DD MM YYYY

Statutory Duty of Candour (SDC) – Final report

Incident no. xx

OFFICIAL

|  |
| --- |
| Delete after readingThis report template may be used to outline the findings from the review or investigation of a serious adverse patient safety event (SAPSE) but must not be used for a SAPSE review (protected review), as it will contain the patient’s name, which must not be published in the protected SAPSE review report. This report template is to be provided to a patient or their next-of-kin or nominated person, under Requirement 7 of the [*Victorian Duty of Candour Guidelines*](https://www.safercare.vic.gov.au/sites/default/files/2022-10/Victorian%20Duty%20of%20Candour%20Guidelines%20-%20FINAL.docx), within 50 business days of a SAPSE being identified by the health service entity or 75 business days for a multi-agency review.The review report include the matters required by section 128ZC of the *Health Services Act 1988*, being:* 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.

This report could be short or long depending on the level of harm. Within the report, the health service entity must:* avoid jargon or legalistic wording
* ensure the patient is aware of the timeline for review.

The health service entity may also consider offering the report in a language understandable to the patient. If the report requires translation, inform the patient that this may require more time and document any delay in the appropriate location.*If providing this document in a printed version, this page should be left empty so that the body of the document begins on the following page.* *Delete this instruction box but do not delete the section break on the previous page, or the section break after this box.*  |

Details

|  |  |
| --- | --- |
| **Incident number** |  |
| **Date incident occurred** |  |
| **Patient identification number** |  |
| **Patient name** |  |
| **Patient date of birth** |  |
| **Health service entity** |  |
| **Campus** |  |
| **Ward/unit** |  |

|  |
| --- |
| *If providing this document in a printed version, this page should be left empty so that the body of the document begins on the following page.* *Delete this instruction box but do not delete the page break on the previous page below the table, or section break after this box.*  |

# Example apology/email to accompany report

## This must be personalised for each health service entity and each SAPSE. It must only be used as a guide as it must be tailored to each patient.

Dear <insert patient/representative name>,

I am writing to provide you with <your/patient’s name> review report as part of the open and transparent process known as duty of candour. The information detailed in this report is in relation to the care/treatment you received during your recent visit on/during <insert date> at <insert health service entity name>. We believe that honesty and transparency are essential to maintaining trust between patients and healthcare providers, and we want to ensure that you have all the information you need about your care.

During your stay, you were diagnosed with <medical condition>, which required <treatment or procedure>. While our goal was to provide you with the best possible care, we acknowledge that there were some issues that arose during your treatment that we want to disclose to you.

Upon assessment, the issues that arose during your treatment have been considered a serious adverse patient safety event. We conducted an impartial and thorough review of your safety event by convening a review panel, including independent experts and a consumer, to determine the most appropriate outcomes and recommendations. The recommendations are provided in this report, which has been endorsed by the hospital executive and senior leaders.

[Give a brief summary in this letter of the incident or issue that occurred, using clear and concise language. Be honest and transparent and provide as much detail as possible. Take responsibility for any mistakes or errors that were made and explain what steps you are taking to prevent similar incidents from occurring in the future.]

On behalf of <insert health service entity name>, I would like to sincerely apologise that this has happened and for any harm or distress that this may have caused you/your family. We are committed to learning from this experience to improve the quality of care we provide to our patients.

We understand that this may have affected your trust in us as a service, and we want to assure you that we take this matter seriously. We are dedicated to making things right and ensuring that you receive the best possible care in the future.

If you have any questions or concerns regarding your care, we encourage you to contact <insert point of contact/consumer liaison officer>. We are here to support you and help you through this process.

Sincerely,

<insert name of lead reviewer/clinical governance staff member/CEO>

# Facts and timeline in relation to the serious adverse patient safety event (SAPSE)

## What happened and why. Including timeline leading up to the SAPSE.

### Tips:

* Use a clear and concise writing style.
* Use subheadings where necessary to make it easier to read.
* Avoid jargon and legalistic wording.
* Consider using dot points if easier to follow.
* Have an index for abbreviations.

# Description of <health service entity name> response to the SAPSE

## What the health service entity did at the time and after the event.

### Tips:

* Immediate actions and improvements.
* Outline any support offered to the patient, and whether accepted or declined.
* Utilise timelines if appropriate.
* What are the lessons learned?
* How were the family’s questions considered and responded to?

# Steps that <health service entity name> has taken to prevent a reoccurrence of the event

## What else is being done to prevent re-occurrence?

### Tips:

* What recommendations are in place to prevent re-occurrence specific to the event?
* If they are unachievable recommendations, do not include them.
* Include timelines if appropriate.
* Consider using a table for the recommendations.
* Incorporate patient/family/carer recommendations where appropriate.

Please use Safer Care Victoria’s Sentinel Event [developing recommendations](https://www.safercare.vic.gov.au/sites/default/files/2023-04/Developing%20recommendations.docx) document to assist in building recommendations: [https://www.safercare.vic.gov.au/sites/default/files/2023-04/Developing recommendations.docx](https://www.safercare.vic.gov.au/sites/default/files/2023-04/Developing%20recommendations.docx).

Example table:

|  |
| --- |
| Recommendation no. xx |
| Recommendation  |   |
| Actions to achieve recommendations  |   |
| Recommendation category  |   |
| Outcome measure  |   |
| Exec sponsor  |   |
| Position responsible/accountable\*  |   |
| Program responsible/accountable\*  |   |
| Due date for completion  |   |