Peterborough and Stamford Hospitals
NHS Foundation Trust

Duty of Candour (Being Open)

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Duty of Candour Definition

Duty of Candour involves apologising and explaining what happened to patients/clients who have been harmed as a result of an incident/omission. It encompasses communications between healthcare professionals / social care professionals and patients/clients and their relatives.

What is Duty of Candour?

Openness, transparency and candour throughout the system on matters of concern:

- Statutory duty of candour: individual and organisational
- Full disclosure where moderate/death/ serious harm may have been caused or prolonged psychological trauma
- Requirement to provide open and honest information to:

Regulators TDA /Monitor and CQC

Criminal offence for any registered healthcare professional or director of organisation to fail to provide honest information or obstruct that process

Where did it all start?

"We must develop a culture of openness in the NHS. This is a key part of how a modern NHS should be – open and accountable to the public and patients to drive improvements in care.

That's why we are introducing a requirement on providers to be transparent in admitting mistakes. We need to find the most effective way to promote openness and hold those organisations who are not open to account.

A more transparent NHS is a safer NHS where patients can be confident of receiving high quality care."

Andrew Lansley 2012

Duty of Candour and Social Care

- In the wake of the Mid-Staffs Public inquiry DoC was extended to all providers registered with the CQC
- Think Local Act Personal (TLAP) worked alongside DoH to consider candour in respect of social care provision.
- Care Act has strengthened the responsibility to deal with harm incidents through the increased responsibilities in respect of Adult Safeguarding.
- Any organisation registered with CQC must have robust DoC policies and comply with disclosure

CQC and DoC (Reg 20)

- The aim of this regulation is to ensure that 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.
- Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning.
- There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body

General Medical Council and NMC emphasise the importance of candour:-

'*If a patient under your care has suffered serious harm, through misadventure or any other reason, you should act immediately to put it right , if possible. You should explain fully to the patient what has happened and the likely short and long term effects. When appropriate you should offer an apology*'

GMC, Good Medical Practice Guide

Criminal offence for any registered healthcare professional or director of an organisation to fail to provide honest information or obstruct that process

What should your organisation have?

- Providers should have policies and procedures to support a culture of openness and transparency, and ensure that staff follow them.

- Providers should also take action to tackle bullying, harassment and undermining, and investigate any instances where a member of staff may have obstructed another in exercising their duty of candour.

Levels of Harm

- “moderate harm” means harm that requires a moderate increase in treatment

- “prolonged psychological harm” means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days; this includes prolonged unnecessary pain

Levels of Harm

- “severe harm” means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions

- the death of the service user, where the death relates directly to an incident rather than to the natural course of the service user’s illness or underlying condition
  i.e sepsis from infected bed sores etc

How does Duty of Candour help?

Displaying candour with people about what has happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the after effects.

The Principles of Duty of Candour

1. Acknowledgement and apology
2. Truthfulness, timeliness and clarity of communication

3. Risk management (Policies)
4. Escalation / safe haven

5. Continuity of care
6. Professional support/lessons learnt

Examples

A new member of staff on induction was shadowing another care worker delivering care to a person who needed to be hoisted. Two trained members of staff were required to operate the hoist safely and the new member of staff had not yet been trained in moving and handling. The new care worker was asked to assist with the manoeuvre and did not attach one of the loops of the sling to the hoist properly. As a result, during the manoeuvre, the person slid out of the sling and onto the floor. The person sustained a broken hip requiring emergency surgery.

Interpretation

This would be an example of an incident leading to a service user experiencing changes to the structure to the body (regulation 20 (9)(b) (iii)

In other words: changes to the structure of the service user's body – moderate / severe harm

Examples

A person with a learning disability was prescribed antipsychotic medicines. They were assessed as needing full staff support in the management of their medicines. Over a period of two weeks they became increasingly anxious and distressed. When the person's medicines were checked it was discovered that their antipsychotic medicines had not been ordered the previous month and did not show on the MAR chart. This was because the correct procedure for ordering and the checking in of medicines had not been followed and the error had gone unnoticed for 18 days. This resulted in a prolonged deterioration in the person's mental health for more than 28 days.

Interpretation

This would be an example of an incident leading to prolonged psychological harm (regulation 20(9)(a)(iv)

In other words: the service user experiencing prolonged pain or prolonged psychological harm

Any Questions

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