Dedicated Family Contact Information Pack

A RESOURCE FOR STAFF ASSIGNED TO SUPPORT FAMILIES DURING A SERIOUS ADVERSE EVENT REVIEW

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

Dedicated Family Contact Information Pack

Table of contents

Dedicated Family Contact Information Pack

1. Serious adverse event review requirements

Fact sheet

When serious patient harm occurs, it is reviewed to find out what happened, why it happened and how to prevent a similar incident happening again. The Health Service is working out what weaknesses in the system may have led to or contributed to the incident. The review process is not about blaming individual staff members. If a performance issue is identified, this is dealt with outside the review process.

Health Service obligations when a clinical Harm Score 1 incident is notified

- Reportable Incident Brief – Part A: Within 24 hours of incident notification
- Preliminary risk assessment: Within 72 hours of incident notification
- Reportable Incident Brief – Part B: Within 72 hours of incident notification
- Serious adverse event review: Within 60 days of incident notification
    - Finding report: Usually within 50 days
    - Recommendations report: Within 60 days

Reportable Incident Brief – Part A

A nominated staff member completes RIB Part A within 24 hours to provide key early information about what happened to the Health Service Chief Executive and to the Ministry of Health.

Preliminary Risk Assessment

A Chief Executive-appointed team of assessors undertake a preliminary risk assessment (PRA) within 72 hours of an incident being notified. This initial assessment is to provide advice to the Chief Executive to guide next steps. It allows for any remaining risks to be identified and addressed earlier.

At this time, a staff member is assigned to the family, to act as a dedicated family contact.

Feedback from the PRA is provided to the family by the Open Disclosure team. This meeting is arranged by the dedicated family contact.

Reportable Incident Brief – Part B

Information gathered during the preliminary risk assessment is used to complete the Reportable Incident Brief – Part B, which is submitted within 72 hours to the Ministry of Health.

Serious adverse event review

The Chief Executive appoints a team to complete a serious adverse event review (SAER). The purpose of the SAER to find out what happened, why it happened and recommend action to prevent it happening again.

The SAER team is made up of 3-5 staff with essential knowledge of the care processes where the incident occurred. Where possible, there is one external team member. None of the team members will have been involved with the incident or have a personal connection with the clinicians.

Depending on the incident, the Chief Executive will direct the SAER team to use one of four methods:

1) Root cause analysis
2) London Protocol
3) NSW Health Concise incident analysis
4) NSW Health Comprehensive incident analysis

Dedicated Family Contact Information Pack

SAER is completed in two stages:

- Firstly, find out what happened and why it happened – prepare a Findings Report
- Secondly, make recommendations to prevent a similar incident happening – prepare a Recommendations Report. The CE may appoint additional experts to assist with preparing this report

Feedback from the findings is provided to the family by the Open Disclosure Team.

The family are provided with an opportunity to make recommendations for how the incident could be prevented in the future.

Feedback from the Recommendations Report is provided to the family by the Open Disclosure team. This meeting is arranged by the dedicated family contact.

There is always a Findings Report. There are times when there is no Recommendations Report.

The report/s from the SAER are submitted to the Ministry of Health.

What happens after the report is completed?

- Recommendations are actioned in agreed timeframes. Local Health Districts have processes in place to track progress, which includes reports to a peak committee.
- The Ministry of Health reviews reports from SAERs.
- Special committees of expert clinicians read the reports to understand what happened and take action to make improvements across NSW Health. If there is a risk identified for other patients then this can result in new or updated state-wide policies, programs or practices.

The family can ask to be updated about any state-wide changes that take place through their dedicated family contact

Guiding principles

When things go wrong we act with immediacy, accountability and kindness.

Immediacy
We act immediately when people are harmed or at risk of harm

Accountability
We are open when things go wrong
We investigate to learn
We make changes to improve
We share what we find and learn

Kindness
We are caring
We are fair and just
We support all who are affected

For further information contact your Clinical Governance team or look out for updates on the Clinical Excellence Commission website www.cec.health.nsw.gov.au/

v.1, December 2020

Infographic

2. Preliminary risk assessment

A preliminary risk assessment (PRA) is undertaken for all serious clinical incidents in New South Wales (NSW).

A PRA involves a small team of assessors appointed by the Chief Executive (CE) completing an initial assessment to help guide the next steps. It allows for earlier identification of remaining risks and earlier discussions with family.

Questions about the PRA process

When is a PRA required?

- For clinical Harm Score 1 incidents (reportable incidents) being unexpected death or Australian Sentinel Events[2].
- The CE may appoint a PRA team for a clinical Harm Score 2, 3 or 4 incident they determine may be due to a serious systemic problem.

How does a CE appoint PRA team?

- Memo or letter
- Email
- Standing appointment (pre-determined assessors for all PRAs e.g. Director Clinical Governance and General Manager).

Assessors must be informed of their requirements under the Health Act[1]. Sample letters on the CEC website can be adapted for use by health services.

What is the timeframe for a PRA?

It must be completed within 72 hours or sooner if directed by the Ministry of Health (MoH) or CE.

What do PRA assessors do?

They work through a mandatory NSW Health PRA report template. To do this they may visit the workplace, read notes, take photos and speak to staff.

The PRA assessors identify immediate actions for people to be safe and supported. They ensure any outstanding risks are escalated and make any immediate notifications e.g. Coroner, TGA

How are the findings of the PRA documented?

The PRA report needs to be completed in ims+ ensuring that all mandatory fields are completed. A copy of the template can be printed directly from the ims+ system or CEC website. There is an optional action log that can be used to assist the team to track actions.

Can the findings of the PRA be disclosed?

The findings of the PRA can be discussed with the patient, carer or family via the Open Disclosure process. Reasonable steps are taken not to identify staff during this discussion. A formal record is kept of the meeting. A copy of the PRA cannot be provided as this is in breach of privilege.

A copy of the PRA report is provided to the serious adverse event review team, ensuring that privilege is maintained during this transfer.

Under Section 23 of the Act[1] the CE may authorise the release of the report to the Secretary and other bodies or agencies

Is the PRA privileged?

A PRA completed for a clinical Harm Score 1 incident is legally privileged. This means that assessors cannot be compelled to provide evidence in any proceedings. The team must not share any documents or discussions with other people.

Other clinical reviews requested by the CE for serious systemic issues also attract privilege.

How is privilege maintained?

During the privileged PRA the team will generate documents including preliminary notes, records, minutes of meetings and records of discussions with people. Assessors must not share any of these records or discussions with other people.

To protect privilege, records must be maintained in a separate team file marked ‘privileged’ and stored securely in a location nominated by the Director Clinical Governance (DCG) to ensure that privilege is upheld in the event of a subpoena or application for access under GIPA. This location can be a secure electronic filing system (e.g. TRIM) with specific permissions assigned to each incident.

Dedicated Family Contact Information Pack

Health Services need to ensure processes are in place to manage the transfer of privileged documents. Email templates are available (link) to ensure the electronic transfer of information maintains privilege. Privileged material must not be sent in the general post.

Records relating to privileged reviews must be retained for a minimum of seven years after the last action[3].

The dedicated family contact

During this time, a dedicated family contact is assigned. This member of staff is the primary point of contact for the family during the review process and beyond if required.

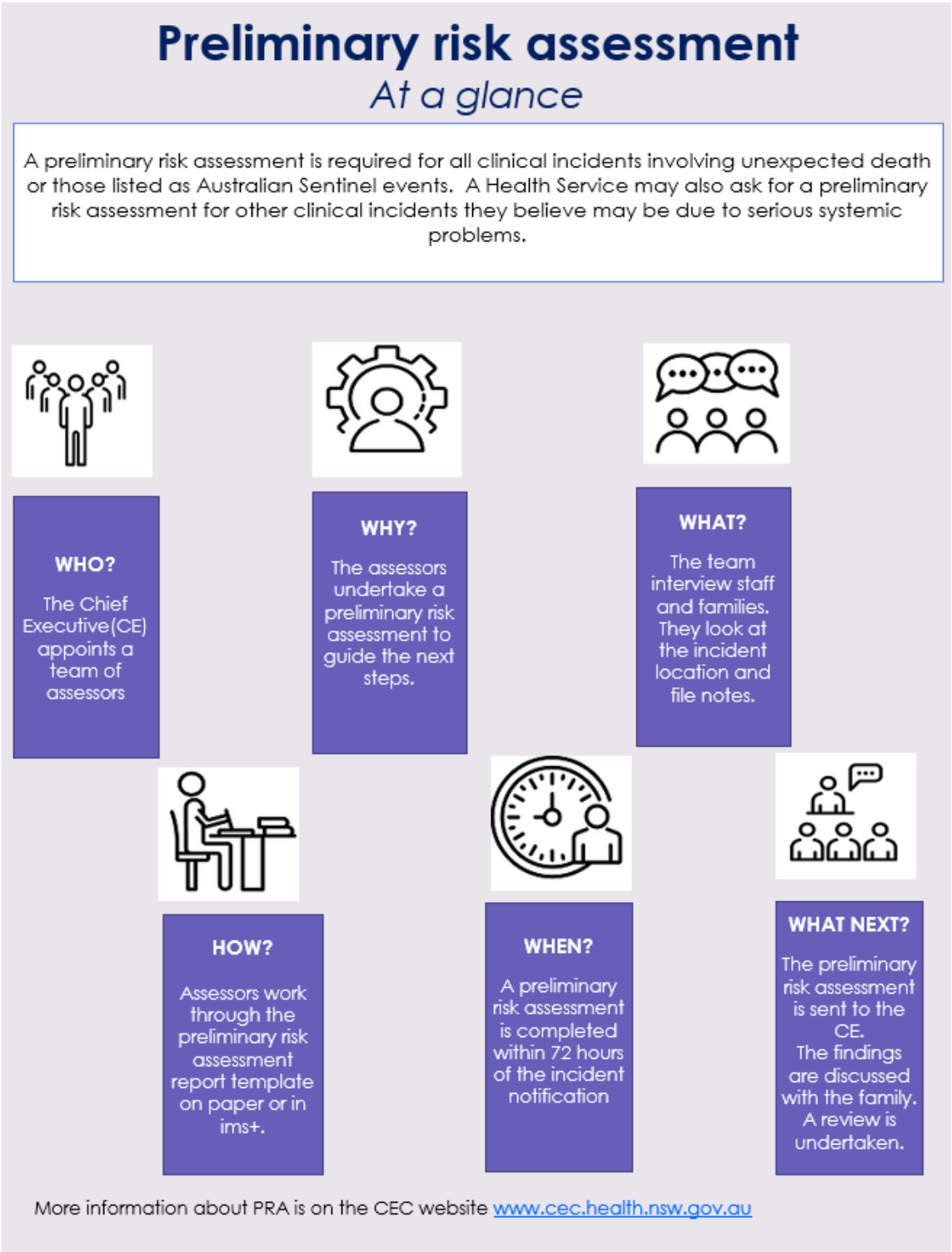
The dedicated family contact maintains regular communication and assists the family in setting up meetings with the Open Disclosure Team and review team.

Where does the PRA fit in to the incident management process?

When a serious incident occurs:

- A staff member notifies the incident in the incident management system, ims+
- A nominated staff member completes the reportable incident brief (RIB) Part A in ims+. This is approved by the CE and submitted to the Ministry of Health (MoH) within 24 hours. It has the basic information known at the time of the incident.
- The CE appoints assessors to undertake a PRA and submit the PRA advice within 72 hours or sooner to the CE.
- The PRA generates further information that can be used to complete RIB Part B which is then approved by the CE and submitted to the MoH.
- The CE then appoints a team to undertake a comprehensive review of the incident which is called a serious adverse event review (SAER).

Infographic



3. Dedicated family contact

Role description

Overview

The dedicated family contact is a staff member assigned to support a patient, carer or family during a serious adverse event review and beyond if needed.

The dedicated family contact has (or is able to establish) rapport, credibility and trust with the family.

The dedicated family contact is the primary contact for the patient, carer and family. They maintain regular communication and help them to navigate the health system and understand the incident review process.

Key tasks

- contact the family after a serious incident and establish an approach for ongoing communication
- ensure any concerns are directed to relevant health service staff
- maintain regular contact and establish agreed time intervals when communication with the family will be offered i.e. communication touch points
- mobilise any support needed e.g. Social Worker, Advocate, Interpreter
- help the family navigate the health system
- explain the review process including timelines, the steps involved and the scope of the review
- liaise with the review team and Open Disclosure team
- seek assistance from dedicated family contact lead or Clinical Governance to addresses any unresolved family concerns / issues

Dedicated Family Contact Information Pack

Frequently asked questions

A dedicated family contact is a staff member assigned to a patient, carer or family following a clinical Harm Score 1 incident.

The dedicated family contact:

- is a consistent point of contact for families
- establishes rapport and trust with the family
- coordinates communication with the health service during the incident review.

When do we need a dedicated family contact?

Health Services must undertake a preliminary risk assessment (PRA) for all clinical Harm Score 1 incidents. During the PRA, a dedicated family contact is assigned.

A serious adverse event review (SAER) then takes place. The dedicated family contact provides continuity to the family for throughout the SAER.

What does a dedicated family contact do?

- Manages communication according to the family's preferences
- Respectfully manages expectations about the review including:
    - steps involved
    - timeframes
    - focus on system issues, not individuals
- Provides practical support e.g. engage interpreters or social work, arrange accommodation
- Invites the family to provide information to the SAER team leader
- Liaises with the review team and open disclosure team

When does dedicated family contact touch base with the family?

When first assigned, the dedicated family contact meets and establishes a relationship with the family. They then touch base

1. After the preliminary risk assessment
2. After the SAER findings
3. After the SAER recommendations.

They also contact the family at other points, as per the family's wishes. This may include beyond the incident review process.

Can the dedicated family contact be part of the open disclosure or review team?

No. The dedicated family contact is not part of the review team or open disclosure team. The dedicated family contact needs to be separate to avoid confusion.

How does a dedicated family contact interact with the open disclosure team or review team?

The dedicated family contact can set up meetings, raise questions or relay information to or from the family.

What if the dedicated family contact knows the family?

Wherever possible, it is important that the dedicated family contact is not personally connected to the family. This may not always be possible in rural or remote areas

4. Open disclosure

What is open disclosure?

Open disclosure is defined in the Australian Open Disclosure Framework[2] as:

"an open discussion or series of discussions with a patient and/or their support person(s) about a patient safety incident which could have resulted or did result in harm to that patient while they were receiving health care."

The five essential elements of open disclosure are:

1. an apology
2. a factual explanation of what happened
3. an opportunity for the patient to relate his or her experience
4. a discussion of the potential consequences
5. an explanation of the steps being taken to manage the event and prevent recurrence.

When is open disclosure required?

An open disclosure discussion is required whenever a patient has been involved in a patient safety incident.

Serious incidents require two broad stages of open disclosure over time:

- clinician disclosure immediately following an incident

  and

- formal open disclosure by an assigned team of staff.

Each stage may consist of several discussions, depending on the patient's condition, understanding of events and any questions that may arise.

When a serious incident review is completed the following times present an opportunity for open disclosure with the family

Time interval	Purpose
Immediately following incident	Clinician disclosure –clinician explains what happened and provides an apology and explanation of next steps
Following preliminary risk assessment (PRA)	Open disclosure team meet with family, provide PRA findings and explanation of next steps
Following completion of Findings Report	Open disclosure team meet with family, provide findings and explanation of next steps
Following completion of Recommendations Report	Open disclosure team meet with family and describe actions to be taken to prevent similar incidents recurring

What is the difference between clinician disclosure and open disclosure?

Open Disclosure begins with clinician disclosure – the initial discussion with a patient and/or their support person(s) following a patient safety incident. It is an informal process designed to advise and support the patient and/or their support person(s) and to offer an apology for what has happened.

Formal open disclosure is a structured process which follows on from clinician disclosure as soon as is practicable. To enable this process, a multidisciplinary open disclosure team is activated before meeting with the patient and/or their support person. A senior clinician or manager who is trained as an open disclosure advisor guides this team through preparation, delivery and debriefing the formal open disclosure discussion with the patient and/or their support person.

How does the dedicated family contact relate to the open disclosure team?

The dedicated family contact assists the family to engage with disclosure team. Examples of how assistance is provided include setting up meetings, raising questions or relaying information.

Dedicated Family Contact Information Pack

What if the family don't want to meet with the open disclosure team?

A family may indicate that they do not wish to participate in open disclosure, or they may request deferral of the formal open disclosure discussion. The dedicated family contact person should advise them that they are able to request that open disclosure proceeds at any time in the future.

Where can you find more information?

The NSW Health Open Disclosure Policy (PD2014_028) sets out the minimum requirements for implementing consistent open disclosure processes within NSW health services, describes when open disclosure is required, defines the two stages of open disclosure, outlines the key steps and outlines the key responsibilities of health care staff in relation to open disclosure.

Staff assigned to the role of dedicated family contact may wish to complete the following modules on My Health Learning:

1. Open Disclosure Advisor. Course Code: 59186195
2. Breaking bad news. Course Code: 39962615

Completion of these modules will assist staff to support families by developing an understanding of communication principles following a serious incident.

For further information contact your Clinical Governance team or look out for updates on the Clinical Excellence Commission website www.cec.health.nsw.gov.au/.

Australian Commission on Safety and Quality in Health Care (ACSQHC) Australian Open Disclosure Framework, Sydney, 2013

Health Service communication with families after a serious patient harm incident

We are committed to regular contact with families, as we review what happened, why it happened and how we can prevent it happening again.
A dedicated family contact is the primary contact for the family. There is also contact with the open disclosure team, and the review team, as per the family's wishes.

When? After the patient harm

	Who?	What?
1	Clinical staff member	Disclose incident within 24 hours, apologise and explain next steps

When? After the preliminary risk assessment

	Who?	What?
2	Dedicated family contact	Introduce self and set up family meeting with open disclosure team
3	Open Disclosure team	Explain what is known about the incident in the first 72 hours

When? During the review

	Who?	What?
4	Dedicated family contact	Set up meeting with review team or offer to pass on information
5	Review team	Gain insights from family about the incident (if desired)

When? After the first stage of the review

	Who?	What?
6	Dedicated Family Contact	Set up family meeting with open disclosure team
7	Open Disclosure team	Explain findings of review

When? After the second stage of the review

	Who?	What?
8	Dedicated Family Contact	Set up family meeting with open disclosure team
9	Open Disclosure team	Explain recommendations made and how they will be monitored

.....and beyond as per the family's wishes

5. Communicating with families

The dedicated family contact is the primary contact for a family following a serious patient harm incident. The dedicated family contact develops rapport and a trusting relationship with the family as soon as possible and maintains regular communication.

This guidance has been developed to support positive communication between the dedicated family contact and family.

General principles

Wherever possible, communication with the family should:

- be in person
- take place in a quiet area to maintain confidentiality and provide privacy
- at a location and time that is convenient and easily accessible for the family
- allow sufficient time to relay information, listen to the concerns, address questions and check communication has been understood as intended
- be free from interruptions e.g. ask colleagues to cover pager or carry mobile phone
- sensitive to cultural, language and communication needs.
- is sincere
- avoid jargon, which can alienate families
- uses clear, lay explanations of medical terms

The approach to communication should be in keeping with the family's wishes.

In some cases, the family may find it challenging to visit the health service. It may be appropriate for the dedicated family contact to meet the family off site or in their home. It is also possible that the family may prefer phone contact. Clearly document offers of face to face meetings and family preferences for in person and/or telephone contact.

Once the dedicated family contact has been assigned, they telephone the nominated family member. During this first interaction they:

- introduce themselves as the dedicated family contact and describe their role in the organisation
- offer an apology and express condolences if appropriate
- explain the role of the dedicated family contact and provide contact details.
- invite family to meet in a face to face meeting.

If family are agreeable with a face to face meeting, a time and meeting place are agreed upon. A meeting place should be agreed upon from where the family can be accompanied to the meeting room.

When setting up the first meeting, the dedicated family contact needs to recognise and support cultural needs e.g. Aboriginal people, culturally and linguistically diverse communities. The needs of people with learning, cognitive disabilities or health literacy are considered.

First meeting with the family

The first meeting provides an opportunity for the dedicated family contact to establish a rapport with the family. Sufficient time should be allocated to enable information to be exchanged and any questions answered.

The discussion should include:

1. introductions
2. an apology or expression of empathy and regret for what has happened

3. explanation of the role of the dedicated family contact to all family members.
4. listening to the family and understanding their concerns and queries
5. agreement on how communication with the family will take place e.g. who will be contacted, when will they be contacted, where communication will take place and how other family members will be kept updated
6. an offer of practical assistance such as referrals to other health care professionals, social worker or assistance with accommodation, parking
7. assurance to the family that they will be kept informed regularly about reviews and an estimate of when they can expect to next hear from the dedicated family contact
8. a description of the review process including timelines and an explanation of the difference between the Open Disclosure and review teams
9. an offer to organise the meeting with the Open Disclosure team to discuss the preliminary risk assessment
10. an overview of the scope of the review indicating that:
    - the focus is systems issues, not individuals
    - the cause of death is not determined by the review team. This is the role of the Coroner of medical officer
    - recommendations are approved by the Chief Executive.
11. an invitation for the family to meet with the serious adverse event review team leader. If they decline the dedicated family contact should pass on family queries, recollections or recommendation ideas to the review team leader as appropriate.

Anticipate the response

It is unrealistic to think that the first meeting will be easy or quick, especially when the patient has been involved in a serious adverse event that has caused harm. The meeting should be open-ended if possible and closed only when the patient/family are ready; ending a meeting prematurely may make the family resentful. Expressions of anger, resentment and other emotions should be expected, and the patient/family may want the names of 'who is responsible'. The role of the dedicated family contact is to listen and acknowledge the feelings being expressed.

What to do

- Name the 'feeling' not the 'person'. The feeling is the focus for validating impact and outcome of the incident and establishes empathy.
- Stay with the person in the moment by acknowledging their emotions. Focus on how they feel ensures you don't dismiss or endorse their perspective.

For example, if they say 'the doctor killed my father'. Acknowledge their feelings with an empathic response:

You feel really sad / angry / disappointed /furious

You feel really let down by your doctor

- Restorative actions are useful but don't over commit or offer something beyond your capacity to provide. Clarify what action or response you can offer with words such as "this is what I can do".

What not to do

Avoid the following:

- Defensive response
- Blaming response
- Agreeing with the person
- Offering something you cannot give them.

It should be explained to the family that the review is being conducted to identify system issues and implement corrective actions, and that the team will not be assigning blame to anyone involved in the event.

Communication is an intervention; you need to be mindful of its impact during every encounter

Tips for good communication

Communicating with patients, carers and families when they are experiencing anxiety and or grief may take time and information may need to be repeated, basic principles applied should be:

1. Work through the family's agenda rather than your own.

2. Strong emotions need to be dealt with empathically. Empathy is the experience of being heard and understood, empathy includes:

- active listening
- reflecting the patient/families experience back to them
- acknowledging the emotions they may be feeling.

3. Avoid being drawn into an argument.

4. Provide information in an objective and clear manner

5. Tell the family when you will contact them next and let them know they can contact you sooner if required

Follow up meetings with the family

The dedicated family contact telephones the nominated family representative at defined phases of the review process. Refer to *Communicating with patients, families and carers after a serious incident*.

During each contact the dedicated family contact:

- explains the stage of incident review
- provides clarification on any issues previously raised by the family
- offers to organise a meeting with the open disclosure team or review team as appropriate
- checks to see if any further practical assistance needs to be arranged
- invites questions from the family
- check that the family's expectations have been met

The dedicated family contact offers to meet with the family in person. This should be arranged to take place in accordance with the family's wishes.

It may be appropriate for the family to meet with the dedicated family contact prior to meeting with the open disclosure or review teams.

Planning for meetings

In preparation for meetings with the family the dedicated family contact:

- books room on site or car if visiting family off site
- follows up on any previous questions raised

- ensures that any offers or practical assistance previously promised have been actioned
- anticipates questions and where possible prepares for these

Documentation

Any communication or attempted communication with the family is documented. This should be a factual recount of what was discussed and the family's response. Staff appointed to the role of dedicated family contact should check with the dedicated family contact lead about where this should be recorded.

For further information contact your Clinical Governance Unit or look out for updates on the Clinical Excellence Commission website www.cec.health.nsw.gov.au/.

6. Providing written information

A key task of the dedicated family contact is to provide the family with information about the serious adverse event review process. This is done through discussions, supported by written information.

What impacts on a family's ability to take in information?

- the emotional impact of grief and loss
- trust in the health service
- literacy levels
- language spoken at home
- preferences on how much information is required.

Wherever possible, a discussion should take place in person or on the telephone before providing any written information.

Resources for families

Written resources for families are available on the Clinical Excellence Commission website.

They include:

- Information for patient carers and families: What to expect when a serious incident occurs summary
- Information for patient carers and families: What to expect when a serious incident occurs booklet
- Fact sheets on individual elements e.g. open disclosure
- Infographics on individual elements e.g. preliminary risk assessment

Which resource gives families an overview of the NSW Health incident management process?

The *Information for patient carers and families: What to expect when a serious incident occurs summary* provides a high- level overview of the review process and has been written using plain English principles. It has been translated into the top 10 community languages and should be offered in the family's preferred language where possible.

When you first meet with the family

At the first meeting, the dedicated family contact should ask the family if they have received the *Information for patient carers and families: What to expect when a serious incident occurs summary.* They may have received a copy during clinician disclosure.

If the family have not previously received the *Information for patient carers and families: What to expect when a serious incident occurs summary*, the dedicated family contact should provide the document with an explanation of the information included. The family should be invited to ask any questions or clarify information. In addition, the dedicated family contact should advise the family that there is also a more detailed booklet available and if they would like it.

Offering additional information

Prior to issuing any additional written information, the dedicated family contact should have a discussion with the family to determine the right approach.

Approaches include:

1) No additional information provided as per the request of the family

2) Supplementary fact sheets and / or infographics provided – where families are engaged with the dedicated family contact and the review process, these could be provided to families at each stage of the process so as not to overwhelm families with the booklet.

3) Provision of *Information for patient carers and families: What to expect when a serious incident occurs booklet*

In determining the approach to providing written information, the dedicated family contact considers literacy levels, language preferences and family preferences to receiving information which is available.

The dedicated family contact should check in with the family at each contact to make sure that they have received information in keeping with their needs

Information about support services

In addition to providing written information about serious adverse event review processes, the family might benefit from details of local support services.

The dedicated family contact should provide details about services such as grief counselling, financial hardship and others they feel may benefit the family. This will be based on the dedicated family contacts assessment / judgement after the initial interaction with the family. Further information can be obtained from the dedicated family contact lead and /or Clinical Governance.

The Open Disclosure team will provide the family with a copy of the Findings and Recommendations report on completion of the serious adverse event review

7. Briefing, debriefing and reflection

It is recommended that staff appointed to role of the dedicated family contact brief and debrief before and after each contact with the family. This will enable sufficient opportunity to plan for meetings and then reflect on them for future improvement.

The ability to access briefing and debriefing will vary from site to site. As a starting point, the dedicated family contact should speak to their Clinical Governance Unit to determine what is available. It is recommended that sessions be set up in advance.

Briefing before a family contact

Briefing can be defined as orientating a person to an experience, which includes the instructions, goals and rules within which participants in the activity can achieve their goals[1]

Briefing before a family discussion enables the dedicated family contact to plan for the session by considering the issues that may arise. It can also be a valuable opportunity for the staff member to express their concerns in a safe environment and draw on their individual strengths.

Issues for consideration during a briefing session include:

- what information needs to be relayed and what the role can provide for the family including:
    - Referral
    - Liaison
- managing family expectations including questions they may ask and how to answer them
- developing a rough plan for the session
- preparing for emotional containment including:
    - anticipating the family's response
    - setting clear limits to manage reactive responses and potential escalation
- any other concerns the dedicated family contact person may have

Debriefing after a family contact

Debriefing is a discussion; its goals is to discuss the actions and thought processes involved in a particular situation, encourage reflection on those actions and thought processes, and incorporate improvement into future performance[2].

The purpose of debriefing for the dedicated family contact is to identify aspects of the discussion that went well and those that did not. The discussion then focuses on how to improve future communication with the family.

Generally, the content of debriefing sessions involves the following broad questions:

- description of what happened
- what went well and why?
- what were the more challenging components and why?
- are there any family issues / concerns which require escalation? Have these been addressed and the family informed?
- how can future communication with the family be improved?

Reflective practice after a family contact

Reflective practice is about looking back and reflecting upon an experience that has occurred during practice. It encourages reflection and thoughts about what happened, decisions that were made, actions that were taken and the consequences of those decisions and actions

Dedicated Family Contact Information Pack

The dedicated family contact is encouraged to reflect following each contact with the family. There are many different models of reflective practice however, they all share the same basic aim to get the best results from the learning. One simple model was developed by Driscoll and is referred to as the *What? So What? and Now What?* Approach[3]. Using this model, the dedicated family contact reflects on:

- **What happened?** Description of the meeting / contact.
- **So what?** A scrutiny of the situation and what has been learnt through the experience
- **Now what?** Reflection on ways in which staff can personally improve and the consequences of their response to the experience

Where can I find more information?

If staff appointed to the dedicated family contact role require additional support, they are encouraged to contact the Employee Assistance Program (EAP).

EAP is a free, confidential counselling, coaching and wellbeing service available to all NSW Health staff and their immediate family.

Check your local intranet or speak with your Human Resources (HR) team for details.

For further information contact your Clinical Governance team or look out for updates on the Clinical Excellence Commission website www.cec.health.nsw.gov.au/.

1. Pearson, M. & Smith, D. 1986. Debriefing in experience-based learning. Simulation Games for Learning, 16, 155–172.
2. Agency for Healthcare Research and Quality. 2019. Debriefing for Clinical Learning.

   https://psnet.ahrq.gov/primer/debriefing-clinical-learning
3. University of Cambridge 2020. Reflective Practice Toolkit

https://libguides.cam.ac.uk/reflectivepracticetoolkit/models

8. Glossary

Term	Definition
Clinician disclosure	An informal process where the treating clinician discusses with a patient/family the occurrence of a patient safety incident; actively seeks input and feedback from, and listens to, the patient /family and provides an apology for the occurrence of the event.
Dedicated family contact	A staff member who is the primary contact for the patient, carer and family for a serious incident review and at times beyond. They are assigned during the preliminary risk assessment and liaise between the patient, carer and family, open disclosure team and review team.
Formal open disclosure	A structured process which follows on from clinician disclosure, to ensure effective communications between the patient / family and the organisation occurs in a timely manner. It is delivered by a multidisciplinary team including a senior manager.
Preliminary risk assessment	A preliminary risk assessment is completed following notification of a serious incident. It involves a small team of staff undertaking an initial assessment to ensure that people and the environment are safe and supported. It allows for the identification of any remaining risk factors in order that they be addressed earlier
Privilege	Privilege protects preliminary risk assessment and serious adverse event review team members and documents produced as part of the review process from use as admissible evidence in any legal proceedings Preliminary risk assessment and serious adverse event review team members maintain privilege by not disclosing any information obtained during the investigation, unless it is for a purpose that is part of the RCA process
Serious incident	A clinical incident that resulted in the unexpected death of a patient or is listed as an Australian Sentinel event.
Serious adverse event review team	A team appointed under the legislation to conduct a root cause analysis or other type of review prescribed by the legislation The team are part of the health services and have experience with care processes in the area where the incident occurred.
Serious adverse event review methodology	Serious adverse even review is a methodology used to review a serious incident. The purpose of a Serious adverse even review is to identify system issues that contributed to or resulted in the incident occurring and to provide recommendations on actions to be taken to prevent or minimise a recurrence of a similar incident.

Term	Definition
	Serious adverse even review is not used to apportion blame to staff; it is designed for learning and improving the quality of the health system. The following methods are approved methodologies: 1. Root cause analysis 2. Systems review of clinical incidents – London Protocol 3. NSW Health Concise incident analysis 4. NSW Health Comprehensive incident analysis