What to expect when a serious incident occurs

Detailed information for patients, carers and families

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

What to expect when a serious incident occurs

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1. Introduction

We are sharing this information with you because you or someone you care for has been involved in a serious incident in a hospital or health care facility. NSW Health would like to apologise for the distress caused to you and your family at this time.

NSW Health staff work hard to deliver the best possible outcomes for every patient. When things go wrong, we support families and have procedures in place to make sure we take action.

We are committed to letting you know what happened and why it happened, learning from this experience, and making changes to prevent future harm to other patients. We will answer your questions as best we can. This is called open disclosure.

When things go wrong, we follow these principles

Immediacy
We act immediately when people are harmed or at risk of harm

Accountability
We are open when things go wrong
We review to learn
We make changes to improve
We share what we find and learn

Kindness
We are caring
We are fair and just
We support all who are affected

You have been assigned a dedicated family contact person who will assist you during the review process. They will contact you regularly and you can call them if you have questions or concerns.

Dedicated family contact

Name _____ Position title _____

Phone number: _____ Alternate phone number _____

email address _____

Days of work _____

2. Stages of review

The review of serious incidents occurs in stages.

The Health Service will communicate with you at each stage as follows:

Incident – you will be told about a serious incident within 24 hours of it happening

Clinician Disclosure – a member of the clinical team such as a doctor or senior nurse will explain what happened, provide an apology and describe next steps.

Preliminary risk assessment – you will be informed about the findings of a rapid review that is completed within the first 72 hours.

Serious adverse event review – you will be invited to meet with a team who review the incident. You will be able to share your understanding of what happened and make suggestions about how processes can be improved**.** On completion, the review team present their findings and recommendations in a report which will be shared with you.

Further details on these stages can be found further on in this booklet.

All health services are required by law to complete a serious adverse event review within 60 days of the incident happening. Serious Incidents are reported to the Ministry of Health and reports provided to them in conjunction with the review process.

3. Contact with the health service

Your dedicated family contact will get in touch with you by phone or in person within the first few days and will maintain regular communication. They will invite you and your family to attend meetings in person of if required phone or video conferencing can be arranged. These meetings could be with the review team or the open disclosure team.

The table below lists other times you can expect to be contacted. If there is a change or delay in the process, the dedicated family contact will let you know.

If you want to be contacted more or less often, please tell your dedicated family contact. You may also want us to keep in touch after the review to hear about the progress of the recommendations.

Agreed date of contact with health service	Who will contact the family?	Why?	What happens next?
	Dedicated family contact	To introduce themselves and arrange any assistance needed. Offer to meet with Open Disclosure team to discuss preliminary risk assessment finding	They will explain the review process. You will be asked if there are recollections you want to pass on or if you will want to meet with the review team. Meeting arranged with Open Disclosure team if wanted
	Dedicated family contact	To organise a meeting with the Open Disclosure team to discuss the findings of the review	Open disclosure team meets with family and provides review findings
	Dedicated family contact	To organise a meeting with the Open Disclosure team to discuss the review team recommendations and next steps	Open disclosure team meets with family and provides the review reports and talks about next steps

Dedicated family contact fact sheet

NSW Health is committed to supporting people who have been impacted by a serious patient harm incident.

How will support be provided?

The Health Service will assign a dedicated family contact following a serious patient harm incident to support families. This individual is a healthcare worker who understands the review process and has experience supporting those impacted by serious incidents.

What does a dedicated family contact do?

The dedicated family contact maintains regular communication with families, and carers during the review process and sometime beyond. They assist the family in meeting with key teams.

The two teams are:

Review Team: who find out what happened, why it happened and recommend actions to prevent it happening again.

Open Disclosure Team: who share what is learnt during the review process including the final report and recommendations.

A dedicated family contact:

1. Contacts families within 72 hours of when a serious incident has occurred, or become known by the health service.
2. Identifies any needs for immediate support e.g. engages interpreters or social work
3. Understands and considers any family dynamics and cultural sensitivities
4. Explains how the review of the incident will happen, the steps involved, the time frames and the focus of the review.
5. Asks the patient, family, or carer what their communication preferences are, including: how often and the type of communication they would like.
6. Invites the family to provide information to the review team leader
7. Liaises with the review team and the open disclosure team.
8. Responds to the family whenever they have questions or concerns.

What happens if the family are unhappy with their dedicated family contact?

If difficulties arise that cannot be resolved, the family can raise this with the Director Clinical Governance.

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Further information is available on the Clinical Excellence Commission website www.cec.health.nsw.gov.au/

4. Understanding disclosure

NSW Health is committed to:

- Communicating openly with you about a patient safety incident
- Providing you the opportunity to tell us about your experience, concerns and feelings
- Treating you respectfully

What is open disclosure?

Open disclosure is an open discussion with a patient and / or their family about an incident that resulted in harm to that patient, while they were receiving health care. It is a way of ensuring the open, honest and respectful discussions occur between patients / families and health care staff after an incident.

The key elements of open disclosure are:

1. a factual explanation of what happened
2. an opportunity for the patient/ family to relate their experience
3. an explanation of the steps being taken to manage the event and prevent recurrence.

How is open disclosure delivered?

There are two broad stages of open disclosure:

1. clinician disclosure immediately following an incident

   and

2. formal open disclosure by an assigned team of staff.

Open Disclosure begins with clinician disclosure; it is the initial discussion with a patient / family following a patient safety incident. It is an informal process to advise and support the patient /family and to offer an apology for what has happened.

Formal open disclosure is a structured process which follows on from clinician disclosure. It is given by a team of healthcare staff and takes place over a series of meetings. An open disclosure team is formed to coordinate discussions with the family.

When does open disclosure take place?

Time interval	Purpose
Immediately following incident	Clinician disclosure –clinician explains what happened and provides an apology and explanation of next steps
Following preliminary risk assessment	Open disclosure team meet with family, provide preliminary risk assessment findings and explanation of next steps
Following completion of findings	Open disclosure team meet with family, provide findings and explanation of next steps
Following completion of final report	Open disclosure team meet with family and describe actions to be taken to prevent similar incidents recurring

The dedicated family contact will explain the open disclosure process to the family at their first meeting. If the family have questions, they can ask the dedicated family contact at any time.

5. Preliminary risk assessment

Fact Sheet

The review of serious incidents in New South Wales is completed in stages. The preliminary risk assessment is the first stage of this process and is explained here.

A preliminary risk assessment is a legal requirement for incidents that result in an unexpected death or are listed as an Australian Sentinel Event[1].

Assessors

The Chief Executive assigns a team of assessors to complete a preliminary risk assessment within 72 hours. The team are usually two or more staff who are independent of the serious incident. The Ministry of Health is also notified of serious incidents and can direct that a preliminary risk assessment is completed sooner.

Purpose

1. Understand the events around the serious incident
2. Early identification of remaining risks for other patients or staff
3. Identify immediate actions for people to be safe and supported
4. Appointment of a dedicated family contact to liaise with the family or carer
5. Make any immediate notifications to external parties e.g. Coroner
6. Guide the next steps to be taken

Reporting

The assessors work through a set of mandatory questions. When required, they will visit the location of the incident, read notes, access records, take photos, speak to staff, families or other people that may have information to provide. These conversations will be kept confidential.

The report from the preliminary risk assessment team is given to the Chief Executive and the team undertaking the detailed incident review. The report is discussed with family or carers and a formal record is kept of the meeting.

Legal considerations

It is important to note that a preliminary risk assessment and report are privileged. This means that the team involved in carrying out the assessment and writing the report cannot be compelled to provide evidence in any legal proceedings or any of the working documents.

The dedicated family contact

The dedicated family contact is assigned during the preliminary risk assessment. This staff member will support, assist and regularly communicate with family, carers and the review team.

The open disclosure team will share the findings of the preliminary risk assessment with the family. The dedicated family contact arranges the meeting.

[1] Australian Sentinel Events

Preliminary risk assessment

At a glance

A preliminary risk assessment is required for all clinical incidents involving unexpected death or those listed as Australian Sentinel events. A Health Service may also ask for a preliminary risk assessment for other clinical incidents they believe may be due to serious systemic problems.

WHO?

The Chief Executive(CE) appoints a team of assessors

WHY?

The assessors undertake a preliminary risk assessment to guide the next steps.

WHAT?

The team interview staff and families. They look at the incident location and file notes.

HOW?

Assessors work through the preliminary risk assessment report template on paper or in ims+.

WHEN?

A preliminary risk assessment is completed within 72 hours of the incident notification

WHAT NEXT?

The preliminary risk assessment is sent to the CE.
The findings are discussed with the family.
A review is undertaken.

More information about PRA is on the CEC website www.cec.health.nsw.gov.au

6.Serious adverse event review

Fact sheet

A serious adverse event review is completed when serious patient harm occurs. The process commences as soon as the Preliminary Risk Assessment has been completed and its findings have been reported.

What is a serious incident?

A serious incident refers to a clinical incident that resulted in the death of a patient or is listed as an Australian Sentinel event.

The Health Service completes the review to find out what weaknesses may have led to or contributed to the incident. The review process is not about blaming individual staff members. If a performance issue is identified, this is dealt with outside the review process.

Serious adverse event review process

The Chief Executive appoints a team to complete a serious adverse event review. The purpose of the serious adverse event review to find out what happened, why it happened and recommend action to prevent it happening again.

The serious adverse event review team is made up of 3-5 staff with essential knowledge of the care processes where the incident occurred. Where possible, there is one external team member. None of the team members will have been involved with the incident or have a personal connection with the clinicians.

Depending on the incident, the Chief Executive will direct the serious adverse event review team to use one of four methods:

1) Root cause analysis
2) London Protocol
3) NSW Health Concise incident analysis
4) NSW Health Comprehensive incident analysis

A serious adverse event review is completed in two stages:

- Find out what happened and why it happened – prepare a Findings Report
- Make recommendations to prevent a similar incident happening – prepare a Recommendations Report. The Chief Executive may appoint additional experts to assist with preparing this report.

The serious adverse event review must be completed within 60 days from the date of the incident. This always includes the Findings Report. However, there are times when there is no Recommendations Report.

The report/s from the serious adverse event review are also required to be submitted to the Ministry of Health.

What happens after the serious adverse event review is completed?

- The report findings and recommendations are made available to families and carers via the dedicated family contact and the open disclosure team.
- Recommendations are actioned in agreed timeframes. Local Health Districts have processes in place to track progress, which includes reports to a peak committee.
- The Ministry of Health reviews reports from serious adverse event review.

What happens after the report is completed?

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Any recommendations in the report need to be implemented by law. Local Health Districts have responsibility for making sure that actions are put in place. Each health service has their own processes for tracking progress.

The family can ask to be updated about progress through the dedicated family contact.

The Ministry of Health reviews all serious incidents reports. Special committees made up of expert clinicians read the reports to understand what happened and take action to make improvements across NSW Health. If there is a risk identified for other patients then this can result in new policies, programs or practices.

The family can ask to be updated about any sate-wide changes that take place through their dedicated family contact

Serious incident review process

WHO?
The Chief Executive appoints a team of 3-5 staff to undertake a serious adverse event review

WHY?
To find out what happened, why it happened and recommend actions to prevent it happening again.

HOW?
The team read medical records and other documents, review local processes, and interview staff, patients and families.

WHAT?
The team complete a findings report and if needed a recommendations report.

WHEN?
Reports are submitted to the Ministry of Health within 60 days of incident notification

WHAT NEXT?
Findings and recommendations reports are shared with the family. Action is taken locally and state-wide committees look for state-wide learnings.

A dedicated family contact communicates regularly with the family over the 60 days of the review and sometimes beyond in keeping with the wishes of the family

More detailed information can be found on the Clinical Excellence Commission website
www.cec.health.nsw.gov.au

7. Glossary

Term	Definition
Clinician disclosure	Soon after it is recognised that something has gone wrong a person from the hospital (or service) will speak to a family member and let them know what happened as best as we know at that time. This is very often a senior doctor and they will also want to hear what you know or saw if anything that might help us understand what went wrong. This is known as clinician disclosure. And is an important step for us to tell you what we know at the time and to apologise.
Dedicated family contact	A staff member who is the primary contact for the patient, carer and family for a serious incident review and at times beyond. They are appointed during the preliminary risk assessment and liaise between the patient, carer and family, open disclosure team and review team.
Open disclosure	A structured process which follows on from clinician disclosure, to ensure effective communications between the patient / family and the organisation occurs in a timely manner. It is delivered by a team of healthcare staff including a senior manager
Incident	An unplanned event that results in, or has the potential for patient harm, including near misses
Preliminary risk assessment	A review undertaken in the first 72 hours of incident notification to guide the next steps of the incident review process.
Privilege	Privilege protects serious adverse event review team members and documents produced as part of the review process from use as admissible evidence in any legal proceedings. Serious adverse event review team members maintain privilege by not disclosing any information obtained during the review, unless it is for a purpose that is part of the review process
Serious incident	A clinical incident that resulted in the unexpected death of a patient or is listed as an Australian Sentinel Event. This is known in the legislation as a reportable incident.
Serious adverse event review team (the review team)	A team appointed under the legislation to conduct a serious adverse event review as prescribed by the legislation. The team are part of the health service and have experience with care processes in the area where the incident occurred. They were not involved in the care provided to the patient and the time harm occurred.

Term	Definition
Serious adverse event review	Serious adverse event review (SAER) is a methodology used to review a serious incident. The purpose of a serious adverse event review is to identify system issues that contributed to or resulted in the incident occurring and to provide recommendations on actions to be taken to prevent or minimise a recurrence of a similar incident. A serious adverse event review is not used to blame individual staff; it is designed for learning and improving the quality of the health system.

Notes Pages

The remaining few pages have been left blank so that you can take any notes or jot down questions

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