Duty of Candour Policy

1. Purpose

This policy sets out the approach [Company Name] takes to ensure openness, transparency, and candour when things go wrong with patient care. It supports our duty to be honest with patients and/or their families when a notifiable safety incident occurs, in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, particularly Regulation 20: Duty of Candour.

2. Scope

This policy applies to all employees, contractors, and clinical professionals working for Korus Health and Korus Ultrasound across all sites and services, whether NHS or privately funded.

3. Definitions

Duty of Candour:

The legal obligation to be open and honest with patients (or their representatives) when something goes wrong that causes (or could cause) significant harm

Notifiable Safety Incident:

- For NHS-funded services: An unintended or unexpected incident that has occurred in respect of a service user and has resulted in death, severe harm, moderate harm, or prolonged psychological harm.
- For private services: A similar threshold applies, with definitions based on clinical judgment and patient experience.

4. Legal and Regulatory Framework

This policy complies with:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20
- Care Quality Commission (CQC) Regulation 20: Duty of Candour guidance
- NHS Serious Incident Framework
- General Medical Council (GMC), Nursing and Midwifery Council (NMC), and HCPC guidance on professional duty of candour

5. Policy Statement

Korus Health and Korus Ultrasound recognises the fundamental right of patients

to be informed when something goes wrong with their care.

We are committed to:

- Being open and honest with patients and their representatives
- Apologising meaningfully when incidents occur
- Supporting patients and staff through the process
- Learning from incidents to improve care quality

6. Procedure for Responding to a Notifiable Safety Incident

6.1 Identification and Immediate Action

- Incident is identified by staff, reported via internal incident reporting system
- Ensure patient safety and provide immediate clinical support
- Notify Clinical Governance Lead or Registered Manager immediately

6.2 Incident Review and Confirmation

- Confirm if the incident meets the threshold of a notifiable safety incident
- Log the incident in the incident management system

6.3 Communication with Patient/Representative

As soon as reasonably practicable:

- A senior clinician or manager informs the patient or their representative
- A clear, honest explanation is provided, including known facts
- A written apology is given
- The patient is offered ongoing support
- All discussions are documented

6.4 Ongoing Duty

- Provide updates if new facts emerge
- Engage the patient in investigation outcomes
- Share learning with the team

7. Roles and Responsibilities

- All Staff: Responsible for identifying and reporting incidents
- Clinical Leads / Registered Manager: Assess incidents and oversee Duty of Candour actions
- CEO/COO: Ensure organisational culture supports openness and learning
- HR & Compliance Lead: Supports training and documentation

8. Training and Support

- All staff will receive Duty of Candour training on induction and annually
- Refresher modules will be available online and in team meetings
- Scenario-based learning is used to ensure staff can apply principles in practice

9. Monitoring and Audit

- Compliance monitored via internal audits of incident handling and documentation

- Duty of Candour themes reviewed quarterly by Clinical Governance Committee
- Failures to comply will trigger review and potential disciplinary action

10. Policy Review

This policy will be reviewed annually or sooner if:

- Legislation or CQC guidance changes
- Organisational changes impact roles or structure
- Internal audit or incident analysis indicates improvement is needed

11. References

- Care Quality Commission – Regulation 20: Duty of Candour
- Department of Health – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- NHS England – Serious Incident Framework
- General Medical Council – Openness and honesty when things go wrong
- Nursing and Midwifery Council – Duty of Candour guidance
- Health and Care Professions Council – Duty of Candour Guidance
- NHS Resolution – Saying Sorry Guidance

Quick Reference Guide for Incident Response

- Identify and report the incident immediately.
- Inform clinical lead / registered manager.
- Determine if incident meets Duty of Candour threshold.
- Inform the patient/representative ASAP.
- Provide a clear explanation and verbal apology.
- Document the conversation and details.
- Send written notification and apology.
- Offer ongoing support and next steps.
- Continue to update patient as needed.
- Record learning