Safer Care Victoria

Policy: Adverse patient safety events

The role of an adverse event management system is to enhance patient safety by learning from adverse events and near misses that occur in health services. This policy assists in the development of a robust reporting, review and learning system within an organisation.

Please align your policy to this.

What is the purpose of this policy?

To outline individual, health service and Safer Care Victoria (SCV) responsibilities when responding to an adverse event.

Who does this policy apply to?

All public and private health services, including services under their governance structure.

This includes:

- Ambulance Victoria
- bush nursing centres
- Forensicare (Thomas Embling Hospital)
- public sector residential aged care facilities
- hospital in home services
- private day surgery facilities.

What is an adverse patient safety event?

An incident that resulted in harm to a person receiving care (Australian Commission on Safety and Quality in Health Care [ACSQHC]). Harm includes disease, suffering, impairment (disability) and death.

Policy principles

A consistent approach to managing adverse events

Ensuring consistency in the approach to incident management and organisational learning across Victorian health services.

Open and transparent reviews and the creation of a safe reporting environment

Providing open disclosure to patients and their families and carers after an adverse event.

Assuring patients, families and the community that adverse events are reviewed and acted on.

Consumer involvement

Ensuring consumers participate in the review process and development of recommendations.

Prioritising the review of adverse events

Creating a patient safety learning culture so that recommendations from reviews can be implemented and distributed widely.

REVIEW RESPONSIBILITIES

Health services

Report all adverse events in a standard, timely manner in accordance with:

- SCV guidelines
- your health service's procedures
- statutory and other requirements.

Review all adverse patient safety events to identify the action required to prevent, or reduce, the likelihood it will reoccur.

Formally review all Victorian Health Incident Management (VHIMS) ISR1 and ISR2 rated events (see table below) and:

- develop recommendations to eliminate, control or accept causal/contributory factors
- develop a pathway to oversee the implementation and operation of those recommendations.

Openly communicate with patients and their families/carers in line with the guidance on open disclosure.

Report sentinel events to SCV within three days of becoming aware of them.

The **Process for reporting and reviewing adverse events** can be found over page.

VHIMS Incident Severity Ratings (ISR)

ISR	Degree of impact
1	Severe/death
2	Moderate
3	Mild
4	No harm/near miss

For further VHIMS information go to https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS

Safer Care Victoria

SCV will:

- acknowledge receipt of notification of sentinel events within two business days
- support review of sentinel events
- give feedback on reports and recommendations.

For more information on the categories including the sub-categories under Victorian 11, go to **bettersafercare.vic.gov.au/sentinel-events.**

Sentinel event categories

A sentinel event is a particular type of serious incident that is wholly preventable and has caused serious harm to, or death of, a patient.

1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death

2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death

3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death

4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death

5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death

6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward

7. Medication error resulting in serious harm or death

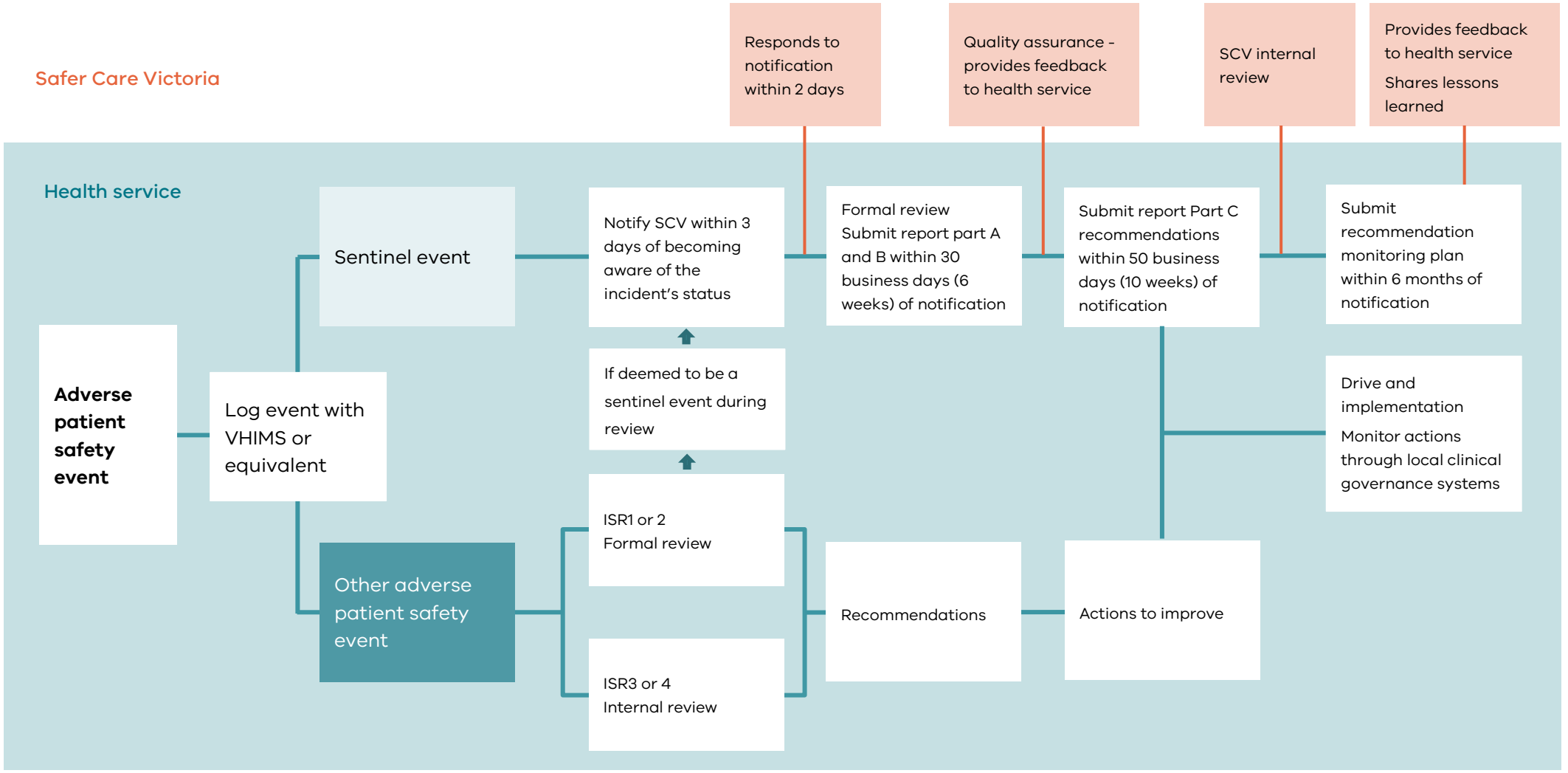
8. Use of physical or mechanical restraint resulting in serious harm or death

9. Discharge or release of an infant or child to an unauthorised person

10. Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death

11. All other adverse patient safety events resulting in serious harm or death

Process for reporting and reviewing adverse events



TERMINOLOGY

Harm

Examples of harm include disease, suffering, impairment (disability) and death:

- disease: a psychological or physiological dysfunction
- suffering: experiencing anything subjectively unpleasant. This may include pain, malaise, nausea, vomiting, loss (any negative consequence, including financial) depression, agitation, alarm, fear or grief
- impairment (disability): any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with a past or present harm.

Health service

Health service collectively refers to public health services and public hospitals which are defined under *Health Services Act 1988* (Vic).

Near miss

An incident that did not cause harm (ACSQHC). A near miss is also an incident that had the potential to cause harm but didn't, due to timely intervention and/or luck and/or chance.

Open disclosure

The process of open communication with patients and their families following an adverse event.