ORGANISATIONS DON'T LEGALLY have to tell you about incidents that cause a 'low level of harm' (e.g. minor or short term harm) or 'near misses' but it is good practice to be open and to learn from all incidents reported.

THE DUTY COVERS any incident that appears to have caused, or has the potential to cause, **SIGNIFICANT** harm.

If you would like further information or assistance please contact:

Patient Safety Team
Integrated Governance
Tameside and Glossop Integrated Care
NHS Foundation Trust
Silver Springs Building
Darnton Road
Ashton-Under-Lyne
OL6 9RW

Tel: 0161 922 4045
(9:00-16:00 Monday - Friday)

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

Duty of Candour

Patient Information Leaflet

The Duty of Candour process and what to expect

A Guide for patients, families and carers

Version 3 2018

THE DUTY OF CANDOUR

The Duty of Candour is a legal duty for all health and social care organisations to inform and apologise to patients if there have been mistakes in their care and treatment that have led to **significant** harm.

Duty of Candour aims to help patients receive accurate and truthful information from health providers.

To meet the requirements of the regulation the Trust has to:

- Make sure it has an open and honest culture across and at all levels within its organisation.
- Tell patients in a timely manner when particular incidents have occurred.
- Provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that organisation will carry out.
- Offer an apology in writing.
- Provide reasonable support to the person after the incident.

The regulations apply to the patient themselves and, in certain situations, to people acting on their behalf, for example when something happens to a child - or to a person over the age of 16 who lacks the capacity to make decisions about their care.

Promoting a culture of openness and transparency is essential to improving our patient safety and the quality of the services we provide.

What can you expect when you are told about an incident?

For incidents that have led to moderate harm and or severe permanent harm and or death:

- We ensure patients and family are supported and have a key contact identified for the incident
- We ensure there is an appropriate level of investigation
- We ensure that the patient/family/patient representative is informed of the decision that the incident is a moderate/permanent harm incident
- We aim to ensure that the initial notification should be verbal or face to face and this is accompanied with an offer of a written notification
- We ensure an apology is provided and documented
- We ensure that a step by step explanation is offered as soon as possible pending the investigation
- We ensure full written documentation of all meetings are kept with the patient/family and filed for future reference
- We ensure full written documentation is kept of all staff interviews and meetings about the incident and filed in the incident/complaint account
- We ensure the final investigation will be shared with the patient/family/patient representative
- The Trust will be monitored by the Commissioners as part of our monthly Quality Contract around our contractual