Open Disclosure (including SAPSE)

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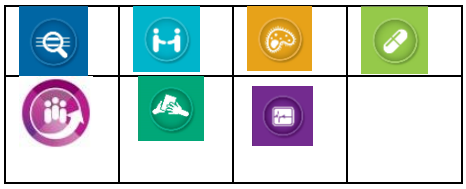
National Standards: 	**Personnel Affected:** **All personnel**

Purpose

To ensure all staff at Wyndham Clinic Private Hospital (WCPH) are aware of the Open Disclosure and Serious Adverse Patient Safety Events (SAPSE) processes and how and when to apply them.

Definitions

An adverse event is an incident that results in harm whether physical or psychological to a patient while receiving healthcare.

Open disclosure is defined as an open discussion with the patient, family and/or significant others that result in harm while receiving healthcare.

The Statutory Duty of Candour (SDC) is required to patients when they have suffered SAPSE while receiving health care/services. The SDC builds on the principles and elements of open disclosure within the Australian Open Disclosure Framework.

Compliance

Review of any major incident process

Policy

All incidents/risks/hazards are reported via WCPH Incident Management System (Risk Clear).

Where an incident has occurred Wyndham Clinic Private Hospital will ensure that communication with, and support for all affected patients and staff, occurs in a supportive and timely manner.

Wyndham Clinic Private Hospital takes the 'no-blame approach' and it is very important to ensure that our staff feel comfortable about speaking up about adverse events so we continually improve our systems and processes.

Wyndham Clinic Private Hospital encourages the involvement of Consumers in any review processes and discussions with patients and carers.

Where a SAPSE has occurred, the process will be followed by all staff to ensure compliance with Victorian Legislation.

Any SAPSE review is overseen by the CEO/DON.

A standardised approach is in place for all staff at Wyndham Clinic Private Hospital, to communicate with the patient and/or their nominated relatives/carers after a clinical incident

Open Disclosure (including SAPSE)

Procedure

The individual who detected the incident should make an initial assessment of the incident, in consultation with a senior clinician. This process will consider the severity of harm and the level of response required. The level of response required will be determined by the effect, severity, or consequence of the incident.

If a major incident occurs ensure the safety of all staff patients and visitors

Escalate where required via the Emergency Response process to the senior clinician on duty and to the Executive on duty or on call.

WCPH is required to comply with any timelines and requirements set out in the Victorian Duty of Candour Guidelines (legislative instrument). If the event is classified as a sentinel event, they must also comply with any relevant timelines within the Victorian sentinel event guide.

For assistance and/or reporting clarification please contact;

Incident Response Team at Safer Care Victoria 03 9096 1546 or via email at sentinel.events@safercare.vic.gov.au

If a patient suffers a SAPSE in the course of receiving health care, the health service entity responsible for providing those services owes a Statutory Duty of Candour to the patient and must do the following unless the patient has opted out:

- provide the patient with:
    - a written account of the facts regarding the SAPSE;
    - an apology for the harm suffered by the patient;
    - a description of the health service entity's response to the event;
    - the steps that the health service entity has taken to prevent re-occurrence of the event;
    - any prescribed information; and
- comply with any steps set out in these Guidelines (see Appendix 1)

Mandatory Reporting

WCPH will submit data when required to the Health Collect portal in line with Statutory Duty of Candour reporting requirements and SAPSE reporting schedule https://www.healthcollect.vic.gov.au

The Open Disclosure Process (see detail at Appendix 2) should be used of any incident that is not a SAPSE and will commence after the detection of a clinical incident by:

- Open and timely communication
- An acknowledgement
- An apology or expression of regret
- Supporting and meeting the needs and expectations of patients and significant others
- Supporting and meeting the needs of healthcare providers
- Review to ensure that any learnings from the incident are incorporated into clinical practice

- Adverse events are reported to and discussed at Clinical Governance, Medical Advisory and Nursing Advisory Groups
- Any recommendations from the governance groups are feedback to the clinical areas
- Confidentiality is maintained for staff, patient, and anyone else involved in the open disclosure process

Where appropriate, the multidisciplinary team and all other clinicians involved in the adverse event, including the most senior clinician, will communicate as soon as possible after the event to achieve the following.

- Establish the basic facts (clinical and other facts).
- Assess the event to determine the appropriate response.
- Identify who will take responsibility for discussion with the patient, their family and carers.
- Consider the appropriateness of engaging patient support at this early stage, including the use of a
- facilitator or a patient advocate.
- Identify immediate support needs for everyone involved.
- Ensure that all team members maintain a consistent approach in any discussions with the patient, their
- family and carers.
- Consider legal and insurance issues, both for the organisation and the clinicians, and notify the relevant
- people.
- Consider how to address issues regarding ongoing care such as billing and other costs, which should be
- addressed at the earliest opportunity.

The individual leading the open disclosure should, where possible, be the most senior clinician who is responsible for the care of the patient. Ideally, the lead person should:

- be known to the patient, their family, and carers
- be familiar with the facts of the adverse event and the care of the patient
- be of appropriate seniority to ensure credibility
- have received training in open disclosure
- have good interpersonal skills
- be able to communicate clearly in everyday language
- be able and willing to offer reassurance and feedback to the patient, their family and carers
- where possible and appropriate, be willing to maintain a medium to long-term relationship with the
- patient, their family and carers.

The decision about who will make the disclosure should, where possible, be made in consultation with the patient, their family and carers and senior management. If for any reason the senior clinician is unable to lead the open disclosure, a substitute will need to be selected but, ideally, the senior clinician should still be present at the discussion. The person leading the open disclosure may require the support of a senior staff member with appropriate skills.

The Open Disclosure Discussion Summary is to be completed and kept in the patient file.

Open Disclosure Training and Education for WCPH Leadership Team

- All Clinical Managers at WCPH complete the Safer Care Victoria eLearning Modules for Open Disclosure including SAPSE. This training forms part of WCPH Mandatory Training for managers and is completed bi-annually.
- Training completion evidence is linked to Training profiles on Risk Clear Training Register.

References

Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework – better communication a better way to care. 2013

Australian Commission on Safety and Quality in Health Care. Implementing the Australian Open Disclosure Framework in small practices

Safer Care Victoria website

Protections for serious adverse patient safety event (SAPSE) reviews

Statutory Duty of Candour and protections for SAPSE reviews | Safer Care Victoria

Targeting zero report: Better, Safer Care, Delivering a world-leading healthcare system

Victorian Duty of Candour Framework

Victorian sentinel events guide

Policy: Adverse patient safety events

Revision History

Version	Date	Committees and Persons Involved in Review	Authorised By
1	May 2015	BOM	DON
2	April 2016	BOM	DON
3	July 2017	BOM	DON/CSM
3 reviewed	July 2018	HOD Clinical Governance	DON
4	Nov 2019	HODS	DON
5	November 2020	MAC, HODs	DON
5 reviewed	November 2021	No changes, HODS, MAC, BOM	DON
6	November 2022	Addition of SAPSE, CGC, MAC	DON
7	March 2025	Consolidation of two WCPH Open Disclosure Policies, duplicate content in both policies – Merge into one policy document.	CEO/DON, QM

Appendix 1: SAPSE Requirements

The steps set out in these Guidelines that must be followed are the Requirements below. The remainder of the Guidelines include recommendations that the health service entities may consider when discharging the SDC. At WCPH these requirements are overseen by the Executive

Stage 1: Apologise and provide initial information

- **Requirement 1:** The health service entity must provide a genuine apology for the harm suffered by the patient and initial information, as early as practicable (and **no longer than 24 hours**) after the SAPSE has been identified by the health service entity.
- **Requirement 2:** The health service entity must take steps to organise an Statutory Duty of Candour meeting within **3 business days** of the SAPSE being identified by the health service entity.

Stage 2: Hold the Statutory Duty of Candour Meeting

- **Requirement 3:** The SDC meeting must be held within **10 business days** of the SAPSE being identified by the health service entity.
- **Requirement 4:** The health service entity must ensure that it provides the following in the SDC meeting:
  - an honest, factual explanation of what occurred in a language that is understandable to the patient;
  - an apology for the harm suffered by the patient;
  - an opportunity for the patient to relate their experience and ask questions;
  - an explanation of the steps that will be taken to review the SAPSE and outline any immediate improvements already made; and
  - any implications as a result of the SAPSE (if known) and any follow up for the patient.
- **Requirement 5:** The health service entity must document the SDC meeting and provide a copy of the meeting report to the patient within **10 business days** of the SDC meeting.

Stage 3: Complete a review of the SAPSE and produce report

- **Requirement 6:** The health service entity must complete a review for the SAPSE and produce a report outlining what happened and any areas identified for improvement. If the SAPSE is classified as a sentinel event, the health service entity must also outline in the report clear recommendations from the review findings.
- **Requirement 7:** The report created from Requirement 6 must then be offered to the patient within **50 business days** of the SAPSE being identified by the health service entity. If the SAPSE involves more than one health service entity, this may be extended to **75 business days** of the SAPSE being identified by the initial health service entity.

Documentation and reporting

- **Requirement 8:** The health service entity must ensure that there is a record of the SDC being completed, including clear dates of when the SAPSE occurred and when each stage of the SDC was completed.
- **Requirement 9:** The health service entity must report its compliance with the SDC as legally required.

Appendix 2: Principles of Open Disclosure

1. Open and timely communication

If care doesn't go to plan, the patient should be provided with information about what happened in a timely, open, and honest manner. The open disclosure process is fluid and will often involve the provision of ongoing information.

2. Acknowledgement

All adverse events should be acknowledged to the patient as soon as practicable, and open disclosure initiated. Indemnity insurers should be notified.

3. Apology or expression of regret

As early as possible, the patient should receive an apology or expression of regret for any harm that resulted from an adverse event. An apology or expression of regret should include the words 'I am sorry' or 'we are sorry', but must not contain speculative statements, admission of liability or apportioning of blame.

4. Supporting, and meeting the needs and expectations of patients

The patient can expect to be:

- fully informed of the facts surrounding an adverse event and its consequences
- treated with empathy, respect and consideration
- supported in a manner appropriate to their needs.

5. Supporting, and meeting the needs and expectations of those providing health care

Clinicians and other practitioners should be:

- encouraged and able to recognise and report adverse events
- prepared through training and education to participate in open disclosure
- supported through the open disclosure process.

6. Integrated clinical risk management and systems improvement

Wyndham Clinic Private Hospital will review adverse events to prevent recurrence, enable lessons to be learnt and the quality of care to be improved. The information attained about incidents from open disclosure should be incorporated into these processes.