Serious adverse event review
Information for staff affected by a serious incident

When serious patient harm occurs, a serious adverse event review (SAER) is undertaken to find out what happened, why it happened and how to prevent a similar incident happening again. The purpose is to identify system weaknesses that may have caused or contributed to the incident. The review process is not about blaming individuals and if there is a potential performance issue, it is dealt with outside the review process.

SAERs are underpinned by:

- Just culture –individuals are treated fairly and not held accountable for system failings over which they have no control
- Focus on systems – review teams consider the conditions under which individuals work
- Human factors – action is taken to improve the way staff interact with the environment and work with one another
- Learning – insights are shared to prevent similar incidents occurring again.

Before the SAER

When a serious incident occurs:

- A staff member notifies the incident in the incident management system, ims+
- A nominated staff member completes reportable incident brief (RIB) Part A in ims+ It has the basic information known at the time of the incident. Once approved, it is submitted to the Ministry of Health (MoH) within 24 hours.
- The Chief Executive (CE) appoints assessors to undertake a preliminary risk assessment (PRA) as soon as possible. PRA assessors visit the incident site, meet with staff, read records and may take photos. They submit a PRA report to the CE within 72 hours of incident notification.
- The PRA generates further information that can be used to complete RIB Part B. Once approved, it is submitted to the MoH within 72 hours of incident notification.
- The CE then appoints a team to undertake a comprehensive review of the incident. This is called a serious adverse event review (SAER).

SAER process

Review team

The SAER 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.

Review methodologies

Depending on the incident, the CE will direct the SAER team to use one of four methods

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

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Staff interviews

You may be contacted to provide your recollection of events. Your information helps the SAER team to understand more about what was happening around the time of the incident other factors which might have influenced events, such as the physical environment, resources or staff workload.

You may choose to provide a written version of events to the SAER team. This will help them to understand more about what was happening before they commence the interview process.

A SAER is covered by legal privilege which means the information you provide during an interview cannot be shared or accessed outside of the review team. Staff cannot be compelled to produce or give evidence related to the communication in any court proceedings. You will be provided with a letter explaining the SAER process.

You can bring a support person to your interview.

Findings report

The SAER team prepares a findings report that 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.

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 make recommendations for systems improvement.

Receiving feedback

A SAER is completed within 60 days of incident notification. The findings and recommendations (if any) will be shared with you. Feedback may be offered as a group or individually based on staff preferences and the sensitivity of the findings

Documenting your understanding of the incident

Sometimes, an incident is reviewed by a number of different parties including the Health Service, Health Care Complains Commission and the Coroner. You may be asked by each of these parties to contribute to their review process. The *Reflective Tool** on the following pages will be useful to you if you are required to provide information at a later date. You are encouraged to complete it as soon as possible after an incident. This is for your own personal use and does not need to be shared.

Support for staff

NSW Health values the wellbeing of staff and recognises that reviews may be stressful for those involved. Support is available from your manager and / or the Employee Assistance Program (EAP). Contact details for EAP can be found on the intranet site of each Local Health District.

If clinical supervision is available you are encouraged to take advantage of this opportunity to reflect on the incident.

For more information
www.cec.health.nsw.gov.au/Review-incidents/Upcoming-changes-to-incident-management

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Reflective tool*

This tool will assist you to reflect on an incident and consider any contributing factors. It will help to clarify your role, the role of others, and how these interacted.

This document is private; it may be used to assist in your discussions about the event with the SAER team or when you debrief with a colleague or EAP.

It is recommended that you complete this reflection as soon as practical following an incident.

Description of incident
What happened? How were you involved?

Feelings
What were you thinking and feeling at the time of the event, or when you first learned about it?

Evaluation
What was good (a desirable feature or point in favour), and what was bad or undesirable about the experience:

a) From the patients, carer's of family's point of view

b) From your viewpoint or position

c) From the health service's point of view

Analysis

What sense can you make of the situation? Why did things happen the way they did? Consider if any of the following factors contributed:

Factor	Description
Yourself / your state of mind	
Expectations and assumptions	
Communication between various parties, and interpretation of signals	

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Factor	Description
Equipment and environment	
Patient factors	
System and cultural factors	

Conclusion
What else might you have done? Could you be better prepared in future to influence any of the above factors?

Action plan
If the situation arose again, what would you differently?

**Acknowledgement to Southern NSW Local Health District*