DUTY OF CANDOUR
what to expect

Patients and their families or carers have the right to a full explanation and apology when a patient suffers significant harm, known as a serious adverse patient safety event (SAPSE). This open and honest process is called Duty of candour.

What is significant harm?

Significant harm is a serious adverse patient safety event (SAPSE) and is an event that:

- occurred whilst a patient was receiving care from a health service, and
- resulted in unintended or unexpected
  - moderate or severe physical harm
  - death
  - prolonged psychological harm.

A registered health practitioner will review the event to determine whether significant harm occurred.

What to expect: There are three stages to the Duty of candour process.

STAGE 1:
APOLOGISE AND PROVIDE INITIAL INFORMATION

The health service will apologise and share initial information known about the harm experienced:

Within **24 hours** of the harm being recognised by the health service. The health service will offer a genuine apology to the patient and/or family or carer, and share any information known at the time.

Health service will take steps to organise a Duty of candour meeting:

Within **3 business days** of the harm being recognised by the health service, the health service will take steps to organise (not necessarily hold) the Duty of candour meeting.

Your rights

- You will have a Point of Contact person or Consumer Liaison Officer to act as your main contact during this process
- You can decide not to be part of the Duty of candour process, this is called opting-out, but must be via a signed statement which the health service can provide
- You can ask for a delay in the process if you are not ready yet
- You can choose to have a carer or family member with you throughout this process
- You can ask for support from the health service e.g., interpreters, counsellors
- You can ask that certain people are not present at the meeting
- You can decide how you would like to join the meeting - over the phone, videoconference call, at the hospital or at an alternate location if the service has that capability.

How you can prepare for the meeting

To help you get ready for the meeting, you might want to write down:

- What you remember of the event, or if the event affected someone else, what they may have told you
- Any questions or comments you have about:
  - What happened
  - What went wrong
  - The potential long-term impact that the event may have on you / your family member going forward
  - How you would like to be involved in the review process
- Anything else you would like the reviewers to be aware of.

STAGE 2:
HOLD THE DUTY OF CANDOUR MEETING

At the Duty of candour meeting the health service will:

- Take measures to make sure you feel supported
- Explain what happened, based on what is known at the time of meeting
- Apologise for the harm suffered
- Give you the chance to ask questions and explain what you experienced
- Explain what steps they will be taking to review and manage the event, and make improvements
- Explain what, if any, follow up care is needed for you and any implications

The meeting is held within **10 business days** of the harm being recognised by the health service.

The health service will give you notes from the meeting:

Within **10 business days of the meeting**, the health service will give you a copy of the meeting notes.

Your rights

- You can have your support person (e.g. family member or carer) with you at this meeting
- The meeting is two-way process
  - You can ask any questions you need to help you understand what happened
  - You can share your experience about the event
- If you think the meeting notes are wrong or missing anything, talk or write to your Point of Contact person or Consumer Liaison Officer.

STAGE 3:
COMPLETE A REVIEW OF THE HARM EVENT AND PRODUCE A REPORT

The health service wil complete a review of the harm and write a report. A copy of the report will be shared with you:

Within **50-75 business days** of the harm being recognised by the health service, you will receive a copy of the report with the following minimum requirements:

- An apology
- The facts of the event – meaning what happened and why. This may include the timeline leading up to the harm event
- The health service response to the event – meaning what the health service did at the time and after the event
- The steps being taken to prevent similar events from happening again.

Your rights

- The health service will write a report about the harm experienced and any improvements they will make as a result and share this with you. Depending on the harm experienced, it may be a short or long report
- If you are not satisfied with the Duty of candour process, you can make a complaint. This includes making a complaint:
  - Direct with the health service (recommended you try first)
  - To the Health Complaints Commissioner, call **1300 582 113**
  - To the Mental Health Complaints Commissioner, call **1800 246 054**
  - To the Coroners Court of Victoria, call **1300 309 519**.

Throughout the process you can expect:

- To be heard
- To be treated with respect
- To have the support you need
- To have open and honest communication from the health service
- To have your questions answered.

For more information, contact:

To learn more about the the legal requirements of Duty of candour

Go to:

www.safercare.vic.gov.au/ duty-of-candour-resources-for-patients-families-and-their-carers

Safer Care Victoria