Notes

Your family liaison person is

Name .....

Title .....

Email .....

Phone .....

Next steps...

This resource was co-designed with consumer representatives and staff at Safer Care Victoria in consultation with Victorian health services.

Patient Safety Review Team, Safer Care Victoria
IRTreviews@safercare.vic.gov.au
2022: Version 1.0

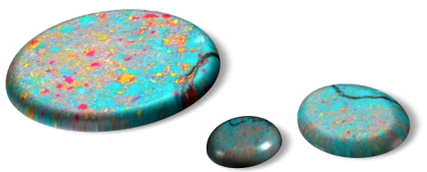
What's next?

When something happens and you or someone you care for experiences harm while in the care of a health service, we want to understand why.

This is important so that we can:

- provide you with answers about what happened
- identify if there were things that could have been done to prevent what happened
- identify any changes to our service that could improve the safety and quality of the care we provide.

From 30 November 2022, it is a legislative requirement under Victoria's *Statutory Duty of Candour* that we make an apology and explain what went wrong. We must also let you know what action will be taken and what improvements will be put in place. While this will be done as soon as possible, sometimes all the factors that led to the harm taking place are not immediately clear before we investigate further.



Reviewing what happened

To fully understand what happened, in the coming days we will put together a team of people to independently investigate what occurred. This is called a **serious adverse patient safety event review***. To ensure its independence, members of the review team will not have been directly involved in the event that caused the harm, but will interview those who were.

People on the review team may include:

- staff who have knowledge and understanding of relevant clinical issues
- staff from external organisations who can provide an independent perspective
- a person who represents patient perspectives called a consumer representative.

What will they do?

The team will collect and examine all relevant information, for example medical records, patient notes, internal and external policies and guidelines. They will also speak with staff involved in the care of the patient.

Information provided by the patient, their family or carers is also invited and encouraged.

The review team will then analyse what led to the adverse outcome and put forward recommendations to address any service improvements that might be necessary.

* This internal review is in addition to any investigations deemed appropriate by external bodies e.g. the Coroner's Office, the Australian Health Practitioner Regulatory Agency, Health Complaints Commissioner, etc.

Your input

Patients, families, carers or friends often have important information that can help us understand what happened.

If you have information you would like to contribute to the review, or specific issues or questions you would like the review team to consider, we encourage you to let your **family liaison person** know. We have included their details on the back of this brochure. They will ensure the review team receives your input.

It is also okay for you to choose not to be involved in this process if you don't wish to. However, please let your family liaison person know if this changes.

The report

A copy of the review team's report and recommendations will be provided to:

- the executive of the health service, who will ensure recommendations are actioned
- Safer Care Victoria (if required) – the government organisation responsible for improving health service safety in Victoria
- the patient and/or their family or carer/s. We can also organise a meeting to discuss the report in detail with you. Please let your family liaison person know if you would like this to happen.

While the report cannot be used as evidence in a court of law, this does not prevent you from accessing and using information otherwise available under the *Freedom of Information Act 1982* or the *Health Records Act 2001*.