COVID-19 Care in the Community Adverse Event Review Guide

This guide is designed to support a rapid review of adverse events (AE) involving consumers and whānau receiving Covid-19 Care in the Community (CCC). It enables an understanding of the care provided with the intention of keeping consumers and whānau safe (physically, psychologically, and culturally) and avoiding hardship, while receiving care for Covid-19 in the community.

An AE is defined as an event with negative or unfavourable reactions or results that are unintended, unexpected, or unplanned.[1] In the context of CCC, this can be understood as an event that results in harm or has the potential to result in harm to a consumer or their whānau. See appendix 1 for COVID-19 Care in the Community Severity Assessment Code examples.

The rapid adverse event review template was informed by the Safety Engineering Initiative for Patient Safety (SEIPS Model),[2] a well-established process for taking a 'systems approach' in safety improvement and the Yorkshire Contributory Factors Framework.[3] It endeavours to reflect the COVID-19 Care in the Community Framework (the Framework).[4] The development of this template is iterative and anticipated to change as further information becomes available, reflecting the evolving environment of COVID-19 care requirements. We also expect the list of severity assessment code examples in appendix one to be added to, as more is understood about the process of care in the community.

Adverse event reviews are required[5] to be built on the following principles:

- **Open communication** – consumers and their whānau are ethically and legally entitled to truthful and open communication at all times following an AE. In Aotearoa New Zealand, health and disability (H&D) service providers have a legal duty to take steps to ensure that open communication is practised by staff and supported by management.
- **Consumer, whānau and care provider participation** – AE need to be considered within the context of the whole consumer and whānau experience of care. Including the consumer perspective in the review process enables a broader understanding of the circumstances surrounding an AE. It is expected that, at a minimum, consumers and whānau who have been involved in an AE will be offered the opportunity to share their story as part of the review process and that review findings and recommendations will be shared with them. Service providers should also consider involving independent consumer representatives in the review process.
- **Culturally appropriate review practice** - the cultural viewpoint and practices of a consumer and their whānau should be considered in the open communication, reporting, review and learning process.
- **System changes** - reporting is only of value if it is accompanied by meaningful analysis that leads to system changes designed to prevent recurrence of AE and near misses. Lessons learnt must be shared locally by individual H&D service

[1] https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/National_Adverse_Events_Policy_2017/National_Adverse_Events_Policy_2017_WEB_FINAL.pdf
[2] https://qualitysafety.bmj.com/content/qhc/30/11/901.full.pdf
[3] https://improvementacademy.org/tools-and-resources/the-yorkshire-contributory-factors-framework.html
[4] https://www.health.govt.nz/system/files/documents/pages/301121-covid-19-care-in-the-community-framework-dga.pdf
[5] Ibid

providers who are also strongly encouraged to share learnings with other providers and centrally with the Health Quality & Safety Commission (the Commission). The Commission's role is to share lessons learnt nationally and promote a national approach to reporting, review, and learning.

- **Accountability** – this is provided by assuring consumers, whānau and the wider community that when adverse events and near misses occur, action is taken at both the local and the national level. Action at the local level focuses on learning, improving safety and reducing the possibility of recurrence.
- **Reporting must be safe** - consumers, whānau and staff must be empowered to report adverse events and near misses without fear of retribution. Adverse events must be investigated with a focus on determining the underlying system failures and not blaming or punishing individuals. Health and disability service providers must ensure a just culture prevails, so individuals are not held accountable for system failures. Incidents that involve a criminal act, substance abuse by a health practitioner, a deliberate unsafe act or deliberate consumer harm will be managed in a separate process and may involve the relevant regulatory authorities.

Users of the rapid adverse event template will need to consider how they are meeting these principles during the review process.

Equity

When reviewing AEs, the reviewers must be mindful that in Aotearoa New Zealand, inequities in health, and in the determinants of health, are pronounced. Of concern are the large and persistent inequities experienced by Māori. The reviewers should not only consider the factors that impacted care within the health care setting or service, but also the wider socioeconomic determinants that can impact outcomes. Social determinants, such as living conditions, are a significant cause of inequity in the health and wellbeing of Aotearoa New Zealand's population. That is, they shape the wellbeing of individuals and their families/whānau and influence their outcomes. The reviewers should also consider factors that impacted on the continuum of care at individual, societal and health systems levels. Additionally, reviewers should consider how the health services may have contributed to any inequities, as well as how they may have contributed to reducing inequities. When developing recommendations, reviewers must consider how the recommendations may affect health inequalities and inequities. The Health Equity Assessment Tool [6] (HEAT) or Health Impact Assessment [7] (HIA) tool can be used to assess recommendations for their future impact on health equity.

Although some of the prompts in this guide focus on equity issues, it is not possible to list all factors that influence equity. Users of this tool will need to consider how equity of outcomes was, and can be, supported when reviewing AEs.

How to use this guide

This guide is intended to provide a rapid review of an adverse event. It is designed for events involving CCC.

Due to its rapid nature, it may not provide the same depth of learning as other review methods. If, during the gathering of information, it appears that there are issues with

[6] www.health.govt.nz/publication/health-equity-assessment-tool-users-guide
[7] www.health.govt.nz/our-work/health-impact-assessment

underlying policies and processes, as opposed to the implementation of them, then a more detailed review, such as a learning review[8], may be required.

It is important to note that whilst the rapid adverse event review template is in a 'list layout' this does not imply a linear process, rather consideration must always be given to the complexity of CCC and the interactions between all agencies.[9] This is further demonstrated in appendix 2 and the SEIPS model.

The rapid adverse event review template is designed to be used by all agencies providing CCC. It is expected that agencies will work together to carry out one review per event, and there is no expectation that events will be reviewed multiple times by different agencies. It is the responsibility of all agencies providing care to determine who is best placed to lead, and/or carry out the collaborative review.

Sharing experiences to learn

It is important that there are robust clinical quality and safety governance structures at a local and national level supporting CCC, to ensure lessons are shared and recommendations are implemented and followed up. The Commission's supplementary paper 'Initial guidance for establishment of quality and safety governance' provides guidance for district health boards, and other key stakeholders and partners, establishing local quality and safety governance for CCC. Governance ensures clear processes for:

- reporting (SAC1 & 2 to the Commission) and investigation of adverse events (AEs)
- quality systems improvement and quality assurance
- consumer and whānau engagement
- workforce oversight, support for wellbeing, and education.

[8] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/4249/
[9] 'Agencies' refers to the multiple stakeholders noted in the COVID-19 Care in the Community Framework page 6

REPORTABLE EVENT NUMBER: [*insert local event identification*]	
Consumer's name:	Location of event:
NHI Number:	Date of birth (dd/mm/year) / **Age**:
Ethnicities: Iwi affiliation:	Gender:
Date and time of event:	Primary Health provider:

REVIEW TEAM – **reflects lead care agencies involved and when an adverse event involves Māori consumers, at least half the review team should be Māori, in line with the Te Tiriti partnership.**	
Role:	**Designation:** Review Leader
Role:	**Designation:** Consumer representative
Role:	**Designation:** Māori representative Pacific representative
Role:	**Designation:** Māori representative Pacific representative
Role:	**Designation:** Team member
Date review completed: / /	

REPORT CONFIRMED AND AUTHORISED BY:			
Signature 1:		**Signature 2:**	
Name:		**Name:**	
Role:		**Role:**	
Date:	/ /	**Date:**	/ /

EXECUTIVE SUMMARY

REVIEW

a. Background- succinctly describe the event

b. System Influences

Situational Influences		
Team factors		
Individual roles and responsibilities were clearly delegated		
Multidisciplinary team referrals were made		
The model of care supported teamwork		
All required agencies were aware of roles		
Mechanisms were in place to alert staff of changes to consumer circumstances and changes in clinical pathways		
Individual staff influences		
Staff were safe to perform home visits e.g., de-escalation training provided, not expected to make face to face visits alone		
Staff had access to clinical supervision and/or debriefing services as required?		
Staff received appropriate breaks during working day, and regular rostered time off		
Task characteristics		
Staff had appropriate resources available to be able to carry out role		

The initial assessment of COVID-19 Care in the Community allocated the consumer as care level 1 or Level 2.		*Did a change in level occur?*
Consumer and whānau influences		**Comments**
There was a safe and appropriate environment to stay during isolation period		
The consumer's underlying health was good enough that they could safely isolate in the community		
The consumer's primary healthcare provider was contacted to obtain further information about the consumer's medical history if more information was required to determine the appropriateness of community care		
Toileting needs were addressed		
Communication/vision/hearing needs were addressed		
A support person was available for consumer and whānau with 24/7 contact details provided to them		
Financial and practical resources to obtain necessities such as groceries and medication was available to consumer and whānau		
Communication resources such as phone and internet access was available to consumer and whānau		
Cognitive impairment/confusion/delirium was assessed		
If not safe to mobilise independently, the consumer and whānau were provided with appropriate aides.		
Care provided met the cultural needs of consumer and whānau		
Care provided met the spiritual needs of consumer and whānau		
The consumer and whānau understood the process and could participate as required		

Information was provided to consumer and whānau in an appropriate format/language		
Consumer's consent for isolation was documented		
Other factors?		
Local Working Condition influences		
Workload and staffing issues		
Adequate staff were available to carry out tasks		
Available staff had appropriate skills and knowledge and knew how to get specialist assistance as required e.g., medical, cultural, social support		
Actual availability and skill mix of staff matched need		
A plan was in place to mitigate demand outstripping staffing resources		
Leadership, supervision, and role influences		
All agencies had a clear understanding of roles and responsibilities		
Processes were in place for handovers to ensure no loss of information or continuity of care		
A lead agency was appointed		
Delegations were appropriate		
Clear escalation pathways for concerns existed		
Medications, equipment, and supply influences		
Appropriate PPE was available for staff		
Fit testing of masks was carried out for staff		
SpO2 device was available if indicated, incl. batteries/charger/appropriate instructions (verbal and written, in an appropriate language and health literacy level)		
Medical equipment provided was suitable for consumers and whānau of all ethnicities and dids not reinforce existing inequities		
Appropriate PPE was provided for consumer and whānau use with		

appropriate instructions in terms of language and health literacy		
Cleaning supplies were provided to consumer and whānau		
Consumer and whānau were trained on use of PPE, SpO2 devices, and any other requirements in a manner that met their language and health literacy needs		
Organisational Influences		
Physical home environment		
Mitigation was in place for any hazards present (for example ability to ventilate)		
The home was assessed as suitable to isolate in		
Support from other agencies		
IT system access was provided to all who needed it		
All staff/agencies had prompt and simple access to required information		
Pathways were in place to transfer/escalate care as necessary		
Staff training and education		
Training was provided for any IT systems used e.g., training on use of the Border Clinical Management System (BCMS)		
Staff were trained in correct use of PPE		
Clinical staff were able to identify basic welfare needs		
Support staff were able to identify basic health needs		
Te Tiriti o Waitangi considerations		
Whānau were given options for their care ie access to Kaupapa Māori services if desired		
There was self-determination in service delivery for consumer and whānau ie they could shape how care was delivered		
The care plan was designed within a partnership model between providers and consumer and whānau ie the decision-making power was shared		

External influences		
Coordination of care plan		
Initial clinical assessment was undertaken to define level of care required and frequency of check-in points was adhered to		
Identified care coordinator for household was conveyed to consumer and whānau and achievable contact mechanisms were in place (see communication above in consumer section)		
Appropriate equipment was provided to consumer and whānau with verbal and active demonstration of how to use the equipment and interpret the results (if required), including information in appropriate language (e.g., pulse oximeters)		
Any equipment given to consumers and whānau was checked for functionality e.g., calibration within required timeframe		
If a pulse oximeter was used it was provided through care in community team (that is not sourced independently)		
A welfare assessment was completed, and needs provided with regular follow up and review of ongoing needs e.g., accommodation, household needs, essential needs		
National policies and guidelines		
COVID care in the community framework informed care planning		
Covid-19 case management in adult's health pathway followed		
Communication and Culture Influences		
Safety culture		
Cross agency openness to raise concerns of patient safety occurred (for example safe for patient, safe for health care providers attending the home)		
The views and experiences of involved care providers were captured in this review (work-as-done)		
What trade-offs or workarounds (adaptations) occurred to support safety to the consumer or care providers		• *What prompted the adaptation?* • *How was the need for adaptation anticipated?* • *What purpose did the adaptation serve?* • *What made it work/not work?*

Could the adaptations be helpful in the future		• *How does the adaptation relate to everyday practice?* • *Who should know about it/be involved?* • *Who will be affected?* • *Is it useful to make it standard practice?* • *Are there any risks?* • *• What would help in the future?*
Verbal and written communication		
Appropriate handover systems between healthcare agencies were available		
Huddles to share information at the beginning of day for team input and review of care took place, information was discussed with consumer and whānau as required and care plans reviewed		
A full clinical picture was able to be obtained from documentation (e.g., no non-standard abbreviations, illegible notes, inadequate documentation)		
The consumer, whānau and staff from different agencies could contact key personal as required		
Pathways were in place for inter-agency sharing of information		
There was evidence of a shared goals of care discussion and decision and transfer of this information if consumer required higher level of care		
Independent interpreting services available and used as appropriate		

c. Key Findings (determine underlying systems or process issues involved in adverse event)	
1.	
2.	
3.	

d. Additional Findings (identified as a quality issue)	
4.	
5.	
6.	

RESOLVE - **Act to help reduce the chances of it happening again**	
a. SMART Recommendations	
Finding	**Recommendations**
b. Organisational learning informed through understanding work-as-done	
Ensure learning is practical and meaningful informed from experiences and adaptations that relate to everyday practice	

Appendix 1

Adverse Events Recommendation Action Plan					
RE number:	**Service:**		**Report date:**		
Key finding	**Recommendation**	**Actions required & progress**	**Person/role responsible**	**By when**	**Date completed**
1.					
2.					
3.					

Authorising Signature (1): Date:

Authorising Signature (2): Date:

Appendix 1

COVID-19 Care in the Community (CCC) Severity Assessment Code (SAC) examples 2021–2022

This list is for guidance only. All events should be rated on actual outcome for the consumer and whānau while receiving CCC. The always report and review list 2018–2019, general SAC examples, and SAC rating and triage tool for adverse event reporting contain more guidance on adverse event reporting. It is expected that agencies will work together to carry out one review per event, and there is no expectation that events will be reviewed multiple times by different agencies. It is the responsibility of all agencies providing care to determine who is best placed to lead, and/or carry out the collaborative review.

SAC 1 **Death or permanent severe loss of function**	**SAC 2** **Permanent major or temporary severe loss of function**	**SAC 3** **Permanent moderate or temporary major loss of function**	**SAC 4** **Requiring increased level of care OR no injury, no increased level of care; includes near misses**
• Delayed recognition of consumer deterioration resulting in permanent disability or death	• Suspected suicide or serious self-harm by a consumer • Delayed recognition of consumer deterioration resulting in admission to intensive care, cardiopulmonary resuscitation and/or intubation • Eclamptic seizure within 48 hours of routine antenatal or postnatal assessment • Development of a venous thromboembolism prior to commencement of VTE prophylaxis for a high-risk pregnant woman	• Unplanned admission to hospital from community setting outside of agreed escalation pathways*	• Unplanned in-home clinical assessment outside of agreed escalation pathways • Initial clinical assessment of consumer was not completed within 48 hours of positive COVID-19 result timeframe* • Routine check-in points of consumer did not occur within 24 hours of the timeframe determined by the level of care • Consumer's manaaki, including welfare needs, identified in initial assessment.

* *COVID-19 Care in the Community Framework for Public Health, DHBs, PHOs, Providers, Social and Well-being Organisations*. 2021. Ministry of Health.

Safety Engineering Initiative for Patient Safety (SEIPS)