Duty of Candour Policy

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Duty of Candour Policy

All health and social care services in Scotland have a legal 'Duty of Candour', i.e. a duty to be open and honest. The legal requirement means that, when unintended or unexpected events happen which result in harm or death, as defined in the Act, the people affected understand what has happened and receive an apology, and we (Erskine) learn how to improve for the future. The Duty of Candour applies equally to resident safety incidents and near misses.

The statutory requirements are set out in The Duty of Candour Procedure and regulations in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) implemented in April 2018. This policy has been informed by the Act and the accompanying Scottish Government Duty of Candour guidance.

Communication should be open, honest, and occur as soon as possible following an incident. In addition to the statutory (legal) requirement, there is also an ethical and professional responsibility, for health care professionals and their managers to inform residents (or family/relative where appropriate) who have suffered as a result of any event caused by the organisation's action or in-action that has resulted in harm.

Definitions

It is important that there is clear understanding of the language used within the Duty of Candour regulations and this policy, therefore please note the definitions below:

Harm: an injury (physical or psychological), disease, suffering, ill health or death to a resident.

Incident: any unintended or unexpected event that could have or did lead to harm**.**

Serious Incident: an incident which has a significant adverse outcome for the resident, and/or is also likely to produce significant legal, media or other interest which, in addition to harm, loss or damage, may result in loss of the Erskine's reputation or assets.

Significant Clinical Incident: any event that had or could have had significant or catastrophic impact on the resident and may adversely affect the organisation and its staff and have potential for wider learning (i.e. learning that can be gained for future care delivery).

Notifiable Safety Incident: any unintended or unexpected incident that in the reasonable opinion of a healthcare professional has resulted in severe harm, death or prolonged psychological harm (that is, psychological harm which a person has experienced, or is likely to experience, for a continuous period of at least 28 days).

N.B. although the Care Inspectorate have a list of incidents/accidents they require reported to them, not all of these will reach the threshold of being Duty of Candour reportable.

Responsibilities & Accountabilities

The Director of Care is accountable for ensuring that the policy is adhered to and that the relevant staff have access to Duty of Candour training; this is a delegated responsibility from the Chief Executive.

The Clinical & Care Governance Committee Trustees will monitor that the processes in place regarding Duty of Candour, works effectively and commits the organisation to promote and maintain a culture of openness within the services provided.

Responsibilities of all staff:

- Always be open and honest with residents and those close to them.
- Identify and report all situations which demand candour.
- Be familiar with this clinical policy and the Duty of Candour Procedure.
- To identify the need to activate the Duty of Candour Procedure.

Staff should be aware that the guidance is not intended for circumstances where a resident's health gets worse due to the natural progression of their age/illness. It applies when something goes wrong with a resident's care, and they experience harm or distress as a result.

The legislation clearly states that providers have a duty to act in an open and transparent way in relation to the care and treatment provided to people. There is no specific 'harm threshold', it applies generically to all care and treatment provided.

Effective communication between staff who recognise an incident, and their line manager, is vital, to ensure that the incident is referred to the Director of Care (the registered health professional) and the Duty of Candour process is implemented from the outset.

As soon as a resident safety event is identified, where harm has occurred (as defined above), the immediate priority is to ensure appropriate clinical care is given and action is taken to prevent further harm.

Following the decision that the Duty of Candour must be activated, the Duty of Candour Procedure must be followed (see procedure document).

Training

It is acknowledged that all clinical/care staff have a responsibility to ensure a professional Duty of Candour (generally being open and honest with residents regarding their care) and will already have a level of competence and understanding in this area prior to the implementation of this legislation.

All clinical staff, who may be involved in the procedure will complete the Duty of Candour module on TURAS.

Governance – Monitoring and Reporting

All incidents of harm will be reported through the incident reporting systems (Care & Clinical) and recorded on SharePoint (Governance site). There may also be a requirement to complete a Health & Safety report, which in turn may trigger a requirement to report the incident to the Health & Safety Executive.

Any incidents where Duty of Candour has been triggered will be reported to the Care Inspectorate and to the Clinical and Care Governance Committee (CCGC). A summary report will be provided to the CCGC and advised to the Board of Trustees by the Committee chair.

An annual record of incidents will be reported to the CCGC and published on public noticeboards throughout all the Homes; it will also be included in the annual returns to the Care Inspectorate. Due to the small number of incidents, the public notices will not contain details of incidents as this could lead to the identification of the resident(s) involved.

The published information will include:

1. The number of incidents which have triggered the Duty of Candour process.
2. Any learning and improvement which has been identified from these incidents and how any learning has been disseminated.

References

Organisational Duty of Candour. Scottish Government

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill 2016

http://www.gov.scot/Resource/0053/00533470.pdf

NB – this will be a separate procedure document from the above Clinical Policy; they are joined here for ease of review

Duty of Candour Procedure

All health and social care services in Scotland have a legal Duty of Candour, i.e. a duty to be open and honest; the people affected should understand what has happened and receive an apology, and that organisations learn how to improve for the future.

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) implemented in April 2018 is the underpinning legislation for this policy.

Training

All staff who may be involved in the Duty of Candour Procedure must complete the TURAS learning module, available here.

Definitions

Duty of Candour is triggered as a result of an event that was caused by the organisation's action or inaction and has resulted in harm to a resident.

Broadly speaking there are four levels of incidents and professional clinical judgement needs to be made as to where an event sits and what action is required. If in doubt, any incident should be discussed with the Director of Care as soon as possible after the event has occurred.

Incident: any unintended or unexpected event that could have or did lead to harm. Harm is defined as an injury (physical or psychological), disease, unnecessary suffering or death to a person.

Serious Incident: in addition to harm to a resident, it may lead to loss or damage to Erskine's reputation or assets. All serious incidents should be considered as to whether they are Duty of Candour reportable.

Significant Clinical Incident: any event that had or, could have had significant or catastrophic impact on the resident and may adversely affect the organisation and its staff and have potential for wider learning (i.e. learning that can be gained for future care delivery).

Notifiable Safety Incident: any unintended or unexpected incident that in the reasonable opinion of a healthcare professional has resulted in severe harm, death or prolonged psychological harm (that is, psychological harm which a person has experienced, or is likely to experience, for a continuous period of at least 28 days). NB although the Care Inspectorate have a list of incidents they require reported to them, not all of these will reach the threshold of being Duty of Candour reportable.

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Process

The Duty of Candour applies equally to resident safety incidents and near misses.

In all cases there should be a consideration as to whether the event is a health and safety incident and need escalated to the Health & Safety Manager.

Communication must be open, honest and occur as soon as possible following an incident.

In addition to the statutory requirement, there is also an ethical and professional responsibility, for health and care professionals, and their managers, to inform residents (or family/relative where appropriate) who have been harmed due to our actions or inactions (NMC, HCPC, SSSC Codes apply).

All members of staff have a duty to report an incident. Our first duty is to ensure that no further harm is caused, therefore appropriate action should be taken to protect the resident's health and wellbeing.

The key stages of the procedure are:

- Notify the resident affected (or family/relative where appropriate)
- Provide an apology; an apology does not mean you are accepting blame, it is not an admission of wrongdoing, it is an expression of regret that an unintended or unexpected incident has resulted in harm
- Carry out a review into the circumstances that led to the incident
- Meet with the resident affected and/or their family, where appropriate
- Provide the resident (or appropriate other) with an account of the incident
- Provide information about further steps taken

As soon as is practical, the incident should be reported to the most senior person on duty – in some cases this may be the Response Nurse. A written record should be made of what has occurred and actions taken. All subsequent decisions should also be recorded sequentially.

Staff should be encouraged to write down their immediate recollections of what has happened.

Communication

As soon as is practical, the Home Manager and Director of Care must be informed of the circumstances around the incident, immediate actions taken and the current clinical picture. In some circumstances it will be the Home Manager who informs the Director of Care.

The Home Manager will designate a senior individual to be the lead contact person with the resident (or appropriate other); it may be the Home Manager themself that takes this role.

The Home Manager and/or the Director of Care will assess if the incident requires reported to the Health & Safety Manager. The Health & Safety Manager will advise what additional actions are required, regarding health and safety matters.

The Director of Care will inform the Chief Executive of the incident and immediate actions taken.

The Home Manager will complete the appropriate Care Inspectorate notification using the online forms.

The Director of Care will assess the need to commission a Significant Incident Review (SIR); this will be discussed with the Home Manager and relevant others e.g. Chief Executive, Home Manager, Deputy Director of Care, Health & Safety Manager.

An SIR is a formal process whereby a senior clinician is commissioned to lead an independent review into what has happened. A SIR is not about blame, it is about establishing factors involved and actions that can be taken to prevent future re-occurrences of the incident. Learning points from SIRs will always be shared across the organisation as appropriate.

Annual Report

A central log will be maintained, by the Director of Care, of all incidents that have happened across the organisation, this log will inform the annual report.

The legislation requires us to produce an annual report on the number of incidents that have occurred each year across the organisation. Information related to the number of incidents that have occurred will be shared publicly – this will be done on public noticeboards in each House and in appropriate public areas around the Homes.

Due to the low number of incidents that occur, there will be no details included that could identify a resident(s).

Information related to Duty of Candour will be included in the Erskine Annual Financial Report and Statement.