Lindsey Lodge Hospice

Duty of Candour Policy

As a healthcare provider, Lindsey Lodge Hospice strives to ensure that we are open, transparent and promote a duty of candour. Excellence in care is something we aim for and we look for ways in which we can improve the service we deliver and foster a culture of safety that supports organisational and personal learning.

This means we will act in the following ways;

Openness

We enable service users, staff and volunteers to raise concerns and complaints freely and without fear of being questioned.

Transparency

We are truthful about information regarding our performance and outcomes and share this with staff, patients, the public and regulators

Candour

Any person who is harmed by the provision of our service is informed in timely manner and is offered an appropriate remedies.

Whilst we look to minimise risk of harm or incident to our patients. Despite all our best efforts, Lindsey Lodge Hospice recognises that sometimes incidents occur. It is important that we act with integrity following every incident and seek to learn lessons where mistakes have been made or where systems have failed.

All members of staff should be aware of their obligation to act with a duty of candour. In the event that a service user (patient) is involved in a clinical incident (physical injury, medication error) whether they are harmed as a result or not, the following procedure must take place:

- Tell the relevant patient, in person, as soon as reasonably practicable after becoming aware that a safety incident has occurred, and provide support to them in relation to the incident, including giving information to them. If the patient is too unwell to have a conversation or lacks capacity, then the discussion must take place with their next of kin.
- Provide and account of the incident which, to the best of the staff member's knowledge, is true of all the facts about the incident.
- Advise the relevant person (patient or next of kin) what further enquiries or actions are appropriate, including a review by the doctor if clinically required.
- Offer an apology and provide every reasonable support to help overcome the potential impact of the incident.
- Follow up the apology by offering the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.
- An incident report needs to be completed in the usual manner and in accordance with the agreed process
- For all incidents involving medications, a reflection form should be completed by the staff member(s) involved.
- Incidents are individually investigated and every quarter are analysed to look for themes or system issues.

REFERENCES: CQC regulation 20: Duty of Candour Guidance June 2015
Lindsey Lodge Visions and Values 2017
Freedom to Speak out Policy (Whistleblowing Policy) LLH 2017
Nursing and Midwifery Council (NMC) The Professional Duty of Candour June 2015
Risk Management Strategy – Lindsey Lodge 2017

Author of Policy: Dr Lucy Adcock **RATIFICATION DATE BY TRUSTEES April 2017**

Review interval: 3 years

To Be reviewed	Review completed	By	Approved By	Circulation
April 2020				