group policies and procedures

# duty of candour policy

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| Category | Corporate Governance |
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| Responsible Director | Dr Dominic Hennessy |
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**Related policies and guidance**

**Document revision and approval history**

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# INTRODUCTION

THE DUTY OF CANDOUR is a statutory (legal) duty to be open and honest with patients (or ‘service users’), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England. GPs already have a professional Duty of Candour, but this duty is now extended to the organisation as well as individuals.

# castleman healthcare ltd duty of candour

Castleman Healthcare Ltd should act in an open and transparent way:

1. With relevant people
2. In relation to care and treatment provided
3. To service users
4. In performing a regulated activity

After becoming aware that a notifiable safety incident has occurred, Castleman Healthcare Ltd must:

1. Notify the relevant person as soon as is reasonably practicable (suggested timescale is 10 days)
2. Provide reasonable support, such as an interpreter or emotional support if needed.

The notification must:

1. Be given in person by at least one representative of Castleman Healthcare Ltd, and followed by a written notification.
2. Provide a true and accurate account of the incident
3. Provide advice on what further enquiries into the incident are required
4. Include an apology
5. Be recorded in a written record, which should be kept securely.

# What kind of incidents are covered by the duty of candour?

The regulations for registration with the CQC place an over-arching responsibility on health and social care organisations to be open and transparent.

There are two meanings of a **notifiable safety incident** stated in the Regulations – one for a health service body and one for registered persons (i.e. GPs).

To quote from the Regulation:

“In relation to a registered person who is not a health service body, ‘notifiable safety incident’ means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional –

1. Appears to have resulted in
	1. The 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,
	2. An impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
	3. Changes to the structure of the service user’s body,
	4. The service user experiencing prolonged pain or prolonged psychological harm, or
	5. The shortening of the life expectancy of the service user, or
2. Requires treatment by a health care professional in order to prevent –
	1. The death of the service user, or

Any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).”

**What is harm?**

Harm is defined as prolonged psychological pain or prolonged pain, in both cases where the service user has experienced, or is likely to experience, this for a continuous period of at least 28 days.

# Castleman Healthcare Ltd Process

1. When a notifiable safety incident occurs, this should be raised with the Manager(s) and/or Senior Partner where the service is being delivered and to the Clinical Governance Director at Castleman Healthcare Ltd. All staff are encouraged to be open and honest about mistakes, and to share these with the team.
2. The incident will be discussed as a Significant Event, and the Duty of Candour section actioned as appropriate. In order to respond in a timely manner to the person affected, this incident may be discussed outside of a scheduled Significant Event meeting. There is a Duty of Candour Recording Form to complete in order to record the various steps taken, and ensure full compliance with the requirements of the Regulation (see appendix).
3. The incident will also be reported to the National Reporting and Learning system using the link <https://report.nrls.nhs.uk/GP_eForm>. CQC also have a requirement to be informed of certain significant events or incidents –notifications can only be made by registered persons, i.e. the Partners and Practice Manager (see appendix) and Governance Director at Castleman healthcare Ltd.
4. The Governance Director will identify the most appropriate person to contact and notify the person affected.
5. The same person will produce the written follow-up letter, which will be accompanied by a cover letter from Governance Director.
6. The Castleman Healthcare Board will support the team member involved in the notification. This can be through in-house support / discussion or via Occupational Health if necessary.
7. If a member of the team has a concern regarding a notifiable safety incident having occurred but not been reported to the Board or Practice Manager(s), they can raise this under the Whistleblowing Policy.

# Confidentiality

The principles of confidentiality and information governance should be applied to the being open process to ensure appropriate information sharing whilst protecting personal information.

Details of any incident are at all times to be considered confidential. Any disclosures beyond those staff involved should be on a strictly need to know basis e.g. as part of an investigation. Only anonymous data about incidents is disseminated beyond the healthcare professionals and investigating team. It is best practice to inform the affected person about who will be involved in the investigation and give them an opportunity to object.

# Communication to the persons affected in the incident;

Following completion of the investigation, feedback to those involved should take the form most acceptable to them. Whatever method used the communication will include:

1. reference to the chronology of clinical and other relevant facts;
2. reference to details of any concerns and complaints raised;
3. an apology for the harm suffered and any shortcomings in the delivery of services;
4. a summary of the factors that contributed to the incident;
5. information on what has been and will be done to avoid repetition;
6. how these improvements will be monitored.

# Appendix

CQC notifications are required for:

1. Death of a person using the service if that death occurs whilst the regulated activity is being provided or within 2 weeks of that regulated activity having been provided if death was or may have been as a result of that activity and the death is not attributable to the course that illness or medical condition would have taken under usual treatment.
2. Serious injury of a person whilst regulated activity was being provided
3. Abuse or allegations of abuse (also notify appropriate safeguarding persons locally and police, if appropriate)
4. Incidents reported to the police
5. Events that stop the practice from being able to run safely and properly, such as issues with infrastructure, equipment, premises etc.
6. Change to practice partnership or other named individuals.

# appendix - Contacts

1. **Care Quality Commission (CQC)**

The CQC is the independent regulator of health and adult social care organisations in England and is responsible for monitoring compliance with standards such as the duty of candour. The CQC has legal powers to take action against organisations who do not comply.

Tel: 03000 61 61 61

Full regulations themselves and the CQC guidance for organisations on how to comply at:

[www.cqc.org.uk/duty-candour](http://www.cqc.org.uk/duty-candour)

1. **Dorset CCG Duty of Candour Policy**

Click here for this [Duty of Candour and Being Open Policy](https://www.dorsetccg.nhs.uk/wp-content/uploads/2018/04/Duty-of-candour-policy.pdf)

1. **Dorset Advocacy**

Patients, their families and carers may need considerable practical and emotional help and

support after experiencing a patient safety incident. The most appropriate type of support

may vary among different individuals, it is therefore important to discuss their needs. Support may be provided by patients’ families, social workers, religious representatives and healthcare organisations such as Independent Complaints Advocacy Service (ICAS). Support for those who have no other social support and who lack full capacity is also provided through Independent Mental Capacity Advocacy (IMCAs). Dorset Advocacy is the independent provider for Dorset residents requiring ICAS or IMCAs and can be contacted at **Dorchester Office:** Unit 13-15, Jubilee Court,

Paceycombe Way, Poundbury DT1 3AE. Phone: **01305 251033;** Fax: **0843 8492689** Email: enquiries@dorsetadvocacy.co.uk

1. **Action against Medical Accidents (AvMA)**

AvMA is the charity for patient safety and justice, providing free specialist advice and support to people when things go wrong in healthcare. Helpline: 0845 123 2352 [www.avma.org.uk/help-advice](http://www.avma.org.uk/help-advice)

# appendix - Duty of Candour Reporting Form – part a

**Part A – to be completed by the person reporting the Significant Event then sent to Practice Manager and Governance Director at Castleman Healthcare Ltd for SUI Risk Assessment and before discussion at any meetings.**

|  |  |
| --- | --- |
| **Date of Event** |  |
| **Reporting Date** |  |
| **Person Reporting** |  |

|  |
| --- |
| **Type of Event (please indicate)** |
| Clinical  | Non-Clinical |
| **Person Involved** |
| Patient | Doctor | Nurse | Receptionist |
| Admin Staff | Visitor | Other NHS Staff  |
| Other – please specify |
| **Category of Event (please indicate)**  |
| Duty of Candour Issue  | Equipment/System Failure | Accident Injury | Violence |
| Security Incident | Confidentiality Breach | Attitude of Staff | Death |
| Drug Error | Clinical Judgement | Patient Safety | Communication |
| Physical/Verbal Abuse | Harassment | Primary/Secondary Care Breakdown | Emergency Admission |
| Other – please specify |
| Was the incident preventable? | Yes | No |
| **Signed** | **Print Name** |

# appendix - duty of candor form - Significant Event Analysis

**Nature of Event – Please complete all necessary additional information in this section and continue on additional page if necessary.**

|  |
| --- |
| Patient identifier:  |

Email to service Practice Manager and Governance Director. **NB – if the category of event was related to abuse or harassment please email immediately on completion.**

|  |  |
| --- | --- |
| Date received by Practice Manager  |  |
| Date received by Castleman Governance Director  |  |
| **For completion by Governance Director** |
| Risk Assessment Required | Yes | No |
| If yes, date completed  |
| Outcome of RA | Likelihood, risk | Severity |
| SUI?  | Yes | No  |
| If no, date returned for Part B | If yes, date completed  |  |
| Comments |  |  |
| Date reported to LAT |  |  |

# appendix - Duty of Candor Form – Part B Significant Event Analysis

**Part B to completed at Significant Events Meeting following discussion by all parties concerned**

|  |  |
| --- | --- |
| Date of Meeting | Lead Person |
| **Perceived root cause (can tick more than one)**  |
| No cause identified | Human error | Lack of training/education |
| Communication | System/Process Failure | Equipment Failure |
| Poor Compliance/Expectation |  |  |
| Other – please specific |  |  |
| **Severity Score:**  |
| 1. Death or serious injury has occurred
 |
| 1. Where possible serious harm to the patient/staff could have taken place, i.e. near miss
 |
| 1. Where clinical care could have been improved
 |
| 1. Inconvenience to patient/staff
 |

|  |  |  |
| --- | --- | --- |
| **Action to be taken/general discussion** | **By whom?** | **By when?**  |
|  |  |  |

|  |
| --- |
| **Outcome of Events (more than one box can be ticked)** |
| Innovative ideas | Guidelines/protocols | Patient information leaflet |
| Introduction of new service | Better communication | Evaluation of staff |
| Risk Assessment | Other – please specify |

**Review Date**

**Name & Signature**