

# When Things Go Wrong in Healthcare

## Evaluating the impact of **Statutory Duty of Candour** on health consumers, professionals, and services.

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**Introduction:** The *Statutory Duty of Candour* (SDC) is a legal requirement introduced in Victoria, Australia in 2022. Following a serious adverse patient safety event (SAPSE), healthcare organisations must provide patients, families, or carers with a written explanation, an apology, and details of actions taken to prevent recurrence.

This study presents a state-wide evaluation of SDC, focusing on the perspectives of healthcare staff and health consumers.

**Aim:** To establish knowledge, experiences and impacts of SDC on the management of serious adverse safety events from the perspectives of healthcare staff and patients/consumers.

**Method:** Semi-structured interviews with 25 healthcare staff, and 56 patients, families, and consumers (incl. anonymous feedback). Reflexive thematic analysis was used to identify the key perspectives about the implementation of SDC in Victoria for healthcare staff and consumers.

## Findings



### Healthcare Staff

- *Inconsistent SAPSE identification.*
- *Threshold for SDC is subjective to interpretation.*
- *Services lack capacity to administer SDC.*
- *Clinical workforce requires upskilling about SDC promoting organisational accountability.*
- *Creating space for patient and family perspectives.*
- *Context-specific implementation requirements.*

“ I think it's (SDC) **given structure for accountability** because I don't know if that was necessarily there before (Staff 3)



### Patients / Consumers

- *Genuine apology from SDC strengthens trust following SAPSE.*
- *Conceptual support, yet intent apprehension.*
- *General lack of awareness about SDC.*
- *Differing perceptions about adverse event severity and impact.*
- *Burden of SDC on patients & families.*
- *Inconsistent resolution following SDC process.*

“ Even if no mistakes are made, it would be **reassuring to know** processes like this (SDC) are in place. (Consumer 41)

## Conclusion



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SDC has improved safety event management **structure and consistency**, enriched by the **inclusion of patients and families** in the review process. While SDC shows potential to **strengthen trust**, some consumers remain **sceptical of its intent**.

Opportunities for improvement include more **person-centered approaches**, flexible SDC timeframes, consistent identification of SAPSE, and **greater community awareness** of SDC processes.

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