Duty of Candour Policy

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The Care Act Duty of Candour Act
Codes of Practice:
NMC Code of Practice
Purpose:
Promoting a culture of openness is a prerequisite to improving service user safety and the quality of healthcare systems.

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November 2017	1.0	Closed
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Date	**Key Revision**

Please check to ensure this is the most current electronic copy of this document as it is updated and published in electronic format only (hard copies may become out of date).

Equality Impact Assessment for this policy

Protected Characteristic (domain)	Area of conflict	Resolution
Age	Nil	Nil
Disability	Nil	Nil
Gender Reassignment	Nil	Nil
Pregnancy & Maternity	Nil	Nil
Race	Nil	Nil
Religion or Belief	Nil	Nil
Sex	Nil	Nil
Sexual Orientation	Nil	Nil
Marriage and Civil Partnership	Nil	Nil

All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Registered Manager and the service will actively respond to the enquiry.

Duty of Candour Policy

Promoting a culture of openness is a prerequisite to improving service user safety and the quality of healthcare systems. It involves apologising and explaining what happened to service users who have been harmed as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident.

This policy is aimed at any staff member responsible for ensuring the infrastructure is in place to support openness between health and social care professionals and service users and/or their carers following an incident. It gives advice on the 'dos and don'ts of communicating with service users and/or their carers following harm.

This document describes how Inmind implements the Being Open Framework

2009 "Being Open – Saying Sorry When Things go Wrong" (National Service user Safety Agency (NPSA)), and Safety Alert 2009, the Duty of Candour requirement 2013 (Department of Health) and Regulation 20(CQC).

1. Introduction

Being Open is a fundamental process affecting integrated governance throughout Inmind. This document is integrated with the incident, Serious Incident and Complaints processes. A culture of transparency is fundamental to learning from mistakes.

This document provides a framework for:

• Service users/relatives to receive the open, accurate and timely communication, apology and support they need.

• Staff to be encouraged to admit shortcomings and mistakes learn from errors and be supported.

• Root cause analysis, investigation and learning to occur systematically.

All moderate, severe harm and death incidents must have documented evidence of the Being Open process. This is referred to as the Duty of Candour and is a contractual requirement reflecting the Francis Report (2013) following the Mid Staffordshire Enquiry.

2. Scope of the Policy

Inmind policy for the reporting and management of incidents encourages staff to report all service user safety incidents, including those where there was no harm or it was a prevented service user safety incident. However this policy only relates to incidents graded with a consequence of 'High' or 'Extreme', using the NPSA risk rating matrix.

Incidents graded as 'Low' or 'moderate' do not have to be dealt with using this policy. However, there may be circumstances in which 'Low' and 'No harm' incidents would be appropriate to be communicated to the service user and/or their carer. An example would be where the incident could have resulted in severe harm or death but through luck did not, and the service user's consent is needed to investigate the incident. The benefits and problems associated with communicating 'No Harm' and 'Low' graded incidents with service users and/or their carers should be discussed and will depend on the circumstances.

2.1 Benefits

Being Open is supported by the 7 Steps to Service user Safety (NPSA, 2003) initiative which describes a methodical approach to developing a service user safety culture in healthcare organisations.

Results of surveys of service users and relatives show that receiving an apology, followed by investigation and support, and were considered more important than financial compensation or disciplinary action (MORI – Making Amends DH 2003). In addition to this, there are benefits to staff from increased satisfaction that communication with service users and relatives has been handled appropriately and that the experience will increase their own professional development.

4. Key Elements of Being Open

Effective communication with service users begins at the start of their booking and should continue throughout their transfer with Inmind. This should be no different when a service user safety incident occurs. Openness about what happened and discussing service user safety incidents promptly, fully and compassionately can help service users cope better with the after-effects. Service user safety incidents also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims.

Openness when things go wrong is fundamental to the partnership between service users and those who provide their care.

• Acknowledging, apologising and explaining when things go wrong.

• Conducting a thorough investigation into the incident and reassuring service users and/or their carers that lessons learned will help prevent the incident recurring.

• Providing support to cope with the physical and psychological consequences of what happened.

For Inmind staff, Being Open has several benefits, including:

Satisfaction that communication with service users and/or their carers following a safety incident, has been handled in the most appropriate way.

• Improving the understanding of incidents from the perspective of the service user and/or their carers. The knowledge that lessons learned from incidents will help prevent them happening again.

• Having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Service users handled using the Being Open/Duty of Candour policy are more likely to forgive errors if they are discussed fully in a timely and thoughtful manner. By Being Open and transparent, staff can decrease the trauma felt by service users following a service user safety incident.

4.1 Communications with Service users/Families

All communications with service users/families must be timely, using understandable language. Being Open meetings must allow sufficient time for discussion and questions. Staff must demonstrate that

they are approachable through written communications, the way they speak and their body language. Openness is promoted by staff showing they are caring and sympathetic, and providing several opportunities for service users/relatives to ask questions and gain information.

Disclosing to the service user that an incident has occurred, which they may be unaware of, has to occur as soon as possible (and within 10 working days of the incident) by a member of staff with understanding and experience/support as part of a planned process. Face to face communication is best.

It is usual to share the findings of investigations with the service user/family afterwards in a letter and a meeting. Service users/families are asked how they would prefer this to occur.

Being Open is based on evidence that this approach helps service users/relatives to have better outcomes following errors and a reduction of trauma. It also helps Inmind to prevent and resolve complaints and reduces the risk of service users/relatives escalating their complaint to the Public Health Service Ombudsman.

A key aim of the document is to help all Inmind staff to feel they can be open and honest whenever mistakes are made, and not be reluctant to apologise to service users.

The principles of this document apply to all communications with service users and their families when errors have been made. This applies to incidents as well as complaints. It applies in personal explanations and apologies as well as in local resolution meetings which are arranged to try to resolve remaining concerns following a formal complaint investigation. The principles also apply to internal inquiries.

5. The Ten Principles of Being Open

Being Open is a process rather than a one-off event. With this in mind, the following principles have been drawn up to support the policy.

i. Principle of acknowledgement

All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the service user and/or their carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all staff. Denial of a service user's concerns will make future open and honest communication more difficult.

ii. Principle of truthfulness, timeliness and clarity of communication

Information about a patient safety incident must be given to service users and/or their carers in a truthful and open manner by an appropriately nominated person. Service users want a step-by-step explanation of what happened, that considers their individual needs and is delivered openly.

Communication should also be timely: service users and/or their carers should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time.

Healthcare staff should explain that new information may emerge as an incident investigation is undertaken, and service users and/or their carers should be kept up to- date with the progress of an investigation.

Service users and/or their carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff. Medical jargon, which they may not understand, should be avoided.

iii. Principle of apology

Service users and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a service user safety incident. This should be in the form of an appropriately worded apology, as early as possible. Both verbal and written apologies should be given. The decision on which staff member should give the apology should consider seniority, relationship to the service user, and experience and expertise in the type of service user safety incident that has occurred.

Verbal apologies are essential because they allow face-to-face contact between the service user and/or their carers and the Inmind team. This should be given as soon as staff members are aware an incident has occurred. It is important not to delay for any reason. Delays are likely to increase the service user's and/or their carer's sense of anxiety, anger or frustration. A written apology, which clearly states that Inmind is sorry for the suffering and distress resulting from the incident, must also be given. An apology is not an admission of liability.

iv. Principle of recognising service user and carer expectations

Service users and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences in a face-to-face meeting. They should be treated sympathetically, with respect and consideration.

Confidentiality must be maintained at all times. Service users and/or their carers should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a service user requiring additional support, such as an independent service user advocate or a translator.

v. Principle of professional support

Inmind creates an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Managers should ensure that staff members are supported throughout the incident investigation process as they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action.

vi. Principle of risk management and systems improvement

Root cause analysis (RCA) should be used to uncover the underlying causes of a service user safety incident. Investigations should focus on improving systems of care, which will then be reviewed for their effectiveness.

vii. Principle of multidisciplinary responsibility

This policy applies to all staff members that have key roles in the service user's care. Most provision involves multidisciplinary teams and communication with service users and/or their carers following an incident that led to harm, should reflect this. This will ensure that the Being Open process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

viii. Principle of senior management meetings

Being Open has the support of patient safety and quality improvement processes through the Operations and Board meeting framework, in which service user safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability to the Chief Executive to ensure these changes are implemented and their effectiveness reviewed.

The findings are disseminated to staff so that they can learn from patient safety incidents through manager's feeding back briefings locally. These actions are monitored to ensure that the implementation and effects of changes in practice following a service user safety incident.

ix. Principle of confidentiality

Full respect should be given to the service user, their carers and staff's privacy and confidentiality. At all times details of a patient safety incident should be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the staff involved in treating the service user. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communications with parties outside of the Inmind team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the service user and/or their carers about who will be involved in the investigation before it takes place and give them the opportunity to raise any objections.

x. Principle of continuity of care

Service users are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion during a transfer. If a service user expresses a preference for their transfers to be taken over by another organisation, the appropriate arrangements should be made for them to receive services elsewhere.

6. The Being Open /Duty of Candour Process

6.1 Incident Detection or Recognition

The Being Open/Duty of Candour process begins with the recognition that a service user has suffered moderate harm, major harm, has died, as a result of a patient safety incident.

A patient safety incident may be identified by:

- A member of staff at the time of the incident
- A member of staff retrospectively when an unexpected outcome is detected

• A service user and/or their carers who expresses concern or dissatisfaction with the service user's care either at the time of the incident or retrospectively

• Incident detection systems such as incident reporting or medical records review

• Other sources such as detection by other service users, visitors or non-clinical staff

As soon as a patient safety incident is identified ensure that prompt and appropriate clinical care and prevention of further harm is in place. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the service user and with appropriate consent.

6.1.1 Patient Safety incidents occurring elsewhere

A patient safety incident may have occurred in another organisation, and during transfer with Inmind.

The individual who first identifies the possibility of an earlier service user safety incident should notify the operations manager who will then contact their equivalent at the organisation where the incident occurred and establish whether:

• The patient safety incident has already been recognised

• The process of Being Open has commenced

• Incident investigation and analysis is underway

The Being Open /Duty of Candour process and the investigation and analysis of a service user safety incident should normally occur in the organisation where the incident took place.

6.1.2 Criminal or intentional unsafe act

Service user safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, the Chief Executive should be notified immediately.

6.2 Initiating the Being Open/Duty of Candour Process

Staff must report the incident via incident forms and to line managers immediately,

Face to face discussion is best or a telephone conversation. Verbal communication should always occur before a letter is sent. It is useful to identify an appropriate senior staff member to be a single point of contact.

Make Initial Disclosure and Apology with the Service user/Family as Soon As Possible and Within 10 Working Days of Incident. Delay in disclosure must be avoided. The initial communication must occur even if details are not yet clear. This communication can occur by any appropriate means – face-to-face is best, but it can be a telephone call or invitation to a meeting. Reference should be made to the investigation which may provide different or further information. This initial communication must be recorded including with a heading "Duty of Candour meeting" – Date, time, people present (including service user and family names), apology, what was discussed, concerns raised by the family, arrangements for further communication/support etc.

The communication is to disclose that an incident has occurred, offering apology and sympathetic support. It is important to avoid giving too much detail about the incident until the incident investigation has been completed. The service user/family can be told they will be invited to a meeting to discuss details either during or after the investigation, as preferred by the service user/family. Service user/family concerns, preferences etc. should be recorded and considered in the investigation.

An offer to meet is made to the family. This is usually at the end of the investigation so the findings can be shared and discussed, but may also occur before the investigation starts or during the process. The approach is agreed with the service user/family. The service user/family may require meetings at any stage during the investigation.

6.2.1 Preliminary team discussion

The Inmind team, including individuals involved in the patient safety incident, should meet as soon as possible after the event to:

• Establish the basic facts

• Assess the incident and determine the level of immediate response

• Identify who will be responsible for discussion with the service user and/or their carers

• Identify immediate support needs for the staff involved

• Ensure there is a consistent approach by all team members around discussions with the service user and/or their carers.

In addition to this, it will be advantageous to provide facilities for formal and informal debriefing of the team involved in the service user safety incident, where appropriate, as part of the support system and separate from the requirement to provide statements for the investigation. Staff may also benefit from individual feedback about the final outcome of the patient safety incident investigation.

6.2.2 Initial assessment to determine level of response

All incidents should be initially assessed by the team to determine the level of response required and then discussed with the Operations Director if it requires a high level of response. The level of response to a patient safety incident depends on the severity of the incident.

Low (minimal harm) and moderate (short term harm)

Unless there are specific indications or the service user requests it, the communication, investigation, analysis and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident.

High (permanent or long term harm) or Extreme (caused by the incident)

High – Permanent/long-term harm; permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including brain damage related directly to the incident (and not a natural cause

of the service user's illness or underlying condition). A higher level of response is required in these circumstances.

The Medical Director should be notified immediately and be available to provide support and advice during the Being Open/Duty of Candour process if required.

6.3 Timing

The initial Being Open/Duty of Candour discussion with the service user and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this discussion include:

• Clinical condition of the service user. Some service users may require more than one meeting to ensure that all the information has been communicated to and understood by them

• Availability of key staff involved in the incident and in the Being Open/Duty of Candour process

• Availability of the service user's family and/or carers

• Availability of support staff, for example a translator or independent advocate, if required

• Service user preference (in terms of when and where the meeting takes place and who leads the discussion)

• Privacy and comfort of the service user

• Arranging the meeting in a sensitive location

6.4 Involving healthcare staff who made mistakes

Some patient safety incidents that resulted in major harm or death will result from errors made by staff while caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the Being Open/Duty of Candour discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the staff member concerned. In cases

where the staff member who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting. In cases where the service user and/or their carers express a preference for the staff member not to be present, it is advised that a personal written apology is handed to the service user and/or their carers during the first Being Open/Duty of Candour discussion.

6.5 Content of the initial Being Open/Duty of Candour discussion with the service user and/or their carers

With the service user's agreement, carers and those close to the service user can be included in the discussions and decision making. If the service user is unable to participate or has died, then the carers or people closely involved with the service user may be provided with limited information in order to make decisions. Carers and people close to the service user can be referred to the Coroner for more information.

• The service user and/or their carers should be advised of the identity and role of all people attending the Being Open/Duty of Candour discussion before it takes place. This allows them the opportunity to state their own preferences about which staff should be present

• There should be an expression of genuine sympathy, regret and an apology for the harm that has occurred

• The known facts are agreed by the team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed. The service user and/or their carers should be informed that an incident investigation is being carried out and more information may become available following the investigation

• It should be made clear to the service user and/or their carers that new facts may emerge as the incident investigation proceeds

• The service user and/or carers understanding of what happened should be taken into consideration, as well as any questions they may have.

• There should be consideration and formal noting of the service user's and/or carers views and concerns, and demonstration that these are being heard and taken seriously

• Appropriate language and terminology should be used when speaking to service users and/or their carers. If a service user's and/or their carers first language is not English, or they have other communication difficulties, their language needs should be addressed as well as providing information in both verbal and written formats

• Information on likely short and long term effects of the incident (if known) should be shared. The latter may have to be delayed to a subsequent meeting when the situation becomes clearer. Some service users may not wish to know every detail of an incident. They should be reassured that if they change their minds, this information will be made available to them

• An offer of practical and emotional support should be made to the service user and/or their carers. This may involve giving information on third parties such as charities and voluntary organisations to the service user/carer, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without the service user's consent. The service user may not wish third parties to know every detail of the incident.

• The service user/carer should be given the contact details of one member of staff who will acts as a contact point for them. Their role will be to provide both practical and emotional support in a timely manner

• Service users/Carers should be given information on the complaints procedure and offered assistance if they wish to make a complaint

• It should be recognised that service users and/or their carers may be anxious, angry and frustrated, even when the Being Open/Duty of Candour discussion is conducted appropriately.

It is essential that the following does not occur:

• Speculation

• Attribution of blame

• Denial of responsibility

• Provision of conflicting information from different individuals

The initial Being Open/Duty of Candour discussion is the first part of an ongoing communication process. There should be repeated opportunities for the service user and/or carer to obtain

information about the incident and many of the points raised here should be expanded on in subsequent meetings.

7. Supporting Staff involved in Incidents, Complaints and Claims

Being involved in an incident, complaint or claim which is under investigation can be an incredibly stressful experience. Inmind endeavours to supports service users, carers, relatives and staff during this difficult time through a number of support mechanisms. The duty of the Registered Manager is to:

• Ensure that the appropriate support is offered in traumatic events, be they potential victims, witnesses, those accused or investigators.

• Ensure that risk assessments are undertaken that take into account mental and physiological hazards and that suitable control measures to reduce risk and support vulnerable staff are put into place.

• Ensure that good human resource and management practice is adopted.

• Deal sensitively and effectively with staff reporting symptoms or feelings that could be stress related as a result of such an event.

Individual staff members must:

• Bring to their managers attention if they feel they cannot cope with the pressures and demands of work placed upon them as a result of a traumatic incident, complaint or claim.

• Participate fully in the risk assessment process and observe any control measures introduced as a result of the risk assessment.

8. Documentation

8.1 General

The communication of patient safety incidents must be recorded. Required documentation includes:

• A copy of relevant clinical information

• Incident reports

• Records of the investigation and analysis process

• Copy of the Duty of Candour letter

The incident report and record of the investigation and analysis process will be recorded on the serious incident spreadsheet.

The initial incident will be reported using the procedures detailed within the Incident Policy.

8.2 Written records of the Being Open/Duty of Candour discussion

There should be documentation of:

• The time, place, date, as well as the name and relationships of all attendees

• The plan for providing further information to the service user and/or their carers

• Offers of assistance and the service user's and/or carers response questions raised by the family and/or carers or their representatives and the answers given

• Plans for follow-up as discussed

• Progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user and/or their carers

• Copies of any statements taken in relation to the patient safety incident

• A copy of the incident report

A summary of the Being Open/Duty of Candour discussion should be shared with the service user.

9. Preliminary Follow-Up

The preliminary follow-up discussion with the service user and/or their carers is an important step in the Being Open/Duty of Candour process. The following guidelines should assist in making the communication effective:

• The discussion should occur at the earliest practical opportunity, once there is additional information to report

• Consideration should be given to the timing of the meeting, based on both the service user's health and personal circumstances

• Consideration should be given to the location of the meeting. Feedback should be given on progress to date and information provided on the investigation process

• There should be no speculation or attribution of blame. Similarly, the staff member communicating the incident must not criticise or comment on matters outside their own experience

• A written record of the discussion should be kept and shared with the service user and/or their carers

• All queries should be responded to appropriately

• If completing the process at this point, the service user and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the service user's records

• The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant staff member.

10. Completing the Process

10.1 Communication with the service user and/or their carers

After completion of the incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

• The chronology of clinical and other relevant facts

• Details of the service user's and/or their carers concerns and complaints

• A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident

• A summary of the factors that contributed to the incident

• Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example: where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; where specific legal requirements preclude disclosure for specific purposes. In these cases the service user will be informed of the reasons for the restrictions.

10.2 Continuity of care

When a service user has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed, in an accessible way, of the ongoing clinical management plan.

Service users and/or their carers should be reassured that they will continue to be treated according to their needs even in circumstances where there is a dispute between them and the team.

10.3 Monitoring of Action Plans

Any recommendations for systems improvements and changes implemented will be detailed in an action plan. This will be linked to the incident on the serious incident spreadsheet. The progress, final completion of and effectiveness of the action plan will be monitored and reported through the senior management team meetings.

10.4 Communication of changes to staff

Effective communication with staff is a vital step in ensuring that recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of service

user safety issues and the value of Being Open. Team meetings and newsletters are all available to help communicate with staff.

11. Monitoring

The Operations and Board management team will monitor compliance with this policy. Evidence from serious incident reports will be collected to monitor use of the Being Open/Duty of Candour Policy.