Te Tāhū Hauora
Health Quality & Safety Commission

Event of harm review tool

This review tool is intended to be used by those writing learning reports following an event of harm, to inform the development of the written report.

Te Tāhū Hauora has received permission from HSSIB to adapt the tool for use in Aotearoa New Zealand.

Te Tāhū Hauora acknowledges the development of this tool by NHS Scotland.

January 2025

Review methodology:	Reference:	Title:

Area of review (Descriptor)		Attainment level			Comments/examples of text quotes Add comments to clarify your choice, this may be things that can be improved or content that you thought worked well and should be used in other reports.
1	**People affected by harm events are meaningfully engaged and involved** The report demonstrates that all those affected by the event of harm such as staff, consumers, whānau, and carers have been actively listened to and emotionally supported where required (ie, perspectives of those affected are included in the report).	Met ○	Partially met ○	Not met ○	
2	**Cultural needs have been met** All consumers and whānau have had access to services to support their cultural values and beliefs and are supported to engage with those services.	Met ○	Partially met ○	Not met ○	

3	**A systems approach is applied** The report demonstrates consideration of system-based factors (for example, see **Systems Engineering Initiative for Patient Safety [SEIPS]**) and how these interacted to contribute to the harm event.	Met ○	Partially met ○	Not met ○	
4	**Human error is considered as a symptom of a system problem** Human error or similar (eg, nurse error, medical error, loss of situational awareness) is not concluded to be the cause of the event of harm. Instead, multiple factors which influenced the event are explored.	Met ○	Partially met ○	Not met ○	
5	**Blame language is avoided** Language does NOT directly or indirectly infer blame of individuals, teams, departments, or organisations and/or focus on human failure (eg, the nurse failed to follow policy; the doctor lost situational awareness).	Met ○	Partially met ○	Not met ○	

6	**Local rationality is considered** The report clearly explains why the decisions and actions taken by individuals involved felt right at the time (ie, the situation and context faced by those individuals is explored and described).	Met ○	Partially met ○	Not met ○	
7	**Counterfactual (eg, could have, should have, would have) reasoning is avoided** The report focuses on what happened and understanding why an event of harm happened. The report does not make a judgement on what people, departments or organisations 'could' or 'should' have done during or before the incident.	Met ○	Partially met ○	Not met ○	

8	**Learning opportunities and actions for improvement:** • have been developed collaboratively with relevant stakeholders and with consideration of wider organisation priorities and improvement work • use an appropriate equity assessment tool, where relevant, so that improvement actions do not worsen inequities • focus on system elements (IT, equipment, care processes/ pathways) not individuals • are specific, robust and actionable ie, they don't add to 'safety clutter' • are accompanied by a plan to monitor progress over time • are demonstrably linked to the report.	**Met** ○	**Partially met** ○	**Not met** ○	
9	**The written report is clear and easy to read** The report is concise, written in plain English (or if required in a langauge that meets the consumer and whānau needs) and uses inclusive language (ie, it is written to 'inform rather than impress').	**Met** ○	**Partially met** ○	**Not met** ○	

General comments:

Is there anything else that can be improved, or content that you thought worked well and should be used in other reports?