(NAME OF HOME)

QUALITY POLICY STATEMENT QP-61

Title: DUTY OF CANDOUR POLICY *(KLOES)*

1.0 INTRODUCTION

1.1 The Care Quality Commission through Regulation 20 requires providers to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

1.2 It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

2.0 POLICY

2.1 To ensure that the requirements of Regulation 20 are met and our service is open and transparent with Service Users and relevant persons' (people acting lawfully on their behalf) in relation to the provision of care and treatment when things go wrong.

3.0 TRANSPARENCY AND FAIRNESS WITHIN OUR SERVICE

3.1 We will endeavour to promote a culture of fairness and transparency which will be led by the manager and senior staff of our team. The team will be responsible for embedding into the service attitudes and conduct of staff, and the need to be open and fair in their dealings and approach with Service users and their families.

3.2 As part of the staff induction, we will reinforce the values of fairness and transparency.

3.3 If an incident occurs, it is the responsibility of all staff to demonstrate accountability and report the incident through the homes reporting systems. It is the responsibility of the manager as part of their obligations under duty of candour to share information about the incident and provide full support to the Service user and family. To discuss, and act upon and document a resolution to any concern or incident that has occurred.

3.4 We will establish professional relationships with key organisations and work in partnership with openness, fairness and transparency to ensure that the best possible outcomes are achieved for the Service User. Organisations should include the local authority, safeguarding teams and clinical commissioning groups and multidisciplinary teams, to support care provision, service development and joined-up care.

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4.0 ACTIONS TO BE TAKEN FOLLOWING THE OCCURRENCE OF A NOTIFIABLE SAFETY INCIDENT

4.1 As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred the manager **must**:

(a) Notify the Service User that the incident has occurred in accordance with paragraph (3), of the Regulation and the manager is required to

(b) Provide reasonable support to the Service User in relation to the incident, including when giving such notification.

4.2 The notification to be given under paragraph (2) (a) **must**:

(a) Be given in person by one or more representatives of the registered person,

(b) Provide an account, which to the best of the managers knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

(c) Advise the Service User what further enquiries into the incident the manager believes are appropriate,

(d) Include an apology, and

(e) Ensure these notification are recorded in a written record which is kept securely by the manager.

4.3 Where a relevant person is involved (people acting lawfully on their behalf). A written notification must be given or sent to the relevant person containing:

(a) The information provided to the Service User

(b) Details of any enquiries undertaken

(c) The results of any further the results of any further enquiries into the incident, and

(d) An apology.

4.4 If the relevant person cannot be contacted, the manager must ensure that a written record is kept of the attempts made to make contact or to speak to the relevant person.

4.5 The manager will keep a copy of all correspondence with the relevant person.

5.0 DEFINITIONS

5.1 This regulation refers to the following definitions:

"Apology" means an expression of sorrow or regret in respect of a notifiable safety incident; "moderate harm" means—

(a**)** **Harm** that requires a moderate increase in treatment, and

(b Significant, but not permanent, harm;

"moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

"notifiable safety incident" has the meaning given in paragraph 3.1.of this policy

"prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days,

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"relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

(a) On the death of the service user,
(b) Where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
(c) Where the service user is 16 or over and lacks capacity in relation to the matter; "severe harm" means 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.

In relation to a health service body, "notifiable safety incident" means 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 the service user's illness or underlying condition, or
(b) Severe harm, moderate harm or prolonged psychological harm to the service user.

In relation to a registered person who is not a health service body, **"notifiable safety incident"** means 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—

(a) Appears to have resulted in—
(i) The death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,
(ii) An impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
(iii) Changes to the structure of the service user's body,
(iv) The service user experiencing prolonged pain or prolonged psychological harm, or the shortening of the life expectancy of the service user; or
(b) Requires treatment by a health care professional in order to prevent—
(i) The death of the service user, or
(ii) Any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

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Guidance for managers

What the Care Quality Commission requires

Key Lines of Enquiry 2018 - **Well-Led W1: Is there a clear vision and credible strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people?**

Prompt	Compliance Evidence
W1.2 How does the service promote and support fairness, transparency and an open culture for staff?	Section 3.0 of this policy addresses the prompt. Refer to QP-60 Positive Culture
W1.4 Does the service show honesty and transparency from all levels of staff and leadership following an incident? How is this shared with people using the service and their families in line with the duty of candour, and how does the service support them?	Section 3.0 of this policy addresses the prompt.

Key Lines of Enquiry 2018 - **Well-Led W5: How does the service work in partnership with other agencies?**

Prompt	Compliance Evidence
W5.1 How does the service work in partnership with key organisations, including the local authority, safeguarding teams and clinical commissioning groups and multidisciplinary teams, to support care provision, service development and joined-up care? Does it do so in an open, honest and transparent way?	Section 3.0 of this policy addresses the prompt. Refer to QP-68 Information Governance

Managers will need to demonstrate to CQC that they are complying with the regulation and Fundamental Standard by following the procedure or policy that provides the evidence.

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