Company Name: George Springall Homecare Partnership

GEORGE SPRINGALL HOMECARE

Leading the way in outstanding care

Policy No: 03-1016	Authorised: Roxane Lane	Date: 15/05/2022

DUTY OF CANDOUR

This Policy will summarise the Organisation's philosophy towards promoting a culture of openness, transparency and truthfulness as a significant factor in improving the safety of our service users and the quality of the care services provided, and detail the procedure to be followed upon discovering that a notifiable safety incident has occurred. This is in accordance with Part 3; Section 2; Regulation 20; of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014:

1. DEFINITIONS & TERMINOLOGY:

Specific terminology is used in this Policy, which have the following explanations:

1.1 "*Notifiable safety incident*" - any unexpected or unintended health or safety incident that occurred with respect to a service user during delivery of the care service that, in the opinion of a health care professional, could result, or appears to have resulted in, severe harm, moderate harm, prolonged psychological harm, or the death of the service user (where the death relates directly to the incident rather than a natural progression of the service user's underlying medical condition).

1.2 "*Severe harm*" - a permanent lessening of sensory, bodily, motor, physiological or intellectual functions that relates directly to the incident rather than a natural progression of the service user's underlying medical condition.

1.3 "*Moderate harm*" - significant but not permanent harm, or harm that may require a moderate increase in the service user's care or treatment regime (e.g. a prolonged episode of specialist care, admission to hospital as an out-patient).

1.4 "*Prolonged psychological harm*" - psychological harm that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

1.5 "*Advocate*" - a person acting lawfully on behalf of the service user under the following circumstances: (see also *Policy No 3101 - Service User - Advocacy*):

1.5.1 Upon the death of a service user.

1.5.2 Where the service user is under 16 and not competent to make decisions concerning their care.

1.5.3 Where the service user is 16 or over and lacks the mental capacity to make decisions concerning their care. (Reference sections 2 and 3 of the *Mental Capacity Act 2005*).

2. DUTY OF CANDOUR is also referred to as "Being Open", and involves 3 key principles of honesty which are implicit in our management philosophies:

2.1 Acknowledging, apologising and explaining when things go wrong.

2.2 Conducting a thorough investigation into the incident involving the service user, and providing reassurance that lessons have been learned that will help to prevent a recurrence of the incident in the future.

2.3 Providing support for the parties involved (service users and staff) to help cope with the physical and psychological consequences of the incident.

3. PROCEDURE:

Upon discovering that a notifiable safety incident has occurred, the Manager of the Organisation will conduct the following

procedure:

3.1 Notify the service user (or advocate), in writing, of the incident.

3.2 Provide the service user (or advocate) with an open, honest and transparent account of all the facts that are known about the incident as at the date of the incident.

3.3 Provide a written apology to the service user (or advocate), expressing appropriate sorrow and regret concerning the incident, and providing any special support requirements that the service user may have as a result of the incident.

3.4 Advise the service user (or advocate) what further enquiries are to be made and / or action to be taken that the Organisation deems appropriate to satisfactorily resolve the matter.

3.5 Develop a plan of corrective action, identifying responsibilities and time frames, and implementing this Corrective Action Plan. This may involve the pursuit of more in-depth enquiries, as appropriate.

3.6 Within 10 days, advise the service user (or advocate) in writing of the results of these further enquiries, and of the results of implementing the Corrective Action Plan, ref. clause 3.5 of this Policy.

3.7 Complete the Incident & Action Log (ref *Form No: 2-107*) as appropriate.

3.8 Create an *Incident File*, which must contain full and comprehensive records of the following:

- Details of the notifiable safety incident and subsequent consequences;
- Copies of all appropriate reports and correspondence, including a written apology;
- Copy of any Action Plans developed, and results of any action taken;
- Any changes to management Policies made as a result of these investigations;
- Records of all relevant telephone calls between the Organisation and service user / advocate;
- Records of any other relevant telephone calls between the Organisation and external agencies;
- Management sign-off and closure of the incident.

3.9 If the service user (or advocate) cannot be contacted, or declines to co-operate with the Organisation, full records of positive attempts to do so will be included in the Incident File.

FORMS REFERENCES:

Form No: 2-107 Incident & Action Log