# COVID-19 SAER findings and recommendations report

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| Health Service |  | Patient age |  |
| Facility |  | Ward |  |
| Incident number |  | MoH RIB number |  |
| Date of incident |  | Health Service reference |  |
| Date of PRA |  | Date of incident notification |  |
| Date due to MoH |  | Date sent to MoH |  |
| Referral to other agencies or committees |  | Review decommissioned?If yes, has a review been undertaken on systems issues? |  |
| Contact |  |

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| **Section 1. Determination of Healthcare Associated COVID-19**COVID transmission events clearly identified as healthcare acquired - directly associated with care - must complete all sections. Where there is uncertainty with acquisition and contributing factors, consult with local Infection Prevention and Control (IPAC). |
| 1. Date and time of first positive COVID-19 test:
 |  |
| 1. Has the patient been an inpatient < 72hrs prior to diagnosis of COVID-19?
 | [ ]  Yes 🡪 This is unlikely a HAI, go to Q6[ ]  No 🡪 Continue to Q3 |
| 1. Was the patient isolated and under precautions?
 | [ ]  Isolated Date of isolation: [ ]  Cohorted[ ]  Transmission based precautions[ ]  Nil isolation or precautions |
| 1. Can a source of infection be identified?
 | [ ]  Yes 🡪 Identify the source: [ ]  patient 🡪 Continue to Q5 [ ]  staff 🡪 Continue to Q5  [ ]  visitor 🡪 Continue to Q6[ ]  Indeterminate 🡪 Consider patient timeline, possible exposure event(s), surveillance and testing results and IPAC advice. Complete Q5 **OR** Q6 |
| 1. This **is** suspected Healthcare Associated COVID-19?
 | [ ]  Yes 🡪 Proceed to section 2 and all sections in form, in line with usual SAER processes |
| 1. This is **not** suspected Healthcare Associated COVID-19?
 | [ ]  Yes 🡪 No further form entry/SAER required. Complete review in ims+ |

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| **Section 2. Background related to Healthcare Acquired COVID-19** |
| Admission date |  | [ ] Emergency [ ] Elective |
| Reason for admission |  |
| List relevant medical/surgical history |  |
| Patient’s COVID Vaccination Status | [ ]  Unvaccinated [ ]  Partial [ ]  Full  |
| Did open disclosure (OD) occur? | [ ]  Yes [ ]  No  |
| Is OD documented in the medical record? | [ ]  Yes[ ]  No  |
| Has the ims+ incident number been documented in the medical record?  | [ ]  Yes[ ]  No |

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| **Section 3. Review outcomes and summary** |
| Organisational factors | Indicate whether there was an identified breach (non/low compliance) with any of the following factors on the ward/ unit?[ ]  Personal protective equipment (PPE)[ ]  PPE training [ ]  Hand hygiene[ ]  Environmental cleaning[ ]  Cleaning of shared equipment[ ]  Ventilation and air circulation in clinical areas[ ]  Ventilation and air circulation in non-clinical areas[ ]  COVID-19 testing, monitoring and surveillance processes[ ]  Management of patient factors (eg wandering, falls risk, cognitive impairment)[ ]  Other policy or procedure, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If no or low compliance with any of the above, please specify the plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_In this case, did low or noncompliance contribute to the cluster / outbreak?[ ]  Yes[ ]  No[ ]  Partially[ ]  Not applicable |

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| Description – Incident Timeline and Summary |
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| Analysis - Lessons learned |
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| Findings from Infection Prevention and Control review including areas for review |
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| **This review was conducted by (tick all that apply)** | [ ]  Infection Prevention and Control[ ]  Infectious Diseases[ ]  Treating medical team[ ]  Patient Safety/Clinical Governance [ ]  Nursing Unit Manager/Delegate[ ]  Other – please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Recommendations for SAER

*Recommendations must be appropriate and have a staff member allocated to ensure implementation and must be recorded in the ims+ management section under recommendations once they have been approved.*

*Add/delete rows as required*

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|  | Recommendation | Relevant Factor/s | Outcome Measure | Timeframe | Oversight committee | Person Responsible | Management Agrees? |
| 1 |  |  |  |  |   |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |

REPORT SIGN OFF

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Signature** | **Date** |
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I, , the Chief Executive/ authorised delegate of

[ ]  **endorse** the recommendation(s) of the serious adverse event review.

[ ]  **do not endorse** the recommendation(s) of the serious adverse event review.

If the Chief Executive or authorised delegate does not endorse one or more recommendations, the Chief Executive or authorised delegate has attached alternate recommendations to this report.

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| Signed by |  |  |  |
|  | **Chief Executive or authorised delegate** |  | **Date** |