Every health care professional must be open and honest with patients. Every healthcare establishment, since November 2014, has a statutory Duty of Candour.

Candour is defined by Robert Francis as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report has been made'.

The Being Open principles and ethical duty of openness apply to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, significant harm or death has occurred.

It is a matter of judgement that needs to be exercised on a case by case basis to determine whether an incident meets the Duty of Candour criteria has occurred. What may not appear to be such an incident at the outset may look very different once more information comes to light, and may therefore lead to an incident becoming notifiable under the Duty of Candour.

The requirements of the Duty of Candour are as follows:

As soon as reasonably practicable after becoming aware that a safety incident has occurred that falls into the moderate harm or more serious categories the healthcare professional must:

a) Notify the relevant person (this is usually the patient but may in some circumstances be the relative, carer or advocate) that the incident has occurred and
b) Provide reasonable support to the relevant person in relation to the incident.

The notification must:

a) Be given in person by one or more members if staff
b) Provide an account of all the facts known about the incident to date
c) Advise the relevant person what further enquiries into the incident will be undertaken
d) Include an apology and/or sincere expression of regret and
e) Be recorded in writing in the notes

The notification must be followed up in writing to the relevant person.

The member of staff should be clear in the first meeting that the facts may not yet have been established, tell the relevant person only what is known and believe to be true and answer any questions honestly and as fully as they can.

The aim of the Duty is to ensure that patients are told when harm occurs as a result of the care they receive. Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must be notified.

Guidance letter template for initial communication letter in accordance with requirements of Duty of Candour.

NB This is provided purely for guidance. All letters must be personalised and tailored to the individual needs of the person receiving the letter.

Dear Mrs/Mrs xxxxxxxxxxx

I am writing to express my sincere regret that (you/your relative XXXXX) has been involved in an incident whereby ……(describe event here). As a Clinic we are committed to being open with patients and carers when events such as these occur so that we gain a shared understanding of what happened, and what we can do to prevent such an incident occurring again in the future.

An investigation is already underway to try and establish the cause of the incident. If you would like to meet with a member of staff to discuss this, please let me know within the next two weeks, and we will arrange a mutually convenient time and place to meet.

Staff member XXXXX is acting as your lead contact for the duration of the investigation. They can be contacted by email on xxxxxxxxxxxxxxx or on telephone number xxxxx xxxxxxx

Yours sincerely

Duty of Candour Actions Flow Chart

AS SOON AS INCIDENT OCCURS

Provide immediate support and assistance to the patient and any staff affected by the incident.

Record incident in patient record.

Discuss next steps with Medical Director to define Duty of Candour roles.

Within 10 working days of incident being reported

Notify patient that the incident has occurred and establish whether patient consents to share information with family/carer.

Notification must .....

- Be verbal
- Be conducted in person
- Provide all facts currently known about the incident
- Include an appropriate apology
- Be supplemented by a written notification.
- Be recorded in writing in the clinical notes.

Within 28 days of the incident being reported

Investigating Officer conducts investigation using Root Cause Analysis

Offer interim update to patient/family during the course of the investigation and provide appropriate support to patient and staff

Maintain full written records of any meeting or contact with the relevant person in relation to the incident

Record any refusal by patient/family of a meeting or other contact or information in relation to the incident

Within 10 working days of investigation being completed

Offer to provide the patient/next of kin with the findings of the investigation report

Requires sign-off by Medical Director

Provide copy of investigation together with letter to the patient/ next of kin. Copies in patient file.