# 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.



# 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:

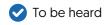
- An apology
- The facts of the event meaning what happened and why. This may include the timeline leading up to the harm event
- The health service response to the event meaning what the health service did at the time and after the event
- The steps being taken to prevent similar events from happening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



