

## Learning session voiceover script

1. Welcome to this HCPC learning session where we will be exploring the principles, importance, and challenges of being open when things go wrong.
2. Here is an outline of the learning session. We are going to start by looking at the HCPC standards, move on to learn about the duty of candor and its importance, we will discuss how we can be open when things go wrong and then explore some of the challenges we might need to overcome.
3. First of all, what are HCPC standards?
4. HCPC, or the health and care professions council is a regulator of health and care professions in the UK. They provide the HCPC standards of conduct, performance, and ethics. This is the ethical framework outlining 10 standards which must be met by all professionals registered with HCPC. You have likely encountered these during your studies but let's start by having a look at all 10...
  5. Number 1 is to promote and protect the interests of service users and carers
  - Number 2- to communicate appropriately and effectively
  - Number 3- Work within the limits of your knowledge and skills
  - 4- Delegate appropriately
  - 5- Respect confidentiality
  - Number 6- Manage risk
  - Number 7- Report concerns about safety
  - Number 8- Be open when things go wrong
  - Number 9- Be honest and trustworthy and finally
  - Number 10- Keep records of your work.As health and care professionals it is really important you are aware of and understand these standards. You can find out more about each one on the HCPC website under 'Standards'. Today's session will focus on number 8...
6. "Be open when things go wrong". We will look in detail at this standard and what it means for you as a professional. Whilst we will be focusing on this individual standard, it will be helpful to keep all 10 standards in mind throughout the session...  
AND CONSIDER WHERE THERE MIGHT BE SOME OVERLAP
7. Now we have recapped all of the HCPC standards, we are going to look at...  
THE DUTY OF CANDOUR
8. What is the duty of candour?
9. Before we start, I want you to imagine you are a service user, and there has been a mistake in your care which you weren't aware of but could have caused you great harm. How you what the healthcare professional involved in your care to act? Would you rather they
  - A: Fixed the problem themselves without informing you
  - B: Pretended everything was okay and carried on as normal
  - C: Informed you of their mistake and explained how they would fix it

Not everyone will answer this question the same. It may be hard for healthcare professionals to know what is best for their patient. In this scenario, the healthcare professional should refer to the duty of candour

10. The duty of candour, according to the HCPC, is our ethical responsibility to be open and honest with service users and our employers when things go wrong with a person's care. Simply put, it is being open when things go wrong.
11. Now we understand the duty of candour,
12. WE WILL LOOK AT WHO IT IS IMPORTANT FOR AND WHY
13. The duty of candour is important for multiple groups of people: service users and carers, individual professionals and wider organisations. Let's look at each group in more detail
14. To begin with, the duty of candour has many of benefits for service users and their carers
15. First of all, it ensures service users are treated with respect by ensuring they are treated as equals in their care  
It allows service users to remain involved in their care, ensures they are able to make informed decisions and increases their autonomy  
Increases trust and confidence in healthcare professionals if service users know information will not be hidden from them  
Allows service user to receive guidance and support following an incident which otherwise might have been dismissed
16. Next, let's look at the importance
17. FOR YOU AS AN INDIVIDUAL AND A PROFESSIONAL
18. The duty of candor ensures you act in accordance with HCPC regulations which is a vital part of being a responsible clinician and could cost you your license if not followed  
  
It allows you to recognize mistakes, reflect and learn from them: all of which are important elements of CPD  
  
It maintains your honesty and integrity as a professional and an individual
19. Finally let's think about
20. Wider organisations and the healthcare system
21. knowing there is guidance to be followed when things go wrong, and they will be kept informed in those situations public trust and confidence in the healthcare system  
  
The duty of candor also prevents future adverse incidents as we can learn from each other's mistakes and put plans in place to avoid things happening again  
  
Finally, it Promotes an honest working environment, moving away from punitive and blame culture where people feel ashamed or scared to raise concerns
22. Now we have a good understanding of the principles of being open,
23. Let's look at what it means practically for you as a healthcare professional

24. This time I want you to imagine you are a student healthcare professional on placement with your practice educator. Your practice educator asks you to do a task which don't feel confident doing but want to try in order to avoid looking incompetent. Whilst completing the task, you make a mistake which causes minor harm to the service user. What would you do?

A Remain calm and ignore the mistake in front of the patient, explain the mistake to your PE and ask that they don't tell anyone else to avoid anything escalating or other people finding out you made a mistake

B Acknowledge your mistake and apologize to the service user in the moment, explaining how you are going to rectify the issue and get advice from your PE

C Do what you can to fix the mistake in the moment without asking your PE, keep it to yourself and deny any mistake if it is brought up in the future, maintaining your reputation with your PE

Whilst some of these options might seem harmless, and much easier to face, the HCPC provides guidelines which should be followed when mistakes have been made.

25. The HCPC standards outline 4 main steps involved in being open with service users.

First, informing service users or, where appropriate, their carers, that something has gone wrong

Next, Providing reasonable support, truthful information, and an apology

Then, taking action to put matters right if possible, including reporting the issue where relevant

Finally, making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any likely effects. Importantly, the apology should not wait until all the information is gathered and a resolution has been found. An initial apology should be given as soon as possible with the reassurance that service users will be kept up to date with any updates

26. Openness and honesty extend beyond service users. You also have a responsibility to be open and honest to managers and employers.

This includes keeping accurate records of any incidents and reporting incidents appropriately.

This can seem scary as it is an official process but as previously discussed, it has many benefits for all involved.

27. The process of reporting incidents varies depending on where you live and word and the nature of the incident. When reporting incidents, you should refer to your local reporting systems:

It is your personal responsibility to find out about incident reporting mechanisms. You can get information from your manager or employer, your allocated incident manager or your local Group Governance Team

28. Now we understand the practicalities of being open and honest, we should consider

29. Any challenges we might face in being open when things go wrong and how we can overcome them
30. Let's reflect again. What barriers can you think might stop you, or a colleague, being open and honest with service users and/ or managers?
- Maybe think of a time you made a mistake at work; how did you feel about admitting to it and apologising?
31. These are the 4 main barriers to being open when things go wrong identified in research by the professional's standards agency
- We will look at each one in more detail.
32. First, many people avoid reporting mistakes for fear of criticism or isolation from colleagues and seniors, often referred to as 'whistleblowing'.
- HCPC recommends creating a positive and safe working environment and working on having open discursive relationships with supervisors to make the reporting process easier.
- However, if you don't feel supported, you can escalate concerns to managers or the HR department. If you still don't feel supported within the workplaces, you can contact external bodies such as HCPC, your regulating body, Citizens Advice Bureau, or your local Freedom to Speak up Guardian
33. Many people are scared to be open about their mistakes for fear of regulatory or criminal action and the impact this might have on their career. However, despite commonly held beliefs, evidence shows that apologizing reduces your chance of mitigation. If an incident were to be investigated, an apology would be considered as a mitigating factor as it demonstrates reflection and insight if an incident were to be investigated, an apology would be considered as a mitigating factor as it demonstrates reflection and insight. Helen Vernon, Chief Executive at NHS Resolution was quoted saying "We have never, and will never, refuse cover on a claim because an apology has been given" In contrast, if it came to light that you had tried to hide an error, this would act against you in an investigation. . In contrast, if it came to light that you had tried to hide an error, this would reflect badly on you.
34. Apologies and reporting incidents are often overlooked, due to workload or a busy working environment. The HCPC recommends prioritizing patient safety and ensuring a situation is managed before apologizing. For example, it might not be appropriate for a paramedic to apologize in the moment if a mistake is made at the scene of an emergency. Also, it is okay to take time for reflection following an incident or seek support and advice before speaking to the service user. These are all valid reasons to delay apologizing, however delays should not be unnecessary, and apologies should be made at the soonest appropriate moment.
35. Finally, the fear of shame and embarrassment around admitting you have made a mistake can also act as a barrier and hoping the issue will go away may seem like an easier option. However, apologizing shows strength of character by demonstrating insight and remorse. It is also helpful to remember that despite being difficulties, the importance of apologizing should outweigh any of these feelings. Being open and honest as a healthcare profession is not only moral but also a statutory requirement.

36. Now we recognise the importance of an apology, let's think about the best way to apologise. Think of a time someone apologized to you. How did it make you feel? What was good about the apology? What would you have wanted to be different?

37. Here is some information from NHS Resolution giving advice on saying sorry.

It is important to remember that saying sorry is not an admission of liability or guilt. Remember from earlier in the session that an apology cannot be used against you.

It is always best to apologise as soon as possible, in an appropriate environment. For example, if the patient is in a lot of pain or highly distressed, it might not be appropriate to begin an apology. However, this doesn't mean there should be no apology at all. It is best to wait for an appropriate moment, where the service user will feel supported and calm.

Equally, following an incident where harm was caused, or there was a potential for harm, service users are likely to feel strong emotions, and may react with anger or upset. They may also want to make a formal complaint. These are all understandable reactions, and you should be prepared for that when you apologise.

Having said that, you don't have to deal with an incident alone. Remember standard 3, "work within the limits of your knowledge and skill. You can always ask for support with your apology or knowing what to do following an incident.

finally, remember, saying sorry is the first step to learning from the event and preventing it recurring. Whilst it can be scary, it is a really important step in moving forward.

38. Here are some dos and don'ts for apologising.

Do

Ensure your apology is heartfelt and sincere- I'm sure we've all been on the receiving end of an insincere apology, and it often feels worse than not receiving an apology at all

Do explain what you know so far and what will do to find out more and reassure service users and their carers that they will be kept in the loop throughout that process

Don't

Place blame on the service user or provide a conditional apology such as "I'm sorry if you're upset".

As ever when speaking to service users and carers, don't use acronyms or jargon to explain the situation.

And finally, whilst it might feel like the more caring thing to do, don't hide information from the service user to avoid upsetting them. They have a right to know the full picture and you have a duty to support them through that.

Now we know the theory of apologising, let's have a look at some examples.

39. Let's look at these four examples of apologies. Pause the video now and read through them. Try to identify which are good apologies and how you would improve the others.

So the first apology, did you think this was a good or a bad apology?

This is a good apology. They take responsibility, they say 'I'm sorry' with no conditions, they explain the next steps and reassure the service user that will be kept informed

In contrast, the next is not a good apology- did you agree? Apologies should not be followed by 'I'm sorry but...'. Equally, minimising the event is inappropriate as it does not reflect the potential for harm and distress and undermines the services users' reaction

The third apology also needs improving. It is not an apology for the action, this is an apology for the other persons' feelings. Also, making excuses is not appropriate

Finally, what did you think about the last apology? This is a good apology. Apologising on someone else's behalf can be appropriate, it does not mean you are taking the blame. Reassuring the service user and explaining the next steps allows the person responsible to reflect and proceed appropriately whilst the service user gets the apology as soon as possible.

40. We've now covered all the content for today's session. Before we finish, let's have a little summary of what we have discussed.
41. Time to test your knowledge. Pause the video and read through the following statements, deciding which ones are true and which ones are false. Once you've have chosen, press play.

Okay, let's go through the answers.

Number 1: It is better to protect service users than upset them by telling them about a mistake. What do you think? This is false. As we discussed, service users have a right to know about what has happened in their care, even if that might upset them and you have a duty as a healthcare professional to provide that

Next: You should apologise as soon as possible, even if you don't have all the information. This is a tricky one, but it is true. The important thing being "as soon as possible". This relies on you making a judgement call about whether it is appropriate in the moment and if not, when the next possible situation would be to apologise. However, you should not wait until you have all the answers. Part of making your apology involves explaining what you know and how you are going to find out what you don't know

Next, you should only report the incident if the service user wants to escalate the issue. This is false. You should always escalate the issue if it caused harm or there was a chance of harm, even if the service users seems completely unaffected.

Okay, number 4. Apologies can be used as part of your continuous professional development. Yes, in fact, they are a really important element of your CPD. They provide an opportunity for reflection and learning, which will help you grow as a health care professional.

Lastly, The Duty of Candour is relevant on both an individual an an organizational level. This is true, if you want to find out more about this distinction you can look on The Duty of Candour section of the HCPC website.

42. Let's now look back at the 10 HCPC standards. We have looked in detail at number 8, be open when things go wrong. But let's reflect how that link to other standards. In fact, the duty of candor and the important of being open and honest overlaps with all 10 of the HCPC standards of conduct. Can you think of an example for each one?

43. To sum up, here are 4 key points from today's session.

Remember,

Being open when things go wrong is an expectation of all HCPC registrants

Being open is important for service users, their carers, individual professionals and wider organisations

Apologising is a key element of being open when things go wrong

Being open will always be the right thing to do throughout your career as a health and care professional

Feel free to add anything else you think is particularly important to remember.

44. If you want to find out more about being open when things go wrong or any of the other HCPC standards, you can visit any of the resources on the screen now.

45. Finally, I'd like to finish on this quote from Vince Clarke, a paramedic and HCPC partner who says "When something goes wrong, openness is in everybody's interests"