# Reviewing workplace-acquired healthcare worker COVID-19 infections

## Review tool & report

### Safer Care Victoria (SCV), in collaboration with WorkSafe Victoria, has developed a review tool to guide health services in reviewing workplace-acquired healthcare worker COVID-19 infections. Before using this review tool, refer to the supporting guide.

1.a Review team

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| Review role | Name | Position |
| Executive Sponsor |  |  |
| Review lead |  |  |
| Review team member |  |  |
| Review team member |  |  |
| Review team member |  |  |
| Review team member |  |  |
| Review team member |  |  |

1.b Endorsement of report

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Position | Date | Signature |
| Prepared by |  |  |  |  |
| Approved by |  |  |  |  |
| Endorsed by |  |  |  |  |

1. Clinical governance

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Committee | Recipient on behalf of committee | Date | Signature |
| Committee(s) received a copy |  |  |  |  |
|  |  |  |  |
| Action plan monitored by |  |  |  |  |

1. What happened, what is already known, and what has been done?

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| **Incident Summary** | **Response** |
| **The HCW COVID-19 infection***Describe the flow of events on the day of the suspected transmission event and any relevant events leading up to the transmission/infection* |  |
| **Immediate outcomes for staff***Injuries or harm to staff as a result of the HCW COVID-19 infection* |  |
| **Vaccination Status***Identify what the vaccination status of the patients / visitors and staff involved in the incident was* | What was the Staff vaccination status at the time of the incident?[ ]  Fully Vaccinated [ ]  Partially Vaccinated [ ]  Unvaccinated [ ]  Unknown [ ]  NA [ ]  OtherWhat was the Patients/ visitors vaccination status at the time of the incident?[ ]  Fully Vaccinated [ ]  Partially Vaccinated [ ]  Unvaccinated [ ]  Unknown [ ]  NA [ ]  Other |
| **Outcomes for patients***Injuries or harm to patients as a result of the HCW COVID-19 infection* |  |
| **Outcomes for the health service***Impact on operations, management, reputation as a result of the HCW COVID-19 infection* |  |
| **Outcomes for the community***Impact on the community (close contacts, secondary infections)* |  |
| **Notifications***Check that all reports and notifications have been completed* | [ ]  VHIMS or equivalent (incident report) [ ]  Department of Health [ ]  WorkSafe Victoria [ ]  Has open disclosure occurred? [ ]  Yes [ ]  No [ ]  NA |

4.a Which staff were interviewed for this case review?

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| **Frontline staff:**[ ]  Nurses[ ]  Medical[ ]  Allied Health[ ]  Pharmacy[ ]  Non-clinical[ ]  Security[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Operations management**[ ]  NUMs/ANUMs[ ]  Medical heads of units[ ]  Bed allocation group [ ]  Committees[ ]  Infection Prevention [ ]  OH&S Team[ ]  Patient Safety & Quality[ ]  Training [ ]  Equipment Manager[ ]  Facilities Manager[ ]  Procurement manager[ ]  IT support services[ ]  Human Resources[ ]  Other\_\_\_\_\_\_\_\_\_\_\_ | **Governance and administration**[ ]  CEO[ ]  The Board of Directors[ ]  Executive Team[ ]  Chief Operating Officer[ ]  Governance Committees[ ]  Legal Officer[ ]  Capital and infrastructure[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **External influences**[ ]  Government[ ]  Regulators[ ]  Unions/Employer Associations[ ]  Equipment suppliers[ ]  Patient transfer[ ]  GPs[ ]  Pathology provider[ ]  Nursing home[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

4.b: What systems that were accessed for this review?

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| **Patient systems**[ ]  EMR[ ]  Physical records[ ]  Referral letters[ ]  Transfer information**Patient activities**[ ]  Entry/exit[ ]  Bedside engagement (incl behaviour)[ ]  Hygiene activities[ ]  Aerosol generating procedures or other high-risk activities[ ]  Other\_\_\_\_\_\_\_\_\_\_\_ | **Staff systems**[ ]  Logbooks[ ]  Swipe access[ ]  EMR[ ]  Rosters[ ]  Other\_\_\_\_\_\_\_\_\_\_\_**Staff activities**[ ]  Entry/exit[ ]  Clinical work[ ]  Non-clinical work[ ]  Breaks[ ]  Other\_\_\_\_\_\_\_\_\_\_\_ | **Governance and administration**[ ]  Policies and procedures[ ]  Meeting minutes[ ]  Action plans[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **External influences**[ ]  Government policies and procedures[ ]  Regulators guidance and standards[ ]  Unions/Employer Associations guidance[ ]  Equipment suppliers, manuals, and information[ ]  Patient transfer information[ ]  Referral letters[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. How and why did the HCW COVID-19 infection occur?

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| **What patient factors contributed to the HCW COVID-19 infection occurring?**  |
| [ ]  Language and communication[ ]  Patient use of mask, hand hygiene, physical distancing and cough etiquette | [ ]  Physical health co-morbidities (complexity and seriousness) [ ]  Social / mental health issues | [ ]  Asymptomatic COVID-19 infection (not suspected/not diagnosed)[ ]  Patient movement / eave form the designated are i.e. ward | [ ]  Family/close contact visits[ ]  Patient behaviour[ ]  Any other patient/consumer factors missing from the above list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Review questions to consider***Controls are the preventative measures in place to minimise COVID-19 spread. i.e., policies, protocols, PPE, signage, training, spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
| **Were any controls missing?** | [ ]  No [ ]  Yes What were they? |
| **Recommendations** *Identify feasible and practicable actions to address the issues identified above*  |  |

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| **What staff factors contributed to the HCW COVID-19 infection occurring?**  |
| [ ]  Physical health[ ]  Mental health[ ]  Fatigue[ ]  Stress[ ]  Distraction[ ]  Rushed[ ]  Level of experience | [ ]  Respect for colleagues[ ]  Splash/puncture injury with contaminated material[ ]  Working in more than one health service[ ]  Fear of infection[ ]  Trust in wider system | [ ]  Familiarity with facility[ ]  Trust of PPE[ ]  Use of PPE[ ]  Donning and doffing of PPE[ ]  Compliance/adherence to infection control procedures[ ]  Compliance/adherence to other procedures | [ ]  Contact with other staff who have been exposed to COVID positive patients[ ]  Contact with other HCW outside of work settings[ ]  Asymptomatic COVID infection (not suspected/not diagnosedAny other staff factors missing from the above list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Review questions to consider***Controls are the preventative measures in place to minimise COVID-19 spread. i.e., policies, protocols, PPE, signage, training, PPE spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
| **Were any controls missing?** | [ ]  No [ ]  Yes What were they? |
| **Recommendations***Identify feasible and practicable actions to address the issues identified above*  |  |

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| **What task and technology factors contributed to the HCW COVID-19 infection occurring?**  |
| **Work processes**[ ]  COVID-19 PCR testing (incl. asymptomatic testing) [ ]  COVID-19 PCR results[ ]  COVID-19 equipment protocols[ ]  Decision making aids | [ ]  COVID-19 status known/readily available[ ]  Screening checklist[ ]  Shared use of work tools and equipment including admin tools | **Work design**[ ]  Difficult task[ ]  Unfamiliar task[ ]  Monotonous task[ ]  Task switching (multi-tasking)[ ]  Task frequency[ ]  Task design | [ ]  Task design (PPE donning and doffing)[ ]  Type of procedure[ ]  Hand hygiene[ ]  Any other task and technology factors missing from the above list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Review questions to consider:** *Controls are the preventative measures in place to minimise Covid Spread. i.e. policies, protocols, PPE, signage, training, PPE spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
| **Were any controls missing?** | [ ]  No [ ]  Yes What were they? |
| **Recommendations***Identify feasible and practicable actions to address the issues identified above*  |  |

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| **What team factors contributed to the HCW COVID-19 infection occurring?**  |
| **Team design**[ ]  Team roles[ ]  Staff sick leave / staff availability[ ]  Team leadership | [ ]  Co-worker support[ ]  Task allocation[ ]  Remote supervision[ ]  PPE spotters | **Communication**[ ]  Communication between staff[ ]  Provision of information to staff[ ]  Collection of information from staff | [ ]  Documentation [ ]  Clinical handover[ ]  Any team factors missing from the above list? |
| **Review questions to consider:** *Controls are the preventative measures in place to minimise Covid Spread. i.e. policies, protocols, PPE, signage, training, PPE spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
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| **What work environment factors contributed to the HCW COVID-19 infection occurring?**  |
| **Environment** [ ]  Shared facilities (patients)[ ]  Patient’s own home[ ]  Patient visibility[ ]  Layout[ ]  Space to maintain physical distancing in clinical work/office areas[ ]  Space to maintain physical distancing in staff break areas | [ ]  Noise [ ]  Lighting[ ]  Temperature[ ]  Ventilation[ ]  Donning and doffing areas[ ]  Staff amenities[ ]  Facility/ward not fit for purpose[ ]  Availability of COVID-safe reminders[ ]  Physical barrier to separate staff and patients/visitors | **Equipment provision and maintenance**[ ]  Equipment suitability and design[ ]  Equipment availability[ ]  Equipment cleaning & maintenance[ ]  Management of used disposable equipment[ ]  Management of non-disposable equipment | [ ]  Availability of appropriate cleaning products [ ]  Availability of appropriate PPE[ ]  Labelling and packaging[ ]  Management of linen[ ]  Management of waste[ ]  Any other work environment factors missing from the above list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Review questions to consider:** *Controls are the preventative measures in place to minimise Covid Spread. i.e. policies, protocols, PPE, signage, training, PPE spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
| **Were any controls missing?**  | [ ]  No [ ]  Yes What were they? |
| **Recommendations:** *Identify feasible and practicable actions to address the issues identified above.* |  |

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| **What organisation & management factors contributed to the HCW COVID-19 infection occurring?** |
| **Management systems**[ ]  Local PPE policies, guidelines, and procedures[ ]  Surveillance systems[ ]  In-home clinical care procedures[ ]  Outbreak management plan[ ]  Cleaning and decontamination procedures and schedules[ ]  Asymptomatic / regular screening for staff and/or patients[ ]  Patient transfer policies and procedures[ ]  Other policies and procedures[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **Leadership**[ ]  Safety culture/Just Culture[ ]  Change management[ ]  Support for health and wellbeing of staff[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_**Supervisory and cross-departmental support**[ ]  Support from supervisor(s)[ ]  Support from other departments[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_**Patient management**[ ]  Bed management[ ]  Patient transfer[ ]  COVID patient load[ ]  Cohorting of patients[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **Work and staff support systems**[ ]  Protected time for aching/learning[ ]  Staff welfare check ins and provision of support[ ]  Out of hours support[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_**Planning and resources**[ ]  Planning for service demand[ ]  Mobile or temporary staff[ ]  PPE internal supply chain[ ]  Material and equipment internal supply chain[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **Work scheduling**[ ]  Frontline staff roster[ ]  Non-frontline staff roster[ ]  Staff movement between wards / locations / facilities[ ]  Clinical workload[ ]  Non-clinical workload[ ]  Lunch/break time scheduling[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_**Training**[ ]  PPE training[ ]  Quality of training[ ]  Training update frequency[ ]  Other training[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Any other organisation and management factors missing from the above list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Review questions to consider:** *Controls are the preventative measures in place to minimise Covid Spread. i.e. policies, protocols, PPE, signage, training, spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
| **Were any controls missing?** | [ ]  No [ ]  Yes What were they? |
| **Recommendations:** *Identify feasible and practicable actions to address the issues identified above.* |  |

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| **What Government, regulators and external influences contributed to the HCW COVID-19 infection occurring?** |
| **Government and regulators**[ ]  Legislation and regulations[ ]  National guidelines[ ]  State guidelines[ ]  NEAT targets[ ]  Other COVID information for HCW (excluding guidelines)[ ]  Communication and feedback between health services and government[ ]  Multiple government agencies with COVID-19 responsibilities[ ]  Infection prevention resources (incl tools and response kits)[ ]  Building codes and/or standards[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **Unions & Employer associations**[ ]  Guidelines from peak bodies (non-government)[ ]  Information from unions[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_**Suppliers**[ ]  External PPE supply chain[ ]  External pathology providers[ ]  Equipment standards[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **External care providers**[ ]  Diversion of patients from surrounding health services[ ]  Transfer of patients to/from health services and facilities (incl patient information)[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_ | **Other**[ ]  Media[ ]  External influences and pressures[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Any other government, regulator and external influences factors missing from the above list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Review questions to consider:** *Controls are the preventative measures in place to minimise Covid Spread. i.e. policies, protocols, PPE, signage, training, spotters, air filtration, vaccination* |
| **What controls were in place to prevent or minimise the HCW COVID-19 infection occurring?** |  |
| **What controls worked well and why?** |  |
| **Were any controls missing?** | [ ]  No [ ]  Yes What were they? |
| **Recommendations:** *Identify feasible and practicable actions to address the issues identified above.* |  |

1. What can be done about it? recommendations and findings

Summarise all the above recommendations. Identify feasible and practicable actions to address the recommendations

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| **REVISION OF RISK CONTROLS: ACTION PLAN** |
| **ID** | **Recommendation**  | **What action will be required?** | **How will it be implemented?** | **Who is responsible for implementation?** | **When will it be implemented by?** | **How will success be evaluated?** | **Status** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |

1. Findings: Is there anything else worth exploring further before feasible and practicable actions can be implemented and assigned?

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| --- | --- | --- | --- |
| **ID** | **What issue will be explored further?** | **How will the issue be explored further?** | **Who will be responsible for monitoring and reporting back?** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

1. Learnings: Are there any other related learnings that were identified but did not directly contribute to the HCW COVID-19 infection event?

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| --- | --- | --- | --- |
| **ID** | **Learning identified** | **Action required or N/A** | **Where will this be recorded / stored for future consideration** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |