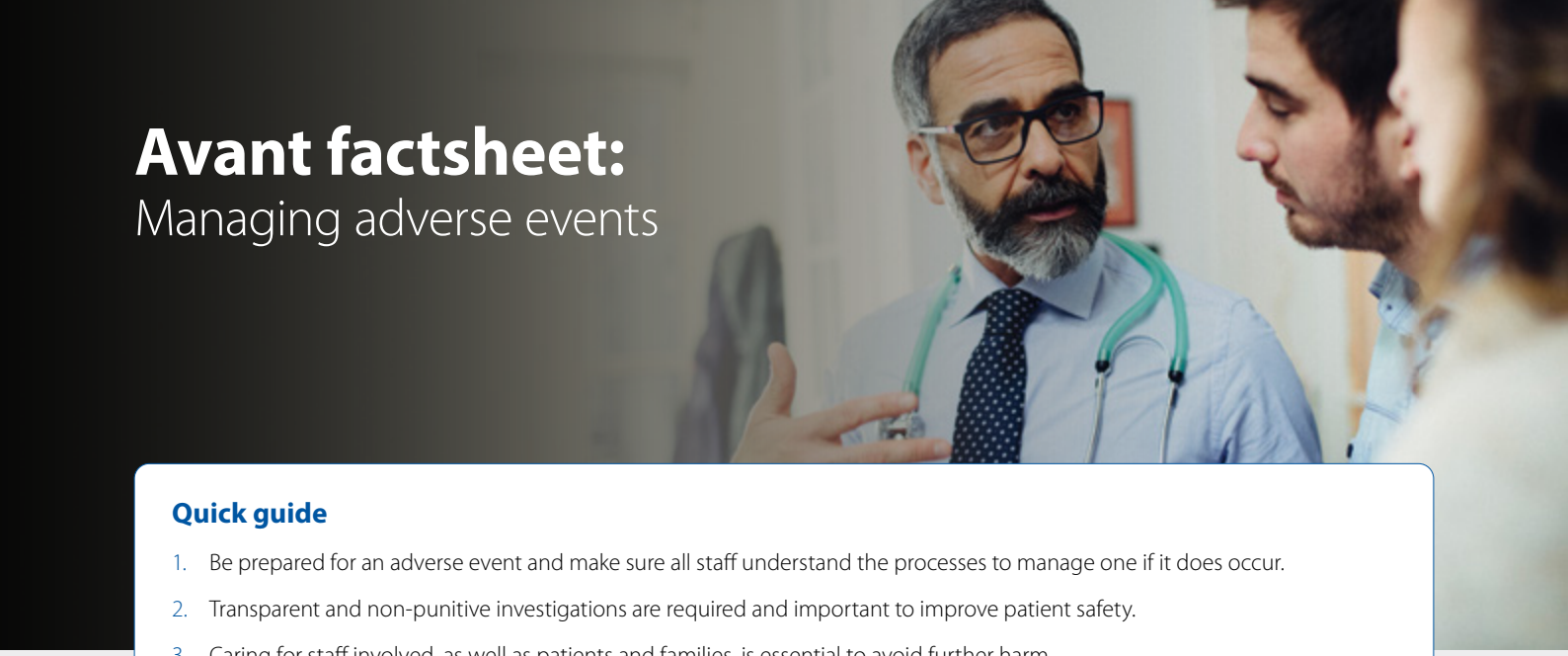
Avant factsheet:
Managing adverse events



Quick guide

1. Be prepared for an adverse event and make sure all staff understand the processes to manage one if it does occur.
2. Transparent and non-punitive investigations are required and important to improve patient safety.
3. Caring for staff involved, as well as patients and families, is essential to avoid further harm.

Responding to an adverse event

Despite the best efforts of healthcare practitioners, patients can be harmed by their treatment. In Australia, the National Safety and Quality Health Service Standards set out a framework for healthcare organisations to respond to adverse events. The Medical Board of Australia's *Good medical practice: a code of conduct for doctors in Australia* also outlines how individual practitioners are expected to respond if a patient is harmed. These frameworks include broadly similar elements, outlined in more detail below.

Promoting a patient safety culture

Underpinning these frameworks is a goal of improving patient safety and reducing the likelihood of future harm. This needs to be supported by organisational cultures that prioritise patient safety and encourage everyone to report and act on adverse events and near misses. It is important that all processes minimise blame but support professional accountability.

Being prepared

Delays in responding, investigating or communicating with patients and families are likely to exacerbate any adverse event. Preparation is essential to be able to respond as effectively as possible. This includes having policies about adverse events and complaints handling and making sure all staff are aware of these.

Policies need to be clear about what staff should do if an adverse event occurs, whether it is identified by another staff member, the patient or the patient's family. All reports must be taken seriously and given due attention.

Response level

Processes should also make sure the response is appropriate and proportionate to the type of incident. The *Australian Open Disclosure Framework* recommends response levels for a range of incidents.

Lower-level response process

For a minor incident or near miss, it may be appropriate to acknowledge the event and apologise to the patient and family. The discussion needs to be documented, and this may conclude the process.

Higher-level response process

Major events generally require a higher-level response, which requires a more structured approach. This will include an investigation. Details below.

Patient care

As soon as an adverse event is identified, the priority is to ensure the patient receives any necessary care and support. A multidisciplinary or practice meeting may be needed to discuss the patient's ongoing management.

Communication with patient and family

It is very important to provide an explanation to patients and/or their family as soon as possible after an adverse event occurs. Early communication can be valuable, to make contact and let them know you are gathering information, with a more detailed explanation to follow.

The most common reason patients and families give for complaining after an incident is to gain a better understanding of what occurred. They may also need to understand the likely consequences for them and what ongoing clinical support may be required or is available.

Patients are also often comforted if they are assured that the clinical team has learnt from the incident, and processes have been adopted to reduce the chance of the adverse event occurring to others.

In Australia, healthcare organisations and healthcare professionals must implement a process of open disclosure in accordance with the *Australian Open Disclosure Framework*. For more information on this process, please see Avant's factsheet: Open disclosure: how to say sorry.

Investigation

The investigation aims to gather evidence and explore the causes of the adverse event. In a practice environment, it may take the form of a quality audit. In a hospital environment, depending on the severity of the incident, a root cause analysis may be initiated.

An investigation should not be punitive; however, it may identify individuals who are responsible and need to take professional accountability for mistakes. It may also identify systems and processes that can be improved to reduce the likelihood of a recurrence of the issues.

Root cause analysis

Following a serious adverse event, you may be required to participate in a root cause analysis (RCA) or serious adverse event review investigation, particularly if the event took place in a hospital environment. The aim of an RCA is to prevent future harm by identifying risks and learning the lessons from an adverse event. RCAs do not focus on individual performance. The investigation team will interview all staff involved in the incident to determine the facts and what, if any, changes need to be made to processes and systems. All Australian states and territories provide for information collected as part of this process to be legally privileged, which means it cannot be produced or admitted in court, although it can be requested by a coroner.

If you are asked to an interview, attendance is usually required as a condition of your employment. You should participate fully in the process in the spirit of transparency and co-operation. It can be a good idea to review the RCA policy, if it has been some time since you last read it, or you have not been through the process before.

Ensure you are familiar with all the details of the incident and the patient records of the events.

Keep your answers factual as they relate to your involvement. It is best not to be too defensive, speculate or draw unfounded conclusions.

Documentation

If you were involved in an incident you will generally be asked to document your knowledge of the event. Accurately document the pertinent details related to the event and the investigation. Objectively record facts. Refer to your involvement in the incident and things you did directly or that you observed.

Depending on the circumstances, it may be appropriate to make an addendum in the clinical records, ensuring any additional entry has the date and time the information was added, making it clear it is not a contemporaneous entry. It may be appropriate to include additional information in an incident report or other relevant document.

Feedback

Conducting a clinical review and investigating adverse events focuses on the management of clinical risk and making changes necessary for improving systems of care. It is an important part of the learning process to use the feedback from an adverse event to improve patient outcomes.

Support and advice

When something goes wrong within the patient's care, it can be stressful for you and all other healthcare staff involved.

If you are involved in an adverse event, you will need to notify your insurance company. It is also common to need help and support to manage your professional concerns and emotional needs after an adverse event.

For further advice and assistance, contact Avant's Medico-legal Advisory Service on **1800 128 268**.

See also **Key Support Services** on our Health and Wellbeing website.

Additional resources

Avant webinar: Creating a just culture

Australian Commission on Safety and Quality in Health Care.

Australian Open Disclosure Framework. ACSQHC, Sydney, 2013.

NSW Government Clinical Excellence Commission on Root Cause Analysis

You can find additional resources including articles, podcasts and webinars in the **Avant Learning Centre** under Adverse events.

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