Duty of candour and promoting a safety and learning culture

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Saying sorry

- Not an admission of liability
- Part of Duty of Candour
- The right thing to do
Definitions: apology

• An ‘apology’ is an expression of sorrow or regret in respect of a notifiable safety incident;
• It is not an admission of guilt.
Duty of candour requirements

- Make sure that you act in an open and transparent way.
- Tell the relevant person, in person as soon as possible and support them.
- Provide an account of the incident, offer an apology, do so in writing and keep a written record.
Perceptions about Duty of candour

• Perception that the threat of litigation is a barrier to candour.

• That the patient shouldn’t be told that something has gone wrong, just in case they decide to bring a claim.

• That no one should say sorry, just in case it is in some way seen as an admission of liability.

• That insurers and lawyers are called in, just in case the words of an explanation lead to legal trouble further down the line.
Nothing can be further from the truth

- Honesty and openness from the outset is more likely to prevent rather than cause a claim.
- If a patient has suffered harm, which means that they are entitled to compensation, we will do our best to resolve their claim as quickly as we can and without litigation.
- The NHS LA is part of the NHS, we are not an insurer. We have never and will never refuse cover on a claim because an apology has been given.
- We see our role very much as to support openness, transparency and candour when things go wrong.
Challenges in practice

- Is it a notifiable patient safety incident (it is important to note that this means unintended or unexpected, there is no requirement for this to have been a mistake or negligent).
- Has the incident resulted or appear to have resulted in harm or could it result in harm?
- Does that harm fall into one of the four categories of moderate, severe, prolonged psychological harm or death?
- The NHS treats 1 million patients every 36 hours. Studies estimate that there are 4,000 adverse events each day and that there are 2,000 avoidable adverse events each day.
Practical considerations and steps which organisations need to take

• The inclusion of unintended events, catches significant complications for which no-one is at fault. In addition, moderate harm, includes numerous minor events which cause significant temporary harm.

• This involves a degree of judgment, this needs a combination of awareness, training and experience over time.

• Reviewing and re-launching local policies dealing with communication and apologies.

• Publicising details of support systems for both staff and patients.
Practical considerations and steps which organisations need to take

- Board level training to ensure a trust wide approach with an emphasis on board responsibilities and duties.
- Periodic reports to the board about how the duty is being met and the sort of events that are being reported.
- Training for managers on how to advise front-line staff and answer questions.
- Training for the front-line on how to deliver candour in practice.
- Tightening up of documentation so that discussions and letters are logged and dated.
- Taking opportunities to learn as the process evolves.
Action for trusts to take

• Verbal apologies as soon as staff are aware of an incident.
• Following up with a written apology.
• Avoiding delay which can dilute the value of this.
• Explaining likely short term and long term effects.
• Explaining what is still uncertain and responding honestly to concerns.
• Identifying named Executive and Directorate leads which will usually be the most senior health professional involved in treatment or a nominated clinical lead.
• Being fact specific as to who should be involved – who does the patient actually want to hear from.
Example one

- An elderly patient undergoes a coronary artery bypass operation. The patient is appropriately consented for the risks of the operation, including stroke and death. Unfortunately, the patient sustained a large stroke during the operation and subsequently died as a result.
Example two

- A doctor causes a pneumothorax whilst placing a central venous catheter (a recognised complication). The patient requires a chest drain to be inserted and a short stay in the Intensive Care Unit. The patient makes a full recovery.
Example three

- A distressed aggressive patient required physical restraint whilst receiving an injection of anti-psychotic medication. During the restraint, the patient’s arm was broken which required manipulation and treatment in plaster for six weeks. He made a full recovery from the injury.
Example four

- A radiology department holds a monthly near miss/error meeting where they regularly review cases, to support and share learning. One of the cases involves a patient who has just had lung cancer confirmed on computerised tomography, on review of a previous x-ray taken three years earlier there is a very small nodule present. It is very unlikely that an intervention would have been taken at the time.
Creating a culture of learning – understanding accountability and culture

- Safety and confidence to speak up.
- Listening to those that speak up.
- Taking action.
- Supporting colleagues.
Opposite of candour – What it is not?

• Fixated behaviours
• Communication
• Arrogance/hierarchies
• Cover up
• Fear of speaking up
Some of the reasons why people make claims

- Seeking answers and explanation
- Acknowledgement /apology
- Want lessons to be learnt
- To get resolution and closure
- To be compensated
Support the NHS to learn from things that go wrong, to reduce harm and improve patient safety”..

= fewer less costly claims
= reduction in the cost of Clinical Negligence Scheme for Trusts contributions
### Scorecard

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<th>Value</th>
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<tbody>
<tr>
<td>Anaesthesia</td>
<td>1</td>
<td>£ 4,042,000</td>
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<tr>
<td>Casualty I A &amp; E</td>
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<tr>
<td>Neurosurgery</td>
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<tr>
<td>Orthopaedic Surgery</td>
<td>2</td>
<td>£ 3,210,000</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>£ 13,025,000</strong></td>
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</tbody>
</table>

| Chemical Pathology/Biology   | 1  | £ - |
| Dentistry                   | 2  | £ 6,723 |
| Dermatology                 | 1  | £ 23,832 |
| District Nursing            | 1  | £ 52,000 |
| Gastroenterology            | 2  | £ 950 |
| General Practice            | 1  | £ - |
| Histopathology              | 1  | £ 88,076 |
| Intensive Care Medicine     | 2  | £ - |
| Miscellaneous               | 1  | £ 13,212 |
| Oncology                    | 2  | £ 65,000 |
| Other                       | 1  | £ 34,880 |
| Otorhinolaryngology Ears    | 2  | £ 537,242 |
| Radiology                   | 1  | £ 17,038 |
| Surgical Speciality - Oth   | 2  | £ 135,000 |
| Vascular Surgery            | 1  | £ 13,107 |
| **Grand Total**             |    | **£ 20,437** |

<table>
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Data correct at 30 June 2014
Blame or accountability?

- Blame is to be accountable in a way deserving of censure, discipline, or other penalty, either explicit or tacit. Accountable does not mean "blame-able".
- Accountability means to be responsible for and answerable for an activity. If something goes wrong, those accountable are expected to answer for their part in the goings-on, because there is a need for their knowledge to perfect our ‘flawed’ systems.

Is It Blame or Is It Accountability?
by Rick Brenner
www.chacocanyon.com/pointlookout/051221.shtml
Accountability and blame differ in at least four dimensions

• **Learning v’s punishment** - If blame is the goal, instead of real organizational learning, activity usually stops after the culprit or culprits have been found.

• **Incidence of fear** - Fear of accountability is a strong indicator of blaming.

• **Organisational chart altitude distribution** - Where those accountable are at many levels of the org chart, we are more likely to be assigning accountability; when we find those accountable concentrated at the bottom of the org chart, chances are that we are assigning blame.

• **Acknowledging interdependence** - finding those accountable will probably result in a long list i.e system failure.
**Decision Tree for Determining Culpability of Unsafe Acts**

1. **Were the actions as intended?**
   - No → Unauthorized substance?
   - Yes → Medical condition?

2. **Unauthorized substance?**
   - No → Substance abuse with mitigation
   - Yes → Were procedures available, workable, intelligible and correct?

3. **Medical condition?**
   - No → Were procedures available, workable, intelligible and correct?
   - Yes → Deficiencies in training & selection or inexperience?

4. **Were procedures available, workable, intelligible and correct?**
   - No → Possible reckless violation
   - Yes → System-induced violation

5. **Deficiencies in training & selection or inexperience?**
   - No → System-induced error
   - Yes → Blameless error but corrective training, counseling needed

6. **Blameless error**

7. **System-induced error**

8. **System-induced violation**

9. **Possible negligent error**

10. **Diminishing culpability**

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**Cases:**
- Sabotage, malevolent damage, suicide, etc.
- Substance abuse with mitigation
- Possible reckless violation
- System-induced violation
- System-induced error
- Blameless error but corrective training, counseling needed
- Blameless error

**Questions:**
- Were the actions as intended?
- Unauthorized substance?
- Medical condition?
- Were the consequences as intended?
- Unauthorized substance?
- Medical condition?
- Were the consequences as intended?
- Substance abuse with mitigation?
- Substance abuse without mitigation?
- Did the consequences as intended?
- Medical condition?
- Did the procedures available, workable, intelligible and correct?
- Deficiencies in training & selection or inexperience?
- System-induced violation?
- System-induced error?
- Blameless error but corrective training, counseling needed?
Decision tree simplified

The USA have modified it to apply the following questions:

- Did the employee intend to cause harm?
- Did the employee come to work drunk or impaired?
- Did the employee knowingly and unreasonably increase risk?
- Would another similar trained and skilled employee in the same situation act in a similar manner (reason substitution test)?
- If the answers to the first three questions are no and to the question 4 is yes, this points to the error being a system problem. The error would require a full root cause analysis to understand and then seek to rectify the system error.
Three things you can do tomorrow

Number one

• Review your current disciplinary policy.
• Ensure it accounts for when incidents are investigated that there is an understanding of human factors and the just culture.
• Your key issue is to ensure that learning from the events outweigh the deterrent effect of punishment and your staff feel able to speak out, raise concerns and report incidents.
Three things you can do…

Number two

- Conduct a culture survey of your staff (may need to have an anonymous route).
- Ask them if mistakes are made if they feel safe to come forward so that the organisation can learn from the event.
- Feedback the information on a unit by unity basis not the whole organisation.
Three things you can do…

Number three

Review your incident reporting system – if your incident reports are mainly about:

– Problems with processes and equipment – you have a low reporting culture – these are easy to do without backlash on individuals.

– Individuals reporting on other individuals – you have a low reporting culture – it is easy to point the finger at others.

– Individuals reporting their own mistakes – you have a good reporting culture – the individual will act against their own self interest and report so that others can learn.
Three things you can do…

Number three (…continued)

Review your incident reporting system – if your incident reports are mainly about:

- Individuals reporting their own violations – you have an outstanding reporting culture – they understand that you understand that violations are not disciplinary actions and are to be learned from.
Conclusion

• Look at your score cards in detail with your teams to see what is driving your claims.
• Triangulate within your departments with complaints, incidents, and patient feedback.
• Implement quality improvement initiatives with preventative measures to target where harm has occurred.
• If harm occurs, ensure immediate steps to work with families through duty of candour and evidence your learning.
• Share good practice widely.
Questions?