What happens after patient harm?

OFFICIAL

This factsheet provides information for consumers (patients, families, and carers) who have been harmed as a result of an adverse event at a health service. It provides a high-level introduction to the review process that health services must follow to investigate an adverse event.

A **serious adverse patient safety event** (**SAPSE**) is an event that results in harm to a person receiving care (Australian Commission on Safety and Quality in Health Care). Harm includes disease, suffering, impairment (disability) and death.

Sentinel events are a subset of SAPSE that must be reported by health services to Safer Care Victoria (SCV). For more information see Sentinel events | Safer Care Victoria.

An **impacted consumer** is a patient who has been harmed or has died as a result of an adverse patient safety event, and/or their family members or carers.

Family Liaison Person (FLP) is a staff member assigned to act as a central liaison point for the impacted consumer throughout the review process. This can be assigned on a case-by-case basis to the most appropriate role, such as a Consumer/Patient Liaison Officer, Aboriginal Liaison Officer, clinician, manager or executive.

A **Dedicated Family Support Partner (DFSP)** is a health service staff member who has specialised, culturally informed consumer engagement skills, who supports the impacted consumer, family, carer and/or loved ones throughout a paediatric and neonatal SAPSE review process. The DFSP provides a single, consistent point of contact, helping those impacted navigate the process and receive support during a challenging time.

Introduction

When a SAPSE occurs, it is important that the health service and the impacted consumer understand what happened and why it happened. It is also an opportunity for the health service to learn from what went wrong and to improve systems related to patient safety. This is achieved through an investigation called an **adverse event review**.

What is an adverse event review?

An adverse event review is a process to investigate what happened, why it happened, and what can be done to prevent it from happening again. The steps include:

- forming a team of about 4-6 people
- reviewing documents, including medical records, and interviewing staff and impacted consumers
- using this information to find out what happened and why
- writing a report, including recommendations and actions (reports do not identify people by name)

- sharing the final report with the impacted consumer
- reports for sentinel events will be submitted to Safer Care Victoria (SCV).

How is the impacted consumer involved?

The health service will:

- inform you that an adverse event has happened and that a review (investigation) will be taking place
- provide you with information about the review process and invite you to contribute if you wish, and to the level you want. Not all impacted consumers will want to be interviewed or provide information, but your health service is expected to offer you the opportunity
- communicate with you during the review process and assign a FLP or DFSP to you. This person will be your main contact throughout the review
- arrange the logistics of your involvement (such as meetings) and ensure that your communication preferences are understood and met
- will listen to your account, either via a face-to-face physical or digital meeting or via your written account. Your account may include:
  - a description of the event/s from your perspective
  - the factors that you believe may have contributed to the event
  - how the event has affected you, e.g. from a health, wellbeing, personal, employment or financial perspective
  - what you think might prevent the event from reoccurring
- ensure that it maintains an accurate reflection of your account and provide you with a written summary of what you have said before they provide this to the review panel
- give equal consideration to your account of events alongside health service staff perspectives and ensure that your ideas and improvement suggestions are also considered when the review team is developing recommendations
- provide you with a copy of the review team's final report in a language and communication style you understand[1]
- provide you with the option to have a meeting or discussion about the review outcomes and report
- ask you to be involved in a post-review survey or discussion to ask whether you felt listened to and respected throughout the process
- provide you with an update on their progress in implementing recommendations on your request.

Who are the members of an adverse event review team?

The adverse event review team must be independent. Nobody who was directly involved in the adverse event, including health service staff or the impacted consumer, can be on the adverse event review team. The team incudes people who work in the health service and people from other health service organisations.

A review team may include:

- the **facilitator**, who is often a quality and safety professional who will coordinate review team formation and meeting logistics, gather, and share information and collate review findings

[1] Reports that are completed as a protected review are not admissible as evidence in legal proceedings. More information is available here Statutory Duty of Candour and protections for SAPSE reviews | Safer Care Victoria

- **general review team members**, who are included to bring specific subject matter knowledge, such as doctors, nurses, midwives, allied health professionals and/or health information professionals
- at least one **external expert** to provide an independent, objective perspective. They do not have current employment or association with the health service where the event occurred
- an **independent consumer representative** who provides a patient-centred perspective and ensures that the patient remains at the centre of the review. They must be independent of the event being reviewed and are not the impacted consumer
- a health service executive to oversee the process.

What is the role of SCV in adverse event reviews?

SCV oversees the sentinel event program in Victoria. Health services submit sentinel event reports to us, and we support them to form review teams, including connecting with external members, and providing guidance on review methods.

Will an adverse event review identify personal responsibility?

No. Adverse event reviews are focused on system and process improvements, not people. The aim is to create a culture where it is safe for staff to speak out honestly and openly when things go wrong, so that lessons can be learned and shared more broadly.

If you have concerns about the care provided and want to raise a complaint, you can do this via the health service's complaints process.

If you have concerns about the competency of an individual involved in the incident, and you consider that your concerns have not been adequately addressed by the review, you can raise a complaint to external regulation authorities as per below. A complaint about a health practitioner can be made to:

- Australian Health Practitioner Regulation Agency
- Victorian Health Complaints Commissioner
- Mental Health Complaints Commissioner (MHCC).

What legal or statutory requirements must health services meet following an adverse event?

Your health service must meet the requirements under the Australian Open Disclosure Framework and the Victorian Statutory Duty of Candour.

What support can an impacted consumer access throughout the adverse event review process?

You will be assigned an individual to be your FLP or DFSP, i.e. your contact throughout the review process. If you have any issues, you should raise them with your FLP or DFSP in the first instance.

How long should the review process take?

Most reviews will be completed within two to three months of the adverse event. This allows time for the review team to undertake detailed enquiries, e.g. interviews, document review or expert input, analyse this information in a structured and logical way, and reflect this in a final report. Your FLP or DFSP should provide information and updates to you about review timeframes.

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