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Duty of Candour - introduction

- The **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**
- The NHS LA's duty of candour guidance seeks to demystify **how health providers can deliver on candour**, achieving a wholly transparent culture in health provision **– being open when errors are made and harm caused**
- All NHS provider bodies registered with the Care Quality Commission (CQC) have to comply with a new Statutory Duty of Candour
- Subject to further Parliamentary legislation, all independent sector health providers will need to comply from 1 April 2015

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New NHS LA Duty of Candour Guidance

WHAT IS CANDOUR?

- Recognising when an incident occurs that impacts on a patient in terms of harm.
- Notifying the patient something has occurred.
- Apologising to the patient.
- Supporting the patient further.
- Following up with the patient as your investigations evolve.
- Documenting the above discussions and steps.

WHAT TRIGGERS THE STATUTORY DUTY OF CANDOUR

- The death of a patient when due to treatment received or not received (not just their underlying condition).
- Severe harm - in essence permanent serious injury as a result of care provided.
- Moderate harm - in essence non-permanent serious injury or prolonged psychological harm.

WHEN MIGHT IT ARISE?

- Whilst the patient is an in-patient, i.e. at the "bedside".
- When a patient is back at home following discharge or via community based care.
- Following a patient's death.

WHAT DOES CANDOUR LOOK LIKE?

- Open discussions between the patient and the healthcare provider when things go wrong.
- Acceptance by healthcare staff that open conversations will take place at an early stage.
- Reduction in overly defensive approaches to information sharing about incidents in relation to the patient in question.
- Engaging the patient with the outcome of investigations; and
- An apology in relation to the incident.

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What is an apology

Clinical staff may worry that being open with patients may compromise the ability to deal with a claim if one is subsequently made by the patient. In reality candour is all about sharing accurate information with patients and should be encouraged. The facts are the facts and staff should be encouraged and supported to help patients understand what has happened to them.

Where staff should be more cautious is where the facts are not yet know or where they are being asked to speculate beyond what is known. It can be more damaging to a relationship with the patient to speculate inaccurately than to investigate and find the facts and then provide the extra information.

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Saying Sorry

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Saying Sorry

Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. Of those that have suffered harm as a result of their healthcare, fifty percent wanted an apology and explanation. Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has occurred.

How should this happen?

Verbal apologies are essential because they allow face-to-face contact between the patient, their family and carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

Who should say sorry?

Information about a patient safety incident must be given to patients and their families in a truthful and open manner by an appropriately nominated person. Staff may be unclear about who should talk to patients when things go wrong and what they should say; there is the fear that they might upset the patient, say the wrong things, make the situation worse and admit liability. Having a local policy that sets out the process of communication with patients and raising awareness about this will provide staff with the confidence to communicate effectively. The local policy should state who is the most appropriate member of staff to give both verbal and written apologies to patients and their families; the decision should consider seniority, relationship to the patient, experience and expertise. Most healthcare provision is through multidisciplinary teams so any local policy on openness should apply to all staff that have key roles in the patient's care.

What if there is a formal complaint or claim?

Poor communication may make it more likely that the patient will pursue a complaint or claim. It is important not to delay giving a meaningful apology for any reason, including where there is a formal complaint or claim. It is also essential that any information given is based solely on the facts known at the time. Healthcare professionals should explain that new information may emerge as an investigation is undertaken, and that patients, their families and carers will be kept up-to-date with the progress of an investigation.

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Saying Sorry

Is an apology the same as an admission of liability?

Saying sorry is not an admission of legal liability; it is the right thing to do. The NHS LA is not an insurer and we will never withhold cover for a claim because an apology or explanation has been given. The NHS LA claims teams are always happy to provide support and advice where there is a potential claim.

What about the staff involved?

Healthcare organisations must create an environment in which all staff, whether directly employed or independent contractors of NHS care, are encouraged to report patient safety incidents. Staff should feel supported throughout the investigation process because they too may have been traumatised by being involved. Sometimes patients can suffer significant harm. In these circumstances, the member(s) of staff involved may find it hard to participate in the discussion with the patient and their family. Every case needs to be considered individually, balancing the needs of the patient and their family with those of the healthcare professional concerned. In cases where the healthcare professional responsible wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting. In cases where the patient and their family express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient, their family and carers during the initial Being Open discussion.

For more information

Being Open Guidance (National Patient Safety Agency)
www.nrls.npsa.nhs.uk

Reports and Consultations on complaint handling (Parliamentary and Health Service Ombudsman)
www.ombudsman.org.uk

Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture (Clwyd and Hart)
www.gov.uk

Key messages

Timeliness: The initial discussion with the patient and their family should occur as soon as possible after recognition that something has gone wrong.

Explanation: Patients and their families should be provided with a step-by-step explanation of what happened, that considers their individual needs and is delivered openly.

Information: Patients and their families should receive clear, unambiguous information. They should not receive conflicting information from different members of staff. The use of medical jargon and acronyms, which they may not understand, should be avoided.

On-going support: Patients and their families should be given a single point of contact for any questions or requests they may have. They should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.

Confidentiality: Policies and procedures should give full consideration of, and respect for privacy and confidentiality for the patient, their family and staff.

Continuity of care: Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

"Achieving timely and fair resolution, enhancing learning and improving safety."

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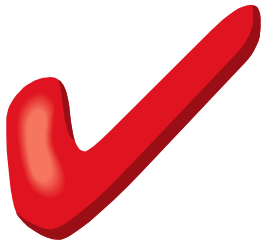
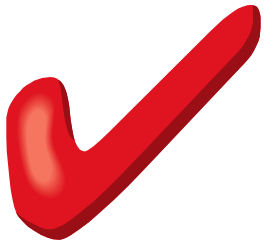


DOs

1. **Do** ensure your staff understand your organisation's incident reporting process and accurately report when things go wrong.
2. **Do** understand what it means to be open with patients.
3. **Do** ensure your staff understand their role within the organisation's statutory Duty of Candour requirements.



DOs

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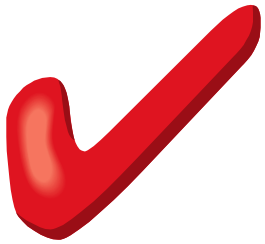
4. **Do** ensure staff are trained and supported on how to share information with patients when things go wrong both in principle and in practice. For example in relation to the notification discussion they need to have considered:

   - → 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).



DOs

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5. **Do** ensure that when reporting any subsequent claims, copies of the documentation capturing candour in relation to the incident are sent to the NHS LA.
6. **Do** keep in mind that when something has gone wrong, this can be devastating to the staff involved and therefore do make sure support is available to them.
7. **Do** encourage feedback from patients about how your organisation is embracing candour and what improvements could be made to your approach.

DON'Ts

- **Do not** forget other avenues by which candour might arise i.e. not only incidents but also complaints and claims.
- **Do not** assume that apologising to patients amounts to an admission in relation to a subsequent civil claim.
- **Do not** miss the opportunity to share learning from such incidents and discussions through your organisation's internal clinical governance routes.

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