ST CATHERINE'S HOSPICE

Duty of Candour Policy

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Associated Documents

Raising a Concern Policy
Complaints Policy
Safeguarding Adults Policy
Safeguarding Children Policy
Incident Management Policy

References

[1] CQC Regulations for service providers and managers http://www.cqc.org.uk/content/regulations-service-providers-and-managers [accessed 6/7/18]

[2]Francis, R. 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. http://www.midstaffspublicinquiry.com/ [accessed 6/7/18]

[3]The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 http://www.legislation.gov.uk/uksi/2014/2936/contents/made [accessed 6/7/18]

[4] *Being Open Guidance* (National Patient Safety Agency) http://www.nrls.npsa.nhs.uk/beingopen [accessed 6/7/18]

[5] NHSLA *Saying Sorry* leaflet http://www.nhsla.com/Claims/Documents/Saying Sorry - Leaflet.pdf [accessed 6/7/18]

[6] Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents [accessed 6/7/18]

[7] *Openness and honesty when things go wrong: the professional duty of candour* (GMC and NMC) June 2015 https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand pdf-61540594.pdf [accessed 6/7/18]

[8] National Patient Safety Alert 2009. *Being Open: Patient Safety Alert NPSA/2009.PSA/003*

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1. Introduction

The effects of harming a patient can have devastating emotional and physical consequences for patients, their families, and carers. It can also be distressing for the professionals involved.

Being open and honest about what happened - discussing the incident fully, openly and compassionately - can help all those involved cope better with the consequences of harm, whether potential or actual, in managing the event and also in coping in the longer term. In addition, being open and candid when things go wrong ensures that the investigation gets to the root cause of the event and promotes organisational learning.

The Duty of Candour is a contractual requirement for all bodies delivering patient care in the UK under the DH Operating Framework and is included as a professional responsibility under the NHS Constitution. In CQC's new fundamental standards for all care providers[1], which came into force in April 2015, there is a specific regulation - Regulation 20 - addressing the duty of candour. Healthcare professionals are also bound by an ethical duty of candour as outlined by their professional body (eg GMC, NMC[7]).

The introduction of CQC's Regulation 20 is a direct response to the recommendations of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust[2], which recommended that a statutory duty of candour be imposed on healthcare providers. St Catherine's supports this approach wholeheartedly as we recognise our responsibility to patients and their families.

2. Scope of policy

This policy applies to all permanent, locum, agency, bank and voluntary staff of St Catherine's Hospice, whilst acknowledging that for staff other than those directly employed by the Hospice the appropriate line management will be taken into account. Whilst the policy outlines how the Hospice will be open with patients, families and carers, implementation does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

This policy will always apply in the event that a service user is admitted to hospital as a result of an injury whilst under the care of St Catherine's.

3. Definitions

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
Notifiable safety incident	any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in: a) the death of the service user, where the death relates directly to the incident rather than to the natural course of a service user's illness or underlying condition; or b) severe harm, moderate harm or prolonged psychological harm to the service user
Moderate harm**	harm that requires a moderate increase in treatment, and significant, but not permanent, harm. Eg an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area
Severe harm**	a permanent lessening of bodily, sensory, motor, physiologic 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 user's illness or underlying condition.
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
Relevant person	usually the service user who has been harmed or affected; if the service user has died, or is deemed to lack capacity, the relevant person is their next of kin

* These definitions are taken from the Francis Report[2]

** As per CQC definitions – to be used to ensure clarity and consistent decision

4. Policy statement and aims

We have a duty under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[3] to act in an open and transparent way following *any* incident, complaint, or claim occurring as a result of care or treatment provided within or by the Hospice which has or could have resulted in moderate or severe harm to a service user or death of a service user (occurrences which are referred to as *'notifiable safety incidents'*).

This policy aims to ensure that:

- the patient's right to openness from the Hospice is clearly understood by all staff;

- this right is integrated into the everyday business of the Hospice;
- the Hospice learns from mistakes with full transparency and openness;
- patients and their families and carers can trust the Hospice to share information with them in an open and collaborative way;
- Hospice staff ensure appropriate support is offered to the patient, their family/carers and colleagues.

This policy refers specifically to notifiable safety incidents (examples of notifiable safety incidents can be found in Appendix 1). As an organisation we must, however, ensure we act in an open and transparent way following *any* incident, complaint, or claim occurring as a result of care or treatment provided within or by the Hospice, whether or not severe or moderate harm has occurred. Hospice colleagues are directed to the NHSLA's leaflet 'Saying Sorry'[5] and to the NPSA's 'Being Open' guidance[4] for further information and support on how to appropriately implement this.

All professional hospice colleagues are reminded of their ethical duty of candour as stated by professional bodies such as the GMC and NMC[7] and the requirement that they follow local incident reporting and complaints policies.

Colleagues not covered by such professional standards should follow our complaint and incident management policies and discuss matters with their line manager or the Quality and Information Manager (Q&I) if, at any time, they have concerns about patient or our overall safety.

5. Accountability and responsibility

The **Chief Executive** is accountable for the implementation of this policy and responsible for ensuring the organisation is fully compliant with all Duty of Candour legislation.

The **Director of Care Services/Registered Manager** is the owner of this policy, responsible for keeping an overview and ensuring that the policy is reviewed and updated as appropriate, and adhered to. Also to ensure all relevant notifications are submitted in a timely way to statutory bodies where required.

Managers are responsible for investigating Duty of Candour related incidents and informing the Registered Manager; and for ensuring their direct reports are aware of this policy and its procedure, how to access it and when to use it. Managers and supervisors are also responsible for ensuring their direct reports have the knowledge and skills to implement this policy.

Staff are responsible for taking appropriate steps to familiarise themselves with the policy and its procedure and for ensuring they adhere to this policy.

All Hospice based colleagues should note that the Director of Care Services/Registered Manager can be contacted by all/any Hospice colleague to talk through any aspect of this policy and its use should any clarification or guidance be required at any time.

6. Procedure

6.1 Duty to notify the relevant person of the notifiable safety incident

The “Being Open” process begins with the recognition that a patient has suffered harm as a result of an unexpected event in the course of their care. If an incident has occurred, the top priorities are prompt and appropriate clinical care and prevention of further harm. If the incident is considered to have caused moderate or severe harm or caused the death of a patient then it will be subject to Duty of Candour requirements.

6.1.2 If a notifiable safety incident occurs, employees should notify the appropriate manager immediately; this means:
a) In hours - their line manager (who will then escalate as appropriate)
b) Out of hours - the senior nurse, consultant or SMT member on call who will then escalate as appropriate (see *Incident Management Policy POL 28 - Appendix 2 Procedure for management of serious incidents* for guidance)

6.1.2 Failure to report a notifiable safety incident as soon as practicable after becoming aware of it, or suspecting it has occurred, demonstrates a lack of professional integrity and may result in disciplinary action up to and including dismissal.

6.1.3 The relevant person must be contacted as soon as is practicable, but within 10 working days of the notifiable safety event being reported

- This must be done in person after an initial telephone or face to face contact to invite the relevant person to a meeting
- This initial contact should include an apology for the fact that something has occurred that the Hospice feels needs investigating
- This should be followed in writing, to confirm the details that were shared via the initial contact.

6.1.4 The meeting to notify the relevant person of the incident must be with the clinician/manager responsible when the notifiable incident occurred. If this is not possible (eg due to the impact the incident has had on the clinician/manager), an appropriate person should be nominated to undertake this role. At the meeting:

- all facts as known at the date of the meeting must be provided truthfully
- manage the expectations of the relevant person by explaining how the incident is being investigated and when the investigation will be completed and its conclusions available
- if possible, agree with the relevant person what further enquiries into the incident are appropriate
- provide an appropriate apology

The meeting must be documented and the relevant person offered a copy of the documentation.

6.1.5 Appropriate support should be offered and if accepted provided to the relevant person. This might include, for example, emotional support, providing access to any necessary treatment, or signposting to advocacy and support services. It is advisable to separate out the duties of support from the provision of facts about the incident and progress/outcome of investigation as there may be conflicts of interest.

6.1.6 Explain to the relevant person that new information may emerge during the course of an investigation and that they will be informed of this. Agree the most appropriate method for doing this and provide them with all reasonable opportunities to be involved in the

progression of any investigation. Advise the relevant person who to contact during the course of the investigation should they require further information and how to do this.

6.1.7 Advise the relevant person of the timeframe for completing an investigation (within 28 days of the event). The relevant person should be provided with a copy of the investigation report within 10 working days of the investigation being closed and signed off.

6.2 Who is the relevant person?

The relevant person is usually the service user. If the service user has died, or is deemed to lack capacity, the relevant person is their next of kin. If the service user is assessed as lacking capacity, then the relevant person will be determined in line with the principles of the Mental Capacity Act[6] and best interests decision making. Any wishes made in the course of advance care planning must be taken into account. In all other circumstances the information can only be disclosed to a third party if that third party has a legal right to the information (for example, under a health and welfare lasting power of attorney) or if the service user has given explicit consent for it to be notified to that person.

6.3 Providing an apology

6.3.1 Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. An apology should be a sincere expression of sorrow or regret for the harm that has occurred. Saying sorry is not an admission of legal liability; it is the right thing to do.

6.3.2 A verbal apology should be given as soon as staff are aware an incident has occurred. Verbal apologies are essential because they allow face-to-face contact between the patient, their carers and the care team. The verbal apology should be given to the relevant person by the most appropriate manager available at the time.

6.3.3 Following the verbal apology, a written apology must also be given, in which StCH clearly states that it is sorry for the suffering and distress resulting from the incident and summarises the information given via the verbal apology. This letter should be drafted in accordance with our complaints policy.

6.4 What happens if the relevant person cannot be contacted?

If the relevant person cannot be contacted or declines to be contacted, a written record must be kept of all attempts made to contact them. The appropriate manager must make daily attempts to contact the relevant person by phone for a period of seven days from the date of the incident, following which an email or letter will be sent to the relevant person giving them the opportunity to contact the manager.

6.5 Other notifications

The following bodies must also be notified:

- CQC, in accordance with Regulation 20 of the Care Quality Commission (Registration) Regulations 2014
- Commissioners (where relevant)

- Social Services (if it is appropriate to make a safeguarding alert)
- The Hospice's insurers.

6.6 Records

- A record of the written notification should be kept along with any enquiries and investigations and the outcome or results of the enquiries or investigations.
- A record of all communications sent to or received from the relevant person should be maintained. This includes written and telephone contacts.
- The Hospice's web-based incident management system (Datix) will be used for maintaining all relevant records as described above.

7. Dissemination

On launch and after each review, the policy will be disseminated to all Hospice colleagues as per the policies dissemination plan:

- the author will email all staff to notify of new/re-issued policy, giving the link to its location
- the author will email all managers to reiterate above information and to remind managers of their responsibility to ensure their staff are aware of the policy and where to find it
- managers will use relevant opportunities (eg team meetings, 1:1s) to highlight the policy to all staff
- The Quality and Risk Manager will use Headlines to further highlight the policy after its launch/re-issue
- The Quality and Risk Manager r/other managers will use staff updates to highlight the policy after its launch/re-issue.

All new staff and volunteers will be made aware of the Duty of Candour Policy as part of their induction.

A copy of the policy will be available on the Hospice's intranet.

8. Monitoring and review

To ensure that the Hospice learns from incidents covered by this policy and uses them to identify and implement improvements, the following will happen:

- the relevant departmental manager will record all learning outcomes as part of the documentation of the incident (see 6.8 above)
- the Hospice's SMT will review incidents by exception on a monthly basis and receive quarterly reports of all incidents, to ensure all relevant actions have been taken and any required improvements embedded.
- the Hospice's Quality Committee will receive quarterly reports of all incidents.

This policy will be reviewed every 3 years or sooner if changes in legislation require it.

Policy Impact Assessment

The impact assessment is used to ensure:

- we do not inadvertently discriminate as a service provider or as an employer
- that the information governance implications of any changes in the way we work, implicit in any new policies or revisions to existing policies, are considered and addressed appropriately.

To be completed and attached to all policies when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Equality Impact**		
a.	Does the policy affect one group more or less favourably than another on the basis of - race - ethnic origins - nationality - gender - culture - religion or belief - sexual orientation (including lesbian, gay & bisexual people) - age - disability (eg physical, sensory or learning) - mental health	**N**	
b.	If potential discrimination has been highlighted, are any exceptions valid, legal and/or justifiable?	**n/a**	
c.	Is the impact of the policy likely to be negative? If so, can the impact be avoided or reduced?	**N**	
2.	**Information Governance Impact**		
a.	Is the policy (or any of its associated procedures) likely to have an adverse impact on: - information quality - information security - confidentiality - data protection requirements	**N**	
b.	If so, have these issues already been raised with the Information Governance Group? What action has been agreed?	**n/a**	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Information Governance Committee, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact any one of the following:

Caldicott Guardian (StCH Medical Director)
A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Organisations that access patient records are required to have a Caldicott Guardian. Acting as the 'conscience' of an organisation, the Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information.

Data Protection Officer (STCH Head of Quality and Clinical Governance)
HQDP takes the lead in ensuring the promotion of data protection compliance and best practice in an organisation. This involves setting and maintaining standards, and establishing appropriate procedures across all departments and functions.

Senior Information Risk Owner (StCH Finance Director)
A SIRO is a senior person responsible for ensuring the organisation's information risk is identified and managed, and that appropriate assurance mechanisms exist.

Appendix 1

Examples of notifiable safety incidents

(taken from CQC Duty of Candour Guidance - Adult Social Care section)

Example 1.
An OT completed an assessment with a care home resident whose mobility was deteriorating. The OT advised that grab rails were needed in the person's bathroom before it was safe for them to use the bath and that in the meantime staff should assist the person to have a strip wash each morning. The manager failed to update the person's care plan or inform the care staff of this change, so staff supported the person to take a bath the following morning as usual. The person slipped when getting out of the bath and sustained a broken arm. The arm was put in a plaster cast and the person needed full assistance for all aspects of their care for 6 weeks until the cast was removed. The person made a full recovery.

This would be an example of an incident leading to a service user requiring further treatment to prevent the service user experiencing prolonged pain.

Example 2.
A new member of staff on induction was shadowing another care workers delivering care to a person who needed to be hoisted. Two trained members of staff were required to operate the hoist safely and the new member of staff had not yet been trained in moving and handling. The new care worker was asked to assist with the manoeuvre and did not attach one of the loops of the sling to the hoist properly. As a result, during the manoeuvre, the person slid out of the sling and onto the floor. The person sustained a broke hip requiring surgery.

This would be an example of an incident leading to a service user experiencing changes to the structure to the body.

Example 3.
A person with a learning disability was prescribed antipsychotic medicines. They were assessed as needing full staff support in the management of their medicines. Over a period of two weeks they became increasingly anxious and distressed. When the person’s medicines were checked it was discovered that their antipsychotic medicines had not been ordered the previous month and did not show on the MAR chart. This was because the correct procedure for ordering and the checking in of medicines had not been followed and the error had gone unnoticed for 18 days. This resulted in a prolonged deterioration in the person’s mental health for more than 28 days.

This would be an example of an incident leading to prolonged psychological harm.