Advice for Directors of Clinical Governance

Reviewing individual cases of COVID-19 patient death

Purpose

To guide the review of individual COVID-19 cases resulting in patient death. This advice sits alongside the NSW Health Incident Management Policy (PD2020_047).

Scope

COVID-19 deaths related to care delivered in a health facility or out of a health facility which meet the definition of a 'reportable incident' as set out in Appendix D of PD2020_047.

For deaths within a cluster/ outbreak, refer to Advice for Directors of Clinical Governance for Reviewing a COVID-19 patient cluster/ outbreak in a healthcare setting.

Notification

Notify each patient death which is a reportable incident in ims+.

Classification

- Select "**Patient**" for "Who or what was most affected?"
- Select "**Unexpected death related to care**" for "Outcome"
- Select **"Healthcare Associated Infection"** for the "Principal Incident Type"
- Include the term **"COVID-19 exposure"** in "What Happened? – Details".

Open Disclosure

Communicate with families as per NSW Health Open Disclosure Policy (PD2014_028).

Escalation

Send a reportable incident brief (RIB) to the Ministry of Health.

Undertake a preliminary risk assessment (PRA).

Review

Undertake a serious adverse event review (SAER) using a rapid root cause analysis methodology. Use the new "SAER Individual COVID-19 incidents resulting in patient death" template.

Reports

Provide an individual report to the family. The new "Family report for SAER for a COVID-19 case" template is recommended or use a similar local template.

Send the SAER report to the Ministry of Health within 60 days or sooner.

If they request it, the COVID-19 SAER report is to be made available to the family.

Team membership

Consider Infection Prevention and Control (IPAC), Public Health Unit, Infectious Diseases, Nurse Unit Manager, Staff Specialist, Microbiology, Engineering or any other relevant persons.

Consultation

Consider Clinical Excellence Commission, State Health Emergency Operations Centre (SHEOC), Ministry of Health.

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State-wide Learning

The Clinical Excellence Commission will review and analyse of the Cluster/ outbreak reviews (corporate) and the COVID-19 SAERs via a sub-committee of the Clinical Risk Action Group.

Classifying individual cases

COVID-19 infections cause mortality and for some people, death can be “the natural course of illness”. Consider each patient death on a case-by-case basis to determine if the reportable incident definition applies.

Care delivered in a health facility

Think carefully about:

- Co-morbidities
- Vaccination status
- Whether a patient was on an end-of-life pathway
- Whether a hospital onset for a patient’s COVID infection is likely.
- The overall risk in NSW at the time of a patient’s COVID infection (e.g. 7-day case numbers average across the state and in the Local Government Area; Local Government Area of Concern).

Care delivered out of a health facility

Think carefully about:

- Co-morbidities
- Vaccination status
- Whether a COVID positive patient was acting against healthcare advice (e.g. Chose to remain in the community when advised they required in-patient care)
- The overall risk in NSW at the time of a patient’s COVID infection (e.g. 7-day case numbers average across the state and in the Local Government Area; Local Government Area of Concern).

Use established frameworks or evidence to support decision making. The Victorian Department of Health hospital onset COVID-19 definition below is recommended.

- Definite hospital-acquired COVID-19 (diagnosed during hospital stay)
    1. Confirmed positive RT-PCR test OR symptom onset on day >14 of hospital stay
- Definite hospital-acquired COVID-19 (diagnosed post-discharge)
    1. Confirmed positive RT-PCR test OR symptom onset within 2 days following discharge from hospital AND patient was admitted to hospital at least 14 days prior to symptom onset
- Probable hospital-acquired COVID-19 (hospital stay)
    1. Confirmed positive RT-PCR test OR symptom onset on day 8-14 of hospital stay AND no known exposure or risk factors prior to hospitalisation
    2. Confirmed positive RT-PCR test OR symptom onset on day 3-7 of hospital stay

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AND strong suspicion of healthcare transmission AND no known exposure or risk factors prior to hospitalisation

3. Confirmed positive RT-PCR test OR symptom onset within 14 days of an exposure to a confirmed COVID-19 case during previous hospitalisation AND no known exposure or risk factors in the community.

- Probable hospital-acquired COVID-19 (diagnosed post-discharge)

1. Confirmed positive RT-PCR test OR symptom onset on day 3-14 following discharge from hospital AND strong suspicion of healthcare transmission AND no known exposure or risk factors after discharge or prior to hospitalisation (where admission occurred less than 14 days prior to symptom onset)

2. Confirmed positive RT-PCR test OR symptom onset within 2 days following discharge from hospital AND patient was admitted to hospital less than 14 days prior to symptom onset AND strong suspicion of healthcare transmission AND no known exposure or risk factors after discharge or prior to hospitalisation (where admission occurred less than 14 days prior to symptom onset).

Considerations for appointing PRA and SAER teams

Standing appointments are recommended. Consider using the same team members for the PRA and SAER for each case. Additional members can be appointed individually.

What is different to the regular PRA and SAER processes?

- A delegate can convene a PRA team and/ or a SAER team on behalf of the Chief Executive
- An expert panel for COVID-19 may be chosen as the PRA and/ or SAER members
- Standing appointments for PRA or SAER can name more positions than required. A record must be kept of actual team members
- Interviews are undertaken as deemed relevant
- The SAER report for Individual COVID-19 cases is a combined findings and recommendations template.

For further information and support, please contact the Clinical Excellence Commission Patient Safety Directorate.

Speak with a dedicated Patient Safety Analyst liaison or contact Sharon Campbell, Associate Director, Patient Safety, on 0417 098 400 or at Sharon.Campbell1@health.nsw.gov.au