Duty of Candour (Being Open) Policy

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Aim of the Policy

Following the Francis Enquiry into the failings at Mid Staffordshire, The Department of Health introduced a contractual Duty of Candour on care organisations and a statutory duty came into force in November 2014. The duty largely builds on the existing National Patient Safety (NPSA) Being Open Framework supplemented by a Patient Safety Alert issued in November 2009 but it outlines deadlines for verbal and written communication with patients. The statutory duty is now enshrined in a joint professional statement from the General Medical Council (GMC) and Nursing & Midwfiery Council (NMC).

This policy is based on the updated framework and aims to give clear guidance to staff who have been involved in patient safety incidents so that they communicate with patients, relatives and/or carers effectively. Elizabeth Finn Homes Ltd believes that, if a resident is harmed as a result of a mistake or error in their care, they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response. This is defined as *Being open* and this policy sets out the commitment by Elizabeth Finn Homes Ltd to:

- apologise for the harm caused;
- explain, openly and honestly, what has gone wrong;
- describe what we are doing in response to the mistake;
- offer support and counselling services that might be able to help;
- provide the name of a person to speak to;
- give updates on the results of any investigation.

The above paragraph and bullet points are taken from the National Patient Safety Agency's patient charter 'Being open with our patients' (September 2005). Elizabeth Finn Homes Ltd is committed to this charter in all its activities and interfaces with residents.

The Duty of Candour statutory and contractual requirements mandate us to implement being open discussions for all residents who have suffered moderate, severe harm or death as a result of an incident. These need to be clearly documented in letters and our records.

This policy also sets out the documentation required so that evidence can be provided to Regulators.

Policy Statement

Introduction

The Statutory Duty of Candour became law as part of regulations from The Health & Social Care Act enacted in 2014. This outlined the process by which an organisation must acknowledge, apologise and explain when something goes wrong to the individual concerned. They also are required to investigate and learn lessons where possible while providing support to those involved.

In March 2015 the Care Quality Commission issued Regulation 20: Duty of Candour, which gives providers information on how they can comply with the law.

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The GMC and NMC issued a joint professional statement which outlines the responsibilities of medical and nursing staff to be open and honest with patients, or those close to them, if something goes wrong.

All of these new requirements build on the NPSA supporting information to their Patient Safety Alert on Being Open (NPSA, 2009).

The benefits of *Being open* are widely recognised and supported by policy makers, within the Department of Health, the National Health Service Litigation Authority (NHSLA), Medical Defence Union (MDU) and the Medical Protection Society (MPS). It is also enshrined in the NHS Constitution for England (2013):

"*when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again"*

Fear of legal action may be prevent some healthcare professionals from being open with residents, but guidance from professional bodies aim reassure healthcare professionals that they are not admitting liability if they apologise when something has gone wrong with their treatment of a patient."

Elizabeth Finn Homes Ltd welcomes the policy direction outlined above. Elizabeth Finn Homes supports and promotes a culture of openness, which entails apologising and explaining what happened to residents who have been harmed as a result of their care. It ensures that communication is open, honest and occurs as soon as possible following an incident or complaint between the home, care teams and residents, their families and/or their carers.

Purpose

The primary purpose of this policy is to ensure that when an unintended or unexpected incident occurs led to harm for one or more residents there is open communication between all parties, residents their families and carers, they feel supported and an appropriate apology is issued in line with the 10 principles of Being open (Appendix B) and that this is clearly documented in the records and /or in communications with the resident and /or family.

In addition, the purpose of this policy, is to provide clear information to staff on what they do when they are involved and the support available to them to cope with the consequences of the event and to foster a fair and open culture for reporting in accordance with the principles set out in the Elizabeth Finn Homes Risk Management Policy and the NPSA 'Being Open' Framework.

This policy is designed to ensure that Elizabeth Finn Homes Ltd meets its obligations to residents, relatives and the public by being open and honest about any mistakes.

The desired aims and outcomes of this policy are:

- To improve the resident experience and satisfaction with Elzabeth Finn Homes Ltd
- To ensure that residents and/or their relatives receive a meaningful apology when things go wrong
- To ensure residents and/or their relatives are further supported
- To ensure that staff feel supported in apologising and explaining to residents and/or their relatives
- To ensure that Elizabeth Finn Homes Ltd will learn lessons to prevent similar harm for occurring to someone else.

Seven steps to patient safety (NPSA, 2003) explains the importance of organisational commitment to improving patient safety. This commitment is required throughout the whole of Elizabeth Finn Homes Ltd, from the board through to clinical and non-clinical staff. Board and senior managers and Home Managers must ensure Being Open principles are embedded in the organisation and demonstrate the core values and culture of the organisation.

3. Definitions

In respect of this policy the following definitions apply:

Patient Safety Incident - is defined by the NPSA as any unintended or unexpected incident which could have or did lead to harm for one or more residents receiving care

Complaint: an expression of dissatisfaction by a resident or their representative which the resident or representative wishes to be investigated under the Elizabeth Finn Homes Ltd complaints procedure

Concern: an expression of dissatisfaction by a resident or their representative which the resident or representative does not wish to be investigated under the Elizabeth Finn Homes Ltd complaints procedure

Claim: a claim is defined as any allegation or demand for compensation made against Elizabeth Finn Homes Ltd following an adverse incident that results in:

- Personal injury to resident, staff or third parties
- Damage/ loss to resident, staff or third parties

Being Open - means apologising and explaining what happened to residents and/or their relatives if any harm is caused during an episode of care, or following the identification of concerns, either formally or informally, regarding any aspect of their care.

Duty of Candour- means that Elizabeth Finn Homes Ltd has a duty disclose material facts. In the context of care the approach to disclosure should be in line with “being open” requirements.

Representative – a relative, carer, advocate or other individual nominated by the resident or, in the case of the resident being deceased, their next of kin, to act on their behalf. (This does not include lawyers, etc, acting in an official capacity).

Care professionals – staff working for Elizabeth Finn Homes Ltd

Root Cause Analysis (RCA) – a systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for resident safety incidents, it looks beyond the individual concerned and seeks to understand the underlying causes and environmental context in which an incident happened.

Scope

This policy applies to all staff (temporary or permanent) working in all the locations registered by Elizabeth Finn Homes Ltd with the Care Quality Commission (CQC), to provide its regulated activities. This also includes volunteers, contractors, students and/or trainees. The CQC summary of regulation 20 is included as Appendix A.

The statutory requirements (Nov. 2014) state that the duty of candour applies to all resident safety incidents that result in moderate harm, severe harm or death. It will not apply to low/no harm incidents to avoid excessive burdens but these incidents should still be reported to the resident if appropriate. This policy endorses this approach to being open. With lower level incidents where there is no or low

harm, Elizabeth Finn Homes Ltd incident reporting process should still be followed and actions taken to prevent similar occurrences.

In cases which could involve the Coroner, the Coroner may request the case is not discussed with other parties until the facts have been considered. However this should not preclude a verbal and written apology or expression of regret where appropriate.

Roles and Responsibilities

Board of Trustees

The Board of Trustees has executive and non executive leads responsible for ensuring Being Open principles are embedded within the Trust and link to the organisation's values and culture.

Committee Structure

The following Committees have a role in the Being Open Processes:

- **The Audit and Risk Commi**ttee is a sub-committee of the Board and is the committee responsible for the strategic management of clinical and non-clinical risks. The Committee will be responsible for ensuring Elizabeth Finn Homes Ltd promotes a culture of openness to improving resident safety.

- **The Health ,Safety and Risk Management Committee** has responsibility for receiving reports and monitoring that communication has happened between the Elizabeth Finn Homes Ltd and the resident / their relative / carer for all non-clinical incidents.

The Chief Executive Officer

The Chief Executive Officer has ultimate responsibility for ensuring that there a culture of openness and support for both resident and staff when a resident safety incident occurs in the organisation

In conjunction with the Board of Trustees, the Chief Executive is responsible for actively championing the Duty of Candour process by promoting an open and fair culture that fosters peer support and discourages the attribution of blame. He/ she will also ensure that the non- Executive Directors,Safeguarding Lead for the Board and Chair of the Board are informed of quality issues so they able to challenge our approach to being open.

Senior Managers / Registered Manager

Following the discovery of an incident, it is the responsibility of the Senior Manager on Duty or Registered Manager to enter into communication with the resident, their relative or carer. At this stage further advice may be gained from the Chief Executive Officer, Elizabeth Finn Homes Ltd Safguarding Lead or the Health, Safety and Risk Manager. The care staff involved in the residents care may require emotional support and advice and home managers and their deputies are to ensure that the necessary are provided along with feedback on the final outcome. Clear records should be kept to document the content of these conversations.

All staff

All staff working within Elizabeth Finn Homes Ltd will be expected to adhere to this policy. All staff have a responsibility for ensuring that resident incidents are acknowledged and reported as soon as they are identified. In cases where the resident and/or carers inform staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all staff.

Principles of Being Open

Being Open is governed by ten Key Principles (see Appendix B). These provide a framework to ensure a proactive approach to 'Being Open' in order to enable to the Trust to learn from patient safety incidents.

Being open involves:

- Acknowledging, apologising and explaining in a timely manner when residents have experienced harm, or have expressed concerns about their care
- Residents' right to expect openness and honesty in their healthcare based on factual information
- Provision of support to residents and staff to cope with the physical and psychological consequences of what happened
- Conducting a thorough investigation into the incident and reassuring residents and / or their relatives that lessons learned will help prevent the incident recurring
- Developing action plans and recommendations to prevent recurrence of incidents and improve services
- Satisfaction that communication with residents and/or their relatives following a resident safety incident has been handled in the most appropriate way.
- Improving the understanding of incidents from the perspective of the resident and / or their relatives.
- The knowledge that lessons learned from incidents will help prevent them happening again.
- Having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.
- Applying the principles of this Being Open policy to communicate to residents / relatives is more likely to lead to forgiveness and understanding of errors in care delivery if they are discussed fully in a timely and thoughtful manner.
- By *Being Open*, staff can decrease the trauma felt by residents following a resident safety incident.
- Sharing lessons both within Elizabeth Finn Homes Ltd and with stakeholders

Saying sorry is not an admission of liability and it is the right thing to do. Staff may feel cautious about apologising for things that go wrong as they worry that they might say the wrong things, make the situation worse and may automatically be blamed for the mistake. However, residents and their families can cope better if staff are open about mistakes.

It is also essential that any information given is based solely on the facts known at that time. Staff must explain that new information may emerge as an incident investigation is undertaken, and that residents, and their families will be kept up-to-date with the progress of an investigation. Residents and their families must have a single contact person who is responsible for any questions or requests they may have. They should receive clear, unambiguous information which is free from jargon.

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Fair and Open Culture

A clinical or non-clinical error, accident or incident, however serious, is rarely caused wilfully. It is not, in itself, evidence of carelessness, neglect or a failure to carry out a duty of care. Errors are often caused by a number of factors including, process problems, human error, individual behaviour and lack of knowledge or skills. Learning from such incidents can only take place when they are reported and investigated in a positive, open and structured way.

Determining safe practice is an important part of successful risk management. Moving away from punishing errors to learning from them will promote a fair and open culture and safe practice throughout the organisation. This will enable Elizabeth Finn Homes Ltd to identify trends and take positive action to prevent the error or adverse incident from happening again.

To promote a fair and open culture and encourage the reporting of incidents, Elizabeth Finn Homes Ltd will take a non-punitive approach to those incidents it investigates. Staff remain accountable to residents and their professional bodies for their actions, but a non-punitive approach means that action (under disciplinary or capability procedures) will not be taken against a member of staff for reporting an incident, except in rare circumstances such as:

- *Professional or gross personal misconduct*
- *Repeated breaches of acceptable behaviour or protocol*
- *An incident that results in a police investigation.*

Openness when things go wrong is fundamental to the partnership between residents and those who provide their care. The initial 'Being Open' discussion must occur as soon as possible after the acknowledgement of the resident safety incident. All communication with the resident/relative should be documented in the residents notes and must be a true reflection of what was said to the resident/relative.

Effective communication with residents and their relatives

- Should begin at the start of their care
- Should continue throughout their stay in an Elizabeth Finn Home
- Should be no different when a resident safety incident occurs
- Should be open and honest about what happened, noting that discussing resident safety incidents promptly, fully and compassionately can help residents / relatives:
    a. Cope better with the after-effects
    b. Can help prevent events becoming formal complaints, claims and litigation avoiding distress and possibly incurrence of extra costs through litigation and further treatment
    c. Establishes partnership between residents / relatives and those who provide their care

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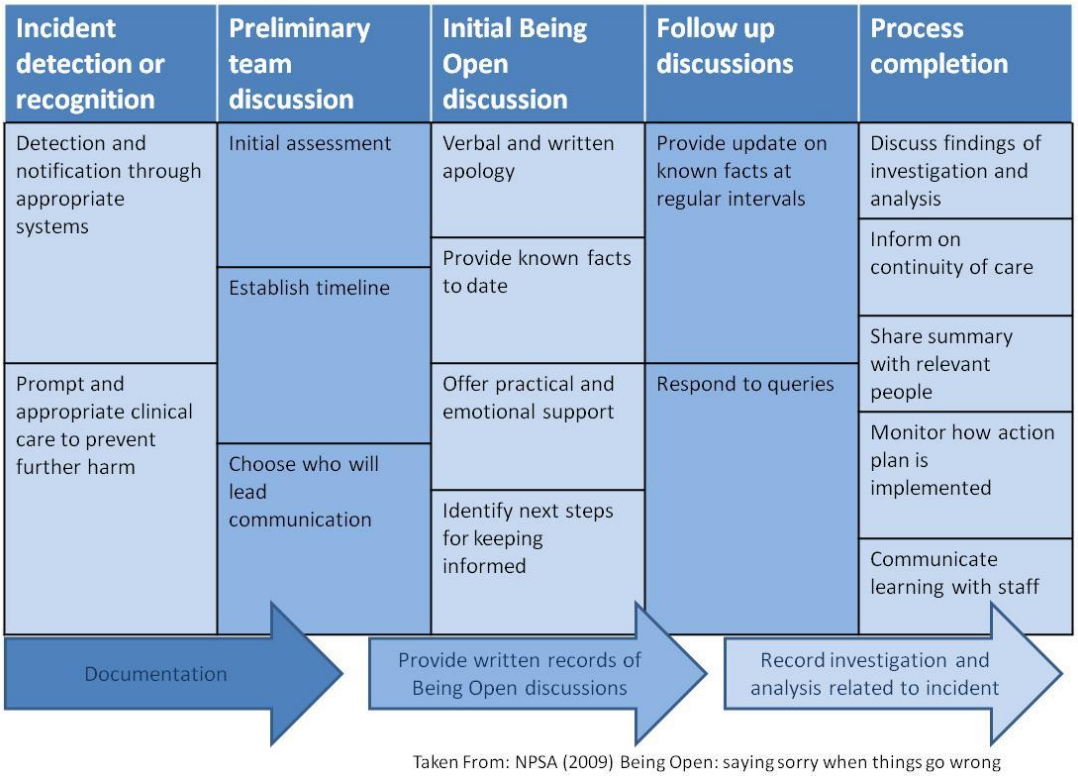
Overview of the Being Open Process



Taken From: NPSA (2009) Being Open: saying sorry when things go wrong

The Being Open process

The Being Open Process has been summarised above. Each stage of the process will now be outlined in more detail:

Stage 1: Incident Detection and Recognition

The *Being Open* process begins with the recognition that a resident has suffered moderate harm, severe harm, or death, as a result of an incident. (A full definition of moderate incidents is included in Appendix C). This occurrence may be identified by:

- a member of staff at the time of the incident
- a member of staff retrospectively when an unexpected outcome is detected
- a resident and/or relative who expresses concern or dissatisfaction with the residents care either at the time of the incident or retrospectively
- incident detection systems such as incident reporting
- other sources such as detection by other residents, visitors or non-clinical staff

Notification and Documentation - As soon as a resident incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable with appropriate consent. The Incident Reporting Policy and Procedure should be implemented. This would include:

- Informing senior/line management

- Completing an incident form and an entry on Access and Clinical
- Immediate rapid response review (within 48 hours)
- Clear documentation of all of the above in the residents notes

Stage 2 Preliminary team discussion

There should be a preliminary team meeting led by the Operational Support Manager / General Manager The meeting should aim to:

- establish basic facts and assess the response required based on the level of harm
- agree responsibilities for individuals
- identify who will be able to communicate with the resident and / or family on a consistent basis. This will normally be the most senior person responsible for the residents care. They should also have good communication skills, be aware of the facts and any cultural requirements. In exceptional cases a substitute may be identified such as someone with a health safety, risk or governance brief.
- Consider use of advocates where necessary
- Identify support for the care staff involved. Junior staff may wish to be involved in a discussion but should not be expected to lead.
- The resident / family must be informed that a suspected or actual resident safety incident has occurred as soon as possible but at least within 10 working days of the incident being reported. The initial discussion should be verbal and face to face unless factors dictate otherwise. The discussion must be accompanied by the offer of a written notification, which should be sent no later than 10 days after the initial conversation. This should be documented in the resident notes and on the incident reporting system.

NB Members of staff involved in any error may wish to be present but this should be based individually and also on resident or family wishes. In cases where the healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting. Alternatively a personal letter may be given to the resident or family if a meeting is not acceptable to one of the parties.

The meeting should take place as soon as practically possible based on the condition of the resident and the availability of staff.

Stage 3 The initial *Duty of Candour* discussion

The initial *Being Open* discussion is the first part of an ongoing communication process with the resident or family. There should be repeated opportunities for the resident and/or family to obtain information about the incident. The following is an outline for the content of the first Being Open discussion, subject to resident and family preferences:

- **An expression of genuine sympathy**
- **Details of the investigation process**
- **Facts that have been established by the multidisciplinary team**
- **An invitation for the resident or family to share their understanding of events**
- **An explanation short and long term effects of the harm**
- **An explanation of what will happen next**
- **An offer of emotional support**
- **Where relevant, family may be referred to the Coroner for more information.**

It is essential that the following **does not** occur during the "*Being Open"* initial discussion:

- **Speculation**
- **Attribution of blame**
- **Denial of responsibility**
- **Provision of conflicting information from different individuals**

Stage 4 Follow up discussion

Further meetings may be needed depending on the circumstances and complexity of the incident. These meetings should:

- Occur as soon as possible
- Provide the most up to date factual information with the resident and/or family
- Be formally documented
- Not speculate or attribute blame
- Offer the resident/family the opportunity to ask questions and contribute to the process
- Offer the resident/ family the opportunity to discuss with another professional
- Consider whether to ask the resident or family if they are satisfied with the investigation
- Offer contact details in case the resident/family needs to communicate at a later date.
- Ideally be held in a quiet room away from the place of the incident.

After any formal investigation or meeting a letter should be sent to the resident and /or their representative with an apology for any shortcomings, a chronology of the event, details of the residents/representative's concerns and complaints, a summary of contributing factors and information on what is to be done to avoid recurrence. A template letter is attached for use at Appendix D.

Stage 5 Process completion

Communication with the resident and/or family

After completion of the incident investigation, feedback must be simple to understand and must take the form most acceptable to the resident / family The feedback communicated to the resident / family must be recorded in the resident's notes. Whatever method is used for the feedback, the communication is to include:

- The chronology of clinical and other relevant facts
- Details of the resident's and/or their relatives concerns and complaints
- A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the resident safety incident
- A summary of the factors that contributed to the incident
- Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored

In most cases there will be a complete discussion of the findings of the investigation and analysis but in some cases information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the resident
- Where investigations are pending coronial processes
- Where specific legal requirements preclude disclosure for specific purposes

In these cases the resident / relative must be informed of the reasons for the restrictions.

All residents and their relatives who are affected by an incident which is being investigated need to be made aware of their right to pursue any issues they have about the incident via the Elizabeth Finn Homes Ltd complaints procedure if they wish. This does not replace the incident investigation but takes place alongside it.

Continuity of Care

When a resident has been harmed during the course of care and requires further therapeutic management or rehabilitation, they must be informed of the ongoing care plan.

Residents are to be reassured of their continued care as required by their care needs, even in circumstances where there is a dispute between them and the home.

They should also be informed that they have the right to continue their care elsewhere if they have lost confidence in the care team involved in the resident safety incident.

Communication with the General Practitioner

The home might also consider including the GP in one of the follow-up discussions.

Feedback and Communication of changes to staff

The results of Duty of Candour/Being Open discussions with residents and/or relativesmust be fed back by the Home Manager to the staff to indicate the lessons learnt and actions taken to prevent reoccurrence. These should be included in the full incident report so that monitoring of the actions can be completed.

Documentation

A full record of the incident should be recorded in the residents notes and an incident form should be completed as soon as possible.The Duty of Candour conversation and follow-up letter must also be documented on the residents file

There should be documentation of:

- the time, place, date, as well as the name and relationships of all attendees
- the plan for providing further information
- details of any apology given
- offers of assistance and the residents and/or families response
- questions raised by the family or their representatives and the answers given
- plans for follow-up as discussed
- progress notes relating to the care situation and an accurate summary of all the points explained to the resident / relative
- copies of any statements taken in relation to the resident safety incident
- a copy of the incident report
- Feedback to staff
- Communication withGP

Residents / Relatives who do not agree with the information provided

When a resident or relative do not agree with the information provided whether it is due to breakdown in communication, interpretation of the events, bereavement and/ or any other issues, immediately follow the guidelines below:

- Inform the Operations Support Manager
- Offer the resident or relative another contact person within the team directly involved in the patient case and with whom they may feel more comfortable
- Ensure information regarding access to support services are provided
- Ensure the resident or relative are fully aware of the complaint procedures
- Consider use of a mutually agreed mediator
- Write a complete list of points that the resident or relative disagree with and reassure them you would follow up on these issues and give timely feed to them

References

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- Department of Health. (1999). HSC 1999/198. The Public Disclosure Act 1998: Whistle blowing in the NHS. London: Department of Health
- General Medical Council/Nursing Midwifery Council (2015)Openness and honesty when things go wrong: the professional duty of candour. London GMC&NMC
- National Patient Safety Agency (NPSA). (2009). Being Open: Saying sorry when things go wrong. London: NPSA
- National Patient Safety Agency (NPSA). (2009). Seven Steps to Patient Safety in General Practice. London: National Patient Safety Agency.
- National Patient Safety Agency (NPSA) (2010) *Medical Error: What to do if things go wrong: A guide for junior doctors*
- Nursing & Midwifery Council (NMC) (2010 [2008]) *The Code: Standards of conduct, performance and ethics for nurses and midwives'*

Appendix A: Regulation 20

Regulation 20: Duty of candour

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(1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) 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 registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

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

(d) an apology.

(5) But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person —

(a) paragraphs (2) to (4) are not to apply, and

(b) a written record is to be kept of attempts to contact or to speak to the relevant person.

(6) The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).

(7) In this regulation—

"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 paragraphs (8) and (9);

“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;

“prolonged pain” means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

“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.

(8) 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.

(9) 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

(v.) 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)

Appendix B

Ten Principles of Being Open

1. Principle of acknowledgement

All resident safety incidents should be acknowledged and reported as soon as they are identified in line with the Incident Reporting Policy. In cases where the resident or family inform care staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all Home staff. Denial of a resident's concerns will make future open and honest communication more difficult.

2. Principle of truthfulness, timeliness and clarity of communication

Information about a resident safety incident must be given in a truthful and open manner by an appropriately nominated person. Residents / Family want a step-by-step explanation of what happened, that considers their individual needs and is delivered openly. Communication should also be timely: 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. Staff involved in the "Being Open Process" should explain that new information may emerge as an incident investigation is undertaken, and they will be kept up-to-date with the progress of an investigation.

Residents / Families 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. Medical jargon, which they may not understand, should be avoided.

3. Principle of apology

Residents / Family should receive a sincere expression of sorrow or regret for the harm that has resulted from a safety incident. This should be in the form of an appropriately worded apology, as early as possible.

Both verbal and written apologies should be given. The decision on which staff member should give the apology should consider seniority, relationship to the resident, and experience and expertise

Verbal apologies are essential because they allow face-to-face contact between the Resident / Family and Home Manager. It is important not to delay for any reason, including: setting up a more formal multidisciplinary *Being Open* discussion, fear and apprehension, or lack of staff availability. Delays are likely to increase anxiety, anger or frustration.

A written apology, which clearly states Elizabeth Finn Homes Ltd is sorry for the suffering and distress resulting from the incident, must also be given. An apology is not an admission of liability.

4. Principle of recognising Resident / Family expectations

Residents / family can reasonably expect to be fully informed of the issues surrounding a safety incident and its consequences in a face-to-face meeting. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. They should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include an independent advocate.

5. Principle of professional support

Elizabeth Finn Homes Ltd Open and Fair culture creates an environment in which all staff, whether directly employed or independent contractors, are encouraged to report safety incidents. Managers should ensure that staff feels supported throughout the incident investigation process as they too may have been traumatised by being involved. They should not be **unfairly** exposed to punitive disciplinary action, any threat to their registration.

Where there is reason for Elizabeth Finn Homes Ltd to believe that a member of staff has committed a punitive or criminal act Elizabeth Finn Homes Ltd will take steps to preserve its position, and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff will also be encouraged to seek support from relevant professional bodies such as the, Royal Colleges, and the Nursing and Midwifery Council.

6. Principle of risk management and systems improvement

Root cause analysis (RCA) should be used to uncover the underlying causes of a safety incident. Investigations should focus on improving systems of care, which will then be reviewed for their effectiveness. This policy should be read in conjunction with Elizabeth Finn Homes Ltd Risk Management Policy, Incident Reporting Policy and the Serious Incident Policy

7. Principle of multidisciplinary responsibility

This policy applies to all staff that has key roles in the residents's care. This will ensure that the *Being Open* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

8. Principle of clinical governance

Being Open has the support of resident safety and quality improvement processes through the clinical governance framework, in which resident safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the Chief Executive to the Board of Trustees to ensure these changes are implemented and their effectiveness reviewed. The findings are disseminated to staff so that they can learn from residents safety incidents through manager's feeding back locally.

Training will be included in Elizabeth Finn Homes Ltd Induction and training programs..

9. Principle of confidentiality

Full respect should be given to the resident and staff's privacy and confidentiality. Details of a safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the team involved in caring for the resident. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information.

Communications with parties outside of the Home and Senior Managers Team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the resident / family about who will be involved in the investigation before it takes place and give them the opportunity to raise any objections.

10. Principle of continuity of care

Residents are entitled to expect that they will continue to receive all usual care commensurate with their care plan and continue to be treated with respect and compassion. If a resident expresses a preference for their care needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Appendix C

Definition of levels of harm

- **Death** – the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition;
- **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.
- **Moderate harm** – means harm that requires a moderate increase in treatment, and significant, but not permanent harm.
- **Moderate increase in treatment** – means an unplanned surgery, a prolonged episode of care, admission to hospital
- **Prolonged psychological harm** - psychological harm a resident has experienced, or is likely to experience, for a continuous period of at least 28 days.

Appendix D – Template letter

Private and Confidential

Dear *Insert Name,*

I am writing, on behalf of Elizabeth Finn Homes Ltd – (HOME NAME), to express my sincere regret that (*you/your relative*) has been involved in an incident whereby *(describe the event/incident including date and place)*. I would like to offer my sincere *apologies* at this distressing and difficult time (*or other appropriate words).*

What comes here will depend on what the addressee already knows from the initial Duty of Candour conversation that is documented in the notes, for example: "I understand that *(insert name)* has already spoken to you and explained that a full investigation will take place"*.*

As an organistaion we are committed to being open with residents and their families when events such as these occur so that we gain a shared understanding of what happened, and what we can do to prevent such an incident occurring again in the future.

An investigation is already underway to try and establish the cause of the incident. If you would like to meet with a member of staff to discuss this, please let me know, and we will arrange a mutually convenient time and place to meet.

Staff member (*name/or I)* will be acting as your lead contact for the duration of the investigation. If you have any questions, or if you would like to discuss any aspect of this Moderate Incident/Serious Incident (SI) investigation *(delete as appropriate*)*, they / I* can be contacted by email on xxxxxxxxxxxxxxx or on telephone number xxxxx xxxxxxx

Once again, please accept my sincere *apologies* and those of all the staff involved in (*insert residents name)* care and treatment here at (HOME NAME)

Yours sincerely

Firstname Lastname
Job Title

Issue Date	Review Date
December 2020 CL	December 2023

	**Duty of Candour (Being Open Policy)**