OA Reablement service	OA Day Care	OA Residential Care	Domiciliary Services	DMH Day Services	DMH Supported Living	DMH Residential Services	EIA'd
✓	✓	✓	✓	✓	✓	✓	✓

D3
DUTY OF CANDOUR – CQC Reg 20
(Being open and honest)

POLICY

To ensure service users, their advocates and staff feel supported when an incident occurs. To ensure prompt disclosure and apology is provided to the correct individuals, in a timely manner, which helps the understanding of why the incident has occurred, what actions are being taken to prevent recurrence and / or minimise the impact of any harm already experienced.

DEFINITIONS

Being Open - is the fundamental principle that all employees should use when communicating with others. This could include being open with: the service user, social workers, colleagues, family, advocates, statutory agencies.

Duty of Candour – the legal requirement to report a notifiable safety incident to the relevant person / people.

Notifiable Safety Incident – A notifiable incident is any unintended or unexpected incident which occurs when a service user is being treated or cared for.

Apology – an expression of sorrow or regret in respect of a notifiable safety incident.

Relevant Person – The person who is receiving services or someone acting lawfully on their behalf in the following circumstances: on their death, or they are 16 or over and lack the mental capacity in relation to the matter in accordance with the Mental Capacity Act 2005. For registered services this includes CQC.

Notifiable Safety Incidents

Harm level	Descriptor
Low harm	Any service user safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving our care. Pressure ulcer grading - when incident reporting all pressure ulcers grade 1 and 2 should be graded as low harm unless: • There is extensive damage to the skin or / and if the pressure ulcer was avoidable.

Moderate harm	Harm that requires moderate increase in treatment, and significant but not permanent harm. For example a “moderate increase in treatment” means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).
Prolonged pain	Prolonged pain means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.
Prolonged psychological harm	Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days
Severe harm	A permanent lessoning of bodily, sensory, motor, physiological or intellectual functions, including removal of the wrong limb or organ, or brain damage, that is related directly to the incident and not related to the natural course of the service users illness or underlying condition.
Death	Any service user safety incident that directly resulted in the death of one or more persons within our care.
AND	Where the SU requires treatment by a health care professional in order to prevent Death or 1 of the above 5 outcomes.

PROCEDURE

1. All staff must be aware of the principles of being open and honest under duty of candour. Staff must report all safety incidents to their line manager immediately. Managers and supervisors are expected to lead on the process regarding the duty of candour and link in with their operations manager on duty. A chronology of the incident must be recorded in the service users records and be kept up to date. In addition, all relevant forms must be completed which may include: ICASS, significant event book, CQC (for registered services only).

2. As soon as reasonably practicable after becoming aware that a safety incident has occurred the manager / supervisor must:
   - Notify the relevant person that an incident has occurred, providing an oral account and ensuring the service user or their representative understands what has gone wrong. This can be over the telephone or face to face, but must be recorded.
   - Give an account that is true to the best of their knowledge
   - Clearly state what further enquiries into the incident will now take place
   - In respect of the incident, apologise, expressing sorrow or regret. By apologising, the manager is not admitting fault or liability in respect of the incident.

- Ask the relevant person if they have any questions related to the incident that they would like the manager to address and keep a written record of this conversation on file
- Notify your operations manager or if out of hours the on call manager

3. The next stage is for the manager / supervisor is to follow this up in writing. The letter needs to:
    - Repeat the information, and apology given in the oral notification.
    - Inform the recipient of the managers continuing duty to keep the service user or their representative informed, in writing, of any further enquiries and investigations, should they wish to receive it.
    - Give results of any further enquiries into the incident.

    Ensure that copies of this and any further correspondence or documentation are retained. An example letter is at Appendix 1

4. If the relevant person cannot be contacted in person or declines to speak to the manager / supervisor, a written record of the attempts to contact or speak to the relevant person must be recorded. A letter must still be sent in accordance with paragraph 3 above.

5. Saying sorry is not an admission of legal liability. You do however need to be careful how you frame your apology. Managers should:

    - Stick to the facts known at the time. Do not stray into opinion or speculate about what might have occurred.
    - Provide a step by step explanation of what has happened.
    - Keep the language and tone composed and measured. Remain calm and polite.
    - Be clear and unambiguous and if necessary repeat information until the manager is satisfied that the relevant person has understood.
    - All communications should be between the relevant person and the manager in relation to the Notifiable Safety Incident.
    - Consider the need to arrange an investigation. This should be discussed with your operations manager.
    - Keep the relevant person and identified family members updated of the progress of any investigation.
    - Communicate any new facts to the relevant person or identified family members.

6. CQC guidance states that the duty to make a candour notification is required where an incident occurs but the degree of harm resulting from an incident is

not yet clear. This means the level of harm may change and families would need to be notified accordingly.

7. Managers / supervisors must ensure staff are given the candour procedure and in house training in this subject is provided. This is in addition to safeguarding, crossing the line and dignity and respect.

8. Staff should be clearly aware of their own responsibilities to report all health safety and wellbeing issues to the relevant person as required. Managers / supervisors should encourage a culture of honestly and openness and be actively supportive of their staff when reporting incidents and concerns. If staff feel unable to report concerns to their line manager they should contact their manager's line manager. There is a whistleblowing and harassment procedure which can be found on the Cumbria County Council Intouch, and may be appropriate in such instances.

9. For more information go to the CQC website Regulation 20: Duty of candour.