



**Supplementary  
guidance on the  
professional  
duty of candour**

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**What is the  
professional  
duty of  
candour?**



## What is the professional duty of candour?

1. All healthcare professionals have a professional duty of candour — this is a professional responsibility to be open, honest and transparent with patients when things go wrong.
2. This professional duty of candour was agreed in October 2014 in a joint statement from eight regulators of healthcare professionals in the UK.<sup>1</sup> This was in response to findings and recommendations from both the Mid-Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry) into poor patient care at Mid Staffordshire NHS Foundation Trust in 2013 and the UK Government's response to this Inquiry: *Hard Truths: The Journey to Putting Patients First* published in January 2014.
3. The General Optical Council's *Standards of Practice for Optometrists and Dispensing Opticians* (standard 19) and *Standards for Optical Students* (standard 18) reflect this professional duty of candour.

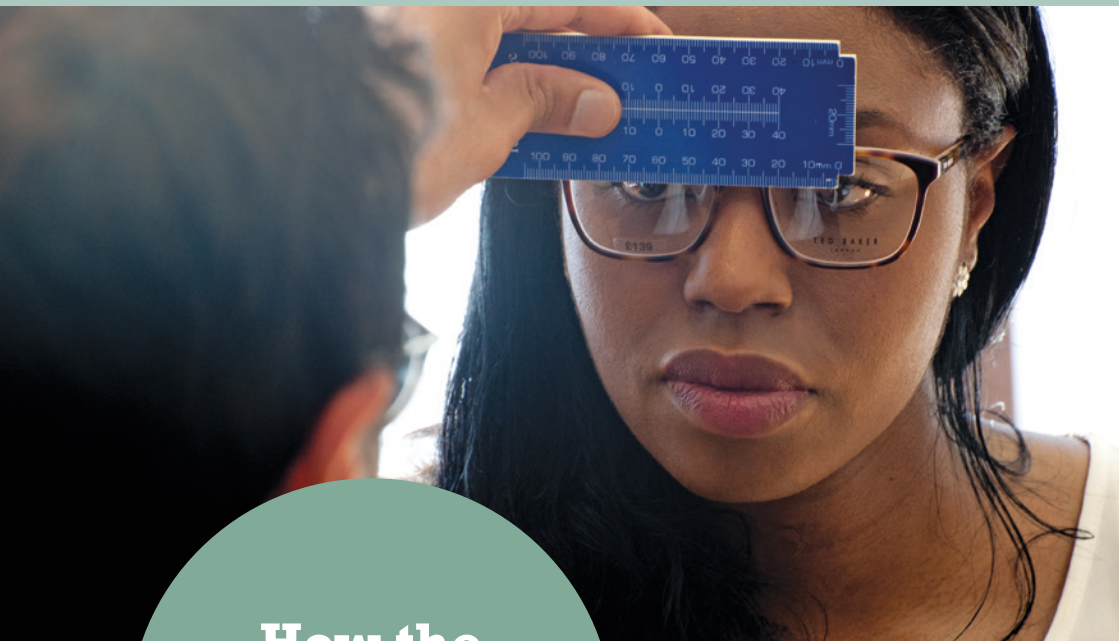
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<sup>1</sup> General Chiropractic Council, General Dental Council, General Medical Council, General Pharmaceutical Council, General Osteopathic Council, Health and Care Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.

## Standards of Practice for Optometrists and Dispensing Opticians:

19. Be candid when things have gone wrong.
  - 19.1 Be open and honest with your patients when you have identified that things have gone wrong with their treatment or care which has resulted in them suffering harm or distress or where there may be implications for future patient care. You must:
    - 19.1.1 Tell the patient or, where appropriate, the patient's advocate, carer or family that something has gone wrong.
    - 19.1.2 Offer an apology.
    - 19.1.3 Offer appropriate remedy or support to put matters right (if possible).
    - 19.1.4 Explain fully and promptly what has happened and the likely short-term and long-term effects.
    - 19.1.5 Outline what you will do, where possible, to prevent reoccurrence and improve future patient care.
  - 19.2 Be open and honest with your colleagues, employers and relevant organisations, and take part in reviews and investigations when requested and with the General Optical Council, raising concerns where appropriate. Support and encourage your colleagues to be open and honest, and do not stop someone from raising concerns.
  - 19.3 Ensure that when things go wrong, you take account of your obligations to reflect and improve your practice as outlined in standard 5.

4. Being candid should not be misunderstood as admitting liability or wrong doing. An apology or other step taken in accordance with this guidance does not of itself amount to an admission of negligence or a breach of statutory duty. The action taken, whether on behalf of yourself, your employer or another healthcare colleague is the right thing to do for the patient.
5. Being candid should not be confused with handling complaints. This guidance on candour applies whether or not a complaint has been made or a concern raised.
6. This professional duty of candour should not be confused with the contractual duty of candour or the statutory duty of candour. These are separate duties that apply to providers who have a contract to provide NHS care and organisations regulated by the Care Quality Commission. These duties are unlikely to apply to you as an individual.
7. This guidance should also not be confused with the GOC's policy on Raising Concerns with the GOC (whistle blowing). It focuses on the conversation required with the patient when something has gone wrong. You will need to consider separately whether there is a requirement to take any further action in relation to raising concerns.



**How the  
guidance  
applies  
to you**

## About this guidance

8. This document gives guidance on how to meet the GOC's standard on the professional duty of candour. It does not create new requirements or give legal advice.
9. The word 'must' indicates a mandatory requirement, for example, registrants must comply with the law and must meet the GOC's standards.
10. You should use your professional judgement to apply this guidance to your own practice and the variety of settings in which you might work.
11. If you are not sure about how to proceed in a specific situation, you should ask for advice from appropriate professional colleagues, your employer, your professional indemnity insurance provider, your professional or representative body, or obtain independent legal advice.
12. Student optometrists and student dispensing opticians should also seek advice from their tutor, supervisor or training provider.
13. Support may also be available from employers who have policies and procedures in place to support a culture of openness and transparency. These should outline how the employer manages breaches of the professional duty of candour, including the investigation of any instances where a member of staff may have obstructed another in exercising their duty of candour.
14. Throughout the guidance we talk about your responsibilities towards patients or people in your care. We recognise that care is often provided by a number of different optical professionals or in conjunction with other types of healthcare professionals and that you may be one of several healthcare professionals involved in a patient's care.



15. While every healthcare professional will have a professional duty of candour, we would not expect every professional involved in the care pathway to talk to the patient about the same incident. But you must make sure that an appropriate person — usually the lead or accountable clinician — takes responsibility for speaking to the patient or (in certain situations) those close to them if something goes wrong.



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## Be candid when things have gone wrong

16. The professional duty of candour applies when you become aware that something has gone wrong and a patient in your care has suffered physical or psychological harm or distress, or there might be implications for their future care. This might include minor incidents that cause temporary distress (for example, use of incorrect eye drops which might cause an undesired effect such as blurred vision) or more serious incidents (for example, failure to detect signs of disease or abnormality).
17. Being open and honest means you must inform the patient about what has gone wrong. This will usually mean speaking to the patient as soon as possible after you realise something has gone wrong with their care.
18. You do not need to wait until the outcome of an investigation before speaking to a patient. The patient must be told:
  - that something has gone wrong;
  - what happened;
  - the likely short and long term effects;
  - what can be done to put matters right; and
  - what can be done to avoid reoccurrence and improve patient care.
19. You must also offer an apology. Saying sorry does not mean admitting liability or wrongdoing but it is important to patients that you express regret for any harm, distress or adverse consequences to their health and wellbeing.
20. Offering an apology is an important part of being candid as it shows that you recognise the impact of the situation on the patient and that you empathise with them.
21. Patients may find it more meaningful if you personally apologise for something going wrong.

22. When speaking to a patient you should consider the following:
- a. You must share information in a way that the patient can understand.
  - b. You should give information that the patient may find distressing in a considerate way, for example, asking them if they would like to have someone with them.
  - c. You should respect your patient's right to privacy and dignity, making sure that conversations take place in appropriate settings where possible.
  - d. If there is an on-going investigation you should be clear that the facts have not yet been established. Tell them only what you know and believe to be true, and answer any questions honestly and as fully as you can.
  - e. You should make sure the patient knows whom to contact to ask any further questions or raise concerns.
  - f. You should record the details of your apology in the patient's clinical record. In certain circumstances, a verbal apology may need to be followed up by a written apology.
23. If you are unable to apologise to the patient, or those close to them, with the required care and compassion, you must:
- a. make sure that an appropriate person takes on the responsibility to talk to the patient. This could be within your own optical team or a different healthcare professional who is working with you in delivering care for the patient, for example, an ophthalmologist; and
  - b. develop your skills and experience in this area to fulfil this role in future.

## Speaking to those close to the patient

24. If the patient lacks consciousness or capacity, you must be open and honest with those close to the patient. Take time to convey the information in a compassionate way, giving them the opportunity to ask questions at the time and afterwards. You should refer to our consent guidance for more information on when it is appropriate to discuss a patient's care with those close to them.
25. You should make sure, as far as possible, that those close to the patient have been offered appropriate support, and that they have a specific point of contact in case they have concerns or questions at a later date.

## Adverse events that did not result in harm or distress

26. Sometimes you may encounter an adverse event in practice that had the potential to cause harm or distress but this did not occur, for example, because of preventative action that you may have taken. You should use your professional judgement when considering whether to inform patients about these events.
27. You should consider whether failure to be open could damage their trust in you and the healthcare team. There may be information that the patient would want or need to know about and, in these cases, you should talk to the patient about what has happened. For example, you discover that the follow-up examination date for a patient has been entered incorrectly on a patient record or that a referral which you agreed with the patient has not been forwarded to the relevant healthcare professional. In both cases, this may not have resulted in immediate harm or distress for the patient, but the delay in the patient receiving the required care should be rectified and consideration should be given to informing the patient of the reasons for this.

28. In some circumstances, patients do not need to know about something that has not caused (and will not cause) them harm, and telling them may distress or confuse them unnecessarily.
29. As with all adverse events, registrants should reflect on why the event happened and what action should be taken in future to prevent reoccurrence by sharing learning to help ensure patient safety.

### Learning from adverse events

30. When things go wrong with patient care, the cause is usually either a flaw in an organisational system or human error. It is important that lessons are learnt so future patients are protected from harm. Standard 5 and Standard 12 of the *Standards of Practice for Optometrists and Dispensing Opticians* encourage fully qualified registrants to reflect on their practice to keep their knowledge and skills up to date and to ensure a safe environment for patients.
31. As a healthcare professional, you should regularly review your own standards and performance as outlined in the *Standards of Practice for Optometrists and Dispensing Opticians*: '5.4 Reflect on your practice and seek to improve the quality of your work through activities such as reviews, audits, appraisals or risk assessments. Implement any actions arising from these.' You should take part in regular reviews and audits of the standards and performance that your team, practice or employer operates for this purpose and take steps to resolve any problems.

32. You should consider what action you can take as an individual to prevent reoccurrence of an adverse event. Your employer, professional or representative body or other organisations may have in place processes or policies to help individuals to collate, review and share information on adverse events in order to improve practice and these should be used where appropriate.
33. Depending on your role and scope of practice you might also be able to utilise a number of national schemes in the UK which are used to report adverse events and for healthcare professionals to review the learning from these events to inform good practice. These include:
- a. The UK-wide Yellow Card Scheme run by the Medicines and Healthcare products Regulatory Agency (MHRA) for reporting suspected adverse drug reactions or adverse incidents involving medical devices (including spectacles and contact lenses): **[www.gov.uk/report-problem-medicine-medical-device](http://www.gov.uk/report-problem-medicine-medical-device)**. Please refer to the independent prescribing guidelines for optometrists for further details on adverse drug reactions.
  - b. The National Reporting and Learning System for reporting adverse events and patient safety incidents in England and Wales (for registrants providing NHS care): **<https://report.nrls.nhs.uk/nrlsreporting>**
  - c. The Healthcare Improvement Scotland national framework, which outlines consistent definitions and a standardised approach to adverse event management across the National Health Service (NHS) for Scotland: **[www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)**

d. The procedure for the reporting and follow-up of serious adverse incidents in Northern Ireland is set out on the Department of Health, Social Services and Public Safety's website. This includes the Northern Ireland Adverse Incident Centre (NIAIC) for the voluntary reporting and investigation of adverse incidents involving medical devices, non-medical equipment, plant and building elements and for providing relevant safety guidance in relation to these items: **[www.health-ni.gov.uk](http://www.health-ni.gov.uk)**

34. If you are an optical student then you should consult with your supervisor, tutor or training provider about any necessary action required to inform learning from adverse events that have occurred during your training.

### **Optometrists and dispensing opticians with high profile or management responsibilities**

35. Optometrists and dispensing opticians in positions of influence have a particular responsibility to set an example and encourage openness and honesty in reporting adverse incidents.

36. Optometrists and dispensing opticians with management responsibilities should provide advice and guidance to colleagues on complying with the duty of candour.



# Notes

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## Alternative formats

You can get this booklet in Welsh or other alternative formats by emailing: [communications@optical.org](mailto:communications@optical.org)

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