

# Duty of Candour Awareness



- **Being open** with patients when things go wrong
- **Being honest and transparent** with information

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Aim: To raise staff awareness of Duty of Candour and their roles and responsibilities in relation to it.

## Objectives:

- To understand what is meant by the term 'Duty of Candour'
- To be aware of individuals professional accountability in relation to Duty of Candour.
- To be aware of the support processes in place to support staff through the being open process
- To encourage staff to be open and communicate with colleagues regarding patient safety incidents, reinforcing that learning from incidents is a key priority for the trust

- 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**
- All NHS provider bodies registered with the Care Quality Commission (CQC) have to comply with a new Statutory Duty of Candour

“All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients when things go wrong”.

*The professional duty of candour (2014)*  
- joint statement from 8 regulators of UK Health Professionals available at:  
[www.gmc-uk.org/Joint\\_statement\\_on\\_the\\_professional\\_duty\\_of\\_candour\\_FINAL.pdf\\_58140142.pdf](http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf)

## WHAT IS CANDOUR?

**“the quality of being open and honest”**

- 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 the investigations evolve.
- Documenting the above discussions and steps.

## 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 LHCH 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.

## 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.

## Triggers – when will the duty apply?

Where a **notifiable patient safety incident** has occurred which in the reasonable opinion of a healthcare professional could result in, or appears to have resulted in:

### Moderate harm

A moderate increase in treatment - defined as including:

An unplanned return to surgery or re-admission; or

A prolonged episode of care; or

Extra time in hospital; or

Cancellation of treatment or transfer to another treatment area;

#### **AND**

Significant harm which is not necessarily permanent

Or

### Severe harm

Defined as a permanent lessening of bodily, sensory, motor, physiological or intellectual functions; including:

removal of the wrong limb; or brain damage

Must be related to the incident not the natural course of the illness/underlying condition

Or

### Prolonged Psychological Harm

For at least a continuous period of 28 days

Or

### Death

- Oral notification in person by one or more representatives of LHCH (10 days)  
(Consultant/Senior Manager)
- An account, which to the best of your knowledge is true, of all known facts as at the date of the notification
- Include an apology (verbal and subsequently written). Not an admission of liability but an expression of “sorrow or regret” for the harm
- Advice as to further enquiries required
- Record in writing and keep securely
- **Written notification** must then be given or sent
- LHCH requirement for completing the process

- Being open, honest and transparent is the right thing to do for our patients and their families.
- We will also be held accountable by our regulators (such as the CQC). They will be interested in how we,
  - Offer staff training
  - Evidence of good incident reporting (section included in Datix) & notification
  - Provide support for staff
  - Ensure that we assure that we are delivering our duty of candour

When sharing information with patients as part of our duty of candour, staff may want to consider,

- Who should be part of and who should lead that conversation?
- Where should the conversation take place?
- 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).

If in doubt about anything in relation to Duty of Candour, please just ask for support

1. Duty of Candour is being open with patients when things go wrong and being honest and transparent with information.
  
2. We want you to raise any concerns
  - Speak out safely
  - HALT
  - Incident Reporting (including near misses)
  - Escalate to your manager or professional lead(s)
  - LHCH Freedom to Speak up Guardian
  
3. Support, Advice and Guidance on Duty of Candour is available from Helen Martin (ext. 1051) of Joan Mathews (ext. 1653) or via email.
  
4. Policies for Being Open, Raising Concerns, Clinical Claims and Incident Reporting can be found on the staff intranet in the Policies and Procedures section