Healthcare organisations (other than health service bodies) registered with CQC in England are now subject to a statutory duty of candour, introduced in April 2015. Organisations who are not health service bodies include general dental practices and dental professionals working in purely private practice.

Rupert Hoppenbrouwers, head of the Dental Defence Union, explains the new law, which sits alongside the ethical requirement on individual clinicians to be open and honest.

For many years the DDU has advised dental professionals to tell patients when things have gone wrong, to apologise and to try and put things right. Dental professionals understand this ethical duty, and that having an open dialogue with patients is not something to be afraid of.

Now the government has introduced a statutory duty of candour on general dental practices and independent dental providers registered with CQC – one required, and enforceable, by law.

Ethical duty

The GDC, along with other healthcare regulators, recognises a common professional duty to be open and honest when things go wrong. The professional duty of candour means that when something goes wrong with patients’ treatment or care and which causes (or could cause) harm or distress, dental professionals must:

a. tell the patient (or their representative) when something has gone wrong;

b. apologise to the patient;

c. offer an appropriate remedy or support to put matters right, if that is possible; and

d. explain fully to the patient the short- and long-term effects of what has happened.

Statutory duty of candour

For many years the Dental Defence Union has advised dental professionals to tell patients when things have gone wrong, to apologise and to try and put things right. Dental professionals understand this ethical duty, and that having an open dialogue with patients is not something to be afraid of.

Now the government has introduced a statutory duty of candour on general dental practices and independent dental providers registered with CQC – one required, and enforceable, by law.

Statutory duty of candour

The obligations associated with the statutory duty of candour are contained in regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are:

1. Care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout an organisation.

2. The statutory duty applies to organisations, not individuals, though it is clear from CQC guidance that it is expected that an organisation's staff cooperate with it to ensure the obligation is met.

3. As soon as is reasonably practicable after becoming aware of a notifiable patient safety incident, the organisation must tell the patient (or their representative) about it in person.

4. The circumstances that give rise to a requirement to tell the patient or their representative about something that has gone wrong are the same as those that are required to be notified without delay to the CQC. This notification to CQC is separate from and in addition to the statutory duty of candour which requires the organisation to keep copies of correspondence with the patient.

5. The organisation has to give the patient a full explanation of what is known at the time, including what further enquiries will be carried out.

6. Organisations must also provide an apology and keep a written record of the notification to the patient. Failure to make that notification may amount to a criminal offence.

7. A notifiable patient safety incident has a specific statutory meaning: it applies to incidents where something unintended or unexpected has occurred in the care of a patient and appears to have resulted in:

a. their death, where this relates to the incident and is not simply due to the natural progression of the illness or condition;

b. impairment (of sensory, motor or intellectual function) that has lasted or is likely to last for 28 days continuously;

c. changes to the structure of the body (for example, erroneous extraction);

d. prolonged pain or prolonged psychological harm. The pain or psychological harm must be, or likely to be, experienced continuously for 28 days or more;

e. shortening of their life expectancy;

f. or where the patient requires treatment by a healthcare professional in order to prevent death, or the adverse outcomes listed above.

8. There is a statutory duty to provide reasonable support to the patient. Reasonable support could be providing an interpreter to ensure discussions are understood, or giving emotional support to the patient following a notifiable patient safety incident.

9. Once the patient has been told in person about the notifiable patient safety incident, the organisation must provide the patient with a written note of the discussion, and copies of correspondence must be kept. Following the initial notification the patient must be given written notification including details of any further enquiries into the incident and their results and an apology.

Although the statutory duty of candour applies to organisations, dental professionals, who are used to having candid discussions with their patients, are most likely to be the organisation’s representative under the statutory duty. It is important that you cooperate with your organisation’s policies and procedures, including the requirement to alert the organisation when a notifiable patient safety incident occurs.
An area of difficulty may be deciding whether an incident reaches the threshold for notification under the statutory duty. This may be confusing, as the threshold is low for the dentist’s ethical duty (any harm causing distress to the patient) but high for the statutory duty.

Where an organisation’s clinical governance procedures for reporting and investigating incidents are followed, it is unlikely that a notifiable patient safety incident will be overlooked. And in any event, dental professionals must always follow their ethical duty, irrespective of whether the statutory duty applies.

References

1. Joint statement from the Chief Executives of statutory regulators of healthcare professionals, 13 October 2014
2. Care Quality Commission (Registration) Regulations 2009, regulations 16 and 18.

Case study

**Damage to lingual nerve**

A 26-year old woman attended her general dental practitioner for removal of an impacted lower right third molar that was causing recurrent pericoronitis. The dentist was experienced in removing wisdom teeth and proceeded with the extraction under local anaesthetic.

However, the procedure was not as straightforward as the dentist had hoped and took 25 minutes to complete. The woman, although anxious about the procedure, was otherwise well and was given advice on surgical aftercare and told to come back if she had any problems. The woman returned 10 days later, reporting tingling and a loss of sensation on the right side of the tongue and floor of the mouth, with occasional throbbing. On examination, the dentist found reduced sensation to pinprick. The dentist realised that the right lingual nerve had been damaged, possibly when using the periosteal elevator during the extraction.

He explained what had happened to the patient and, although he had warned about the possibility of nerve damage before undertaking surgery, he nonetheless apologised that it had occurred. The dentist offered to refer her to a maxillo-facial surgeon with a specialist interest in nerve damage, to which the patient agreed.

Later that day the dentist discussed the adverse incident with two of his partners and the practice manager. They concluded that although the neural symptoms may well resolve, they were likely to persist for at least 28 days continuously. Therefore, it was a situation where the statutory duty of candour would apply. It was also necessary to notify CQC without delay to comply with registration requirements. The partners agreed that the initial notification to the patient had been entirely appropriate, and that they should write to her as well.

Although he understood that the statutory duty of candour falls on the organisation, not the individual, the dentist believed it was right for him to write personally to the patient, on behalf of the organisation, reiterating his initial apology. The practice manager notified CQC.

Several weeks later, the practice reviewed the case as a significant event audit. By that time the woman had seen the maxillo-facial surgeon who believed the prognosis was good and that she could be expected to recover. The discussions, which took into account comments from the maxillo-facial surgeon, reached the conclusion that although it had been reasonable to offer removal of the third molar in the practice, with hindsight there were some features on the x-ray which may have merited referral for hospital removal.

The dentist wrote again to the patient detailing the further discussions, and apologising once again. He also offered her a meeting to discuss the matter, which she accepted. Her lingual nerve symptoms began to improve, and she was optimistic that she would recover totally. She was pleased that the dentist and practice had been so open about what had happened, and had immediately offered an apology for what had been a distressing and worrying experience. As she expected to recover, the patient said she considered the matter closed.

COC asked the practice manager to update them when there were further developments. This was duly done and COC informed the practice that it noted the incident had been notified promptly and that the duty of candour had been followed. No further action was required.

For dento-legal queries

24-hour advisory helpline
Call  freephone 0800 374 626
Email  advisory@theddu.com
Visit  theddu.com

This information is intended as a guide. For the latest dento-legal advice relating to your own individual circumstances, please contact us directly.

Our dento-legal team is available between 8:30am-6:00pm Monday to Friday. Advice is available 24 hours a day, 365 days a year for dento-legal emergencies or urgent queries.