

How to engage with consumers following an adverse event

Engaging consumers in adverse event review can help to improve health care. Consumers can provide insights into the circumstances of an adverse event that can shed greater light on what happened and lead to a deeper analysis of underlying causes. This can encourage providers to think about alternative perspectives and provide insights into possible improvements and solutions to prevent further events. Consumer involvement can also have the added benefit of being healing and restorative for the person involved.^{1,2}

Consumers may also include whānau, especially where the affected consumer has died or is not able to participate in a review. When discussing adverse events with whānau, it is important to ensure the Health Information Privacy Code 1994³ and local policies are followed.

The Commission has developed an eight-step guide to engaging with consumers following an adverse event. In engaging with consumers, it is important to differentiate between consumers who are ‘affected’ by an adverse event and ‘independent consumers’ who actively contribute to the adverse event review process.

Step 1: Inform the affected consumer an adverse event has occurred

Consumers have a right to know when something harmful or potentially harmful has happened to them. Open communication (also referred to as ‘open disclosure’) is a core principle of the National Adverse Events Reporting Policy⁴ – ‘consumers are ethically and legally entitled to truthful and open communication at all times following an adverse event’.

According to the Health and Disability Commissioner’s *Guidance on open disclosure policies*,⁵ open communication following an adverse event should:

- be timely (usually within 24 hours of the event occurring or the harm or error being recognised)
- be led by the provider with overall responsibility for the affected consumer’s care

¹ Health Quality & Safety Commission. 2015. *Engaging with consumers: a guide for district health boards*. Wellington: Health Quality & Safety Commission.

² Health Quality & Safety Commission. 2017. *Learning from adverse events 2016–17*. Wellington: Health Quality & Safety Commission.

³ See the full code at: <https://privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code-1994>; and the Health Information Privacy Fact Sheet 1 at: <https://privacy.org.nz/news-and-publications/guidance-resources/health-information-privacy-fact-sheet-1-overview>.

⁴ Health Quality & Safety Commission. 2017. *National Adverse Events Reporting Policy 2017*. Wellington: Health Quality & Safety Commission.

⁵ Health and Disability Commissioner. 2009. *Guidance on open disclosure policies*. Wellington: Health and Disability Commissioner.

- include acknowledgement of the event, an explanation of what has happened and, where appropriate, what actions have been taken to prevent it happening again
- include a sincere apology.

Step 2: Explain the review process to the affected consumer

A key aspect of open communication is providing an explanation of what happened. However, this explanation is often not available until a review of the adverse event has taken place.

Early communications between the provider and the affected consumer should include information about the review process, what will be involved, how long it will take, who will be the key contact for the consumer and how the consumer can be involved in the review. The consumer should be updated regularly about the progress of the review.

Affected consumers should be made aware that contributing to the review is voluntary and they should be given a choice about how much they want to be involved. Not all consumers who have been involved in an adverse event will want to be interviewed or provide feedback on the review report, however they must be offered the opportunity.

Step 3: Listen to the affected consumer's story

All consumers who have been affected by an adverse event (and/or their key support people or representative) should be offered the opportunity to tell their story of the event. Providers should start reviews by interviewing the affected consumer, listening to and documenting their story of what happened. This should include how the person feels about what happened, what they think may have contributed to the event, how the event has affected them and what they think might prevent the event happening again. The person should be reassured that their information will be kept confidential. At this time it is important to ascertain what support the consumer will require, offer that support and provide a person (and deputy) who the consumer can contact when they need to.

Step 4: Be open to consumer perspectives in review of the event

The consumer's story should be given equal consideration with provider perspectives in analysis of the adverse event. One way of strengthening the consumer voice in the event review process is by inviting an independent consumer to be a member of the adverse event review team. This person is not generally an employee of the provider organisation and will not have been affected by the adverse event under review but may have been affected personally or had a family member affected by an adverse event in the past. They are on the review team to provide a consumer perspective on understanding what happened and what might be done differently in the future.

Providers should aim for diversity and inclusion when engaging independent consumers to be part of adverse event review teams. This means involving people who reflect the lived experiences and characteristics of the population using the health service (eg, age groups, cultural backgrounds, socioeconomic status and education levels). This also means

considering and addressing the barriers that prevent different groups from participating in adverse events review, particularly those involving people from a different culture.^{6,7}

Examples of ways to increase consumer involvement in the adverse review process include:

- having an independent consumer on the review team who is from the same cultural group as the affected consumer taking into consideration their willingness to participate in the review process
- having a range of cultural advisors available to contribute to the review where appropriate.

If the consumer has been under mental health services, then there may already be consumers and family advisors within the district health board (DHB) employed specifically for supporting consumers.

Step 5: Check the draft report with the affected consumer

Providers should give the affected consumer the opportunity to check the draft review report, including findings and recommendations, and provide feedback on it. The affected consumer's feedback should be given serious consideration. While not all feedback will result in a change to the report, all feedback must be considered, and an explanation provided where feedback does not result in a change to the report.

Step 6: Communicate all review findings to the affected consumer

The affected consumer should be given a copy of the final review report. In line with the principles of honest and full communication, providers should produce one final review report for all, including providers and consumers.

Step 7: Commit to taking action

The provider should commit to implementing any recommendations made from reviews. They should also monitor and follow up recommendations to ensure they are effectively implemented.

Step 8: Follow up with the affected consumer on actions taken

The affected consumer should be kept updated on actions taken as a result of the review. Organisational governance plays a critical role in this final stage of consumer engagement in review and learning. Governance bodies are responsible for implementing and following up review recommendations and keeping consumers updated on implementation progress. It is important to ask consumers what they would like in terms of ongoing update on progress.

A summary of these steps is below (see Associated resources).

⁶ Health Quality & Safety Commission. 2017. [Learning from adverse events 2016–17](#). Wellington: Health Quality & Safety Commission.

⁷ Health Quality & Safety Commission. 2015. [Engaging with consumers: a guide for district health boards](#). Wellington: Health Quality & Safety Commission.

Further resources and reading

Health Quality & Safety Commission. 2017. [Learning from adverse events 2016–17](#). Wellington: Health Quality & Safety Commission. Chapter 2, Consumers as partners in learning from adverse events. Note this chapter also contains additional resources.

Health Quality & Safety Commission. 2017. [Representing the consumer voice in an adverse event review](#) (video).

Health Quality & Safety Commission. 2015. [Engaging with consumers: a guide for district health boards](#). Wellington: Health Quality & Safety Commission.

Canadian Patient Safety Institute. 2017. [Engaging patients in patient safety: a Canadian guide](#). Ontario: Canadian Patient Safety Institute.

Canadian Patient Safety Institute. nd. [Communicating after harm in healthcare](#). Ontario: Canadian Patient Safety Institute.

Mental health family/whānau advisors and consumer mental health and addiction support networks:

- [Matua Raki: DHB family whānau advisors](#)
- [Mental Health Foundation: Consumer/Tangata Whaiora Networks](#)

Associated resources

[Eight-step guide to partnering with whānau following an adverse event](#)