of review and it would be left to the local team to liaise with the family as appropriate.

Draft reports should be forwarded to the AERG within the timescale. AERG will review the report and discuss/clarify issues with the Review Team.

NB in this context draft means as close to completion as possible, awaiting final approval by the AERG

Timescales: Clinical Record Review has a 20 working day timescale for completion and return to the AERG. The report will be reviewed by the AERG and discussed with the co-chairs of the review if there are elements that are unclear or where the AERG has further questions for consideration.

This discussion will be completed with the review approved, by AERG, within 35 working days of the review commissioning date.

The completed report will be approved by AERG and sent to the appropriate CSM for the Service Management Team to create the action plan following the report recommendation. The action plan will also be shared with and approved by the AERG. This will be entered on the AERG Review Report tracker system, which will be reviewed weekly until all the actions are completed.

4.1.2 Adverse Event Review

This type of review will be undertaken by an external review team, it will always consist of a chair and co-chair, one of whom must be a clinician. In this context 'external' means

someone not working directly within the service involved, however it will be the norm that they work within MHS in NHS A&A.

The review is very likely to involve meeting with the individual service user, their family or their carer(s) as is appropriate to the situation.

The review will always involve meeting with the clinicians involved.

Draft reports should be forwarded to the AERG within the timescale. AERG will review the report and discuss/clarify issues with the Review Team.

NB in this context draft means as close to completion as possible, awaiting final approval by the AERG

Timescales: Adverse Event Reports have a 45 working day timescale for completion and return to the AERG. The report will be reviewed by the AERG and discussed with the co-chairs of the review if there are elements that are unclear or where the AERG has further questions for consideration.

This discussion will be completed with the review signed off, by AERG, within 60 working days of the review commissioning date.

The completed report will be approved by AERG and sent to the appropriate CSM for creation of the action plan following the report recommendation. The action plan will also be shared with and approved by the AERG. This will be entered on the AERG Review Report tracker system, which will be reviewed weekly until all the actions are completed.

4.1.3 Non-commissioned review (Local Review)

It is considered normal practice that, when an incident occurs, the local team would review this, at a local level. This review would include the multidisciplinary clinical staff and the local manager. When conducting a local review the service should consider the appropriateness of including the service user and their family in the local review process. Where an Adverse Event has been commissioned the scope of the local review can be a limited review, as relevant to the area concerned. However in the absence of an AER or SAER it is expected that local teams will undertake a thorough review within their own service.

In addition to commissioned reviews the AERG may request a copy of the Local Review, which would be carried out routinely by the local service. Following receipt of this report the AERG may request further information, commission additional review or action or confirm they are content with the outcome of the Local Review.

It is not necessary to submit all local reviews to the AERG, only where this is specifically requested, or when the service identifies issues requiring escalation to the AERG for information/consideration for further investigation.

Of note*: a Local Review is different from an immediate de-brief which should always take place to ensure staff are appropriately supported.*

4.2 Report templates

A Clinical Record Review template (Appendix 7) will be provided to the chair and co-chair of the review. This is the format required to report back on the final outcome of the review.

Investigation of an Incident

An Adverse Event Review Report template (Appendix 8) will be provided to the chair and co-chair of the review. This is the format required to report back on the final outcome of the review.

A Local Review template is available if requested (Appendix 6) but services can choose to use other formats, provided they are clear in presenting the information that is required.

To aid learning and development the AERG have produced guidance for the review team in completing templates and this guidance can be found in appendices 6, 7 and 8.

4.3 Nomination Chair / Co-Chair

The process of nominating a 'chair and co-chair', in normal circumstances, is:

- AMD nominating a doctor, who will usually, but not always, have competed Root Cause Analysis training.
- AND nominating a senior nurse or clinical manager, who will usually, but not always, have completed Root Cause Analysis.

The HCMs are an integral part of the AERG and would nominate 'chair & co-chair' in the absence of the AND/AMD.

A list of staff who as part of their role are able to carry out a review is always available at AERG meetings. It is this list that nominations are taken from. In normal circumstances the next person on the list is nominated as chair/co-chair.

NB at least one of the nominations' will NORMALLY have completed RCA training

4.4 Review - expectations and responsibilities

The review chair and co-chair carry equal responsibly to ensure the quality of the review, and that it is completed on time.

The review will be supported by a member of the admin team (from the area where the Chair or Co-chair is based) who will be nominated by the Administration Co-ordinator to support the process.

The Chair/Co-chair will contact the CSM for the area involved who will identify a service contact who is likely to be the local manager.

The service contact must be included in communications around organising meetings and contact staffing, for the following reasons:

- to ensure that relevant staff are identified
- ensure the review team's access to information is expedited
- to ensure staff are supported in what can be a difficult and emotional time for them
- to facilitate staff being available to meet with the review team
- if required to organise accommodation within the base
- to ensure that staff receive feedback on the outcome of the review.

It makes sense to include the local manager at an early stage and throughout the process as they will be involved in implementing any recommendations. They should be updated throughout the process as early findings may require prompt action; close links with the service throughout will facilitate learning from the adverse event. The local manager should also be aware of the identity of staff in anonymised reports so that they can provide appropriate support.

4.5 Recommendations

The purpose of the review is to consider the root cause of the adverse event. A root cause is a failure in a process that, if eliminated, would prevent an adverse event from occurring. Recommendations require to be S.M.A.R.T (Specific, Measurable, Achievable, Realistic and Timed) and focus on findings related to 'root cause' of the adverse event rather than other learning that did not have a direct effect on the outcome. Where a root cause has been identified an action plan will be developed to aid the organisation to reduce or eradicate the risk of re occurrence. These action plans are the responsibility of the service in which the incident occurred. They are reviewed and monitored through the AERG structure until such point as the recommendations have been met and the action plan complete with evidence of effective implementation submitted and approved by the AERG.

4.6 Learning Points

Issues that arise during the review that did not contribute to the incident itself can and should be highlighted by the review team; however these would not ordinarily form part of the recommendations but can be identified as learning points, which should be shared with the service in which the incident occurred and a local action plan on improving clinical effectiveness should be developed.

Examples of a learning point would include where staff not following established processes/standards have been identified by the review team however they do not feel that this was a "root cause" of the incident.

In order to improve clinical effectiveness/standards this is shared with the service to enable them to identify and implement service improvement plans.

This action plan should be reviewed and monitored within the service Clinical Governance framework which is reportable to the Governance and Development Group. Where "themes" or learning points that effect more than one service are identified this learning can be shared through the use of Learning Notes and published on AthenA.

The use of 'Learning Notes' is an ideal way for additional learning points to be highlighted to other teams/services.

4.7 Anonymising

Anonymise = to remove all identifiable information.

Reports should avoid identifying the service user or staff by name and use 'patient' and the convention Nurse A, Doctor B etc. The names and grade of staff should only be included in section 2.0 of the report, for the purposes of sharing reports. This will enable the report to be shared more easily across a range of stakeholders, including with the individual service users, their family, staff and appropriate governance groups. The Chair and Co-chair must be identified in the report, – this was made clear in the Information Commissioners report in 2012. Prior to reports being shared with families and other staff, the AERG will remove identifiers from section 2.0 and PDF the report.

4.8 Feeding Back to the Service User / Family / Staff

Once approved by the AERG the Adverse Event report can be shared with the individual service user, their family and with staff.

Investigation of an Incident

The review team should be sensitive to all issues, including timing of contact, when considering involvement/engagement of the family in the preparation and feedback of any review. The review team should work closely with the clinical team to agree who is more appropriate to liaise with the family, as per the families needs.

Individual guidance on when/how to share should be sought from the AERG where there is an element of doubt. There may be circumstance where Caldicott Guardian approval is required, this would normally be done in conjunction with the AND/AMD. Staff should be reminded that although reports are anonymised they are not redacted and that they should be treated in the same way as any other confidential patient information.

5.0 Action Plans

5.1 Root Cause Recommendations

Where a recommendation has been made by the review team as a result of an identified root cause of an incident and the removal of this root cause would minimise or eradicate re occurrence of this type of incident the Service Management Team will create an action plan that details what the service is going to do to achieve the recommendation and describe the evidence of effectiveness of any actions. The Action Plan should be submitted to the AERG for approval within 15 working days. The Action Plan will remain live and tracked by the AERG until all actions are completed, and supporting evidence is submitted.

The Service Management Team is responsible for ensuring all Action Plans within their service are completed timeously. They are also responsible for the collation and submission of evidence of completion – it would be the norm that the CSM submits information on behalf of the Service Management Team.

All updates are reported and reviewed by the AERG who will consider if the actions have been completed and that the recommendations have been achieved i.e. the "root cause" of the incident has been minimised or eradicated and the service has provided sufficient evidence of this being achieved. Following submission of this the AERG provide final approval and sign off. This is a critical step in the process as the AERG are frequently asked to provide evidence of effective implementation, to HQGSU and other agencies.

5.2 Learning Points

Where a recommendation has been made by the review team as a result of learning points identified in an incident the Service Management Team will create an action plan that details what the service is going to do to achieve the recommendation and describe the evidence of effectiveness of any actions.

The Action Plan, related to Learning Points does not need to be submitted to the AERG. The service Clinical Governance Group (CGG) will take responsibility for tracking and reviewing this action plan. The CGG will consider if the actions have been completed and that the recommendations have been achieved, the CGG will report any updates to the Governance and Development Group.

The CGG will, on request, be able to provide updates and evidence of implementation to the AERG if required.

6.0 Learning Notes

Learning notes are used to share information and findings from adverse events, local incidents, complaints or where it is noted that there is a deviation from good practice. Learning Notes can also be used to share examples of good practice. They can be drafted by either the Adverse Event Review Team, the local service or the AERG but require approval by the AERG prior to circulation.

All Learning Notes are issued by the AERG, they are always uploaded to, and available on AthenA. Additionally the Learning Notes should be circulated widely through a variety of clinical governance fora, including (but not exclusively):

- Governance and Development Group – thereafter to each service Clinical Governance Group
- Senior Nurse Group

- MHS Nursing Advisory Committee
- Clinical Services Management Team
- Clinical Directors Meeting

Learning Notes are structured in SBAR format and, where possible, are one page in length. There is a clear expectation that Learning Notes are discussed at individual ward/team/department level. It is the joint responsibility of service management teams (Clinical Service Manager, Senior Nurse and Clinical Director) to ensure the Learning Notes are circulated across and within their services.

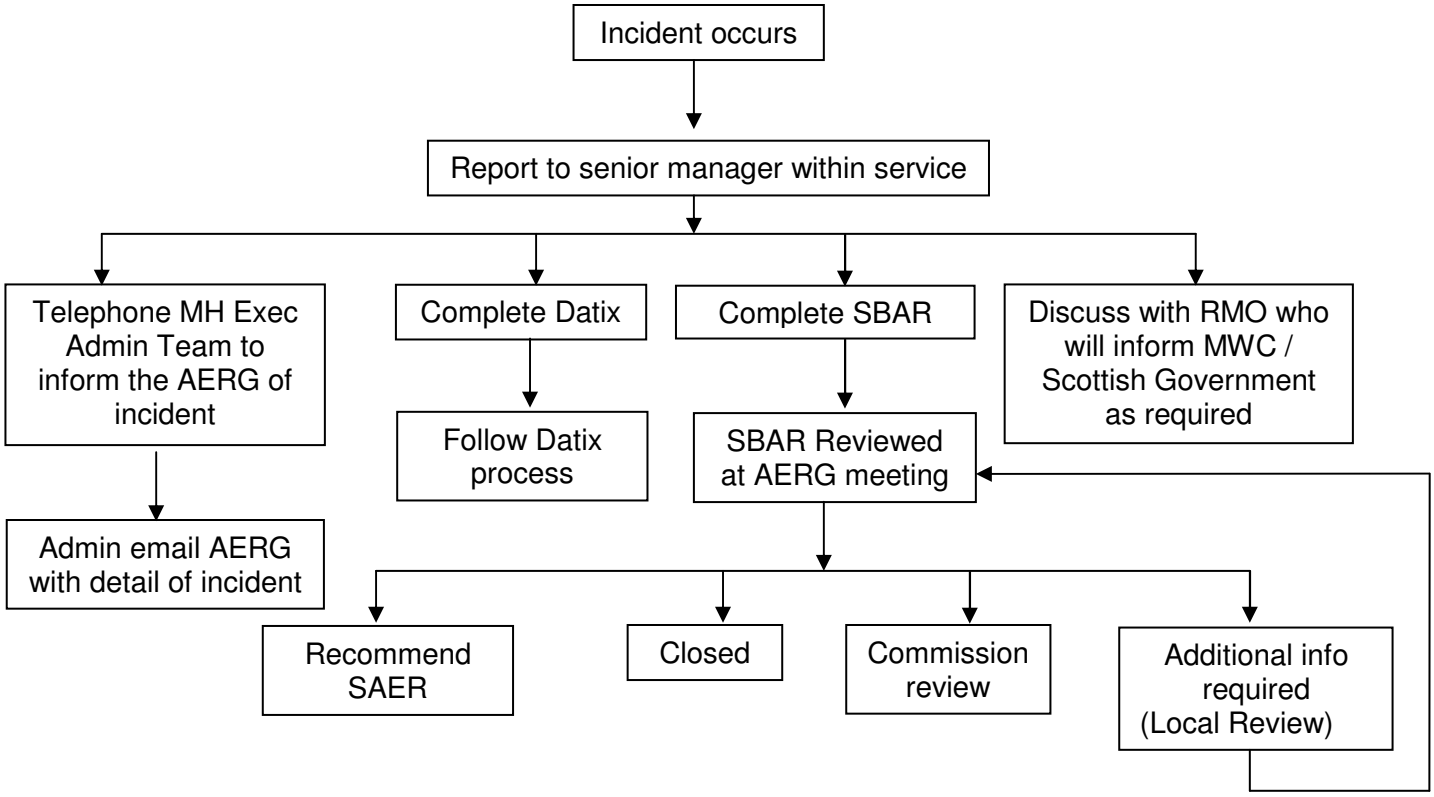
Learning Notes can also be used to share learning from complaints and from other sources e.g. HIS reviews, SAERs etc.

7.0 Appendices

Appendix 1 – Flowchart for reporting an incident
Appendix 2 – Flowchart for investigating an incident
Appendix 3 – Flowchart for learning from an incident
Appendix 4 – AERG SBAR Incident Form – Template with Guidance
Appendix 5 – AERG Review Commissioning Form
Appendix 6 – AERG Local Review Report – Template with Guidance
Appendix 7 – AERG Clinical Record Review Report – Template with Guidance
Appendix 8 – AERG Adverse Event Review Report – Template with Guidance

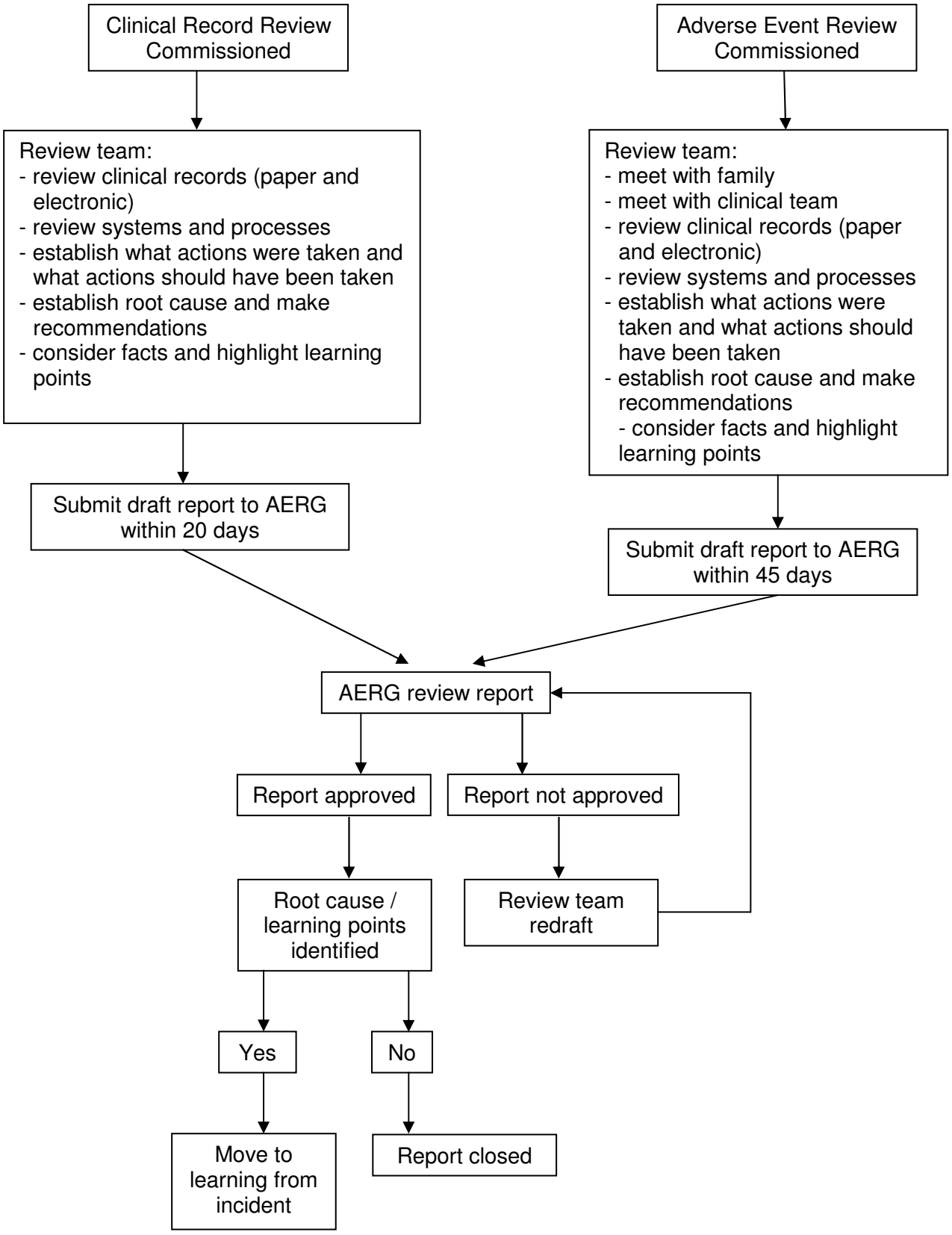
Appendix 1

Reporting an Incident – Flowchart



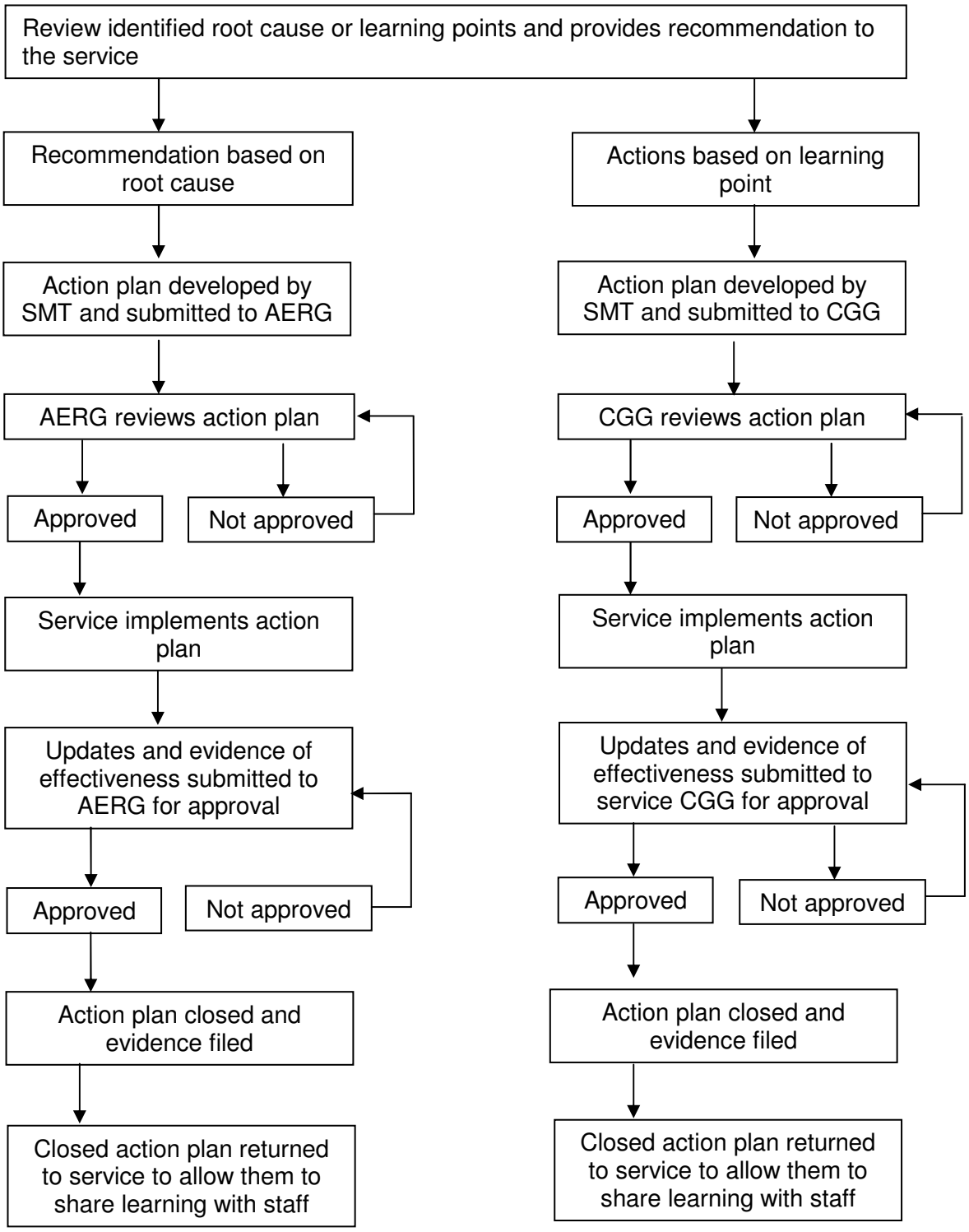
Appendix 2

AERG Investigating an Incident – Flowchart



Appendix 3

Learning from an Incident – Flowchart



Appendix 4

MHS Adverse Event Review Group (AERG) SBAR Incident Form

This should be emailed to the AERG mailbox within 24 Hours of the incident. If further information is received this SBAR should be updated and resubmitted to the AERG mailbox.

Service & Ward/Team	*Insert name of service/ward/team that is reporting incident e.g. Ward 1D, Adult Mental Health Inpatient Services*		
Author & Job Title	*Name of person completing SBAR and job title*		
Date of Incident	DD/MM/YY	**Date notified to Service**	DD/MM/YY
Date notified to Exec Office	DD/MM/YY	**Date notified to AERG**	DD/MM/YY
Datix ID Number		**CHI Number**	

Situation	*In this section provide detail of the situation, it should:* • *Clearly describe the type of incident that has occurred i.e. death of a service user, incorrect medication dispensed, serious self harm, violence and aggression etc.* • *Identify where the incident occurred i.e. within an inpatient setting, in a clinic, in the service users home etc.* • *Identify who was involved in the incident i.e. a current or former service user (if discharged from the service within the past 12 months), a member of staff etc.* *EXAMPLE* *[Nurse Name] (C/N) Adult CMHT contacted by GP to report sudden death of [Service user's name] at their home address. They were found by a family member who contacted police, no cause of death known at this time.*
Background	*In this section please provide any relevant background information that is available at the time of reporting the incident e.g.* • *Brief summary of recent contact with the service* • *Recent presentation including Mental/Physical Health/Diagnosis* • *Details of any prescribed medication* • *Summary of risk assessment and management plan if known* • *Additional information including other services involved* *EXAMPLE* *[Service user's name] had a long history of mental illness from1995 and had a diagnosis of Schizophrenia. Their mental health has remained stable for many years and they had received regular support from the service during this time. They were prescribed Flupentixol Deaconate 100mg administered every three weeks, last dose administered by the CPN two weeks ago at a home visit. At that time they reported no ongoing problems with their mental health and reported no side effects as a result of their depot medication. They did not have any known underlying physical health problems, and they lived alone with support three times a week from Richmond Fellowship. The most recent risk assessment was completed three months ago – no risk to self or others recorded at that time.*
Assessment	*In this section please provide a brief assessment of the incident based on the information available at the time of reporting. This could include any additional information that you believe is relevant to the incident and any initial learning points or additional risks identified by the service that could inform further decision making by the AERG. Include any actions taken by the service in response to the incident.*

	EXAMPLE • *[Service user's name] was well known to the service and had received regular support for a number of years.* • *In the last six months they had been seen fortnightly for administration of depot medication.* • *At last contact there had been no concerns noted and their reported death is unexpected.*
Recommendations	*In this section please provide any recommendations that the service is making as a result of this incident e.g.* • *Await post mortem results from Prosecutor Fiscals Office (if incident is a death)* • *Service to initiate a local review of this incident* • *Service to debrief staff following incident* • *Other recommendations relating to any initial learning points* *EXAMPLE* • *Offer Support to staff* • *Liaise with RMO – Discuss support for the family* • *Liaise with Police/PF regarding cause of death* • *initiate a local review*

Date	**Update (NB this should not be filled in prior to first submission to AERG)**

For Adverse Event Review Group Use Only			**Date first reviewed by AERG**		
Action Agreed by Adverse Event Review Group					
Request further information	Yes ☐	No ☐	Notification to HIS	Yes ☐	No ☐
Request copy of Local Review	Yes ☐	No ☐	Notification to MWC	Yes ☐	No ☐
Complete Review Commissioning Form	Yes ☐	No ☐	Notification to SGHD	Yes ☐	No ☐
Complete SAER Recommendation SBAR	Yes ☐	No ☐	Adult Support & Protection	Yes ☐	No ☐
Closed	Yes ☐	No ☐	Child Protection	Yes ☐	No ☐

Further Comments/Questions Raised by the AERG	
Date	**AERG Comment**

Appendix 5

MHS Adverse Event Review Group (AERG) Review Commissioning Form

Date of Incident	
Date SBAR Reviewed	
Datix ID Number	

Terms of Reference

1.0 The Mental Health Services Adverse Event Review Group (AERG) have commissioned the following review

☐ MHS Adverse Event Review
☐ MHS Clinical Record Review

to investigate the circumstances surrounding the management of [insert service user name and CHI] within [insert service] up to and including the events of Datix ID [insert number or insert on date] considering also the care and management following this specific incident.

1.1 Datix ID [insert number] and the SBAR Incident Form are available as an attachment to this Terms of Reference

2.0 The remit of this review is:

☐ To meet the patient/next of kin/family to consider the issues they wish to raise in relation to care received and agree areas/themes they wish reviewed.

☐ To meet with the clinical team in involved in the care of the patient.

☐ To identify and review the systems and processes utilised to organise, manage and guide the provision of care for this patient. To establish what actions were taken and what, if any, other actions should have been taken. To determine the timeousness and appropriateness of the patient care provided.

☐ To establish root cause of the incident and identify any recommendations for the service.

☐ To identify any other areas of concern about the care received and identify any learning points for the service.

☐ To consider the facts of this case and make recommendations and learning points.

☐ To feedback to members of the family involved in the review and provide them with a copy of the final report (where approved and agreed by AERG)

☐ To feedback to clinical team the outcome of the review and to provide them with a copy of the final report (where approved and agreed by AERG).

3.0 Appointed Chair _____ Date Notified: _____

Appointed Co-Chair _____ Date Notified: _____

NB Administration support will be identified by an Administration Coordinator

4.0 Date review report due back to AERG _____ (XX days after review commissioned)

5.0 This review was agreed and confirmed by the following AERG members on: _____

☐ Linda Boyd ☐ Derek T Barron ☐ Carol Fisher ☐ John Taylor

6.0 Date Review Commissioning Form sent to CSM for uploading to datix _____

Mental Health Services
Local Service Review Report - Guidance

Datix ID number	[insert number]
Service	[insert service]
Date review commenced	00/00/0000
Lead Reviewer	[insert names]
Date review due for completion	00/00/0000
Date review sent to AERG (if applicable)	00/00/0000
Report Version	Draft – 1.0

Review Report Content

1.0 Adverse Event Summary……

2.0 Summary of Recent Contact Leading up to Event…….

3.0 Findings…….

4.0 Recommendations……..

5.0 Learning Points……

6.0 Action Plan……

When writing this review the author should be aware that this report could be shared with various external organisations including: HIS, MWC, Procurator Fiscal.

1.0 Adverse Event Summary

This section should provide a brief background of what has happened and should act as an introduction to the report and it should:

- *Identify who was involved in the incident (name of service user, any witnesses, part of service incident occurred)*
- *Clearly describe the type of incident that has occurred*
- *Identify where the incident occurred*
- *Identify when the incident occurred*

This section can also include any additional information that is relevant to the incident (eg if a suicide note was found or if there is a confirmed cause of death) and any initial learning points or additional risks identified by the reporting service and include any initial actions taken by the service. A summary of the authors conclusions should be recorded along with a brief outline of the recommendations being made.

2.0 Summary of Recent Contact Leading up to Event

This section should provide a summary of recent contact with Mental Health Services. The summary should provide an overview of the types of contact and the outcome of any contact i.e. attended/DNA/admitted etc, and any relevant information pertaining to the incident.

You should not record in this section any detailed records that have been "cut and pasted" from FACE or case notes. (If applicable) the family would not be provided with detailed information from clinical notes as part of a completed report nor would this information be released into the public domain, however this information will be made available to Health Improvement Scotland (HIS) or the Mental Welfare Commission (MWC).

3.0 Findings

This section should provide the detail on the discussion and analysis of the incident by the review team and should respond to the remit of the review as outlined in the terms of reference

Importantly the review team must include in this section, based on their findings:

- *their consideration of the facts of the case and the care and treatment provided*
- *what happened in this incident and,*
- *identify the root cause of the incident*

In this section the review team should clearly provide:

- *An analysis of the care and treatment provided including information on the actions taken by the care team, and/or actions that were not undertaken and why*
- *Details on any areas of concern about the care received and identify any learning points for the service.*
- *Details on any areas of good practice that should be shared with the service*

4.0 Recommendations

Recommendations should:

- *be clearly linked to identified root cause (s) and address all of the root causes*
- *be designed to significantly reduce the likelihood of recurrence and/or severity of outcome*
- *be clear and concise and kept to a minimum wherever possible*
- *be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated*

5.0 Learning Points

Issues that arise during the review that did not contribute to the incident itself can and should be highlighted by the review team; however these would not ordinarily form part of the recommendations but can be identified as learning points, which should be shared with the service in which the incident occurred and a local action plan on improving clinical effectiveness should be developed.

Examples of a learning point would include where staff not following established processes/standards have been identified by the review team however they do not feel that this was a "root cause" of the incident.

In order to improve clinical effectiveness/standards this is shared with the service to enable them to identify and implement service improvement plans.

6.0 Action Plan

NB This section is to be completed by the Service Management Team only.

Action plan approved for progress	Yes ☐	No ☐	Date	

No	Recommendation *In this section the recommendations from Section 4 should be entered.*	Action *Each cell here should contain an action that is specifically linked to the recommendation on the left.*	Target Completion Date *The date when it is planned the action will have been completed*	Responsible Officer *This should contain the job title/role of the person who will be responsible for implementation.*	Evidence of Effective Implementation *At the point of creating the action plan this is the description of the evidence that will be sought to confirm that the action has been effectively implemented. When the action has been closed the details of the evidence in support of effective implementation needs to be linked.*	Action Status *This should contain Open or Closed.*

Mental Health Services
Clinical Record Review Report - Guidance

Datix ID number	[insert number]
Service	[insert service]
Date review commissioned	00/00/0000
Chair / Co-Chair	[insert names]
Date review due for completion	00/00/0000
Date review returned to AERG	00/00/0000
Report Version	Draft – 1.0

On completion return to AERG Mailbox, Mental Health Services

Review Report Content

1.0 Adverse Event Summary……

2.0 Terms of Reference……..

3.0 Service User Details……

4.0 Summary of Recent Contact Leading up to Event……

5.0 Findings…….

6.0 Recommendations……..

7.0 Learning Points……

8.0 Action Plan……

When writing this review the review team should be aware that this report will be shared with the service user / their family, the staff involved in the service users care, and could be shared with various external organisations including: HIS, MWC, Procurator Fiscal.

1.0 Adverse Event Summary

This section should provide a brief background of what has happened and should act as an introduction to the report and it should:

- *Identify who was involved in the incident (name of service user, any witnesses, part of service incident occurred)*
- *Clearly describe the type of incident that has occurred*
- *Identify where the incident occurred*
- *Identify when the incident occurred*

This section can also include any additional information that is relevant to the incident (eg if a suicide note was found or if there is a confirmed cause of death) and any initial learning points or additional risks identified by the reporting service and include any initial actions taken by the service as recorded in their Local Review. A summary of the review teams conclusions should be recorded along with a brief outline of the recommendations being made.

2.0 Terms of Reference

This section will be populated by the AERG based on the type of review that is requested.

In every case the review team should:

- *Identify and review the systems and processes utilised to organise, manage and guide the provision of care for this patient. To establish what actions were taken and what, if any, other actions should have been taken. To determine the timeousness and appropriateness of the patient care provided.*
- *To establish root cause of the incident and identify any recommendations for the service.*
- *Identify any other areas of concern about the care received and identify any learning points for the service.*
- *Consider the facts of this case and make recommendations and learning points.*

3.0 Service User Details

Surname		
Forename(s)		
Known As/Alias		
Address		
Date of Birth		
CHI Number		
Gender (mark as appropriate)	**Male** ☐	**Female** ☐
Occupation(s)		
Marital Status		
Ethnicity		
Next of Kin/Named Person/Family Contact (1) (Name/Address/Contact No)		
Next of Kin/Named Person/Family Contact (2) (Name/Address/Contact No)		
Active on case load (mark as appropriate)	**Yes** ☐	**No** ☐
If not active on caseload, date of discharge		
Legal Status (informal/detained - inc Act and Section)		

4.0 Summary of Recent Contact Leading up to Event

This section should provide a summary of recent contact with Mental Health Services. The summary should provide an overview of the types of contact and the outcome of any contact i.e. attended/DNA/admitted etc, and any relevant information pertaining to the incident.

You should not record in this section any detailed records that have been "cut and pasted" from FACE or case notes. (If applicable) the family would not be provided with detailed information from clinical notes as part of a completed report nor would this information be released into the public domain, however this information will be made available to Health Improvement Scotland (HIS) or the Mental Welfare Commission (MWC).

5.0 Findings

This section should provide the detail on the discussion and analysis of the incident by the review team and should respond to the remit of the review as outlined in the terms of reference

Importantly the review team must include in this section, based on their findings:

- *their consideration of the facts of the case and the care and treatment provided*
- *what happened in this incident and,*
- *identify the root cause of the incident*

In this section the review team should clearly provide:

- *An analysis of the care and treatment provided including information on the actions taken by the care team, and/or actions that were not undertaken and why*
- *Details on any areas of concern about the care received and identify any learning points for the service.*
- *Details on any areas of good practice that should be shared with the service*

6.0 Recommendations

Recommendations should:

- *be clearly linked to identified root cause (s) and address all of the root causes*
- *be designed to significantly reduce the likelihood of recurrence and/or severity of outcome*
- *be clear and concise and kept to a minimum wherever possible*
- *be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated*

7.0 Learning Points

Issues that arise during the review that did not contribute to the incident itself can and should be highlighted by the review team; however these would not ordinarily form part of the recommendations but can be identified as learning points, which should be shared with the service in which the incident occurred and a local action plan on improving clinical effectiveness should be developed.

Examples of a learning point would include where staff not following established processes/standards have been identified by the review team however they do not feel that this was a "root cause" of the incident. In order to improve clinical effectiveness/standards this is shared with the service to enable them to identify and implement service improvement plans.

8.0 Action Plan

NB This section is to be completed by the Service Management Team only.

Action plan approved for progress	Yes ☐	No ☐	Date	

No	Recommendation *In this section the recommendations from Section 6 should be entered.*	Action *Each cell here should contain an action that is specifically linked to the recommendation on the left.*	Target Completion Date *The date when it is planned the action will have been completed*	Responsible Officer *This should contain the job title/role of the person who will be responsible for implementation.*	Evidence of Effective Implementation *At the point of creating the action plan this is the description of the evidence that will be sought to confirm that the action has been effectively implemented. When the action has been closed the details of the evidence in support of effective implementation needs to be linked.*	Action Status *This should contain Open or Closed.*

Mental Health Services
Adverse Event Review Report - Guidance

Datix ID number	[insert number]
Service	[insert service]
Date review commissioned	00/00/0000
Chair / Co-Chair	[insert names]
Date review due for completion	00/00/0000
Date review returned to AERG	00/00/0000
Date notified to HIS (if Suicide Review)	00/00/0000
Date final report sent to HIS (if Suicide Review)	00/00/0000
Report Version	Draft – 1.0

On completion return to AERG Mailbox, Mental Health Services

Review Report Content

When writing this review the review team should be aware that this report will be shared with the service user / their family, the staff involved in the service users care, and could be shared with various external organisations including: HIS, MWC, Procurator Fiscal.

1.0 Adverse Event Summary

This section should provide a brief background of what has happened and should act as an introduction to the report and it should:

- *Identify who was involved in the incident (name of service user, any witnesses, part of service incident occurred)*
- *Clearly describe the type of incident that has occurred*
- *Identify where the incident occurred*
- *Identify when the incident occurred*

This section can also include any additional information that is relevant to the incident (eg if a suicide note was found or if there is a confirmed cause of death) and any initial learning points or additional risks identified by the reporting service and include any initial actions taken by the service as recorded in their Local Review. A summary of the review teams conclusions should be recorded along with a brief outline of the recommendations being made.

2.0 Review Team

Appointed Chair	
Co-Chair	
Member (3)	
Secretary/Administration Support	

Date of Review Team Meeting						
Venue of Meeting						
Invitees to Review Meeting			Attendance	Apologies	Non Attendance	Statement Submitted
Name	**Job Title**	**Organisation**				
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

3.0 Terms of Reference

This section will be populated by the AERG based on the type of review that is requested.

In every case the review team should:

- *Meet the patient/next of kin/family to consider the issues they wish to raise in relation to care received and agree areas/themes they wish reviewed.*
- *Meet with the clinical team in involved in the care of the patient.*
- *Identify and review the systems and processes utilised to organise, manage and guide the provision of care for this patient. To establish what actions were taken and what, if any, other actions should have been taken. To determine the timeousness and appropriateness of the patient care provided.*
- *To establish root cause of the incident and identify any recommendations for the service.*
- *Identify any other areas of concern about the care received and identify any learning points for the service.*
- *Consider the facts of this case and make recommendations and learning points.*
- *Feedback to members of the family involved in the review and provide them with a copy of the final report (where approved and agreed by AERG)*
- *Feedback to clinical team the outcome of the review and to provide them with a copy of the final report (where approved and agreed by AERG).*

4.0 Method of Analysis

This section should be a summary of and include information on the approach the review team took when carrying out the review eg:

- *root cause analysis,*
- *timeline analysis,*
- *clinical record review*
- *professional discussion/judgment comparison,*
- *any local guidelines/policies – SIGN/Safe & Supportive Clinical Observation Guideline,*

NB if the review team feel appropriate they can include these workings as appendices in this report.

List of documents reviewed		
☐ Medical Record	☐ GP Records	☐ Relative's Statements
☐ FACE	☐ Social Services Records	☐ Staff Statements
☐ Suicide Note	☐ Procurator Fiscal Report	☐ SBAR Incident Form
☐ Other:	☐ Datix (please note the ID number of each report referred to):	

5.0 Information Pertaining to Review

Are there / will there be any other review/investigation which the review team are aware of:		
☐ NHS A&A	☐ Local Authority (CP)	☐ Healthcare Improvement Scotland
☐ Complaint	☐ Local Authority (ASP)	☐ Mental Welfare Commission
☐ Procurator Fiscal	☐ Other Care Agency	☐ Information Commissioner
☐ MSP Enquiry	☐ Fatal Accident Enquiry	☐ Freedom of Information Request
☐ Other:		

6.0 Service User Details

Surname		
Forename(s)		
Known As/Alias		
Address		
Date of Birth		
CHI Number		
Gender (mark as appropriate)	**Male** ☐	**Female** ☐
Occupation(s)		
Marital Status		
Ethnicity		
Next of Kin/Named Person/Family Contact (1) (Name/Address/Contact No)		
Next of Kin/Named Person/Family Contact (2) (Name/Address/Contact No)		
Active on case load (mark as appropriate)	**Yes** ☐	**No** ☐
If not active on caseload, date of discharge		
Legal Status (informal/detained - inc Act and Section)		

7.0 Care Team

Please use the identifier when referring to staff in the body of the report.

Identifier	Role	Name	Job Title
	Consultant		
	Named Nurse		
	Mental Health Officer		
	GP		
	Other:		

8.0 Clinical History

You should not record in the following sections any detailed records that have been "cut and pasted" from FACE or the case notes. (If applicable) the family would not be provided with detailed information from clinical notes as part of a completed report nor would this information be released into the public domain, however this information will be made available to Health Improvement Scotland (HIS) or the Mental Welfare Commission (MWC).

8.1 Diagnosis / ICD 10 Code

If a diagnosis is available please record along with ICD 10 code. If no diagnosis available please record "No diagnosis".

8.2 Timeline: chronological record of service contact inc previous detentions/admissions.

In this section please provide a record of contact with the patient by Mental Health Services in the previous 12 months. This should be in chronological order from oldest to most recent contact and should provide an overview of the types of contact and the outcome of any contact i.e. attended/DNA/admitted etc, and any relevant information pertaining to the incident but does not require you to include analysis as this will be recorded in section 9.0 Findings. The review team may wish to include a summary of the salient historical aspects that impacted on care, or where there is a link to what happened e.g. tried to take their own life previously by carbon monoxide poisoning.

For Example
01/01/2011 – outpatient clinic appointment with Consultant psychiatrist
02/01/2011 – home visit with CPN
03/01/2011 – attended A&E
04/01/2011 – admitted to Adult Mental Health Inpatient ward etc

Or

28/06/2013: Reviewed by Consultant Psychiatrist in Ward XY, no changes to management plan.

25/07/2013: Liaison Nurse 2 notes that Risperidone was commenced on 1/7/2013 with a plan of 3 weeks oral medication before commencing depot Risperdal Consta – to be discussed with Consultant Psychiatrist.

31/07/2013: Medication reviewed by Consultant Psychiatrist and to continue on current dose until transfer to acute psychiatric inpatient ward.

8.3 Risk Assessment

This section should include a summary of the risk assessment(s) completed and recorded, this should include (if applicable) a note of any previous suicide attempts, Adult Support and Protection and/or Child Protection issues. If no risk assessment is evident please record "No formal risk assessment complete".

8.4 Risk Management Plan

This section should provide a summary of any Risk Management plan(s) that have been recorded.

8.5 Prescribed Medication

This section should provide a list of medication (including dose and frequency) prescribed at the time of the incident. If no medication prescribed please record "No Medication". It should also include medication history relevant to the event e.g. previous allergic reaction or previous OD or previous discontinuation syndrome etc.

8.6 Known Substance Misuse History

This section should provide a summary of any known alcohol use, non prescribed (illicit) drug use or misuse of prescribed substances relevant to this incident.

8.7 Significant Physical Health Problems

This section should provide a summary of any physical health problems that are relevant to this incident.

8.8 Relevant Forensic/Legal/Criminal History

This section should provide a summary of any relevant forensic/legal/criminal history that are relevant to this incident.

8.9 Relationship Issues

This section should provide a summary of any relationship issues that are relevant to this incident.

8.10 Early Warning Signs/Triggers

This section should include a summary of any early warning signs/triggers that have been recorded.

9.0 Findings

This section should provide the detail on the discussion and analysis of the incident by the review team and should respond to the remit of the review as outlined in the terms of reference

Importantly the review team must include in this section, based on their findings:

- *their consideration of the facts of the case and the care and treatment provided*
- *what happened in this incident and,*
- *identify the root cause of the incident*

In this section the review team should clearly provide:

- *The views and any concerns raised by the family and the outcome of any discussion with the family (if applicable)*
- *The views of the care team involved in this incident*
- *An analysis of the care and treatment provided including information on the actions taken by the care team, and/or actions that were not undertaken and why*
- *Details on any areas of concern about the care received and identify any learning points for the service.*
- *Details on any areas of good practice that should be shared with the service*

Where the review team have been unable to meet with the patient/next of kin/carer or the clinical team involved in the care of the patient the report should clearly demonstrate the steps taken to make contact and the record the reasons why no contact has been made.

10.0 Recommendations

Recommendations should:

- *be clearly linked to identified root cause (s) and address all of the root causes*
- *be designed to significantly reduce the likelihood of recurrence and/or severity of outcome*
- *be clear and concise and kept to a minimum wherever possible*
- *be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated*

11.0 Learning Points

Issues that arise during the review that did not contribute to the incident itself can and should be highlighted by the review team; however these would not ordinarily form part of the recommendations but can be identified as learning points, which should be shared with the service in which the incident occurred and a local action plan on improving clinical effectiveness should be developed.

Examples of a learning point would include where staff not following establishes processes/standards have been identified by the review team however they do not feel that this was a "root cause" of the incident.

In order to improve clinical effectiveness/standards this is shared with the service to enable them to identify and implement service improvement plans.

12.0 Action Plan

NB This section is to be completed by the Service Management Team only.

Action plan approved for progress	Yes ☐	No ☐	Date	

No	Recommendation *In this section the recommendations from Section 10 should be entered.*	Action *Each cell here should contain an action that is specifically linked to the recommendation on the left.*	Target Completion Date *The date when it is planned the action will have been completed*	Responsible Officer *This should contain the job title/role of the person who will be responsible for implementation.*	Evidence of Effective Implementation *At the point of creating the action plan this is the description of the evidence that will be sought to confirm that the action has been effectively implemented. When the action has been closed the details of the evidence in support of effective implementation needs to be linked.*	Action Status *This should contain Open or Closed.*

13.0 Adverse Event Review Summary Report

The purpose of this section is to provide a summary report to enable learning and good practice to be shared with the wider service. This section should be anonymous and should not provide details of specific staff/teams/areas. This report should be written in a way that it can be uploaded to AthenA and/or shared as a paper at clinical governance meetings. An example report has been given below:

Summary of Event

This section should provide a brief background of what has happened and it should:

- *Clearly describe the type of incident that has occurred*
- *Identify where the incident occurred*
- *Identify when the incident occurred*

This section can also include any additional information that is relevant to the incident (eg if a suicide note was found or if there is a confirmed cause of death) and include any initial actions taken by the service as recorded in their Local Review.

Summary of Findings

This section should provide a summary on the discussion and analysis of the incident by the review team and include in this section, based on their findings: In this section the review team should, where appropriate, provide:

- *A summary of any concerns raised by the family*
- *A summary of the views of the care team involved in this incident*
- *Details on any areas of concern about the care received*
- *Details on any areas of good practice that should be shared with the service*

Learning Points

Issues that arise during the review that did not contribute to the incident itself can and should be highlighted by the review team; however these would not ordinarily form part of the recommendations but can be identified as learning points, which should be shared with the service in which the incident occurred and a local action plan on improving clinical effectiveness should be developed.

Recommendations

Recommendations should:

- *be clearly linked to identified root cause (s) and address all of the root causes*
- *be designed to significantly reduce the likelihood of recurrence and/or severity of outcome*
- *be clear and concise and kept to a minimum wherever possible*
- *be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated*

Conclusion

This section should provide the detail on the discussion and analysis of the incident by the review team and should respond to the remit of the review as outlined in the terms of reference. Importantly the review team must include in this section, based on their findings:

- *their consideration of the facts of the case and the care and treatment provided*
- *what happened in this incident and,*
- *identify the root cause of the incident*

14.0 Appendix 1 – SBAR Incident Form/Datix Entry for Incident

Please copy and paste SBAR/Datix Entry

15.0 Appendix 2 – Initial Team Review

Please copy and paste minutes/notes from initial team review or local service review report

16.0 Appendix 3 – Root Cause Analysis/Timeline

Please copy and paste the Root Cause Analysis, Timeline etc if completed

You should not record in this section any detailed records that have been "cut and pasted" from FACE or the case notes. (If applicable) the family would not be provided with detailed information from clinical notes as part of a completed report nor would this information be released into the public domain, however this information will be made available to Health Improvement Scotland (HIS) or the Mental Welfare Commission (MWC).

Mental Health Services
Adverse Event Review Report

Datix ID number	[insert number]
Service	[insert service]
Date review commissioned	00/00/0000
Chair / Co-Chair	[insert names]
Date review due for completion	00/00/0000
Date review returned to AERG	00/00/0000
Date notified to HIS (if Suicide Review)	00/00/0000
Date final report sent to HIS (if Suicide Review)	00/00/0000
Report Version	Draft – 1.0

On completion return to AERG Mailbox, Mental Health Services

Review Report Content

1.0 Adverse Event Summary

2.0 Review Team

Appointed Chair	
Co-Chair	
Member (3)	
Secretary/Administration Support	

Date of Review Team Meeting			Attendance	Apologies	Non Attendance	Statement Submitted
Venue of Meeting						
Invitees to Review Meeting						
Name	**Job Title**	**Organisation**				
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

3.0 Terms of Reference

4.0 Method of Analysis

List of documents reviewed		
☐ Medical Record	☐ GP Records	☐ Relative's Statements
☐ FACE	☐ Social Services Records	☐ Staff Statements
☐ Suicide Note	☐ Procurator Fiscal Report	☐ SBAR Incident Form
☐ Other:	☐ Datix (please note the ID number of each report referred to):	

5.0 Information Pertaining to Review

Are there / will there be any other review/investigation which the review team are aware of:		
☐ NHS A&A	☐ Local Authority (CP)	☐ Healthcare Improvement Scotland
☐ Complaint	☐ Local Authority (ASP)	☐ Mental Welfare Commission
☐ Procurator Fiscal	☐ Other Care Agency	☐ Information Commissioner
☐ MSP Enquiry	☐ Fatal Accident Enquiry	☐ Freedom of Information Request
☐ Other:		

6.0 Service User Details

Surname		
Forename(s)		
Known As/Alias		
Address		
Date of Birth		
CHI Number		
Gender (mark as appropriate)	**Male** ☐	**Female** ☐
Occupation(s)		
Marital Status		
Ethnicity		
Next of Kin/Named Person/Family Contact (1) (Name/Address/Contact No)		
Next of Kin/Named Person/Family Contact (2) (Name/Address/Contact No)		
Active on case load (mark as appropriate)	**Yes** ☐	**No** ☐
If not active on caseload, date of discharge		
Legal Status (informal/detained - inc Act and Section)		

7.0 Care Team

Identifier	Role	Name	Job Title
	Consultant		
	Named Nurse		
	Mental Health Officer		
	GP		
	Other:		

8.0 Clinical History

8.1 Diagnosis / ICD 10 Code
8.2 Timeline: chronological record of service contact inc previous detentions/admissions.
8.3 Risk Assessment
8.4 Risk Management Plan
8.5 Prescribed Medication
8.6 Known Substance Misuse History
8.7 Significant Physical Health Problems
8.8 Relevant Forensic/Legal/Criminal History
8.9 Relationship Issues
8.10 Early Warning Signs/Triggers

9.0 Findings

10.0 Recommendations

11.0 Learning Points

12.0 Action Plan

NB This section is to be completed by the Service Management Team only.

Action plan approved for progress	Yes ☐	No ☐	Date	

No	Recommendation *In this section the recommendations from Section 10 should be entered.*	Action *Each cell here should contain an action that is specifically linked to the recommendation on the left.*	Target Completion Date *The date when it is planned the action will have been completed*	Responsible Officer *This should contain the job title/role of the person who will be responsible for implementation.*	Evidence of Effective Implementation *At the point of creating the action plan this is the description of the evidence that will be sought to confirm that the action has been effectively implemented. When the action has been closed the details of the evidence in support of effective implementation needs to be linked.*	Action Status *This should contain Open or Closed.*

13.0 Adverse Event Review Summary Report

Summary of Event

Summary of Findings

Learning Points

Recommendations

Conclusion

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