

January 2023

*Healing, learning and improving from harm: national adverse events policy 2023* *| Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023*

# **Sector consultation**

Thank you to everyone who took the time to provide feedback on the revised *Healing, learning and improving from harm: national adverse events policy 2023*. As part of the consultation process, we collated and considered the feedback and incorporated many of the suggestions into the final document. Overall, the new direction of the policy was well accepted, and the prologue clearly positions the policy for the new approach to harm.

# **Summary of feedback**

* The feedback supports the relational approach this policy is founded upon. However, there is acknowledgement that, at a time when the pressures on the sector are considerable, a significant culture shift, as well as leadership, resources, support and education, will be required to enact it effectively. Most respondents agree that the move to encompassing all harm will bring challenges with operationalising, especially how to quantify and review without minimising or trivialising and the potential of compounded harm for people involved.
* There was a strong wish for an extensive user guide that reflects all areas of the sector and provides guidance on how to implement the policy. Clarity will be required around specific obligations of the policy. The current version was thought to be a mix of guidance, policy statements and evidence, some of which is more appropriate for a user guide. The final policy needs to make mention of the supporting guide and the transitional period to allow providers time to build resources to support the new approach.
* There was general agreement that the eight principles provide a strong foundation and that they place consumers, whānau and equity at the centre. Comments included the need for the construct of safety versus harm and for an understanding that the issues being addressed are at the level of the individual consumer and their ‘feelings and experiences’. Care needs to be taken to ensure the policy reflects the realities of work.
* There was clear visualisation of a te ao Māori worldview weaved throughout, although guidance on enacting this would be required, particularly for smaller providers. The equity principle was well received but was thought to lack the diversity of the overall population.
* There were considerable concerns that the policy was repetitive and that some criteria were unrealistic as part of an adverse event review (eg, addressing the whānau’s social determinants of health). Many felt that descriptors for some criteria were too broad.
* Several commented on the importance of not compounding harm and of providing a safe environment for health care workers when undertaking reviews. Doing reviews across boundaries is challenging, and respondents asked how the Health Quality & Safety Commission (the Commission) would support and promote this. This requires a change in culture in, and across many organisations to allow the sharing of learning focused on a systems level.
* The use of the word ‘must’ in several places led people to wonder how this would be monitored and assessed. Clarification was also sought around the word ‘consumer’ and what was meant by an ‘independent consumer’ on a review panel. Several providers commented on the need to reword specific descriptors in some of the principles and the criteria.

***Additional feedback for specific principles***

### **Consumer and whānau participation**

Several mentioned the need to accept that involving consumers and whānau occurs within its own timeline, which often doesn’t meet the current reporting requirements. Feedback indicated the need to be mindful of consent requirements for whānau to be involved, privacy and managing data sovereignty.

Several concerns were raised about how consumer and whānau reporting of harm would occur. A request was made for a clear process for care concerns outlining how the revised policy aligns with complaints, the Health and Disability Commission, mortality reviews, the code of consumer engagement and current/future feedback methods.

People accepted the need to have specific support allocated to consumers and whānau during a review process but queried where funding and services would come from if whānau required additional ongoing support.

The focus on meeting the needs of consumers and whānau was well accepted, as was the importance of having a culturally appropriate way of responding to all people involved in the event. The need to truly understand the consumer and whānau lived experience was seen as essential.

### **Restorative practice and hohou te rongopai**

Capacity and capability will need to be increased before restorative practice and hohou te rongopai can be practically implemented and will therefore require a transition phase. Guidance is needed, including criteria for when restorative practice is used and the extent to which it is required.

There is some confusion around whether providers use restorative practice instead of or alongside a learning review and whether a learning review happens first, given the time required for restorative practice. The voluntary nature of restorative practice is late in the documents narrative, which means it initially feels mandatory.

The need for regionally or nationally funded support and access to restorative practice facilitators (restorative network) was a consistent theme in the responses. Guidance will be required on the iwi process for hohou te rongopai. The requirement to restore wellbeing may not always be achievable. The feedback suggested that, sadly – for some people who are harmed – repair across physical, psychological and relational parameters is not possible. It might be more realistic to make this an aim rather than a requirement. It was felt that much of the information, including the table, would be better placed in the user guide with only a concise description in the policy.

### **System accountability**

It would be helpful to include clear identification of the responsibilities and accountabilities of providers (across boundaries) when collaborating in the investigation and reporting of and learning from harm events or near misses.

Respondents asked how to create a culture where health care workers are safe to identify risk to prevent harm and evaluate systems, with clear lines of local and central responsibility. It was also noted that solving the issues often competes with a clinician’s ability to provide care to consumers and organisational priorities.

### **System learning**

A clear emphasis is needed to develop collaborative processes for learning that are consistent nationally and regionally. There is a need to solve local issues locally and make visible the wider issues centrally. To do so, it will be important to share both the learning and the solutions that have had a positive sustainable result.

Feedback included that a rationale for the learning review is required and asked why only the learning review or restorative practice is recommended (eg, what about the London protocol, does this mean other methods are excluded by omission?). Closed-loop follow-up is required for all those involved to assist with engagement in the process and to demonstrate that actions and improvements are achieved and sustainable long term.

### **User guide suggestions**

The feedback included the following list of suggestions to be incorporated within a user guide, which will be considered as we develop the supporting resources in early 2023:

* clear guidance on how to meet the criteria in the principles
* guidance to create national consistency on the use of the severity assessment criteria (SAC) rating tools and the creation of additional SAC rating guides
* Include a reviewed always report and review (ARR) list and extend or modify its purpose.
* clarification of the process required by providers new to the policy (particularly those outside of hospitals)
* Make readily available the national resources, education and development opportunities to support the policy.
* examples of learning reviews
* a learning report template
* simple methods for sharing learning
* generic templates to record and assist with the process
* shared tools to enable collaborative analysis across boundaries
* guides for the primary sector and how general practitioners are expected to enact it
* The user guide needs to contextualise the response to different levels of harm
* equity tools (Māori and Pacific peoples)
* cultural guidance for when meeting with families, for example, a hui process
* guidance on how complaints and harm overlap and how to bring the two processes together
* restorative practice training information.
* information on micro-credentialling and how it will be sourced and funded
* a nationally developed suite of ‘investigation science’ tools (incorporating safety science, facilitation skills, restorative practice, data analysis, human factors, and so on)
* links to support around privacy issues.

### **Other suggestions**

* Grow a learning culture by sharing learnings through national forums, conferences and clinical networks
* What will be available nationally to share learnings: thematic analysis, open books? A learning repository
* a consistent place to access what learning is coming out of relevant reviews nationally
* a nationally developed suite of ‘investigation science’ tools (incorporating safety science, facilitation skills, restorative practice, data analysis, human factors, and so on)

# **Response to feedback**

As a result of the feedback received through the consultation period, the following changes were incorporated in the final policy document that was presented to the Commission’s board.

* The language for specific criteria and some descriptors was simplified or corrected to improve clarity and context.
* Repetition was removed.
* The definition of harm was reworded for clarity.
* Some of the wording around evidence and guidance was transferred for use in the user guide.
* Aotearoa New Zealand’s population was more clearly articulated to be culturally responsive to all.
* the consumer and whānau were prioritised and the need for enabling the psychological safety of health care workers to prevent compounded harm highlighted.
* Specific expectations/obligations within the criteria were clarified.
* Timeframes of reporting were changed for both part A and part B.
* The definitions were changed to reflect words used in the policy, and rationale was provided around the use of the word ‘consumer’, recognising that different specialties and health services use different terminology.
* The terminology around ‘good catch’ was removed, and a greater focus on ‘near misses’ was applied.
* The sub criteria in the equity section regarding the social determinants of health were removed and the remaining text simplified so the scope of every review is not unrealistically widened.
* Wording around ‘out of scope’ was changed to include separate consideration of the Employment Relations Act 2000 and the Health and Safety at Work Act 2015.
* Clarification was added to note that the Commission recommends the learning review but does not preclude other review methods.
* The SAC definitions were modified to reflect harm and decrease ambiguity.

Future activities will include:

* substantial work in early 2023 to develop the example guidance for different specialties as part of the user guide
* re-evaluating how the ARR list works and what is essential to capture
* developing a tracer audit tool to be used by the Ngā Paerewa Health and Disability Services Standard auditors and by providers to evaluate their review process to ensure it meets the criteria
* developing a process flowchart as part of the user guide
* redesigning the part A and Bs in collaboration with representatives from the sector
* revising the adverse events learning programme to include the concepts described in the 2023 policy (this will be in place from July 2023).

The policy will become active on 1 July 2023. However, before this, the Commission will communicate and undertake socialisation activities with the sector. Providers should understand that there is a caveat for a transitional period during the 2023/24 year. This includes an expectation around the implementation of restorative practice, allowing a 5-year transition period to grow capacity and capability.

The Commission team are communicating with Te Whatu Ora and Te Aka Whai Ora regarding the requirements of the policy to ensure it matches new national expectations. The need for and resourcing and a consistent single computer software system, as highlighted by those in the sector, as potential barriers to effective implementation of the revised policy.

The Commission team has met with the groups undertaking the national feedback policy work to help ensure wording is consistent between the policies. The Commission is also collaborating with Te Ngāpara Centre for Restorative Practice to facilitate scholarships for professionals to undertake micro-credentialling and a pathway to accreditation.