INPLASY

Mapping the risks and benefits of involving consumers in paediatric adverse events. A rapid scoping review of the literature

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ADMINISTRATIVE INFORMATION

Support - N/A.

Review Stage at time of this submission - Formal screening of search results against eligibility criteria.

Conflicts of interest - None declared.

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Amendments - This protocol was registered with the International Platform of Registered Systematic Review and Meta-Analysis Protocols (INPLASY) on 29 September 2025 and was last updated on 29 September 2025.

INTRODUCTION

Review question / Objective Mapping what are the risks and benefits of involving consumers in paediatric adverse events. This research aims to explore what has been done into the involvement of patients, their families and health professionals into the review of AE in healthcare. This review will focus on paediatric and young people with the aim to develop a protocol for local implementation. The aim of the research is to scope the evidence within peer reviewed journal as to the possibility to include consumers on significant AE reviews for paediatric and young people. Understanding what has been done will help determine how other health service organisations may change practice to have a paediatric focused review of incidents.

Background People who seek healthcare from health professionals, unfortunately may inadvertently experience an harm from an adverse event (AE) whilst receiving care to make them better. The prevalence of AE is estimated to be one in ten people will suffer an AE whilst receiving care globally (Panagioti, 2019; World Health Organization, 2024). In Australia, for every 100,000 discharges (separations) from a hospital, 5.2 will result in an AE (2022-23) (Australian Commission on Safety and Quality in Health Care, 2025). In addition to these classifications there are also Sentinel Events, these are wholly preventable incidents where serious harm or death occurs. In Australia this incidence is low (n=64) (2021-22) however the consequences to the 64 people each year who experience major harm or even death is catastrophic (Australian Institute of Health and Wellbeing, 2023).

Within the Australian context a patient incident is defined as “An incident is an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may be a near miss. Incidents may also be associated with omissions where patients are not

provided with a medical intervention from which they would have likely benefited (ACSQHC 2021, p4)". This broad definition covers everything from near miss events to significant events causing harm, and death. The WHO (2020) classifies patient safety incidents into the following categories.

Rationale Reducing harm from AE is a key priority for all Australian hospitals with key elements of hospital accreditation linked to incident management and strategies to reduce harm (ACSQHC 2021). All states have adopted the Australian Open Disclosure Framework (ACSQHC 2013) with many states having different interpretations of how open disclosure should be undertaken with the consumer. This paper will explore how the healthcare service organisations within Australia and globally manage the review of significant AE and how the patient involved in the review, how are patients' families/carers involved and how are the health care professionals involved.

METHODS

Strategy of data synthesis Covidence.

Eligibility criteria Children, young people and their families.

Source of evidence screening and selection CINAHL, OVID, SCOPUS, PROQUEST.

Data management Endnote and Covidence.

Language restriction English.

Country(ies) involved Australia.

Keywords Adverse Event; Sentinel Event; Patient Incident; consumer participation; Open Disclosure; candour; , "Never Event".

Dissemination plans Conferences Presentation, Publication.

Contributions of each author

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