



## Duty of Candor

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# Duty of Candor

Due to the number of calls we have received asking for information on this regulation, Redcrier has put together the following information. We hope you find it helpful, please use it in any way appropriate.

Duty of candour is regulation 20 of the Health and Social Care Act 2008. This regulation grew out of the findings of two reports into the failings of Mid Staffordshire's hospital trust. These were written by Robert Francis, a Barrister specialising in the NHS and medical negligence.

Duty of candour relates to all aspects of care and treatment.

The following are definitions as defined in Robert Francis' reports:

## **Openness:**

Enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

## **Transparency:**

Ensuring information about the truth about performance and outcomes is shared with staff, patients, the public and regulators.

## **Candour:**

Any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

This Regulation puts a duty on the care provider in the following ways:

- To be open and transparent to clients using their service about any incidents relating to the client, where the client has been harmed. This should be done by informing the client of the incident, explaining how it is being dealt with and where applicable, offering an apology, regardless of whether a complaint has been made or a question asked.
- Ensuring information about how to raise concerns and make complaints is clear and easily accessible to all.
- Making sure everyone in your workplace feels able to raise any concerns they have and know the concerns will be dealt with in a professional manner.
- Ensuring that information about performance and outcomes is truthful and available to all involved including clients, their relatives, staff and relevant professional bodies like CQC.



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**CQC (Care Quality Commission) will be looking for the care provider to have in place systems to meet these requirements. These systems should include:**

- In house training for all staff on communicating with people who use services about notifiable safety incidents.
- Incident reporting forms which support the recording of a duty of candour notification.
- Support for staff when they notify people who use services when something has gone wrong, this should include a clear process that must be followed.
- A robust complaints procedure that's accessible to all.
- Policies and procedures that support a culture of openness and transparency and checks to ensure staff are following them.
- Procedures should be in place that address bullying harassment and undermining, which may prevent staff from exercising their duty of candour.

**Look at the systems you have in place, you may be meeting this requirement already or maybe you just need to make some adjustments to your current system.**

## **Notifiable safety incidents.**

These can include incidents involving injury, death, impairment, abuse, prolonged pain, any safety incident reported to or investigated by the police.

And

Any incident that may have a negative impact on the clients care such as:

An insufficient number of suitably qualified staff, an interruption of gas, water, electricity supply for more than 24 hours, physical damage to premises which is likely to have a detrimental effect to the care or treatment of the client or failure of fire alarms or safety devices for a period of more than 24 hours.

Although Duty of Candour is a new regulation, it need not be viewed as something completely new, and therefore all of your systems need renewing. In most care settings it will be a case of building on existing systems where needed.

**More information about the regulation and guidance can be found on CQC (Care Quality Commission) website [www.cqc.org.uk](http://www.cqc.org.uk).**



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