

# CLINICAL GOVERNANCE

September 2000

## Bulletin

### Risk management

#### Editorial

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The second issue of the *Clinical Governance Bulletin* deals with risk management. Clinical governance, by making chief executives accountable for quality, has been a powerful influence for the introduction of systematic processes and systems to monitor care and thus assure the quality of the care patients receive. Risk management is one of these processes. The importance of using critical incidents reporting within the NHS to monitor care as well as individual practice was emphasised in 1997 in the government's white paper *The New NHS. Modern, Dependable*<sup>1</sup>. Clinical risk management is about identifying what goes wrong in patient care and why, and learning lessons from these events to ensure action is taken to prevent recurrence. It is also about minimising risks by ensuring that:

- clinical teams are appropriately skilled;
- individual members of the team are aware of their respective roles and responsibilities;
- the environment in which the team operates is safe.

To deliver this agenda, health-care organisations need to have in place:

- a sound clinical risk management process that encourages critical incident reporting and that is understood by all staff;
- effective claims management<sup>2,3</sup>.

The organisations need to create a culture of openness, in which staff do not feel afraid of reporting untoward events and of learning from them so that the lessons may be implemented and shared across all services. They also need to ensure that all clinical staff, including consultants, are appraised regularly to ensure that they maintain their skills and competences by attending relevant professional development sessions.

To date, clinical risk management has not been universally applied and thus critical incidents are not systematically monitored. One of the reasons may be the patchy development of clinical information systems, which would make recording of these events easy; another may be the fact that complications in patient treatment are not systematically recorded in the UK. The implementation of the recommendations contained in the report recently published by the Expert Group on Learning from Adverse Events in the NHS<sup>4</sup> may help in this respect.

This issue thus deals with many practical examples of how clinical risk management has been used to improve care, and includes information on recent research into untoward events, a summary of the Expert Group's report and the media's perspective, particularly when faced with serious failure in the NHS.

For the next issue we have chosen the theme of clinical effectiveness and we would very much encourage

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you to submit a contribution that shares your practical experience and highlights the key learning points. The goal is that all those involved in the implementation of clinical governance can learn from your experience.

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# Adverse events in hospitalised patients: a pilot study and preliminary findings

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- Retrospective record review is an established method for detecting adverse events.
- This pilot study examined the applicability of US and Australian methodology and the potential value of a parallel study in the UK.
- A review of 1014 records drawn from two London hospitals revealed 119 adverse events experienced by 110 patients (10.8%). About half the adverse events were judged to have been preventable.
- More than half of the preventable events were a result of deficiencies in ward practice.

The recently published report *An Organisation with Memory*<sup>1</sup> and the *NHS Plan*<sup>2</sup> recognise the problem of adverse events in clinical practice (occasions on which patients are harmed by treatment). Both documents call for the establishment of a mandatory reporting system to improve the quality and safety of patient care. Such a scheme may prove a valuable early warning system but will not detect the overall numbers of adverse events, as studies have shown substantial under-reporting of adverse incidents<sup>3</sup>. In the UK, information on adverse events is also provided by confidential enquiries,

studies of claims and complaints and from other sources. However, there are no reliable data on the overall scale and nature of adverse events, each study providing only a partial view.

Studies in the USA<sup>4</sup> and Australia<sup>5</sup> have shown that up to 16.6% of patients admitted to hospital suffer an adverse event. The present study (a full report of which is in preparation) was designed to explore the applicability of the US and Australian methodology in the UK and to assess the value and feasibility of a national study. No direct international comparisons of results should be made, owing to methodological difficulties which are yet to be resolved.

## Definition of adverse events

Adverse events are occasions on which patients are harmed by treatment, rather than by the disease, during a specified admission to hospital. The injury must be of sufficient importance to lead to disability at the time of discharge (including death) or prolonged/subsequent hospital stay, or both. Adverse events may result from the directly harmful effects of treatment or the omission of an important aspect of standard care. They may or may not

be preventable, a judgement which is made separately.

## Method of study

Case records of 1014 patients, randomly selected from four specialties (general surgery, orthopaedic surgery, general medicine and obstetrics), were assessed by nurse reviewers using 18 pre-defined screening criteria. Positive records were then examined by clinicians who identified the occurrence of an adverse event and completed detailed questions on their nature, likely causation, impact on the patient and extent to which the event was preventable.

## Preliminary results

Of the 1014 patients, 110 (10.8%) suffered a total of 119 adverse events, of which 48% were judged preventable. Elderly patients were more at risk, with the mean age of patients suffering adverse events (63 years) being higher than that of those not experiencing adverse events (50 years). Adverse events led to an average additional 8.4 days' hospital stay. For the 119 adverse events, the total extra bed-days amounted to 999, of which 460 (46%) were judged preventable.

Adverse events can be broadly classified as those caused by diagnostic mistakes, those due to errors occurring during invasive procedures, those resulting from poor clinical management on wards and those which are drug-related. More than half of the preventable events were a result of drug-related errors and poor clinical management.

## The need for a full study

In the USA<sup>4</sup> and Australia<sup>5</sup>, major record reviews have provided a foundation and driving force for major patient safety initiatives which aim both to reduce harm to patients and to make huge financial savings. We believe that the pilot findings, although preliminary, provide justification for a full, national study in the UK.

In a more extensive and detailed study, certain sections of the analysis would identify situations and behaviour patterns which seem to predispose to adverse events. These in turn would help to identify changes in practice required. Relatively small intervention studies<sup>6</sup>

could then be carried out which would be applicable to all NHS hospitals.

An alternative approach for future studies would be to decentralise the study by inviting individual hospital trusts to participate. They would be required to nominate two or three clinicians to spend a fortnight collecting data from a nearby hospital. The clinical risk unit or an equivalent research group would be responsible for the training of assessors, quality control and the analysis of data. Such a system would allow most of the costs of the study to be absorbed locally and participating trusts to own the data.

### Acknowledgements

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# An Organisation with a Memory. Summary and implications for health-care organisations

## Myriam Lugon

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- NHS organisations should ensure that individual services systematically report incidents, trigger events and near misses.
- Clinical services should be provided with the available information to ensure the multidisciplinary team learns from what goes wrong and takes the necessary action to improve patient care.
- Appropriate linkages need to be made between complaints, incidents, claims, clinical indicators and outcome measures so that warning signs can be identified before patients are affected.
- A process systematically to consider and implement the recommendations from national enquiries should be developed.

The introduction of clinical governance has seen the development of systems and processes to monitor care and to ensure care is of the highest quality. This systematic approach should allow lessons to be learnt so that clinical practice can improve and be based on an open and supportive culture that fosters learning. While all NHS organisations have implemented a risk management process to a greater or lesser extent, the lessons learnt from one organisation are rarely disseminated to others; moreover, the lessons learnt in one service are not always shared with others in the same organisation. The recommendations of confidential enquiries are also not systematically implemented by individual services. There is therefore a need to develop a more comprehensive process to ensure that the NHS identifies adverse incidents and learns from them so that systems, processes and practice can be improved, thus preventing such events happening again.

An Expert Group under the chairmanship of the Chief Medical Officer for England was charged with the task of establishing the way forward to ensure that the NHS

learns from what goes wrong. It was therefore asked to:

examine the extent to which the National Health Service and its constituent organisations have the capability to learn from untoward incidents and service failures so that similar occurrences are avoided in the future. To draw conclusions and make recommendations.<sup>1</sup>

The Group's report, *An Organisation with a Memory*, has recently been published. It is an extensive review of the state of the NHS information systems for reporting and analysing incidents and learning from them. It gives details of the scale and nature of adverse events in the NHS, as well as a number of case studies of, for example, the administration of incorrect medication, problems with the use of technical procedures, failure of communications and maladministration of drugs by spinal injection.

It draws on the research evidence in the health-care and non-health-care fields, in order to understand the causes of failure and what affects the learning process in these cases, and to identify the barriers to learning.

Important points are made, such as:

- The culture of the organisation plays an important role in learning from failures, but the culture in the NHS does not encourage reporting, as individuals are often blamed when things go wrong.
- Near misses are an important source of information to prevent such incidents occurring again.
- There is a need to close the loop but also to look at the root cause of the problem.
- There is a need to do careful analysis to identify common themes, as these may be used to predict and prevent future incidents.

The report examines the strengths and weaknesses of the NHS systems for learning from adverse events and

recognises that, currently, all staff do not understand the definition of an adverse event – there is therefore no consensus about what to report. It also notes that incident reporting varies widely across the NHS and that current systems (complaints, claims, incidents, etc.) are not properly linked, which hinders the early identification of warning signs. It also suggests that appropriate links should be made between systems used for learning from failures and those used for detecting problems in performance.

In the final chapter, the Group summarises the findings and makes 10 recommendations, covering the following areas:

- a mandatory reporting scheme
- a scheme for confidential reporting by staff
- a culture of learning and enquiring
- a system for analysing and disseminating lessons from incidents and near misses
- the use of available information
- the arrangement for reporting adverse events
- a basic research programme into adverse events
- the role of new NHS information systems in helping staff access learning from adverse events
- the implementation of important lessons
- specific categories of serious adverse events

Some of these recommendations identify work to be undertaken by other bodies, such as the NHS Executive, the National Institute for Clinical Excellence, the Commission for Health Improvement and so on. Four specific aims are to be achieved over the next five years: these cover maladministration of spinal injection, negligent harm in the field of obstetrics and gynaecology, serious errors in drug prescribing and suicide by hanging from non-collapsible beds or shower curtain rails on wards.

While there is no timescale for the implementation of the recommendations, health-care organisations should, as part of their clinical governance agenda, encourage incident reporting, support individual services in identifying trigger events to be systematically reported, provide services with the available information to help the multidisciplinary team to reflect on their practice and make the necessary changes to improve

patient care, develop a system to check that recommendations made by national enquiries are acted upon and ensure that lessons learnt are widely disseminated.

## Avoiding medication errors and adverse incidents: the way forward

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- The reporting procedure for medication errors should be clear, and should allow honest reporting as well as complete coverage of the episode.
- Audit is the best means to identify areas for improvement and set objectives to enhance the quality of care.
- Audit should be multidisciplinary, participative, cyclical and lead to tangible changes.

A vital element of clinical governance is risk management, where adverse events are detected, openly investigated and discussed, and the lessons learned promptly applied. Medication errors therefore should be high on the clinical governance agenda of all trusts.

A medication error is a failure in the treatment process that leads to, or has the potential to lead to, harm to the patient<sup>1</sup>. Most such cases arise from human error, the frequency of which depends on what people are trying to do and the circumstances in which they are trying to complete the task<sup>1</sup>.

### Multidisciplinary Medication Error Monitoring Group

The Bath & West Community NHS Trust established its Multidisciplinary Medication Error Monitoring Group<sup>2</sup> in 1998. It comprises a clinical effectiveness coordinator, the principal pharmacist, the specialist registrar in care of the elderly, the risk management coordinator, a

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- 1 Department of Health. *An Organisation with a Memory. Report of an Expert Group on Learning from Adverse Events in the NHS.* London: The Stationery Office, 2000

senior nurse and a clinical development nurse, and meets every three months. It sets standards for the management of medication errors with a view to improve overall clinical care. It aims to reduce variation in clinical practice, limit risk and make best use of resources. A 'no blame culture' was adopted to encourage drug errors to be reported more frequently and honestly.

A form for the reporting of medicine/drug incidents already existed to identify medication errors, but inconsistency in reporting provided few opportunities for learning from mistakes and did not allow for the detection of trends. Modification of the form made it compatible with the 'no blame culture'. The new 'Multidisciplinary Medication Incident Form' was also designed to allow wider coverage of the incident, honest appraisal and a clearer reporting process. A successful implementation of a pilot study led to the new form's adoption by the trust throughout one of its hospitals (with 156 consultant beds). It is now planned to roll it out to the trust's five GP community hospitals. The Multidisciplinary Group has been retained to coordinate and monitor the process and implement change.

### National audit of evidence-based prescribing for older people

The trust also participated in the national sentinel audit for prescribing for older people. The

audit was a worthwhile exercise in three main areas.

- It reinforced those areas in which the trust performed well, which was encouraging and supportive for the staff.
- It was useful for the trust to see its performance in the context of national performance.
- It provided an effective learning exercise in areas that needed improvement, namely documentation of allergy information, avoiding the potential risk of paracetamol overdose and appropriate use of benzodiazepines<sup>2</sup>.

### Audit of missed medication

The trust also audited missed medication on one ward. The most common reason for missed medication was patient refusal but there was little evidence of any documentation regarding reasons for refusal<sup>4</sup>. It highlighted the need for full documentation of missed medication in patients' notes.

### Outcomes

The key messages derived from these audits were conveyed to consultants, junior doctors, nurses and pharmacists. The outcome was presented at the multiprofessional clinical

effectiveness/clinical audit open forum of the whole trust this year and is now discussed routinely in the teaching sessions of the new junior staff.

The nursing staff of all wards now undertake bimonthly 'micro-audits' to check the prescription chart for: legibility, completion of the 'allergy box', and recording of the maximum dose and the frequency of the drugs prescribed on a regular or as required basis. The results of these audits are discussed at clinical departmental meetings.

- The 'allergy box' is now completed in 90% of prescription charts (the figure was 30% in the national sentinel audit).
- Entries are entirely legible in 90% of charts.
- The frequency of administration is recorded in 97% of charts (64% for drugs prescribed as required in the national sentinel audit).
- The correct dose and route of administration are recorded in 92% of charts.

### Conclusions

Medication errors can arise from human error. Risk control measures should be in place to encourage honest reporting, the reduction of errors to a minimum and learning

from them. Audit identifies areas that need improvement or change. The key to the success of these audits was the multidisciplinary ownership of the process and the outcomes. If problems are to be remedied permanently, it is believed that education will need to be continuous, because of staff turnover<sup>5</sup>. The principles should be included in staff induction. There is a need for clear documentation of justification if there is a deviation from the evidence-based standard practice. The Multidisciplinary Medication Error Monitoring Group is a way of meeting some of the objectives of clinical governance.

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## Anti-cancer chemotherapy – time to focus on risk management

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- Anti-cancer chemotherapeutic agents are by design highly toxic and errors in chemotherapy can be catastrophic.
- The scale of errors in anti-cancer chemotherapy is unknown but published data suggest the risks are significant.
- The number of cancer patients receiving chemotherapy will increase significantly in the next few years.
- Risk management is an important approach to reducing errors in chemotherapy.

### Increased numbers of patients and increased complexity of care

The numbers of cancer patients receiving chemotherapy in the UK is increasing exponentially owing to new developments in treatment, evidence-based guidance and less inequity of access. The complexity of treatments is also increasing, for example with the more frequent use of high-dose regimens and Hickman lines. The latter require the

additional management of anti-coagulation and sepsis risks. Many patients now receive third- and fourth-line therapy.

### Good anti-cancer chemotherapy is about calculated risks

Anti-cancer chemotherapy is by design cytotoxic. Oncologists balance the predictable risks (e.g. myelosuppression, cardiomyopathy, neuropathy) against hoped for

benefits (cure or palliation). As the management of predicted toxic side-effects improves, so doses are increasing in an attempt to gain higher cure rates. The aim of high-quality chemotherapy is not to prevent all side-effects but to minimise those caused by errors.

## Errors in anti-cancer chemotherapy

Obvious medication errors (MEs) include over- or under-dosing, incorrect administration (wrong speed, diluent, route or patient) and inadequate pre-treatment assessment. Errors may lead to 'adverse drug events' (ADEs), defined as injuries that, under optimal care, are not a normal consequence of a patient's disease or treatment. Despite guidance from many sources, serious errors continue to be reported and some, such as the intrathecal administration of vinca alkaloids, have been repeated, despite the risks being publicised<sup>1</sup>.

Reported errors are likely to be only the tip of the iceberg. Errors may be masked by the inherent risks of the therapy and the patient's poor long-term outlook. Across all medications it has been estimated that 6–10% of hospital inpatients experience ADEs, with up to one-third being due to errors<sup>2</sup>. MEs are 50–100 times more common<sup>3</sup>. Most are harmless, 1–2% cause injury and 5% are 'near misses', that is potential ADEs that fail to cause injury by chance or because they are detected before the drug is administered. A study of serious ADEs found 39% occurred at the prescription stage, 38% at the administration stage and 12% during pharmacy dispensing<sup>4</sup>. The frequency of ADEs or MEs in chemotherapy is unknown. A survey of American chemotherapy nurses reported MEs in 63% of their workplaces<sup>5</sup>.

## Current guidance and controls to reduce risks

Because radiation is involved and the consequences of errors are likely to apply to batches of patients at a time, radiotherapy treatment is subject to stringent controls. Within this tight framework, the risk of errors is reduced to an absolute minimum. This is not the case for chemotherapy.

There is a range of generic guidance that needs to be applied to

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ensure the safe use of anti-cancer chemotherapy, such as the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulations (1988). The Joint Council for Clinical Oncology produced guidance on quality control in cancer chemotherapy, and the Board of Faculty of Clinical Oncology, with the Royal College of Radiologists, produced guidance on risk management in clinical oncology in the mid-1990s<sup>6,7</sup>, although the latter contained less than half a page on chemotherapy.

While there are many publications, mainly from the United States, on the avoidance of drug errors, there is little specifically on anti-cancer chemotherapy. Despite this, progress has been made in many trusts. The need for training and protocols for administration and the management of side-effects has been recognised, but the extent to which the guidance has been fully implemented is variable.

## The role of risk management

Risk management involves a two-pronged approach to identifying both points at which risk occurs in a system and solutions to reduce those risks. The first depends on reporting adverse events and 'near misses' with full multidisciplinary review of the circumstances. The second depends on systems analysis, examining the structures and processes, from writing of the prescription through

preparation and dispensing of drugs to their administration.

The aim is to develop operating procedures that reduce reliance on memory and therefore minimise the opportunity for error. These operating procedures should include:

- standardisation
- simplification
- use of protocols
- use of constraints (design of a task to make it difficult to go wrong)
- forcing functions (design of a task to make it impossible to do it wrong)

For example, prescribing could be limited to named individuals, preprinted pro formas could be used for prescribing drugs, and these could be linked to approved regimens, and prescriptions could then be checked by designated pharmacists who were part of the multidisciplinary chemotherapy team. Computer-based prescribing, with dose limits and other warnings incorporated, is likely to be a significant advance.

## Priorities for risk management in anti-cancer chemotherapy

### Informed consent

For radiotherapy, patients are routinely asked for written consent to treatment. For chemotherapy, this is rarely the case. This position is clearly unacceptable, especially in the light of the risks, and must be addressed.

### Reporting and reviewing errors

There should be multidisciplinary review of all adverse events and near misses by the team with responsibility for chemotherapy, including the lead medical oncologist, other oncologists, oncology nurses and pharmacists. These reporting mechanisms and reviews should also fit with the proposed national reporting mechanism<sup>1</sup> and the trust's clinical governance programme.

### Accountability

With the establishment of cancer networks, lines of accountability for the chemotherapy service need to be clarified, particularly where the service is provided as a satellite or outreach facility by a cancer centre to a cancer unit. Distances between trusts, associated with poor communication and poorly defined accountability, increase risks.

### Training in risk management

More clinical staff, particularly those with lead responsibilities, need training in risk management. The recent circulation of guidance on the prevention of intrathecal administration

of vinca alkaloids to trust chief pharmacists and cancer network lead clinicians across a region produced two unsolicited statements of intent from other members of staff within two trusts that they would not to follow the guidance, in particular on the separate delivery of intravenous and intrathecal drugs to the ward. These decisions had clearly not been taken following appropriate processes.

### Conclusions

The extent of errors in anti-cancer chemotherapy and the impact of these on patients and the NHS need to be quantified and risk management needs to become integral to chemotherapy services. Trust chief executives are responsible for ensuring that this is translated into safe operational procedures. These have been shown to reduce chemotherapy ADEs by 50%<sup>8</sup>. Proposed national standards will help to ensure that structures and processes are in place to facilitate the safe delivery of chemotherapy and will support the development of detailed operational procedures.

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## Developing risk reporting in a hospital trust

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- Prompt and meaningful feedback to those reporting incidents is crucial to the success of the system.
- Staff will lose interest and stop reporting if they do not see improvements resulting from their reports.
- Adverse clinical events will be reported if it is shown that the reason for collecting the information is not to apportion blame.

Over the past five years the West Dorset General Hospitals NHS Trust has developed an incident reporting system which, we believe, will significantly help in achieving the clinical governance and controls assurance agendas as well as addressing the

Chief Medical Officer's recent report *An Organisation with a Memory*<sup>1</sup>.

For some years previously the trust had an incident reporting system in place but it was used almost entirely to report patient falls and staff accidents. It was referred to by staff as 'the accident form'. Statistics were kept and reported centrally but very little use was made of the data.

A system was needed to encourage staff to report all untoward incidents, including near misses, together with a programme of education to raise awareness and catch the imagination of staff in order to enlist their support. A system was proposed that was based on an untoward incident report card that anyone could use to report anything which caused them concern, be

it an actual incident or a situation which, in other circumstances, may have resulted in an incident.

The trust board endorsed this and a simple, user-friendly card was designed. To encourage and empower staff to use the system effectively, basic principles had to be agreed and communicated and committed to throughout the organisation.

### A system of openness

The principles underpinning the system were made clear:

- anyone could report anything, anonymously if they so wished;
- the cards would be posted into locked boxes and collected weekly;

- the cards would be confidential and seen only by a small group of impartial people;
- staff would not be censored or criticised for reporting any matter;
- the identity of the sender would be protected when a follow-up investigation or action was instigated and cards would be shredded after use;
- the relationship between incidents reported and the trust's disciplinary procedure was made clear – cards would not be used as evidence in disciplinary proceedings, although an investigation could result in the disciplinary procedure being invoked.

The success of any scheme designed around such principles lies in the perception of staff that trust management is committed to the concept and will ensure that the principles are upheld, that issues reported will be taken seriously, and that action to make improvements will be taken.

The Incident Review Group was formed and meets weekly to lead the process, its remit being to promote and encourage incident reporting, to review all incidents, to instigate any follow-up action required and to use the information gained to decide and implement a risk management programme. Such a system has little chance of succeeding if feedback and action come months later. Patient complaints and legal claims are similarly rich sources from which preventable occurrences may be identified and these are therefore reviewed at the same time. The group membership was carefully thought out to reflect the remit:

- chief executive (chair)
- medical director
- director of nursing and quality
- three consultants (surgeon, physician, radiologist)
- clinical practice manager
- risk/litigation manager

A risk database has been developed in-house to collect and categorise data and this enables trends and 'hot spots' to be identified. Specific risk information is produced for the management team of each directorate who attend a meeting of the group on a rolling programme to discuss their 'risk hit list' and the action they propose to take to address the issues. Progress is monitored when

they next attend the meeting for their review.

## Changing the culture

Changing the culture of any organisation to one of openness in reporting adverse events takes time and continuous demonstration that the 'no blame' principles that have been agreed are adhered to. An indication of the scheme's success is that 80% of incidents are not reported anonymously, which suggests that staff feel 'safe' to sign the cards and ask for feedback. The number of incident reports received has risen from 5–10 per week in the early days to a steady 30–40 per week now.

Although the subject matter of incident reports is wide and diverse, it soon became obvious that the reporting of actual clinical mishaps was rare. Medical accidents, adverse outcomes and patient dissatisfaction with treatment were not seen as reportable incidents that would constitute risk. This is not surprising. Clinical mistakes that may have caused harm to patients are obviously the most difficult and uncomfortable incidents to bring into the open. The trust realised that simply expecting clinical staff to report when things have gone wrong was unreasonable and that they need help and support to do so.

The approach was to develop specialty-specific trigger event reporting. It was piloted first within maternity services, since this is recognised as a high-risk area and the team managers were already receptive to using adverse outcomes as a learning experience to improve services. The maternity team, including the consultant and middle-grade medical staff and midwives, with assistance from the trust risk manager, agreed a set of significant adverse events that might occur throughout the progress of a patient's maternity episode. These included excessive bleeding, ruptured uterus, baby born in poor condition and other complications. The occurrence of any of these events triggers an incident report, which is investigated and acted upon as necessary.

The incidents are also entered on the trust's risk management database. Information is fed back regularly to the maternity team so as to identify hot spots and concentrate efforts for improving care. The early identification of adverse events has

the added bonus of pre-empting complaints and potential claims so that they can be, in some cases, averted altogether.

Several other specialties and many individual clinicians have adopted trigger event reporting.

## Five years on

The Incident Review Group has extended and developed its role significantly.

Once the incident reporting system was well established, it was clearly not an effective use of the whole group's time to review all individual incidents, complaints and claims. This is now done outside the meeting, with a report on the risk issues brought forward to the group. Anonymous reviews of serious complaints are carried out by group members and learning points disseminated for discussion within all directorates. Settled claims are similarly reviewed with the relevant directorates and action plans drawn up to minimise the risk of recurrence. The group's efforts are now concentrated on ensuring that the risk management programme is disseminated and addressed throughout the organisation.

## Conclusions

Many improvements are still necessary but a far more open culture is now developing. Staff see the need, in the interests of providing a high-quality service, to identify, report and address areas of organisational risk, poor performance or practice error, including clinical errors and adverse patient outcomes.

The commitment, in terms of both time and enthusiasm, shown at executive director level and by senior medical staff is significant. The meetings start at 8.00 a.m., before clinical commitments begin, and the time given and additional work undertaken by members of the group are considerable.

The trust believes that this demonstrable commitment is one of the main factors in establishing a successful risk management system, engendering staff confidence in it and bringing about improvements.

## Reference

- 1 Department of Health. *An Organisation with a Memory. Report of an Expert Group on Learning from Adverse Events in the NHS.* London: The Stationery Office, 2000

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# Can risk management be applied to the media?

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**Jo Revill**

*Health Correspondent, The Evening Standard, London,  
email jo.revill@standard.co.uk*

- Be sure of all the facts.
- Tell colleagues what you are doing.
- Know your message.

If there has ever been a time when doctors are in need of some good publicity it is now. Not a week goes by when one of the national papers does not reveal a new 'dodgy doc', or when a scandal which has been bubbling under the surface for years, such as Alder Hey or North Staffordshire, suddenly engulfs the public's attention.

Doctors feel embattled, believing that in this climate they can never win a fair press, but I don't think that pessimism is justified. From my own experience of seven years as a medical correspondent, the difference between a positive and a negative story often hinges on whether the doctor concerned is prepared to be open about it.

Can risk management be applied to the media? The term implies that you can avert a problem by taking early action. An oil spill can be contained if the barriers and sprays

are deployed at the first signs of a spillage. I would say that, on some occasions, you can actually prevent a negative story from appearing, but these are rare. Realistically, what you are aiming for is to mitigate the worst effects and to put over your side of the story.

Damaging articles tend to fall into two categories:

- those involving individual cases;
- those which amount to a systems failure and affect the whole unit or hospital and its patients.

The two categories demand different approaches.

## Individual tales of woe

If we take the first category, then I would think about how you react, for example, if a journalist rings you up asking why a child has died of meningitis just hours after attending your accident and emergency department. The absolute priority is to tell the reporter that you, or

someone else, will get back to them as soon as possible, while you decide what to say. What you don't want is for the story to run without any comment at all from your side. The next action must be to scoop up the medical notes, talk to the staff and find out exactly what happened.

Next comes the hard bit. If you are sure that your team acted correctly, that they looked at all the symptoms and gave the right advice, you should talk to the reporter concerned and explain that. You can be sure that the family has given the journalist a blow-by-blow account of what happened. It's easy to hide behind a 'no comment', but it looks much, much worse in the final paragraph of a story than the comments of a doctor who is at pains to clarify what happened.

Be aware that the reporter you are talking to might not have much medical knowledge. It could be their first day in the newsroom for all you know. Explain how the illness works; explain that it is very difficult to diagnose. Tell them that sometimes it doesn't appear with a rash and that the patients can deteriorate quickly. This obviously applies to stories involving many conditions. Use simple language, not medical terminology.

Others in your hospital trust might want you to say nothing, on the grounds of patient confidentiality. There will be times when, clearly, you cannot say anything about a patient's condition or treatment. But if the family has spoken to the press, this changes the circumstances. And if you are not sure what went wrong, then tell the reporter that you are fully investigating the case. Don't let anyone think you are complacent.

## Systems failures

The second category, which would loosely cover NHS pressures, is a different matter, because your comments will have an impact on the whole hospital. If a reporter rings you up asking why dozens of heart surgery operations have been cancelled, you need to talk to many more people about what to do. 'No comment' is not an option.

Some doctors feel impelled to speak out about the lack of resources, be it money or staff, and it is undeniable that, when they do, they get into hot water. Certain chief executives are much more sanguine

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than others about such 'trouble-makers', as they are seen.

But a reporter has many different sources of information. If there is a nursing shortage that has led to the cancellation of operations, for example, they could find out about that through the community health council, through the local union representative or through patients' groups. In my view, it is better to be honest from the start about the problems, because from there you can talk about how you are trying to solve them. If surgery has been cancelled because of clinical problems, on the other hand, I would say it is the medical director or the chief executive who needs to deal with this.

Talking to the press demands a certain amount of trust on the doctor's part. How do they know they are not going to be stitched up, or their comments taken out of context? They don't, unless they

have built up a relationship with the journalist or the newspaper. This is an essential long-term strategy. Having a good rapport doesn't prevent terrible stories from appearing, but it will ensure that your side of the story is put over.

### Press officers

A good hospital press officer is invaluable. Some of the large London teaching hospitals have four or five press officers, whose job goes far beyond fielding difficult enquiries. They go round departments garnering information which can be turned into features or positive news stories as a counterbalance to all the negative reports.

### Off the record

If you get to know a journalist well, you can talk to them off the record. In my experience, this rarely

backfires; it's hardly in the reporter's interest to betray someone who will be a good source of information for the future. Talking off the record is extremely important because you can explain the particular circumstances around a case. Off the record means that the information can be used but cannot be attributed.

### Conclusions

Amid all the doctor-bashing, it's important to realise that newspapers have a constant, insatiable appetite for positive medical stories: new treatments, breakthroughs, patients saved, diseases spotted and so on. Doctors come second only to nurses in terms of public popularity (journalists are 70 percentage points below them according to the latest opinion poll). Use papers to your advantage to publicise your work – it will help when the going gets rough.

## Using incident reporting to learn lessons

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- Incident reporting should not only identify specific accidents but also provide information about organisational failures that may lead to accidents.
- Clinical staff need to understand the rationale for reporting incidents.
- Staff must believe that incident reporting produces results.
- Staff must be aware that, generally, incident reporting is not associated with blame.
- For junior doctors, access to risk management training is usually difficult and perhaps teaching time for it should be sought in the final year of the undergraduate curriculum.

Clear evidence that clinical risk management reduces the number of accidents to patients is hard to come by, although common sense would suggest that the early identification

of accidents and the speedy settlement of claims or complaints save money and are inherently better for patients. Incident reporting is a requirement of both insurers, the Central Negligence Scheme for Trusts in England and the Welsh Risk Pool in Wales. Hospitals in Maryland in the United States that had implemented programmes regarding physician and nurse responsibilities in quality assurance and risk management have been shown by Morlock and Malitz<sup>1</sup> to reduce both the number of claims and the sum awarded.

About 75% of accidents are caused by human beings. Nowadays modern equipment fails less often than perhaps was the case 20 years ago. As equipment becomes more sophisticated, however, the human-equipment interface becomes an increasing source of accidents. A common example of this problem lies

in the use of various pumps to deliver intravenous drugs. In many hospitals the available devices vary from one ward to the next; often different types of equipment are on the same ward. Many staff receive little training in their use and locums and agency staff practically none. Finally, the ability to work out accurate doses in concentrated solutions requires mathematical skills that some staff find difficult.

Incident reporting should inform the risk manager about specific accidents to patients, to allow the situation to be managed, the patient counselled and specific enquiries made. It should also act as a means of monitoring the level of risk in the environment in which staff work and the suitability of the defences, policies and procedures and so on that are designed to protect against human error, following the outline of accident progression described by

Reason<sup>2</sup>. Thus the definition of an incident needs to capture not only actual accidents to patients but also the organisational problems that usually contribute to their cause. A useful definition is 'any occurrence which is not consistent with the routine care of the patient or the routine operation of the institution', while a near-miss can be defined as 'an occurrence which but for luck or skilful management would in all probability have become an incident'.

Collecting trust-wide incident data permits the analysis of trends that identify organisational, system and environmental problems which may promote the likelihood of human error. Fallibility is part of the human condition – you can't change it – but you can change the conditions under which people work.

Staff are unlikely to fill in incident forms willingly in a strongly disciplinary environment and hence a trust philosophy of wanting to learn from accidents rather than seeking to blame is likely to lead to improved reporting<sup>3</sup>.

The experience of most hospital staff is that clinical incident forms depart for a black box, never to be seen again. The risk manager should endeavour to provide regular feedback to staff following incident reporting, with the provision of incident trends by type and frequency. The motivation of staff to report adverse clinical incidents is enhanced if they see that risk management has positively improved the system. For example:

- an elderly and unreliable operating table in a delivery room was replaced after pressure from the risk management committee placed it first in the annual capital equipment programme;
- incident reports about bed shortages and inappropriate trauma patients as outliers in medical beds prompted a review of bed allocation across the trust;
- an increase of pathology request forms that were inadequately completed led to a revised induction module on the importance of correct information on forms for new house officers and senior house officers.

If reporting leads to an adverse incident being investigated and

analysed, it is vital that staff feel supported and are provided with feedback. This will lead to positive reinforcement for the programme as staff notice that action follows their use of the incident report form.

Nurses, generally, are used to filling in incident forms, while doctors use them less frequently. Induction training for junior doctors is an important first step in persuading them to report incidents. Apart from induction, for junior doctors access to risk management training or meetings is usually difficult. The combination of Calman training regulations and hours of work has led to a fragmented pattern of work for most individuals and when they are on duty they are usually too busy to attend risk management meetings. The answer may lie in persuading medical schools to allow some time in the final year of the undergraduate curriculum so that by the time house officers arrive on the wards they have an understanding of the rationale for reporting incidents.

Opportunities to demonstrate trend data as the result of incident reporting may be available by asking for a slot at directorate lunchtime or evening meetings – often subsidised by health-care companies – when the risk manager can feed back to

the directorate the previous months' incidents. This practically always provokes an interesting discussion, in which changes to practice will be suggested.

Clinical governance can be delivered only at directorate level and risk management reports are one part of the clinical information that clinical directors need to use as monitors of the quality of care. These risk management reports, along with details of deaths, readmissions, complaints and claims, are bound to be a feature for discussion at the directorate audit meetings, at which all grades of medical staff will be present.

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## Contributions

*Clinical Governance Bulletin* is a bi-monthly publication for clinicians and managers working in trusts, health authorities and PCGs and aims to communicate practical examples, pool shared experience and highlight and disseminate best practice on a broad range of issues in health management. Themed issues will address:

- Patient experience
- Clinical effectiveness
- Resource effectiveness
- Communication
- Risk management
- Effective teamwork and learning
- Strategic effectiveness
- Clinical information

Contributions that are practical and relevant to everyday practice are welcomed. They should be 500–800 words in length, with a maximum of five references in Vancouver (numerical) style. Please send your contribution, by post (with floppy disk) or email, to one of the Editors:

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# Consultant peer appraisal. A structured system to support clinical governance and revalidation

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<sup>2</sup>Consultant Anaesthetist, Southmead Hospital, Bristol; <sup>3</sup>Directors, Edgcumbe Consulting Group Ltd, Clifton, Bristol

- The policy of both government and the General Medical Council is that all doctors should have regular appraisals.
- A system of consultant peer appraisal has been developed in the North Bristol Department of Anaesthesia that has explicit criteria, involves the use of portfolios and the collection of data from colleagues, and a structured interview leading to the production of a personal development plan.
- The process has been motivating and preliminary evaluation shows that confidence among appraisers and appraisees has increased.
- Appraiser skills are essential and time is a major constraint.

Embodied in the plans for clinical governance is the need for health professionals to be able to develop professionally and have the opportunity to reflect on their progress. In 1998 the anaesthetic departments of Frenchay and Southmead Hospitals began to develop consultant peer appraisal. A group of six consultants, together with two external advisers in business psychology (SL) and medical education (JH), designed a system that seeks to combine support with challenge. The experience gained from the existing anaesthetic trainee appraisal<sup>1</sup> and work done in general practice appraisal<sup>2</sup> formed the basis for our approach.

## Terminology

We used the definition for appraisal given in *The Good Assessment Guide*<sup>3</sup>:

a co-operative process in which individuals are encouraged to review their careers and make plans for the future, both to retain existing skills and maintain interest in their work by seeking new challenges.

## Criteria

We identified 117 criteria by which a consultant anaesthetist could be

appraised. These covered five different areas of activity (e.g. clinical, teaching) and five groups of attributes (e.g. attitudes, interpersonal skills). Only 12 criteria were specifically related to anaesthesia. Attitudes and team working were seen as being especially important.

## Gathering information

Each consultant compiled a portfolio, which included audit data from the hospital clinical information system as well as personal details, evidence of continuing education and other relevant material. Each one nominated three or four colleagues (such as surgeons, anaesthetic technicians, theatre nurses, secretaries) who could be approached by the appraisers for comments about them.

## The appraisal interview

All consultants in the group had previously attended a two-day appraisal training course, which included interviewing and feedback skills. Each consultant selected two colleagues as appraisers: evidence suggests that choosing your own appraisers does not significantly alter the results<sup>4</sup>. The interview lasted about 90 minutes and followed a structured pattern in which various aspects of the appraisee's life and work were discussed, against the contents of the portfolio and the comments of colleagues. Feedback was given at the end, also following a structured approach, and agreement was reached on development points for the future, which were listed in a plan.

The use of two appraisers allowed more detailed analysis of the appraisee's comments than might otherwise have occurred. Further, there could be occasions when it would be wise to have witnesses present. In our project, one appraiser was from a different hospital site to

the appraisee in each case. Subsequent experience on training courses has demonstrated the value of having one appraiser from a different discipline.

## Appraisal and performance management

Opinions differ about whether confidential appraisal discussions should be part of performance management by the trust. We think the two procedures should be separate. Evidence suggests that mixing them may interfere with the appraisee's agenda<sup>5</sup>. However, we suggest that, in addition to the appraisee's own personal development plan, a form indicating a satisfactory outcome and listing key development points should be completed and made available to the medical or clinical director. Another advantage of this approach is that appraisals can then be done by a larger number of consultants, rather than just the clinical and medical directors.

## Evaluation

Preliminary findings suggest that, from this exercise and subsequent training based on it, consultants come to regard appraisal positively. Their confidence in the process and skills needed are boosted and they are reassured that the process can be helpful, fair and motivating. The time needed to do it is the main concern. This has to cover the construction and maintenance of a portfolio, the collection of colleagues' views (an alternative, computerised, 360-degree feedback system is now available), and an interview involving two or three people, in addition to the skills training needed at the outset. Effective, accurate and easy-to-use hospital audit and information systems are essential. A climate of support, rather than blame, must exist if appraisal is to succeed.

## Acknowledgements

The project was supported by Southmead and Frenchay NHS Trusts and the NHS Executive South and West. We would like to thank the other members of the working party: Dr Gareth Wrathall, Dr Nik Koehli, Dr Robin Weller and Dr Judith Dunnet.

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- 5 Fletcher C. *Appraisal*. London: IPD, 1997

# Significant event audit – a key tool for clinical governance

## Jonathan Stead<sup>1</sup>, Grace Sweeney<sup>1</sup> and Richard Westcott<sup>2</sup>

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- Significant event audit (SEA) is increasingly popular as a clinical governance tool and represents a uniquely effective way to tackle the clinical governance agenda.
- Research experience has helped develop a definition and approach to SEA.
- SEA can satisfactorily address what have been suggested as the five cornerstones of clinical governance.

Significant event audit (SEA) was defined by Pringle *et al.* in 1995 as occurring when:

individual cases in which there has been a significant occurrence (not necessarily involving an undesirable outcome for the patient) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care and to indicate changes that might lead to future improvements.<sup>1</sup>

With the introduction of clinical governance in April 1999, following the publication of *A First Class Service*, growing numbers of health-care teams have instituted SEA as a regular and systematic way for the team to learn from experiences – both good and not so good<sup>2,3</sup>. More recently, the Chief Medical Officer's document *An Organisation with a Memory* has highlighted the need for systems to be introduced for ensuring that lessons are learnt from adverse incidents<sup>4</sup>. We suggest that SEA meets this need.

- 2 Royal College of General Practitioners. *What Sort of Doctor?*, Report from General Practice No. 23. London: Royal College of General Practitioners, 1985
- 3 Joint Centre for Education in Medicine. *The Good Assessment Guide*. London: JCEM, 1997
- 4 Ramsey PG, Wenrich MD, Carline JD, et al. Use of peer ratings to evaluate physician performance. *Journal of the American Medical Association* 1993;269:1655-60
- 5 Fletcher C. *Appraisal*. London: IPD, 1997

SEA has been adopted enthusiastically in primary care, with some early experience in secondary care, social care and prison health services<sup>5</sup>. Clinical governance lead personnel, both at primary care group/trust level and at practice level, seem to value SEA as a focus for clinical governance activity. Evidence is emerging that SEA is a useful tool for improving the quality of patient care<sup>6,7</sup>. What is it about SEA that makes it so powerful?

Five cornerstones of clinical governance have been suggested, namely systems awareness, teamwork, communication, ownership and leadership<sup>8</sup>. SEA provides a tool for addressing each of these in a practical and straightforward way.

## Systems awareness

SEA takes a 'no blame' approach, looking at what is wrong, not who is wrong. Issues are raised during SEA meetings that are often quite complex. These cannot always be solved during the particular meeting, but a small team is identified to work through the problem and come back with suggestions for improving the system. For example, a mistake with repeat prescribing in a general practice may lead to an overhaul of the repeat prescribing system. The small group nominated to undertake the task might include the practice manager, receptionist, doctor and possibly dispenser.

## Teamwork

Patients hardly ever experience health-care involving only one person or profession. For example, the long-term care of people with diabetes takes place for the most part in general practices. Although the practice nurse is increasingly becoming the key worker, the GP has a critical role, as does the chiropractor, dietician and diabetes specialist nurse in certain circumstances. From the patients' viewpoint, their support team may change over time, but the practice nurse will probably remain the key point of contact. At times, the team will cross the traditional boundaries between primary and secondary care. SEA helps team members to understand more about the role of others and to value their contribution<sup>6</sup>.

## Communication

Many adverse events arise due to poor communication between individuals and between organisations. Getting teams into a room on a regular basis to discuss such events will not only highlight communication deficits but also begin to improve the situation. Inviting visitors to contribute on certain agenda items at the SEA meeting not only helps to get more inclusive solutions but also helps those involved to see things from the perspective of others. The elderly patient who has been waiting for months for an appointment at a pain clinic is understandably devastated when the ambulance fails to pick him up. The ambulance staff should be involved in the discussions to prevent it happening again.

## Ownership

With simpler problems, the team will be involved in generating the solution during the meeting, ensuring ownership of those present. The meetings are minuted and circulated to the whole team, but those present will have a higher level of ownership. With more complex problems, a small group will be delegated to produce draft proposals for the next meeting, when the wider team can adapt and support the recommendations. SEA meetings are often the first opportunity for people – notably those not traditionally in positions of decision making – to shape solutions.

Early on, receptionists and secretaries appreciate this new feeling of influence. Conversely, the usual decision makers, such as doctors and senior managers, often relish the opportunity to include others to achieve better solutions and encourage wider ownership.

## Leadership

The success of SEA meetings depends on good facilitation and leadership. As SEA is taken up by more teams, there will be a need to develop the leaders. The traditional leaders are not necessarily the best facilitators of SEA. In one of our studies in a hospital unit, where a consultant started as chairman, the meetings were well attended by doctors but by only a few nurses. The lead was changed to a nurse manager and the meeting was immediately much more popular and effective. A similar switch from doctor to nurse had an identically beneficial effect on another ward. A newly appointed woman partner with a quietly efficient manner proved an excellent

leader of the SEA meetings in a general practice comprising a number of powerful medical personalities with little history of teamwork.

## Discussion

As well as being a force for quality improvement, SEA is also an important part of multidisciplinary continuing professional development. It identifies learning needs as well as being a means of team learning, linking to individual learning portfolios and also the revalidation process. There is also the mutual support element, which is crucial at a time of rising levels of stress.

Clinical governance and SEA are both focused on people – patients and professionals. They are both about improving care and learning together. SEA provides an important link between learning and quality improvement in a multidisciplinary setting. It is simple and enjoyable, which probably explains why it is being taken up so widely with such enthusiasm.

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## Books of interest

### Set phasers on stun and other true tales of design, technology, and human error. 2nd edn.

Steven Casey.  
ISBN: 0-9636-1788-5. US\$29.  
Santa Barbara, CA: Aegean Publishing, 1998.

This book gives a factual and highly readable account of 20 disasters that were waiting to happen.

- Bhopal 1984 – a massive gas leak, 2500 people die and tens of thousands are injured.
- The *Herald of Free Enterprise* – someone falls asleep and 188 people die.
- East Texas Cancer Center 1986 – faulty hospital equipment and several patients receive massive radiation overdoses.
- Idaho, 1961 – nuclear reactor accident kills three and injures 23.
- Baghdad – 60,000 people injured

after inadequately labelled poisoned grain is consumed.

There are 20 graphic illustrations of how poor system design, failure to build in safety mechanisms and constraints, inadequate training, lack of foresight and poor planning set people up to make errors, to fail. Casey shows how, even when retrospective investigations have identified system deficiencies and produced numerous recommendations for improvement, the collective inclination is still to blame an individual, find a head to roll.

He wisely remains an invisible narrator. In resisting the temptation to draw conclusions for his readers he moves them gently towards more powerful conclusions of their own.

Casey does indeed tell tales. His book is a superb introduction to systems awareness. It reinforces with real examples how faulty system design and woefully poor communication will lead eventually and inevitably

to disaster. It is a fascinating read, and its subplot will reinforce an understanding of the cultural changes and the new thought processes that are a prerequisite for the successful implementation of clinical governance.

### The art of systems thinking – essential skills for creativity and problem solving

Joseph O'Connor and Ian McDermott.  
ISBN 0-7225-3442-6. US\$15.  
New York: Thorsons, 1997.

O'Connor and McDermott illustrate how becoming a 'systems thinker' can change lives and organisations. Systems thinking encourages a broad view of the world. It enables a sharp focus on the real problems, the limiting factors, the blocks to improvement. It makes the interconnections within and beyond organisations and individuals explicit; it enables identi-

fiction and therefore utilisation of weaknesses, leverage points, and strengths.

Systems thinking encourages the correct analysis and interpretation of a set of measures by framing them in their wider context. It encourages generative learning where feedback adjusts mental models so that feedback and learning are both embedded in development.

The two authors illustrate each of these concepts and others with familiar references viewed through a

prism. They add interest with mental puzzles and visual exercises, and so they both explain and exploit the 'outside your box' thinking they endeavour to encourage.

We come to understand that 'a collection of parts which do not connect is not a system – it is a heap'. And, by the finish, we smile in knowing recognition at the irony that 'post mortems do not discover the secret of life, but death'.

This is a great start for anyone wanting to understand how systems

pervade our lives and our organisations. It becomes an entertaining starter manual for anyone who is prepared to rattle at the foundations of an NHS which has examined postmortem specimens for far too long at the expense of talking to its staff and listening to the patients in its beds.

**Susanna Nicholls**  
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## WhoWhatWhere?

### Clinical governance on the web

#### Government and affiliated bodies

Department of Health  
<http://www.doh.gov.uk>

National Institute for Clinical  
Excellence (NICE)  
<http://www.nice.org.uk>

Commission for Health  
Improvement  
<http://www.doh.gov.uk/chi>

The Audit Commission  
<http://www.audit-commission.gov.uk>

#### Other organisations

Institute of Healthcare  
Management  
<http://www.ihm.org.uk>

British Association of Medical  
Managers  
<http://www.bamm.co.uk>

European Health Management  
Organisation  
<http://homepages.iol.ie/~ehma/aims.html>

PCG Resource Unit  
<http://163.1.123.60/pcgru/index.html>

Cochrane Collaboration  
<http://www.cochrane.org>  
A worldwide network of researchers producing methodologically rigorous and systematic reviews of the effectiveness of health-care interventions based

### The Editors' Choice

The University of Texas – Human Factors Research Project:  
<http://www.psy.utexas.edu/psy/helmreich/nasaut.htm>

This site gives an excellent insight into the similarities and overlaps between airline flight crew and health-care workers. The site is rich in online papers, PowerPoint material and links to other very useful sites, including the fascinating anonymous critical incident reporting system for anaesthesia run by the University of Basle at: <http://www.medana.unibas.ch/ENG/CIRS/Cirs.htm>

primarily on assessments of evidence from randomised trials.

Headquarters Healthcare Quality (HQHQ) educational website  
<http://www.hqhq.org/home.html>  
HQHQ Ltd is a company providing accredited postgraduate distance learning for doctors, dentists, nurses and health-care managers.

The Wisdom Centre  
<http://www.wisdom.org.uk>  
The Wisdom project delivers networked professional development (NPD) for primary health-care, using Internet technologies for information sharing and communication. The Wisdom Centre provides virtual conferences on clinical governance.

The King's Fund  
<http://www.kingsfund.org.uk>  
This independent charity works to improve the health of Londoners. It carries out research and development work to bring about better health policies and services.

NHS Centre for Reviews and  
Dissemination (CRD)  
<http://www.york.ac.uk/inst/crd>

Centre for Health Information  
Management Research (CHIMR)  
<http://www.shef.ac.uk/uni/academic/I-M/is/lecturer/chimr.html>

Health Services Management  
Centre  
<http://spp3.bham.ac.uk/hsmc>  
This is a department of the University of Birmingham that provides graduate courses, publications and conferences for health-care managers.

### Why not email us your suggestions?

If you know of any useful websites that you would like us to mention in *Clinical Governance Bulletin* please email [kirsty.orriss@roysocmed.ac.uk](mailto:kirsty.orriss@roysocmed.ac.uk). In the next issue we will be listing the URLs of relevant publications.

# Top tips for risk management

## David Hewett<sup>1</sup> and Keith Haynes<sup>2</sup>

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We asked two people the following question:

**What are your five key tips to ensure that risk management arrangements are about improvement, not judgement?**

### David Hewett

- The first is about valuing and respecting the staff who work with patients in the NHS. Health-care staff are culturally motivated to do their best for patients. They do not come to work expecting to harm those in their care. Thus when something goes wrong they are often devastated and deeply affected by what has happened. This has to be explicitly recognised. The reiteration of errors by opinion formers and their re-emphasis in high-profile media campaigns are unhelpful.
- NHS organisations must move away from a culture of 'naming and shaming' those involved in clinical incidents. It must be clearly recognised that, because of inadequate systems, organisations often put staff into positions where errors are more likely to occur. Organisations need to become 'systems aware' so that all resource and care planning decisions are made with a wide organisational view.
- Suspension of staff from duty is not a neutral act and is not perceived as such. Exclusion, unfortunately, is often associated with guilt. Thus after an incident, and during the subsequent investigation, staff must be supported and not excluded unless the circumstances make it unavoidable.
- After an incident, the investigation has to be seen to be fair, systematic and logical, leading clearly to recommendations that

will both prevent recurrence and improve the delivery of care. Recommendations arising from an investigation must be implemented and then followed up by a formal monitoring process. The NHS has a long tradition of not 'learning its lessons'; it must learn and adapt.

- The last point is about organisational culture. The NHS has to change so that making reports on what has happened when something has gone wrong becomes a normal response. This means that chief executives and other senior trust managers have publicly and repeatedly to endorse the values needed to bring this about. Being aware of risks and taking action to prevent mistakes is everyone's business.

### Keith Haynes

- Recognise and promote risk management as a tool to improve the quality of services provided. Although risk management in health-care had its origins in the litigation crisis of the 1970s and 1980s in the United States, it soon came to be recognised as a technique for improving quality of care. If introduced and used in the right way, risk management can be a powerful tool for improving quality. Read on.
- Start by identifying your organisational/departmental risks by carrying out a risk assessment. Sit the multidisciplinary team down and identify and rate the risks, using one of the tried risk assessment tools such as that found in the Australian/New Zealand risk standards. This is really a good way of developing an awareness of those operational issues and problems that are most risky and that, if left unattended, will actually cause problems for the organisation/department at some future time. Whenever I have used this approach it has proved to be an excellent way for staff to articulate their current operational problems and to agree the steps necessary to improve things. It might be the system for the handling of test results or the need to improve the prescribing arrangements. This is risk management in action, generating the quality improvement agenda.
- Make it a regular feature of the work routine to learn from your lessons by reviewing complaints, claims and serious events. This is easier said than done in a culture that has often been about apportioning blame, but a great opportunity is missed to improve the quality of care when complaints, claims and serious events are not reviewed. Ensure that regular team meetings include this material and that each event is reviewed to identify the risks and the opportunities for improvement. If this is too sensitive, why not start by using entirely anonymised case studies to get the team thinking about areas for improvement in their own workplace? Try it sometime.
- Be careful to review the whole system. When learning from your lessons ensure that the review concentrates on the whole system issues rather than focuses on the role of particular individuals. Remember that when things go wrong it is more likely to be about errors in systems supporting individuals than about any particular part of the individual had to play.
- My final tip: effective risk management is about improving the quality of the care you provide. It can also help you reduce the number of occasions on which you think 'There but for the grace of God!' It works – try it!