Adverse event reporting and management policy

This policy is for all Southern Cross Healthcare (SCH) staff, medical practitioners, and contracted staff.

It describes the responsibilities, principles and how to manage an adverse event(s) that results in harm, loss or damage to patient staff, visitor or the organisation as well as the purpose for identifying and reporting near miss events.

Prompt action is essential so that we can identify the cause(s) that we learn from these events and minimise the risk of future harm, or near misses are acted on so that a similar recurrence is avoided.

Every person has a responsibility to identify and report events and take steps to avoid any further harm.

This policy is a mandatory requirement to comply with

- Health, Quality and Safety Commission (HSQC) New Zealand National Adverse Events Reporting Policy 2017
- Health and disability sector standards NZS 8134:2021
- Health and Disability Commissioner (HDC) Code of Rights
- The Health and Safety at Work Act 2015
- Privacy Act 2020

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Definitions

Term	Definition
Adverse event ('event')	An event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned resulting in harm, loss or damage. These maybe clinical or non-clinical events and can affect a patient, staff, visitors or the organisation.
Adverse event brief (AEBs)	This is the two-part form used to transmit information about adverse events and

Term	Definition
	near misses to the Health Quality & Safety Commission. **1. Adverse events Part A submission form** is used to communicate the nature of the event. It must be sent to the National Quality and Risk Team within **25 working days** of the event being notified to enable them to notify HSQC within 30 working days of notification of the event. Part A is also used to transmit urgent information (alerts) to the Commission. **2. Adverse events Part B brief** is used to provide a summary of the review findings and recommendations related to the adverse event or near miss. It must be sent to the National Quality and Risk Team within **110 days** to enable them to notify HSQC within 120 working days of the event being reported in SafeHub.
Always Report and Review Events (ARR)	A subset of adverse events that should be reported and managed in the same way as SAC 1 and 2 rated events, irrespective of whether or not there was harm to the consumer. ARR events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems. This list is updated regularly by the HSQC
Contributory factors	The influencing and causal factors that contributed to the safety event. These factors affect the chain of events. They may be positive as well as negative, and they may have mitigated or minimised the outcome of the event. You may select more than one contributory factor**.**
Eventful cases	All events affecting patients that meet the criteria outlined in the Hospital Clinical Governance Committee (HCGC) Guidelines
Harm	Harm is an outcome with a negative effect. Harm to a person (consumers, members of staff; carers; family members, and visitors) or groups of people (including organisations) may

Term	Definition
	result from worsening of a medical condition, the inherent risk of an investigation or treatment, system failure, provider performance issues, service disruption, financial loss or adverse publicity. Adverse events will be categorised as per the harm levels in the process for the management of adverse events
Human factors	The principles and practices of human factors focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment.
Near miss	A near miss is an event that does not reach the patient, staff, visitor or the organisation because of chance, unplanned or planned intervention
Open communication	Open communication, or open disclosure, refers to the timely and transparent approach to communicating with, engaging with and supporting individuals when an event occurs.
Review	Is a formal process that is carried out by a person or team to analyse an adverse event or near miss and develop recommendations based on the findings. There are a variety of review methodologies that you can use (Yorkshire factors framework, 5 whys etc.). Reviews can be undertaken at different levels, depending on the adverse event (e.g., comprehensive, concise, or single aggregated review of similar events).
SafeHub	Is our system for reporting and reviewing adverse events and consumer feedback. Refer to Event workflow process
Severity assessment code (SAC)	Is a numerical rating assessment tool which defines the severity of harm from events and the required level of reporting and review to be undertaken. Refer

Term	Definition
	Process for management of adverse events

Roles and responsibilities

To be effective, adverse event management needs a whole of organisation approach that fosters a just culture that incorporates the following responsibilities at an organisational level

Role	Responsibility/accountability
All SCH employees	• Inform person in charge in a proper and prompt manner • Enter event into SafeHub within 24 hours or before the end of your shift • To assist in the review of any event or near miss.
Chief of Quality and Risk (CQR)	• Develops, manages, and reviews policy, systems and processes that support the implementation of this policy. • Ensures all reporting staff are aware of their responsibilities in relation to event management • Advises, supports, and approves serious event processes • Informs Chief Executive Officer (CEO) and Chief Operating Officer (COO) and as appropriate the Chair of applicable governance committees. • Assists with notification and communication to the insurer, legal and, external agencies as required. • Seeks expert advice as appropriate. • Oversees the review of moderate to severe events and that recommendations are implemented.
Chief Executive Officer (CEO)	• Authorises any communication strategy, public relations assistance, and implements Media policy and support relating to specific events.

Role	Responsibility/accountability
	• Reports events to the Board as appropriate. • Approves (or assigns delegate) AEBs being sent to the HSQC
General Managers (GMs)	• Ensures compliance with this policy at the facility. • Completes insurer notification. • Notifying for support and advice National Quality, and Risk advisor for all events that have caused severe or major harm or have the potential to and, complaints and any external agency notifications
Hospital Quality Managers (QM)	• Ensuring that the events are classed and risk assessed appropriately. Discussions with teams must be undertaken to ensure that the true harm level and risk assessment is reflected in the events. • Ensuring that all events are reviewed, investigated and closed as per this policy and its supporting guidelines. • Undertaking ad-hoc audits of closed events and monitoring improvement with compliance of this policy and procedure and ensuring that the education material is updated in line with any key findings • Escalate severe, major and always report and review events to GM and National Quality and Risk team **within 24 hours**. • Coordinates event review reports, trends and clinical indicator data and presents to relevant governance committees within expected timeframes. • Ensure that where an event follow-up has identified a risk that cannot be resolved locally, that this is recorded and managed in accordance with the Enterprise Risk Management guidelines

Role	Responsibility/accountability
	• Ensures AEBs are submitted to the NSO Quality & Risk leads as per the submission times
All managers (Clinical and non-clinical)	• Manage, monitor and review events within their areas of delegated responsibility. • Escalate any severe, major or "always report review" events immediately to QM and GM Supporting staff involved in the event and debriefing as required and offered the opportunity to access appropriate support • Ensuring that all members of their staff receive sufficient training so that they fulfil their individual responsibility Ensuring appropriate feedback mechanisms are in place to share learning with relevant staff on investigation findings and lessons learned • Ensuring the completion and implementation of any action plans arising from event review
IPC Nurse	
National Quality and Risk Advisors/Lead and Health and Safety Lead	• Provide oversight and guidance on event management. • Keep CEO, COO, Director of Nursing (DON), and hospital / National Support Office teams informed as appropriate. • Contribute and support relevant governance committee reporting as required • Submits AEBs to HSQC

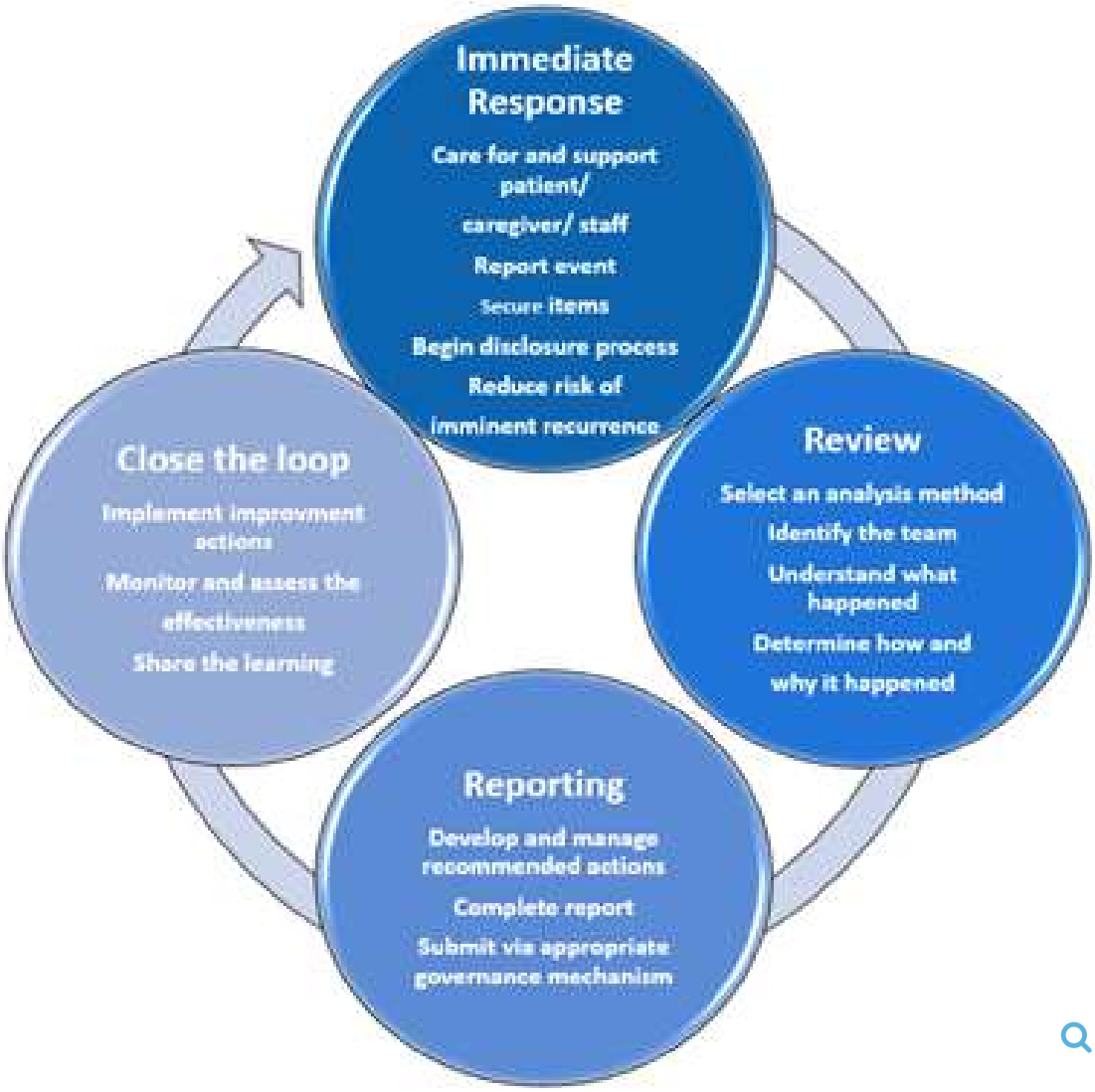
Principles of event management

Open communication	Patients and their whānau are ethically and legally entitled to truthful and open communication at all times following an adverse event. Open communication/disclosure of an event to an involved individual is expected to occur

	in a timely manner in accordance with the Guidelines for open disclosure with patients. This is an ongoing process that will typically involve the medical practitioner, hospital general manager (as appropriate) or other area manager.
Accountability	Hospitals have a duty to take reasonable care to avoid harm to patients, staff, and visitors. When harm does occur, action is taken to improve safety and reduce the possibility of reoccurrence. Action focuses on analysing trends, locally and across the network and through sharing the results and information about actions the possibility of recurrence is reduced.
System changes	Reviews will include meaningful analysis that leads to system changes to prevent recurrence of events. Implementation and evaluation of recommendations is essential. Lessons learned are to be shared across teams, hospitals, SCH network and HSQC.
Consumer participation	Consideration should be given to consumers and whānau who have been involved in an event an opportunity to share their story as part of the review process and that review findings and recommendations will be shared with them. Hospitals 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.
Just culture	Individuals must be empowered to report events without fear of punishment and will be entitled to fair treatment. Analysis and review of events focuses on identifying and correcting underlying system problems rather than focusing on an individual. This enables a culture that is supportive to quality improvement rather than a punitive approach when systems or processes break down and errors occur.

Key steps to managing an event

When an adverse event occurs, it must be reported as soon as practicable and any necessary immediate actions are undertaken to minimise harm and to reduce any further risk. The types of adverse events required to be reported can be found here



Timescale and level of review dependent on the SAC rating

Severity/SAC level	Timescale	Level of review
Severe (SAC 1) and Always Report and Review Events	70 days	Comprehensive review *(using RCA or similar methodology)*
Major (SAC 2)	70 days	Concise or comprehensive review
Moderate (SAC 3)	30 days	Concise review
Minor, Minimal and near miss (SAC 4)	30 days	Close and monitor for trends or use multi-event analysis. Near miss will depend on potential r

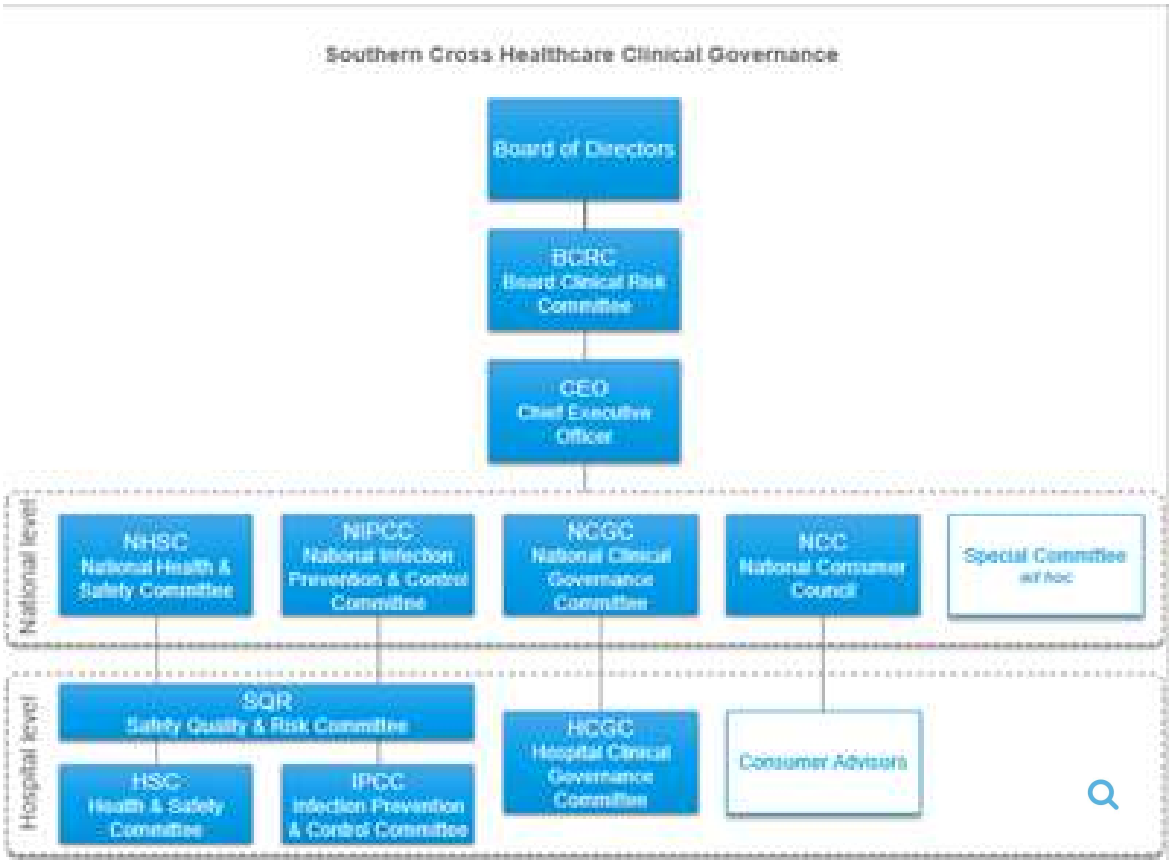
Reporting and monitoring events

To support a nationally consistent approach to reporting and learning, all SAC 1 and 2 rated events, always report and review events and near miss events where there is value for national learning will be reported to the HSQC. The process can be found in the HSQC adverse event reporting process.

National Support Office will send all forms to HSQC and the CEO (or senior delegate on their behalf) will sign off the adverse event brief: parts A and B before sending to the commission.

Adverse events are managed and improvements are monitored locally and key event learnings are shared across the network.

Clinical governance and management committees are responsible for monitoring event investigations; and clinical eventful cases to ensure investigation, management and implementation of recommendations and shared learning. National committees are responsible for overseeing and monitoring the functions of the hospital committees and hospital clinical governance processes.



References

- Clinical Incident Management Toolkit 2019, Department of Health. Western Australia

- Health, Quality and Safety Commission (HSQC) New Zealand National Adverse Events Reporting Policy
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