



Abercorn Clinic Duty of Candour Policy

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1. Purpose of Policy

This policy outlines Abercorn Clinic's procedure for fulfilling its organisational Duty of Candour, ensuring that:

- Individuals affected by an unintended or unexpected incident receive timely and appropriate notification, information, and a sincere apology.
- Incidents are reviewed thoroughly to understand what happened and identify areas for improvement.
- Learning from incidents is shared and embedded into practice to prevent recurrence.
- Support is provided to both affected individuals and staff involved in incidents.

2. Policy statement

Abercorn Clinic is committed to a culture of openness, honesty, and transparency in all aspects of our service delivery. In accordance with the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and the Duty of Candour Procedure (Scotland) Regulations 2018, we will ensure that when an unintended or unexpected incident occurs in the provision of our mental health services that results in, or could result in, harm (as defined by the Act), we will be open, honest, and supportive with the affected individual (or their relevant person). We view such incidents as valuable learning opportunities to enhance the safety and quality of our care.

3. Scope

This policy applies to all staff, including permanent employees, sessional therapists, contractors, volunteers, and students working within Abercorn Clinic, when providing mental health services.

4. Definitions

The Duty of Candour is a legal and ethical obligation for healthcare organisations and individual professionals to be open and honest with individuals (or their families/representatives) when an unintended or unexpected incident occurs during the provision of care, and that incident results in, or could result in, harm. This includes explaining what happened, offering a sincere apology, and ensuring that lessons are learned to prevent recurrence. In Scotland, the organisational Duty of Candour is a statutory requirement under the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

An unintended or unexpected incident refers to an event that occurred during the provision of a health or care service which was not planned and was not a foreseeable consequence of the person's illness or underlying condition. It's the kind of event that, in the reasonable opinion of a healthcare professional not involved in the incident, has resulted in, or could result in, a defined level of harm.

In the context of the Duty of Candour in Scotland, **Harm** refers to specific outcomes resulting directly from an unintended or unexpected incident, rather than the natural course of the person's illness or underlying condition. These outcomes include, but are not limited to:

- Death of the person.
- Permanent lessening of bodily, sensory, motor, physiologic, or intellectual functions (severe harm).
- An increase in the person's treatment.
- Changes to the structure of the person's body.
- Shortening of the life expectancy.
- An impairment of sensory, motor, or intellectual functions lasting, or likely to last, for a continuous period of at least 28 days.
- Experiencing pain or **psychological harm** lasting, or likely to last, for a continuous period of at least 28 days.
- Needing health treatment to prevent any of the above outcomes.

Psychological harm (within the context of Duty of Candour) refers to significant emotional distress, mental suffering, or a detrimental impact on a person's mental well-being that has been, or is likely to be, experienced for a continuous period of at least 28 days, directly as a result of an unintended or unexpected incident in care. This is a crucial element for a mental health clinic.

An **apology** within the Duty of Candour is a sincere expression of sorrow or regret for any harm or distress caused by an incident. Importantly, under Scottish law, offering an apology is **not** an admission of legal liability. It is a fundamental part of showing compassion and openness.

The **Affected Person** (also referred to as the "Relevant Person" in Scottish legislation) is the individual who received the health or care service and was directly impacted by the unintended or unexpected incident. If that person has died, or is, in the opinion of the responsible organisation, lacking capacity or otherwise unable to make decisions about the

service provided, then a person acting on their behalf (e.g., a legally appointed representative, guardian, or next of kin) becomes the "Relevant Person."

The **Responsible Person** refers to the organisation or individual (if they directly provide a service and meet specific criteria) that has the legal duty to carry out the Duty of Candour procedure. In the context of your clinic, "Abercorn Clinic" as an organisation is the Responsible Person.

A **review** is a systematic process undertaken to investigate the circumstances surrounding an incident that triggered the Duty of Candour. Its purpose is to understand what happened, identify contributory factors, determine lessons learned, and identify actions to prevent similar incidents from occurring in the future.

Learning and Improvement refers to the process of using insights gained from incidents and Duty of Candour reviews to implement changes in practice, policies, or procedures. This ensures that the organisation continuously enhances the safety and quality of its services based on real-world experiences.

Definition of Incident Triggering Duty of Candour

The Duty of Candour is triggered when, in the reasonable opinion of a registered health professional not involved in the incident, an **unintended or unexpected incident** occurring in the provision of our mental health service has resulted in, or could result in, one or more of the following outcomes (not related to the natural course of the individual's illness or underlying condition):

- **Death of the person.**
- **Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions** (e.g., severe and lasting cognitive impairment directly attributable to the incident, not the mental health condition itself).
- **An increase in the person's treatment** (e.g., requiring unplanned additional psychological or pharmacological intervention beyond the usual course of care due to the incident).
- **Changes to the structure of the person's body** (less likely in mental health, but included for completeness).
- **Shortening of the life expectancy of the person** (less likely in mental health).
- **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** (e.g., prolonged severe dissociation or cognitive impairment directly caused by the incident).
- **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** (this is particularly relevant for a mental health clinic, e.g., significant exacerbation of symptoms, new onset of severe psychological distress directly attributable to a service incident).
- **The person needing health treatment to prevent any of the above outcomes.**

5. Procedure

Upon becoming aware of an incident that triggers the Duty of Candour, Abercorn Clinic will follow these steps as soon as reasonably practicable:

5.1. Identification and Assessment:

- Any staff member who identifies a potential incident triggering the Duty of Candour must immediately report it to the Clinic Manager/Clinical Lead.
- A registered health professional (not involved in the incident) will assess if the incident meets the criteria for Duty of Candour as defined in Section 4.

5.2. Notification to the Affected Person (or "Relevant Person"):

- The affected person (or their legally appointed representative, guardian, or next of kin if the person has died or lacks capacity to make decisions about the service) will be notified of the incident.
- This notification will be given without undue delay, clearly explaining what happened.
- The notification will be delivered sensitively, face-to-face where appropriate, and followed up in writing.

5.3. Apology:

- A sincere and meaningful apology will be offered to the affected person at the earliest opportunity.
- The apology will acknowledge that something went wrong and express regret for any harm or distress caused.
- It is understood that an apology is not an admission of legal liability.

5.4. Review of the Incident:

- A comprehensive review into the circumstances leading to the incident will be undertaken. This will involve:
 - Gathering all relevant information and documentation.
 - Speaking with all staff involved.
 - Identifying the immediate and underlying causes of the incident.
 - Determining what lessons can be learned.
 - The review will be conducted by individuals not directly involved in the incident where possible.

5.5. Offer of a Meeting:

- The affected person will be offered a meeting (or series of meetings) to discuss the incident, the findings of the review, and any actions taken.
- They will be encouraged to ask questions and express their views.
- They may bring a supporter to the meeting.

5.6. Provision of an Account of the Incident:

- A clear and factual account of the incident will be provided to the affected person, explaining what happened, why it happened (if known), and the likely consequences. This may be provided verbally and/or in writing.

5.7. Information on Further Steps Taken:

- The affected person will be informed about any actions taken as a result of the incident review, including changes to practice, policies, or procedures implemented to

prevent recurrence.

5.8. Provision of Support:

- Information about, or direct provision of, support services will be offered to the affected person(s) and their families. This may include signposting to advocacy services, counselling, or other relevant support organisations.
- Appropriate support will also be provided to staff members involved in the incident, recognising the potential impact on their well-being.

6. Responsibilities

Clinic Director / Clinical Lead (Overall Organisational Responsibility)

The Clinic Director or Clinical Lead holds ultimate responsibility for ensuring the clinic's compliance with the Duty of Candour. Their responsibilities include:

- **Policy Ownership:** Ensuring the Duty of Candour policy is robust, up-to-date, and in full compliance with the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018, and HIS guidance.
- **Culture of Candour:** Fostering and embedding a positive organisational culture of openness, honesty, and learning from incidents, ensuring staff feel supported to speak up.
- **Resource Allocation:** Ensuring adequate resources (time, training, personnel) are allocated to enable the effective implementation of the Duty of Candour.
- **Oversight of Investigations:** Ensuring that all incidents potentially triggering the Duty of Candour are appropriately assessed, investigated, and reviewed in a timely and thorough manner.
- **Accountability:** Holding individuals accountable for fulfilling their responsibilities under this policy.
- **Annual Report:** Ensuring the accurate preparation and timely publication of the annual Duty of Candour report.
- **External Reporting:** Ensuring any required reporting to regulatory bodies (e.g., HIS) is completed accurately and promptly.

Clinic Manager / Designated Duty of Candour Lead (Operational Responsibility)

This role (which may be combined with the Clinic Director in smaller clinics) is responsible for the day-to-day operational management of the Duty of Candour process. Responsibilities include:

- **Initial Assessment and Triage:** Receiving notifications of potential incidents and, in consultation with a non-involved registered health professional, determining if the Duty of Candour is triggered.
- **Coordination of Procedure:** Overseeing and coordinating all steps of the Duty of Candour procedure, including:
 - Ensuring timely and sensitive notification to the affected person.
 - Arranging for the sincere apology to be delivered.
 - Commissioning and overseeing incident reviews.
 - Coordinating meetings with affected individuals.
 - Ensuring the provision of factual accounts and information on

- learning/actions.
 - Arranging appropriate support for affected individuals and staff.
- **Record Keeping:** Ensuring all relevant documentation relating to Duty of Candour incidents and actions is accurately maintained and securely stored.
- **Training & Development:** Identifying training needs related to Duty of Candour and ensuring staff receive appropriate education and support.
- **Liaison:** Acting as the primary point of contact for the affected person throughout the Duty of Candour process.
- **Learning Dissemination:** Ensuring that lessons identified from incidents are effectively disseminated and embedded into clinical practice and policies.

All Staff (Clinical and Non-Clinical)

Every staff member has a vital role in upholding the Duty of Candour. Their responsibilities include:

- **Awareness:** Being familiar with the clinic's Duty of Candour policy and procedure.
- **Identification & Reporting:** Identifying and promptly reporting any unintended or unexpected incident that has resulted in, or could result in, harm to the Clinic Manager/Clinical Lead. This includes reporting even if they were directly involved.
- **Openness & Honesty:** Being open, honest, and cooperative during any incident review or investigation.
- **Participation in Reviews:** Actively participating in incident reviews when requested, providing factual information and insights.
- **Communication:** Communicating sensitively and honestly with affected individuals, following guidance from the Duty of Candour Lead.
- **Apology (when appropriate):** Being prepared to offer a sincere apology when appropriate and guided by the Duty of Candour Lead.
- **Learning & Reflection:** Engaging in personal and team reflection on incidents to identify learning and improve practice.
- **Seeking Support:** Utilising available support mechanisms if personally affected by an incident.

Registered Health Professional (for Incident Assessment)

A *non-involved* registered health professional (e.g., a Clinical Psychologist who was not part of the incident) plays a specific, crucial role:

- **Objective Assessment:** Providing a professional, independent opinion on whether an unintended or unexpected incident meets the criteria for triggering the Duty of Candour as defined in the policy (i.e., whether harm, as defined by the Act, has resulted or could result).

Incident Review Team / Investigator

For significant incidents, a dedicated team or individual may be appointed to conduct the review:

- **Impartial Investigation:** Conducting a thorough, objective, and impartial review of the incident.
- **Fact-Finding:** Gathering all relevant evidence, including documentation, witness statements, and system analysis.
- **Cause Analysis:** Identifying the direct and underlying causes and contributing factors to the incident.
- **Recommendations:** Developing clear, actionable recommendations for improvement

- to prevent recurrence.
- **Report Writing:** Preparing a comprehensive report on the findings of the review.

7. Enforcement / Compliance

Training and Support for Staff

- All staff will receive mandatory training on the Duty of Candour policy and procedure as part of their induction and ongoing professional development.
- Training will cover the legal requirements, the definition of an incident, how to communicate openly and honestly, how to deliver a sincere apology, and available support for staff.
- Supervision and management will ensure staff feel supported and confident in fulfilling their Duty of Candour responsibilities.

Record Keeping

- Detailed records will be kept of all incidents triggering the Duty of Candour, including:
 - Date and time of incident.
 - Description of the incident and its outcome.
 - Date and method of notification to the affected person.
 - Details of apology given.
 - Summary of the incident review and findings.
 - Details of meetings held.
 - Actions taken as a result of the incident.
 - Support offered and provided to affected individuals and staff.
 - All records will be managed in line with our Data Protection and Confidentiality policies.

Annual Report

- Abercorn Clinic will prepare and publish an annual Duty of Candour report at the end of each financial year (1st April – 31st March).
- This report will be published on our website (if applicable) or made available through other suitable arrangements to people who use our services.
- The report will include:
 - The number of times the Duty of Candour procedure was applied.
 - The types of incidents that triggered the duty (e.g., psychological harm for 28 days or more).
 - An overview of the learning derived from incidents.
 - Information on improvements made as a result of the Duty of Candour.
 - The report will not include any information that could identify an individual.