Statutory Duty of Candour: Patient Resources

Usage instructions for health service staff

**OFFICIAL**

The Statutory Duty of Candour (SDC) is a legal requirement under the *Health Services Act 1988*, the *Ambulance Services Act 1986*, and the *Mental Health Act 2014*, and ensures that patients or their family/carers receive an apology and open, honest communication when they suffer a serious adverse patient safety event (SAPSE). Safer Care Victoria (SCV) partnered with the Health Issues Centre to create 3 patient resources: a poster, a flyer, and a Frequently Asked Questions (FAQ) document. Each of these resources were co-designed with a consumer advisory group consisting of lived experience members, family members and carers.

# About the resources

The poster and flyer can be **co-branded** by adding a logo to the left of the SCV logo. The files are not available in an editable format due to the legislative nature of requirements. Resources can be printed in colour or black and white.

We have listed areas where resources can be best displayed to empower consumers seeking further information about their rights in relation to the SDC.

If you would like to make modifications to the text, please contact [dutyofcandour@health.vic.gov.au](mailto:dutyofcandour@health.vic.gov.au) for advice.

## Poster

* The poster is A3 size and in PDF format. It includes a brief introduction to the SDC and gives a general overview of a SAPSE and the SDC requirements.
* If a patient or resident believes they have suffered a SAPSE after reading the poster:
* the resource has a dedicated space for Consumer Liaison Officer (or similar) contact details
* the FAQ document contains further information, (including the full definition of a SAPSE) which the health service can provide.
* Please display the poster in inpatient or resident, public and waiting areas, consulting rooms, and anywhere else appropriate.
* The poster has a QR code and a link to access the SCV webpage for further resources and information.

## Flyer

* The flyer is A4 size and in PDF format. It outlines the 3 stages of the SDC process and the SDC rights of the patient.
* The patient (or their family/carer/nominated person if they cannot participate) should be given the flyer when they have suffered a SAPSE, as outlined in the SDC process. It should be provided prior to the initial SDC meeting and can also be displayed in inpatient or resident areas as appropriate.
* Space is available for a Point of Contact or Consumer Liaison Officer details for the patient to seek more information.
* The flyer has a QR code and a link to access the SCV webpage for further resources and information.

## Frequently Asked Questions (FAQ) document

* The FAQ document is in PDF format and was developed in response to questions arising from the consumer advisory group.
* This resource should be given to a patient (or their family/carer if they cannot participate) who has suffered a SAPSE to assist with any questions they may have. It can also be available in inpatient or resident areas as appropriate.
* The FAQs include a full definition of a SAPSE as outlined in the *Health Services (Quality and Safety) Regulations 2020.* They explain:
* who will be involved in the SDC meeting and review
* how the patient/family/carer can contribute to the SAPSE review
* the support they can access
* how to opt-out or delay the process
* what to do if they disagree with the review findings.
* The FAQ document has a QR code and a link to access the SCV webpage for further resources and information.

## Further information

### Consumer Liaison Officer (CLO)

* When a CLO (or equivalent) is contacted, it is recommended that they:
* listen to the patient’s recollection of the harm event
* ask questions to gain an understanding of the situation
* acknowledge that the event will be reviewed and contact them with further information
* ensure that the clinical incident management system (or similar) is reviewed to ascertain if an event has been entered.
* If the event has not been entered, a registered health practitioner should:
* examine the patient’s medical record and evaluate if the harm event was identified but not recorded
* speak to relevant staff involved in the unit or area
* ascertain if the event meets the criteria of a SAPSE and enter it into the system
* if the event meets criteria of a sentinel event, notify SCV via the sentinel event portal. ([View more information on how to do this](https://www.safercare.vic.gov.au/notify-us/sentinel-events#:~:text=Adverse%20patient%20safety%20events%20that,received%20a%20shortened%20life%20expectancy)).
* The health service should follow internal SAPSE and Open Disclosure (OD) or SDC policies, and commence the SDC process or OD as per the [Australian Open Disclosure Framework](https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework) as appropriate (depending on the level of harm).
* The CLO can also contact the SCV team for further information or advice by emailing [dutyofcandour@health.vic.gov.au](mailto:dutyofcandour@health.vic.gov.au).
* **Note**: A registered health practitioner is someone registered under the Health Practitioner Regulation National Law. This is listed on the [Ahpra website](https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx).

### Complaints

* It is important to note that the complaints process is separate to the SDC process. Health services should follow usual policy and processes relating to complaints.
* Throughout the SDC process, if the patient or their family/carer request details for the CLO (or equivalent) and they haven't already been supplied, then these must be provided.
* If the patient or their family member/carer uses an escalation of care pathway within a service, this process should occur as usual and may provide further information into the OD or SDC process.
* Although a SAPSE may be identified first through a patient complaint, the requirements 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), including timelines, must still be followed. A patient complaint can occur through multiple avenues, including the health service’s complaints process, Health Complaints Commissioner, Mental Health Complaints Commissioner, or via the Secretary for Health or Minister for Health.
* If the complaint is directly related to a clinician, the patient or their family/carer should be directed to [Ahpra](https://www.ahpra.gov.au/About-Ahpra/Complaints.aspx).

### Next Steps pamphlet

* SCV has developed a [Next Steps pamphlet](https://www.safercare.vic.gov.au/publications/next-steps-pamphlet) that outlines the review process following an adverse event. This can be given to patients and their families/carers to assist with any questions they may have and help them to understand the process.

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