Duty of Candour Policy

Policy:	Duty of Candour Policy
Purpose:	This policy sets out when the duty of candour procedure must be activated and to clarify staff responsibilities for complying with the law.
Review Date:	This is a new policy, next review date will be August 2025
Legislation	Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 Duty of Candour Procedure (Scotland) Regulations 2018.
Other Relevant Policies	Equality and Human Rights Code of Conduct Health and Safety Data Protection Complaints Notifiable Events
SHR Regulatory Standards	Standard 2: The RSL is open about and accountable for what it does. It understands and takes account of the needs and priorities of its tenants, service users and stakeholders. And its primary focus is the sustainable achievement of these priorities. Standard 5: The RSL conducts its affairs with honesty and integrity.
Care Inspectorate Guidance standards	**Health and Social Care: my support, my life** 4.4 I receive an apology if things go wrong with my care and support or my human rights are not respected, and the organisation takes responsibility for its actions. **Scottish Social Services Code of Conduct:** 1.4 Give workers clear information about their roles and responsibilities, relevant legislation and the policies and procedures they must follow in their work. **Organisational Duty of Candour guidance March 2018**
Responsible Officer	Care Service Manager
Date reviewed by Policy Review Working Group (PRWG):	02 August 2022
Date approved by Board (or PRWG if delegated):	
Publish on the Website:	Yes

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1.0 INTRODUCTION

1.1 As a housing support provider, Dalmuir Park Housing Association has a legal requirement to comply with the organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018.

1.2 Organisations providing health services, care services and social work services in Scotland are required by law to follow The Duty of Candour Procedure when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

1.3 The Scottish Government published Organisational Duty of Candour guidance in March 2018. This outlines the issues which organisations will want to consider at each point in the procedure; suggest best practice; and provides a checklist of the steps to be taken to fulfil the duty.

2.0 FOCUS OF DUTY OF CANDOUR LEGISLATION

2.1 The focus of the duty of candour legislation is to ensure that organisations tell those affected that an unintended or unexpected incident has occurred.

2.2 Apologise, involve those affected in meetings about the incident, review what happened with a view to identifying areas for improvement.

2.3 Organisations must ensure that support is in place for their employees and for others who may also be affected by unintended or unexpected incidents.

3.0 RESPONSIBLE PERSON

3.1 Every organisation covered by the duty of candour legislation is regarded as a "responsible person" with the definition as set out in section 25 of the Act. This means that the new Duty applies to organisations and not individuals.

3.2 The responsible person for the Association will be the Care Service Manager who has responsibility for:

- Carrying out the procedure
- Undertaking any training required by regulations
- reporting annually on the duty

4.0 INCIDENTS WHICH ACTIVATE THE DUTY OF CANDOUR PROCEDURE

4.1 The duty of candour procedure must be carried out by the responsible person as soon as possible, after becoming aware that an individual who has received a health,

social care or social work service has been the subject of an unintended or unexpected incident that resulted in or could result in:

- The death of the person
- A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions
- An increase in the person's medication
- 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
- The person requiring treatment by a registered health professional to prevent the death of the person; or any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above

Where an unintended or unexpected incident occurs, the Association's legal advisers and insurers will be notified without delay.

5.0 RELEVANT PERSON

5.1 A 'relevant person' is the person who has been harmed during the incident, or where that person has died, or is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided, a person acting on behalf of that person. This is set out in section 22(3) of the Act.

6.0 VIEW OF A REGISTERED HEALTH PROFESSIONAL

6.1 In the event that an incident occurs, the Association will require to source a registered health professional, who must give their view on the incident and its relationship to the occurrence of death or harm and pre-existing illnesses or underlying conditions.

6.2 The Association must ensure that the registered health professional is not someone who was involved in the incident. However, registered health professionals with an existing involvement with the relevant person should be contacted where possible.

6.3 This means that the final decision by the Association about whether to activate the duty of candour procedure for a particular incident will be informed by the views of a health professional who has not been personally involved.

6.4 In the first instance, the Care Services Manager or the Chief Executive will compile the following core information to the registered health professional:

- Details of the incident- what was the incident?
- The outcome of the incident.
- The illnesses and underlying condition of the person if known.

6.5 When a registered health professional has agreed to provide the Association with their view, this should cover the following:

- Based on the background information provided, does it appear that this incident resulted in or could result in the death or harm described?

- Does the natural course of the person's illness or underlying condition directly relate to the death or harm described?

- Health services will be contacted to assist in identifying a registered health professional who would be able to provide the required view in such circumstances.

- Where we experience difficulties in identifying a registered health professional, advice will be sought from Healthcare Improvement Scotland or the Care Inspectorate.

7.0 WRITTEN REPORT

7.1 The Association must prepare a written report of the review, which must include:

- A description of the way the review was carried out.

- statement of any actions to be taken by the Association for the purpose of improving the quality of service it provides and sharing learning with other persons or organisations to support continuous improvement in the quality of health, care, or social work service.

- A list of the actions taken for the purpose of the procedure in respect of the incident and the date each action took place.

7.2 The Association must offer to send the relevant person:

- A copy of the written report of the review.

- Details of any further information about actions taken for the purpose of improving the quality of service provided by the organisation or other health, care, or social work services.

- Details of any services or support which may be able to assist or support the relevant person, considering their needs.

8.0 RECORDS

8.1 The Association must keep a written record for each incident to which the duty of candour procedure is applied, including a copy of every document or piece of correspondence relating to the application of the duty of candour procedure.

8.2 Written record should be retained by the Association in accordance with our relevant local policies and procedures.

9.0 REPORTING & MONITORING

9.1 The Act requires the Association to prepare an annual report, as soon as reasonably practicable after the end of that financial year. The report content must comply with the Duty of Candour guidance.

9.2 The Care Services Manager will prepare the annual report on the duty of candour and report to the Chief Executive and Board.

9.3 The Care Service Manager will be responsible for notifying the Care Inspectorate of the publication of our report and in some cases a report will be sent to the Scottish Housing Regulator.

9.4 The Association will publish this annual report on our www.dpha.org.uk Website.

9.5 All Notifiable Events are reported to the Care Inspectorate and Board through the Chief Executive's report.

10.0 STAFF TRAINING & SUPPORT

10.1 The Association will ensure that all care support staff receive appropriate training including E-Learning, on the duty of candour procedure.

10.2 This training will be included within the induction process for new staff.

10.3 The Association will provide any staff member involved in an incident with details of appropriate services or support which may be able to assist or support, considering the circumstances relating to the incident, and the employee's needs, this may take the form of debriefing, counselling, or direct support

11.0 EQUALITY AND HUMAN RIGHTS

11.1 We are committed to promoting an environment of respect, understanding, encouraging diversity, and eliminating discrimination by providing equality of opportunity for all. This is reflected in our Equality and Human Rights Policy.

12.0 MAKING A COMPLAINT

12.1 Although we are committed to providing high levels of service, we accept that there may be occasions where you may not be satisfied with the service you have received from us. We value all complaints and use this information to help us improve our services. Our Complaints Policy describes our complaints procedure and how to make a complaint.

13.0 DATA PROTECTION

13.1 We will treat your personal data in line with our obligations under the current data protection regulations and our Data Protection Policy. Information regarding how your data will be used and the basis for processing your data is provided in our Customer Fair Processing Notice

14.0 POLICY REVIEW

14.1 This policy will be reviewed by the Board every 3-years or earlier if required.

APPENDIX 1

DUTY OF CANDOUR RECORD

SECTION 1: RELEVANT PERSON DETAILS (The person who has been harmed)		
Name of Relevant Person		
Address		
Mobile Number	**Telephone Number**	**E-mail address**
Date of Incident		**Location of incident**
Please provide details of the incident being reported		
Please provide illness and underlying conditions of the relevant person (if known)		
Please provide the outcome of the incident		

SECTION 2: RESPONSIBLE PERSON (Person leading the investigation)	
Responsible Person's name and position	**Date Incident Received**
Date notification that triggered the duty of candour was made to the Care Inspectorate and Chief Executive	
Initial apology to be made with the relevant person and others involved in the incident (within 2 days) **Note of the apology:**	
Responsible person to review what happened with a view to identifying areas of improvement	

SECTION 3: ACTION TAKEN & RESOLUTIONS (Include timescales)
SECTION 4: REGISTERED HEALTH PROFFESSIONAL
Has a registered health professional required to give their view on the incident? YES / NO
Date responsible person provided core information to registered health professional (Details of the incident-what was the incident-the outcome of the incident-the illness and the underlying conditions of the person if known)
Registered health professional view:
SECTION 5: LESSONS LEARNED AND FINAL REPORTS
Date of follow up meeting with the relevant person and/or their family/represetative with final written report
Date notification update to close the incident to the Care Inspectorate
Date complaint's register closed on incident
Date of Board meeting to present the final written report

Relevant person signature:	**Date:**
Responsible person signature:	**Date:**