Policy

Policy Directive: compliance is mandatory

Lookback Review Policy Directive

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Summary

The Lookback Review Policy Directive describes a standardised coordinated, timely process for conducting a lookback review or investigation of a cluster or group of patient incidents that may have arisen from a systemic error or issue and that involves a systems failure or multiple systems failure, that does or has the potential to, place other patients directly at risk.

Keywords

Lookback, lookback review, cluster incident, incident, patient incident, open disclosure, Safety Learning System, SLS, adverse incidents, safety, quality, policy directive, reporting, harmful incidents, notification, Lookback Review Policy Directive

Policy history

Is this a new policy? *Y*
Does this policy amend or update an existing policy? *N*
Does this policy replace an existing policy? *N*

Applies to

All SA Health Portfolio

Staff impacted

All Staff, Management, Admin, Students; Volunteers

EPAS compatible

Yes

Registered with Divisional Policy Contact Officer

Yes

Policy doc reference no.

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Version control and change history

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Contents Page

1. Objective 4
2. Scope 5
3. Principles....5
4. Detail 5
5. Roles and Responsibilities....10
   5.1 The Department is responsible for: 10
6. Reporting....10
7. EPAS....11
8. Exemption 11
   8.1 Exemption Scope....11
   8.2 Exemption Process....11
9. National Safety and Quality Health Service Standards 11
10. Risk Management 11
11. Evaluation 12
12. Definitions 12
13. Associated Policy Directives/Policy Guidelines 13
14. References, Resources and Related Documents....13

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Lookback Review Policy Directive

1. Objective

A lookback review is the process triggered when a report made into the Patient Incident Module of the Safety Learning System (SLS), or concern from any source, requires the:

- notification
- investigation and
- management

of a group of patients who were or could be affected by the same cluster incident.

The incident may arise from complications or errors relating to diagnostics or treatment that the patient has received or products or the health service environment that the patient has been exposed to during the course of their care.

A cluster incident occurs when:

- there is a group or series of harmful incidents that are the result of one systemic error or issue, and
- that involves a systems failure or multiple systems failure that does or has the potential to place more than five patients directly at risk.

The commonality of these incidents may be related to time, place, and/or treatment. Treatment may include the use of a faulty medical device or equipment and/or inappropriate/inadequate treatment or diagnostics.

The purpose of this policy is to ensure a consistent, coordinated and timely approach for the reporting, investigation and management of the cluster incident, including the appropriate open disclosure process with potentially/affected patients and the appropriate communication with the general public.

The objectives of this policy are to:

1. Assist the health services to plan for the timely management of appropriate and relevant care for affected groups of patients.
2. Establish a standard approach for the timely and appropriate notification and support of patients and their families affected by or potentially affected by, a cluster incident.
3. Ensure that the appropriate notification and communication with the Minister for Health, the Chief Executive SA Health and Health Service executives occurs in a consistent and timely manner.
4. Ensure that, if required there is a plan made in collaboration with SA Health Media and Communications Branch for clear, consistent and open communication with the general public.
5. Ensure that the health services have established and consistent processes in place when a lookback review is undertaken, including commissioning and conduct of an independent review if required.
6. Ensure that the processes and outcomes, actions arising and recommendations of the lookback review are documented.

For the purpose of this policy, the term ’health services’ refers to the Local Health Networks (LHNs) and health care units including statewide clinical support services and SA Ambulance Service.

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2. Scope

All SA Health employees or persons who provide health services on behalf of SA Health must adhere to this policy. This includes contracted health services.

Lookback reviews related to communicable/infectious diseases and investigations, control and review *stipulated* under the *South Australian Public Health Act, 2011* which include:

- all notifiable conditions and contaminants
- controlled notifiable conditions
- other serious disease which is, or may be, infectious; and which the Chief Public Health Officer reasonably believes to present a serious risk to public health
- management of significant emergencies – public health incidents and emergencies
- reviews and appeals - notices relating to general duty

are outside the scope of this policy.

3. Principles

SA Health is committed to creating and maintaining a sustainable, high-quality care environment, in which there is:

- a lookback review conducted for all cluster incidents that is appropriate for the magnitude, complexity, harm both actual and potential and other impacts from the incident
- an open, just and transparent culture of incident management where the patient, their family and carers will be supported to recover from an incident through being :
  - fully informed of the facts surrounding an incident, its consequences for them, and the steps being taken to manage the incident and prevent recurrence
  - treated with empathy, respect and consideration
  - offered support in addition to treatment and care provided by the clinical treating team
  - supported in a manner appropriate to their needs, including the opportunity to ask questions or to make a complaint
  - assured of their privacy and confidentiality.
- timely action taken to improve the safety of patients, staff and others that is informed by incident management, best practice and other internal review processes.

4. Detail

When is a Lookback Review triggered?

The lookback review process is triggered when a group of patients are affected by a cluster incident.

The lookback review process involves:

- Identifying, tracing, communicating, and providing appropriate ongoing advice to, and/or management of, the group of patients.

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- Notification to appropriate external bodies, senior management and executives of the Health Service, and the Department for Health and Ageing.
- Establishment and implementation of a coordinated plan for review, investigation and determining recommended actions to prevent recurrence.
- Formation of a communication strategy, including:
  - notification to the wider public, where appropriate.

The following steps are to be included in any local lookback review process.

4.1 Step 1 – Immediate Action

- Ensure that immediate action has been taken to ensure the safety and wellbeing of the patients in accordance with the Patient Incident Management and Open Disclosure Policy Directive.

4.2 Step 2 – Steering group

Identify members of the Health Service to form a steering group. The group must be led by a member of the Health Service Executive and include the Director of Clinical Governance /Safety, Quality and Risk, and a local Media and Communications Branch delegate. A relevant delegate from the Department for Health and Ageing (the Department) will be allocated to work with the Health Service Team at all stages of the lookback review where appropriate.

Within 24 hours of recognition of the triggering event, the steering group must:

- undertake a risk assessment to determine the size/magnitude, complexity and nature of the risk/harm to patients/carers, in order to plan an appropriate lookback review process
- determine the extent of notifications both internal and external to SA Health that is required
- address and manage issues of notification to the Department via a brief in accordance with the Patient Incident Management and Open Disclosure Policy Directive and ensuring that it has been reported into SLS, and emailed to Health:sentinel events@sa.gov.au.

  Information contained within the brief is to include:

  1) urgency
  2) need for Department participation/involvement/oversite
  3) determining who has been affected and how - physical and/or psychological harm, or no known harm
  4) process for determining risks.
- agree on the formation of an Expert Advisory Group comprising experts in the area of concern, relevant clinicians, and department or directorate heads to devise and implement a detailed action plan
- agree on a patient communications plan. Communication with the patient/family is a priority and should be proactive in managing the manner in which affected patients receive relevant information.
  - Individual High/Level 1 open disclosure response(s) must be led by trained Open Disclosure facilitator.
  - Patients and families must be informed of any planned media release.

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- Agree on a media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries.

Communication management

Communications management throughout the lookback review process should be guided by the principles of open disclosure outlined in the Patient Incident Management and Open Disclosure Policy Directive.

If it is determined that communication with the public is required, ideally it should occur as soon as possible following the discovery of the triggering event and include:

- being open with information as it arises from the lookback review
- ongoing liaison with the media throughout the lookback review process
- preliminary notification being made public where a situation requires additional time for the discovery of accurate information to be provided to patients and the wider public.

Media management

Any requests from the media for interviews or information should be directed to the health service Media and Communications Branch. Any response provided should be authorised by the executive leading the lookback review.

The lead member of the Health Service Team should ensure that the health service Media and Communications Branch advises the Department Media and Communications Branch at the earliest possible time. The health service and Department Media and Communications Branches are to collaborate on a communication strategy for the media and the general public for the duration of the lookback review.

The health service media and communication staff will:

- nominate a spokesperson for public and media communications
- determine key messages
- minimise the delay in response to the public and the media
- develop questions and answers in advance
- work with the Health Service Team to develop a strategy for notification of external organisations such as appropriate medical colleges and any other affected organisations. It is appropriate that the Health Service Team in accordance with advice from the Department and Health Service Media and Communications Branch conduct such notifications.

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4.3 Step 3 – Expert Advisory Group

An expert advisory group must be convened as soon as possible and at the latest within five calendar days of the triggering event. The group will provide expert technical advice to the Steering Group including guidance with a detailed action plan and timeframes. The group will liaise closely communication with the Director of Clinical Governance/Safety, Quality and Risk until all actions are complete.

If there is no harm or risk to patients, the lookback review process can be closed. The expert advisory group will communicate this to the Director of Clinical Governance/Safety, Quality and Risk. In these circumstances, the near miss should prompt the organisation to review and investigate issues associated with the event to ensure future patient safety.

4.4 Step 4 – Action Plan and Implementation

Identifying and tracing affected patients, families and/or carers

The health services are responsible for the identification and tracing of the affected patients and must allocate appropriate resources to ensure that this is undertaken.

Patient communication and support

The expert advisory group should provide advice to the Director of Clinical Governance/Safety, Quality and Risk in determining the person/s best suited to communicating sensitive news with affected patients their families and/or carers. The health service should document the details of actions according to local policy and procedure.

Communication and support of patients/families should include:

- identifying immediate and ongoing management needs of patients their families and/or carers
- ensuring that patients understand the processes for ongoing management and have written advice/fact sheets concerning this
- ensuring that relevant fact sheets containing information on the lookback review are published on the health service inter/intranet website
- ensuring adequate resources are in place to provide the level of service required.

All information should be given in accordance with the SA Health Patient Incident and Open Disclosure Policy Directive and SA Health Privacy Policy Directive. Initial communication should be direct, either face-to-face or via telephone, where the patient must be given the opportunity to ask questions.

The following should be included in the patient communication and support plan:

- access to professional interpreters as required
- a designated point of contact for patients their families and/or carers
- regular and ongoing information updates provided to patients their families and/or carers
- affected patients are offered a written apology by the health service
- establishment of a toll free telephone hotline for patients and families/carers to ask any questions and to obtain information
- affected patients who need additional consultation have these appointments expedited to allay any anxieties or concerns that they may have.

Patients, their families and/or carers should not incur any cost from any additional consultations required:

- Provision of follow-up at no cost to patients, their families/carer.
- The health services offer to pay for any additional consultation (eg General Practitioners or Specialists Medical Practitioners) for affected patients, arising out of the lookback review.
- Affected patients who have had to pay for additional consultations are reimbursed for these expenses.

Group meetings should not be undertaken for reasons of confidentiality of patient information and protection to the privacy of those involved. Every attempt should be made to inform all patients involved at approximately the same time and in advance of any media attention of the issue.

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The health service is to form teams consisting of counsellors and mental health clinicians to offer/provide counselling and psychological support to all affected patients, their families/carers. Appointing an independent body to conduct counselling services during the lookback review process should be considered.

Staff communication and support

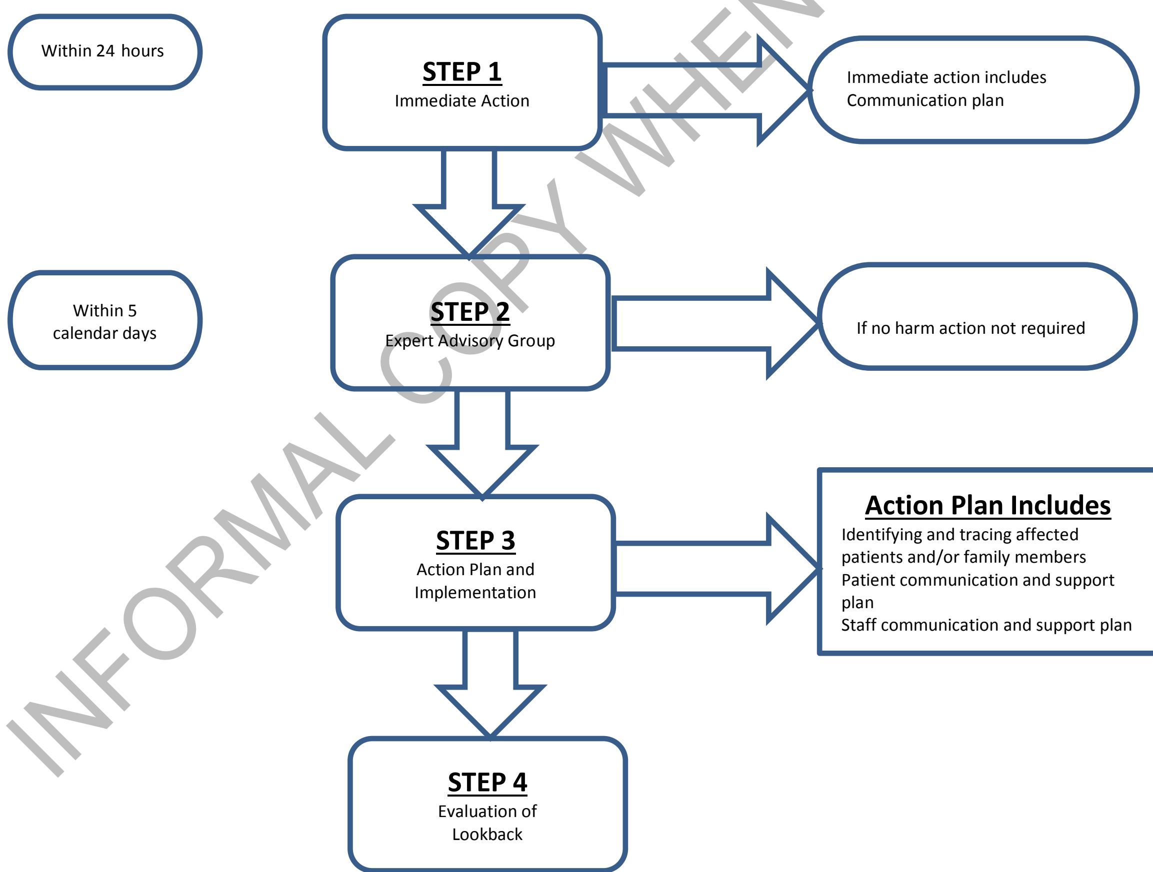
A communication and support plan should be devised for staff. This should include communication and support for:

- all staff who are managing the lookback review process
- all staff working in the area of concern
- all other staff that may be affected.

Record keeping

The health service is to maintain records of the open disclosure process that has taken place for all affected patients. This includes documentation in the patient's medical record and SLS, see section 4.4.5 of the Patient Incident Management and Open Disclosure Policy for further information.

Diagram 1: Lookback Review Process



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5. Roles and Responsibilities

5.1 The Department is responsible for:

- Dissemination of information and notification to other relevant health services of the cluster incident.
- Assisting the health services with the lookback review process and coordinating communications where more than one health service is involved.
- Assisting the health services with the development and management of communication strategies.
- Allocating an executive to work with the health services at all stages of managing the lookback review.

5.2 The Health Service Chief Executive Officer is responsible for:

- Initiation of the lookback review process.
- Coordination with any other involved health services.
- Decisions on public notifications, media management and advising the Chief Executive SA Health and the Minister for Health.

5.3 The Director of Health Service Clinical Governance/Safety, Quality and Risk is responsible for:

- Development and documentation of local lookback review policy and procedures.
- Actioning and management of the lookback review process.
- Conducting an evaluation and review as required when a lookback review has been completed and reporting the results to the Health services Clinical Governance Committee or equivalent.
- To liaise with clinicians involved in the lookback review.

5.4 The Clinicians are responsible for:

- Liaise and act in accordance with the Director of Clinical Governance/Safety, Quality and Risk and expert group throughout the lookback review.
- Apply Open Disclosure principles (see Patient Incident Management and Open Disclosure Policy Directive) when communicating with patients, families and/or carers.
- Maintain records of open disclosure discussions in the affected patients' medical record and SLS.

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6. Reporting

All incidents are to be reported into SLS in accordance with the Patient Incident Management and Open Disclosure Policy Directive.

Cluster incidents are to be reported to appropriate external bodies, senior management and executives of the Health Service, and the Chief Executive SA Health as dictated by the magnitude, complexity, level of patient harm and other impacts of the incident.

Lookback Review Report 1 and 2, including performance measures and recommendations are to be submitted electronically via the SLS patient Incident to the Department for Health and Ageing within 70 Days. Report 2 is to be provided to the health services Clinical Governance Committee or equivalent and the Chief Executive SA Health.

7. EPAS

EPAS and other medical records forms are used to document the care provided before during and after an incident, including results of any examination and/or tests relating to any injury or harm that was incurred.

8. Exemption

8.1 Exemption Scope

Nil

8.2 Exemption Process

Not applicable

9. National Safety and Quality Health Service Standards

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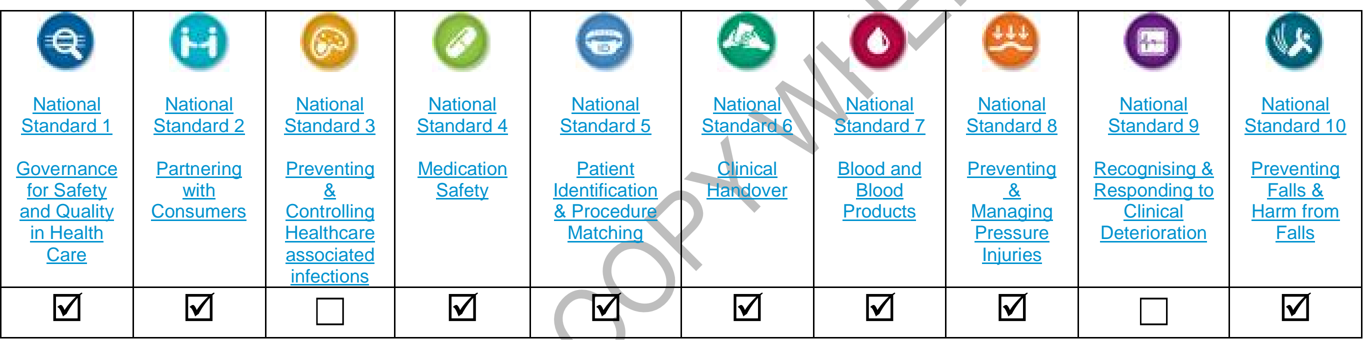

National Standard 1 Governance for Safety and Quality in Health Care	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare associated infections	National Standard 4 Medication Safety	National Standard 5 Patient Identification & Procedure Matching	National Standard 6 Clinical Handover	National Standard 7 Blood and Blood Products	National Standard 8 Preventing & Managing Pressure Injuries	National Standard 9 Recognising & Responding to Clinical Deterioration	National Standard 10 Preventing Falls & Harm from Falls
☑	☑	☐	☑	☑	☑	☑	☑	☐	☑

This policy is relevant to all National Safety and Quality Health Service Standards that require services to have robust systems for investigating and change management to respond to an incident, with the exception of Standard 3 which is outside the scope of this policy.

10. Risk Management

There is the potential for considerable risk to the patients and the organisation if the lookback review process is not embedded, consistently applied, and effective.

Patient risk associated with non-compliance with this directive includes, but is not limited to:

- not all patients affected by the incident are identified
- appropriate corrective action is not implemented.

Organisational risk associated with non-compliance with this directive includes, but is not limited to:

- future harm to patients, if patient incidents go unreported or un-actioned
- complaints and negative consumer feedback arising from patient incidents, unaddressed patient and family concerns, inadequate open disclosure
- litigation, medical malpractice or coronial investigations

- loss of the opportunity to improve the safety and quality of care through learning gained from the lookback review
- reduction in staff morale from inadequate governance; a poor safety culture; failure to improve safety and quality of care; and from experience of distressing incidents
- adverse media attention, loss of reputation and community confidence.

11. Evaluation

Directors of Clinical Governance/Safety, Quality and Risk are required to evaluate the management of the lookback review to assess the efficiency and effectiveness of the process. Key measures should be assessed and strategies for further improvement should be implemented and reported to the Chief Executive as required.

Directors of Clinical Governance/Safety, Quality and Risk are to:

- implement strategies to prevent this or similar events from recurring
- communicate lessons learned from the lookback review process to the Department and other health services.

Performance Measures

The following process performance measure is to be developed and reported to the Chief Executive by the health service.

- Documented local policies and procedures consistent with this policy are in place in each health service.

Key measures showing compliance with this policy must be reported as part of the lookback review evaluation.

- All patients who are of immediate risk to be contacted within two weeks.
- Patients are to be contacted with two months of the triggering event, in the event that further information/investigations are required to evaluate risk to patients and such risk is eventually detected.

12. Definitions

Clinician means: A health practitioner or health service provider regardless of whether the person is registered under a health registration act.

Cluster Incident means: a type of adverse incident where there is a group or series of harmful incidents that are the result of one systemic error or issue, and that involves a systems failure or multiple systems failure that does or has the potential to place more than five patients directly at risk.

Department means: The South Australian Department for Health and Ageing.

Error means: a failure to carry out a planned action as intended, or application of an incorrect plan. An error can be by commission (doing the wrong thing), or by omission (not doing the right thing) (World Health Organisation).

Health Services means: Local Health Networks and health care units including statewide clinical support services and SA Ambulance Service.

Incident means: any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a person or consumer/patient and/or to a complaint, loss or damage during an episode of health care.

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Near Miss means: a patient incident that did not cause harm, but had the potential to do so. An arrested or interrupted sequence where the incident was intercepted before causing harm. The incident cannot be a near miss if the consumer/patient was harmed or injured.

Open Disclosure means: a process of providing an open, consistent approach to communicating with consumers/patients and their carer/support persons following a patient incident.

Safety Learning System (SLS) means: The electronic system and database used in SA Health for reporting information about all phases of patient incident management. Documentation pertaining to both the review and analysis phases of patient incident management is entered and stored in the SLS. The SLS includes other sections for reports of work health safety incidents, security incidents, and modules for consumer feedback, and Notifications such as coronial and medical malpractice notifications.

13. Associated Policy Directives/Policy Guidelines

Patient Incident Management and Open Disclosure Policy Directive (New).

14. References, Resources and Related Documents

Lookback Review Action Plan Template
Conway J, Federico F, Stewart K, Campbell MJ. Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011
The SA Health Lookback Review Policy has been adapted from the New South Wales Lookback Policy PD2007_075; 28 September 2007

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