

Duty of Candour (England) Policy

Policy Reference:	<i>A36 (Previously AH5)</i>
Version Number:	3
Applies to:	<i>All care home, residential college and domiciliary care staff.</i>
Associated documents:	
Approved by:	<i>Quality Team</i>
Implementation date:	<i>April 2023</i>
Next review due by:	<i>April 2025</i>
<i>This policy has been reviewed to ensure it promotes safeguarding and does not present barriers to participation or disadvantage any protected groups</i>	

1. Introduction

1.1 Purpose

The policy sets out the approach of this care service to meeting its statutory requirements to be open and transparent with its service users if it makes mistakes when providing care and treatment that result in their suffering moderate or serious harm.

1.2 Legal Framework

These are situations that must be notified to the Care Quality Commission under Regulation 18 of the Care Commission (Registration) Regulations (as amended in 2015) “Notification of Other Incidents” and trigger a formal requirement to exercise a duty of candour as defined in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. Policy Statement

This service understands that it must always act in an open and transparent way with service users and the people closely involved in their care. This is reflected in our Statement of Purpose and our approach to leadership and management and in all of the service’s relationships with its users and others involved in their care and treatment.

The service understands that it owes a duty of candour particularly when things go wrong with service users’ care and treatment. Thus it recognises that whenever an incident has occurred, which must be notified to the Care Quality Commission (CQC) (under Regulation 18 described above), it must also carry out the following actions.

The registered person, registered manager or a suitable person in authority acting on behalf of the registered person or registered provider will (in addition to notifying the CQC):

- › be open with the service user and other relevant persons about the incident
- › provide suitable support to the service user and others affected by the incident
- › explain directly and in person to the service user and/or their representatives exactly what has happened
- › apologise, for example express sorrow and regret for what has happened
- › say what is being done to investigate and learn the lessons from what has happened and further actions that might be taken
- › undertake to put in writing what has happened and the apology
- › keep full records of the incident, including all associated correspondence and the actions that have been taken to carry out the duty of candour with the service user and/or representatives.

Where the person has given consent to their care and support the above actions will be directed at them personally and to others with their agreement. Where the person has been unable to give their consent to their care because of mental incapacity the actions will be followed through communication with their lawful representatives with the expectation that the service user will be involved as much as possible.

The service understands that the incidents to which a specific duty of candour is owed (as opposed to the general duty to act openly and transparently) are those described in the duty

of candour Regulation 20.9, i.e. unintended or unexpected incidents that might occur in the delivery of the care service that: “in the reasonable opinion of a health care professional

1. appears to have resulted in
 - a. 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,
 - b. 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,
 - c. changes to the structure of the service user’s body,
 - d. the service user experiencing prolonged pain or prolonged psychological harm, or
 - e. the shortening of the life expectancy of the service user; or
2. requires treatment by a health care professional in order to prevent
 - f. the death of the service user, or
 - g. any injury to the service user which, if left untreated, would lead to one or more of the outcomes” described in (a) above.

The service will review and amend as necessary this duty of candour policy in the light of any experiences of having to apply it and CQC guidance.

3. Staff Conduct

The service expects its staff in line with their professional code of conduct to apply a duty of candour in all of their work with service users. It requires them:

- › to be open and honest
- › to admit mistakes where they occur
- › to apologise for them
- › to put matters right promptly and
- › to follow all applicable reporting and recording procedures.

The service will take appropriate disciplinary action if there is evidence that staff committing mistakes are doing so in breach of their professional code of conduct.

4. Training

Staff training covers the service ethos of openness and transparency, individual responsibilities to act in open and transparent ways and the procedures which the service will follow in exercising its duty of candour following incidents that fall within its scope.

5. Review

This policy will be review every two years by the Quality Advisor.