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**Quality check for adverse event analysis (SAC 1 and 2)**

***Purpose: To help providers critique their own adverse events reviews to improve the quality of review processes and learning from adverse events.***

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| **Component** | **Criteria definition** | **Yes/No/N/A** | **Comments** | **Rationale for criteria** |
| Methodology used | Systematic analysis method/type used, eg, root cause analysis, London protocol, serious event analysis, critical systems analysis.  Human factors framework utilised.  Other review used, eg, mortality and morbidity review. |  |  | The National Adverse Events Reporting Policy 2017, section 8.4, page 5 states that formal review is undertaken for SAC 1 and 2 rated adverse events.[[1]](#footnote-1)  The human factors categories, such as communication, training, fatigue, scheduling, environment, rules, policy and barriers, help to identify the human interaction that may have contributed to the patient harm.[[2]](#footnote-2) |
| Open disclosure | Patient and family/whānau are informed of and offered the opportunity to provide information to the review team.  Timeframe for sharing outcome of review is provided.  The report offers an apology and condolences if death has occurred. |  |  | Timely information is crucial and demonstrates respect to patients, families and whānau.[[3]](#footnote-3) |
| Patient profile | Patient details are documented:   * age * sex * medical history * ethnicity. |  |  | Details such as age, comorbidities, past history of falling are important in considering both risk and actions. |
| The analysis team | Evidence of analysis being conducted by an appointed team.  A person from the area where the adverse event occurred is on the team.  A consumer representative is on the team.  Composition of the analysis team is multidisciplinary and does not include those involved in the adverse event. |  |  |  |
| Chronology of what happened | Evidence of a timeline/sequence of events, including:   * documented care * interview information * clinical letters and other electronic records * patient/family/whānau input. |  |  | A common problem with root cause analysis failure is that the facts are not established before the root cause is decided upon.[[4]](#footnote-4) |
| Depth of the analysis | Evidence that staff have been interviewed; if they have not been interviewed, it should be noted in the report.  Evidence that the patient/family/whānau have been interviewed; if they have not been interviewed it should be noted in the report.  Evidence all relevant documents have been accessed.  References to indicate current best practice evidence is noted.  Expert opinion, if obtained, is noted. |  |  | A common problem is the failure to establish all the facts including witness interviews and the patient/family/whānau view.  The team must review and interpret all sources of information and interview all relevant staff involved in the event (with their permission).[[5]](#footnote-5) |
| Identification of contributing factors | Contributing factors (including human factors)[[6]](#footnote-6) are identified and documented in the report. |  |  | The examination of contributing factors helps the team understand the underlying system causes of the incident and ultimately make decisions about recommendations.[[7]](#footnote-7)  The contributing factors must be identified to understand why the event occurred. |
| Recommendations | Recommendations have been proposed. |  |  | The more recommendations, the less likely they are to be implemented.[[8]](#footnote-8)  Generally fewer than five recommendations should be made. |
| Measurability | The report states how the implementation of the recommendation will be measured. |  |  | There is no point having a recommendation that is not measurable because the service provider and patient/family/whānau will not know whether the change has made a difference or will help prevent the event occurring again.[[9]](#footnote-9) |
| Accountable person assigned | The report states who is the accountable person for the implementation and evaluation of the recommendations. |  |  | It is essential to link the recommendations to an accountable position.  Assigning an accountable person will increase the likelihood of the recommendation being implemented and evaluated. |
| Timeframe for action | The report states the timeframe for recommendations to be actioned. |  |  | Provides timeline for the accountable person and for auditing the implementation and effect of the recommendations. |
| The strength | Are the recommendations easy to implement?  Are the recommendations strong enough/have enough impact to make a difference?  *See* [*Appendix 1: Effort vs impact tool*](#Appendix1)*.[[10]](#footnote-10)* |  |  | The stronger the action, the more likely it is to work. The weaker the action, such as writing a policy or training staff, the less effective it will be in preventing a similar event occurring again.[[11]](#footnote-11) |
| Contributing factors inform recommendations | The recommendations address the contributing factors and root causes identified. |  |  | The recommendations must target the problems/factors needed to be addressed for the patient (the root cause of the event).  There is no point having a recommendation that will not make a difference for the individual patient, or for future patients. |
| Format of final report | Is the report formatted for sharing with others such as the Health Quality & Safety Commission, Health and Disability Commissioner, Coronial Services, other staff and the patient/family/whānau?  Is it de-identified of staff and patient details (unless the patient, family or whānau chooses to be identified)?  Is the language at a level suitable for all to understand, that is, free of medical terminology and in plain English? |  |  | A report that tells a real story and can stand alone and be shared is a powerful learning tool.  If set out to be shared, a report can provide one source of information and save time in writing reports for all those who request a copy.  Most importantly, a report shows respect to the patient/family/whānau involved and commitment to recording and learning from patient harm. |
| Patient/family/whānau | Has the patient/family/whānau been offered the opportunity to:   * provide further information to the team * provide comment on the draft review and final review report?   Is there a plan to communicate progress with implementing the recommendations? |  |  | The patient/family/whānau story should be given equal consideration with provider perspectives in analysis of the adverse event.  It is important to close the loop by implementing the recommendations and informing the patient/family/whānau.[[12]](#footnote-12) |

**Appendix 1: Effort versus impact tool**

**LOW IMPACT**

**HIGH EFFORT**

**HIGH IMPACT**

**LOW EFFORT**

**BEST**

1. Health Quality & Safety Commission. 2017. National Adverse Events Reporting Policy 2017. Wellington: Health Quality & Safety Commission. URL: [www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy](http://www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy) (accessed 30 May 2018). [↑](#footnote-ref-1)
2. Dekker S. 2011. *Patient Safety: A Human Factors Approach*. CRC Press. [↑](#footnote-ref-2)
3. Queensland Health. 2014. *Best practice guide to clinical incident management.* Fortitude Valley, QLD: Queensland Health. URL: <https://clinicalexcellence.qld.gov.au/sites/default/files/2018-01/clinicalincidentguide.pdf> (accessed 30 May 2018) [↑](#footnote-ref-3)
4. *Ibid.* [↑](#footnote-ref-4)
5. *Ibid.* [↑](#footnote-ref-5)
6. Dekker S. 2011. *Patient Safety: A Human Factors Approach*. CRC Press. [↑](#footnote-ref-6)
7. Queensland Health 2014, *op. cit.* [↑](#footnote-ref-7)
8. *Ibid.* [↑](#footnote-ref-8)
9. *Ibid.* [↑](#footnote-ref-9)
10. *Ibid.* [↑](#footnote-ref-10)
11. Dekker S. 2002. *The Field Guide to Human Error Investigation*. England: Ashgate Publishing Limited. [↑](#footnote-ref-11)
12. Queensland Health 2014, *op. cit.* [↑](#footnote-ref-12)