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NHS Foundation Trust

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Duty of Candour

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From JRCPTB palliative medicine curriculum:

8.3 Aspects of the Law Particularly Relating to Palliative Medicine
Knowledge of appropriate guidelines produced by BMA, GMC, Royal Colleges and medical defence bodies

13.1 Complaints and Medical Error
To recognise the causes of error and to learn from them, to realise the importance of honesty and effective apology and to take a leadership role in the handling of complaints

13.2 Prioritisation of Patient Safety in Clinical Practice
Describe the investigation of and report significant events, serious untoward incidents and near misses

13.3 Principles of Quality and Safety Improvement
To recognise the desirability of monitoring performance, learning from mistakes and adopting no blame culture in order to ensure high standards of care and optimise patient safety

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Why so much emphasis on duty of candour?

THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

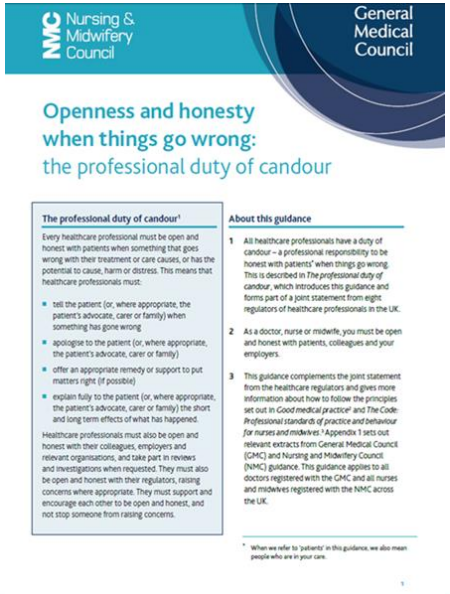
Chaired by Robert Francis QC

CareQuality Commission

Regulation 20: Duty of candour

Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare

March 2015


NMC Nursing & Midwifery Council
General Medical Council

Openness and honesty when things go wrong:
the professional duty of candour

The professional duty of candour[1]

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

About this guidance

1 All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients* when things go wrong. This is described in *The professional duty of candour*, which introduces this guidance and forms part of a joint statement from eight regulators of healthcare professionals in the UK.

2 As a doctor, nurse or midwife, you must be open and honest with patients, colleagues and your employers.

3 This guidance complements the joint statement from the healthcare regulators and gives more information about how to follow the principles set out in *Good medical practice*[2] and *The Code: Professional standards of practice and behaviour for nurses and midwives*.[3] Appendix 1 sets out relevant extracts from General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance. This guidance applies to all doctors registered with the GMC and all nurses and midwives registered with the NMC across the UK.

* When we refer to 'patients' in this guidance, we also mean people who are in your care.

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Key problems identified by the Francis report

- Culture focused on doing the system's business – not that of the patients
- Institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern
- Too great a degree of tolerance of poor standards and of risk to patients
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else
- Failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession

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Suggestions from the Francis report

- Foster a common culture shared by all in the service of putting the patient first
- Ensure openness, transparency and candour throughout the system about matters of concern
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service

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GMC & NMC duty of candour 2015

- Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress
- Healthcare professionals must:
  - tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
  - apologise to the patient (or advocate, carer or family)
  - offer an appropriate remedy or support to put matters right (if possible)
  - explain fully to the patient (or advocate, carer or family) the short and long term effects of what has happened

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How would / do you interpret this?

Case 1

- 70 year old man
- Known prostate cancer with widespread bone metastases (including spine)
- Admitted due to falls at home
- MRI scan showed spinal cord compression T9-T10

- While on ward, he fell overnight from standing height – legs buckled under him
- Hit his back on chair; denied hitting head
- Following morning he was less well – drowsy, slurred speech
- CT scan showed sub-dural haematoma
- Discussed with neuro-surgery – not for intervention at moment

Case 2

- 80 year old lady with advanced dementia
- Falls in hospital when trying to stand and breaks her hip
- She can't remember what has happened
- She is not medically well enough for surgical intervention

Thinking of duty of candour, what would you do?

Patient with capacity

- Explain what has happened to them
- With their permission, meet them and their family to apologise & explain what has happened
- Send written letter of apology and explanation to family – duty of candour letter
- Internal investigation
  - copy of this to patient / family, if they wish
  - To be shared with clinical team & learn lessons, if appropriate

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Patient without capacity

- Attempt to take practicable steps to optimise capacity
- Assuming that patient does not have capacity:
  - Best interests decisions
  - Meet with family – apologise and explain what has happened
  - Send written letter of apology and explanation to family – duty of candour letter

Does duty of candour pose any problems?

Summary

- Common culture of putting the patient first
- Ensure openness, transparency and candour
- Make all those who provide care for patients properly accountable for what they do

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Thank you