Derbyshire County Council - Adult Social Care & Health

Duty of Candour for Direct Care Policy

Version 2

Contents

If you would like to make any comments, amendments, additions etc please email ASCH.adultcare.policy@derbyshire.gov.uk

Introduction

Following the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, a statutory 'Duty of Candour' was introduced for all health and care providers.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposes a duty upon providers carrying out regulated activity to always act in an open and transparent manner. The regulation sets out specific requirements for when things go wrong. The Duty of Candour obligation is triggered when a *'**notifiable safety incident**'* occurs. The definition of notifiable safety incident is defined in the regulations and is detailed below.

In broad terms the Care Quality Commission has provided guidance that our Duty of Candour obligations are triggered when an unintended or unexpected incident occurs during the provision of care and the staff involved have made a mistake or not done something they should have done.

Aims

This policy provides guidance on the statutory Duty of Candour requirements to all staff working within Derbyshire County Council's regulated services.

The aim is to improve the quality, consistency and speed of communication with individuals/ families and carers when a 'notifiable safety incident' occurs.

The intention is to help ensure that all employees are able to identify a 'notifiable safety incident' and to take the appropriate action following such an incident.

What is a Notifiable Safety Incident?

'Notifiable safety incident' is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications.

A notifiable safety incident must meet all 3 of the following criteria:

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of a regulated activity
3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

This element varies slightly depending on the type of provider.

In the reasonable opinion of a healthcare professional, the incident appears to have resulted in, or requires treatment to prevent:

- the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
- the person experiencing a sensory, motor or intellectual impairment that has lasted, or is likely to last, for a continuous period of at least 28 days
- changes to the structure of the person's body
- the person experiencing prolonged pain or prolonged psychological harm, or

- a shorter life expectancy for the person using the service.

These definitions of harm are aligned to CQC's notification system for reporting deaths and serious injuries.

What should you do if a Notifiable Safety Incident occurs?

All staff must report what they consider to be a notifiable safety incident immediately to the registered manager of the service. Where a registered service manager or their nominated deputy (where applicable) considers that a 'notifiable safety incident' has, or may have occurred, it is their responsibility to take the following steps as soon as reasonably practicable after they become aware of such an incident:

- inform the service manager and group manager of the incident - the group manager will complete an internal 'notifiable incident form'
- complete the 'client incident and action record' workflow on the Mosiac system
- complete relevant notification and submit to the Care Quality Commission (CQC). See the process for making notifications to the CQC at Appendix 1
- notify the relevant person of the incident - this means speaking to the individual directly if this is possible and appropriate, or to a person acting lawfully on their behalf if the individual has died or they do not have the required capacity - this will usually be a family member or an advocate if the client does not have any family
- this must be in person in the first instance and then followed up in writing.

The initial contact must:

- be given in person by the registered person or one or more of their representatives
- provide an account which is true and includes all the facts known at that time
- advise whether further enquiries into the incident are considered to be necessary and what they are
- include an apology - please note this is not an admission of guilt but rather a sincere expression of sorrow or regret that something has gone wrong
- a case note should be made to record this initial contact.

The follow up letter must:

- be completed in writing - please see suggested templates at Appendix 2a or Appendix 2b for an outline - these templates are for guidance only and should be modified accordingly depending upon the circumstances
- be checked, logged and approved by the central Quality and Compliance (Q&C) team before sent
- include details of the initial conversation which would have taken place in person, in accordance with the guidance above
- provide an account which is true and includes all the facts known at the time of writing
- provide details of any further enquiries which have been undertaken and the results of those enquiries; and

- include an apology - please note this is not an admission of guilt but rather a sincere expression of sorrow or regret that something has gone wrong
- this letter should be sent within 10 days of the notifiable safety incident occurring.

Please note that where the individual/family/advocate cannot be contacted in person or declines to speak to the registered manager, then the notification requirements do not apply but a record should be kept of the attempts to make contact.

Reasonable support should be provided to the individual and their family when you notify them of the incident.

Please be aware that if any person attempts to prevent you acting in accordance with the Duty of Candour obligation this should be escalated immediately to your line manager or refer to the council's 'Whistle Blowing Confidential Reporting Code' for alternative options.

The CQC has produced guidance to providers of social care with respect to the Duty of Candour obligations.

Author History

Approval and Authorisation History

Name	Date
Authored by Safeguarding, Quality and Compliance team	January 2023
Approved by DMT	January 2023

Change History

Version	Date	Name	Reason
Version 1	January 2023	Quality and compliance team	New guidance
Version 1.1	November 2023	Quality and compliance team	Review and minor changes
Version 2	October 2024	Quality and compliance team	Changes to make the process clearer