Department: Supported Living

Title: Duty of Candour Policy

**Scope:** This policy outlines the understanding of the Duty of Candour and the approach taken by Care Stream in relation to this.

**Document owned by:** Care Stream Limited

**Implementation date:**

**Review date:**

**Next review date:**

Please note: for service users please read as individual(s) or people we support

**Authors:**

## POLICY & PROCEDURES DUTY OF CANDOUR

##### Policy statement

This is a new 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 are not risk free and evidence heard at the Dalton review confirmed what was already known.

#### Introduction

Duty of Candour is a legal requirement. It places a formal obligation on providers

of Health and Social Care to be open and honest with their patients when they suffer

moderate harm or above (see definitions) related to their care or treatment provided by Care Stream.

#### 2 Purpose

This policy has been developed to ensure a simple and robust processes in respect to the implementation of Duty of Candour and to ensure that openness, transparency and candour are complied with.

#### Scope

This policy applies to all Health and Social Care staff working within Care Stream, including those employed on a bank, agency or locum basis.

There is a statutory of Duty of Candour on registered healthcare professionals to inform their employer where they believe or suspect that treatment has caused death or serious injury and it is a criminal offence for any healthcare professionals to fail to do so.

#### Process for Implementing Duty of Candour

All staff must ensure that any service users’ safety incident is reported as soon as possible after making the service users’ situation safe.

If the service user has suffered an injury or incident whilst receiving Social Care thought to be due to a lapse in care, that is of a level of moderate harm

or above, the team leader/ manager/ relevant other must speak to the service user and offer an apology and explain the event will be investigated and an investigating officer identified.

Subsequently, should the event, upon investigation be found to be due to a lapse in care, the Duty of Candour must be followed.

The investigating officer will ask what specific questions the service user wants answering, be a formal contact point and ask how they would like the investigation to be fed back

to them e.g. via a meeting or by sending a copy of the investigation to them.

This will be followed up with a letter sent to the patient/service user – Appendix A and appendices thereafter are templates that can be modified to accurately reflect the

situation and Care Stream response. These letters must be saved in the Duty of Candour folder referencing the corresponding incident.

* If the service user has suffered severe permanent disability, death or lacks capacity – Duty of Candour will be implemented by the investigating lead as a part of the serious incident process through the Next Of Kin (NOK) or Legal Guardian (LG).
* If the service user does not wish to be part of the investigation or Duty of Candour process (the patient has capacity), then a letter confirming the discussion should be completed (Appendix B) and sent. These letters must be saved in the Duty of Candour folder referencing the corresponding incident.
* Similarly, if the service user lacks capacity and the NOK or LG does not wish to

be part of the investigation or Duty of Candour process then a letter confirming the discussion should be completed (Appendix B) and sent. To be saved in the Duty of Candour folder referencing the corresponding incident.

If the service user/carer is not satisfied with the outcome of the investigation, they should be offered local resolution via further communications. However, it is the right of the service user, should they wish to, to lodge a complaint via the normal processes.

If more clarity on a specific incident is needed re the harm level, outcome etc., then a meeting with the Clinical Lead and Director of Operations should be convened and the proceedings recorded and attached to the incident recorded.

Please note: All Duty of Candour documentation sent to the service user/carer must be in a format which is easy to understand, free from medical jargon and acronyms.

##### Notifications and reporting

Notify the relevant people that the incident has occurred e.g. family, next of kin, advocate and any other professionals involved.

The harmed person is informed of the incident and support is provided where appropriate.

Record the incident and details of the incident is provided that are factual, true and including the date of the notification.

Advise them of the relevant steps or actions which are to be taken including the apology.

The notification must be sent in writing and confirming all the above points.

If the person declines to engage in the process, this should be recorded and include the attempts to engage with them

#### Process for Monitoring Compliance and Effectiveness

Monitoring of the implementation of this procedure will be through incident management, incident reviews and quality assurance audits.

1. **Definitions**

* Harm Levels

**Moderate**, Any unexpected or unintended incident that resulted in a moderate increase in treatment e.g. continuous prolonged pain or psychological harm likely to last more than 28 days, an unplanned return to theatre for corrective surgery, an unplanned admission, a prolonged

episode of care, cancelling of treatment, or transfer to another area (e.g. such as Intensive Care), and which caused significant but not permanent harm, to one or more persons receiving funded care.

**Severe** Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

**Death** Any unexpected or unintended incident that directly resulted in the death of one or more persons.

In this regulation: “Apology” means an expression of sorrow or regret in respect of a Notifiable

safety incident.

“Notifiable” means to an external regulator e.g. Care Quality Commission, Health and Safety Executive. Separate guidance is to be issued with regard to this Regulation and this policy will be reviewed and amended in publication of further guidance.

**Related Policies** Good Governance Notifications

##### Training Statement

The management need to be fully aware of this legal duty and it will be incorporated into inductions 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 it may lead to disciplinary process where a culture of openness and accountability is circumvented by intent.

# \*\*THIS IS A TEMPLATE LETTER - PLEASE AMEND AS APPROPRIATE\*\*

*(Insert name & address)*

Dear *(Insert title & name)*

As part of Care Stream’s ongoing work to monitor all service user safety incidents, we are reviewing an episode of care relating to you/your *[insert relationship and name]* care at Care Stream on *[insert date or interval range if not known].*

On behalf of Care Stream, I am sorry that this incident occurred and for the distress caused to you and your family as a result.

This outcome was not what was expected and, as Care Stream, we are committed to being open with our service users and carers when events such as this occur, and in undertaking a robust review so that we gain a shared understanding of what happened.

My reason for writing to you now is to explain how the review will proceed and to ascertain if, and how, you would like to be involved in the review, in the feedback of the results and any actions arising.

***Either***

I am aware that a member of the Senior Management Team *[insert name and role of the team member]* has already discussed the incident with you *[delete if not appropriate]* ***Or***

Staff member, *[insert name]*, is acting as your lead contact for the duration of the review. He/She can be contacted by email at *[insert email address],* or on telephone number *[insert number].*

The incident involving you/your *[insert name]* has been recorded on Care Stream incident reporting system and a review has started. The review will seek to identify the circumstances which resulted in the incident, together with any other contributing factors. You may have some specific questions you would like to be included in the review.

If you have not already had the opportunity to put forward any questions, please contact *[insert name]* as soon as possible to discuss them.

Please also indicate how you would like us to feedback our findings to you. Yours sincerely

Appendix b

# \*\*THIS IS A TEMPLATE LETTER - PLEASE AMEND AS APPROPRIATE\*\*

*(Insert name & address)*

Dear *(Insert title & name)*

I am writing to follow up on the conversation we had on *[insert date]* when you agreed you were satisfied with the explanation provided and declined to be part of a review and the Duty of Candour process.

Again, I would like to express my sincere apologies that you/ your *[insert relationship/name]* has been involved in a service user safety incident whereby *[provide appropriate factual details here]*.

At Care Stream, we are committed to being open with patients and carers when events such as these occur so that we gain a shared understanding of what happened and what we can do to prevent such an incident occurring again in the future.

The incident involving you*/[insert name]* has been recorded on Care Stream’s incident reporting system and a review has started. Care Stream will continue to review the occurrence of incidents to ensure any learning can be shared and changes made.

If you would like to meet with 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.

Staff member *[insert name]* is acting as your lead contact for this incident and s/he can be contacted by email at *[insert email address]* or on telephone number *[insert number].*

Yours sincerely

Appendix C

# \*\*THIS IS A TEMPLATE LETTER - PLEASE AMEND AS APPROPRIATE\*\*

*(Insert name & address)*

Dear *(Insert title & name)*

I am writing to let you know that we have now conducted the review, which is known as a Root Cause Analysis, into *[give details of the incident].*

### Either

As discussed earlier, we have arranged to meet on *[insert date & time]*. The meeting will be taking place at *[insert venue]*. I would be grateful if you could contact *[insert name]* on telephone number *[insert number],* email *[insert email address]* or at the address above to confirm that you are still able to attend. *[insert name]* can also explain who will be present at the meeting. You may also wish to consider whether you would like to bring a friend or family member with you.

### Or

I would therefore like to invite you/your *[insert relationship/name]* to meet with me to discuss the findings of the review and would be grateful if you would contact *[insert name]* on telephone number *[insert number],* at email *[insert email address]* or at the above address, so that we can organise an appropriate day, time & venue should you wish to meet. *[insert name]* can also explain who would be present at the meeting.

You may also wish to consider whether you would like to bring a friend or family member with you.

If, however, you do not wish to attend a meeting, I can arrange for the final report to be sent directly to you.

Finally, on behalf of myself and the staff at Care Stream, we are very sorry for any suffering and distress caused as a result of this incident.

I wish to assure you that we have learnt from the events surrounding your / *[insert name]*

care and have agreed / or are in the process of changing *[insert relevant information here].*

Yours sincerely

##### The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person’s ability to make a decision due to ‘an impairment of or

disturbance in the functioning of the mind or brain’ the practitioner must implement the Mental

Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

## “The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual’s right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make

**decisions to protect themselves”. (3)**

All staff can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists online. If you are in doubt speak with your manager.