Duty of Candour – Policy for Scottish Services
Policy Statement and Legal Context

This policy sets out how WNHC will respond to the statutory requirement to be open and transparent with people who use our services and their representatives if a **serious adverse event** occurs which results in harm or death.

This policy document also outlines the process by which staff must comply with the professional, contractual, and statutory Duty of Candour to make sure that if a harmful event occurs, people who use our services and their relatives and or representatives, are fully and **directly and meaningfully** involved. This policy reflects our commitment to meeting the requirement that we offer to meet with the affected person and / or their representative, and also establish what their preferred method of communication is and use this throughout.

Care Inspectorate

Any incident which invokes the Duty of Candour must be notified to the Care Inspectorate under ***The Duty of Candour Procedure (Scotland) Regulations 2018 Scottish*** Ministers made these regulations in exercising their powers granted to them by: ***The Health (tobacco, Nicotine etc. and Care) (Scotland) Act 2016 Section 22 (1) and (2)***

What is the Duty of Candour?

Candour *– the quality of being open, honest, and frank.*

The Duty of Candour came into effect in Scotland 1 April **2018.**

It is a legal duty that all health, social work, and care services have to identify, inform and **apologise** to people using our services and their representatives when an unintended or unexpected **serious** adverse event happens, during the provision of care, which appears to have caused harm or death.

This is the case when the harm is not related to the **natural course** of the person's illness or current condition for which they are receiving care. Or if additional treatment is required to prevent injury that would result in death or harm. A serious adverse event is not always caused by a human factor, sometimes the cause might be a process or procedure.

Harm

Care at Home (WNCH

Duty of Candour – Policy for Scottish Services

WNCH understands that the incidents in which a specific duty of candour is owed as opposed to the general duty *(to act openly and transparently)* are those described in the Duty of Candour Procedure (Scotland) Regulation 2018 Regulations 2-7

i.e., unintended, or unexpected incidents that might occur in the delivery of the care service that: *"in the reasonable opinion of a registered health care professional appear to have resulted in:*

A. The death of the person.
B. Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm").
C. Harm, which is not severe harm, but which results in one or more of the following criterions:
   - an increase in the person's treatment.
   - changes to the structure of the person's body.
   - the shortening of the life expectancy of the person.
   - an impairment of the sensory, motor, or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days.
   - the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.

D. The person requires treatment by a registered health professional to prevent:
   - the death of the person.
   - any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph B or C.

The responsible person

The Duty of Candour applies to **organisations**, known in the legislation as the **responsible person**, rather than individuals within the organisation. The duty helps us in our commitment to have a reflective culture where we are open, transparent, willing to learn and to continually improve.

The duty is not about blame and as the legislation states, staff can be expected to be supported where the duty has been invoked. Our apology to a person harmed will.

also reflect this commitment to a learning culture and be a genuine statement of regret that harm has been experienced.

Near misses

The Duty of Candour procedure will not be activated for near misses. This is because no death or harm (as defined by the Act) will have occurred and so the statutory nature of the procedure cannot apply. We will continue to review near misses as part of our commitment to learning.

Our Process

WNCH understands that whenever an incident subject to the duty of candour occurs, this must be notified to the Care Inspectorate and the following process followed:

- **Inform without delay** the person harmed, referred to in the legislation as the *relevant person* (hereafter referred to as service user) and / or their representative, that an incident has occurred. This should take place **within 10 working days** of the procedure start date – the date a registered health professional confirms that the incident may have resulted in specific harm.
- Make available or provide information about **support** to the service user.
- **Directly involve** and explain to the service use and/or their representative the exact details of the incident.

- Acknowledge that harm has occurred and **offer a sincere apology,** including expressing sorrow / regret for what has happened and the impact on the service user.
- Offer to **meet with** the service user and / or their representative.
- Describe in detail what action we are taking to **investigate** and assure the service user and/or their representative of our commitment to keeping them fully involved and informed.
- Establish with the service user and/or their representative their **preferred method of communication** for their continued meaningful involvement throughout any investigation of the incident.
- Provide the service user and/or their representative with a detailed account of the incident **in writing** and a corresponding apology in writing if a written apology is requested.
- Keep **full records** of the incident, including all associated correspondence and action taken with the service user and /or their representative to carry out the duty of candour.
- Conduct a **review** of the incident, within 3 months of the procedure start date, and provide updates and a final report of the **outcome**, in the method of communication agreed.
- If a person has given consent to their care and support, the above actions will be

directed to them personally, and to others, with their personal agreement.
- In circumstances where a person hasn't been able to give their consent about their care due to mental incapacity, the actions will be communicated to them lawful representative(s); with the expectation that the service user will be involved as much as possible.

Staff training

Staff will be trained in the policy and associated procedure from the point of induction to reflect and instil our culture of openness and transparency. They will be supported to understand their individual responsibility to identify where **specific** harm, relevant to the act, has occurred. Staff will also be supported to ensure they follow the procedure for duty of candour when any incident falls within its scope. Training will help staff understand that an apology isn't *any* admission of blame or an admission of liability in a legal sense. And that an apology is not an admission of negligence.

Annual Report

As a registered care provider, we are also required to produce a short annual report showing our learning from any Duty of Candour incidents each year, to publish this report and notify the Care Inspectorate that it has been published. Our report will include all and any cases we have identified, changes to policies and new ways of working we have adopted because of lessons learned and improvements we have made.