PAGE NOT FOR PRINTING

PRINTING INSTRUCTIONS

- ONLY PRINT PAGES 2–3
- Print in colour
- Double-sided (duplex)
- Select **'Flip on short edge'**

INFORMATION THAT MUST BE INCLUDED IN ANY LOCAL 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*

A copy of any adapted pamphlets should be provided to IRTreviews@safercare.vic.gov.au

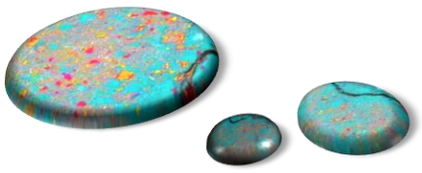
What's next?

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.

As outlined within the Australian Open Disclosure Framework and Victoria's *Statutory Duty of Candour* legislation, we must offer you 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 an **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.

NOTE: For serious adverse patient safety events (known as SAPSEs), the review may result in a report that, while shared with you, cannot be used as evidence in a court of law. This however does not prevent you from accessing and using other information available under the *Freedom of Information Act 1982* or the *Health Records Act 2001.*

Notes

Your family liaison person is:

Name ……

Title ……

Email ……

Phone ……..

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

Next steps…

Patient Safety Review Team, Safer Care Victoria
IRTreviews@safercare.vic.gov.au
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