Adhering to new duty of candour guidance

Understanding why and how to adhere to new guidance about the duty of candour is crucial to improving patient safety and the patient experience.

In this article...

- Stipulations of the new guidance for healthcare staff
- When healthcare staff should apologise
- What to cover when apologising to a patient or patient’s family

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Abstract


New joint guidance from professional regulators focuses on the need for doctors, nurses and midwives to be open and honest with patients when things go wrong. Following the recommendations of the Francis report into care failings at Mid Staffordshire Foundation Trust, which called for a culture of openness and transparency, the guidance shows registered staff how to fulfil a common duty of candour set out in their professional standards, including the NMC code. This article summarises the guidance as it applies to nurses.

Nurses, midwives and doctors must offer patients a prompt explanation and say they are personally sorry if mistakes have caused harm, or may do so in the future, according to new guidance by the professions’ regulators. Openness and Honesty When Things go Wrong: the Professional Duty of Candour (Nursing and Midwifery Council and General Medical Council, 2015) tells staff how to fulfil a common duty of candour set out in their professional standards, including the NMC code. This article summarises the guidance as it applies to nurses.

Be open and honest

Prior to treatment or care, give patients clear, accurate information on the risks, as well as the benefits, of different care options, and check they understand. Besides common risks, inform them of those that are unlikely but more serious, and those they are “likely to think are important”.

When to apologise

You must explain and apologise when a mistake or error in a patient’s care has caused, or could yet cause, harm or distress. Once you realise the error, and have done what you can to put matters right, arrange an apology as soon as possible from the most appropriate team member – usually the lead or accountable clinician – with support from the team.

How to say sorry

Patients should have someone there to support them, such a friend or relative, in this article...

Stipulations of the new guidance for healthcare staff

When healthcare staff should apologise

What to cover when apologising to a patient or patient’s family

5 key points

1 Guideline has been issued for nurses, midwives and doctors on their professional duty to be open and honest with patients when something has gone wrong

2 Health professionals must offer patients, or those close to them, a prompt apology and explanation when mistakes have harmed patients or may have resulted in harm

3 Healthcare teams must use professional judgement to decide whether to inform patients of “near misses”

4 Staff must report adverse incidents and near misses as soon as possible and in line with national and local reporting systems

5 Healthcare organisations must develop an open, honest learning culture that enables staff to admit mistakes and raise concerns, and feel comfortable doing so
and be told what has and has not yet been established. Share:

- What you know, and believe to be true, about what went wrong and why;
- The likely consequences, explaining anything uncertain and answering questions honestly.

Offer patients as much information as they would like. If they do not want to hear the detail, discuss with them their reasons for this. Respect their wishes as far as possible, having explained the potential consequences, record their decision and let them know they can change their mind at any time.

While you are not expected to take personal responsibility for something going wrong that was not your fault, such as system error or a colleague’s mistake, patients have the right to receive an apology from the most appropriate team member, regardless of who or what may be responsible. This should include:

- What happened;
- What can be done to deal with any harm caused;
- What will be done to prevent someone else being harmed.

Saying sorry does not mean you are admitting legal liability, and a fitness to practise panel may view it as “evidence of insight”. To be of value to patients, apologies should feel genuine rather than formulaic, so you should:

- Personalise your apology to make it more meaningful: for example, say “I am sorry…” , rather than giving a general expression of regret about the incident on the organisation’s behalf;
- Speak to patients at a time and a place when they can best understand and retain information;
- Give distressing information in a considerate way, respecting patients’ right to privacy and dignity;
- Let patients know who to contact in the healthcare team if they have questions or concerns, and offer information on services giving practical and emotional support.

Record your apology in the patient’s clinical record. Whether you follow it up with a written apology depends on the patient’s wishes and your workplace policy.

**Severe harm or death**

If the mistake causes a patient’s death, or a patient is unlikely to regain consciousness or capacity, be honest with the people close to the patient, taking time to give information compassionately and answer questions; Box 1 gives an example in which a patient died, and Box 3 gives an example.

**Discussion**

**BOX 1. SEVERE HARM LEADING TO DEATH**

An 86-year-old woman, with a chesty cough and signs of a red and swollen leg, was diagnosed with a chest infection and discharged home from a rehabilitation unit. The community nurse agreed to visit her in the next couple of days but, due to high workload, did not visit until after three days and found the woman dead. An autopsy confirmed the cause was a pulmonary embolism (PE).

The GP notified the person responsible for clinical risk in the clinical commissioning group, who contacted the hospital. The hospital manager met with the woman’s daughters to explain how their mother had died. The consultant in charge, ward nurse manager and managers for duty of candour and clinical risk in both organisations met with the daughters. They explained the cause of death and the missed diagnosis of PE by the nurse and duty doctor, and told them their mother was stable when discharged, but the community nurse’s visit was delayed due to workload. They apologised and explained there would be a full clinical review to learn from the incident, saying they would inform the family of the results and whether the cause of death was the missed PE diagnosis or their mother’s underlying condition.

The consultant apologised again for the lack of a full diagnosis, the nurse manager apologised that the nurse did not assess the swollen leg, and the community manager apologised for the delay in visiting their mother. At the family’s request, it was agreed to provide written apologies and the hospital manager recorded the meeting. Despite the apologies, the family made a formal complaint. This was investigated, after which the trust issued a formal apology, including steps it would take to prevent a similar situation.

**BOX 2. NEAR MISS**

A boy admitted to hospital for a routine operation had known attention deficit hyperactivity disorder. He was with his parents and was put in a ward next to a young girl who had just had an operation. The parents, believing him to be in the charge of the nurses, went for a cup of tea. A nurse entered the ward just as he was about to pull out the young girl’s nasogastric tube, but stopped him before any harm was caused.

The nurse asked a healthcare assistant to stay with the boy until his parents returned, and immediately reported the incident to the ward manager. After discussion, they reported the incident, following the trust’s policy for near misses.

They decided to inform both children’s parents of the incident, giving each an explanation and apology. As neither child had been harmed, both were satisfied with this and did not ask for anything in writing. The nurse who prevented the harm wrote a report, and an action plan was drawn up to prevent anything similar happening again.
where severe harm was caused to a patient. Respond sensitively to the wishes and needs of bereaved people, taking into account patients’ known wishes about what should happen after their death, including the sharing of information. Also ensure you help people access support and assistance.

**Near misses**

In the case of near misses or adverse incidents that could have caused harm but did not, use your professional judgement. Box 2 gives an example of this. Ask yourself whether the patient “needs to know or would want to know”, or whether it could “even help their recovery”. Failing to be open can damage a patients’ trust and confidence, but sometimes “to speak to them about it may distress or confuse them unnecessarily”. If you are unsure what to do, ask your team or a senior colleague.

**Report errors**

Report adverse incidents and near misses as soon as possible, using national and local reporting systems so lessons can be learned and patients can be protected. Your organisation should have a system for doing this locally but you should raise a patient safety concern level if:

- Your organisation does not have a reporting system in place;
- You do not feel supported or are discouraged or prevented from reporting;
- National reporting systems for different types of incident are listed in the guidance.

No staff member should try to prevent others from raising concerns about patient safety, and managers must ensure staff who raise concerns are protected from unfair criticism or action. Staff must take part in regular team performance and standards reviews and audits, and should discuss any adverse incidents and near misses at their appraisal.

**Leaders/managers**

Senior clinicians should lead by example, encouraging openness and honesty; clinical leaders should “actively foster a culture of learning and improvement”. Managers and team leaders should:

- Ensure early warning systems are in place for teams and individuals;
- Investigate and, if necessary, act quickly and efficiently on concerns about performance.

There should also be systems to monitor, review and improve the team’s work, including audit and benchmarking. Managers should:

- Collect and share information on patient experience and outcomes;
- Ensure teams are trained in patient safety and supported to openly report adverse incidents;
- Have systems or processes in place to analyse adverse incidents and near misses so lessons can be learned, shared and acted on, and practice changed where necessary.

**Organisational duty of candour**

Healthcare organisations have a duty to develop an open, honest learning culture in which staff feel supported and equipped to admit mistakes and raise concerns. In the NHS in England, the government has introduced a new statutory duty of candour, overseen by the Care Quality Commission; other UK countries are considering similar initiatives.

**BOX 3. SEVERE HARM CAUSED TO PATIENT**

A woman in labour had a pathological cardiotocograph, which was not escalated until the second midwife came on shift, causing the baby to be stillborn. The two midwives and their supervisor, as well as the obstetric team, gave the parents their condolences and an apology as soon as possible, explaining there would be a full investigation. They were open and honest, saying that although the facts were not yet established, they would answer any questions to the best of their knowledge. This was documented in the notes and an incident report was completed.

The manager responsible for duty of candour held a multidisciplinary team meeting and ensured the parents were present to help them understand more about what went wrong. A bereavement care pathway was also set up. The parents accepted a verbal and formal written apology, including an apology from the first midwife who had made the mistake. They were told the trust was taking steps to prevent it from happening again, including intensive training for all staff. Separately, the first midwife agreed to discuss her training and supervision needs at her next appraisal.

The parents decided not to make a litigation claim as they felt the trust’s response was adequate, but they still wished to formally complain. This was documented and information was given to them enabling them to do so, as outlined in the Nursing and Midwifery Council’s (2015) guidance.

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**References**


