Duty of Candour Policy

Policy Statement

Related regulation: Health (Tobbaco, Nicotine etc. and Care) (Scotland) Act 2016

1.1 We have a duty to acknowledge when something has gone wrong and provide an honest explanation. Being open, honest and transparent is the key to developing good relations, trust and partnership between people and those who care for them.

1.2 Deafblind Scotland has clear expectations for leadership behaviours and attitudes to support openness and learning. All behaviours and attitudes should encourage cultural change and ensures the infrastructure is in place to support this.

1.3 Staff will feel confident that they will be safe and supported to report duty of candour incidents so that lessons are learned and shared to improve and increase the safety of our care system for everyone.

2 Recording and Reporting

All duty of candour incidents will be monitored, recorded and reported by staff within Deafblind Scotland. Deafblind Scotland will produce an annual report which will outline:

- The number and nature of unintended or unexpected incidents which have resulted in death or harm
- Assessment of extent to which the duty was carried out
- Information about the organisation's policies and procedures to support implementation of the duty of candour provisions
- Any changes made to policies or practice as a result of the incidents reported

3 What is harm?

Severe harm is:

- When someone dies
- The permanent disability either physical or psychological (such as removal of the wrong limb or organ, or brain damage

Not severe harm:

- An increase in 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 at least 28 days
- 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
- An injury to them which, if left untreated, would lead to one or more of the harms outlined

4 When is the duty of Candour triggered?

4.1 The procedure should be triggered as soon as a regulated health professional confirms that an unintended or unexpected incident has occurred and has resulted in harm or death, as laid out in the policy. This health professional must NOT be someone involved in the incident.

4.2 The duty of candour procedure can also be triggered as a result of a complaint or feedback received, a significant event which triggers a review or a disclosure under the whistleblowing policy.

4.3 If the Duty of Candour procedure is not triggered a clear audit trail must be kept of that decision making process.

4.4 All incidents should be reported and reviewed. You need to:

- Be able to recognise harm and whether this is unintended or unexpected
- Understand what has gone wrong
- Know who to speak with to discuss concerns/issues
- Understand local decision-making processes and procedures to follow

5 Key steps

5.1 The key steps in the duty of candour procedure should include:

- Notifying the person and/or their family/carer that an unintended or unexpected incident has occurred that has resulted in harm and the duty of candour procedure will be activated
- Making an apology at this stage for what has happened
- Reporting through local systems and following local procedures which will involve carrying out a review of the incident and ensuring that the person and/or their family are included in a way that meets their needs (ensuring that the review is undertaken by an individual NOT involved in the incident)
- Arranging to meet with the person concerned and/or their family to explain what has gone wrong and actions that will be taken
- Providing a written account to the person and/or their family should the person wish this (whilst the person may not want a written account, this should always be offered)
- Asking how the person wants the information to be provided to them and advising them how you are going to store their information

- Outlining support available for those affected including the person and/or their family as well as staff involved
- Recording, reporting and monitoring of the incident to ensure lessons are learned and shared.

Saying Sorry

5.2 Sometime health and social care staff find it difficult to say sorry when something has gone wrong harm has occurred. It can be difficult to know if we can say sorry for something that has gone wrong and worry that the timings for doing this won't be right or that we will make things worse.

Using the 4 R's can help to get this right:

- Reflect – stop and think about the situation
- Regret – give a sincere and meaningful apology
- Reason – If you know, explain why something has happened or not happened. If you don't know, say that you will find out.
- Remedy – Explain what actions you are going to take to ensure this won't happen again, and what the organisation learns from the incident.

An apology is a statement of regret in respect of the incident, it does not in itself amount to an admission of negligence or a breach of a statutory duty. It should be as soon as possible after the event and should be sincere.

Communication

5.3 A lead person should be nominated to deal with internal communication, external communication and responsive communication

6 Annual Reporting Requirements

Deafblind Scotland are required to report on an annual basis the following things:

- Number and nature of incidents
- How the duty was carried out
- Policies and procedures for reporting and identifying incidents
- Any changes to polices, procedure or practice as a result of the incident i.e. learning identified and shared, improvements made
- Support that was made available to individuals and staff

The Report will be available and updated on DbS Website.
www.deafblindscotland.org.uk

To enable learning across the organisation appropriate information needs to be gathered through the review process. This needs to be an ongoing process and not left to the end of the procedure.

7 Related policies:

Deafblind Scotland Incident reporting policy and procedure

Deafblind Scotland Whistleblowing policy and procedure

Deafblind Scotland Complaints policy and procedure

8 Alteration of this policy

This policy will be subject to review, revision, change updating, alteration and replacement in order to introduce new policies from time to time to reflect the changing needs of the business and to comply with legislation. Any alterations will be communicated to you by your line manager.

9 Further resources

Sources of Support

If you are involved in an incident speak to someone within the organisation to provide you with support following an incident in which you have been involved.

Further information is available from the following organisations:

NHS Education for Scotland www.knowledge.scot.nhs.uk/making-a-dierence.aspx

Care Inspectorate www.careinspectorate.com

Scottish Social Services Council www.sssc.uk.com

Healthcare Improvement Scotland www.healthcareimprovementscotland.org

Scottish Government www.gov.scot/topics/health/policy/duty-of-candour Further resources Health (Tobacco, Nicotine etc and Care) (Scotland) Act http://www.legislation.gov.uk/asp/2016/14/pdfs/asp_20160014_en.pdf

General Medical Council – Guidance on Duty of Candour http://www.gmc-uk.org/static/documents/content/DoC_guidance_english.pdf

SSSC Codes of Practice for Social Service Workers and Employers www.sssc.uk.com/about-the-sssc/codes-of-practice/what-are-the-codes-of-practice

HIS Being Open resource http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058625/20150113%20Being%20Open%201.0.pdf

General Medical Council - When things go wrong: the professional Duty of Candour http://www.gmc-uk.org/guidance/ethical_guidance/27233.asp

Nursing & Midwifery Council - Openness and honesty when things go wrong - the professional duty of candour. https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf

Health & Care Professional Council - Standards of Conduct, Performance and Ethics. http://www.hcpc-uk.org/assets/documents/10004EDFStandardsofconduct,performanceandethics.pdf

Australian Commission on Safety and Quality in Healthcare - Open Disclosure Framework https://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf