

Recommended aspects to include in adverse event review report template

Background and summary	Describe the background to the adverse event including 'who, when and how' and record the resulting outcome. Use narrative to help highlight the context and conditions contributing to the event and provide meaningful insight into the nature of any underlying systems defects that caused the adverse event.
Description of review team	List job roles or grades of the members of the review team and describe the multidisciplinary approach.
Review timescales	Record review start and finish dates.
Scope and level of the review	Identify the purpose and terms of reference of the review, including key issues to be addressed. Document the methodology used. For example, review of medical records, written accounts from staff, interviews with staff, cause and effect (Fishbone) diagram, Five Whys Tool.
Patient, family, carer, donor and staff involvement	Record relevant contact with the patient, family, carer, donor or staff. For example, dates they were informed, communications, feedback provided, meetings held, any involvement within the review and what documentation was shared with them. Document any rationale for not involving the patient, family or carers.
Timeline	List dates and times of key events or actions taken in chronological order (or attach timeline as an appendix).
Care and/or service delivery issues	Document any identified issues. For example, incorrect or incomplete observations, issues with procedures not being followed, delays in treatment.
Contributory factors	Document any factors (patient, staff, task, technology, environment) which may have contributed to the event outcomes. For example, patient cognition issues resulting in communication difficulties, busy ward environment, short staffed, poor equipment design, absence of protocols, poor communication between staff.
Root causes or key issues and opportunities for improvement	Identify the factors that caused the adverse event using root cause analysis tools or methodologies.
Assessment and findings	Provide a full commentary of the adverse event and findings from the review.
Review outcome	Indicate which of the following outcomes best applies: 1. Appropriate care and/or service – well-planned and delivered, unavoidable outcome and no care and service delivery problems identified. 2. Indirect system of care/service issues – lessons can be learned but were unlikely to have affected the outcome. 3. Minor system of care/service issues – a different plan and/or delivery of care may have resulted in a different outcome, for example systemic factors were identified although there was uncertainty regarding the impact on outcome. 4. Major system of care/service issues – a different plan and/or delivery of care would, on the balance of probability, have been expected to result in a more favourable outcome, for example systemic factors were considered to have an adverse and causal influence on the outcome.
Good practice identified	Highlight any good practice identified. For example, good note keeping, appropriate patient care, procedures in place.
Recommendations	Present recommendations to address each of the root causes. These may be for local action, unit action or for the NHS board.
Lessons learned	Record the lessons identified through the review.

Arrangements for sharing lessons or learning points	Document how lessons learned will be disseminated and who the learning points will be shared with. Record the rationale for any decision not to share the learning.
Action plan development	A separate action plan should be compiled at the most appropriate level, for example by the relevant management or service team (rather than the review team) to ensure ownership. The action plan should identify the owner of each action, timescale for completion (if appropriate) and progress status. Identify how the action plan will be developed and who will be responsible for monitoring completion of actions. Record the rationale for decisions made not to produce an action plan.
Document control	Include version number and date on all versions of the review report and ensure the final version is labelled 'final'.

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