# Duty of Candour Policy & Procedure

## April 2018

NetherJohnstoneHouse Childcare Services

| Review dates | Reviewed by | Signed |
|---|---|---|
| March 2018 | _____ | |
| March 2019 | _____ | |
| March 2020 | _____ | |

# Contents

## 1. What is the Duty of Candour?

The new duty of candour came into effect on 1 April 2018. It affects all health, social work and care services except childminders. It means that services must take specific steps to carry out their duty of candour when a serious adverse event happens. They will need to let the people affected know, offer to meet with them, and apologise. This is an important part of being open with people who experience care, and also learning from things that go wrong.

Starting from April 2019, care services and social work services must, by law, produce a short annual report showing the learning from their duty of candour incidents that year, publish it, and notify The Care Inspectorate that it has been published. E-form's now include a box that should be ticked for any incidents triggering the duty of candour.

The purpose of the new duty of candour provisions is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm that is not related to the course of the condition for which the person is receiving care.

The Scottish Government recognise that when adverse events occur during the provision of treatment or care, openness and transparency is fundamental in promoting a culture of learning and continuous improvement in health and social care settings.

The duty of candour procedure provisions reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. When harm occurs the focus must be on personal contact with those affected; support and a process of review and action that is meaningful and informed by the principles of learning and continuous improvement.

There is an organisational emphasis on staff support and training to ensure effective implementation of the organisational duty. Staff must feel that they have the necessary skills and confidence if they are to be meaningfully involved in the delivery of the duty of candour procedure.

### 1.1 Key Principles:

- Providing health and social care services is associated with risk and there are unintended or unexpected events resulting in death or harm from time to time.
- When this happens, people want to be told honestly what happened, what will be done in response, and to know how actions will be taken to stop this happening again to someone else in the future.

- There is a need to improve the focus on support, training and transparent disclosure of learning to influence improvement and support the development of a learning culture across services.
- Candour is one of a series of actions that should form part of organisational focus and commitment to learning and improvement.
- Transparency, especially following unexpected harm incidents is increasingly considered necessary to improving the quality of health and social care.
- Being candid promotes accountability for safer systems, better engages staff in improvement efforts, and engenders greater trust in patients and service users.

## 2. Definitions

### 2.1. What type of incidents may trigger duty of candour in Nether Johnstone House?

| Type of Event | Impact on Individual |
|---|---|
| Young person involved in an accident (car or activity) | Loss of limb, physical mobility or death |
| Young person taking illicit substances | Significant life altering injuries or death |
| Trauma based event | Significant psychological damage (perhaps require medical detention) |

This list is by no means exhaustive but provides examples of the type of incident that may invoke the Duty of Candour procedure as outlined in section 7.

**2.2 Severe Harm is described as:**

- The death of a person
- Permanent disability either physical or psychological *(such as the removal of a wrong limb or organ or brain damage)*

**2.3 Not severe harm covered by the legislation is described as:**

- An increase in their treatment
- Changes to the structure of their body
- Shortening of their life

- An impairment which can be sensory, motor or intellectual and has lasted or is likely to last 28 days or more
- Pain or psychological harm which lasts, or is likely to last, for at least 28 days
- Harm also includes the person requiring treatment by a health professional in order to prevent their death, or an injury to them which, if left untreated, would lead to one or more of the harms outlined above.

**2.4 Who is a relevant Healthcare Professional?**

Nether Johnstone House does employee any Healthcare professionals as part of the Service. In the event that an incident occurs which triggers the duty of candour staff in attendance would seek advice and guidance from the relevant Healthcare professional involved in the assessment of the Individual.

**2.5 What is an apology?**

Section 23 of the Act defines 'apology' in relation to the duty of candour provisions and subsection (2) provides that any apology or other steps taken which are in accordance with the duty of candour procedure set out in regulations made under section 22 cannot be taken by itself to be an admission of negligence or a breach of a statutory duty. This means that there is not to be taken to be a link between giving an apology (or otherwise following the duty of candour procedure) in relation to an incident and acknowledgment of any wrong-doing. This does not prevent individuals affected from taking further action in relation to an incident.

Section 3 of the Apologies (Scotland) Act 2016 provides that an apology is a statement (which could be written or oral) made either by the person who is apologising (whether a natural person, or a legal person such as a company), or by someone else on their behalf (e.g. a spokesperson or agent). The core element is an indication that the person is sorry about, or regrets, an act, omission or outcome. Where the statement includes an undertaking to look at the circumstances with a view to preventing a recurrence that qualifies as part of the apology itself. The definition of apology for the purpose of the Act does not include statements of fact or admissions of fault. In any statement that includes both an apology and a statement of fact and/or admission of fault, only the apology is inadmissible as evidence of liability (http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour/FAQ)

## 3. Openness & Learning Culture

### 3.1 Key Points

- Explain honestly and factually what has happened.
- Explain what actions will be taken next.
- Describe what measures are being taken to reduce the risk of an incident like that reoccurring.
- As an employer it is important to create a culture where people are open and honest and not fearful of reporting incidents.
- Organisations should lay out their expectations for leadership behaviours and attitudes to support an open learning culture.
- Staff need to feel secure that they will be able to learn from any incidents of unexpected or unintended harm and not blamed.
- This will help to create a culture whereby staff feel supported to learn and share their experiences to improve how we care for other people.
- Being open and honest is key to developing good relationship, trust and partnerships between people and those who care for them.

## 4. Monitoring, recording & reporting

An annual report must be produced to cover the following info:

- The number and nature of all unintended or unexpected incidents that have resulted in death or harm.
- Assessment of extent to which the duty was carried out
- Information about the organisations policies and procedures to support the implementation of the duty of candour provisions
- Any changes made to policies or practice because of any incidents

- Support made available to individuals and staff

## 5. Further information

Further information, advice and guidance can be found:

- http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour
- http://www.knowledge.scot.nhs.uk/making-a-difference/resources.aspx
- http://www.knowledge.scot.nhs.uk/scormplayer.aspx?pkgurl=%2fecomscormplayer%2fdutyofcandour%2f

## 6. Triggers for the duty of candour procedure:

The duty of candour procedure, as set out in the Act should be followed once a regulated health professional confirms that unintended or unexpected incident has occurred and has resulted in harm or death. This healthcare professional must **NOT** be someone involved in the incident.

It can also be activated because of a complaint or feedback in respect of a significant event which either triggers a review or not, or a disclosure under the whistleblowing policy.

## 7. Procedure

**8.1 Initial Actions**

1. Incident is identified as triggering a duty of candour by relevant Healthcare Professional or advice is sought based on Residential staff's concerns.
2. The incident should be reported immediately to the Senior on shift who must then notify the Service Manager or Assistant Service Manager in their absence. The senior on shift must immediately compile a file containing a duty of candour record of communication ***(1.1)*** & the duty of candour Checklist ***(1.6)***
3. The Service Manager or Assistant Service Manager should complete a Care Inspectorate eform detailing the incident within 24 hours of the occurrence.

4. The Service manager or Assistant Service Manager will then identify a lead person to liaise with the person/family member – this will be a Senior Member of staff or the Assistant Service Manager.

5. The Lead person will make contact with person/family member immediately – advising them that they are sincerely sorry for what has happened and that they will look into why and how the incident occurred and come back to them with more information. A timeframe for this should be given and should not exceed 48 hours in the initial instance. The Lead person should complete a Notification of duty of candour form ***(1.2)*** The Lead person for the person/family should note the information that the individual or family wish to receive (if they do not wish any further info this should be respected and recorded).

6. All communication regarding the incident must be recorded on the Duty of candour record of communication ***(1.1)***

**8.2 Stage 2**

1. The Service Manager or Assistant Service Manager will debrief and take statements from any members of staff involved in the incident (within 48 hours) and record this on Duty of candour witness statement ***(1.3).*** Any supports should be identified for staff or others involved in the incident.

2. The Lead person will arrange a meeting with the individual/family members (Within 48 hours) and offer them the opportunity to ask any questions in advance of the meeting. The meeting should be recorded on the duty of candour meeting form ***(1.4)*** and should cover the following points:

    - A sincere apology
    - An explanation of what happened and the facts as you know them
    - Advise the individual/family members about what next steps are being taken
    - The individual/family members should be given the opportunity to ask any questions or have any points of view noted.
    - Confirmation should be ascertained about how the individual wishes to receive feedback if any (writing or in person).
    - Contact details should be provided for the Lead person and the Service Manager or Assistant Service Manager.

**8.3 The Review Process**

1. A review of the incident will be conducted by the Service Manager or Assistant Service Manager and the findings recorded in Duty of Candour Incident Review Form ***(1.5).*** The review will focus on improving quality and sharing learning. It will include the process in which the review was conducted and any actions taken in respect of the duty of candour

procedure. A copy of the review will be made available to the individual/ family if requested alongside a written apology. The review will also be presented to the Safeguarding board for consideration and feedback.

2. Incident should be logged on NJH Annual Duty of Candour Report ***(1.7)*** and reported to the Care Inspectorate.

## Appendix

### 1.1 Duty of Candour Record of Communication

**Name of individual affected by incident:**
**D.O.B**

**Date of Incident:**

**Staff Involved in Incident:**

**Brief Summary of Incident (injury & location):**

| Date & Time | Method of Communication | Completed by (Name) | Any Outcome/Action Required |
|---|---|---|---|
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 1.2 Notification of Duty of Candour

| **Person Notified:**<br><br>**Notified by:**<br>**Date & Time:**<br>**Apology Provided: Yes/No** | |
|---|---|
| **Details of Incident & Discussion Given** | **Action to be taken** |

| | |
|---|---|
| | |
| **Next Agreed contact:** | **Confirm how contact should be made:** |

**Completed by Lead Worker:** **Signed by Lead Worker:**

## 1.3 Duty of Candour Witness Statement

| |
|---|
| **Name of Witness:**<br><br>**Statement Taken by:**<br>**Date & Time:** |

| Details of Incident & Discussion Given | Action to be taken/ Supports required |
|---|---|
| | |
| **Witness Signature:**<br><br>**Management Signature:** | **Date:**<br><br>**Date:** |

## 1.4 Duty of Candour Meeting Form

| | |
|---|---|
| **Person's in Attendance:**<br><br>**Lead Person:** **Date & Time:**<br>**Apology Provided: Yes/No** **Contact Details Provided:** | |
| **Content of Discussion** | **Key Points noted by Family/ Individual Actions to be taken** |
| **Provide an explanation of what happened and the facts as you know them:** | |
| **Provide Information regarding the action being Taken:** | |
| **Feedback from Individual/Family:** | |
| **Agreement about how the individual/family wish to receive further communication regarding the incident *(by whom, written, in person etc) & timescales for this*.** | |
| **Completed by Signature:**<br>**Date:** | |

## 1.5 Duty of Candour Incident Review Form

| |
|---|
| **Review Conducted by:**<br>**Date:** |
| **Brief outline of Incident that triggered the Duty of Candour** |
| |
| **Immediate Action's taken in response to Incident** |
| |
| **Process used to conduct Review** |
| |
| **Summary of Findings obtained from individual, family and witness statements** |
| |
| **Identified Supports and implementation** |

| |
|---|
| |
| **Identified Training/development needs & actions required**<br>**(please include timescales for Implementation** |
| |
| **Feedback from Safeguarding Board** |
| |
| **Further action taken in respect of Incident** |
| |
| **Completed by Signature:**<br>**Date:** |

## 1.6 Duty of Candour Procedure Checklist

| |
|---|
| **Person involved in incident:**<br><br>**Date of Incident:**<br>**Lead Person:**<br>**Reviewing Manager:** |

| Stage | Action to be taken | By Whom | Form to be completed | Signed & Dated |
|---|---|---|---|---|
| **Initial** | The incident should be reported immediately to the Senior on shift who must then notify the Service Manager or Assistant Service Manager in their absence. The senior on shift must immediately start a Duty of Candour record of communication | Staff involved in Incident<br><br>Senior to notify Service Manager or Assistant Service Manager | 1.1 | |
| | Lead person identified to liaise with Individual/family | Service Manager or Assistant Service Manager | 1.1 | |
| | Lead person to make contact with family (see procedure) | Lead person | 1.1<br>1.2 | |
| **Stage 2** | Debrief and take statements from all staff involved in the incident (within 48 hours) & identify any supports required as a result of the incident. | Service Manager or Assistant Service Manager | 1.1<br>1.3 | |

| | | | | |
|---|---|---|---|---|
| | Meeting to be arranged with Individual/family (within 48 hours) | Lead person | 1.1<br>1.4 | |
| **Review Process** | The Service Manager or Assistant Service manager should conduct a review of the incident and report on findings, feeding back to individual/family, CI and Safeguarding Board | Service Manager or Assistant Service Manager | 1.1<br>1.5<br>1.7 | |
| | Feedback from Safeguarding Board should be received and actioned | Service Manager | 1.5 | |

## 1.7 Nether Johnstone House Annual Duty of Candour Report

| Incident Nos | Procedure Followed | Action Taken/Changes to policy, procedure, practice | Learning & Development |
|---|---|---|---|
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**Completed by:**

**Date:**