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**Duty of Candour Policy**

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| Responsible Person | Registered Manager |
| Date Issued | 9th June 2019 |
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| Authorised by | Angela Chalmers |
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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. Healthcare professionals are also bound by an ethical duty of candour as outlined by their professional body (NMC7).

The introduction of Regulation 20 is a direct response to the recommendations of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust which recommended that a statutory duty of candour be imposed on healthcare providers. Latch On Lanarkshire supports this approach wholeheartedly as we recognise our responsibility to patients and their families

1. **AIM**

Latch On Lanarkshire follows the policy of being open and candid as set out in the principles developed for healthcare staff to use when communicating with patients, their families and carers following a patient safety incident in which a patient has been harmed.

Being Openinvolves:

• Acknowledging, apologising and explaining when things go wrong;

• Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring;

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

***The principles of Being Open***

The following set of principles has been developed to help create and embed a culture of being open.

**Acknowledgement**

All patient safety incidents should be acknowledged and reported as soon as they are identified.

**Truthfulness, timeliness and clarity of communication.**

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

Communication should also be timely: patients 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 patients and/or their carers should be kept up-to-date with the progress of an investigation.

Patients 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, and using medical jargon which they may not understand should be avoided.

**Apology**

Patients and/or their carers should receive a sincere expression of regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology, as early as possible. Both verbal and written apologies should be given.

A written apology, which clearly states Latch On Lanarkshire is sorry for the suffering and distress resulting from the incident, must also be given.

**Recognising patient and carer expectations.**

Patients 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 with a representative from Latch On Lanarkshire. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients 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 patient requiring additional support, such as an independent patient advocate or a translator.

**Professional support**

Latch On Lanarkshire supports an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Staff should expect to feel supported throughout the incident investigation process because they too may have been traumatised by being involved. .

**Risk management and systems improvement**

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

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**Clinical governance**

Being Open requires the support of patient safety and quality improvement processes through clinical governance frameworks, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence.

**Continuity of care**

Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another practitioner, the appropriate arrangements should be made for them to receive treatment elsewhere. A key part of Being Open and Candid is considering the patient’s needs or the needs of their carers or family in circumstances where the patient

**Documentation**

Throughout the Being Open process it is important to record discussions with the patient, their family and carers as well as the incident investigation.

In the case of low and moderate harm incidents a summary of Being Open communication should be documented on the corresponding incident form.

In the case of serious harm incidents a summary of Being Open communication should be documented on the corresponding incident form and in addition documentation of communications will be included within the Root Cause Analysis investigation report.

Patient safety incident documentation should include:

* Incident report
* Records of the investigation and analysis process

Written records of the Being Opendiscussions may consist of:

* The time, place and date, as well as the name and relationships of all attendees;
* The plan for providing further information to the patient, their family and carers;
* Offers of assistance and the patient’s, their family’s and carers’ response;
* Questions raised by the family and carers, and the answers given;
* Plans for follow-up meetings;
* Progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and carers;
* Copies of letters sent to the patient, their family and carers, and the GP for patient safety incidents not occurring within primary care;
* Copies of any statements taken in relation to the patient safety incident;
* A copy of the incident report.

A summary of the Being Opendiscussions should be shared with the patient, their family and carers.