**Adverse**

**Events**

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| Introduction | | | | |
| **Purpose**  **Te whāinga** | The purpose of this document is to:   * Continually improve the quality and safety of services provided to tāngata whai ora/tāngata whaikaha, their whānau/family and the health care workers we employ. * Guide us for using ‘learning review’ and quality improvement approaches to strengthen the safety of our systems. * Comply with the requirements of Ngā Paerewa, health and disability services standard 2021. | | | |
| **Scope**  **Tiro whānui** | This document applies to:   * The health and disability (mental health and addiction) services we provide. * All harm or near miss events that occur, or have the potential to occur to:   + tāngata whai ora/tāngata whaikaha   + whānau/families   + health care workers. * Events that occur because of, or related to, the provision of health and disability services. | | | |
| **Policy** | As recommended by Te Tāhū Hauora – Health Quality and Safety Commission (HQSC) we implement the approach of restorative practice or houhou te rongo when reviewing adverse events. This is essential to learn, heal and improve. Those approaches are relational rather than risk focused.  Our adverse event document and practices align with Te Tāhū Hauora (HQSC) National Adverse Events Policy 2023.  We set up the system to report SAC 1 and SAC 2 events to Te Tāhū Hauora (HQSC) in line with the [Policy user guide](https://www.hqsc.govt.nz/resources/resource-library/user-guide-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-a-motu-mo-nga-mahi-tukino-2023/) or negotiate with Te Tāhū Hauora (HQSC) an alternative reporting process. | | | |
| **Definitions of adverse events** | | | | |
| **Adverse event** | An event in which a person (tangata whai ora/tangata whaikaha) receiving health care experienced harm. | | | |
| **Always report and review (ARR) events** | Events that are reported and reviewed regardless of whether the person was harmed in order to:   * Identify areas of concern. * How safe the systems we have in place are. * Improve systems and service delivery.; | | | |
| **Harm** | Negative consequences for tāngata whai ora/tāngata whaikaha and/or whānau during provision of healthcare:   * Arising from or associated with treatment/intervention/care plans made. * Actions taken or omissions. | | | |
| **Types of harm** | **Physical** | **Psychological** | **Cultural** | **Spiritual** |
| **Harm causing:** | *bodily injury* | *emotional trauma* | *marginalization of*  *tangata whaiora/tangata whaikaha and/or whānau belief and values* | *spiritual distress* |
| *impairment* | *behavioral change* | *impaired ability to experience meaning in life through connectedness with self, others, te ao Māori, world, universe, or a superior being* |
| *disease* | *physical symptoms* |
| **Limitation in:** |  |
| *cognitive functioning and skills* |
| *social and self-care skills* |
| *communication* |
| **Near miss** | An event that, under different circumstances, could have caused harm but did not. | | | |
| **Definitions of adverse event related processes** | | | | |
| **Healthcare workers** | The people employed or contracted by a health or disability provider involved in providing care. This includes clinical and non-clinical staff, and regulated and non-regulated workers. | | | |
| **Houhou te rongo** | Peacemaking from a te ao Māori world view. This process addresses harm by restoring mana, power, authority, and tapu of people and their relationships. | | | |
| **Learning review** | A process designed to explore the system contribution to incidents and to relate the resulting learning products to normal work operations. The process is designed to review negative outcome events and has also been used to understand the pressures and conditions that constitute normal work. | | | |
| **Psychological safety** | A shared belief that a person (tangata whai ora/tangata whaikaha, whānau, health care worker) will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes. | | | |
| **Restorative practice** | A voluntary relational process where all those affected by an adverse event come together in a safe and supportive environment. With the help of skilled facilitators, participants speak openly about what happened. This process facilitates the understanding of the human impacts and clarifies responsibility for the actions required for healing and learning. | | | |
| **Tāngata whai ora/tāngata whaikaha** | Anyone who has used, or is currently using, or is likely to use a health or disability service. [Tāngata whai ora: This term is used to refer to people who are the subject of care, assessment and treatment processes in mental health. 'Tangata whai ora' means 'a person seeking health'(Mason Dury).]  [Tāngata whaikaha: Tāngata whaikaha means people who are determined to do well, or is certainly a goal that they reach for (Maaka Tibble). This term replaces the term ‘disability’.] | | | |
| **Whānau/family** | The nuclear family, extended family or family group of people who are important to tangata whai ora/ tangata whaikaha who receive our service. It includes partners, friends, guardians or other representatives or supports chosen by tangata whai ora/ tangata whaikaha. | | | |
| **Acknowledgement:** All definitions have been taken from Te Tāhū Hauora HQSC. [National Adverse Events Policy (2023)](https://www.hqsc.govt.nz/resources/resource-library/national-adverse-event-policy-2023/)/ with the exemption of tāngata whai ora and tāngata whaikaha. | | | | |
| **Resources** | | | | |
| **Documents** | National Collaborative for Restorative Initiatives in Health. [He maungarongo ki ngā iwi: Envisioning a restorative health system in Aotearoa New Zealand (2023)](https://www.hqsc.govt.nz/resources/resource-library/he-maungarongo-ki-nga-iwi-envisioning-a-restorative-health-system-in-aotearoa-new-zealand/) | | | |
| Te Tāhū Hauora HQSC. Healing, learning and improving from harm. National Adverse Events Policy 2023. [Policy user guide](https://www.hqsc.govt.nz/resources/resource-library/user-guide-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-a-motu-mo-nga-mahi-tukino-2023/).  Note: This document ‘ Adverse Events’ was adapted using the above publication by Creative Commons License CC BY-NC 4.0 <https://creativecommons.org/licenses/by-nc-sa/4.0/>. The changes made relate to terminology, consistency of processes and the relevance to NGO mental health, addiction and disability providers. | | | |
| Te Tāhū Hauora HQSC. [National Adverse Events Policy (2023)](https://www.hqsc.govt.nz/resources/resource-library/national-adverse-event-policy-2023/)/Te kaupapa here ā-motu mō ngā mahi tukino. | | | |
| Te Tāhū Hauora HQSC. [Learning from harm programme restorative responses workbook (June 2023).](https://www.hqsc.govt.nz/resources/resource-library/learning-from-harm-programme-restorative-responses-workbook/) | | | |
| **Video** | [Healing, learning and improving from harm.](https://www.hqsc.govt.nz/resources/resource-library/pou-hihiri-pou-o-te-aroha-healing-and-learning-from-harm/) | | | |
| **Training** | Te Tāhū Hauora [HSQC. Learning from harm education 2023/2024.](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/system-learning/education/learning-from-harm-education/)  [Restorative practice.](https://www.hqsc.govt.nz/our-work/system-safety/restorative-practice/education/)  [Understanding co-design.](https://www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/co-design/)  [LearnOnline Health](https://learnonline.health.nz/totara/catalog/index.php)  We provide training in the adverse event review processes to our lived experience leaders/advisors, whānau advisors and a group of selected staff. | | | |

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| **Managing process related issues** | | |
| **Complaints**  Exclamation Mark Images – Browse 213,362 Stock Photos ... | Fortāngata whai ora/tāngata whaikaha, whānau, or the general public the only avenue for expressing concerns of harm is often through the complaints process.  When we receive a complaint that clearly shows that harm has occurred, we will manage it as an adverse event not as a complaint. | |
| Principles **- Nga matapono o nga kaupapa here – that inform the adverse event management processes** | | |
| Our organisation has contextualized those principles in our Adverse Events policy/procedure in order to be appropriate for a NGO mental health and addiction services environment. | | |
| [Tāngata whai ora/tāngata whaikaha and whānau participation](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/consumer-and-whanau-participation/)  For details: Refer to standard 1 criteria in the National Adverse Events Policy | | [Culturally responsive practice](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/culturally-responsive-practice/)  For details: Refer to standard 2 criteria in the National Adverse Events Policy |
| [Equity](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/equity/)  Refer to standard 3 criteria in the National Adverse For details: National Adverse Events Policy | | [Open communication](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/open-communication/)  Refer to standard 4 criteria in the National Adverse For details: National Adverse Events Policy |
| [Restorative practice and restorative responses/houhou te rongo](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/restorative-practice-and-hohou-te-rongo/)  Refer to standard 5 criteria in the National Adverse For details: National Adverse Events Policy | | [Safe reporting](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/safe-reporting/)  Refer to standard 6 criteria in the National Adverse For details: National Adverse Events Policy |
| System accountability  For details: Refer to standard 7 criteria in the National Adverse Events Policy | | System learning  For details: Refer to standard 8 criteria in the National Adverse Events Policy |

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| The process of reporting, healing, learning and improving from harm | | | | | | |
| **Mental Health restorative, just and learning culture framework - overview**  *(Adapted from Dr. Kathryn Turner and team, Metro North Mental Health, Brisbane, Australia 2023)* | | | | | | |
| Setting the safety culture: Building respect and trust, learning, systems improvement, resilient healthcare. | | | | | | |
| How can harms and relationships be repaired? How can we mitigate the risk of harm in the future? | | | | | | |
| **Who is hurt and what are their needs? Who is responsible for meting their needs?** |  | **Immediate response**  **(healing)** | | **Review process**  **(learning)** | **Formal open disclosure**  **(healing)** | **Implement and evaluate**  **(improving)** |
| **Tangata whai ora/tangata whaikaha or whānau** | Disclosure by health care worker or tangata whai ora/tangata whaikaha or whānau:  Supportive open dialogue | Offer support  or refer | Meet with tangata whai ora/tangata whaikaha and/ or whānau.  Find out if restorative response or hohou te rongo meets their needs  To gain their account.  Their questions for the review group.  Their ideas for improvement.  Or  Participate in the review group that applies a restorative response or houhou te rongo. | Formal open disclosure  (facilitated, supportive).  Participate in restorative response or houhou te rongo)  Agree and document actions going forward). | Evaluation of experience.  Monitor improvement. |
| Provide infor-  mation |
| **Service** | Immediate action for safety.  Organisational response to those affected (health care worker disclosure, service response, peer response).  Determine urgency.  Identify stakeholders. | | Facilitate the review.  Learning review for SAC 1 and SAC 2.  Use restorative response or houhou te rongo.  Review service delivery.  Identify service improvements. | Use restorative response or hohou te rongo.  Facilitate formal open disclosure.  (Supportive, open dialogue, apology.)  Agree and document actions going forward. | Define accountability to implement recommendations.  Evaluate impact of implementation.  Share lessons across the service.  Monitor improvement. |
| **Health-**  **care**  **worker** | Health care worker disclosure of event.  Receive support.  Identify immediate safety issues to be addressed. | | Participate in the review group.  Participate in restorative response or houhou te rongo.  Give their account.  Look for opportunities to improve system. | Formal open disclosure. (Facilitated, supportive, open dialogue.)  Agree and document actions going forward. | Participate in the improvement process. Implement recommendations. Assist in sharing lessons.  Monitor improvement. |

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| Systems activities | | | | |
| **We set up organisational systems to support the reporting, healing, learning and improving from harm kaupapa (policy, process).** | | | | |
| **Organisational**  **culture:** | Events that are reported and reviewed regardless of whether the person was harmed are informed by:   * Understanding the power dynamics that exist between tāngata whai ora/tāngata whaikaha/whānau and health/disability care providers. * Understanding the power dynamics that exist between management and health care workers. * We work to address those power dynamics throughout the reporting, healing, learning and improving from harm processes identified in this document. * Keeping stories of the consumer experience at the heart of our work. | | | |
| **Partnering:** | * We partner with organisations that have restorative practice practitioners. * We consider supporting a staff member to become a restorative practice practitioner and share this resource with other providers. * We participate in the development of restorative practice networks for the mental health, addiction sector through existing networks (for example Platform Trust). * We engage with our existing Māori networks to ensure our adverse event processes are equitable and houhou te rongo is practiced. * We engage with our existing Pasifika community networks to inform our adverse event processes and restorative practices. * We establish networks with cultural and/or ethnic networks in our community to inform our adverse event processes and restorative practices. * We partner with organisations that are willing to share lived experience advisors and whānau advisors. * We engage with our IT provider to ensure that our electronic adverse event records capture the requirements identified in this policy/procedure. | | | |
| **Provision of information about adverse event processes** | **Tāngata whai ora/Tāngata whaikaha Whānau** | | | |
| **When** | | **How** | |
| **Examples:**   * At service entry. * During orientation to our service. * At Tāngata whai ora/ Tāngata whaikaha meetings. * When a harm or near miss event is reported. * At opportunities that represent themselves. | | **Examples:**   * Kōrero mai (talk to me). * In writing. * In the preferred language. * With people of their choice. * Included in our services information pack. * On our website. * On our social media site. * We provide access to Te Tāhū Hauora HQSC [website](https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/consumer-and-whanau-participation/). * [Video](https://www.hqsc.govt.nz/resources/resource-library/pou-hihiri-pou-o-te-aroha-healing-and-learning-from-harm/) and multimedia. * We provide access to training via <https://learnonline.health.nz/>. | |
| **Health care workers** | | | |
| **When** | | **How** | |
| **Examples:**   * During induction – on-boarding. * At staff meetings. * When a harm or near miss event is reported. * During supervision. * During ongoing training. * At opportunities that represent themselves. | | **Examples:**   * Having access to this policy/procedure. * Completing relevant learning/training modules provided by Te Tāhū Hauora -HQSC. * Discussions with colleagues. * [Video](https://www.hqsc.govt.nz/resources/resource-library/pou-hihiri-pou-o-te-aroha-healing-and-learning-from-harm/) * We provide access to training via <https://learnonline.health.nz/> | |
| **On-going Education** | * Lived-experience and whānau advisors that participate in adverse event processes complete the relevant training in adverse event reporting and the process of healing, learning and improving from harm. * Our workforce involved in reporting, reviewing and investigating adverse events complete training on how to engage tāngata whai ora/ tāngata whaikaha and whānau in the processes of healing, learning and improving from harm. * We offer coaching and mentoring to tāngata whai ora/ tāngata whaikaha involved in the reporting and review process. | | | |
| **Monitoring** | Our quality lead:   * Initiates a yearly audit on the implementation of the adverse event processes. * Identifies trends of adherence and non-adherence to the processes. * Identifies if the measures taken to heal, learn and improve have had the anticipated outcomes. * Identifies if the reporting processes are adequate. * Initiates a review of this policy/procedure and practices if the audit indicates this is necessary.   Our service lead:   * Ensures feed-back/comment is sought from the participants of the healing, learning and improvement processes. * Initiates that the result of the feed-back is collated, analysed and trends are identified. * Initiates any healing, learning or practice process improvements if indicated. * Completes the wider and statutory notification requirements. | | | |
| **Records** | * We keep a record of the adverse events and near misses. * We keep a record of each contact with tāngata whai ora/ tāngata whaikaha and whānau. * We keep minutes of meetings related to the healing, learning and improvement processes. * Action plans resulting from reviews will include time frames and accountabilities. | | | |
| **Restorative inquiry**  **(**[Restorative responses workbook](#_Resources)**)** | **Examples and comparison of questions asked during the adverse event reviews vs restorative inquiry:** | | | |
| ***Traditional adverse event review*** | ***Restorative practice*** | | ***Houhou te rongopai*** |
| *What happened?* | *What happened?* | | *What is the reality? (pono)* |
| *How and why did it happen?* | *Who has been hurt and what are their needs?* | | *What is right? (tika)* |
| *Who is culpable and/or what was the intent of the individuals involved?* | *Who is responsible and what are their obligations?* | | *What is compassionate? (aroha)* |
| *What can be done to reduce the likelihood of recurrence and make health care safer?* | *How can harms be repaired and relationships be made right again?* | | *How can we restore diminished mana and tapu? (utu)* |
| *What was learned?* | *How can we prevent it from happening again?* | | *What will it look and feel like to be free of this harm from now on? (whakawātea)* |
| We implement restorative responses and houhou te rongopai inquiry for events that are reported and reviewed regardless of tangata whai ora/tangata whaikaha being harmed. | | | | |

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| SAC 4 - minor safety issues – processes  |  |  |  |  | | --- | --- | --- | --- | | Includes near misses. | Requires little or no intervention. | Minor treatment | Can be physical, psychological, cultural or spiritual | | | | | | | | | | |
| 1. **Event or near miss reported/disclosed by:** | | | | | | | 1. **Response within 24 hours by : enter text** | | |
| Tangata whai ora/ tangata whaikaha /whānau   * Verbally or in writing. | | Health care worker   * Make entry into our adverse events/incidents template. | | | | | * Ensure immediate safety actions have been implemented. * Assess report/disclosure – give preliminary SAC rating. * Thank the person who reported. * Listen to their concerns. * Discuss with tangata whai ora/ tangata whaikaha their immediate needs. Respond. | | |
| 1. **Within 48 hours of reviewing the report/disclosure enter text** : | | | | | | | 1. **Within a week of the report/disclosure enter text** | | |
| * Engage with tangata whai ora/ tangata whaikaha (and if appropriate with whānau) and the health care worker being involved in the event or near miss experience to discuss if a restorative response review or hohou te rongo would meet their needs. * Explain that the purpose of this process is to learn from what has happen. * Inform them that they can bring support to the meeting. * Provide tangata whai ora/ tangata whaikaha (and if appropriate whānau) with contact details if they want to talk at some other time about what happened.   If indicated, for near miss events use the following processes:   * Collect information on trends and review the near misses as clusters. | | | | | | | Options:  Facilitate a meeting with   * Tangata whai ora/ tangata whaikaha /whānau and the health care worker (and their supports) and/or the health care team.   Principles and processes at the meeting:   * Participants speak about their experience. * Apply restorative principles or use houhou te rongopai if Māori participate. * Discuss and agree on SAC rating. * Agree on what has been learned. * Develop learning and sustainable actions for improvement. Include time frames and responsibilities. | | |
| 1. **Examples of other actions taken:** | | | | | | | 1. **Outcome processes monitored by enter text** | | |
| * Initiate extra investigations or observations. * Do a file review. * Provide minor treatment: physical, psychological, cultural or spiritual. | | | | | | | * Open disclosure is applied. * All contact with tangata whai ora/ tangata whaikaha and/or whānau is on record. * Minutes of meetings are taken. * The learning and sustainable actions for improvement plan is monitored for implementation at least monthly (quality, staff, tāngata whai ora/tāngata whaikaha meetings). * Fully complete our adverse event/near miss record. | | |
| SAC 3 – moderate - processes  |  |  |  | | --- | --- | --- | | Harm causing short-term loss of function and/or requiring minimal additional intervention: | | | | Not related to natural course of illness or treatment. | Differs from immediate expected outcome of care. | Can be physical, psychological, cultural or spiritual. | | | | | | | | | | |
| 1. **Event reported/disclosed by:** | | | | | | 1. **Immediate response by: enter text** | | | |
| Tangata whai ora/ tangata whaikaha /whānau   * Verbally or in writing. | Health care worker   * Notify **enter text** immediately. * Make entry into our adverse events/incidents template. | | | | | Ensure immediate safety actions have been implemented. For example:   * Apply first aid. * Visit the GP. * Contact the clinical responsible mental health team and follow their instructions. * Take tangata whai ora/ tangata whaikaha to the Accident/Emergency clinic. * Access psychological, cultural and spiritual support. * Call the Ambulance. * Inform whānau – if consent is given. * Discuss with tangata whai ora/ tangata whaikaha or nominated contact person their immediate needs. * Assess the report/disclosure. Give preliminary SAC rating. | | | |
| 1. **Within 24 hours of the event enter text** : | | | | | | 1. **Within a week of the event enter text** | | | |
| * Engage with tangata whai ora/ tangata whaikaha (and if appropriate with whānau) and the health care worker being involved in the event to discuss if a restorative response review or hohou te rongo would meet their needs. * Invite them to the review. * Explain that the purpose of this process is to learn from what has happen. * Inform them that they can bring support to the review. * Provide tangata whai ora/ tangata whaikaha (and if appropriate whānau) with contact details if they want to talk at some other time about what happened. | | | | | | Facilitate a review of the adverse event with:   * Tangata whai ora/ tangata whaikaha /whānau and the health care worker and/or the health care team.   Principles and processes of the review:   * Apply restorative principles or use houhou te rongopai if Māori participate. * Participants speak about their experience. * Discuss and agree on SAC rating. * Agree on what has been learned. * Develop learning and sustainable actions for improvement. Include time frames and responsibilities. | | | |
| 1. **Outcomes monitored by enter text** | | | | | | | | | |
| * Open disclosure is applied. * Contact with tangata whai ora/ tangata whaikaha and/or whānau is on record. | | | | | | * The learning and sustainable actions for the improvement plan is monitored for implementation at least monthly (quality meetings, staff meetings, tāngata whai ora/tāngata whaikaha meetings). * Fully complete our adverse event record. * Complete statutory notification as required. | | | |
| SAC 2 –major - processes  |  |  |  | | --- | --- | --- | | Harm causing major loss of function and/or requiring significant intervention. | | | | Not related to natural course of illness or treatment. | Differs from immediate expected outcome of care. | Can be physical, psychological, cultural or spiritual. | | | | | | | | | | |
| 1. **Event or near miss reported/disclosed by:** | | | | | 1. **Immediate response by: enter text** | | | | |
| Tangata whai ora/ tangata whaikaha /whānau   * Verbally or in writing. | Health care worker   * Immediately notify **enter text** * Make entry into our adverse events/incidents template | | | | Ensure immediate safety actions have been implemented. For example:   * Apply first aid. * Call the Ambulance. * Call the mental health crisis team. * Notify clinical lead, Board chair, whānau (if consented). * Thank the person who reported. * Listen to their concerns. * Attend (for example de-brief) to the needs of the people having witnessed the event. * Assess the report/disclosure. Give preliminary SAC rating. | | | | |
| 1. **Within 12 hours of the event: enter text**: | | | | | 1. **Within a week of the event enter text** | | | | |
| * Engage with tangata whai ora/ tangata whaikaha (and if appropriate with whānau) and the health care worker being involved in the event to discuss if a restorative response review or hohou te rongo would meet their needs. * Whānau to nominate contact person. * Explain that the purpose of this process is to learn from what has happen. * Inform them that they can bring support to the meeting. * Provide tangata whai ora/ tangata whaikaha (and if appropriate with whānau) with contact details if they want to talk at some other time about what happened. * Access psychological, cultural and spiritual support for those affected by the event. * Carry out a de-brief. | | | | | Options:  Facilitate a review of the adverse event with:   * Tangata whai ora/ tangata whaikaha /whānau, the health care worker disclosing the event and any other stakeholders that have been identified (Examples: Lived experience advisors, whānau advisors, cultural practitioners, other service providers).   Principles and processes at the meeting:   * Participants speak about their experience * Use restorative principles or use houhou te rongopai if Māori participate * Discuss and agree on SAC rating. * Agree on what has been learned. * Develop learning and sustainable actions for improvement.   Learning review:   * If the review needs to address complex issues or clusters of events. * If learning review: complete the template (Appendix). | | | | |
| 1. **Outcomes monitored by enter text** | | | | | | | | | |
| * Open disclosure is applied. * Contact with tangata whai ora/ tangata whaikaha and/or whānau is on record. * Complete statutory notification as required. | | | | | * The learning and sustainable actions for the improvement plan is monitored for implementation at least monthly (Board meetings, quality meetings, staff meetings, tāngata whai ora/tāngata whaikaha meetings). * Fully complete our adverse event record. | | | | |
| **Within 30 working days of the event:** | | | Complete and send the event notification part A to Te Tāhū Hauora - or by any other way Te Tāhū Hauora instructs. | | | | | | |
| SAC 1 – severe - processes  |  |  |  | | --- | --- | --- | | Death or harm causing severe loss of function and/or requiring life-saving intervention. | | | | Not related to natural course of illness or treatment. | Differs from immediate expected outcome of care. | Can be physical, psychological, cultural or spiritual. | Differs from immediate expected outcome of care. | Can be physical, psychological, cultural or spiritual. | | | | | | | | | | |
| 1. **Event or near miss reported/disclosed by:** | | | | | 1. **Immediate response by : enter text** | | | | |
| Tangata whai ora/ tangata whaikaha /whānau   * Verbally or in writing. | Health care worker   * Completes our adverse events/incidents template. | | | | Ensure immediate safety actions have been implemented. For example:   * Apply first aid. * Call the Ambulance. * Call the GP. * Notify clinical lead, Board chair, whānau (if consented). * Thank the person who reported. * Listen to their concerns. | | | | * Assess the report/disclosure. Give preliminary SAC rating.   If death:   * Initiate the processes identified in the ‘Death of Tangata whai ora/tangata whaikaha’ policy/procedure. |
| 1. **Within 8 hours of the event enter text** : | | | | | | | | 1. **Within a week of the event enter text** | |
| * Engage with tangata whai ora/ tangata whaikaha, if they are able and if appropriate with whānau and the health care worker being involved in the event to discuss if a restorative response review or hohou te rongo would meet their needs. * Whānau to nominate contact person. * Explain that the purpose of this process is to learn from what has happen. * Inform them that they can bring support during meetings. * Provide tangata whai ora/ tangata whaikaha (and if appropriate with whānau) with contact details if they want to talk at some other time about what happened. * Access psychological, cultural and spiritual support for those affected by the event. * Carry out a de-brief. | | | | | | | | Options:  Facilitate a review of the adverse event with:   * Whānau of the person being hurt or having passed away, the health care worker disclosing the event and any other stakeholders that have been identified (Examples: Lived experience advisors, whānau advisors, cultural practitioners, other service providers).   Principles and processes at the meeting:   * Participants speak about their experience * Use restorative principles or use houhou te rongopai if Māori participate * Discuss and agree on SAC rating. * Agree on what has been learned. * Develop learning and sustainable actions for improvement.   Learning review:   * If the review needs to address complex issues or clusters of events. * If learning review: complete the template (Appendix). | |
| 1. **Outcomes monitored by enter text** | | | | | | | | | |
| * Open disclosure is applied. * Contact with tangata whai ora/ tangata whaikaha and/or whānau is on record. * Complete statutory notification as required. | | | | | | | | * The learning and sustainable actions for the improvement plan is monitored for implementation at least monthly (Board meetings, quality meetings, staff meetings, tāngata whai ora/tāngata whaikaha meetings). * Fully complete our adverse event record. | |
| **Within 30 working days of the event:** | | | | Complete and send the event notification part A to Te Tāhū Hauora - or by any other way Te Tāhū Hauora instructs. | | | | | |

# Appendix

|  |  |
| --- | --- |
| Examples: restorative principles and values (Adapted from Wailling et al.) | |
| **Principle** | **Practice example** |
| *Process is voluntary* | * Participants are prepared for a facilitated meeting. * Consent to proceed agreed by all partied, including the facilitator. * Confidentiality parameters agreed on. |
| *Process is rational and designed to meet the needs of those impacted.* | * Substantive, procedural and psychological needs of all parties clarified during preparation, e.g. who needs to be involved? How would people like to tell their story and to whom? * Access to emotional support before, during and immediately after a meeting. |
| *Respectful communication* | * Ground rules established during preparation and start of the meeting. * Facilitators minimized interruption and ensured conversational turn-taking. * Facilitators upheld the ground rules and interject to reframe, redirect or remind participants of their commitments when required. * If required, facilitators support private conversations to clarify and repair any perceived hurtful comments. |
| *Safe environment* | * Confidentiality rules agreed at the outset, e.g., what will be shared and with whom. * Emotional support and breakout rooms provided. * Practical/comfort needs to be attended to. |
| *Skilled facilitation* | * Experienced practitioners guide the co-design, preparation, restorative process and debriefing. |
| *Responsible parties are involved* | * Responsible parties heard directly about the harm experience to identify individual and shared responsibilities. |
| *Participants have an equal voice* | * Circle processes and facilitated meetings support a democratic structure that is psychologically safe and supports shared decision-making. * Responsible parties are asked to listen and reflect on key themes. |
| *Collaborative decision making* | * Potential actions are collectively agreed to by consensus. |
| *Outcomes documented and shared.* | * Actions committed to are documented in a shared public document. * Collaborative governance approach for implementation is agreed by all parties. |

| Learning Review (recommended by Te Tāhū Hauora (HQSC) | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Review method** | **Description** | **When to use** | **Strengths** | **Weaknesses** | **Training and resources available** |
| Learning Review | Designed for complex systems, particularly those involving people.  A social sense-making activity that reviews an accident, incident or even normal work for clues as to where staff contribute to the safety of operations or where the system inhibits this capacity.  Designed to facilitate the understanding of the factors and conditions that influence human actions and decisions by encouraging individual and group sense-making at all levels of an organisation. | Designed to be used with complex systems. | Seeks to understand what led people to do what they did at the time.  Avoids use of ‘why’ questions.  Reduces hindsight bias.  Compares work as done with work as imagined.  Uses those doing the work as experts in how to do the work.  Informed by human factors and resilience engineering. | Use of focus groups may be time intensive. | Currently the focus of the Health Quality & Safety Commission’s Adverse Events Learning Programme education: [www.hqsc.govt.nz/our-work/system-safety/adverse-events/education/adverse-events-learning-programme-workshops](http://www.hqsc.govt.nz/our-work/system-safety/adverse-events/education/adverse-events-learning-programme-workshops).  Open Book: Learning Review (March 2021): [www.hqsc.govt.nz/resources/resource-library/open-book-learning-review-march-2021](http://www.hqsc.govt.nz/resources/resource-library/open-book-learning-review-march-2021).  Interactive e-learning module in development (available early 2022) via the Health Quality & Safety Commission’s website. |

# Learning review report cover sheet

The cover sheet is designed for internal purposes and can be removed and saved prior to distributing the report. The guide to a learning review (available within the system learning kete) includes more information to support the process and development of the learning review report.

|  |  |
| --- | --- |
| NHI: | Click or tap here to enter text. |
| Provisional SAC rating: | Click or tap here to enter text. |
| Final SAC rating: | Click or tap here to enter text. |
| WHO code: | Click or tap here to enter text. |
| Terms of reference completed: | Yes  No |
| Date report completed: | Click or tap to enter a date. |

***Review facilitators***

|  |  |
| --- | --- |
| Name | Position |
|  |  |
|  |  |
|  |  |
|  |  |

***Report circulated for feedback to:***

List who the report has been discussed with for feedback before being finalised   
(eg, consumers/whānau/health care workers involved/executive team/board).

|  |  |
| --- | --- |
| Name | Position |
|  |  |
|  |  |
|  |  |
|  |  |

***Final report distribution list***

List who the final report has been distributed to.

|  |  |
| --- | --- |
| Name | Position |
|  |  |
|  |  |
|  |  |
|  |  |

***Final report approved by***

|  |  |  |
| --- | --- | --- |
| **Name** | **Position** | **Signature** |
|  |  |  |
|  |  |  |

Template developed by Te Tāhū Hauora Health Quality & Safety Commission, June 2023, and available online at [www.hqsc.govt.nz](http://www.hqsc.govt.nz).

# Learning review report

Please note descriptions in green are for guidance only. Please remove before final publication of the report.

|  |  |
| --- | --- |
| Organisation | Click or tap here to enter text. |
| Event number | Click or tap here to enter text. |
| Final SAC rating: | Click or tap here to enter text. |
| WHO code: | Click or tap here to enter text. |
| Date report completed: | Click or tap to enter a date. |

***Why we review***

Reviews focus on improving healthcare systems for all and do not look to blame individuals. A learning review seeks to understand the system within which people provide health care and how this led to harm occurring. Learning reviews seek understanding so we can identify opportunities to heal, learn and improve.

***Consumer and whānau***

This section is for consumers and their whānau to express their needs from the review process. The content that may be requested will differ, but could include things such as karakia, whakataukī, poetry or words that talk about the consumer’s life and how the event has impacted them. It could also include questions that the consumer and their whānau would like to be answered during the review process.

The end of this section would be an appropriate place to acknowledge the harm suffered by the consumer and whānau and apologise to the consumer and their whānau if appropriate.

Click or tap here to enter text.

***Event synopsis***

Provide a brief description of the event. This should be at most 2-3 paragraphs in length. This section is solely designed to describe what happened. It must not speculate on cause or assign blame. Use neutral language.

Click or tap here to enter text.

***Collecting information***

**Typical workflow**

During the interview process people should be asked how they normally do their work (work-as-done). This section seeks to understand not only what is done, but why their actions make sense to them. It is not about what they did or were doing when the event occurred, but what they do on a ‘normal’ day. This might include limitations caused by resourcing, contradictory rules/policies or other influences.

Click or tap here to enter text.

**Information gathered**

Describe what happened from the perspective of those involved. This is the time to create an information map of all the stories and information gathered. To prevent a linear timeline becoming the ‘truth’ of what happened include multiple perspectives (multiple timelines). Seek to include what people were thinking and feeling as the event unfolded. Mind maps or the use of a human factor tool such as the SEIPS tool (available in the system learning kete) may be helpful to highlight all the interactions and indicate the factors and pressures that may influence actions and decisions. Include information gathered from the consumer involved and their whānau if they agree to tell their story.

Click or tap here to enter text.

**Organisational perspective**

This section is to present the perspective of the organisational leadership involved with the event. It is helpful to interview those in leadership positions to establish how the organisation thinks people do their work (work-as-imagined).

Click or tap here to enter text.

**Creating the event narrative**

This section should build an overall narrative of the event, which contains all the relevant context and highlights the key actions and influences that are identified by the review facilitators to be presented to the focus group(s). This section should combine the information in the typical workflow, incident narrative and organisational narrative sections above into one. These influences are a starting point only for discussion and may be altered or replaced during the sensemaking process. This section should not be about attributing blame or judging the decisions made at the time of the event and more about what made sense to the people involved at the time of the event. When writing a narrative, it is important to minimise outcome and hindsight bias to prevent a focus on preconceived ideas about why something happened. Include information from an equity perspective including from a disability lens (document the equity tool used).

Click or tap here to enter text.

***Sensemaking***

**Focus groups**

This section should summarise the discussions from the focus group(s). The aim is to understand why people did what they did at the time based on the conditions that they were experiencing.

Click or tap here to enter text.

***Using this information to learn and improve***

**Learning opportunities**

This section describes the learning opportunities suggested by the focus group(s). Learning opportunities are the things that will make it easier for people to perform their work, or make the system safer, or provide greater insight into areas that may require further research or investigation.

Click or tap here to enter text.

**Recommended actions for improvement**

Learning opportunities should be turned into formal recommendations for improvement to meet consumer, whānau, health care worker and organisational needs. A Human Factors tool can assist in designing solutions to ensure they meet the requirements of ‘work-as-done’ Quality improvement tools should be used to create an action plan that is regularly reviewed and evaluated for sustainable change and ensure there are no unintended consequences when change is implemented.

Click or tap here to enter text.

## 

**Glossary**

Ideally this report should be written in plain language with a minimum of jargon and technical terms. If these must be used, provide definitions/explanations of them in this section.

Click or tap here to enter text.

**Supporting information**

This section can be used to add any information used to develop the report, such as mind maps or multiple timelines, photos, descriptions of previous events that share similarities with the event being reviewed or references. It may be helpful to include items such as policies/procedures that were in place at the time of the harm occurring. Additional supporting documents can be attached as appendices.

Click or tap here to enter text.

# Principles for engaging consumers and whānau in mental health and addiction adverse event reviews

This information is provided for mental health and addiction (MHA) services. It is intended to guide adverse eventreview facilitators on the principles of engaging with consumers and their whānau affected by an adverse event and to complement the Te Tāhū Hauora Health Quality & Safety Commission resource How to engage with consumers and whānau following an adverse event.

|  |  |  |
| --- | --- | --- |
| **Cultural needs** | **Consumer** | **Whānau** |
| * Ensure psychological safety for all involved in the adverse event review process. * Seek cultural advice and support throughout the review process. * Be led by the principles of whakawhanaungatanga and kotahitanga * Ensure everyone understands the purpose of each part of the process. * Be clear about the parameters and limitations of the process. * Clarify the expectations of those involved in the process. * Follow tikanga practices. * Have processes in place to support staff resilience so staff can respond when and where needed after an adverse event. * Encourage staff to demonstrate flexibility and adaptability when working with consumers and whānau, both during and after a serious event review. * Be compassionate – listen to understand. | * Keep stories of the consumer experience at the heart of your work. * Provide training in the adverse event review process to your consumer leaders, consumer advisors and whānau advisors. * Understand and work to address the power dynamics that exist in health systems and between consumer and clinical roles. * When involving consumers (both the consumer, staff and/or those affected by the adverse event) be clear what you are asking people to do. Clarify roles, responsibilities and expectations – from both perspectives. * Offer coaching and mentoring to consumers involved in the review process/team, especially if they are at the early stage in their experience of adverse event reviews. | * Timelines for reviews are to be developed in consultation with the affected whānau. * Aim to complete everything that happens in partnership with the affected whānau. * Appoint a 'connector' from your team, who stays involved and provides ongoing information on the process (eg, whānau liaison). * Ask whānau if they want to nominate a spokesperson to stay connected, if the whānau themselves are not ready to be involved. * Be clear that you are speaking to the nominated spokesperson – as designated by the whānau. * Ask whānau what their preferences are for cultural and other support required. * Whānau are unique – respect and honour this. * Establish a centralised log of all whānau contacts: by who, when, actions and next steps. Summarise outcomes. * Meet with whānau at places and times that are convenient and safe for them. |

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# World Health Organization (WHO) codes

**Ngā tikanga a Te Rōpū Hauora o te Ao**

The event codes in the Te Tāhū Hauora (HQSC) adverse event policy 2023, are listed in the table below. Using the codes provides consistency across the sector. We will use those codes.

|  |  |
| --- | --- |
| **General classification of event** | **Event code** |
| Clinical administration (eg, handover, referral, discharge) | 01 |
| Clinical process (eg, assessment, diagnosis, treatment general care) | 02 |
| Documentation | 03 |
| Healthcare associated/acquired infection | 04 |
| Medication/IV fluids | 05 |
| Blood/blood products | 06 |
| Nutrition | 07 |
| Oxygen/gas/vapour (wrong gas, wrong concentration, failure to administer) | 08 |
| Medical device/equipment | 09 |
| Behaviour (eg, intended self harm, aggression, assault, dangerous behavior) | 10 |
| Tangata whai ora/tangata whaikaha accidents (not falls) (eg, burns, wounds not caused by falls) | 11 |
| tāngata whai ora/tāngata whaikaha falls | 12 |
| Infrastructure/buildings/fittings | 13 |
| Resources/organisation/management | 14 |