crescent DENTAL

Duty of Candour Policy

The Duty of Candour, which was introduced by the government through Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, applies to all dental practices as of the 1 April 2015.

The intention of this regulation is to ensure that dental practices are open and transparent with their patients and other relevant persons (i.e. people acting lawfully on behalf of them) in general in relation to care and treatment. It also sets out some specific requirements that practices must follow when things go wrong with care and treatment.

At Crescent Dental Surgery, when things go wrong with care and treatment, which from time to time is inevitable; it is our policy to ensure that our patients are:

- Told the truth
- Provided with a genuine apology
- Offered an appropriate remedy (where this is possible).

All Crescent Dental Surgery team members act in an open and transparent way:

- To patients.
- With relevant people.
- In relation to care and treatment provided.
- In performing a regulated activity.

We ensure that an open and honest culture exists throughout the practice.

Professional duty of candour

In addition to our statutory duty of candour, all General Dental Council (GDC), registrants have a professional duty of candour.

The GDC requires all registrants to be open and honest with their patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

To ensure we comply with this duty, in Crescent Dental Surgerywe require all GDC registrants to:

- Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;

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- 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.

GDC registrants must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested to do so. GDC registrants 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 they must not stop someone from raising concerns.

At Crescent Dental Surgery, we have a process in place to identify and deal with possible breaches of the professional duty of candour by team members who are professionally registered. This includes an investigation and escalation process, which may lead to referral to their professional regulator or other relevant body. The practice whistle blowing policy gives further guidance on this.

Statutory duty of candour

Whilst we understand that the statutory duty applies to organisations, not individuals, we expect all team members to cooperate with it to ensure our obligation is met.

Notifiable safety incidents

Regulation 20 refers to 'notifiable safety incidents', these are incidents that must be reported to the Care Quality Commission (CQC) in addition to the requirements laid out above.

These are likely to be very rare occurrences in dental practice and are described as:

Any unintended or unexpected incident that occurs in respect of a patient during the provision of dental care (a regulated activity) that, in the reasonable opinion of a health care professional results in or has resulted in:

- The death of the patient, where the death relates directly to the incident rather than to the natural course of the patient's illness or underlying condition.
- An impairment of the sensory, motor or intellectual functions of the patient which has lasted, or is likely to last, for a continuous period of at least 28 days.
- Changes to the structure of the patient's body.
- The patient experiencing prolonged pain or prolonged psychological harm.

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- The shortening of the life expectancy of the patient; or that requires treatment by a health care professional in order to prevent the death of the patient, or any injury to the patient which, if left untreated, would lead to one or more of the outcomes mentioned above.

As soon as is reasonably practicable after becoming aware of a notifiable patient safety incident, a representative for Crescent Dental Surgery will tell the patient (or their representative) about it in person. The CQC will also be notified of the incident.

Note: Dental professionals, who are used to having candid discussions with their patients, are most likely to be the practice's representative under the statutory duty.

Patients will be given a full explanation of what is known at the time, including what further enquiries will be carried out

We will offer an appropriate remedy or support to put matters right, if that is possible, and explain fully to the patient the short and long-term effects of what has happened.

We will keep a written record of the notification to the patient which will be kept securely in accordance with our data protection and confidentiality policies. We will provide reasonable support to the patient. This may include providing an interpreter to ensure discussions are understood or giving emotional support to the patient.

Crescent Dental Surgerywill provide the patient with a written note of the discussion, details of any further enquiries into the incident, their results and an apology. Copies of correspondence will be kept.

Our Notifiable Events Guide gives further guidance on notifications.

Guidance on applying duty of candour at Crescent Dental Surgery

To support our team members in complying with their professional and our statutory obligations under duty of candour requirements we aim to:

- Build and foster a culture of openness and transparency in everything we do. This applies to everyone in the practice and to all dealings with fellow team members in addition to all dealings with patients.
- Ensure all team members feel confident they can raise concerns without fear of recrimination or alienation.

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- Tell the patient (or other relevant person), in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when the issue is being explained.
- Provide an account of the incident which, to the best of our knowledge is true, of all the facts the patient or the regulatory body needs to know about the incident as at the date of the notification.
- Advise the patient (or other relevant person) what further enquiries we believe are appropriate.
- Offer a sincere apology. We encourage team members to avoid using the words 'but' and 'however', both of which undermine the apology and have a tendency to create the impression that the apology is not sincerely meant.
- Follow up our apology by providing the same information in writing, and an update on any relevant enquiries we are making.
- Keep a written record of all communication with the patient (or other relevant person).

Never Events

Never Events are events that should never happen. Preventive measures should be in place to reduce the chance of a Never Event happening. The reality is though that even if every effort has been made, there may still be situations in which Never Events occur. We are aware that the NHS requires all holders of NHS contracts to report Never Events. We are also aware that NHS Improvement published an updated list of Never Events in January 2018 and at Crescent Dental Surgery we aim to ensure that we do all we can to ensure that Never Events that are relevant to dental practice do not happen in our practice.

Reporting Never Events

In the event of a Never Event occurring at Crescent Dental Surgery we would report it to the Strategic Executive Information System (StEIS) and the National Reporting and Learning System (NRLS). We ensure that all Never Events are reported. We are aware that a deliberate failure to report a never event is likely to constitute a serious failing and breach of Care Quality Commission (CQC) requirements.

Mis-selection of high strength midazolam during conscious sedation

'Mis-selection' refers to when a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation'.

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Duty of Candour and Never Events

Duty of Candour is applied to Never Events in exactly the same way as all other significant adverse incidents.

This Policy was reviewed and implemented on 04/02/2025.

This policy and relevant procedures will be reviewed annually and are due for review on: 04/02/2026 or prior to this date in accordance with new guidance or legislative change.

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Document Change Record
for
Duty of Candour Policy

The table below is used to register all changes to the policy:

Published Date	Document Version Number	Pages affected	Description of revision	Author
12.2.19	V4.0 amended to v5.0	4 and 5	Addition of section on Never Events	PL
26.07.2021	V5.3	5	Removal of wrong site extraction from the list of 'Reportable Never Events'	PP

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