# Duty of Candour

The practice will adhere to a duty of candour to ensure that when mistakes happen they are acknowledged, an apology given where necessary, with an explanation of what went wrong. Mistakes will be put right quickly and effectively wherever possible. It is the aim of the practice to be open and transparent when incidents occur in relation to the care and treatment of our patients.

All staff have a responsibility to adhere to the policy regarding Duty of Candour.

*The Duty of Candour has been introduced as a direct result of the Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust, which recommended that a statutory “duty of candour” be imposed on all healthcare providers, which defined “Openness”, “Transparency” and “Candour”;*

**Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

**Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

**Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

The intention is that there is a culture of openness and truthfulness to improving the safety of patients, staff and visitors to the Practice, as well as raising the quality of healthcare systems.

**Being Open**

The Duty of Candour is the contractual requirement to ensure that the Being Open process is followed when an incident that affects patient safety results in moderate or severe harm, or death.

**What is a Patient Safety Incident?**

The National Patient Safety Agency defines a Patient Safety Incident as: *“Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care”.*

When a patient safety incident occurs the practice will

* Acknowledge, apologise and explain when things go wrong;
* Carry out an investigations
* Provide support for those involved in the incident (patients and staff) to cope with the physical and emotional impact.
* Reassure patients, families and carers that lessons learned will prevent any patient safety incidents happening in future.

**Definition of “Levels of Harm”**

**No harm**

* Impact prevented – any incident that had the **potential** to cause harm but was prevented and resulted in no harm to staff or patients.
* Impact not prevented - any incident that has occurred, but resulted in **no harm** to people receiving care.

**Low**

An incident that required extra observation or minor treatment and caused **minimal harm**, to one or more persons receiving care.

**Moderate**

An incident that resulted in a moderate increase in treatment (e.g. increase in length of hospital stay by 4-15 days) and which caused **significant but not permanent harm**, to one or more persons receiving NHS-funded care.

**Severe**

An incident that appears to have resulted in **permanent harm** to one or more persons receiving care.

**Death**

An incident that directly resulted in the death of one or more persons receiving care.

**A “Sincere and Meaningful Apology”**

The practice will offer an apology to the affected parties when a patient safety incident has occurred. Events such as these (major or minor) are taken seriously by the practice and it is important that this conveyed to the people affected.

An apology is not an admission of liability. An apology and acknowledgement of the impact it has on them helps to understand that there are lessons that the Practice can learn to ensure this does not happen again in the future.

**Recognising an Incident**

The relevance of the Duty of Candour begins with an acknowledgement that as the result of a safety incident, a patient has suffered moderate or major harm, or has died.

The practice is not required to inform a person when a near miss has occurred and the incident has resulted in no harm to that person.

As soon as an incident has occurred or been identified;

* Clinical care must be administered to prevent further harm and support offered.
* If any additional treatment is necessary, it should happen as soon as reasonably practicable after discussing with the patient (or carer if the patient is unable to participate in discussion) and with the appropriate consent.

Moderate / severe incidents, or any incidents that result in the death of a patient, must be reported to the patient or next of kin (with the appropriate consent) within a maximum of 10 working days from the incident being reported.

The initial notification of the incident must be verbal (face to face where possible), unless the patient/carer/family cannot be contacted or decline notification.

An explanation and a sincere expression of apology must be provided verbally and recorded. At the time of the incident, an initial apology and explanation must be given.

The Patient/Carer must be offered a written notification of the incident along with a sincere apology.

A step by step explanation of the incident must be offered as soon as it is practicably possible, even if this is an initial view pending investigation of the incident. This explanation should use clear language that is jargon free with an explanation of any complicated terms. The practice will consider if it is appropriate to use interpreters, advocates, communication aids etc… whilst being aware of any potential breaches of confidentiality.

***A person acting lawfully on behalf of the person (e.g. persons acting as Carer) using the service must be notified as the relevant person where the person using the service is under 16 and not competent to make a decision regarding their care or treatment.***

The Practice must maintain full written documentation of any letters, discussions, meetings during this investigation, including the response from any of the patients/carers. If any meetings or interviews are offered and declined, then there must be a record of this.

Once the investigation has been completed and a final report has been made, the results should be shared with patient/relatives/carers within 10 working days.

**Support for the patient/relevant person**

The practice will provide reasonable support to the patient/relevant person to help them overcome the physical, psychological and emotional impact of the incident.

This will include some of the following :

* Treating them with respect, consideration and empathy.
* Offering the option of direct emotional support during the notifications, for example from a family member, a friend, a care professional or a trained advocate.
* Offering access to assistance with understanding what is being said e.g. via interpretative services, non-verbal communication aids, written information, Braille etc.
* Providing access to any necessary treatment and care to recover from or minimise the harm caused where appropriate.
* Providing the relevant person with details of specialist independent sources of practical advice and support or emotional support/counselling.
* Providing the relevant person with information about available impartial advocacy and support services, their local **Healthwatch** and other relevant support groups, for example **Cruse Bereavement Care and Action against Medical Accidents (AvMA)**, to help them deal with the outcome of the incident.
* Arranging for care and treatment to be delivered by another professional, team or provider if this is possible, should the relevant person wish.
* Providing support to access the practice complaints procedure.

**Appendix 1 : Actions and Timescales for Duty of Candour requirements**

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| **Requirement under Duty of Candour** | **Timeframe**  |
| Patient or their family/carer informed that incident has occurred (moderate harm, severe harm or death) | **Maximum 10 working days** from incident being reported |
| A verbal notification of incident (preferably face-to-face where possible) unless patient or their family/carer decline notification or cannot be contacted in person.A Sincere expression of apology must be provided verbally as part of this notification. | **Maximum 10 working days** from incident being reported |
| Offer of written notification made. This must include a written sincere apology.  | **Maximum 10 working days** from incident being reportedA record of this offer and apology must be made (regardless if it has been accepted or not) |
| Step-by-step explanation of the facts (in plain English) must be offered.  | As soon as practicableThis can be an initial view, pending investigation, and stated as such to the receiver of the explanation. |
| Maintain full written documentation of any meetings.  | No timeframe If meetings are offered but declined this must be recorded. |
| Any new information that has arisen (whether during or after investigation) must be offered.  | As soon as practicable |
| Share any incident investigation report (including action plans) in the approved format (Plain English)  | **Within 10 working days** of report being signed off as complete and closed |
| Copies of any information shared with the patient to the commissioner, upon request.  | As necessary |