

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Duty of Candour (DoC)

Duty of Candour

- Wales from 1st April 2023 for NHS Bodies.
- There is a professional and legal obligation to comply with Duty of Candour.
- GDC have had a Professional Duty of Candour in place since 2016.
- Practices will need to ensure that NHS staff are aware of their duty in relation to the process for Duty of Candour

GDC Duty of Candour

Council

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.

What are the trigger questions for Duty of Candour

- Has the patient experienced or could experience harm that was unintended or unexpected
- Is the harm moderate or above (severe or death)
- Was the provision of dental/oral care a factor in the patient suffering harm

If ALL three questions are YES then Duty of Candour is triggered

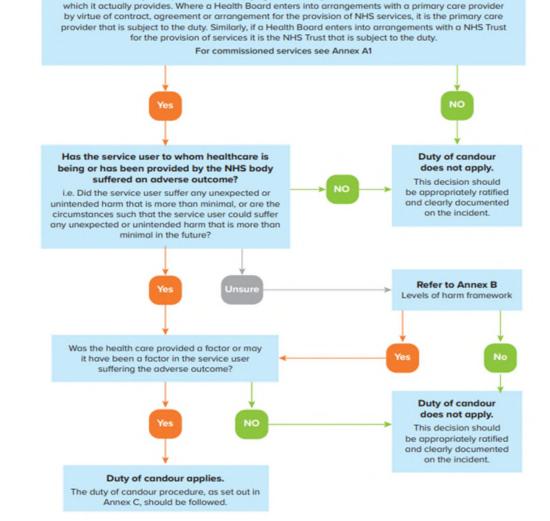
Annex A - Duty of Candour

Trigger review process

When does the Duty of Candour procedure apply?

In practice, the duty of candour is triggered if unexpected or unintended harm that is moderate and above is suffered or may be suffered (referred to as adverse outcome)

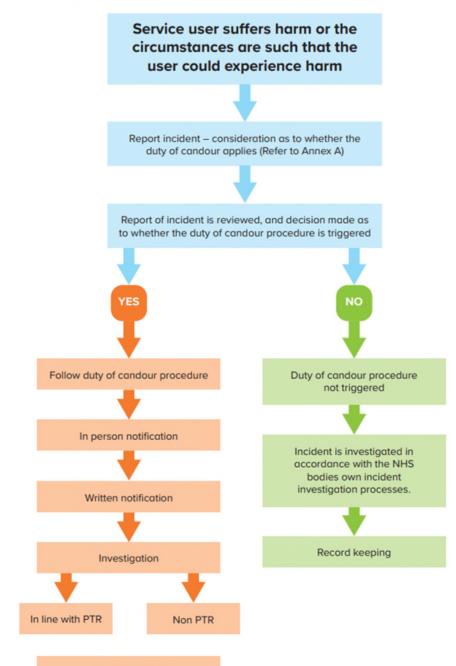
& the provision of healthcare was (or may have been) a factor in the service user suffering that adverse outcome.



Is the NHS body providing care or has it provided care to the service user?

NB: An NHS body is responsible for complying with the duty of candour in relation to all health care,

Review process and record keeping



Record keeping

Notification

On first becoming aware the duty has been triggered, (which is the start date for the duty of candour procedure to be followed), the NHS body must notify the service user/or person acting on their behalf.

B: Where the in-person notification is later than 30 working days after the date on when the NHS body first ecame aware of the notifiable adverse outcome, an explanation of the reason for this should be provided and recorded. This does not mean that the NHS body has one month to make the notification.

The initial notification should be **'in person'** (NHS bodies have discretion as to which method of in person communication is most appropriate). However, the preference of the service user/person acting on their behalf should be considered as well as factors such as the severity of the harm caused.

IN PERSON CAN MEAN By telephone, video call or face to face

Purpose of the in person notification

- Acknowledge what has happened
- Offer an apology (see Annex E).
- Explain what information is known at that time about what has happened.
- Explain the next steps in relation what will happen next. (see Annex F).
- Offer support (see Annex D).
- Provide point of contact details.

Once in person notification has been made, **written notification** must also be provided to the service user/person acting on their behalf within **two working days**.

Purpose of the written notification

- Reiterate the verbal apology (see Annex E).
- Detail any initial information on what is known about what has happened.
- Explain the intended actions to and further enquiries that the NHS body will undertake (see Annex F)
- · Provide the details of the point of contact.
- Provide the details of any support required (see Annex D).

Duty of Candour procedure

Reporting requirements to the Health Board

Compile an Annual Report

- State how often the duty of candour has been triggered during the reporting year;
- Give a brief description of the circumstances in which the duty was triggered; and
- Specify any steps taken with a view to preventing similar circumstances from arising in the future.
- This must be sent for the financial year reporting period (April-March)

The HB will include this anonymised data in their annual report HIW will include compliance when carrying out their inspections and the annual GDS NHS QAS.

Duty of Candour

The focus should be on learning and sharing learning to improve patient care and service provision.

Duty of Candour dental example

- Patient attends the practice for recall. The dentist finds that the patient has candidiasis due to poor denture hygiene. The patient is given denture hygiene advice and a prescription for Miconazole oral gel.
- 2 weeks later his wife calls the surgery to inform them that her husband had been admitted with gastrointestinal bleed due to his INR being above 6
- She said her husband had been placed on Warfarin 4 months earlier
- There was no update of his medical history for the last dental appointment.

Duty of Candour triggers

- Has unintended /unexpected harm occurred?
- Is that harm more than minimal?
- Was the provision of dental care a possible factor?
- If YES to all three questions, DoC is triggered.
- The DoC algorithm must be followed.
- The pharmacist who dispensed the medication should be informed to follow DoC.

Alternative scenario

- The pharmacist, on receiving the prescription, checks the patient's medication and refuses to dispense it. No more than minimal harm has occurred and so DoC does not apply.
- However, an adverse incident has occurred and the dentist must complete incident form/datix and review MH taking as part of lessons learnt.

Duty of Candour

GDS practices will need to ensure:

- GDC registrants understand their responsibilities
- The Putting Things Right lead in the practice understands the process for Duty of Candour
- Awareness raising, education and training of the GDS team
- Policy on notification and monitoring
- Shared Learning
- Annual report to the Health Board