DUTY OF CANDOUR

VERSION No	2
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Policy statement

This is a requirement under the Fundamental Standards Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Put simply, candour means the quality of being open and honest. Candour can only work when it is part of a wider commitment to safety, listening and learning, with an organisational commitment to continual improvement. Care and treatment is not risk free and evidence heard at the Dalton review confirmed what was already known.

When things go wrong in health or care settings, families want to know three things:

- **To be told honestly what happened;**
- **What can be done to deal with any harm caused;**
- **To know what will be done to prevent a recurrence to someone else.**

The Duty of Candour applies to all Health and Social Care providers registered with the Care Quality Commission. *The Duty applies to all cases of "significant harm"* This new composite classification would cover the requirements of the reporting duty for NHS and Social Care Providers currently in place with the Care Quality Commission. These are:

- National Reporting and Learning System (NHS)
- Statutory Notifications (Social Care)

In Social Care this is the "Harm threshold", which is breached when a statutory notification is required to CQC.

Objectives

The objectives of this policy are to evidence that a robust risk management system is in place which reflects the following:

- A service user has a right to expect openness from their healthcare provider.
- The home will learn from mistakes with full transparency and openness.
- A proactive approach to resident safety with the onus on risk management systems and processes identifying incidents which require review and learning.
- Working in partnership with all stakeholders
- Staff do not intend to cause harm but unfortunately incidents do occur. When mistakes happen, residents / relatives / others involved, as appropriate, should receive an apology and explanation as soon as possible. Saying sorry is not an admission of liability and staff should feel able to apologise at the earliest opportunity.
- The home's incident and accident reporting procedure must be followed to ensure that appropriate support is offered to the resident / families / others involved, as appropriate, where a resident safety incident has occurred.
- Management understand that an individual or team might require support during the investigation and, after discussion, should provide appropriate support.

Compassion humanity and candour

The obligations and challenges of candour serve to remind us that for all its technological and forensic advances health and social care are still a deeply human activity. Systems and processes are necessary supports to good compassionate care, but they can never serve as its substitute.

- ***It follows from this that making reality of candour is a matter of hearts and minds more than it is a matter of systems and processes, important as they may be.*** A compliance focused

approach will fail. ***Organisations need to start from the simple recognition that candour is the right thing to do.***

- ***The commitment to candour has to be about values, rooted in the genuine engagement of staff, building on their own professional duties and personal commitment to residents.***
- *It is right to be clear about thresholds and enforcement but nothing will be gained if we lose sight of the fundamental purpose of candour, which is to do the right thing for all users of health and social care services.* Hence, the government's choice of a statutory duty sends an equivocal signal to the health and social care sector that this matters.

Definitions

Apology: a meaningful and sincere expression of sorrow or regret for any suspected harm caused. The guidance on making an apology sets out that saying sorry is not an admission of liability.

- **Being Open**: open communication of resident safety incident that result in harm or the death of a resident while receiving healthcare.
- **Death**: of the service user where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition
- **Duty of Candour:** both a contractual and statutory duty enforceable by the Care Quality Commission that requires providers to be open and transparent with the relevant person when a notifiable resident safety incident occurs in relation to the care provided.
- **Moderate Harm:** harm requiring a moderate increase in treatment (i.e. an unplanned admission hospital, a prolonged episode of care, etc.) and is significant but not permanent.
- **Notifiable safety incident:** any unintended or unexpected incident that occurred in respect of a service user that, in the reasonable opinion of a healthcare professional, could or appears to have resulted in the death of the service user (where the death relates directly to the resident incident rather than any underlying condition) or severe, moderate or prolonged psychological harm. This may be identified in the reporting of an incident, or the course of a complaint.
- **Prolonged psychological harm**: psychological harm that a servicer user has experienced, or is likely to experience, for a continuous period of 28 days or more.
- **Relevant person:** the service user / resident or, in the following circumstances a person acting lawfully on their behalf:
  - On the death of the service user
  - Where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
  - Where the service user is 16 or over and lacks capacity in relation to the matter.
- **Serious Incident:** Serious Incidents in health care are adverse events, where the consequences to residents, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
- **Severe Harm:** a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions that is directly related to the incident and not related to the natural course of the service user's illness or underlying condition.
- **Transparency:** allowing information about the truth about performance and outcomes to be shared with staff, residents, the public and regulators.

Being open

Being open relies initially on the home's staff and the rigorous reporting of Resident safety incidents. The home endorses the Francis Report Recommendation 173; "***Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with residents and the public, and organisational and personal interests must never be allowed to outweigh the duty to be open, honest and truthful.***'

Incident	Definition	Duty of Candour?	Action	Examples
No harm *(including prevented harm)*	An incident occurred where there was no harm / the potential for harm but none materialised.	**No**	Ordinarily, residents are not contacted where there has been a „no harm" or „prevented harm" incident.	A resident who has dementia often forgets that can no longer weight bear and thus tries to get up from an armchair and falls. The person has suffered no injury. Staff start using a sensor to warn staff that the person may be trying to get up and is at risk of fall and perhaps harm. The sensor is used to prevent the risk of harm.
Low harm	Defined as: "***Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons***".	**No**	Low harm incidents should be dealt at the home, applying the principles of being open to include a discussion with the resident by those providing the care.	In an assisted transfer to the ambulance, a resident stumbles and hits their leg on the end of the trolley bed sustaining a bruise.
Moderate harm	In accordance with Regulation 20 this is defined as: "***harm requiring a moderate increase in treatment (i.e. a prolonged episode of care, or transfer to a hospital) and is significant but not permanent***".	**Yes**	Follow process described Appendix 1	A resident is found collapsed on the floor, there is a delayed diagnosis of his clinical condition including a suspected fractured femur, as a result an appropriate transfer was not conducted exacerbating the fracture which saw the resident undergo a prolonged hospital stay.
Severe harm	In accordance with Regulation 20 this is defined as: "***a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions that is directly related to the incident and not related to the natural course of the service user's illness or underlying condition***".	**Yes**	Follow process described Appendix 1	A resident who has fallen from bed. The resident is conscious but lying awkwardly, with a leg that is clearly fractured and twisted. Before carrying out a full assessment or immobilising the cervical spine, staff reposition the resident to straighten the leg. After repositioning, the resident is unable to move any of their limbs, and later investigations identify that they have a cervical fracture and spinal cord damage. The spinal cord was, however, immobilised immediately after repositioning. The resident is left with long-term paralysis from the neck down.
Death	In accordance with Regulation 20 this is defined as: "***where the death relates directly to the resident incident rather than any underlying condition***".	**Yes**	Follow process described Appendix 1	⚠ A window in a resident's room does not have a window restrictor. As a result, the resident falls out of the window from the second floor and dies. ⚠ A bottle of bleach is left in a communal toilet. A resident with dementia finds it, drinks the bleach and dies
Prolonged psychological harm	Under the duty of Candour this is defined as: "***psychological harm that a service user has experienced, or is likely to experience, for a continuous period of 28 days or more***".	**Yes**	Follow process described Appendix 1	A complaint is received which sets out how the elderly resident continues to have panic attacks and flashbacks of an incident 2 months after waiting 4 hours for an ambulance to attend following a fall.

DUTY OF CANDOUR: ACTION FLOW CHART

APPENDIX 1

As soon as an incident occurs

- Provide immediate support and assistance to the resident and any staff affected by the incident.
- Record incident
- Undertake any necessary risk assessment and removed immediate risks
- Discuss next steps with manager define Duty of Candour roles.

Within 10 working days of incident being reported

- Notify resident that the incident has occurred and establish whether resident consents to share information with family /

NOTIFICATION MUST:

- Be verbal
- Be conducted in person
- Be conducted by the Manager
- Provide all facts currently known about the incident
- Include an appropriate and sincere apology
- Be supplemented by a written notification
- Be recorded in writing

Within 28 days of the incident being reported

- **Manager to conduct investigation**
- **Offer regular update to resident / representative during the course of the investigation and provide appropriate support to resident and staff.**
- **Maintain full written records of any meeting or other contact with the relevant person in relation to the incident**
- **Record any refusal by the resident / representative of a meeting or other contact or information in relation to the incident**

Within 10 working days of investigation being closed by the Responsible Person

- **Offer to provide the resident / representative with the findings of the investigation report**
- **Discuss and sign-off by manager**
- **Provide copy of investigation together with Duty of Candour / apology letter.**

The following table sets out whether the Being open principles or the Duty of Candour requirements should be applied to a resident safety incident.

LEVEL OF HARM TO RESIDENT	PROCESS TO FOLLOW
No Harm	Ordinarily residents are not notified of a no harm incident. However, the investigating manager will need to exercise discretion as to whether such events are discussed with the resident dependent upon the circumstances.
Low Harm	Principles of Being Open and the Being Open Procedure
Moderate, severe, prolonged psychological harm or death	Duty of Candour Procedure

Overview of Being Open Process

<table>
<tr><th>Incident detection or recognition</th><th>Preliminary team discussion</th><th>Initial Being Open discussion</th><th>Follow-up discussions</th><th>Process completion</th></tr>
<tr><td rowspan="2">Detection and notification</td><td rowspan="2">Initial assessment</td><td>Verbal and written apology</td><td rowspan="2">Provide update on known facts at regular intervals</td><td>Discuss findings of investigation and analysis</td></tr>
<tr><td>Provide known facts to date</td><td>Inform on continuity of care, treatment and support</td></tr>
<tr><td rowspan="3">Prompt and appropriate care, treatment and support to prevent further harm</td><td>Establish timeline</td><td>Offer practical and emotional support</td><td rowspan="3">Respond to queries</td><td>Share summary with relevant people</td></tr>
<tr><td rowspan="2">Choose who will lead communication (i.e. manager, deputy manager, nurse in charge)</td><td>Offer practical and emotional support</td><td>Monitor how action plan is implemented</td></tr>
<tr><td>Identify next steps for keeping relevant person informed</td><td>Communicate learning with staff</td></tr>
<tr><td colspan="2">DOCUMENTATION</td><td colspan="2">PROVIDE WRITTEN RECORDS OF ALL BEING OPEN DISCUSSIONS</td><td>RECORD INVESTIGATION AND ANALYSIS RELATED TO INCIDENT</td></tr>
</table>

Stage 1: **Resident safety incident detection or recognition:** This covers how resident safety incidents are identified; the prompt and appropriate care and prevention of further harm; and who to notify about the resident safety event.

Stage 2: **Preliminary team discussions:** This covers the preliminary team discussion to establish the basic clinical and other facts; undertaking the initial assessment to determine the level of response required; the timing of the discussion with the resident, their family and carers; and choosing who will be the lead in communicating with the resident, their family and carers

Stage 3: **The initial Being open discussion:** This covers the content of the discussion and what

should not occur: speculation, attribution of blame, denial of responsibility and provision of conflicting information from different individuals.

Stage 4: **Follow-up discussions:** This covers the subsequent discussions with the resident, their family and carers.

Stage 5: **Process completion:** This covers repeating the apology; providing feedback on the findings of the investigation into the resident safety incident; what the organisation will be doing to prevent recurrence. The investigation report has to be shared with the resident or family within 10 working days of approval and sign off by the Trust. It should include provision of an ongoing care management plan (if appropriate) and communicating with relevant community care providers and commissioners what has happened. This will also include monitoring how the recommendations have been implemented and communicating with staff the recommendations to spread the learning.

Duty of Candour Procedure

In accordance with Regulation 20 of the Regulations the home must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users when carrying out its services.

There are specific requirements that must be met when a notifiable safety incident occurs (refer to Appendix 1).

- As soon as reasonably practicable, and at most within 10 working days of a notifiable safety incident being identified, the home must inform the Relevant Person that a suspected or actual notifiable safety incident has occurred (the initial notification). If the home is not able to meet the 10 working days the reason for this must be recorded.
- The Initial Notification:
  a) As soon as reasonably practicable, and at most within 10 working days of a notifiable safety incident being identified, the manager or deputy manager must inform the Relevant Person that a suspected or actual notifiable safety incident has occurred (the initial notification) in person
  b) The manager or deputy are responsible upon notification of a potential notifiable safety incident
  c) Best practice is to contact the Relevant Persons in person or by telephone to arrange the initial-notification meeting.
  d) Regulation 20 provides that the initial notification must be given in person to the Relevant Person and:
     - provide a full account of the facts as known
     - set out what further enquiries the home believes to be appropriate,
     - provide an Apology, and
     - provide reasonable support to them in relation to the incident. Consideration must be given to what support should be offered to the Relevant Person when providing the initial notification.
     - follow up the initial notification in writing
     - ensure that the needs of the Relevant Person are identified in order to that no-one will be disadvantaged in any way
     - be responsible for keeping the Relevant Person up-to-date with the progress of the investigation and ensure that factual feedback is given to the Relevant Person at the earliest opportunity. No communication errors should arise by giving unsubstantiated facts as this can create anxiety.
     - Where a notifiable safety incident, or reportable incident is identified in accordance with the procedures set out in Policy and Procedure, the relevant notification must be made and the home must co-operate in required investigation
  e) Failure to comply: the implications
     - The home aims to promote a culture of openness and recognises that staff do not intend to cause harm but unfortunately incidents do occur.
     - When mistakes happen, service users, or their representative if appropriate,

should receive an apology and explanation as soon as possible.

- The failure to do so can negatively affect the service user or their representative and can limit the extent to which the home can learn from the incident.
- Alongside the implications for the service user, a failure to provide the four elements of the initial notification to the Relevant Person is a breach of 20(2)a and 20(3) of the Regulations which can result in a criminal prosecution being brought by the CQC.
- In addition, a failure to comply with the Duty of Candour can see the Commissioner fine the home the cost of the episode of care, or if unknown, up to £10,000.

f) Learning and reporting:

- All learning from the incidents will be communicated and discussed with the whole organisation
- Policies and procedures may be amended and discussed with staff on staff meetings
- Training if necessary, will be provided
- The management will ensure that where appropriate details are shared with any other healthcare organisation or relevant stakeholder.

Principles Specification:

- **The Principles of Being open:** Being open involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the resident and their family informed as part of any subsequent review.
- **Principle of Acknowledgement:** All resident safety events should be acknowledged and reported as soon as they are identified. In cases where the resident, their family and carers inform healthcare staff that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. The home recognises that denial of a person's concerns or defensiveness will make future open and honest communication more difficult.
- **Principles of Truthfulness, Timeliness and Clarity of Communication Information** about a resident safety incident must be given in a truthful and open manner by the manager or the deputy. Communication should also be timely, informing the resident, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place and that they will be kept up to date. Residents, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.
- **Principle of Apology:** Residents, their families and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a resident safety event or that the experience was poor. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Both verbal and written apologies should be given. *Saying sorry is not an admission of liability and it is the right thing to do*. Verbal apologies are essential because they allow face to face contact, where this is possible or requested. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the resident safety event, will also be given.
- **Principle of Recognising Resident and Carer Expectations:** Residents, their families and carers can reasonably expect to be fully informed of the issues surrounding a resident safety incident, and its consequences, in a face to face meeting with representatives from the organisation and / or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Residents, their families and carers should also be provided with support in a manner to meet their needs. This

may involve an independent advocate or an interpreter.

- **Principle of Professional Support:** The home has set out to create an environment in which all staff are encouraged to report resident safety events. Staff should feel supported throughout the resident safety event investigation process; they too may have been traumatised by the event. Where there are concerns about the practice of individual staff and reason to believe a member of staff has committed a punitive or criminal act, where appropriate, a referral will also be made to the Independent Safeguarding Authority and if necessary the police.

- **Principle of Risk Management and Systems Improvement Root Cause Analysis:** or similar techniques should be used to uncover the underlying causes of resident safety events. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness. Being open is integrated into resident safety incident reporting and risk management policies and processes.

- **Principles of Multi-Disciplinary Responsibility:** Being open document applies to all staff who have key roles in resident care. This is reflected in the way that residents, their families and carers are communicated with when things go wrong. This ensures that the Being open process is consistent with the philosophy that resident safety incidents usually result from system failures and rarely from actions of an individual

- **Principles of management responsibility and accountability:** Being open involves the support of resident safety and quality improvement through the home's governance framework, in which resident safety incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is a system of accountability to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to staff so they can learn from resident safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a resident safety incident.

- **Principle of Confidentiality:** Details of a resident safety incidents should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the resident. Communications with parties outside of the incident lead and those involved in the investigation will be on a strictly need to know basis and, where practicable, records are secure and anonymised where released. Where possible, it is good practice to inform the resident, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections. Principle of Continuity of Care the home acknowledges that residents are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.

Summary

- Every healthcare professional must be open and honest with residents and have, since November 2014, had a statutory Duty of Candour.
- Candour is defined by Robert Francis as: *'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made*'.
- The Being Open principles and ethical duty of openness apply to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, significant harm or death has occurred.
- It is a matter of judgment that needs to be exercised on a case by case basis to determine whether an incident that meets the Duty of Candour criteria has occurred. What may not appear to be such an incident at the outset may look very different once more information comes to light, and may therefore lead to an incident becoming notifiable under the Duty of Candour.
- The requirements of the Duty of Candour are as follows: As soon as reasonably

practicable after becoming aware that a safety incident has occurred that falls into the moderate harm or more serious categories the healthcare professional must:

(a) notify the 'relevant person' (this is usually the resident but may in some circumstances be the relative, carer or advocate) that the incident has occurred and;
(b) provide reasonable support to the relevant person in relation to the incident.

⚠ The notification must:

(a) be given in person by one or more members of staff;
(b) provide an account of all the facts known about the incident to date;
(c) advise the relevant person what further enquiries into the incident will be undertaken;
(d) include an apology and/or a sincere expression of regret, and;
(e) be recorded in writing in the notes.
(f) This notification must be followed up in writing to the relevant person.

⚠ The member of staff should be clear in the first meeting that the facts may not yet have been established, tell the relevant person only what is known and believe to be true, and answer any questions honestly and as fully as they can.

⚠ The aim of the Duty is to ensure that residents are told when harm occurs as a result of the care they receive. Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must be notified.

All Staff Procedure

- All employees must understand their duty for being open and must demonstrate the principles of being open in their work.
- All employees who become aware of an incident or near miss having occurred must follow the Home's Incident Reporting Policy and apply the principles of being open and the Duty of Candour throughout these processes.
- All employees dealing with residents or relatives should abide by the home's complaints procedure and advise who residents or relatives should write to if they wish to formalise a complaint.
- Employees who are concerned about the non-reporting or concealment of incidents, or about on-going practices which present a serious risk to resident safety, must raise their concerns either through established procedure i.e. **Social Care Direct 03456 080191 (safeguarding) or CQC 03000 616161**.
- It is very rare for staff in healthcare to go to work with the intention of causing harm or failing to do the right thing. While we do all we can to minimise risks, it will never be possible to eliminate them fully. It should be acknowledged from the outset that many 'human factors' can increase the risk of incidents occurring such as:
  - ⚠ Workload
  - ⚠ Distractions
  - ⚠ Physical environment
  - ⚠ Physical and psychological demands

  and that it is uncommon for any single action or 'failure' to be wholly responsible. The focus following an incident should always be on learning and prevention rather than individual blame.
- **Being Open and Duty of Candour Processes:** Most Managers will find themselves in the difficult position of having to discuss harm or potential harm with a resident at some time in their career. The following guidance provides a framework for staff to work to. It is recognised however, that many scenarios do not always follow predetermined processes, and staff must use their own professional judgement in deciding, for example, when is the right time to talk to residents and families / representatives. There is no substitute for professional expertise and compassionate care.
- A summary of the stages involved in this process is provided in appendix 2 together with a sample template letter appendix 3 and flow chart of stages in appendix 1.

Brief Summary of the Stages in the Duty of Candour Process		*Appendix 2*
Requirement under Duty of Candour	**Responsible Person**	**Timeframe**
For incidents where moderate or serious harm or death has occurred, the relevant person must be informed.	The registered manager / deputy manager	As soon as possible after the incident has been detected and reported but always within 10 working days of the incident
Initial notification of incident must be verbal (face-to-face, where possible) unless the relevant person declines notification or cannot be contacted in person. Sincere expression of regret or sorrow must be provided verbally. This must be recorded in the notes.	As above	As above.
Step-by-step explanation of the known facts must be offered to the relevant person.	As above	As above
Written notification to the relevant person. The written notification should outline the facts discussed at the notification meeting and include a sincere expression of regret or sorrow.	As above. All letters must be approved by the Registered Manager	As above (*template letter available for guidance only – all letters must be personalised and tailored to the individual needs of the person receiving the letter*)
Maintain full written documentation of any meetings. If meetings are offered but declined this must be recorded	As above. All follow-up letters to residents/ relatives to be approved for release by the Registered Manager	
Share incident investigation report (including action plans) with an accompanying letter.	Investigating person. Letter to be approved by Registered Manager	As soon as reasonably practicable but always within 25 working days of report being signed off as complete.

Guidance letter template for initial communication letter in accordance with requirements of Duty of Candour. (Appendix 3) (*This is provided purely for guidance. All letters must be personalised and tailored to the individual needs of the person receiving the letter****)***

Date

Dear _____,

Re: _____

I am writing to express my sincere regret that (you / your relative _____) has been involved in an incident whereby (describe event here) _____.

At Bendigo Nursing Home we are committed to being open with residents and relatives when events such as these occur. We wish to gain and share understanding of what had happened, and what we can do to prevent such an incident occurring again in the future.

An investigation is already underway to try and establish the cause of the incident. If you would like to meet with me or a member of staff to discuss this, please let me know within the next two weeks, and we will arrange a mutually convenient time and place to meet.

There is an independent advocacy service available to support and assist you in this who can be contacted on _____.

I will be acting as your lead contact for the duration of the investigation. Should you wish to discuss this or any other matter further, please do not hesitate to contact me on: 01323 64 25 99 or via email at: mariana@kindcare.co.uk

Thank you very much

Yours sincerely

Training Statement

The management is fully aware of this legal duty and it will be incorporated in to Induction and a separate briefing will be in place for all managers involved in good governance within their job role. All staff will be made aware of this policy and understand will lead to disciplinary process where a culture of openness and accountability is circumvented by intent.

Related Policies

Accessible Information and Communication
Dignity and Respect
Good Governance
Notification