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Faculty of Health Medicine and Society

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From Policy to Practice: A Retrospective Audit Evaluating Compliance with Duty of Candour in Health and Care Jersey.

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Declaration

I hereby declare that this thesis is my own work and effort and that it is has not been submitted elsewhere for any award. Where other sources of information have been used, they have been acknowledged.

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Abstract

Background: Duty of Candour (DoC) is a professional, ethical, and legal requirement in healthcare, mandating transparency, openness, and honesty when patients come to harm. Although statutory frameworks exist in parts of the UK, Jersey lacks local legislation, relying on organisational policy or professional codes, such as the Nursing and Midwifery Council, General Medical Council and Health and Care Professions Council. Despite the significance of DoC, studies indicate inconsistent understanding, interpretation, and application among healthcare professionals.

Project design: A retrospective descriptive design was used for the clinical audit. Focusing on patient safety incidents that had been investigated as serious incidents, the audit measured compliance with DoC against the local policy. Key elements such as the provision of an apology, delivery of a formal letter, documentation, and timeliness of communication with patients and families were explored.

Findings: Findings from the thirty-two cases illustrated 78% of patients and families were informed of the safety event as soon as possible, 50% were offered an apology and 34% of patients and families receiving reassurance that lessons would be learned. 72% of patients had no initial communication or apology documented in their records with less than 10% of patient's ort their families receiving a formal letter of apology from the organisation.

Conclusion: Despite having an organisational policy, challenges remain in fidelity of application. Improved training, clearer protocols, and improvements to policy are required to promote a culture of transparency. This study offers recommendations to improve consistency with the application of DoC which include to revision of the DoC policy, introduction of a standardised letter template and the delivery of multidisciplinary staff training.

Chapter 1: Introduction and Background

1.1Introduction

The aim of this dissertation is to present a Clinical Audit project exploring Health and Care Jersey's (HCJ) compliance with the Duty of Candour (DoC) policy. A retrospective descriptive clinical audit design will be used. A standard will be identified to measure whether local practice aligns with internal policy, which itself is informed by national legislation and professional regulatory standards (States of Jersey [SoJ], 2020).

In the United Kingdom (UK) DoC constitutes a legal, regulatory, and ethical obligation, requiring healthcare organisations and healthcare professionals to communicate openly, honestly, and transparently with patients/families. This includes other representatives when a safety incident occurs, or when care results in unexpected harm (General Medical Council [GMC] & Nursing and Midwifery Council [NMC] 2022; UK Government, 2014). This multifaceted duty, embedded in statutory regulations such as the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (UK Government, 2014) reinforces the ethical foundations of patient-centred care and professional accountability, while serving as a critical mechanism for promoting transparency, trust, and continuous learning within healthcare systems.

While there is a professional, ethical, and organisational expectation to implement DoC within HCJ, the proposed legislation has not yet been enacted (Government of Jersey [GoJ], 2024). This absence of statutory mandate places greater reliance on internal policy, professional standards, and leadership commitment to uphold the principles of transparency and accountability in practice.

1.2 Background

Over the past two decades, there has been an increasing emphasis on quality and safety within healthcare. Influential national and international publications, such as and 'Organization with a memory' and 'To Err is Human,' have highlighted the nature of preventable harm and the need for systemic learning following safety incidents (Department of Health [DoH], 2000; Institute of Medicine, 2000). Patient safety has been defined as "the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare" (Vincent, 2011, p. 31). It remains a core principle in the delivery of high-quality, patient-focused healthcare and is prioritised globally as a core component of effective health systems (World Health Organization [WHO], 2017). Globally, millions of patients are physically and psychologically harmed, or have died because of preventable and unsafe care (WHO, 2008). Approximately one in ten patients experience physical or psychological harm while receiving healthcare (WHO, 2017), leading to the commissioning of a Serious Incident (SI) investigation, patient safety remains a critical concern for healthcare providers, policymakers and society at large (Andersson et al., 2015; Slawomirski et al., 2017).

The GoJ, (2021) suggests that SIs are adverse events where the consequences to patients/families, and staff are so significant, or the potential for leaning is so great, that a heightened level of response is required. The National Health Service [NHS] England (2015) notes that SIs are uncommon in healthcare and are typically commissioned only when there is clear opportunity for significant learning. In the last 3-years, there have been a notable increase in the number of SIs declared. In 2022, 32 SIs were reported, rising to 43 in 2023; in 2024 the number further increased to 60, indicating a consistent upward trend in recognition and reporting of SIs (HCJ, 2025). This escalation may reflect an increased commitment to patient safety, openness, and transparency, although it highlights the ongoing challenges in achieving zero harm in healthcare (NHS England & NHS Improvement, 2019). The management of SIs including meaningful engagement with patients/families, adherence of DoC and

facilitation of organisational learning, forms a core component of my professional role. As a member of the patient safety team, I am directly involved in ensuring that safety incidents are investigated thoroughly and that communication with those affected is conducted with honesty, empathy, and transparency. This includes supporting clinicians in meeting their professional and ethical obligations with DoC. My position provides valuable insight into both the practical challenges and enablers of DoC, making this an area of both professional relevance and personal interest, and providing strong rationale for undertaking this project. This reflects relevance to quality improvement (QI), ethical practice, and patient-centred care (O'Hara et al, 2018; NHS England, 2015).

Transparency is central to improving patient safety, forming the foundation of DoC. This ethical and, in many jurisdictions, legal obligation requires healthcare professionals and organisations to be open, honest, compassionate, and transparent with patients when harm occurs. DoC reinforces a commitment to organisational learning following safety incidents, supports accountability, and plays a critical role in rebuilding and maintaining trust between healthcare providers and patients (Care Quality Commission [CQC], 2018; Francis, 2013). The CQC (2018) mandates healthcare providers in England inform patients, or their representatives, of notifiable safety incidents, offer a sincere apology[1], and provide a full explanation of what occurred. This should include written correspondence and explanation of the steps taken to prevent recurrence. This requirement aligns closely with the fundamental ethical principles in healthcare, particularly with respect for patient autonomy, beneficence, and justice (Beauchamp and Childress, 2019).

Being open, honest, and transparent following a safety incident respects the patient rights to know and understand what happened in their care journey and fosters trust, supports psychological recovery, and upholds professional integrity. The proactive

[1] In the context of the DoC, a sincere apology involves openly acknowledging the harm caused, expressing genuine regret, and taking responsibility, which helps rebuild trust and supports the healing process for patients and families.

disclosure of safety incidents reflects a commitment to patient-centred care and contributes to a learning culture that prioritises patient safety and accountability (Reason, 2000; Vincent, 2010). Despite its legal mandate and the ethical emphasis placed on openness, consistent implementation of the DoC remains a significant challenge within healthcare settings (O'Hara et al., 2018).

In the UK, the application of DoC in healthcare is influenced by both legal frameworks and organisational culture, with statutory requirements providing formal accountability, and cultural factors influencing how those requirements are interpreted and enacted in practice (CQC, 2018; Francis, 2013; Mannion & Davies, 2015). In England, DoC was given statutory force under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (UK Government, 2014) following the Francis Inquiry, (2013) into the Mid Staffordshire NHS Foundation Trust. The legal status of DoC in England serves as a formal mechanism to enforce transparency, providing regulatory consequences for non-compliance, and reinforcing accountability through mandatory disclosure of notifiable safety incidents (CQC, 2018; DoH and Social Care, 2014). However, despite its statutory basis, implementation of DoC across the UK has been inconsistent. Barriers, such as fear of blame or litigation, unclear definitions of what constitutes a notifiable incident, lack of staff training, organisational pressures, low psychological safety among staff have all been identified as being related to variations in compliance (Edmondson, 1999; O'Hara et al., 2018; Mannion & Davies, 2015). In contrast, Jersey does not yet have a statutory DoC in place.

Although HCJ have implemented a policy that aligns to UK standards, without the legal imperative, compliance is potentially subject to even greater variability, influenced by leadership commitment, staff training, and present organisational values and culture (Jones et al., 2017; Mannion & Davies, 2015; SoJ, 2020; West et al., 2014). This regulatory gap potentially undermines consistency and weakens accountability mechanisms that are present in jurisdictions where candour is legally mandated. Nevertheless, the absence of statutory law should not entirely prevent effective implementation. Organisations should foster a strong culture of openness through

proactive leadership, robust governance structures, and support for staff in engaging with patients/families after incidents (Francis, 2013). Conversely, O' Hara et al., (2018) suggests the presence of a legal requirement does not give assurance of genuine openness and transparency if the organisation is not supported to have a positive safety culture.

1.3 Local Context

While statutory DoC legislation in the UK should provide a stronger framework for accountability, actual implementation is still dependent on cultural and systemic factors. Jersey's reliance on policy rather than statute may constrain enforcement, however, it emphasises the importance of organisational commitment and leadership in promoting transparency practices. This contrast illustrates that legal mandates are necessary, but not sufficient conditions alone for meaningful candour in healthcare (West et al 2014).

In 2023, 5426 safety incidents were reported using the Datix reporting system locally. Of these, 150 safety incidents were reported as causing moderate, severe, or fatal harm to the patient, of which 43 SIs were declared (Health and Community Services (HCS), 2024)[2]. In 2024, there was a 24% increase in Datix submissions, totalling 6527. Despite the increase, the number of safety incidents reported as causing moderate, severe, or fatal harm decreased to 125, but the proportion identified for SIs rose with 60 SIs declared (HCJ, 2025). All safety incidents resulting in moderate harm, severe harm, or death, should initiate the DoC process, which involves timely communication with the patient or their representative, a formal apology, a clear explanation of the events and actions taken. This should then be shared in a compassionate letter (CQC,

[2] The rebranding of Health and Community Services to Health and Care Jersey in January 2025 signified a strategic move to unify and enhance the delivery of health and social care services in Jersey. Consequently, all official documents and communications now use the Health and Care Jersey name to reflect this updated identity, as outlined in the Health and Care Services Division Annual Plan 2025.

2018; SoJ, 2020). All the safety incidents that were declared SIs should have invoked the DoC process. There is a paucity of quantitative data on DoC implementation and qualitative data on experiences of patients who have been involved in the process. This gap raises questions about how effectively the principles of being open, transparent, honest, and learning are being operationalised across HCJ. Although the DoC policy has been embedded in organisational policy locally since 2016 (SoJ, 2020), its consistent and meaningful application remains uncertain in the absence of legal enforcement and routine evaluation. As a result, HCJ has committed to making DoC a key QI priority for 2025 (HCJ, 2025b) seeking to embed the process of DoC across the organisation and will monitor its compliance within Care Group Governance meetings (HCJ, 2025b). Given the gaps in practice, a project to assess compliance with the local DoC policy and identify patterns and trends will be conducted.

Table 1.1 Key points to consider when creating an effective clinical audit.

1. An audit needs to align with standards or guidelines. An audit question needs to be based on existing, evidence-based standards, policies, or regulations. This ensures that the audit measures performance against an authoritative benchmark. A clinical audit should compare current care with explicit standards to identify areas for improvement (NICE, 2002). This audit will use the local DoC policy to benchmark against.
2. Good audit questions need to be focused and should clearly define the subject, population, and expected outcome (HQIP, 2021). This audit will focus on cases that have been declared as an SI within a clearly defined timescale.
3. The question should reflect the aim of the audit. The audit question must capture the purpose of the audit, whether that is to assess compliance or to identify gaps. This audit is looking to assess compliance of a policy.
4. The question should be specific, measurable, achievable, relevant and time bound (NHS England, 2020). This helps ensure the audit is methodologically sound and feasible within the project constraints.
5. Berwick, (2013) suggests that whenever possible the audit should be patient-centred, and questions should consider patient outcomes or experiences.

Table 1.2 SMART Framework (Doran, 1981)

Specific	The audit question clearly focuses on compliance with HCJ's DOC policy in relation to three key elements: disclosure, apology, and documentation.
Measurable	Compliance will be assessed using predefined audit criteria based on HCJ's DoC policy. This will enable measurement of whether appropriate disclosure was made, whether an apology was offered, and whether relevant documentation was completed for each patient following the commissioning of an SI.
Achievable	The audit will be based on retrospective data collected from incident reports and clinical records over a defined six-month period, from 01 August 2023 until 31 January 2024. The scope is manageable within the timeframe and resources available for an MSc-level project.
Relevant	The topic aligns with key patient safety priorities and professional standards. Given the importance of DoC for ethical healthcare delivery, this audit is directly relevant to improving transparency and learning from patient safety incidents.
Timebound	The audit will establish a clear period for data collection and analysis to maintain focus and ensure practical feasibility.

Using the SMART framework (Table 1.2) supported a focused and methodologically sound audit into the compliance of the DoC policy. The application of the SMART criteria ensures the audit will be practically achievable and can produce actionable findings. NICE (2002) suggest using a SMART formulated audit question enhances the accuracy of the audit's objectives, ensures that relevant data is collected and supports comparison against established local standards and expected practices. Framing the audit question within the SMART framework ensures the study upholds the principles of methodological rigour and practical relevance, both of which are fundamental to effective clinical audit and healthcare research. Therefore, the audit question is:

'To what extent does HCJ comply with the Duty of Candour Policy following Serious Incidents, in terms of disclosure, apology and documentation?"

1.4 Project Question, Aims and Objectives

The aim of this project is:

To evaluate compliance with the DoC policy in the management of SIs within HCJ, following the declaration of a patient safety event.

The objectives are:

1. Define audit standards.
2. Measure extent of compliance with the DoC policy standards.
3. Assess the timeliness and consistency of the DoC process (including documentation).
4. Identify gaps in consistency.
5. Make targeted recommendations for improve compliance.

The development of an effective audit question is a crucial step in the design of a clinical audit, where clarity, focus and alignment with the standards are essential. A well formulated audit question will guide the scope of the audit, ensure its relevance to practice, and will facilitate meaningful comparison between current performance and best practice or policy (HQIP, 2011; NICE, 2002). Several key points were considered when posing the audit question (Table 1.1).

1.5 Structure of the Dissertation

This chapter has outlined the background and the rationale for selecting the project focus, situating the topic within the broader context of patient safety in healthcare. It has provided the contextual background to frame the project question, aim and objectives.

In chapter 2 a critical analysis of current literature focusing empirical studies on compliance and challenges to implementation of DoC. It will draw upon key policy documents and scholarly research, the review will evaluate how DoC has been implemented in practice (Francis, 2013; Mannion & Davies, 2015; O'Hara et al., 2018).

In chapter 3, the project design will be justified. Ethical considerations inherent in auditing sensitive and patient safety data, including confidentiality, data protection and the audits registration with the appropriate governing bodies will be considered.

The audit findings will be presented in chapter 4, detailing levels of compliance with the DoC policy over the 6-month audit period.

In chapter 5, a discussion of the findings will provide a critical interpretation of the audit findings in relation to the existing academic, professional and policy literature on DoC. The extent to which the audited practice complied to local DoC requirements will be evaluated. Limitations of the project design will be considered.

Chapter 6 will provide a conclusion to the dissertation, offering recommendations derived from the audit findings. The chapter will consider how these recommendations can support a more robust culture of transparency, learning, and psychological safety across HCJ.

Chapter 2: Literature Review

2.1 Introduction

This chapter presents a literature review which will explore the challenges, barriers and implementation of DoC following patient safety incidents within healthcare systems, both nationally and internationally. A structured search strategy will be utilised across several academic databases, including CINAHL and Medline to locate pertinent peer-reviewed studies. The use of PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework (Page et al., 2021) will follow to identify how studies were screened to ensure methodological transparency and rigour. A data extraction table will be presented to systematically record key information such as, methodologies, strengths, limitations, and findings of each included study (Booth et al., 2016). To synthesise the findings, a thematic analysis will be conducted, which will identify common themes in the literature (Braun & Clarke, 2006).

DoC was introduced following the Francis Report (2013), establishing both a statutory requirement and a professional obligation to promote openness and transparency when patient harm occurs, although locally it does not have a statutory influence (CQC, 2019; Francis, 2013; SoJ, 2020). The review will critically examine the practical implications of DoC in everyday clinical contexts (Mazars, 2022; O'Hara et al., 2018). Whilst a wide range of literature exists on DoC, this literature review focuses on the most relevant sources, and it is acknowledged that not all perspectives or publications can be included within the scope of this literature search. The search strategy was not developed to identify policies, legislative frameworks, and Government documents, these were found through a separate grey literature search. The literature reviewed will inform the rationale for this study.

2.2 Search Strategy

2.2.1 Keywords and search terms

The implementation of a structured search strategy is a critical element of any literature review. A clearly defined search helps to ensure a comprehensive and

unbiased retrieval of pertinent literature by using predetermined keywords, Boolean operators, and explicit inclusion and exclusion criteria. This systematic approach enhances transparency and reproducibility which are key aspects of academic rigour and supports a valid rationale for the study selection (Aveyard, 2019). Additionally, it supports the efficient management of large volumes of information and ensures the evidence base reflects the full scope of current knowledge. In the context of evaluating the application of DoC, a robust search strategy is essential to capture empirical findings. Without such a strategy, there is an increased risk of overlooking key evidence, which can compromise the credibility and analytical strength of the review. Table 1 demonstrates the structured search strategy.

Table 2.1 Search Strategy

	Search Term	Boolean	Number of hits
Search 1	'duty of candour'	OR 'open disclosure' OR 'ethical disclosure'	6937
Search 2	'compliance'	OR 'adherence' OR 'implementation'	1496,742
Search 3	'safety incidents'	OR 'patient safety incidents'	4093
Search 4	'adverse event'	OR 'adverse incident' OR 'unintended harm'	447,231
Search 5		Search 3 OR Search 4	460,548
Search 6	'serious incident investigation'		1,595
Search 7	'barriers'	OR 'obstacles' OR 'challenges'	2,547,308
Search 8		Search 1 AND Search 2 AND Search 5	42
Search 9		Search 6 AND Search 8	0
Search 10		Search 7 AND Search 8	9
Search 11		Search 7 AND Search 9	0

2.2.2 Databases

The use of scholarly databases such as EBSCOhost, CINAHL, and MEDLINE are essential for conducting a rigorous and credible literature review. These databases provide access to up-to-date, peer-reviewed, and high-quality, academic research, which ensures the evidence selected for the literature review is credible and relevant. Unlike general search engines, academic databases apply indexing, quality filters and controlled vocabulary, which enhances the precision and validity of the search results (Booth et al., 2016). The use of established databases like EBSCOhost helps to ensure a transparent and reproducible search strategy is conducted, which is a key component in producing methodologically sound research. For this search strategy, the search platform utilised was EBSCOhost.

While database searching provides a strong foundation, it is not without limitations. Notably, relevant grey literature, including government reports, policy documents, frameworks, and professional guidelines, may be underrepresented or entirely absent in the searching of databases (Adams et al., 2017). The exclusion of this literature can contribute to publication bias, especially in fields such as patient safety and healthcare, where valuable practice-based evidence may not be published in peer-reviewed journals. Additionally, an over-reliance on a limited range of databases can unintentionally limit the breadth of the review, potentially overlooking interdisciplinary perspectives that are important for examining complex issues such as DoC, which span legal, ethical, and organisational dimensions.

Therefore, while academic databases remain essential for locating peer-reviewed literature, a critical and reflective approach to search strategies is vital. To ensure a more comprehensive and balanced evidence base, database searches should be supplemented with grey literature and relevant policy documents (Adams et al., 2017). Furthermore, clearly documenting the search process including databases consulted, search terms used, and any limitations encountered enhances the transparency, methodological rigour, and supports the reproducibility of the review, thereby strengthening its overall credibility.

Table 2.2 List of Databases that were utilised in the search via EBSCOhost.

No.	Database	Rationale
1	Ageline	This database focuses exclusively on the issues of individuals aged 50 years and over. Due to the aging population of Jersey (Policy Centre Jersey, 2024) this database was searched to look for any publications which may have referenced DoC and the over 50 years population.
2	APA PsycArticles	This database uses full text and peer reviewed articles. This database was used to search for psychological and behavioural aspects of DoC, such as staff responses to disclosure and organisational culture in healthcare settings (American Psychological Association, 2023).
3	CINAHL Complete	CINAHL Complete was used as it is extensively used for accessing high-quality, peer-reviewed nursing and allied health literature, making it essential for exploring clinical, ethical, and policy aspects of DoC in healthcare (EBSCO, 2023a).
4	Criminal Justice Abstracts	The Criminal Justice Abstracts database was searched as to provide literature to explore legal and regulatory issues of DoC, particularly regarding professional accountability, and legal responses to healthcare failings (EBSCO, 2023b).
5	eBook EBSCOhost	This provides access to a wide range of academic texts, offering theoretical fundamentals and ethical frameworks relevant to understanding the broader context of DoC in healthcare (EBSCO, 2023c).
6	ERIC	ERIC was utilised to explore educational and training aspects of DoC, including how it is taught and its integration into staff development (Institute of Education Sciences, 2023).
7	Family Studies Abstracts	This database may offer insights into how DoC impacts families, particularly in relation to communication and the emotional consequences of patient safety incidents on relatives (EBSCO, 2023d).
8	International Pharmaceutical Abstracts	This may be relevant for exploring the implications of DoC within pharmaceutical practice, particularly regarding medication errors and the ethical responsibilities of pharmacists in disclosure of patient safety incidents (Web of Science Group, 2023).
9	MEDLINE	This is a key resource for researching DoC, it provides access to a wealth of peer-reviewed biomedical literature, including articles on patient safety, healthcare ethics, and legal and regulatory frameworks (U.S. National Library of Medicine, 2023).
10	SocINDEX	This was used to explore the social, ethical, and policy-related aspects of DoC, particularly in terms of patient rights, healthcare practices, and institutional accountability (EBSCO, 2023e).

2.2.3 Inclusion and Exclusion Criteria

The application of inclusion and exclusion criteria within a search strategy is essential for ensuring methodological rigour and relevance. These criteria help systematically narrow the search for studies that align with the study question, enhancing focus and consistency (Aveyard, 2019). Clearly defining which studies are to be included helps minimise selection bias and enhances both the transparency and reproducibility of the review process (Jesson et al., 2011). Inclusion criteria normally define parameters such as the study population, setting, language and publication date. If research has been peer reviewed, exclusion criteria serve to filter out irrelevant or methodologically weak studies, thereby supporting the integrity and reliability of the search (Booth et al., 2016). A key limitation, by conducting an excessively narrow search, may unintentionally exclude valuable findings, particularly in fields with limited literature. Therefore, it is essential to build an inclusion and exclusion criteria that balance breadth and focus, ensuring the review includes a comprehensive and pertinent range of studies (Gough et al., 2017).

The inclusion criteria focused on studies written in English so they could be easily read and understood. Only peer-reviewed papers were accepted in the literature search as these are considered the gold standard in academic research because they undergo such rigorous evaluation processes by relevant subject matter experts before publication (Aveyard, 2019). Initially, the inclusion criteria specified that only papers published from 2014 onwards would be considered, following the introduction of the DoC law (DoH & Social Care, 2014). However, limiting the literature search to post 2014 may have restricted the scope of the review, potentially overlooking valuable learning from research conducted prior to the implementation of the law. Comparing and contrasting studies from both before and after the law's introduction was deemed a more comprehensive understanding of its impact, highlighting changes in practice and attitudes towards DoC in healthcare services (Aveyard, 2019).

To gain a thorough understanding of DoC, it is important to include not only UK studies but also from other countries that have implemented similar disclosure regulations.

Several countries have introduced patient safety laws or initiatives that are comparable to the UK, offering valuable opportunities for comparative examination. By incorporating research from varied healthcare systems, the review can examine how factors such as culture and legal frameworks affect the implementation and success of these policies.

Table 2.3 Search Strategy Inclusion and Exclusion Criteria

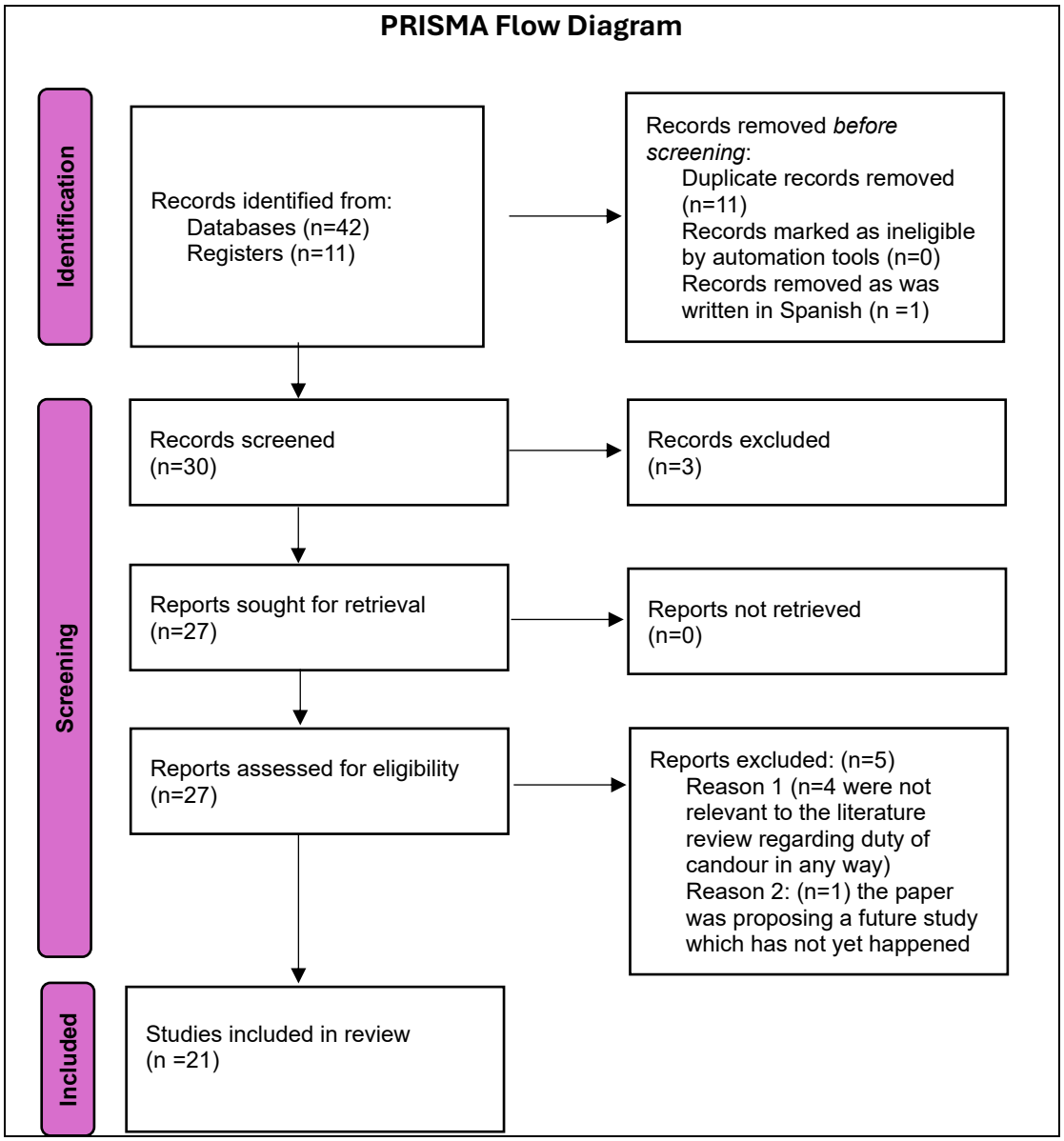
Inclusion Criteria	Exclusion Criteria
Papers written in English	Non-English written apers
Peer reviewed papers	Non peer reviewed papers
Studies focused on healthcare	Duplicate publications
	Studies that are not focused on healthcare

2.2.4 Selection Process (PRISMA)

The inclusion of research older than ten years is often approached with caution due to concerns regarding its contemporary relevance, it is both necessary and justified in the context of this study. In this case, Jersey currently has no statutory DoC in place, making it essential to examine how other healthcare systems have approached openness, honesty, and transparency both before and after the introduction of such legislation. Older UK studies provide detailed insight into the cultural, professional, and organisational barriers that existed prior to the statutory DoC being enacted in 2014 (O'Hara et al., 2018). Findings from the pre-legislation period provide an important baseline for assessing changes in practice and culture following the implementation of statutory DoC. Similarly, examining the Australian context, where mandatory open disclosure legislation was introduced nationally in 2003 provides a valuable longitudinal perspective on the policy's long-term impact and associated challenges (Iedema et al., 2008). This enables a more comprehensive understanding of the factors that may influence the implementation and effectiveness of DoC legislation locally. Therefore, including studies older than ten years is not only methodologically sound, but also critically indicated to evaluate the development of policy and practice across different healthcare systems. Utilising the framework enabled a systematic and transparent approach to the literature search process,

resulting in the inclusion of 21 relevant papers, all of which were accessed in full text (Page et al., 2021).

Table 2.4 PRISMA Flow Diagram



2.2.5: Number of studies in final review

Table 2.5 Data Extraction Table

No	Author/s Year Location	Title of Study Journal	Aims/ Purpose	Design & Data Collection	Sample	Findings
1	Duffy 2012 Ireland	An analysis of the culture in Ireland on open disclosure following adverse events in healthcare. Journal of Patient Safety and Risk Management.	Aims to assess open disclosure in Ireland following adverse events in healthcare.	Questionnaire – mix of open and closed questions (qualitative). And 5-point Likert format and use of a statistical package (quantitative).	192 respondents (67%)	Over 56% of respondents reported no open disclosure policy in their organisation. Fear of litigation (24%) and blame culture (13.1%) were major barriers. While 52.3% acknowledged support availability, many felt it was inadequate or stigmatised. A strong interest (89.1%) in further training and workshops on open disclosure was noted. **Strengths** Combines quantitative (Likert-scale) and qualitative (open-ended) responses, offering both breadth and depth. **Limitations** Study was distributed at 4 study days – this could suggest staff that interested in developing professionally were asked to contribute rather than a wider staff team. Old study 13 years – things may have changed since the introduction of Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. Based in Ireland and not UK.

2	Birks et al., 2014 UK	An exploration of the implementation of open disclosure of adverse events in the UK: A scoping review and qualitative exploration. Health Services and Delivery Research.	To explore how open disclosure of adverse events is understood, experienced, and implemented within the UK healthcare system.	Empirical research, specifically a mixed-methods study, containing: A scoping review of existing literature. A qualitative study involving interviews with patients, healthcare professionals, and stakeholders.	67 studies Conducted 81 interviews across seven NHS case study sites	This study explored how open disclosure policies have been interpreted and put into practice across various UK settings. It found variability in implementation, significant cultural barriers, and a lack of clarity around responsibilities and communication processes. It also highlighted the emotional burden faced by healthcare professionals and the importance of training and organisational support. **Strengths** Comprehensive mixed-methods design. Policy relevant focus. Diverse stakeholder perspectives **Limitations** As the statutory duty of candour had not been legally enforced at the time of data collection, the study can only examine pre-legislation practices and perceptions, not actual compliance under the new law. Non-contemporary study.
3	Ellis and Abbott 2015 UK	Demystifying the duty of candour: what is means for renal managers. Journal of Renal Nursing.	The paper explores the implications of the DoC for renal healthcare professionals, particularly managers. It contextualises the duty within broader ethical and legal frameworks.	No research has taken place.	0	The article outlines: Definitions of candour, openness, and transparency. Legal obligations under Regulation 20. Practical strategies for renal managers to foster a culture of candour. The risks of non-compliance and the moral imperative for ethical leadership.

						Strengths Clear conclusions and strong ethical framing. **Limitations** The paper is policy-focused and lacks original research or case studies to support its claims. Limited scope – only focusing on renal care. Non-contemporary study.
4.	Glasper 2011 UK	Duty of candour: can nurses lead the way in implementation. British Journal of Nursing.	Aim of this article is to discuss the potential for nurses to take a leading role in implementing the DoC within the NHS.	It is a commentary that explores the evolving role of nurses in promoting openness and transparency within the UK's National Health Service.	No research has taken place.	The paper emphasises the ethical and professional responsibilities of nurses to foster a culture of openness and accountability, particularly in the aftermath of adverse events. It also highlights the importance of integrating the DoC into nursing practice to enhance patient trust and safety. **Strengths** Professional emphasis: The paper highlights the ethical and professional obligations of nurses. **Limitations** Non-contemporary study. Lack of empirical data.
5	Saunsbury et al., 2025	Duty of Candour legislation in post-colonoscopy colorectal cancer: a	This study investigated the application of DoC legislation in the context of	National Prospective Audit. (quantitative)	1,724 cases, 1,145 (66%) had	Out of 1,724 cases: 6% resulted in major harm or death.

	UK	prospective cohort study. Endoscopy.	post-colonoscopy colorectal cancers.		completed audits.	Of these, 27% (approximately 75 cases) were deemed probably or definitely avoidable. Hospitals initiated the DoC process in only 53% of these avoidable cases. When moderate harm cases were included, 11% of all cases would trigger the DoC, yet it was deemed necessary in only 41% of such cases. **Strengths** The study provides a comprehensive overview of DoC application across the NHS in England. Structured analysis. Findings offer actionable insights for policymakers to refine DoC guidelines and training. **Limitations** Determinations of avoidability and harm levels may vary among reviewers, potentially affecting consistency. Reliance on administrative datasets may omit nuanced clinical details influencing DoC decisions. Differences in institutional policies and cultures may influence the application of DoC, limiting generalisability. Only colonoscopy departments have been included.
6	Peto et al., 2009	One system's journey in creating a	The primary objective was to develop and implement a formal disclosure and	Descriptive case study of a healthcare system's internal efforts to develop	No sample.	The implementation of the programme created internal pressure to quickly determine the causes of adverse events to facilitate timely disclosures.

	America	disclosure and apology program. The Joint Commission Journal on Quality and Patient Safety.	apology program following adverse events.	a disclosure and apology program.		Degree of responsibility were often unclear and sometimes debated among clinical teams, facilitators, and risk managers. Patient and family expectations. **Strength** Structured Approach. By including emotional support services for both patients and clinicians, the programme acknowledged the impact of adverse events on all parties involved. **Limitations** No empirical research carried out. Much of the content is based on narrative reflections and experiences of the program team. The article does not provide measurable outcomes. Case study of one health system. Non-contemporary study. American.
7	Birks et al., 2015 UK	Being open about unanticipated problems in health care: the challenges of uncertainties. Journal of Health Services Research and Policy.	To explore some reasons for the persistent disclosure gap.	Drew on their research making use of interviews conducted to investigate the implementation of 'being open' policy in England.	67 studies. Conducted 81 interviews across seven NHS case study sites.	Provides foundational insights that remain relevant for understanding cultural barriers and ethical dilemmas in DoC practices. **Strengths** Rich qualitative data. Timely and relevant topic as was conducted during a period of growing interest in patient safety and transparency in the UK, the paper provides contextually important evidence that contributed to

						discussions around the statutory DoC introduced in England in 2014. The paper addresses the grey areas in clinical communication. Thematic analysis. **Limitations** Pre-legislation context. Non-contemporary study.
8	Cantor et al., 2005 America	Disclosing adverse events to patients. The Joint Commission Journal on Quality and Patient Safety.	The aim of this article is to examine the rationale for, and recommended approaches to, disclosing adverse events to patients, drawing upon the experience of the Veterans Health Administration.	Narrative review and policy analysis.	0	**Strengths** The article provides a comprehensive ethical rationale. Offers clear, actionable guidance on when and how to disclose adverse events. **Limitations** Non-contemporary study. American. Lack of empirical data. Lack of generalisation. The article acknowledges psychological and cultural barriers to disclosure but does not delve deeply into strategies for overcoming these challenges in diverse healthcare environments.
10	Berry et al., 2023 UK	Improving compliance with the duty of candour: 5-year experience with an endoscopy department.	Aims to describe the experience of DoC following patient safety incidents related to endoscopy and offer	Datix reports were identified from a specific period, details of the procedure, level of harm and evidence of both verbal and written DoC	33 cases were analysed.	**Strengths** Provides practical insights into DoC implementation within a specific clinical department. The five-year span allows for the observation of trends and the impact of interventions over time.

		Postgraduate Medical Journal.	reflections on improving compliance.	was collected and analysed. (quantitative).		Combines quantitative data with qualitative reflections. **Limitations** Retrospective design which relies on existing records, which may be incomplete or subject to reporting biases. Limited Scope: Focuses solely on endoscopy-related incidents. Single centre study.
11	Sorensen et al., 2009 Australia	Disclosing clinical adverse events to patients: can practice inform policy? Health Expectations.	Aims to understand patients' and health professionals' experience of open disclosure and how practice can inform policy.	Qualitative method using semi structured open ended interviews.	154 respondents.	The study identified critical elements that influence the experience of openly disclosing adverse events: Initiating the disclosure: The manner and timing of initiating the disclosure significantly impact patient perceptions. Apologising for the Adverse Event: A sincere apology is pivotal in maintaining trust and facilitating healing. Taking the patient's perspective: Understanding and acknowledging the patient's viewpoint enhances the effectiveness of the disclosure. Communicating the adverse event: Clear, honest, and compassionate communication is essential. Being culturally aware: Sensitivity to cultural differences ensures that disclosures are respectful and appropriate. Both patients and healthcare professionals generally viewed open disclosure positively.

						Strengths Comprehensive perspectives: By including both patient and healthcare professional viewpoints, the study offers a holistic understanding of open disclosure practices. Policy relevance: The findings provide actionable insights that can inform the development and refinement of disclosure policies in healthcare settings. **Limitations** Contextual specificity: The study's findings are based on experiences within Australian hospitals. Non-contemporary study.
12	Finlay et al., 2013 Australia	Open disclosure: ethical, professional, and legal obligations, and the way forward for regulation. Medical Journal of Australia.	Examine the ethical, professional, and legal obligations surrounding open disclosure in Australian healthcare.	The article does not present new empirical data but instead synthesises existing literature, legal frameworks, and policy documents to inform its recommendations.	0	The paper advocates for a more coherent and supportive legal and regulatory environment to help clinicians confidently and consistently practice open disclosure in the interest of patient safety and trust. **Strengths** It highlights the tensions between ethical duty and legal risk. Its focus on practical legal reforms and regulatory frameworks. Provides actionable recommendations. **Limitations** Lack of empirical data. The analysis is based on the Australian legal and healthcare system. Non-contemporary study.

13	Holmes et al., 2019 Australia	The potential for inadvertent adverse consequences of open disclosure in Australia: when good intentions cause further harm. Medicine, Science, and the Law.	The primary aim of the paper is to explore the barriers and risks associated with suboptimal open disclosure practices in Australia.	This is a narrative review that synthesises existing literature, legal analyses, and policy documents related to open disclosure in the Australian healthcare context.	0	The paper identifies several critical issues: Variations in apology laws across Australian jurisdictions. Fear that apologies may be construed as admissions of liability. Lack of adequate education. When disclosures are perceived as inadequate or insincere, patients may experience further harm. **Strengths** The paper offers an in-depth examination of the multifaceted challenges associated with open disclosure, integrating legal, ethical, and practical perspectives**.** The article provides valuable insights for policymakers. Focuses on patient-centred care. **Limitations** Lack of empirical data. Only focuses on the Australian healthcare system.
14	Manzanera et al., 2021 Spain	Patient Safety Culture in Mutual Insurance Companies in Spain. Journal of Patient Safety.	The aim of this study was to assess the safety culture in a mutual insurance sector. (this sector offers health insurance for work related and occupational illnesses)	Cross sectional study, online survey. The survey measured two dimensions: Attitudinal: 5 items assessing beliefs and values related to patient safety.	499 respondents (61% response rate)	Attitudinal Dimension: Mean score = 7.8 (SD 1.3) This refers to beliefs, values, and attitudes toward patient safety. A mean score of 7.8 out of 10 suggests that, on average, staff have a fairly positive attitude towards patient safety. Instrumental Dimension: Mean score = 8.5 (SD 1.0).

				Instrumental: 5 items evaluating the implementation of safety practices. (quantitative)		This measures the actual safety-related practices and behaviours being implemented. A mean of 8.5 shows an elevated level of safety practice implementation. **Strengths** Sector specific insight. Inclusion of various professional roles across multiple settings enhances the generalisability of findings within the sector. **Limitations** Absence of comparison with other sectors or national benchmarks restricts contextual understanding of the results. Sector specific insight. It was a short questionnaire. Cross-Sectional Design: Limits the ability to assess changes over time or establish causality.
15	Basu et al., 2020 UK	Implementation of duty of candour within neurosurgery: a national survey and framework for improved application in clinical practice. Royal College of Surgeons.	Aims to evaluate the interpretation of duty of candour and what constitutes a notifiable patient safety incident.	Cross Sectional: Online survey. (quantitative)	106 of 357 members participated.	Almost no members triggered the DoC process where adverse events were common, but almost all members triggered DoC when the event was rare. There is considerable nationwide variation among neurosurgeons regarding the threshold of duty of candour. **Strengths** National Scope. **Limitation**

						Small sample size (29.7%) of neurosurgeons.
16	Walton et al., 2019 Australia	Disclosure of adverse events: a data linkage study reporting patient experiences among Australian adults ages > 45 years. Australian Health Review.	Aim is to determine the frequency with which patients who report an adverse event had information disclosed to them about the incident, if they participated in a formal process, their experiences of the process and to what extent they align to policy.	Cross sectional survey. The survey included both quantitative and qualitative components.	20,000 randomly selected participants 7,661 completed surveys, resulting in a 40% response rate. Among these respondents, 474 (7%) reported experiencing an adverse event during their hospitalisation.	**Strengths** Large cohort and representative sample. Methodology - mixed method approach. Patient-centred perspective. **Limitations** Only focused on the Australian healthcare system. 40% response rate. Age restriction the sample included only adults aged 45 and over.
17	Harrison et al., 2019 Australia	Open disclosure of adverse events: exploring the implications of service and policy structures on practice. Risk Management and Healthcare Policy.	The aim of the study was to explore the service and policy structures that impact open disclosure practices in New South Wales, Australia.	Semi-structured interviews were undertaken with 12 individuals. This data was thematically analysed to understand the factors facilitating and creating barriers to openness after adverse events (qualitative).	12 individuals.	This study contributes to the understanding of how service and policy structures impact the practice of open disclosure, emphasising the need for better alignment between policy directives and practical implementation strategies. **Strengths** In-depth qualitative insight. Thematic analysis. Explores the policy-practice gap. **Limitations** Only focuses on New South Wales within the Australian healthcare system.

						Limited sample size.
18	McDonald et al., 2010 America	Responding to patient safety incidents: the “seven pillars.” Quality and Safety in Health Care.	The researchers aimed to develop and describe a comprehensive, institution-wide approach for managing patient safety incidents.	The researchers employed a descriptive case study design, focusing on the implementation and outcomes of the "Seven Pillars" framework within a single healthcare institution.	2000 incident reports were analysed.	**Strengths** It promotes a culture of transparency and learning, aligning with ethical imperatives to disclose harm to patients. The study collected data on a wide range of outcomes. **Limitations** American. Non-contemporary study. Single site study. Limited patient perspective. Descriptive rather than analytical.
19	Iedema et al., 2008 Australia	The National Open Disclosure Pilot: evaluation of a policy implementation initiative. MJA.	To determine which aspects of open disclosure ‘work’ for patients and staff.	Qualitative analysis of semi structured and open-ended interviews.	131 clinical staff 23 patients and family 21 of 40 pilot hospital sites 154 interviews 80 survey questionnaires received, however, due to insufficient information about the total number of staff involved in open	Indicates strong support for open disclosure. Despite support, there was uncertainty among staff regarding the execution open disclosure practices and their potential consequences. Need to be more resourced. **Strengths** Diverse participant representation. Multi-State involvement. Rich qualitative insights. **Limitations** The study did not include all pilot sites, potentially limiting the comprehensiveness of the findings.

					disclosure nationally, the exact response rate could not be determined.	Undefined survey response rate. Non-contemporary study.
20	Mira et al., 2020 Spain	What Ibero-American hospitals do when things go wrong? A cross-sectional international study. International Journal in Quality in Health Care.	Aimed to assess how hospitals in Ibero-American countries respond to adverse events that have serious consequences for patients.	Cross-sectional international study.	A convenience sample of hospital managers and safety leaders, with a minimum of 25 participants from each country. 190 hospital managers and safety leaders participated in the study, representing 190 hospitals.	Most common actions: The actions most commonly implemented across hospitals included the establishment of reporting systems, conducting in-depth analyses of incidents, and adopting non-punitive approaches to error reporting. Least Implemented Actions: Conversely, actions such as providing information to patients about Adverse Events and offering support to healthcare professionals affected by Adverse Events were less frequently implemented. **Strengths** Diverse representation. By evaluating a wide range of actions related to Adverse Event management, the study provided a thorough overview of current practices and areas needing improvement. **Limitations** The use of a non-random, convenience sample may introduce selection bias. Lack of patient perspective.
21	Elwy et al., 2016 America	Surgeons' disclosures of clinical adverse events. JAMA Surgery.	To quantitatively assess surgeons' reports of disclosure of adverse events and aspects of their	An observational study.	A baseline questionnaire administered to 67 of 75	High adherence to certain disclosure practices: Among the 60 completed surveys, a significant majority of surgeons reported adhering to several recommended disclosure practices.

			experiences with the disclosure process.		surgeons (89%). 62 surveys were completed by 35 of these 67 surgeons (52%). Data was analysed using mixed linear random-effects and logistic regression models.	Surgeons who found the disclosure process very or somewhat difficult, or who perceived the event as very or extremely serious, reported being more negatively affected by the event. **Strengths** High response rate. Diverse surgical specialties. **Limitations** Self-reported data. Limited generalisability, the study was conducted within the VA healthcare system, which may limit the applicability of findings to non-VA settings or international contexts. Incomplete follow-up, only 52% of the initial respondents completed the follow-up survey.

2.3 Thematic review of literature

The selected literature (Table 5) was critiqued using the Critical Appraisal Skills Programme (CASP). This provided a structured approach to review each study focusing on the validity, results, and relevance to practice (CASP, 2023). The literature reviewed comprised of a varied range of research methodologies, reflecting the complex nature of investigating DoC practices. Quantitative studies, including retrospective cohort analysis and cross-sectional surveys, offer measurable evidence on disclosure rates, patient outcomes, and aspects of safety culture (Basu et al., 2020; Saunsbury et al., 2025). Qualitative research, including semi-structured interviews and thematic analyses, offer rich information into experiences, perceptions, and emotional complexities faced by healthcare professionals and patients/families during DoC processes (Berry et al., 2023; Harrison et al., 2019). A mixed-method approach incorporates qualitative and quantitative techniques to provide a holistic and nuanced understanding of policy implementation and clinical practice (Basu et al., 2020; Manzanera et al., 2021). Alongside empirical studies, non-empirical sources including descriptive case-studies, narrative reviews, and policy analysis combine existing literature and regulatory frameworks, offering insightful ethical, legal, and organisational perspectives (Cantor et al., 2005; McDonald et al., 2010). This diversity in methodology allows for a robust, comprehensive exploration of the DoC process, highlighting not only what occurs in practice but also why challenges persist and how policy can shape behaviour. However, this variety also introduces challenges in synthesising findings due to differences in scope, data, and generalisability, necessitating careful interpretation and critical appraisal throughout the review.

In total, twenty-one articles met criteria, from a range of international contexts with a primary focus on the UK and Australia. The UK contributed eight papers published between 2011 and 2025, reflecting changing outlooks both before and after the introduction of DoC legislation (Basu et al., 2020; Berry et al., 2023; Cantor et al., 2005; Manzanera et al., 2021; Saunsbury et al., 2025). Seven studies from Australia were included spanning 2008 to 2025, providing valuable longitudinal insights into open disclosure policies, particularly in settings where mandatory policies and

frameworks have been established for a lengthy period (Berry et al., 2023; Harrison et al., 2019; Mira et al., 2020). Four papers originated from the United States, dating between 2005 and 2016, offering ethical and policy analysis (Basu et al. 2020; Cantor et al., 2005). Additionally, two studies from Spain (Manzanera et al., 2021; Mira et al., 2020) and one from Ireland (Duffy, 2012) contributed perspectives from other healthcare jurisdictions. This diverse international body of literature facilitate a comprehensive understanding of DoC and open disclosure practices across different legal and cultural environments.

The literature was thematically analysed. Through the analysis of the retrieved papers, key themes were identified, and the literature is presented by themes. These themes include (1) Cultural barriers to disclosure; (2) Ethical duty and patient/family perspective; (3) Legal and organisational contexts; (4) Variation in compliance and policy implementation; (5) Emotional impact and professional pressures in clinical practice.

2.3.1 Cultural Barriers to Disclosure

Organisational and professional culture emerged as a major influence on how DoC is implemented, with multiple studies highlighting factors such as a culture of blame, fear of litigation or disciplinary action, and defensive practices as major obstacles to effective open, honest and transparent disclosure (Birks et al., 2014; Iedema et al., 2008; Harrison et al., 2019). Although statutory frameworks like the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (UK Government, 2014) have been introduced in the UK, cultural resistance is extensive, especially in hierarchical healthcare settings where organisations and staff within them remain concerned about reputational and professional damage and disciplinary repercussions can deter open and honest disclosure (Basu et al., 2020; Holmes et al., 2019 Equally, studies have shown that healthcare leaders who demonstrate a strong commitment to transparency and foster a culture of learning serve as key enablers in the effective implementation of DoC (Sorensen et al., 2009; Walton et al., 2019). Nonetheless, several more recent articles (Berry et al., 2023; Saunsbury et al., 2025), still highlight a disconnect between

the intention of the policy and the reality of clinical practice, where open, honest and timely disclosure is unpredictably practiced or clinicians lack understanding of the process, despite DoC being legally mandated since 2014.

Empirical research conducted by Berry et al., (2023) and Saunsbury et al., (2025) used retrospective observational and cohort methodologies to demonstrate compliance rates of DoC. However, they lacked in-depth exploration of the cultural factors underlying the low compliance levels. Berry et al., (2023) utilised a retrospective analysis of safety incidents reported via the Datix system, which is useful to recognise trends over a 5-year period which provided quantitative data. Due to the reliance on Datix system and the electronic patient records for confirmation that DoC has occurred, the study lacked qualitative data which limits insight into individual experiences and organisational culture. Nuances such as clinicians expressing verbal apologies to patients could not be captured in this study. A qualitative element may have strengthened the study and revealed staff and patient perspectives. During the study period, reporting culture within endoscopy altered due to a change in the governance teams' approach to reporting which may have shaped the results. Saunsbury et al., (2025) reviewed 1724 cases in the context of post colonoscopy colorectal cancers, which had been reported into a national audit from all NHS trusts in England. All cases were reviewed by local healthcare trusts who assessed the level of harm these patients had suffered, whether the cancer was avoidable, and if DoC had occurred. Strengths of this study include the use of a structured template for standardised data collection and a prospective design that minimises recall bias, enhancing data accuracy and reliability (Hess, 2004). The study lacked qualitative insight and did not capture clinicians' perspectives on why DoC was not applied. The study focused on clinical outcomes, overlooking cultural and emotional factors. Conducting both studies in an endoscopy department may limit the generalisability of findings to broader healthcare settings.

2.3.2 Ethical Duty and Patient/Family Perspectives

DoC, rgrounded in the principle of autonomy, emphasises patient and family involvement after safety incidents is widely recognised view in the literature (Beauchamp and Childress, 2019; Duffy, 2012; Ellis and Abbott, 2015 Glasper 2011). Birks et al., (2015) and Saunsbury et at., (2025) suggest that open, honest, and timely conversations are more than a professional and regulatory obligation, and such conversations promote trustful, honest, and transparent relationships between the patient and their healthcare professional. However, recent empirical studies suggest there are emotional and practical barriers, such as fear of blame, litigation or psychological distress that prevents DoC being implemented consistently (Berry et al., 2023 and Harrison, 2017). The inconsistency between the ethical principles underpinning DoC and its inconsistent application in practice reveals a gap in the literature, highlighting the need for further research that combines ethical analysis with empirical investigation into the barriers hindering its consistent and effective implementation.

Patient/family experiences are a fundamental principle of the DoC process; this perspective is notably underrepresented in much of the existing literature. Manzanera et al., (2021) and Mira et al's., (2020) studies emphasise patients' ardent desire for honest, open, and timely communication following safety incidents. However, these qualitative studies were conducted in Spain and may not be comparable to national and local healthcare systems (Elwy et al., 2016). Nonetheless, numerous studies support the Spanish studies that suggest patients want open and honest communication following safety incidents (Birks et al., 2015; Duffy, 2012; Ellis and Abbott, 2015; Glasper 2011; Saunsbury et at., 2025). While Spain supports patient rights and transparency through the Patient Autonomy Act (Law 41/2002), (Government of Spain, 2002) it does not have a statutory DoC; disclosure is reliant on professional ethics rather than legal obligation (Valverde-Alonso et al., 2021). Excluding the voices of patients/families' risks shaping research, policies, legislation, and frameworks solely around the perspectives of healthcare professionals and organisations, rather than aligning with the needs, expectations, and experiences of those who use services (Elwy et al., 2016; Mira et al 2020).

Although the Health and Social Care Act 2008 (UK Government, 2014) mandates openness and transparency with patients, there remains a lack of recent empirical research in the UK examining patient/family perspectives on the DoC process, and whether the legislation translates into meaningful and impactful experiences for those directly affected. Basu et al., 2020; Berry et al., 2023). This gap is particularly significant in Jersey, where no statutory DoC exists and there is a paucity of evidence about patient/family experiences or expectations in the absence of a legislative framework. The NHS Patient Safety Incident Response Framework [PSIRF] (NHS England, 2022) further highlights the significance of engaging patients/families in patient safety investigations.

2.3.3 Legal and organisational contexts

A further theme revealed how relationships between legal frameworks and organisational policies can influence how consistently and effectively DoC is implemented within healthcare systems. Cantor et al., (2005) and Iedema, (2008) suggest differences between national legislation and local policies can influence the implementation of DoC within a healthcare organisation. These differences influence how clinicians may understand and interpret their DoC obligations, impacting on the consistency of how DoC is carried out. Although these are older studies and were carried out in America and Australia, more recent UK study also supports the argument (Saunsbury et al., 2025).

Several studies propose that legal clarity and good organisational governance are key elements to the effective implementation of DoC (Harrison et al., 2017 and Holmes et al., 2019). Yet despite these, many clinicians continue to communicate their concerns about fear of blame, litigation, or disciplinary actions (Birks et al., 2014; Harrison et al., 2019; Iedema et al., 2008). Methodologically, many of the studies exploring legal and organisational context have used case studies and policy analysis, although these studies have given important insight, but they lack longitudinal or patient outcome data (Berry et al., 2023; Birks, et al., 2015).

The local DoC policy governs the implementation of DoC, (SoJ, 2020), but this is not supported by a legislative framework and the acute healthcare hospital is not regulated by the Jersey Care Commission (JCC). Therefore, compliance may be monitored internally but not externally by a regulator which may influence how DoC is implemented.

2.3.4 Variation in compliance and policy implementation

Despite the statutory requirement for DoC, its implementation is inconsistent across healthcare systems. This may be influenced by fear of blame, fear of litigation, education and training requirements, culture, and lack of understanding regarding the threshold for DoC (Basu et al., 2020; Berry et al., 2023; O'Hara et al., 2018; Peto et al., 2009; Walton et al., 2019). Berry et al., (2023) conducted a 5-year review on the compliance of DoC within an endoscopy unit and found that compliance only improved following a focused QI project, which suggests that policy and legislation alone do not guarantee compliance with DoC. The results of the study demonstrated that 70% of cases received a verbal apology and 61% of cases received a written notification. Verbal apologies were timely although there were substantial delays in written letters being sent to patients/families. Berry et al., (2023) found significant variability in the application of DoC and this was not due to the absence of legislation or policy, but due to cultural, organisational, and human factors in its application. They identified a range of barriers to the consistent implementation of DoC, including uncertainty around thresholds for disclosure, lack of psychological safety, inconsistent leadership support and fear of blame. However, a limitation of the study is its reliance on anecdotal information as no qualitative interviews took place. These findings align with other studies suggesting legislation and policy are necessary but inadequate to change DoC behaviour alone (Basu et al., 2020; O'Hara et al., 2018; Peto et al., 2009).

Audits or retrospective observational designs were used in several of the studies (McDonald et al. (2010); Mira et al. (2020); Peto et al., 2009). Whilst these methodologies are valuable to identify compliance rates and patterns, they may lack the nuanced information detailing the complex barriers to the inconsistent rates of

DoC. Both Basu et al., (2020) and Berry et al., (2023) provide empirical evidence acknowledging poor compliance rates with DoC but neither examine or explore the ethical challenges or individual behaviours that may influence this. The variation in the different standards of DoC afforded to patient/families' raises important questions about equity and predictability in patient care (Harrison et al., 2019; Walton et al., 2019).

The CQC (2019), responsible for monitoring DoC compliance in England, have frequently raised concerns about the varying levels of reporting, inadequate documentation regarding DoC and a lack of evidence that patients/families receive sincere apologies following safety incidents. These concerns support the studies mentioned in this literature review that statutory regulation or local policy is insufficient to ensure compliance with DoC without cultural and educational changes.

2.3.5 Emotional impact and professional pressures in clinical practice.

Several studies consistently demonstrate the emotional impact that healthcare professionals feel when carrying out DoC with patients/families following safety incidents (Birks et al., 2014; Finlay et al., 2013; Holmes et al., 2019). Emotions such as shame, fear, self-doubt and fear of litigation have been listed in studies, and these emotions are intensified by a lack of confidence and feeling incompetent about how they should effectively and compassionately communicate with patients/families (McDonald et al., 2010; Sorensen et al., 2009). Healthcare professionals may understand that compassion, transparency and honesty are fundamental principles of DoC, but many clinicians find these conversations difficult, especially in organisations that may lack strong leaders who provide emotional and procedural support (Birks et al., 2014; Holmes et al., 2019; Finlay et al., 2013; Sorensen et al., 2009).

Holmes et al., (2019) and Finlay et al., (2013) found that many healthcare professionals faced moral distress or internalised a sense of personal failure in cultures where blame and shame were given more importance than systemic learning

and when organisations did not provide the practical tools or emotional support to safely and effectively carry out DoC. Both studies used a limited literature sample and were Australia-based, which may not reflect UK or local practice. The literature cited in Finlay et al., (2013) primarily serves to support the discussion of the professional and legal obligation around open disclosure rather than providing a critical analysis of the methodologies used within that research. Additionally, Holmes et al., (2019) mainly rely on secondary data sources, including literature reviews and policy analysis and it lacks the voices of patients and healthcare professionals directly involved in open disclosure processes. The inclusion of primary qualitative data through interviews or focus groups could offer deeper insights into lived experiences. The study does not include quantitative data to support its claims, including quantitative data could provide empirical evidence to support their argument.

There is growing recognition that healthcare professionals need psychological support, such as coaching, mentoring, debriefs, and psychological safety to effectively and safely conduct DoC conversations. (Harrison et al., 2017; Walton, et al., 2019). With the paucity of evidence to suggest that local healthcare professionals receive the emotional support required to help with the complexities of carrying out DoC, this highlights a need to align best practice to other successful healthcare trusts where their policy is aligned to legislation.

2.4 Conclusion

This chapter presents a structured literature review which explores the challenges, barriers and implementation of DoC following safety incidents within healthcare systems, both nationally and internationally. A thematic analysis of 21 papers was conducted to interpret five common themes from the literature. These themes were (1) Cultural barriers to disclosure; (2) Ethical duty and patient/family perspective; (3) Legal and organisational contexts; (4) Variation in compliance and policy implementation; and (5) Emotional impact and professional pressures in clinical practice. The literature demonstrates the complex relationship between healthcare professionals, legal frameworks, local policy, organisational culture, and ethical imperatives. Although

statutory frameworks are in place for DoC in most jurisdictions, this review highlights the inconsistency in the compliance and implementation of DoC. Gaps were identified in the lack of patient/family voice in the studies. These studies are relevant locally as Jersey prepares for DoC legislation to become enforced. The next chapter will discuss the design of the project detailing the methodological approach.

Chapter 3: Research Design

3.1 Introduction

The chapter begins by defining the clinical audit methodology and explaining the rationale for selecting a retrospective, descriptive design. It then details the data collection methods, including the selection of the sample and the use of categorical data. The method of data analysis is discussed, with particular emphasis on the use of descriptive statistics to summarise findings. Finally, the chapter addresses key ethical considerations, including data management, informed consent, and adherence to core ethical principles such as autonomy and confidentiality. Together, these components aim to form a robust framework for ensuring methodological rigour and ethical integrity.

3.2 Study Design

Batalden and Davidoff (2007) suggest that QI in healthcare enhances the quality, safety, and effectiveness of patient care by employing systematic, structured, and data-driven methodologies, facilitated through continuous evaluation and iterative change. QI utilises structured methodologies, such as the Plan-Do-Study-Act cycle, to systematically identify areas for improvement and implement evidence-based interventions (Batalden & Davidoff, 2007). Clinical audit is an essential method within the QI framework, offering structured methodology for evaluating whether clinical care aligns with established evidence-based standards and identifying areas that require improvement within a specific healthcare context (Bowling, 2014; Creswell and Creswell, 2018; GoJ, 2022). By measuring current practice against evidence-based criteria, clinical audits identify performance gaps and drive targeted interventions aimed at improving outcomes (NICE, 2002). Clinical audit, within a QI framework, follows the positivist paradigm, which views knowledge as measurable, objective, and independent of the researcher (Creswell & Creswell, 2018). This aligns with retrospective audits, as they assess clinical practice against recognised standards, reflecting the positivist emphasis on observable, objective, and measurable reality (Creswell & Creswell, 2018; Neuman, 2014).

HCJ's policy for DoC will be utilised as a benchmark to be audited against. This audit will evaluate whether HCJ is consistently adhering to the principles of honesty, communication, and documentation required within the DoC policy, with the aim of identifying areas for improvement and implementing strategies to enhance transparency and patient trust. It does not aim to explore the experiences of healthcare professionals, patients or their loved ones who have been involved with the DoC process. If the study was focusing on experiences, qualitative research which has a basis in the interpretivist paradigm would have been utilised (Creswell and Poth, 2018; Denzin and Lincoln, 2011; Marvasti, 2004). While benchmarking against the DoC policy provides a clear framework for evaluating compliance, it presents certain limitations. Policies, while essential, can be interpreted and applied inconsistently across clinical contexts, potentially limiting the audit's ability to capture the more nuanced, qualitative dimensions of candour, such as the expression of empathy, the manner of communication, or the perceived authenticity of the disclosure (O'Hara et al., 2021). Additionally, reliance solely on documentation and policy standards may risk overlooking the lived experiences of patients and staff, thus narrowing the scope of improvement to procedural compliance rather than fostering a truly open and transparent culture (Coulter et al., 2014; Mannion & Davies, 2015).

3.2.1 Methodology

The descriptive retrospective study design was chosen as it provides a systematic and structured method for assessing current practice against explicitly defined standards without disrupting current clinical work (Burgess 2020; GoJ, 2022; NICE, 2002). This is particularly appropriate for evaluating clinical practices where the audit questions are grounded in clearly defined, quantifiable standards, such as whether a disclosure was made, an apology offered, or documentation complete, making it both methodologically appropriate and administratively manageable (NICE, 2002). Furthermore, using a retrospective design allows for the analysis of real-world clinical behaviour and policy adherence as it occurred, without influencing the outcomes through observer effects, which can affect prospective studies (Parahoo, 2014). This design typically utilises retrospective data sources, such as patient records, medical charts, or electronic health records, to describe clinical outcomes and assess the

adherence to clinical protocols. The primary objective is to assess and summarise historical data without modifying it, providing valuable insights into existing practices, highlighting areas where improvements can be made and highlighting any identified good practice (Fitzgerald et al., 2013). Descriptive retrospective studies in clinical audits are highly valuable due to their cost-effectiveness and efficiency, as they do not require the collection of new data. They allow for the evaluation of large datasets, providing a comprehensive overview of clinical performance, making it particularly suitable for assessing how well a DoC policy is implemented (NICE, 2002).

Clinical audit is supported by a normative evaluation approach, which seeks to determine where current practice aligns with established expectations by evaluating the extent to which actual practice conforms to predefined professional expectations (CQC, 2022; Ovretveit, 2002). Furthermore, clinical audits produce quantifiable and practical findings that can be readily translated into directed service improvements, this contrasts with the more conceptual and theory-driven nature of traditional empirical research, which, while essential for expanding academic understanding, may not always produce outcomes that are immediately actionable in frontline clinical settings (Burgess, 2020: Ivers et al., 2012). Consequently, while empirical research plays a critical role in generating new knowledge, clinical audit ensures that this knowledge is effectively implemented, monitored, and refined within everyday healthcare practice, thereby supporting continuous QI (NICE, 2002; Ovretveit, 2002).

3.2.2 Data Collection Methods

In this audit, data will be sourced from two principal instruments: the Datix incident reporting system and patient clinical records. HCJ use Datix, a risk management system, to manage all patient safety data (HCJ, 2025). Datix, offers a structured and traceable record of SIs, providing an efficient starting point for case selection and contextual categorisation (Williams et al., 2020). Its utilisation ensures that only incidents officially classified and recorded as SIs are audited, promoting alignment with the audit's inclusion criteria and the requirements outlined in the DoC policy. However, while Datix is instrumental in establishing a factual and procedural framework for each

event, its utility may be constrained by its inherent focus on incident chronology and classification. It often lacks sufficient granularity regarding the qualitative aspects of candour, such as the emotional tone, timeliness, and sincerity of disclosure, elements that are vital in assessing compliance with the ethical intent behind DoC (O'Hara et al., 2018; Mannion & Braithwaite, 2017). Consequently, relying solely on Datix may overlook key interpersonal factors, highlighting the value of incorporating additional sources like patient records.

To supplement Datix records, patient clinical notes will be used as a secondary data source, enabling a more holistic understanding of the care pathway and offered insight into the documentation of communication with patients/families. These records will be interrogated using a bespoke, audit proforma, systematically developed in alignment with the local DoC policy. This structured methodology will mitigate inconsistency and minimised the risk of interpretative subjectivity, which is often a limitation in audits reliant on unstructured narrative data (Burgess, 2020).

3.2.3 Type of Data Collected

Following the retrospective descriptive clinical audit on DoC, the data collected will primarily be categorical data. Categorical data refers to data that is organised into distinct categories or groups, typically represented by non-numeric values, which are used to classify and group observations (Grove et al., 2013). In this audit, categorical data will be collected in relation to the compliance with the DoC policy, categorising instances of DoC adherence into groups such as 'compliant' or 'non-compliant'. Fitzgerald et al., (2013) suggest this type of data is particularly useful in clinical audits as it allows for straightforward classification, ordering and comparison, offering a clear representation of adherence to standards. An advantage of categorical data is its simplicity and clarity; it enables healthcare professionals to easily interpret audit results and make informed decisions (Bowling, 2014). Categorical data can also be efficiently presented through descriptive statistics like counts and percentages, which makes it particularly well-suited for delivering audit findings in a clear and understandable format (Bowling, 2014). Furthermore, categorical data lends itself well

to visual representation through charts and graphs, which are useful tools for engaging clinical teams and support QI discussions. The clinical audit will comprise of gathering categorical data from thirty-two sets of patient records. *See data collection tool in appendix 1.*

3.2.4 Method of Sampling

Random sampling will be utilised as it reduces selection bias, ensuring a more equitable approach and improving the likelihood of capturing routine practice rather than isolated incidents (Bowling, 2014). However, its limitations must be considered, especially when interpreting compliance across varied clinical areas, where random selection may obscure important nuances (Burgess, 2020; Dixon-Woods et al., 2011). Variations in staffing, leadership, and departmental cultures can influence how disclosures, apologies, and documentation are managed (Braithwaite et al., 2020). Critical nuances, such as communication tone, perceived sincerity, or documentation thoroughness, may not be fully captured by random sampling alone (Flick, 2018). This limitation is crucial when evaluating organisational compliance, as it may overlook contextual patterns and practice variations (Gerrish & Lathlean, 2015). While random sampling ensures methodological rigour, it may obscure qualitative insights essential for service improvement. However, its use is justified in this audit, as the primary aim is to assess compliance with measurable, policy-based criteria through systematic review of clinical records (Burgess, 2020; NICE, 2002).

3.2.5 Sampling Strategy

A sample of 32 SIs from a six-month period (01 August 2023 – 31 January 2024) will be selected. This timeframe was chosen for its manageability and relevance, facilitating timely data collection within dissertation timelines and reflecting current practice (Burgess, 2020). While the period was sufficient to identify local compliance patterns, it may not capture broader systemic trends, seasonal effects, or organisational changes (Ivers et al., 2012). Factors such as staff turnover or organisational change could further affect generalisability (Dixon-Woods et al., 2011).

3.2.6 Inclusion/Exclusion/Sample Size

The retrospective audit will focus on incidents officially declared as SIs with a six-month timeframe, ensuring a consistent benchmark for case selection. A sample size of 32 participants is practically manageable and methodologically justifiable, allowing for in-depth review with limited resources (Burgess, 2020). This size will provide a rich insight into compliance behaviours, particularly regarding policy adherence (Gerrish & Lathlean, 2015). To enhance validity, random selection and clear inclusion criteria are essential to reduce selection bias (NICE, 2002). While the sample size is appropriate for the audit's scope, findings should be interpreted within its scale and context.

3.3 Data Analysis Methods

Descriptive statistics will be generated due to the appropriateness in summarising and presenting categorical data from a clinical audit. Given that the data is categorical, inferential statistics will not be necessary. Instead, the analysis will focus on descriptive statistics, calculating compliance rates as percentages. The results will be presented in tables, while bar charts and pie charts will be utilised to enhance visual understanding and interpretation (Burgess, 2020).

3.3.1 Descriptive Statistics

In the analysis of categorical data from a DoC audit, descriptive statistics are essential for providing a clear and straightforward summary of the data. Categorical data is best summarised using descriptive statistics like frequencies and proportions (Field, 2013). These measures enable the presentation of how often each category appears, offering an easily interpretable summary of the audit findings (Field, 2013). By applying these statistics, it becomes possible to quantify compliance with the DoC policy, visually representing the distribution of cases across the defined categories. This approach allows for the identification of trends, such as areas of significant non-compliance,

which can guide future QI initiatives. Ultimately, using descriptive statistics ensures that the audit results are presented in an accessible manner for a wide audience, including clinicians and other healthcare professionals who are key to decision-making.

3.4 Quality Assurance and Ethical issues

When conducting a clinical audit, particularly one involving sensitive patient data, ethical considerations such as confidentiality, data protection, informed consent and autonomy, data storage, data management, ensuring the validity and reliability of data, and the registration of the audit are paramount. These considerations help to ensure the study adheres to ethical standards and relevant regulatory frameworks, safeguarding patient rights and maintaining the integrity of the audit process (Beauchamp & Childress, 2019). Quality assurance within a clinical audit is essential to uphold the credibility of the audit process.

3.4.1 Confidentiality and data protection

Clinical audits typically rely on access to patient records, making data confidentiality a central ethical concern. While identifiable information may not always be used, there is still potential for breaches if data handling protocols are not strictly followed. Auditors must adhere to principles outlined in data protection legislation such as the Data Protection (Jersey) Law 2018, (SoJ, 2018) ensuring that patient data is anonymised where possible and securely stored (Health Research Authority, [HRA] 2021). Names will not be utilised during this audit and each SI was given a code to anonymise the patient.

Clinical audit is subject to stringent ethical considerations, particularly given its reliance on patient data and its influence on healthcare service delivery. The ethical principle

of beneficence is central to its justification, as clinical audits aim to enhance patient care by systematically identifying deviations from best practice and informing QI interventions (Beauchamp & Childress, 2019).

This objective supports public health goals and organisational accountability. By assessing honest disclosure, apology, and documentation after SIs, audits reinforce ethical healthcare delivery and build trust in the clinician-patient relationship (Ocloo & Matthews, 2016). However, the ethical robustness of a clinical audit depends on rigorous data governance, including adherence to confidentiality protocols, secure data storage, and clear inclusion criteria to minimise bias and uphold the principle of non-maleficence. Concurrently, the ethical principle of non-maleficence, places a duty on auditors to ensure that the clinical audit process does not inadvertently compromise patient welfare, particularly in terms of data privacy and confidentiality. This responsibility is heightened in retrospective audits, where clinicians may access sensitive patient information without the knowledge or consent of the individuals involved. As such, there is an ethical imperative to implement robust safeguards that prevent the misuse or unintended disclosure of identifiable data. Adherence to legal frameworks such as the Data Protection (Jersey) Law 2018, (SoJ, 2018) is not only a statutory requirement but also a critical ethical measure to uphold patient trust and professional integrity.

3.4.2 Informed Consent and Autonomy

Informed consent and the ethical principle of autonomy are integral considerations in the management of clinical audits. Autonomy refers to the patient's right to make informed decisions about their own healthcare, which extends to how their personal data is accessed and utilised (Beauchamp & Childress, 2019). This retrospective audit is utilising patient data without seeking their consent, this approach highlights the importance of robust ethical oversight and support to ensure respect for patients' rights. It is imperative the audit fully complies with data protection legislation including the Data Protection (Jersey) Law 2018, (SoJ, 2018) as well as local

policies. To safeguard confidentiality, all data will be anonymised and used solely for audit and QI purposes (HQIP, 2011; HRA, 2021).

3.4.3 Data management and storage

Effective data management and secure storage are fundamental to ensuring the ethical conduct of clinical audits. All data collected during the DoC audit will be handled in compliance with the Data Protection (Jersey) Law 2018, (SoJ, 2018) and local information governance policies, which require that data be stored securely, anonymised, and accessible only to the single auditor (Information Commissioner's Office [ICO], 2021). Secure electronic storage systems with password protection and encrypted drives will be used, and physical records, if any, must be kept in locked storage. These practices uphold the ethical principle of non-maleficence, by ensuring the privacy and security of sensitive data, such as breaches of confidentiality (Beauchamp & Childress, 2019). Appropriate data handling safeguards individuals' rights and contributes to maintaining public confidence in healthcare systems and the integrity of QI initiatives such as clinical audits (ICO, 2021; GoJ, 2022; HQIP, 2011).

3.4.4 Ensuring the validity and reliability of data.

Clinical audits, particularly those using a quantitative design, provide insights into performance against predefined standards, but they have quality assurance concerns. Two critical issues are validity, which ensures the audit measures what it intends to, and reliability, which concerns consistency and reproducibility of findings over time or across assessors (Burgess, 2020; Ivers et al., 2012). Poorly defined audit criteria or lack of standardisation can misrepresent performance and reduce the audit's effectiveness (Burgess, 2020; HQIP, 2011).

The validity of the DoC audit can be safeguarded with operationalised standards derived from the local DoC policy, ensuring compliance is measured against relevant criteria (NICE, 2002). Criteria like open disclosure, timely apology, and accurate

documentation are objective and easily identifiable, reducing subjective interpretation and supporting construct validity (Burgess, 2020).

Reliability can be upheld through a standardised audit tool and data collection template with clear inclusion and exclusion criteria, reducing ambiguity and ensuring consistency across cases (Burgess, 2020; HQIP, 2011).

The discussion of validity and reliability in the context of DoC compliance can be linked to justice, an ethical principle that ensures audit integrity and patient protection. Justice promotes fairness by ensuring all patient groups are treated equally and consistently. Clear criteria and standardised methods prevent bias and ensure equitable treatment in the audit process (Beauchamp & Childress, 2019).

3.4.5 Registration of the audit

Clinical audits are often distinguished from research in terms of regulatory oversight; they are not exempt from ethical scrutiny. Audits involve accessing patient data, evaluating clinician performance, and making judgments about quality of care, all of which raise important ethical questions. Ethical approval for this study was provided by both the local clinical audit department and the university's ethics committee, ensuring that it met institutional standards for methodological rigour, data governance, and ethical oversight. Registering a clinical audit with the relevant governance body is a fundamental requirement for maintaining methodological integrity and ethical oversight. Registration ensures the audit aligns with organisational priorities, avoids duplication, and meets standards for data protection, confidentiality, and clinical safety (Burgess, 2020; HQIP, 2011). It enables tracking and monitoring of audit outcomes, ensuring that findings lead to meaningful service improvement and compliance with national clinical audit frameworks (HCS, 2022).

3.5 Conclusion

In conclusion, this chapter has outlined the methodology for a retrospective, descriptive clinical audit of compliance against the DoC policy. A structured audit approach with clear standards allows for objective assessment of current practice. The use of categorical data and descriptive statistics ensures that results are interpretable and actionable. Ethical considerations, including informed consent, data protection, and patient autonomy, were also addressed to maintain the integrity of the audit. This methodology aims to generate insights that support QI and organisational transparency. Having outlined the methodological approach, the following chapter presents the findings derived from the audit.

Chapter 4: Findings

4.1 Introduction

The aim of this study is to measure the local DoC process following patient safety events being declared as SIs against the standards set in HCJ's DoC policy.

The objectives of this study were:

1. Define audit standards.
2. Measure extent of compliance with DoC policy standards.
3. Assess the timeliness and consistency of DoC process (including documentation).
4. Identify gaps in consistency.
5. Make targeted recommendations for improve compliance.

The audit utilised data from individual patient records, electronic health records, and Datix, to assess the adherence and compliance to the DoC policy. Standards were identified from the local DoC policy, to measure whether local practice aligned with internal policy (SoJ, 2020). These standards include questions about timely disclosure, documentation, and apology.

This chapter presents the findings from the clinical audit. It describes the audit sample including the sample size, time frame, and inclusion and exclusion criteria. It will present data findings in tabular and chart form, and a summary of compliance rates of the standards. It presents incidental findings such as the patient demographics, the type of SIs that were declared and the profession of the staff who are reporting the patient safety event.

For practical reasons, data collection was conducted manually by a single auditor using a standardised checklist embedded within a bespoke audit form. This allowed for structured, consistent extraction of information directly aligned with the local DoC policy. Each case was reviewed in its entirety, and findings were recorded in an anonymised format to uphold data protection and confidentiality principles, especially pertinent given the retrospective and sensitive nature of the cases reviewed (HRA, 2021). While the use of a single auditor promoted internal consistency, it also

increased the risk of subjective interpretation and potential bias. To reduce such risks, the data extraction process was conducted systematically, using a predefined data collection tool designed to obtain all relevant information aligned with the audit criteria (Braun & Clarke, 2019). Each patient record was reviewed retrospectively to ensure consistency and completeness in data retrieval. Following extraction, the data was subjected to objective analysis through a quantitative statistical method of descriptive statistics to summarise compliance rates and identify patterns. The analysis of the data was quantitative and objective in nature, relying on measurable data rather than interpretative or subjective methods typical of qualitative analysis (Creswell, 2014). This approach ensured an unbiased assessment of adherence to the DoC standards and supported the validity and reliability of the audit findings. To further reduce any risk, frequent supervision sessions occurred, and the audit was independently reviewed by a colleague to reduce subjectivity (Braun & Clarke, 2019).

Furthermore, the manual nature of data collection required significant time investment. A key limitation characteristic to retrospective audits is the reliance on historical clinical documentation, the auditor can only audit the information that is documented which may not always be complete (Burgess, 2020; Ivers et al., 2012). Nonetheless, the implementation of clearly defined standards, an audit tool, and triangulation of data sources, collectively enhanced the reliability and feasibility of the audit process.

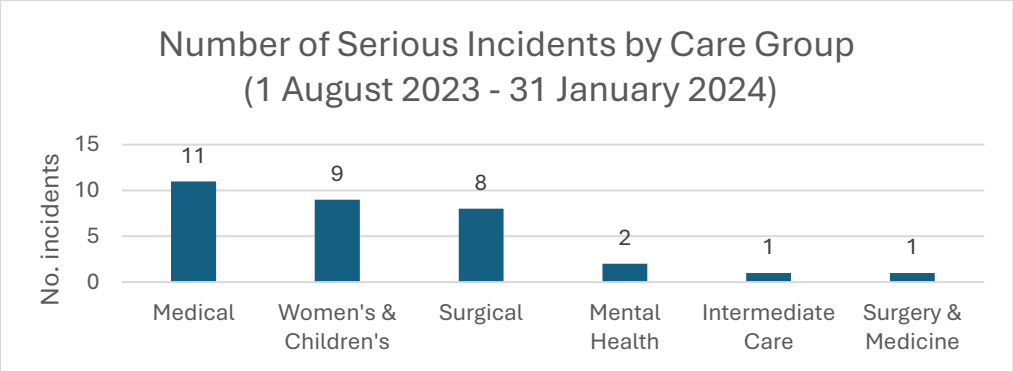
4.2 Description of the Audit Sample

The audit focused on safety incidents that were commissioned as SIs during a six-month timeframe. A sample size of 32 participants was identified. While the sample size is appropriate for the audit's scope, the findings should be interpreted within the context and limitations of its scale, it may not capture wider systemic trends, or organisational changes (Ivers et al., 2012). All care groups and departments were included in the audit including the Acute Hospital, Community Services, Social Care, Intermediate Care and Mental Health Services.

4.3 Number of SIs declared by each Care Group

Reported SIs were distributed across Care Groups (Table 1). The majority were within the Medical Care Group 34% (n=11), whilst the Women and Children's Care Group had 28% (n=9). This high number was the result of a thematic review of multiple cases. Thematic analysis reviews encompass multiple cases, including those that may not meet the threshold for an individual SI. This approach identifies recurring patterns and themes, highlighting both good practice and areas requiring improvement. This facilitates a rich understanding and supports learning from safety incidents (Braun & Clarke, 2006). The Surgical Care Group had the third highest number of SIs declared sitting with 25% (n=8) of the total declared. The remaining 13% (n=4) of SIs sit between Mental Health, the Intermediate Care Group and an SI which is jointly owned between the Medical and Surgical Care Group.

Table 4.1 Number of Serious Incidents by Care Group



Data analysis will identify and categorise key themes and trends emerging from the data, including patterns of variation in practice between departments or incident types. Particular attention will be given to common points of deviation from the policy standards, as well as instances of exemplary practice that may offer insights into enablers of compliance. Data will be presented visually using tables and charts to facilitate a clear and accessible understanding of the results and to support more robust interpretation in the subsequent discussion. This descriptive analysis will serve as the foundation for identifying areas requiring targeted improvement and will provide

a transparent account of current practice within HCJ regarding openness and communication following safety incidents.

4.4 Audit Results

All reviewed safety incidents had been appropriately logged onto the Datix system and harm levels had been correctly reported, necessitating that DoC should be implemented, demonstrating 100% (n=32) compliance in the first two standards of the audit.

Most patients/families 78% (n=25) were notified of the safety incident at the earliest opportunity with 50% (n=16) patients/families being offered an apology. (Chart 1 and 2).

Chart 4.1 Standard 3 results

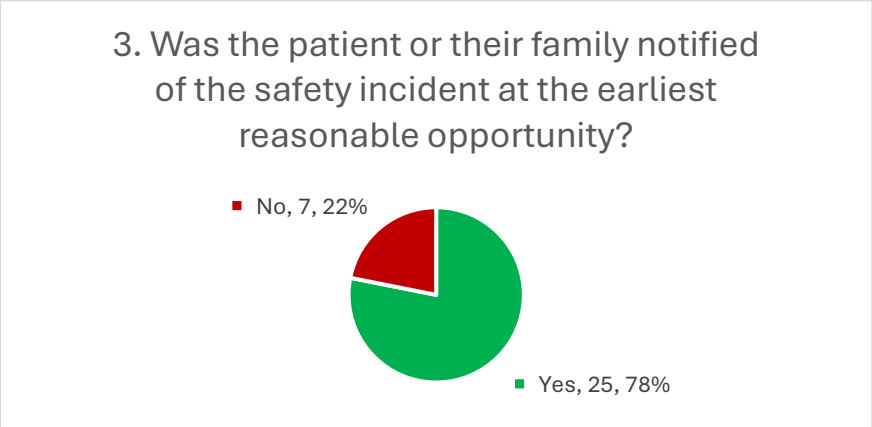
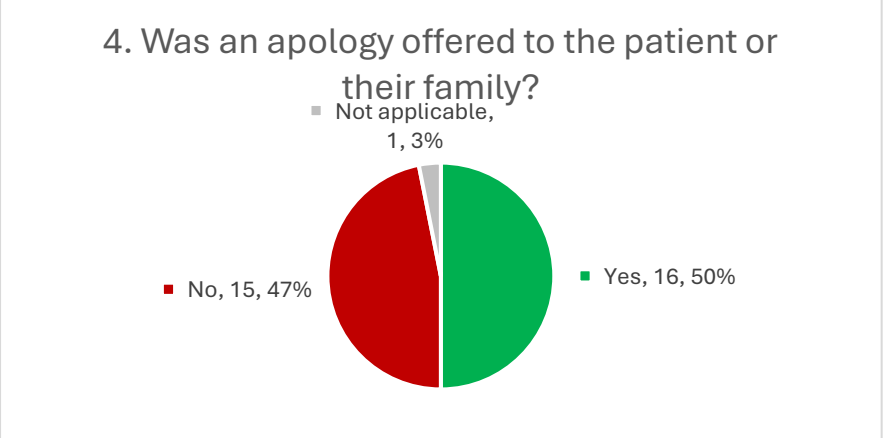


Chart 4.2 Standard 4 results



Only a small number of patients (9%, n=3) were offered a suitable solution or support to resolve the issue, while 47% (n=15) were informed that additional investigations or inquiries would take place.

Chart 4.3 Standard 5 results

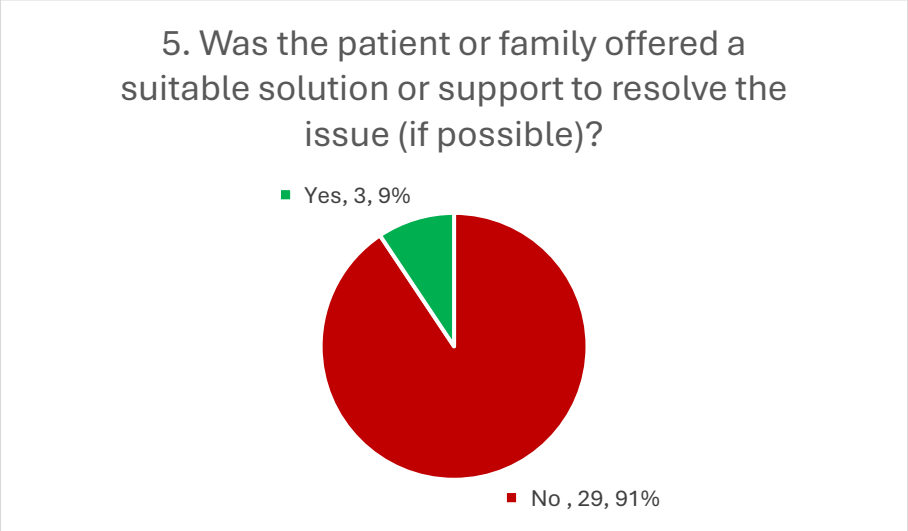
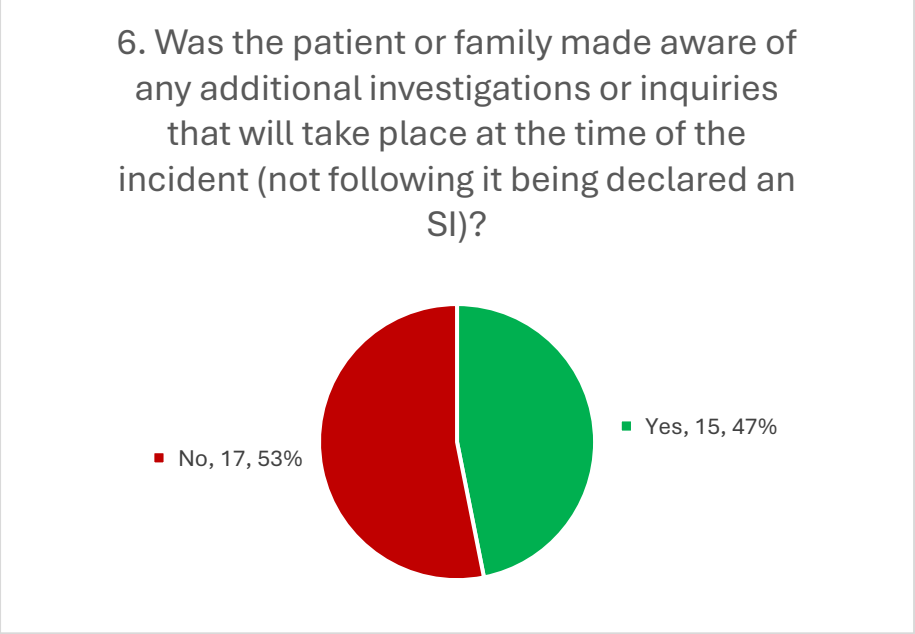


Chart 4.4 Standard 6 results



A contact person was provided to address questions or concerns, or to offer opportunities for further discussion, in 44% of cases (n=14), with one patient/family (3%, n=1) declining the offer. In contrast, 66% (n=21) of records contained no

documentation indicating that patients or families were informed how learning from the incident would help prevent future harm (Chart 5, 6, and 7).

Chart 4.5 Standard 7 results

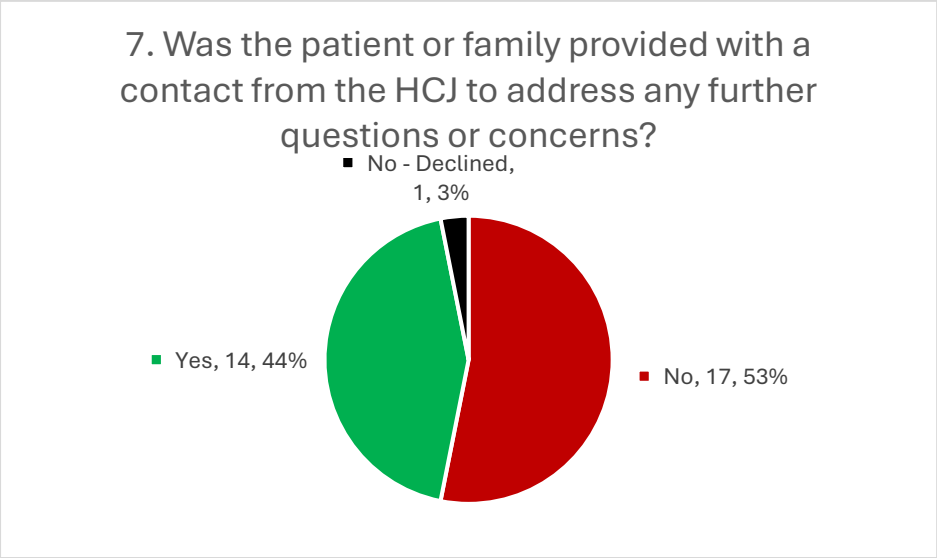


Chart 4.6 Standard 8 results

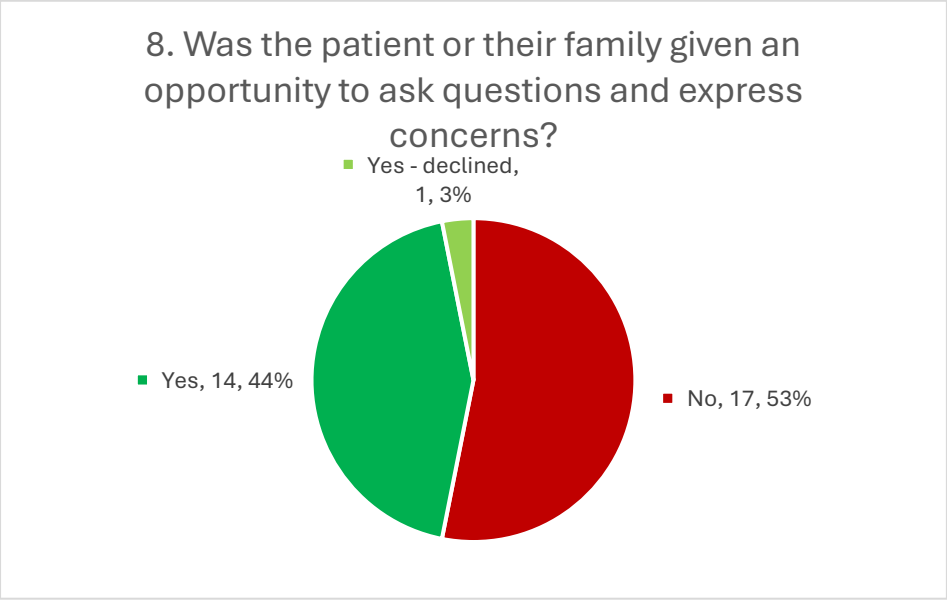
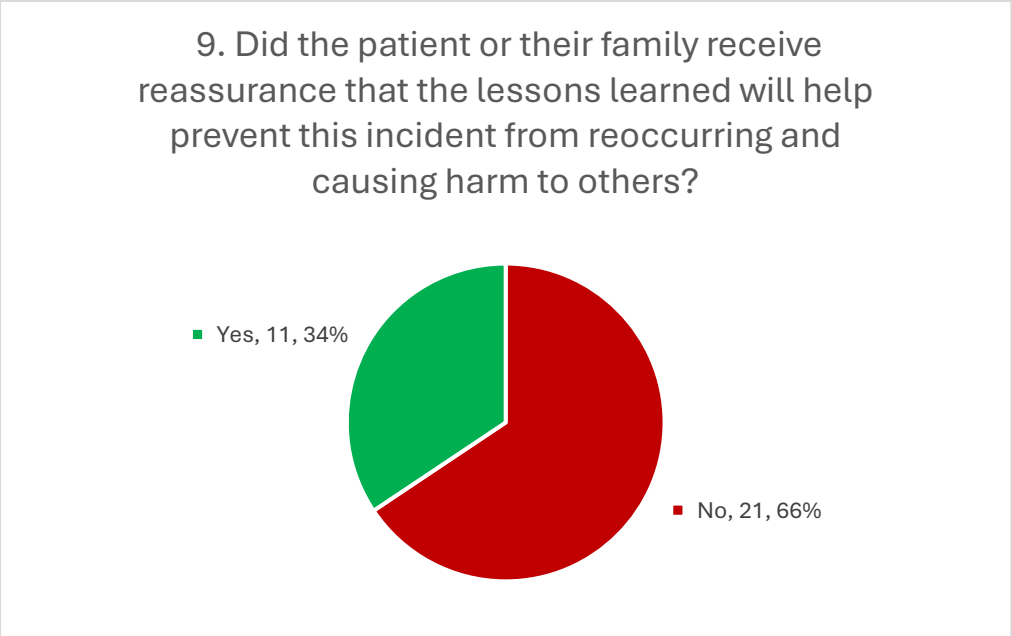


Chart 4.7 Standard 9 results



Initial communication and apology had been documented in 28% (n=9) of patient's records. 91% (n=29) patients/families did not receive formal written DoC communication following the safety incident, with 9% (n=3) receiving formal written communication. Of the letters sent 6% (n=2) were sent within the 10-day timeframe. (Chart 8, 9 and 10)

Chart 4.8 Standard 10 results

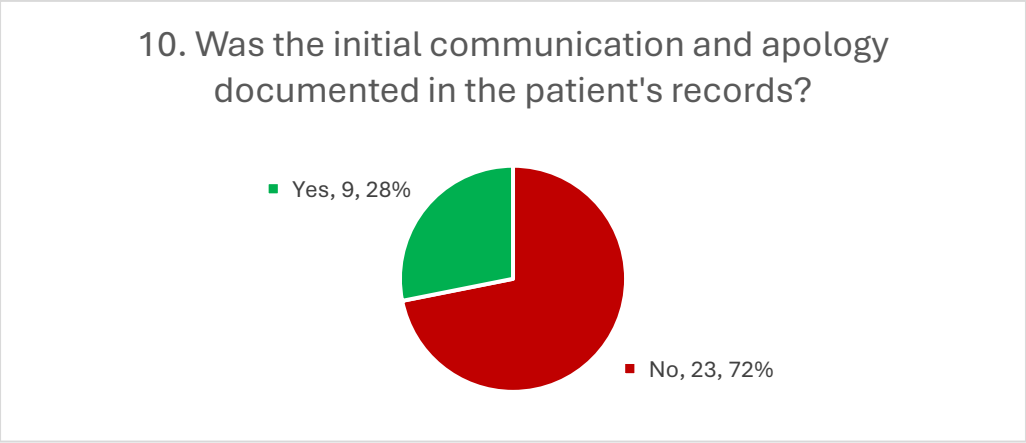


Chart 4.9 Standard 11 results

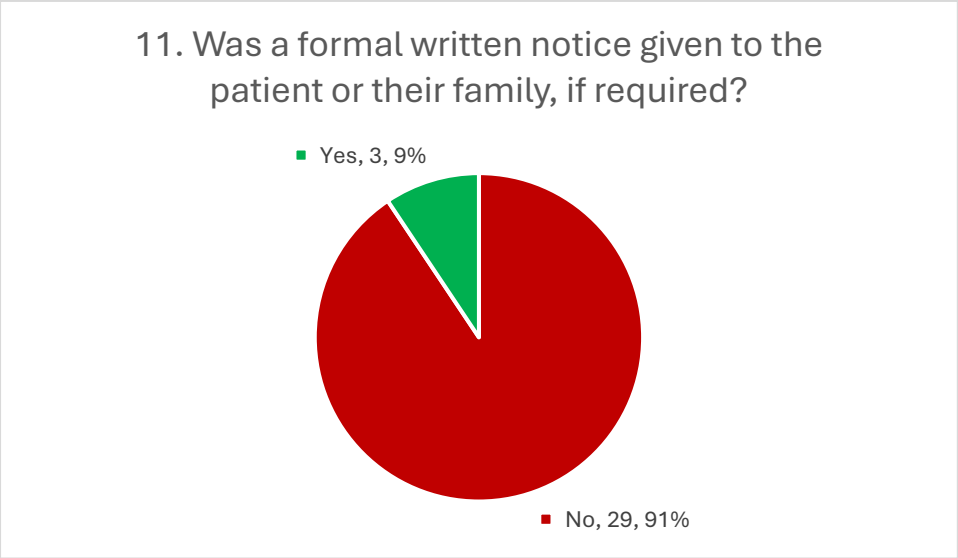
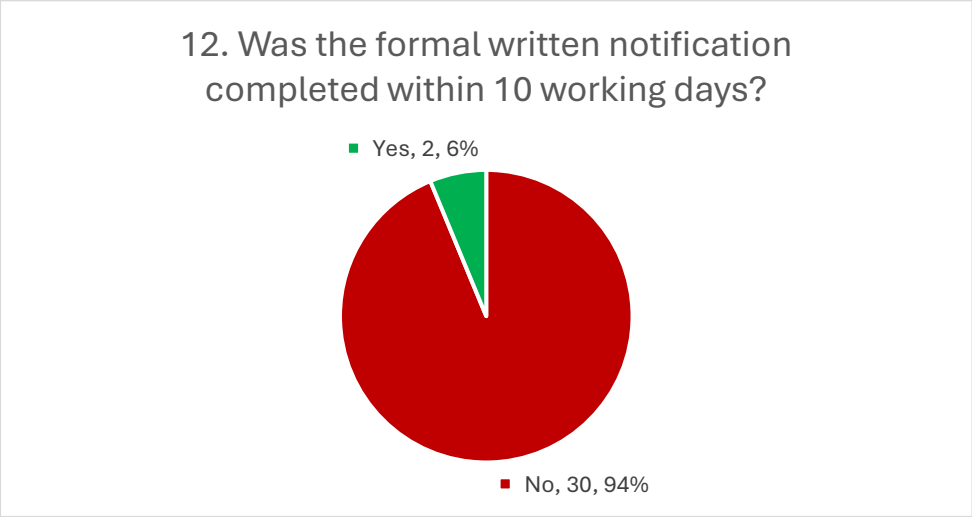
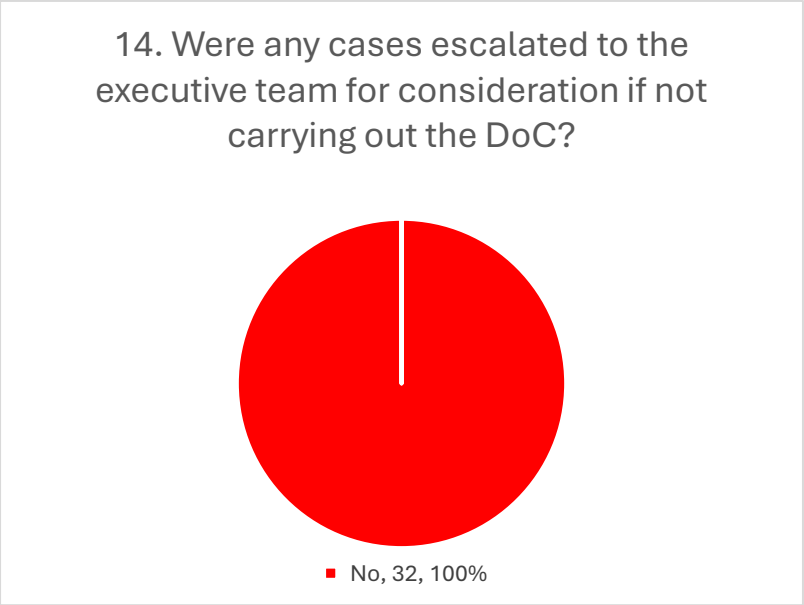


Chart 4.10 Standard 12 results



Sometimes there are circumstances where immediate disclosure may not be appropriate as it may risk causing further harm to the patient/family. For example, when patients are clinically unstable or experiencing severe psychological distress, initiating a DoC conversation may exacerbate their condition. Such cases should be escalated to executive leadership to support delaying DoC. This study discovered that no cases 0% (n=0) were escalated to the executive team for consideration whether to carry out DoC (Chart 11).

Chart 4.11 Standard 13



4.5 Incidental findings

In addition to evaluating compliance with the predefined audit standards, several incidental findings emerged during the audit. These observations, while not directly related to the core audit criteria, provided further insight into the patient demographic and reporting culture of the organisation and offer a broader understanding of current practices beyond the original audit scope.

Table 4.2 displays the range of professionals who reported safety incidents via Datix that were declared as SIs. Nurses reported the most SIs at 44% (n=14), followed by doctors at 28% (n=9). No SIs were reported by several professionals including Physiotherapists, Social Workers, Occupational Therapists or Operating Practitioners.

Table 4.2 Professionals who Reported the incident.

Reporter Profession	Number of SI notifications	Percentage per professional group
Biomedical Scientist	1	3%
Doctor	9	28%
Midwife	4	13%
Mortality team	3	9%
Nurse	14	44%
Radiologist	1	3%
Grand Total	**32**	**100%**

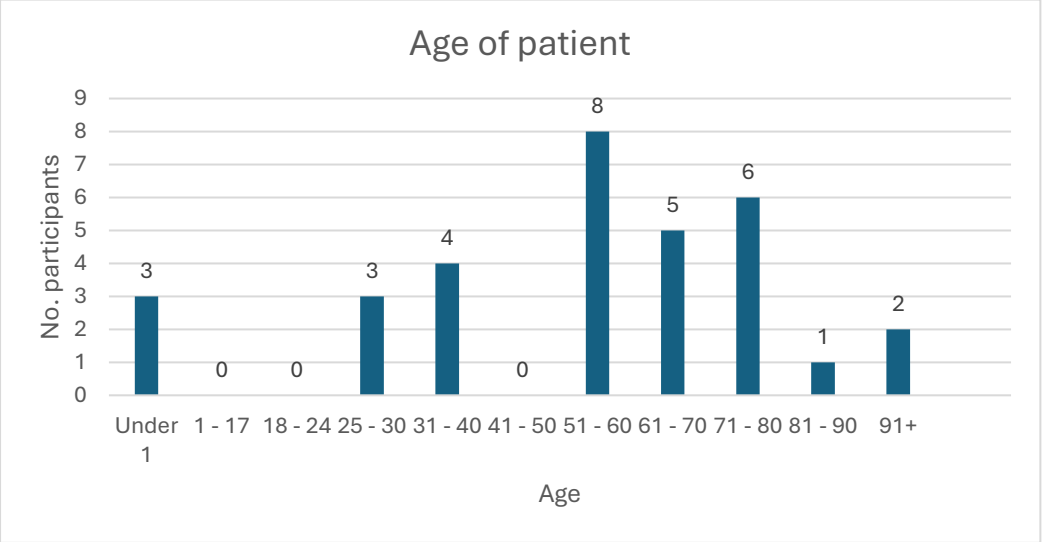
One Never Event (NE) was declared during the audit timeframe. NEs are classified as SIs because they are entirely preventable through established guidance and safety barriers designed to stop them from occurring. The NHS provide a defined list of NEs require reporting (NHS England, 2019). 18% (n=6) of SIs declared were related to delayed or failed diagnosis with 12% (n= 4) relating to the recognition, escalation, and care of a deteriorating patient.

Table 4.3 Type of SI declared.

Type of Serious Incident	No.
Massive Obstetric Haemorrhage	3
Care of the deteriorating patient	4
Delay in scanning	2
Failed discharge	2
Hypoxic-ischaemic encephalopathy	2
Medication Error	2
Pressure Ulcer	2
Absent without leave	1
Delayed or failed diagnosis	6
Incorrect treatment	2
Never Event	1
Restraint	2
Sudden and unexpected death	2
Unplanned return to theatre	1
Total	**32**

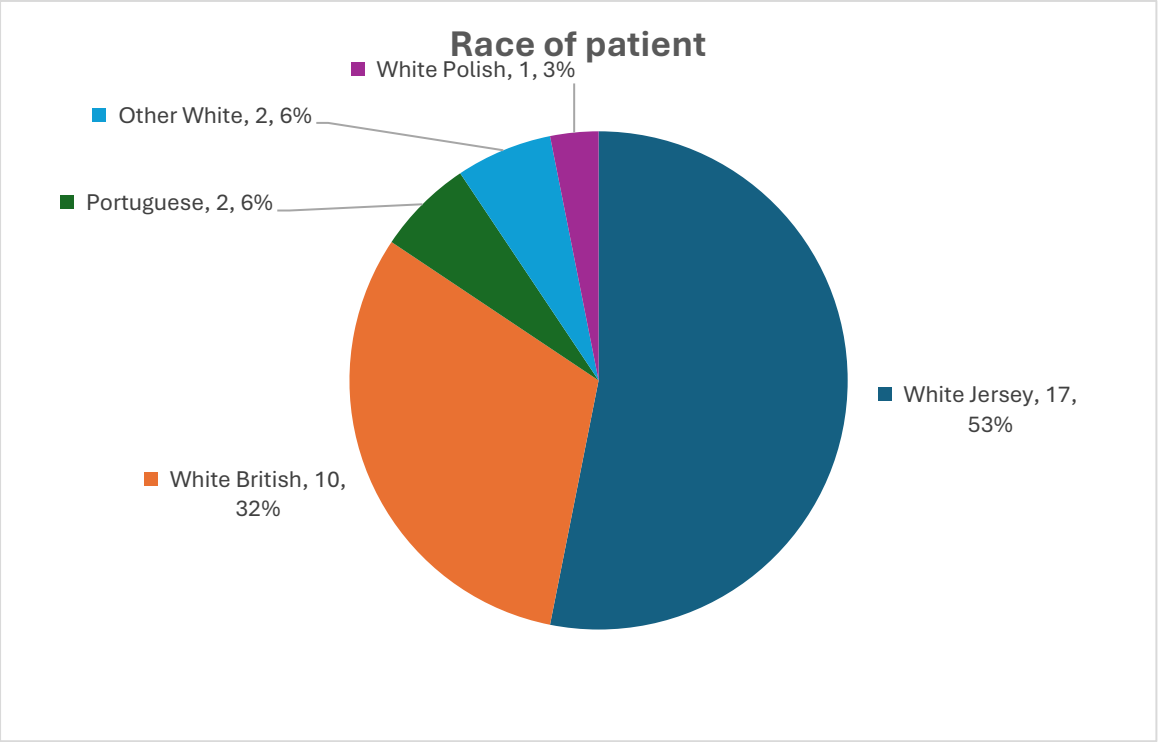
The age of patients involved in SI investigations ranged from under 1 year to over 90 years. 25% (n=8) patients were aged between 51 and 60, with 19% (n=6) patients ranging between 71 and 80 years old. 9% (n=3) patients related to babies under the age of 1. Understanding the age range of patients affected by SIs is important, as it can help identify potential vulnerabilities associated with specific age groups. Analysing age demographics supports targeted public health interventions, which supports with staff training needs analysis (National Patient Safety Agency [NPSA], 2009).

Table 4.4 Patient Age Group



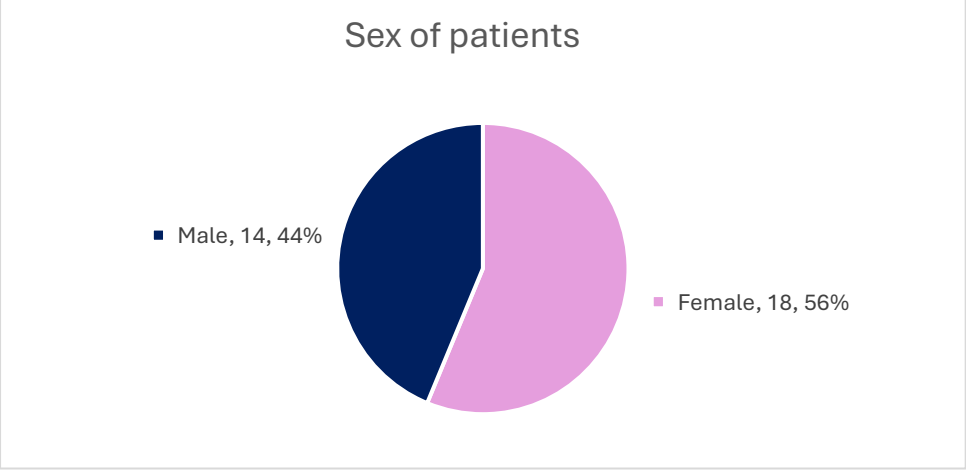
Of the patients reviewed, 85% (n=27) were recorded as White Jersey or White British, 6% (n=2) as Other White, 6% (n=2) as Portuguese, and 3% (n=1) as Polish (Chart 4.11). Further analysis of the 15 patients/families who did not receive an apology shows that none of the Polish and Portuguese patients/families (9%, n=3) received one, and 38% (n=12) of White Jersey, White British, or Other White patients/families also did not receive an apology. Documenting the race or ethnicity of patients involved in SIs can help identify whether certain groups are disproportionately affected by safety incidents. This information can help recognise and address potential healthcare inequalities. Analysing racial and ethnic data can help supports the development of more equitable, and inclusive healthcare (Kapadia et al., 2022).

Chart 4.11 Race of Patients



Just over half of SIs 56% (n=18) declared were relating to female patients with 44% (n=12) relating to male patients. Comparing this data to who received apologies, 50% of both male and female received apologies. Collecting data on the sex of patients involved in SIs supports the identification of any sex-based trends or disparities in care delivery. Analysing sex-based data supports more bespoke clinical responses (WHO, 2019).

Chart 4.12 Sex of patients



4.5.1 Incidental findings pertaining to the Quality and Safety Teams' involvement in the SI process (see appendix 2)

Following the declaration of SIs, the Quality and Safety team informed 81% (n=26) of patients/families that a SI had been declared and informed 81% (n=26) of staff teams. (Tables 5 and 6).

Table 4.5 Did Q&S inform patients/family that a SI had been declared?

Did Q&S inform patient or family that the SI had been declared	No.	%
Yes	26	81
No	6	19
	32	**100**

Table 4.6 Were staff informed?

Were the staff informed the SI had been declared?	No.	%
Yes	26	81
No	3	9
No -Thematic Review	3	9
	32	**100**

Draft Terms of Reference (ToR) were shared with patients/families in 60% of cases (n=19), while in 9% (n=3) they were not applicable due to the thematic nature of the review. The ToR for the thematic review were agreed upon by the executive leadership team to ensure the review addressed the key issues and concerns. The thematic review also examined cases of good practice with no concerns about care quality. As these did not meet the DoC threshold, patients/families were not informed of their inclusion. 50% (n=16) of patients/families provided feedback on the ToR with 25% (n=8) declining. All feedback that was provided was reflected in the final ToR. (Table 6, 7 and 8)

Table 4.7 Were draft ToR shared with patient/family?

Was the draft ToR for the SI investigation shared with the patient or their family?	Number	%
Yes	19	60%
No	10	31%
Not applicable Thematic review	3	9%
	32	**100**

Table 4.8 Was feedback provided?

Did the patient or their family provide any feedback or suggestions on the ToR?	No.	%
Yes	16	50
No - declined	8	25
No	5	16
No -Thematic Review	3	9
	32	**100**

Table 4.9 Was the feedback reflected?

12 Was the feedback reflected in final ToR?	No.	%
Yes	16	50
Not applicable	16	50
	32	**100**

More than half of patients and families (56%, n=18) communicated with the investigator during the investigation, while 22% (n=7) chose not to engage. The findings of the SI investigation were communicated openly and transparently to patients/families in 59% of cases (n=19), as evidenced by letters, emails, and report dates. In 19% (n=6), the invitation was declined, and in 3% (n=1), the investigation was still ongoing at the time of the audit. Findings were shared with involved staff in 97% of cases (n=31), with 3% (n=1) pending due to the investigation's incomplete status. (Table 10,11 and 12)

Table 4.10 Did the patient/family engage with investigator?

Did the patient or their family have any communication with the investigator?	No.	%
Yes	18	56
No - declined	7	22
No	4	13
No -Thematic Review	3	9
	32	**100**

Table 4.11 Were findings shared with patient/family?

Were the findings of the investigation communicated to the patient and/or their family in an open and transparent manner?	No.	%
Yes	19	59
No - declined	6	19
No	3	9
No -Thematic Review	3	9
Investigation is not complete	1	3
	32	**100**

Table 4.12 Were findings shared with staff?

Were the findings shared with the staff team?	No.	%
Yes	31	97
Investigation is not complete	1	3
	32	**100**

4.6 Overall Compliance Summary

All 32 SIs that were reviewed in the audit had been reported on Datix which is reflective of a good reporting culture.

Most patients and families (78%) were informed of the safety incident promptly; however, only half (50%) were offered an apology. Only 3 out of 32 patients/families were offered a suitable solution to resolve the issue, with only 34% of patients/families'

receiving reassurance learning would occur. Most patients (72%) had no initial communication or apology documented in their records, and fewer than 10% received a formal letter of apology from the organisation. No cases were escalated HCJ's executive team for further review.

4.7 Summary of Findings

The audit findings indicate a mixed level of compliance with the standards set out in the local DoC policy. While two standards were met, most standards demonstrated poor levels of compliance, particularly in relation to timely apologies, offering patients/families a suitable solution and support to find a resolution, poor documentation, and the consistent application of the DoC process. The areas of poor compliance highlight potential risks to both patient safety and organisational accountability. The key themes of poor compliance arising from the standards were:

- Verbal communication and apology
- Written communication and documentation
- Support offered to patients/families

The audit demonstrated a good practice of reporting using the Datix system as safety incidents had been reported and had been reported by a variety of clinical staff. Incidental findings have been detailed, which include patient demographics, types of SIs and findings of practice with the Quality and Safety Team once the safety incidents are declared as SIs. In the next chapter, the findings will be critically examined in relation to the wider literature.

Chapter 5: Discussion

5.1 Introduction

This chapter presents a critical analysis of the audit findings and synthase these with the wider literature on the topic to determine if the project question has been answered. It will evaluate the significance of patterns in compliance, highlight areas of strength and inconsistency, with the aim of understanding the barriers, challenges, and enablers of implementing DoC into routine clinical practice. Limitations of the study will be acknowledged to ensure transparency and to contextualise the findings within the scope and constraints of the project design and implications to practice will be discussed.

5.2 Data Analysis

The criteria for the audit were identified from HCJ's DoC policy (SoJ, 2020). These criteria include questions about timely disclosure, documentation, communication, and apology. Descriptive statistics were used to summarise, illustrating trends, recurring patterns, and potential areas of deviation from the standards within the data. Descriptive statistics are particularly beneficial in healthcare audits as the principal objective is to assess clinical practice against established standards and identify areas for improvement without examining associations between variables (Boyle, 2020; NICE, (2002). Descriptive statistics were selected as the most appropriate method of analysis, given the project's aim was to measure existing DoC practice rather than explore causation or co-relation. This method allowed for the identification of key trends and patterns such as rates of verbal apology, written communication, and formal written documentation offering a clear and objective snapshot of current compliance. By focusing on observed practices rather than investigating underlying reasons, descriptive analysis supports learning and facilitates QI initiatives within clinical governance frameworks (Boyle, 2020).

5.2.1 Patient safety incidents that met DoC threshold

The first standard was to ensure the safety incident was reported on Datix. The second was verifying that the level of harm was accurately coded to meet the DoC threshold. The first two standards demonstrated a positive 100% compliance.

HCJ is not part of the NHS, therefore not obligated to follow its standards, although HCJ uses NHS standards as a benchmark where possible. The NHS reports a national average of 63.8 safety incidents per 1,000 bed days, while HCJ reports a higher average of 105.5 per 1,000 bed days (HCJ, 2025). Increased patient safety reporting indicates a strong safety culture, reflecting staff willingness to openly report errors and learn from incidents (NPSA, 2004; Evans et al., 2006; Kaya et al., 2023). HCJ have seen a successful 24% increase in the reporting of safety incidents from 2023 to 2024 (HCJ, 2025). This increase in reporting and the accuracy in coding the levels of harm, may be attributable to the training and education delivered across the organisation from the patient safety team. Although the NHS sets an annual target for safety incident reports, HCJ expect reporting to increase year on year (HCJ, 2025). To continue this increasing trend and accuracy of reporting, the patient safety team will diligently continue to support healthcare staff to complete timely investigations following the submission of a Datix report and ensure learning occurs from the incident, as failure to do this may prevent staff from reporting (Berry et al., 2023; HCS, 2024).

Where standards were less consistently met, the key themes arising from the standards were:

- Verbal communication and apology
- Written communication and documentation
- Support offered to patients/families

5.2.2 The role of apology following a patient safety incident

A prominent theme that arose from the audit was the failure to provide an apology. Apologising to a patient/family following a safety incident is always the right thing to do and should be seen as a priority in response to DoC (SoJ, 2020). That 50% (n=16) of patients were not offered an apology shows a significant deviation from the local DoC policy and the ethical and professional duties of the healthcare professionals involved. An apology when delivered sincerely and promptly, can provide emotional validation for patients/families, helping to reduce emotional distress, promote trust and reduce formal complaints and litigation from being lodged against the healthcare organisation (O'Hara et al., 2018; Saunsbury et al., 2025). Patients/families who do not speak English as their first language may be less likely to receive a formal apology following a safety incident, partly due to language barriers and cultural misunderstandings (Iedema et al., 2008). This was reflected in the audit, where none of the three patients for whom English was a second language received a formal apology. This issue is particularly relevant in Jersey, which has a wide and diverse demographic.

However, the impact of apology extends further than the patient/family, it plays a key role in supporting the psychological and emotional wellbeing of healthcare professionals following a safety incident (Aubin et al., 2022; Liukka et al., 2020). Aubin et al., (2022) propose a framework of mutual healing that recognises the emotional impact of safety incidents on both patients/families and healthcare professionals. Within this framework, an apology is not just a procedural obligation, but an ethical act that promotes a shared recovery for all involved. The framework also recognises the second victim phenomenon, which refers to the emotional and psychological harm healthcare professionals may experience after involvement in a significant safety incident (Wu, 2000). The provision of emotional support to healthcare professionals, alongside the delivery of compassionate communication from healthcare professionals to patients/families, including honest explanations, timely disclosure, sincere apologies and opportunities for shared reflection, fosters mutual healing and may help reduced long term harm for all those involved (Aubin et al., 2022; Scott et al., 2009). This dual approach requires a change from blame-based cultures, which

inhibit candour and discourage open apology, towards systems that prioritise continuous learning and foster a culture of patient safety (Aubin et al., 2022; Liukka et al., 2020; Wu, 2000). Liukka et al. (2020), found that organisations with strong safety cultures, who foster psychological safety and avoid disciplinary and blame cultures are more likely to promote transparent communication and apology after safety incidents. Such organisations empower healthcare professionals to speak candidly, facilitating disclosure to patients/families that is honest, empathetic, and meaningful. When healthcare professionals are supported in psychologically safe and non-punitive organisations, they are more likely to offer sincere apologies without fear of personal, professional, or legal consequences. This is further supported by guidance such as NHS Resolution (2017), which states that expressing regret or saying sorry is not an admission of liability. Future studies could explore compliance with, and accessibility of, wellbeing support services for clinicians, particularly in the aftermath of safety incidents where emotional and professional impacts may be significant.

Despite these findings, literature suggests the delivery of apologies remains inconsistent following safety incidents. Studies reveal that factors such as fear of litigation or disciplinary action, a culture of blame, emotional distress, and uncertainty about what to say often lead to delayed or no apology (Birks et al., 2014; Harrison et al., 2019). However, NHS Resolution (2017) clearly states the offering of an apology does not constitute a legal admission of fault. The misunderstanding of this guidance continues to act as a barrier to effective implementation of DoC. Without an organisational commitment to emotional support and training, apologies may be continued to be omitted, delayed or delivered insensitively, compounding harm. Scott et al., (2009) reveals that interventions such Schwartz Rounds, communication training, and second victim support programs have helped improve the delivery of an apology by providing healthcare professionals with the support and education in how to respond following a safety incident.

Barriers to why to HCJ is not 100% compliant with why patients/families were not offered an apology was not captured in the audit. The findings from the audit are

constrained by the quality and comprehensiveness of the patient records, it is possible that a verbal apology was given but was not documented in the patient notes (Elwy et al., 2016; Saunsbury et al., 2025; Walton et al., 2019). In summary, an apology plays an impotent role in both individual recovery and systemic safety. The provision of psychological and emotional support to all involved promotes transparency, helps restore trust and promotes meaningful organisational learning following safety incidents. There is a clear need for trained staff or interpreters who can effectively support communication and facilitate meaningful apologies for patients and families for whom English is a second language.

5.2.3 Lack of Compliance with Documentation Standards

The audit found that 91% (n=29) of cases lacked evidence of formal written communication to the patient/family. Only 6% (n=2) received it within ten working days, and no cases were escalated to the executive team. This highlights a significant gap in implementing the local DoC policy, which requires formal written communication to patients/families within ten working days. Duffy, (2012) and Saunsbury et al., (2025) reported that many healthcare organisations lacked a standardised DoC letter template, contributing to inconsistent practice. These findings reflect local practice, there are no standardised templates for clinicians to utilise which may be a contributory factor for the very low compliance rate in sending formal written documentation.

Lack of consistency in complying with documentation to record an initial communication or apology highlights a significant gap in the application of the DoC policy. It presents a barrier in achieving transparency, accountability, continuity of care, providing patients with reassurance and closure following a safety incident and organisational learning (Bevan Brittan, 2020; CQC, 2022; O'Hara et al., 2018). When details of safety incidents are not clearly recorded, there is an increased risk of fragmented communication among healthcare professionals, and a missed opportunity to support both the patient and clinician (Iedema et al., 2008; O’Hara et al., 2018). Although it is not clear from the audit whether verbal apologies took place

at the time, recording an apology in the clinical notes was not consistently in evidence. This low compliance rate may reflect the failure to deliver an apology, or it may be a failure to record the apology even if it was delivered verbally.

Effective open disclosure involves not only the verbal delivery of an apology to the patient/family but the clear documentation of the apology in the patient's clinical records, as required by the CQC DoC standards (CQC, 2022). The standards stipulate that a verbal apology is not sufficient, but it needs to be documented in the patients notes and a written apology must be provided, and this letter should be recorded in the patients notes as part of the statutory process. Failure to document this may constitute a violation of legal obligations (UK Government, 2014). Legal guidance highlights the importance of accurate documentation to demonstrate compliance with the statutory DoC. Bevan Brittan (2020) emphasise that to demonstrate compliance with DoC, healthcare organisations must ensure all aspects of disclosure are fully documented and auditable, including the apology, explanation of the incident, and discussion of next steps, such as details of the investigation and remedial actions. They suggest this requirement goes beyond a formal administrative process, as it provides assurance that patients and families have been appropriately informed of the incident and demonstrates that legal and ethical obligations have been met (Bevan Brittan, 2020). Yet, as revealed in the audit and in previous studies, apologies and disclosure may often be delivered without being record in the patients' clinical notes (Harrison et al., 2019; Holmes et al., 2019). A written letter following verbal apology place on the clinical records would provide a critical record as well as support family information.

Written documentation is also essential to ensure that future healthcare professionals involved with the patients' care are informed about the safety incident, supporting continuity of care, transparency and appropriate follow up care and treatment, rather than inadvertently repeating mistakes or failing to acknowledge past harm (Saunsbury et al., 2025; Vincent et al., 2017). Furthermore, the CQC (2022) emphasises that such documentation is not only clinically relevant, but a legal and ethical obligation of DoC. As HCJ moved towards formal regulation, future JCC regulations may include the

monitoring and support of written documentation, such as apology letters, to ensure transparency, accountability, and consistency in communication following safety incidents. The absence of a documented apology in the patients' clinical notes aligns with previous research suggesting that healthcare professionals can be hesitant to document apologies due to concerns about legal liability or uncertainty about what to document (Birks et al., 2014; Harrison et al., 2019; Saunsbury et al., 2025).

Elwy et al., (2016) and Mira et al., (2020) highlighted that patients/families depend on receiving formal written communication to promote candour, transparency and to support ongoing communication. Additionally, further studies found that patients who did not receive formal written communication felt overlooked and were more likely to lodge a formal complaint against the organisation (Berry et al., 2023; Walton et al., 2019). This audit has not reviewed data that compares local data on low compliance rate of patients receiving formal written communication and if these cases have then pursued a formal complaint.

The results of this audit concur with previous studies that evidence a consistent lack of compliance with formal written communication (Berry et al., 2023; Birks et al., 2014; Duffy, 2012; Finlay et al., 2013; Glasper, 2011; Harrison et al., 2019; McDonald et al., 2010; Peto et al., 2009; Saunsbury et al., 2025; Walton et al., 2019).

5.2.4 Support offered to patient/family

Audit findings reflect wider literature showing limited support for patients and families after safety incidents. Few patients were informed of remedial actions (Mira et al., 2020; Walton et al., 2019). Communication about investigations was low, with under 50% informed both locally (53%) and in studies (Birks et al., 2014; Saunsbury et al., 2025). A named contact was absent in 53% of local cases, similar to Holmes et al.'s (2019) 40%. Although 30–35% of patients had opportunities to ask questions in studies by Berry et al. (2023) and Harrison et al. (2019), locally this was higher at

47%. Finally, 26–35% were told about preventive actions, aligning with the local rate of 34% (Manzanera et al., 2021; Mira et al., 2020).

Another theme was poor compliance in the support and communication offered to patients/families following a safety incident. Despite being a requirement under DoC, timely support and engagement were lacking. Prompt, compassionate communication is not only an organisational and ethical duty but also vital for rebuilding trust and fostering a learning culture. (Beauchamp & Childress, 2019; NHS England, 2022; O'Hara et al., 2018). NHS England's PSIRF (2022), emphasis that meaningful involvement of patients/families must occur in a compassionate, open, and person-centred manner. The framework recognises the importance of the quality and timeliness of communication and how it can affect individual's experiences following a safety incident.

Effective communication and engagement with patients/families following a safety incident are grounded in the ethical principle of autonomy, which obligates clinicians to ensure patients are kept fully informed and provided with support in their decision making regarding their care (Beauchamp & Childress, 2019). The principle of autonomy suggests that patients/families have the right to receive timely, candid, honest and relevant information. This aligns closely with the statutory DoC, which legally mandates transparency, apology and an explanation following a safety incident that causes harm (CQC, 2022). If this does not occur, patients/families may experience feelings such as betrayal and confusion, worsening the emotional burden of the original harm caused (O'Hara et al., 2018). However, audit findings indicate that the principle of autonomy, which is central to clinical practice has not been consistently upheld, as evidenced by poor compliance with the audit standards related to timely, honest, and documented communication (Beauchamp & Childress, 2019). This suggests a considerable gap between ethical and organisational expectations and clinical implementation, questioning if patients/families are meaningfully involved in their care following being harmed.

Meaningful disclosure, grounded in ethical principles, upholds patient autonomy and plays a crucial role in building trust, accountability, and promotes a culture of safety within healthcare (Beauchamp & Childress, 2019; Iedema et al., 2008). Healthcare organisations must create cultures where honest, timely, and compassionate communication occurs consistently, alongside providing emotional support and ongoing engagement to patients/families affected by safety incidents (Aubin et al., 2022; NHS England, 2022).

5.3 Limitations

The retrospective nature of the audit introduced several limitations. Firstly, the quality of findings is largely determined by the accuracy and completeness of the recorded data, clinical records, or incident reports, such as those stored in Datix, and may be inconsistently filled or lacking in nuance (Burgess, 2020; O'Hara et al., 2018). As a result, the audit may miss subjective factors like empathy, tone, and sincerity, key elements of ethical transparency in disclosure but rarely documented in structured formats (Iedema et al., 2008). Studies have highlighted that clinicians may have engaged in verbal DoC conversations with patients/families without documenting these interactions in the clinical notes (Finlay et al., 2013; Holmes et al., 2019). Retrospective audits are unable to explore patient/family or staff perspectives who were involved in the safety incident, which can restrict the understanding of the nuanced communication (Duffy, 2012; Elwy et al., 2016) This audit reviewed 32 cases over a 6-month period, which was constrained by the available time to complete the audit, potentially limiting the representatives of the findings, however the sample size was large enough to support the validity of the findings.

Nonetheless, a retrospective audit remains a valid and informative method, particularly when combined with robust inclusion criteria, random sampling to reduce bias, and are valuable to identify trends and highlight areas for improvement (Boyle, 2020).

5.5 Implications to practice

Several implications for clinical practice can be drawn from this project.

1. DoC should be a key priority, aligning with its annual plan (HCJ, 2025b) and commitment to transparency, learning, and patient-centred care.

2. The inconsistent delivery and documentation of verbal apology and formal written communication suggest the need for clearer guidance, education, oversight, and organisational leadership around the ethical, professional, and organisational requirements of DoC.

3. No patients who speak English as a first language receiving an apology, this highlights the need for trained interpreters and culturally appropriate support to facilitate effective apologies and maintain trust in healthcare services.

4. To enhance effective communication, clinicians require targeted training in soft skills such as empathy, active listening, and emotional intelligence. Developing these skills is essential to promote transparency, build trust, and improve overall patient care outcomes.

5. With only 6% (n=2) of patients receiving a formal letter within ten working days, highlights the need to embed robust documentation practices. Standardised letter templates may help clinicians to meet this required criterion.

6. Findings suggest there is a need for a more patient-centred approach following a safety incident. Local findings suggest 53% (n=17) of patients/families were given a named contact to support them following a safety incident or given the opportunities to ask questions. This aligns with existing literature, which

similarly highlights the variability of offering clear points of contact to affected individuals. Addressing these gaps may rebuild trust and reduce the emotional impact on the patient (Manzanera et al., 2021: Mira et al., 2020).

7. HCJ should implement structured wellbeing support programs for clinicians following safety incidents. Providing emotional and psychological support helps mitigate burnout, fosters resilience, and ensures clinicians can continue to deliver safe, compassionate care.

8. The findings suggest the lack of compliance to DoC is a wider cultural issue (Birks et al., 2014; Iedema et al., 2008). Clinical leaders in healthcare organisations must coach, model and lead a culture of candour to support transparency and accountability (Harrison et al., 2019; Holmes et al., 2019).

5.6 Conclusion

In summary, this chapter has critically examined the audit findings in the context of the literature. The project aimed to assess the extent to which HCJ complied with the DoC policy following the commissioning of an SI, focusing on disclosure, apology, and documentation within a specific timeframe. The audit demonstrated there was significant gaps in the quality and the consistency of both verbal and written communication with patients/families following safety incidents. Local audit results mirror findings in the reviewed literature, particularly in relation to undocumented apologies, limited written communication and providing patients/families with updates or reassurance of learning. Despite ethical and professional obligations, factors such as fear of litigation, cultural issues, lack of confidence and lack of training continue to act as barriers. Closing the gap between policy and practice will require targeted quality improvement work, which will be discussed in chapter 6.

Chapter 6: Recommendations and Conclusion

6.1 Introduction

This concluding chapter will summarise the key findings from the project, evaluate whether the original aims and objectives have been achieved, and critically reflect on the value of the project in contributing to current knowledge and practice regarding DoC. It will suggest practical and evidence-based recommendations to improve local practice, especially in the absence of statute. The study aimed to assess the local DoC process after patient safety events were declared SIs, comparing it against HCJ's DoC policy standards to identify strengths and areas for improvement. An action plan will be developed based on the findings, and this chapter will determine if the audit question has been answered.

The objectives of this study were:

1. Define audit standards.
2. Measure extent of compliance with DoC policy standards.
3. Assess the timeliness and consistency of DoC process (including documentation).
4. Identify gaps in consistency.
5. Make targeted recommendations for improve compliance.

6.2 Summary of findings

The audit identified three key concerns about DoC compliance within HCJ:

- Verbal communication and apology
- Written communication and documentation
- Support offered to patients/families

These findings indicate inconsistent DoC practice, but also highlight strengths, including a strong reporting culture and timely notification of safety incidents. The audit identified gaps in consistent compliance related to candour, communication, documentation practices, the need for a more patient-centred approach and how the

DoC is interpreted and enacted in clinical practice. These findings are similar to existing concerns about the inconsistent implementation of DoC, particularly in jurisdictions without strong legal mandates (Berry et al., 2023; Birks et al., 2015). These findings are also consistent with the literature reviewed where five key themes were identified:

1. Cultural barriers to disclosure
2. Legal and organisational contexts
3. Variation in compliance and policy implementation
4. Ethical duty and patient/family perspectives
5. Emotional impact and professional pressures in clinical practice

6.3 Value of study

This study offers an important contribution to the growing body of national and international evidence on the challenges and barriers associated with implementing DoC, particularly in jurisdictions where local legislation is absent. Although statutory DoC has been embedded into English law since 2014, similar legislative frameworks are lacking in Jersey, leading to inconsistent implementation of Doc (CQC, 2018; Harrison et al., 2019). In the absence of legislation, healthcare organisations rely on internal policies, ethical obligations, and professional guidance, such as those issued by the GMC (2024) and the NMC (2018) which lack the legal force of statutory regulations (Holmes et al., 2019; Walton et al., 2019). The most significant contribution of this study is its ability to address a notable paucity in local research surrounding DoC. As Jersey prepares for the introduction of a change in the law which will legally mandate DoC there is no local evidence on organisational readiness, current compliance rates or the potential barriers to implementing candour in practice. Through an audit and literature review, this study offers a structured evaluation of DoC implementation within the local context. This project will support the organisation in strengthening its approach to the DoC by identifying areas for improvement. The audit provides a baseline of compliance rates and identifies areas for improvement. This area of QI aligns with HCJ's annual priority for 2025, which is to ensure that openness, honesty, and transparency are upheld when safety incidents occur (HCJ, 2025). This adds substantial importance for policymakers, and healthcare leaders by offering a

local perspective upon which targeted improvement strategies can be developed, such as training programmes, policy review, and practical support.

6.4 Recommendations for clinical practice

Based on the audit findings and the study's overall value, an action plan and targeted recommendations have been developed. While eight implications for practice were identified, five priority recommendations have been selected to ensure they are realistic, focused, and deliverable within current resource limitations. Several recommendations are proposed to strengthen the implementation of DoC locally. Firstly, the current DoC policy is outdated and requires revision. The audit revealed inconsistencies in verbal communication, written documentation, and support for patients/families, suggesting the policy may lack the clarity needed for consistent implementation. Secondly, the audit revealed poor compliance with written communication to patients/families after a safety incident. To address this, introducing a standardised letter template is recommended. This would offer clinicians a clear structure, serve as evidence of DoC completion, and could be incorporated into the updated policy. It would enhance accountability, promote transparency, and better support patients and families (Berry et al., 2023). Thirdly, a training programme is needed to provide clear guidance on communication skills, emotional resilience, ethical and professional duties, and legal and organisational requirements. This will better equip clinicians to communicate effectively both verbally and in writing in a timely, transparent, candid, and compassionate manner after a safety incident. This recommendation aligns with literature showing that inadequate training can hinder open disclosure and obstruct patient-centred care. (Birks et al., 2015; Holmes et al., 2019).

Fourthly, local governance systems should be in place to promote accountability of DoC through leadership engagement, feedback loops, and clearer escalation protocols. The quality and safety team should develop a standard operating procedure (SOP) following the review of the DoC policy to help ensure consistency, clarity, and accountability of how disclosure is managed locally. An SOP would offer clear

guidance and help ensure healthcare professionals understand their responsibilities following a safety incident. This could help bridge the gap between policy intent and current practice (Harrison et al., 2019; Walton et al., 2019). Finally, to ensure these recommendations help with meaningful and sustained improvement in the implementation of DoC, it is important to conduct another audit within 12 months. This would enable HCJ to assess and evaluate the impact of the recommendations in practice. Re-auditing is a well-recognised mechanism for closing the audit loop, driving QI, and embedding changes into everyday practice (Finlay et al., 2013; Iedema et al., 2008). By implementing these recommendations, it would help with compliance of DoC within HCJ and contribute to a culture of openness, transparency, learning, and patient-centred care.

The incidental findings from the audit, particularly those relating to practices within the Quality and Safety team, while not explored in depth within this dissertation, offer valuable insights into opportunities for improving routine practice. These findings will inform future departmental discussions, influence practice development, and support QI initiatives aimed at strengthening communication and engagement with both patients/families and staff teams.

Table 6.1 Action plan for recommendations

Action	Objective	Action Owner	Timeline	Evidence of Completion	Date of Closure and by whom
1.Review and update the DoC policy.	To ensure the policy reflects current best practice, audit findings, and updated procedures.	Quality and Safety Team/ Medical Director/ Law Office Support	Within 4 months.	The policy will be ratified through the policy, procedure ratifying group (PPRG) and be uploaded on HCJ policy site.	31 December 2025 Medical Director and Associate Director of Quality and Safety.
2. Introduce a standardised letter template for written apologies.	To ensure consistency, completeness, and empathy in written communication with patients/families.	Quality and Safety Team and Legal Manager	Within 2 months.	Template uploaded to the HCJ policy site. Usage of template to be audited monthly and reported to Care Group Governance Meetings.	31 October 2025. Head of Patient Safety, Incidents and Risk.
3. Deliver multidisciplinary staff training sessions on DoC.	To increase knowledge, build confidence and clarity around disclosure, apology, and documentation.	Education Department, Law Office and Quality and Safety Team.	Rollout within 4 months and then will continue as business as usual.	Attendance records, pre and post evaluation training records.	31 December 2025. Medical Director and Head of Nurse, Midwife and Allied Health Professionals Education.

4. Develop and implement a Standard Operating Procedure (SOP)	To provide clear, step-by-step guidance for staff on how to meet DoC requirements.	Quality & Safety Lead / Governance Team.	Within 2 months.	SOP approved at PPRG and disseminated; available on intranet; incorporated into training.	31 October 2025 Head of Patient Safety, Incidents and Risk.
5. Conduct a re-audit of DoC compliance	To assess progress, identify remaining gaps, and inform further action.	Clinical Audit and Effectiveness Team & Quality and Safety Team	12 months from implementation of other recommendations.	Re-audit report completed; action plan updated accordingly and presented at Care Group Governance Meetings.	31 December 2026. Head of Compliance and Head of Patient Safety, Incident and Risk.

6.5 Conclusion

This study has highlighted poor compliance and significant deviations in the implementation of DoC within HCJ, with inconsistencies in communication, documentation, and organisational support following safety incidents. While some countries have a statutory framework for DoC which Jersey does not, compliance remains inconsistent and variable, regardless of whether it is legally mandated. (Harrison, et al., 2019; Walton et al., 2019; Saunsbury et al., 2025). The findings demonstrate a disconnect between policy and clinical practice, with cultural, emotional and organisation barriers preventing full compliance with the policy. This study offers clear recommendations including the development of a SOP, revision if the DoC policy, a standardised letter template and staff training and education. A planned re-audit is recommended to evaluate the effectiveness of the proposed recommendations, ensure changes are embedded, and confirm sustained improvement. Finally, embedding a culture of openness, honesty and transparency is not only an ethical, organisational professional requirement, it is a moral imperative and is central to providing patient-centred care.

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Appendix 1: Audit Questions

No.	Audit Questions
1.	Was the patient safety event reported on Datix
2.	Did the event met the DoC threshold?
3.	Was the patient or their family notified of the safety events at the earliest reasonable opportunity?
4.	Was an apology offered to the patient or their family?
5.	Was the patient or family offered a suitable solution or support to resolve the issue (if possible)?
6.	Was the patient or family made aware of any additional investigations or inquiries that will take place? (being it being declared as an SI)
7.	Was the patient or family provided with a contact from the HCJ to address any further questions or concerns?
8.	Was the patient or their family given an opportunity to ask questions and express concerns?
9.	Did the patient or their family receive reassurance that the lessons learned will help prevent this incident from reoccurring and causing harm to others?
10.	Was the initial communication and apology documented in the patient's records?
11.	Was a formal written notice given to the patient or their family, if required?
12.	Was the formal written notification completed within 10 working days?
13.	Were any cases escalated to the executive team for consideration of not carrying out the DOC?

Appendix 2: Incidental Findings Questions

No.	Question
1.	Did Q&S inform the patient or family that the SI was happening?
2.	Were the staff informed the SI was happening?
3.	Was the draft ToR for the SI investigation shared with the patient or their family?
4.	Did the patient or their family provide any feedback or suggestions on the ToR?
5.	If so, where is this reflected in the ToR? (free text)
6.	Did the patient or their family have any communication with the investigator?
7.	Were the findings of the investigation communicated to the patient and/or their family in an open and transparent manner?
8.	Were the findings shared with the staff team?

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