



Title
Duty of Candour Policy and Procedure
Principle
Homekare Community services is committed to delivering care and support to our clients that is safe, open and honest. We recognise that things can go wrong despite our best efforts. We believe that the right response when this happened is to be transparent with people affected- promptly, compassionately and without defensiveness
Objectives
The purpose of this policy is to: • Set out the statutory duty of candour obligations that apply to Homekare community services as a registered provider • Defines what a notifiable safety incidents and how this will be managed • Specify the step by step procedure team members and management must follow when something goes wrong • Embed our culture of openness , transparency and learning at every level within Homekare Community services • Ensures our clients, their families and relevant persons are treated with honesty and compassion when incidents occur
Scope
This policy applies to: • all team members employed by Homekare Community services including care team, senior team, care manager, HR/ Compliance Lead, Registered manager and the Director/ Nominated Individual • Agency, bank and contracted workers working on behalf of Homekare Community Services • All regulated activities delivered by Homekare Community Service, including personal care, community support, medication administration and care planning7All clients, regardless of age, background, diagnosis or level of need
Responsibilities

Every member of Homekare team has a role in delivering the duty of candour. The table below sets out specific responsibilities by role.

Role	Responsibilities
Director / Nominated Individual	Holds ultimate accountability for the organisation's compliance with Regulation 20. Champions a culture of openness and transparency at board level. Receives the monthly governance report and reviews duty of candour compliance data. Approves organisational learning from serious incidents.
Registered Manager	Accountable registered person for the purposes of Regulation 20. Determines (with professional input where needed) whether an incident is a notifiable safety incident. Leads or oversees the duty of candour process for all notifiable incidents. Signs off written notifications. Submits statutory CQC notifications. Reviews trends and oversees learning.
HR & Compliance Lead	Maintains the incident log and duty of candour record. Ensures training compliance (all team members trained on duty of candour at induction and via mandatory refreshers). Tracks and reports duty of candour KPIs in the monthly governance summary. Ensures policies are kept up to date with legislation and CQC guidance.
Care Manager	Receives and escalates incident reports from team member's promptly. Supports the Registered Manager in gathering information about the incident. Communicates with families/representatives as directed. Tracks action plan progress following duty of candour conversations.
Senior Team	Reports incidents immediately to the Care Manager or Registered Manager. Supports less experienced team members in understanding their duty of candour obligations. Participates in internal reviews and learning discussions.
Care Team	Reports all incidents, near misses, accidents, and concerns to their line manager immediately. Communicates honestly with clients and families within their role. Completes incident documentation accurately and promptly. Does not withhold information or attempt to minimise incidents.

Procedure

1. Homekare Community Service's Overarching Duty — Openness at All Times

The overarching duty of candour applies at all times, in all cases. It does not require a notifiable safety incident to be triggered. Every one of our team member's is expected to be open and honest with client's in every interaction.

The overarching duty means that Homekare Community Service team member's must:

- Be honest with client's and their relevant persons about their care and any concerns
- Not withhold information that our client needs to make informed decisions about their care
- Acknowledge concerns and complaints openly and without defensiveness
- Raise concerns about care quality through appropriate channels, including supervision and the whistleblowing policy
- Support client's to raise concerns and complaints, and never discourage or penalise them for doing so

Even where an incident does not meet the threshold for a notifiable safety incident, the duty to be open and transparent still applies. Team member's must acknowledge what happened, offer support, and be honest about what is known.

2. Notifiable Safety Incidents — Identifying the Trigger

2.1 The Three-Part Test

A notifiable safety incident under Regulation 20 must meet all three of the following criteria:

#	Criterion	What this means in practice
1	Unintended or unexpected	The incident was not planned or anticipated as part of the care or treatment being provided. Note: whether the outcome was foreseeable does not determine whether the incident qualifies — it is whether something unintended occurred during the care itself.
2	Occurred during a	The incident happened during care or support delivered by Homekare Community Service's under

	regulated activity	its CQC registration (e.g. a care visit, medication administration, personal care task).
3	Resulted or could result in serious harm	In the reasonable opinion of a healthcare professional, the incident has resulted in or could result in: death directly caused by the incident; sensory, motor or intellectual impairment lasting 28+ days; changes to body structure; prolonged pain (28+ days); prolonged psychological harm (28+ days); or shorter life expectancy.

If any one of the three criteria is not met, the incident is not a notifiable safety incident. However, the overarching duty of candour to be open and transparent still applies.

2.3 Who Makes the Determination?

The Registered Manager is responsible for determining whether an incident meets the threshold for a notifiable safety incident. Where clinical judgment is required, the Registered Manager will consult with the client's GP, district nurse, or other relevant healthcare professional. The determination must be made as soon as is reasonably practicable after the incident is identified and must be documented.

2.4 Examples in the Community Care Context

Incident	Notifiable Safety Incident?	Why?
Medication error resulting in hospitalisation	YES	Resulted in harm requiring treatment
Missed visit — client is unharmed	UNLIKELY	No harm — but openness duty still applies
Fall during personal care resulting in a fracture	YES	Physical injury; changes to body structure
Wrong medication administered; client experienced prolonged side effects	YES	Prolonged psychological or physical harm
Late visit — no adverse outcome	NO	Below harm threshold — but must still be acknowledged openly
Team member failed to follow care plan; client distressed but unharmed	POSSIBLY	Psychological harm threshold — assess with clinical input

Pressure injury Grade 3 or 4 developing under care	YES	Changes to body structure; serious injury
3. Step-by-Step Procedure for Notifiable Safety Incidents When a notifiable safety incident is identified, the following procedure must be followed without delay. All steps must be documented in the incident record and the duty of candour log.		
1	Immediate Safety Response – Ensure the client is safe and receiving appropriate care or medical attention – Contact emergency services if required – Notify the Senior/ Care Manager and/or Registered Manager immediately → <i>Safety first — address harm before documentation</i>	
2	Identify and Record the Incident – Complete Homekare Community Services incident report form (Available to all team member's on their Nurse buddy app) as soon as practicable – Record what happened, when, who was present, and what actions were taken – Preserve any relevant evidence (care records, medication charts, communications) → <i>Registered Manager notified within same working day</i>	
3	Determine Whether a Notifiable Safety Incident Has Occurred – Registered Manager applies the three-part test (Section 7.1) – Consult clinical professionals (GP, DN, etc.) where harm threshold is unclear – Document the determination and rationale, including who was consulted → <i>Determination documented within 24 hours of incident being identified</i>	
4	Notify the Relevant Person — Verbal – Tell the client (and/or their relevant person) what happened, as soon as reasonably practicable – The conversation must be face-to-face or by telephone where a visit is not immediately possible – Offer a sincere apology — see Section 11 – Provide a truthful account of what is known at that stage; do not speculate – Inform them of any immediate steps being taken – Offer appropriate support → <i>Record the conversation: date, time, who was present, what was said, and how the person responded</i>	
5	Provide Written Notification – Follow up the verbal notification with a written record as soon as practicable	

	– The written notification must include: a factual account of the incident; the apology; details of what action has been or will be taken; details of the investigation process and when findings will be shared; a named contact at Homekare Community Service; and how to make a complaint if they wish to do so → <i>Written notification sent or delivered without undue delay</i>
6	Investigate – Conduct a proportionate investigation into the incident – Gather evidence from care records, staff accounts, care plan documentation, and medication charts – Identify root causes and contributing factors – Involve the client and/or relevant person in the investigation process where appropriate → <i>Investigation completed and findings documented</i>
7	Share Investigation Findings – Share the outcome of the investigation with the client and/or relevant person – Provide a written account of findings – Confirm the actions taken or planned to prevent recurrence – Provide a further apology if appropriate → <i>Findings shared in writing with a compassionate follow-up conversation</i>
8	Notify CQC if Required – Assess whether the incident also triggers a statutory CQC notification obligation (e.g. death, serious injury) – Submit the CQC notification within the required timeframe – Registered Manager is responsible for all CQC notifications → <i>CQC notified where required</i>
9	Record and Learn – Update the duty of candour governance log – Review the incident at the next governance meeting – Identify any changes to care plans, risk assessments, training, or procedures required – Include in the monthly governance report → <i>Learning actioned; care plans updated where required</i>

4. Capacity, Communication, and Relevant Persons

Homekare Community Service is committed to ensuring that every client receives information in a way they can understand. The duty of candour must be applied in a way that is consistent with Aim 3 (Dignity and Respect) and that meets each person's communication needs.

4.1 Where the Client Has Capacity

The duty of candour notification must be made directly to the client in the first instance.

The Registered Manager should ensure that:

- Communication is in the client's preferred format and language
- Information is provided clearly, honestly, and without using jargon
- The client is given sufficient time to process the information and ask questions
- The client is offered support, including independent advocacy if they wish

4.2 Where the Client Lacks Capacity

Where a client lacks mental capacity to receive or understand the notification (assessed under the Mental Capacity Act 2005), the duty of candour notification must be given to the relevant person acting lawfully on their behalf.

This may include:

- A person holding a registered Lasting Power of Attorney for health and welfare
- A Court-Appointed Deputy for health and welfare
- An Independent Mental Capacity Advocate (IMCA), where no appropriate person exists

If the client's capacity is unclear, the Registered Manager must complete a capacity assessment or seek advice from a health professional before proceeding.

4.3 Additional Communication Needs

Where a client has specific communication needs — including learning disabilities, autism, acquired brain injury, dementia, or communication in a language other than English — Homekare Community Services will arrange appropriate support, including:

- Easy-read materials or written summaries
- Interpreter or communication support services
- Additional time and a familiar setting for conversations

5. Duty of Candour and Safeguarding

Where a notifiable safety incident also constitutes or triggers a safeguarding concern, both the duty of candour procedure and the safeguarding procedure run simultaneously and independently. One does not replace the other.

Homekare Community Services operates within the multi-agency safeguarding framework of the Nottinghamshire Safeguarding Adults Board (NSAB) and the Nottingham City Safeguarding Adults Board (NCSAB), which operate joint safeguarding adults procedures and guidance.

Where an incident triggers both duties, Homekare Community Services will:

- Notify the relevant person under the duty of candour as required by Regulation 20

- Report the safeguarding concern to the Local Authority (Nottinghamshire County Council or Nottingham City Council) within 24 hours in accordance with the NSAB / NCSAB joint procedures and Aim 2 of the KPI Framework
- Ensure that duty of candour communications do not compromise the safeguarding investigation — the Registered Manager will coordinate with the safeguarding lead to manage the timing and content of communications carefully
- Contribute fully to any Safeguarding Adults Review (SAR) if required by NSAB, including providing relevant records and completing action plans
- Apply the duty of candour to the person affected regardless of the outcome of the safeguarding process

SCIE guidance confirms that the duty of candour requires providers to tell the person concerned when something has gone wrong as soon as possible, provide support, give an apology, and keep the person informed about further enquiries — including where those enquiries relate to safeguarding.

6. Saying Sorry — Apology Is Not an Admission of Liability

An apology under the duty of candour is not an admission of legal liability. Saying sorry is always the right thing to do. It acknowledges that something went wrong and that the harm caused is regretted. It is the first step in rebuilding trust and in learning from what happened. (CQC Regulation 20 Guidance; NHS Resolution 'Saying Sorry')

All team member's must understand that apologising does not create legal liability. In many cases, it is the absence of a timely apology that leads people to take formal action. Homekare Community Services expects all team member's to:

- Offer a sincere, compassionate verbal apology as soon as it is appropriate to do so following an incident — and certainly during the duty of candour notification conversation
- Repeat the apology in writing as part of the written notification
- Acknowledge the distress and harm caused, regardless of who or what was responsible
- Refrain from being defensive, minimising, or offering partial information

A good apology should:

- Be sincere and personalised — not a formula
- Acknowledge what happened and the impact on the service user and/or family
- Not speculate about causes or assign blame prematurely
- Confirm what steps are being taken in response

7. Supporting Staff

Homekare Community services is committed to a just culture in which team members feel safe to report incidents honestly, without fear of disproportionate

blame. Team members who are involved in a notifiable safety incident may experience significant distress. The organisation will:

- Provide immediate pastoral support to team members involved in serious incidents
- Ensure the Registered Manager or a senior colleague is available to debrief team members promptly
- Refer team members to an Employee Assistance Programme or occupational health support where needed
- Ensure that the investigation process is fair, evidence-based, and proportionate
- Distinguish clearly between human error, at-risk behaviour, and reckless behaviour when determining any response

Where a team member is required to participate in the duty of candour conversation or investigation, they will be given appropriate preparation and support. No member of the team will be penalised for reporting incidents honestly or for participating in duty of candour processes in good faith.

8. Documentation and Record-Keeping

The duty of candour places specific documentation requirements on Homekare Community services. All of the following must be recorded and retained:

Document / Record	What must be recorded
Incident report	Full account of what happened, when, where, who was involved, immediate response taken
Notifiable safety incident determination	The Registered Manager's determination (with reasons and any clinical input) of whether the incident meets the three-part test
Verbal notification record	Date, time, who was present, what was communicated, how the person responded, support offered
Written notification	Copy of the written notification sent to the relevant person, with date of issue
Investigation record	Investigation findings, root cause analysis, contributing factors, evidence reviewed
Investigation findings — shared with person	Record of when and how findings were shared, and with whom
Action plan	Actions identified, owner, target date, completion date
CQC notification (if applicable)	Reference number and date of submission
Duty of Candour Log	Cumulative log of all notifiable safety incidents and the duty of candour steps completed for each

All records must be retained in the relevant client's care file and (where team member-specific) in the HR file, for the duration of care plus a minimum of six years. Records must be available for CQC inspection at all times.

9. Training Requirements

All team member's must receive training on the duty of candour as part of their induction and ongoing mandatory training programme, in accordance with Homekare Community Service Workforce Training Plan.

Training	When	Applies To	Method
Duty of Candour — induction module (linked to Care Certificate Standard 3)	Within 12 weeks of start date	All team members in direct care roles	E-learning + workplace discussion with Senior /Care Manager/ Registered Manager
Being Open and Saying Sorry	Induction	All team members	Included in values and aims overview (Day 1 induction)
Notifiable Safety Incidents — identification and procedure	Induction and annual refresher	Senior/ Care Manager/ Registered Manager	Face-to-face session or blended; scenario-based assessment
Duty of Candour — annual refresher	Annual	All team members	E-learning with knowledge check
Safeguarding and Duty of Candour overlap	Annual safeguarding training	All team members	Incorporated into annual safeguarding adults refresher (blended)
Just Culture and Learning from Incidents	On appointment and following any serious incident	Registered Manager, HR & Compliance Lead	CPD; external leadership training

Training compliance is monitored through the training matrix maintained by the HR & Compliance Lead and reported monthly. A training compliance rate of 95% or above for this module is the required standard.

10. Monitoring, Governance, and CQC Notification

10.1 Monthly Governance Report

The following duty of candour data points must be included in Homekare community service monthly governance report, reviewed at the management meeting:

- Number of incidents reported in the period
- Number of incidents identified as notifiable safety incidents
- All duty of candour processes completed (verbal notification, written notification, investigation, findings shared)
- Any open (in-progress) duty of candour cases and their current stage
- Learning actions identified and their completion status

10.2 CQC Notification

Certain notifiable safety incidents also require submission of a statutory notification to CQC. The Registered Manager is responsible for assessing whether the CQC notification threshold has been met and for completing the notification. This includes (but is not limited to):

- Deaths of clients
- Serious injuries
- Incidents where the duty of candour has been applied

CQC notifications must be submitted promptly and in line with CQC's requirements. Copies must be retained in the duty of candour governance log.

10.3 KPI

The following KPI applies to this policy, in line with Homekare Community Service Aims, KPIs & Appraisal Framework:

- 100% of notifiable safety incidents must have a complete and documented duty of candour process on file
- 100% of incidents are acknowledged to the relevant person within a reasonable timescale
- Monthly governance report includes a duty of candour section (100% compliance)

10.4. Non-Compliance

Failure to comply with the duty of candour is a regulatory breach and may result in CQC enforcement action, including warning notices, requirement notices, or criminal prosecution of the registered person.

Internally, failure to follow this policy by a member of our team may result in action under the performance management or disciplinary procedure, depending on the nature and seriousness of the non-compliance.

Team member's who are found to have actively concealed information, misled a service user or family, or obstructed the duty of candour process will be subject to

a full disciplinary investigation and may be referred to external bodies including the DBS and relevant professional regulators.

Homekare Community services recognises that non-disclosure is often a systemic or cultural failure rather than an individual one. Where non-compliance reflects a broader cultural issue, the organisation will take immediate steps to review its culture, leadership, and training in addition to any individual action.

11. Policy Review

This policy is reviewed annually by the HR & Compliance and Registered Manager, or sooner following:

- Any significant change in CQC Regulation 20 guidance or the CQC inspection framework
- Any amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Any revision to the NSAB / NCSAB joint safeguarding procedures
- Any Skills for Care or SCIE guidance update affecting duty of candour practice
- Any serious incident or duty of candour case that identifies a gap in the policy

Following any material update, the policy is submitted to the Director / Nominated Individual for approval before reissue.

Linked Legislation and Guidance

Regulation 20, HSCA 2008 (Regulated Activities) Regulations 2014	Primary statutory duty- openness, transparency and notifiable safety incident procedure.
Regulation 17 (Good Governance)	Duty to have systems and processes for identifying, assessing and managing risks and incidents, including learning from them
Regulation 12 (Safe care and treatment)	Duty to prevent avoidable harm, links to the obligation to act when something goes wrong
Care Act 2014	Underpins adult safeguarding and the duty to share information when relevant to safeguarding concerns
CQC Fundamental Standards	The duty of candour is a fundamental standard- CQC will inspect and enforce compliance. A breach may result in enforcement action up to criminal prosecution
Skills for Care – Care Certificate (March 2025 update)	Standard 3 (Duty of Care) directly incorporates openness and honesty following incidents. The 2025 refresh strengthens requirements around timely communication and transparent reporting

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