
Next steps pamphlet

Usage instructions for health service staff

Being open with patients, families, and carers (consumers) about the review process following an adverse patient safety event – and their right to be involved in it – is an expectation of the NSQHS Clinical Governance standards, Australian Open Disclosure Framework, and Statutory Duty of Candour (SDC) legislation. Listening to consumers, validating their concerns, and including them in the review process can help mitigate feelings of anger, frustration or mistrust that can develop when they feel left out of the process.

About the pamphlet

The **Next steps** pamphlet is a printed information resource that health service staff can provide to consumers during open disclosure or SDC discussions, to help explain the adverse event review process and invite them to be involved in it.

The pamphlet can be modified for local usage (branding, wording etc), however the following minimum information must be included in any adaptations:

- The legislative requirement under Victorian SDC to be open and honest with consumers after a serious adverse patient safety event (SAPSE)
- That open disclosure must be followed for all other cases of harm and near miss as per the Australian Open Disclosure Framework
- That consumers have a right to contribute information to review team investigations (if they wish)
- The direct contact details of an allocated contact person (Family Liaison Person or equivalent)
- Information about external organisations who may conduct separate investigations (i.e. Ahpra, Coroners Court, Health Complaints Commissioner etc)
- That a formal report of the findings of the review will be provided to the family in a format they understand
- That in the case of a SAPSE review, and subject to health service compliance with relevant SDC legislation, the review report, while still to be shared with families, cannot be used as evidence in a court of law, however this does not prevent families from accessing and using other information available under the *Freedom of Information Act 1982* or the *Health Records Act 2001*

To help SCV measure usage of this resource and to inform future versions, we ask that a copy of locally adapted pamphlets be provided by email to IRTreviews@safercare.vic.gov.au

Why involve consumers in reviews?

- Involvement is a requirement of the Australian Commission for Safety & Quality in Health Care *National Standards*, *Australian Open Disclosure Framework*, and *Incident Management Guide*.
- Consumers who are harmed have an ethical right to be involved in steps taken to understand the event that caused their harm.
- They often have information of value to review teams that might not be available through other sources, and which might therefore be overlooked, missed or remain unknown.
- They may also have practical, high-value:low-cost, patient-centred improvement recommendations that can be useful to the review team.
- Consumer involvement in reviews, and subsequent service improvement plans, can help support requirements of the NSQHS clinical governance and partnering with consumers standards.
- Under new SDC legislation taking effect from 30 November 2022, health services are required to:
 - apologise to any person seriously harmed while receiving care
 - explain what went wrong
 - describe what action will be taken and the improvements being put in place
 - provide a copy of the review report to consumers, next of kin, or carers.

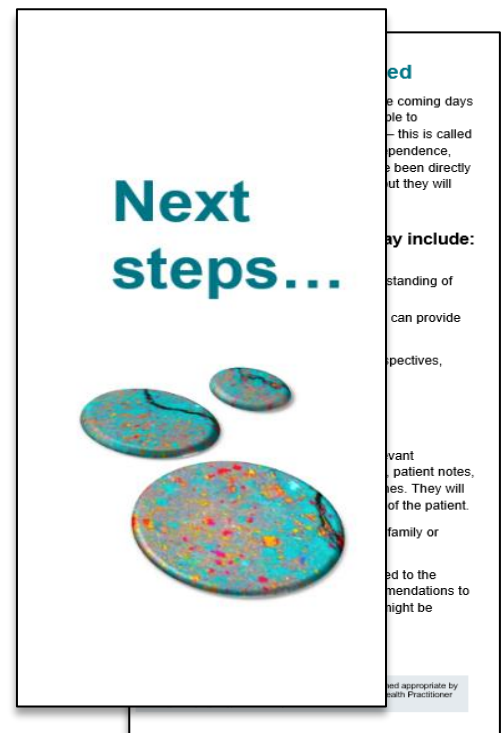
NOTE: Subject to health service compliance with relevant SDC legislation, if a health service conducts a SAPSE review, legal protections will apply to documents created as part of the review. This means that any working drafts, interview records, and final reports, cannot be used in a legal proceeding. However, this does not apply to information otherwise available to consumers under the *Freedom of Information Act 1982* or the *Health Records Act 2001*.

Using the *Next steps* pamphlet

1. An ideal time to introduce the pamphlet is during Open Disclosure and SDC discussions, as this is the point consumers would naturally be made aware of the next steps the health service is taking to investigate the adverse patient safety event (i.e. the review*), and letting them know that they can be involved in that process to the extent they wish.

(* Please note that consumers would not generally use the word 'review' in the same context as a health service, so it is important to clarify its use to consumers as meaning an investigation into what occurred.)

2. Print copies of the pamphlet according to the print directions listed on the e-resource file at <https://www.safercare.vic.gov.au/publications/next-steps-pamphlet>



3. Appoint a staff member to act as the **Family Liaison Person (FLP)** for consumers and write their details on back of the pamphlet where indicated.
 - The FLP must be at the meeting when the pamphlet is provided and should act as the single liaison point for consumers throughout the review process.
 - It is up to individual health services to decide who is best placed to act as an FLP. It may be the same person for all consumers within a health service or, depending upon the circumstances, different FLPs may be appointed to individual adverse patient safety events.
 - The most important criteria when appointing an FLP is to ensure they remain informed, consistent, empathetic, and available to consumers.
4. As the pamphlet is in tri-fold format, it is designed to be part of face-to-face discussions with consumers rather than as a mail out. However, this does not preclude it being mailed out if good communication has already been established.
5. Consumers should have time to look at the pamphlet and ask questions, either at the meeting where it is provided, or by phone or email afterwards. The pamphlet is only as good as the quality of the conversation that precedes it, so how and when it is introduced needs a structured and sensitive approach.
6. At the initial Open Disclosure or SDC meeting let consumers know that you will be providing them with some written information about the review process before they leave (i.e. the **Next steps** pamphlet).
 - While it is important not to overwhelm consumers with too much information at this stage, be guided by their individual preferences.
 - Often having a written resource is helpful for consumers to take with them to look over later.
 - Additional or subsequent conversations can provide more detailed information to consumers. This might include an estimate of the review timeframe and what is involved in the process (i.e. formation of the review team, collection and examination of relevant information, interviews with involved staff, drafting the report, etc).
7. During Open Disclosure and SDC discussions, staff should capture any initial information provided by consumers that may be of relevance to the review process. Let the consumers know that this information will be provided to the review team and ensure this is carried out.
8. Consumers should be encouraged to note down any key thoughts or questions that occur to them over the coming days. The 'Notes' section on back of pamphlet can serve as a starting point for this and should be pointed out to them.
9. Let consumers know their allocated FLP will be in contact with them in the coming days to see if they have any further questions or information that they would like to convey to the review team. Also advise that they can proactively contact their FLP at any time with questions, further information, or to get an update on the review's progress.

Your family liaison person is:

Name
Title
Email
Phone

- Ask how often and by what method they would like to be kept updated about the review team's progress.
Ensure this agreed contact schedule is maintained with consumers, even if there is nothing to update them about.
- Depending on family circumstances, staff can ask consumers to consider nominating a central spokesperson, through which all information can be channelled / disseminated.
- The consumers' appointed FLP should be the health service's primary point of communication, through which all other communication or requests should be facilitated. This includes sharing of the final report.

Some of the ways consumers can help with the review include:

- providing material evidence relevant to understanding the consumer's episode of care
- providing key background information / context about the consumer or their circumstances
- providing input into the draft timeline / description of the event
- fact / sense checking information obtained from other sources
- asking them where they believe things may have gone wrong and why
- inviting their feedback to the draft review report
- suggesting recommendations they feel would help address the issues they encountered.

To receive this publication in an accessible format phone 03 9096 1384, using the National Relay Service 13 36 77 if required, or [email Safer Care Victoria <info@safercare.vic.gov.au>](mailto:info@safercare.vic.gov.au)

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Australia, Safer Care Victoria, October 2022 [update January 2023, v2]

Available at the [Safer Care Victoria website](https://www.safercare.vic.gov.au) <<https://www.safercare.vic.gov.au>>



This resource was developed by the Patient safety review team at Safer Care Victoria: IRTreviews@safercare.vic.gov.au