

Avant factsheet:

Managing adverse clinical events

The risk of patient harm is inherent in all medical care. Adverse events during hospital admission affect nearly one out of 10 patients. More than half of these events are considered preventable.¹ No practitioner is immune to the risk of causing patient harm; the challenge is to identify and assess risks and actively manage those risks to reduce their impact.

What is an 'adverse outcome' or 'adverse event'?

The *Australian Open Disclosure Framework* refers to an **adverse event** as an incident in which a person receiving healthcare was harmed. Accepting the World Health Organisation view, the harm caused may be either physical, social or psychological and may cause temporary or permanent disability, prolonged length of treatment and/or hospital stay or death.² An **adverse outcome** is where an outcome to an illness or its treatments has not met the clinician's or patient's expectations for improvement or cure.³ A **near miss** is an incident that did not cause harm but had the potential to do so.

A doctor who has made a mistake or who is involved in an adverse outcome for a patient may struggle with feelings of guilt or incompetence, which may affect his or her ability to effectively communicate with the patient and family or support person. Only a small percentage of patients who experience an adverse event or outcome go on to make a claim or complaint against a doctor. How the doctor and practice or hospital team communicate with the patient in the wake of an adverse event or outcome can have an impact on the patient's decision to complain. Having a strategy in place for dealing with adverse outcomes and events is part of good clinical practice.

How to respond to an adverse outcome or event

The publication *Good medical practice: a code of conduct for doctors in Australia* s3.10 (Medical Board of Australia) states that when adverse events occur, medical practitioners have a responsibility to be open and honest in their communication with the patient, to review what has occurred and to report appropriately.

¹de Vries EN et al. The incidence and nature of in-hospital adverse events: a systematic review. *Qual Saf Health Care* 2008; 17:216-223.

²Australian Commission on Safety and Quality in Health Care. *Australian Open Disclosure Framework*. ACSQHC, Sydney, 2013; p. 21.

³ibid

You must:

- recognise what has happened
- act immediately to rectify the problem, if possible, including seeking any necessary help and advice.
- explain to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences
- acknowledge any patient distress and provide appropriate support
- comply with any relevant policies, procedures and reporting requirements, subject to advice from your medical indemnity insurer
- review adverse events and implement changes to reduce the risk of recurrence
- report adverse events to the relevant authority, as necessary
- ensure patients have access to information about the processes for making a complaint (for example, through the relevant healthcare complaints commission or medical board).

The level of response required to comply with the code of conduct will depend upon the severity of the harm caused to the patient. The *National Open Disclosure Framework* refers to lower and higher level responses.

Type of incident	Level of response
<ul style="list-style-type: none"> • Near miss or no harm incidents • No permanent injury • No increased level of care • No or minor psychological or emotional distress 	Lower-level response
<ul style="list-style-type: none"> • Death or major permanent loss of function • Permanent or considerable lessening of body function • Significant escalation of care or major change in clinical management • Major psychological or emotional distress • A higher level response can also be made at the request of the patient 	Higher-level response

Lower-level response process

A lower-level response to an adverse event may be to acknowledge the occurrence of the event to the patient and family, and to give an apology or expression of regret. Once documentation of the discussion has occurred, this may conclude the process.

Higher-level response process

A higher-level response requires a more comprehensive approach, including:

- gathering all the information necessary
- maintaining good internal communication
- maintaining good communication with the patient and family
- acknowledging the occurrence of the adverse event
- minimising the blame and shame culture
- having a multidisciplinary or practice meeting to discuss management of patient
- identifying where required and arranging for a support person for the clinician(s) involved
- planning for an open disclosure discussion with the patient and their family (refer to 'How to say sorry' fact sheet for more information)
- where appropriate, complying with hospital, regulatory and legislative reporting requirements
- offering an apology.

Documentation

Accurately document the pertinent details related to the outcome of the open disclosure meeting. Objectively record facts. Be sure that your documentation supports your thought process and decisions.

- Document who was in attendance.
- Describe in detail conversations with the family.
- Do not alter any records.
- Avoid remarks regarding liability for the events.
- Avoid remarks about the practice, hospital or clinic, its staff or other medical practitioners.
- Make sure staff are aware not to admit responsibility or enter into conversation without the medical practitioner's express permission and advice.

Risk awareness

Taking responsibility for an error or adverse outcome is a step towards preventing recurrence of that outcome or error:

- Anticipate errors by analysing systems. If any medical system is not under your control, ask the system administrator to analyse it.
- Identify contributing factors that resulted in the error or adverse outcome. Perform an analysis to find the cause, correct it and/or prevent similar errors from occurring.
- Use the incident as a learning opportunity.
- Preserve any malfunctioning equipment or evidence. Any malfunctioning equipment must be labelled and removed from service. It may be appropriate for you to take a photograph of such equipment.
- Follow up with patient as required. Let them know what changes in the systems have been made to prevent a reoccurrence.
- Provide the patient with psychological support as required.

Further Reading

Australian Commission on Safety and Quality in Health Care. *Australian Open Disclosure Framework*. ACSQHC, Sydney, 2013.

de Vries EN et al. The incidence and nature of in hospital adverse events: a systematic review. *Qual Saf Health Care*, 2008. 17:2.

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