

Procedure:	Duty of Candour Policy and Procedure		
No:	P289	Practice:	Queens Road and Longfrie
Author:	Governance Team		
Ratified By:	Senior Management Team	Review Date:	18.12.2028

Purpose:

To ensure all healthcare providers are open and honest when things go wrong with patient care.

This includes being open and honest with the patient, colleagues, employers and relevant organisations.

Background:

All healthcare professionals have a duty of candour, which is the professional obligation to be open and honest with patients when something goes wrong in their care. In the UK, this duty is enshrined in law under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. It applies when a notifiable safety incident occurs. This is defined as an unintended or unexpected event that has resulted in, or could result in, moderate harm, severe harm, or death. This duty does not apply where a patient's condition deteriorates due to the natural progression of their illness.

While there is currently no statutory duty of candour in the Bailiwick of Guernsey, the Committee for Health & Social Care (HSC) has committed to introducing health and care regulation that will include candour principles. In the meantime, all clinicians and staff within the Practice are expected to adhere to the standards set out in Regulation 20 and by other professional bodies, as reflected in this policy.

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1) Discuss risks before beginning treatment or providing care:

Patients must be fully informed about their care. Clear and accurate information about the risks as well as the benefits of the proposed treatment or care and the risk of any reasonable alternatives must be discussed and understood by the patient. Risks that occur often, those that are serious even if very unlikely, and those that the patient is likely to think are important should all be discussed. Please see Consent, Capacity and Disclosure Policy for further guidance.

2) Informing the patient with details of what has gone wrong:

Patients must be informed as soon as possible after the realisation that something has gone wrong with their care. It is not necessary to wait until the outcome of an investigation to speak to the patient, but it should be made clear what has been done and what has not yet been established.

When informing a patient there should be support available to them, this could be a friend, relative or a professional colleague.

All available knowledge should be shared on what is currently known, what is believed to be true about what went wrong and why, and what the likely consequences will be. If there is still any uncertainty this should be explained, and all questions must be responded to honestly.

Normally patients will want to know the details about what has gone wrong, but they should be given the option not to be given every detail. If the patient wishes not to have further information a discussion on why should be had. If after the discussion the patient's wishes remain the same, these wishes should be respected as far as possible and this must be recorded.

3) Giving an apology:

An apology should be given and documented in the patient's clinical records. Personal responsibility for something going wrong that is not an individual's fault is not necessary, however the patient has the right to receive an apology from the appropriate team member. Saying sorry does not mean admitting legal liability and this is set out in legislation in parts of the NHS Resolution, which advises saying sorry is the right thing to do.

4) Informing someone close to the patient with details of what has gone wrong:

If something has gone wrong which causes a patient's death or such severe harm that the patient is unlikely to regain consciousness or capacity, then it is important to be open and honest with those close to the patient. You should bear in mind and respect their wishes if the patient has previously requested that personal information regarding their condition or treatment is not to be shared with those close to them.

5) Near miss

A near miss is an adverse incident that has the potential to result in harm but did not do so. If a near miss occurs, professional judgment should be considered whether to inform the patient. If in doubt, advice should be sought from the Governance Team.

If there is information that the patient needs to know or would want to know and by telling the patient about the near miss it could help their recovery, then they should be informed. Failing to be open with a patient about a near miss could damage their trust and confidence in the healthcare team.

In some circumstances patients may not need to know about an adverse incident that has not caused and will not cause them harm. If speaking to them about the near miss could distress or confuse them unnecessarily then this should not be done.

6) Learning Event

When something goes wrong with patient care, it is crucial this is reported at an early stage so lessons can be learnt quickly, and patients can be protected from harm in the future.

For further guidance on Learning events, refer to procedure P069, 'Learning event review process and procedures.'

7) References:

[The professional duty of candour - The Nursing and Midwifery Council](#)

[Regulation 20: Duty of candour - Care Quality Commission](#)

[Duty of Candour — Royal College of Surgeons](#)

[The professional duty of candour - professional standards - GMC](#)

Approved: Senior Management Team

Dated: 18.12.2025