Information for serious adverse event review team members

A serious adverse event review (SAER) is required for clinical Harm Score 1 incidents or clinical incidents that the Chief Executive determines may be due to a serious systemic problems.

SAERs are underpinned by:

- Just culture – when an incident occurs, individuals are treated fairly and not held accountable for system failings over which they have no control
- Focus on systems and not people – review processes consider the conditions under which individuals work, taking into account the complexity and interdependencies
- Human factors – action is taken to improve the interaction of staff with one another and the environment in which they work
- Learning – outcomes are shared to generate insights for action.

Who undertakes a SAER?

The Chief Executive appoints a team composed of 3-5 members:

- One team member (usually team leader) has SAER expertise
- One has essential knowledge of the care processes where the incident occurred
- No team member should have been directly involved in the incident or patient's care.

Team members should not:

- Have any personal connection with clinicians involved in the incident
- Have a conflict of interest
- Be the manager of the department or unit where the incident occurred

Team members receive a CE letter of appointment and are informed of their roles and responsibilities.

What does a SAER team do?

The team read medical records, review relevant documentation and undertake interviews with staff and families. An analysis of findings is completed over a series of meetings.

How long does a SAER take?

SAER team members have 60 days to complete the review and prepare a report that is made up of two parts:

1. Findings report
2. Recommendations report

Findings report

A findings report includes what happened, why it happened and any factors that caused or contributed to an incident. It identifies practices, processes or systems that could be reviewed (if any), known as "areas for review findings".

Recommendations report

A recommendations report has recommended actions aimed at preventing or mitigating any factors that caused or contributed to an incident. It may also have system improvement recommendations unrelated to the incident.

Additional team members to prepare the recommendations report

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Members of the SAER team may or may not be asked to participate in the development of the recommendations report. The SAER team leader will remain involved and the CE may appoint additional team members to prepare the recommendations report. Expertise may include a:

- Clinician with knowledge of the service
- Quality improvement / Redesign expert
- Human factors expert
- Manager/leader from another service/facility/agency to support feasibility e.g. eHealth NSW for digital health tools such as the eMR
- Manager/leader from another service/facility/agency responsible for implementing a recommendation e.g. NSW Ambulance, Ministry of Health, eHealth NSW, NSW Health Pathology.
- Manager/leader from the facility or service where the incident occurred to provide assurance that the implementation of recommendations will be supported.

Approved review methodologies

Approved SAER review methods are outlined in the *Health Administration Regulation 2020*. The Chief Executive (CE) determines the review method for each incident:

- Root cause analysis
- Systems analysis clinical incidents – London Protocol
- NSW Health Concise Incident Analysis
- NSW Health Comprehensive Incident Analysis

Privilege

Statutory privilege applies from the time a SAER team is appointed. It protects team members and documents produced as part of the review from use as admissible evidence in any legal proceedings. It does not apply to documents produced previously including the incident report or medical record.

SAER team members maintain privilege by not disclosing any information obtained during the investigation, unless it is for a purpose that is part of the SAER process.

The Incident Management Policy provides further guidance on privilege.

Before the SAER

When a serious incident occurs, there are a series of processes that take place prior to the commencement of a SAER.

These include:

1) Clinician disclosure – staff share what they know about the incident with the patient and/or family
2) The incident is notified in ims+ and relevant staff are informed
3) A reportable incident brief (RIB) is submitted to the Ministry of Health
4) The CE appoints assessors to undertake a preliminary risk assessment (PRA) to guide next steps
5) A dedicated family contact (DFC) is assigned. This staff member is the main

contact for the family during the SAER process. They invite the family to meet with the SAER team

6) The Open Disclosure team meet with the family to share the PRA advice.

After the SAER

1) The Findings and Recommendations Reports are sent to the Ministry of Health
2) The Open Disclosure team meet with the family and provide feedback on the SAER
3) The recommendations are actioned and monitored.
4) Clinical Excellence Commission review the report/s to identify any opportunities for state-wide learning.

For more information speak with your team leader or visit www.cec.health.nsw.gov.au/Review-incidents/Upcoming-changes-to-incident-management