Being open and honest with patients when something goes wrong

[The professional duty of candour]

Joint statement:

The professional duty of candour *

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which 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); and
- 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. Health and care professionals 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

The GDC's *Standards for the Dental Team* already require dentists and dental care professionals to:

- Put patients' interests first (principle one);
- Be honest and act with integrity (standard 1.3); and
- Offer an apology and a practical solution if a patient makes a complaint (standard 5.3.8).

However, candour means being open and honest with all patients, whether they have made a complaint or not.

Being open and honest with patients when something goes wrong

All healthcare professionals have a professional responsibility to be honest with patients when something goes wrong. This is set out in *the professional duty of candour* which introduces this guidance and which is part of a joint statement from eight regulators of healthcare professionals in the UK[1].

This guidance sets out what we expect dentists and dental care professionals to do when something goes wrong with a patient's treatment.[2] It is an additional guidance document which supports the Standards and which you must also follow.

This document is about being open and honest with patients (or their family, carer or advocate). As a healthcare professional, you also have a duty to raise concerns you may have about patient safety even if nothing has gone wrong. See principle 8 of the Standards ('Raise concerns if patients are at risk') and our guidance on raising concerns. For more information on raising a concern, you can contact our confidential advice line run by Public Concern at Work on 0800 668 1329.

The systems regulators in healthcare (i.e. the CQC, HIS, HIW and RQIA) also have requirements in relation to a statutory duty of candour which organisations registered with them must meet. These are separate from the requirements of this GDC guidance which applies to all registered dental professionals as individuals.

Being open and honest with patients

Before treatment starts:

An important part of being open and honest with patients is having a thorough discussion before treatment starts (see principle three of the Standards – 'obtain valid consent'). It is important that patients understand their options for treatment, including the potential benefits and any risks.

You must give patients sufficient information in a way they can understand, make sure that they understand the decision they are being asked to make and give them enough time to make the decision.

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[1] General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland. The statement can be found at http://www.gdc-uk.org/Newsandpublications/Pressreleases/Documents/**Joint statement** on candour 13 Oct 2014 (2).pdf

[2] Throughout this guidance, when we talk about communicating with a patient about something which has gone wrong, we also mean the patient's advocate, carer or family if appropriate.

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Being open and honest with patients when something goes wrong

When things go wrong:
When something goes wrong[4] with a patient's care, you must:

- tell the patient;
- apologise;
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully the short and long term effects of what has happened.

Telling the patient:

As soon as you realise that something has gone wrong with a patient's care which has caused them harm or distress, or which could do so in the future, you must tell them clearly, in a way that they can understand.

Most patients will want to know what has happened, what has been done or can be done to put matters right and what it means for them. You should answer any questions fully and honestly.

If the patient makes clear that they do not want to know the details, you should respect their decision. However, you should let them know that they can have further information later if they change their mind.

You should record your discussion with the patient (including their decision not to have further information, if applicable) in their notes.

Apologising:

When a patient in your care suffers harm or distress because something goes wrong with their care, you should apologise as soon as possible.

An apology is more likely to be meaningful to the patient if it is personal to them and relevant to what has happened, rather than being a general expression of regret.

You should explain:

- what happened,
- what has been done or can be done to put matters right and,
- what will be done to stop the same thing happening to someone else (if relevant).

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[4] 'When something goes wrong' can cover a range of issues, from a patient suffering actual harm during treatment to an issue with the service provided by the practice which causes distress

Being open and honest with patients when something goes wrong

Apologising to the patient is not the same as admitting legal liability for what happened. This is set out in legislation in parts of the UK and the NHS Litigation Authority also advises that saying sorry is the right thing to do. You should not withhold an apology because you think that it might cause problems later.

The most appropriate team member should make the apology and give the explanation to the patient. When apologising to the patient and explaining what happened, you do not have to take responsibility for something that went wrong which was not your fault (such as a mistake by another member of the team)

Make sure that the patient knows who to contact if they have further questions.

Depending on the wishes of the patient and your practice or workplace policy, you may need to follow up a verbal apology with a written one. If the incident is of sufficient seriousness to trigger the statutory duty (see paragraph on systems regulators above), a written apology must be given.

Record your apology in the patient's notes.

If you employ, manage or lead a team:

In the same way that you need to make sure that there is an effective procedure in place for staff to raise concerns, you also need to make sure your staff understand the need to be open and honest with patients and that the culture of the practice or workplace supports this. Training for the whole team in communication skills, including handling complaints, may be helpful.

You must not prevent or try to discourage staff from being open and honest with patients when something goes wrong.

Statutory duty of candour

In addition to the professional duty on individuals set out in this guidance, organisations which provide healthcare have a statutory duty of candour. As part of this, organisations have a duty to support their staff to be open and honest with patients when something goes wrong with their care. Following the publication of the Francis report[6], the governments of each of the four UK countries are considering how to implement the duty of candour in relation to healthcare organisations.

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[5] 'NHS Litigation Authority *Saying Sorry* –The NHS Litigation Authority "will never withhold cover for a claim because an apology or explanation has been given"

[6] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC

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England:

For healthcare providers in England, including dental practices, the CQC has introduced a requirement in relation to candour (Regulation 20) to try to ensure that providers are open and transparent with people who use their services. This duty, which also sets out specific requirements that providers must meet when things go wrong, applies to all registered providers. The CQC has produced guidance to help providers meet this requirement.

Scotland:

The Health (Tobacco, Nicotine etc and Care) (Scotland) Bill was passed by the Scottish Parliament in March 2016. It places a duty on organisations to be open when an unintended or unexpected incident has occurred during the provision of treatment or care which has resulted in certain outcomes. The Bill provides for regulations to be made in relation to the procedures to be followed and confirms that an apology made as part of candour procedures cannot be taken by itself as an admission of negligence. The Bill also provides for support for all involved, and training for any staff involved in responding to an incident.

Wales:

The Welsh Government has published the findings of a consultation on its Green Paper 'Our Health, Our Health Services' which showed that a majority of respondents supported the introduction of a statutory duty of Candour in Wales.

Northern Ireland:

The Health Minister announced in January 2015 that a statutory duty of candour will be introduced in Northern Ireland.

Fitness to practise

The Indicative Sanctions Guidance is used in Professional Conduct Committee (PCC) hearings if the panel decides that a dental professional's fitness to practise is impaired and is considering what sanction to impose. It sets out the approach which panels should take to a range of issues. The current version (effective from October 2015) includes reference to candour and makes clear that "*a panel should take very seriously a finding that a dental professional took deliberate steps to avoid being candid with a patient or to prevent someone else from being so.*"

Effective from 1 July 2016

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[7] CQC: Regulation 20: Duty of Candour. Information for all providers: NHS bodies, adult social care, primary medical and dental care and independent healthcare.