NHS Dorset

Duty of Candour Toolkit

This is a help guide for Practice Managers to outline the Statutory and Professional Duty of Candour process and when Duty of Candour applies.

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Contents:

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Professional Duty of Candour produced in collaboration with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC)

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The Professional Duty of Candour

Every health and care professional must be open and honest with patients and those close to them when something goes wrong with their treatment or care, causes or has the potential to cause harm or distress.

As soon as you realise something has gone wrong with the care of a patient, you should speak to a patient or next of kin (NOK).

- Where possible, speak to the patient or NOK, face to face in a quiet neutral space
- If it is not possible to speak face to face, try and ascertain what their preferred approach would be
- Ensure there is someone available to support them, such as a close friend, relative or professional colleague
- Provide a true account of what has happened, including what is known
- Provide the opportunity for questions to be asked
- It is okay not to immediately know all the facts but you should be clear about what has and has not yet been established
- Saying sorry is crucial – you must apologise from the outset for the harm caused, regardless of the level of harm or fault

Irrespective of the level of harm incurred, you should document and report the incident through your organisations reporting process, and include the actions taken.

- Those responsible for governance within your organisation can advise you if you are unsure whether the statutory duty of candour also applies.

Statutory Duty – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulations

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that healthcare providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The CQC can prosecute for a breach of parts 20 (2)(a) and 20 (3) of this regulation and can move directly to prosecution without first serving a Warning Notice. The CQC may also take other regulatory action.

Definition:

- Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- Duty of Candour aims to help patients receive accurate, truthful information from health providers.
- All NHS provider bodies registered with the Care Quality Commission (CQC) have to comply with a new Statutory Duty of Candour.

When does the Duty of Candour apply?

The requirement to undertake Duty of Candour (Being Open) is a fundamental approach and events should be reviewed, criteria considered and then addressed proportionally with the patient or relevant person.

Triggers to consider **Statutory** Duty of Candour are as follows**:** (identification of a notifiable safety incident)

'*any* ***unintended*** *or* ***unexpected*** *incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional could result, or appears to have resulted in :*

a) the ***death*** *of the service user, where death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition*

OR

a) Severe harm, moderate harm or prolonged psychological harm to the service user.'

This guidance is not intended for circumstances where a patient's condition gets worse due to the natural progression of their illness. It applies when something goes wrong with a patient's care, and they suffer harm or distress as a result.

This guidance also applies in situations where a patient may yet suffer harm or distress as a result of something going wrong with their care. (Duty of Candour, Paragraph 9)

Serious adverse outcome

An adverse outcome resulting in death, permanent or long-term physical disability or disfigurement, medium or long-term pain, or admission to hospital; or other outcomes with a long-term or permanent effect on a patient's employment, social or personal life.

When does the Duty of Candour apply?

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Criteria – 'unintended or unexpected'

- Where something unforeseen has happened during a procedure or episode of care.
- The incident may be a recognised complication or risk/side effect, but if this is unintended then the threshold is met

Criteria - Severe harm

- Permanent lessening of functions directly related to the events but not to the underlying course of illness/condition
- The death of a patient where the death is related to the events but not to the underlying course of illness/condition
- Changes to the structure of a patient's body
- Shortening of Life expectancy

Criteria – Moderate harm

- Moderate increase in treatment **AND** significant harm
- An impairment of sensory, motor or intellectual functions lasting (or likely to last) for a continuous period of 28 days
- Prolonged pain
- Required treatment to prevent death or permanent harm

Criteria - prolonged psychological harm

- For a continuous period of 28 days

Professional vs Statutory Duty of Candour

Professional

Be open and honest when something goes wrong with their treatment or care causes or has the potential to cause, harm or distress.

- Where possible, speak to the patient or those close to them face to face in a quiet, neutral space. If this is not possible, ascertain their preferred approach. Ensure there is someone available to support them, such as a close friend, relative or professional colleague
- Provide a true account of what has happened or whatever is known at that time.
- Provide the opportunity for questions to be asked.
- It is okay not to immediately know all the facts but you should be clear about what has and has not yet been established
- Apologies for the harm caused regardless of the level of harm or fault. Saying sorry is always the right thing to do and is not an admission of liability.
- Ensure the details of a single point of contact are provided of someone who will be involved in the process and can provide updates.
- Irrespective of the level of harm incurred, you should document and report the incident through your organisations reporting process, and include the actions taken.

Statutory

A 'notifiable safety incident' must meet all of the following specific criteria:

1. It must have been unintended or unexpected
2. It must have occurred during the provision of an activity the CQC regulates
3. In the reasonable opinion of a health care professional, the notifiable safety incident could, or already appears to have, resulted in death, or severe or moderate harm to the person receiving care. This includes prolonged psychological harm

You must:

- Open conversation with the relevant person, either the person harmed or a person acting lawfully on their behalf.
- Tell the relevant person face to face that a notifiable safety event has taken place
- Say sorry
- Provide a true account of what happened, explaining whatever is know at that point
- Explain to the relevant person what further enquiries or investigations will take place
- Follow up by providing this information, and the apology, in writing and provide updates on any enquires
- Keep a secure written record of all meetings and communications with the relevant person

Duty of Candour

The below Duty of Candour animation offers guidance on the importance of being open and honest. Being open and honest with patients and those close to them is always the right thing to do and is often referred to as the duty of candour.

NHS Resolution have produced a short animation to help those working in health and social care to better understand the similarities and differences that exist between the professional and statutory duties of candour. The 8-minute animation also offers guidance on how they can be fulfilled effectively.

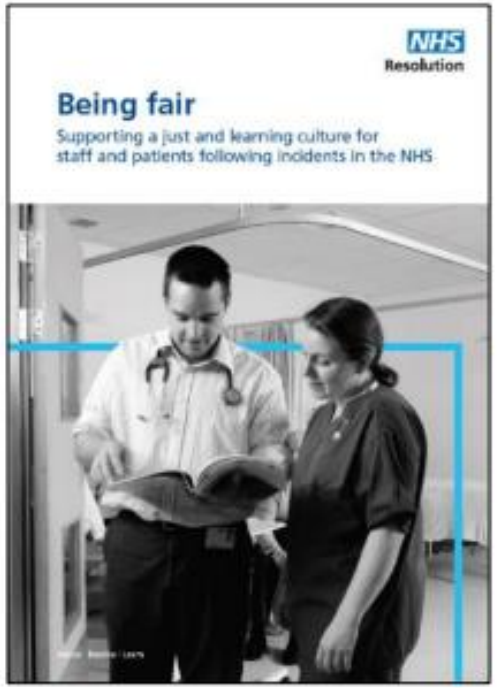
Duty of Candour animation - NHS Resolution

Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS

A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability. Chaffer, D., Kline, R. and Woodward, S.

- All actions should be understood

- Staff should be supported to learn from their actions



Just Culture

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Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.

A just and learning culture requires a balance of learning with accountability and assurance that staff and organisations take responsibility for making changes to help people work safely.

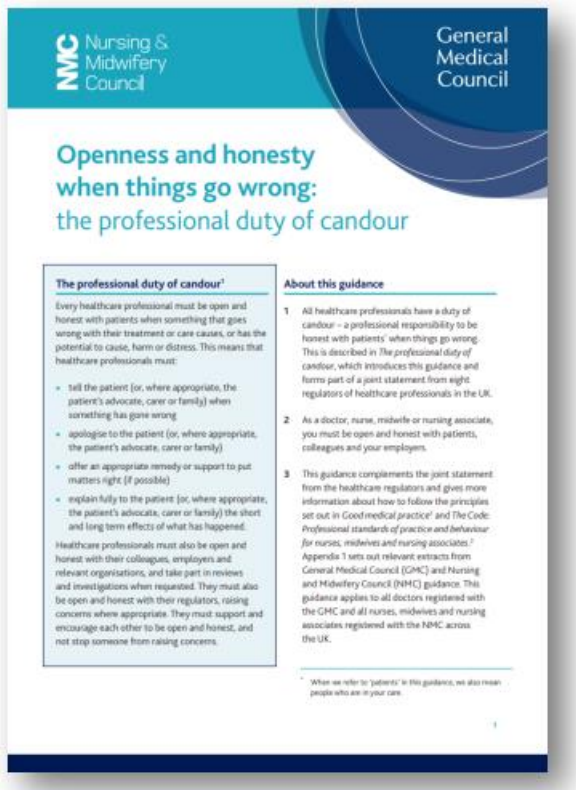
A just and learning culture is for all: staff, patients and organisations. It is not only about safety; it is about how we treat each other, every day

- When things do not go as planned, patients' physical and mental health, and wellbeing will always be of paramount concern to healthcare staff

- At the heart of this are the rights of patients and their families to an apology, an explanation and to be involved in any subsequent reviews or investigations

- They also have the right to seek assurances and / or financial compensation where appropriate

Saying “sorry” - Why does it matter?



Read the guidance

Saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them. Apologising is not an admission of liability.

Saying sorry is:

- always the right thing to do
- not an admission of liability
- acknowledges something could have gone better
- the first step to learning from what happened and preventing it recurring

NHS Resolution is the organisation that manages clinical negligence claims agains

Their ‘Saying sorry’ leaflet confirms that apologising will not affect indemnity cover:

- Verbal apologies are essential as they are face to face contacts with those affected. An apology should be given as soon as staff are aware an incident has occurred.

Saying “sorry” – Types of apology - Verbal

Information about a patient safety incident must be given to patients and their families in an open and truthful manner by an appropriately nominated person (clinician, matron, ward sister, doctor, manager etc). Advice should be given that an investigation will take place, and that the patient/relative will be contacted by the lead investigator to advise them of the terms of reference for the investigation, and the process.

Following the discussion with the patient/ relative the discussions should be documented, so that there is clear evidence that this conversation has taken place.

Things to consider when speak to the patient, relatives or NOK:

- Where should the conversation take place?
- Who should be part of and who should lead that conversation?
- What support should be available to the patient during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the patient?
- Who will capture the discussion in writing and where will that documented account be held?
- If the patient is unable to hold the discussion who should be involved on their behalf? (e.g. because the incident was fatal or the patient lacks capacity or the patient wishes to nominate someone to do it for them).

Saying “sorry” – Types of apology - Verbal

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An apology

- Expression of regret
- Explanation of why the event occurred
- Acknowledgement of responsibility
- Declaration of repentance
- Offer of repair
- Request for forgiveness

You will also need to ensure that support is available to the staff involved in the incident, as this can also be upsetting for them.

Frontline staff must feel empowered to communicate effectively with patients and families where something has gone wrong.

It is often appropriate for the clinician involved to provide the apology and explanation. However, care should be taken when deciding whether those involved in the treatment should attend meetings with patients. On occasion, the patient may prefer that a particular professional is not present.

Saying “sorry” – Types of apology - Written

Statutory Duty of Candour letters

Things to include when writing a letter:

- Acknowledge that a patient safety incident that has occurred and provide an apology
- Refer to and detail the content of any face to face or phone conversation (either with yourself or another colleague)
- Provide assurance that you are investigating the details of the event
- Confirm or offer the opportunity to contribute to the review with any of their or their families/carers queries
- Confirm/offer the opportunity to receive the outcomes of the review in a supported environment
- Provide a contact name and details
- Provide a timescale for completion of the review

Resources

NMC - Openness & honesty when things go wrong

Openness and honesty when things go wrong: the professional duty of candour (nmc.org.uk)

Professional Duty of Candour – General Medical Council

The professional duty of candour - ethical guidance - GMC (gmc-uk.org)

Duty of Candour flowchart - Flowchart

NHS Resolution

- ‘Saying sorry’ guide
- Being-fair
- Duty of candour animation