Duty of Candour Annual Report

1st April 2020 - 31st March 2021

Duty of Candour Report

All health and social care services in Scotland have a duty of candour as an organisation. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report describes how NHS Lothian has operated the duty of candour during the time between 1 April 2020 and 31 March 2021. We hope you find this report useful.

1. About NHS Lothian

NHS Lothian serves a population of 845,000 people living in Edinburgh, East, Mid and West Lothian. We cover a diverse geographical area, including large and small towns as well as some rural areas. We also provide some services for patients in the Borders and in Fife and are a national centre of expertise for some specialties provided to people across Scotland.
Our aim is to provide high quality care for every person who uses our services, and where possible, help people to receive care at home or in a homely setting.

2. Number and nature of Duty of Candour incidents

Since the last annual report, there have been 22 incidents identified where the duty of candour applied. These are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

NHS Lothian identified these incidents principally through our adverse event management process although these can be highlighted through other routes such as a complaint, but it would then be processed through the adverse event management process.

We review and consider all adverse events where the patient outcome was either moderate or major harm or death for application of Duty of Candour. The inclusion in our review of events where there was moderate harm was used to capture instances which did not result in severe harm, but harm which resulted in one or more of the criteria as set out in the legislation.

We identify through the adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Nature of unexpected or unintended incident where Duty of Candour applies	Number of events identified between 1 April 2020 and 31 March 2021
A person died	≤ 5
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	≤ 5
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	≤ 5
Changes to the structure of the person's body	≤ 5
The shortening of the life expectancy of the person	≤ 5
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	≤ 5
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.	≤ 5
The person required treatment by a registered health professional in order to prevent:	
The person dying	≤ 5
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	≤ 5
Total	22

3. To what extent did NHS Lothian follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure in all cases although in one case the communication was dealt with via the complaints process. This means we informed the people affected, apologised to them from the organisation, and offered to meet with them. Reviews have been commissioned for 21 of these events, 20 of which have been completed. In one case, further work is required to agree the approach and scope of the review of care with the person affected before this can be undertaken. In all other cases, we reviewed what happened, what went wrong and what we could have done better and offered to feedback the outcome and learning from the events to the people affected. There have been 6 cases where we have not been able to feed back the outcome and learning to people involved for a variety of reasons which include:

- The patient/family did not wish any feedback on the review, were offered feedback but have not got back in touch with us or do not feel that it is the right time for them to meet with us
- Awaiting a claim process to conclude

Individual and organisational learning has been undertaken in each case with improvement plans developed and completed or in progress for each one.

4. Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our adverse event management policy and associated procedures. This may be retrospective if an adverse event is identified through a claim, complaint or other means. Through our adverse event management process we can identify incidents that trigger the duty of candour procedure. Our adverse event management policy contains a section on communicating with patients and families about adverse events, including implementing the duty of candour where relevant.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the adverse event review, and relevant management teams develop improvement plans to meet these recommendations.

Staff have access to information on the intranet via our dedicated duty of candour page and are encouraged to complete the NES Education Scotland Duty of Candour e-learning module, also sign posted through the intranet pages.

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction. Additional training and advice is also readily available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through our occupational health service.

5. What has changed as a result?

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We always consider what actions we will take to try to prevent a repetition of adverse events.
Some examples of these are highlighted below:

- Following a patient taking the wrong amount of medication resulting in admission to hospital and requiring corrective treatment, a number of improvements were put in place. This included revised labelling instructions to ensure clarity; introduction of a prescription communication document that is sent along with prescriptions to advise pharmacy of any issues that may not be adequately conveyed through the standard prescription template; time is allocated to member of ward staff every day to answer any phone calls from that day; all medication is either handed out in the ward by appointment otherwise it will be dispensed from the pharmacy.
- Following a patient overdosing on medication that was not been appropriately stored, all medications are kept in the main locked drug cupboard.
- Due to a delayed diagnosis of cancer, the relevant service has implemented high risk targeted queues on TRAK to focus capacity on urgency of procedure and reduce delays. An SOP was also introduced to re-triage waiting list queues. A quarterly audit and review of locum pathologist working practices is also taking place when locums are appointed.
- Following the return of a patient to A&E a short time after discharge who required immediate life saving treatment, targeted training on understanding the condition in question was undertaken.
- Following the prescribing/administration of a drug which reacted with a patient's existing medical condition requiring admission to hospital for treatment, the presence/absence of this condition will be included on the relevant checklist that Nurse Practitioners refer to when discussing the prescription with patients. All staff have also been reminded that when prescribing new medications that the patient's electronic record must be reviewed.
- Following the delayed diagnosis of a condition which resulted in significant lasting harm, all patients who have been delayed in the emergency department for more than six hours have a ward round review where standard checks and care rounding documents are utilised. An SOP for admission to the relevant specialist area has been developed and published which includes the requirement for blood tests to be taken unless there is a clearly documented reason by ED Consultant as to why not. Training has taken place for all nursing teams on recording NEWS and GCS, triggers and escalations. Staff have also undertaken training in interpretation and understanding of the care plans for this group of patients. Guidance around the Review "Fit 2 Sit" initiative has been updated to include an addition regarding patient requirement for undressing and hospital gown, without compromising dignity and individuality.
- Following staff not being aware of the photosensitivity side effects of a drug which resulted in a patient subsequently suffering a severe allergic reaction due to exposure to sunlight and admission to hospital overnight for observation and treated for burns, there has been a project to ascertain the

side effects of all the commonly used drugs within the service, particularly looking to identify other medications which have photosensitivity side effects. This information has been displayed and shared across teams and is available on hard copy in each unit and was shared on the safety brief daily over the summer months.

- Following an attempted suicide, the use of electronic patient records has been reviewed to ensure that they include a comprehensive case summary including all risk assessments and safety care planning. An audit is in place to ensure this is being implemented. Care planning and risk assessment training is in place via the clinical education team with input from clinical staff. An E-learning module relating to working with risk and mental health has been developed and is mandatory for clinical staff. Awareness training on standards for clinical record keeping; developing audit processes to monitor documentation standards and expected standards (including those within NMC Code of Conduct) has been incorporated into the induction and staff appraisal processes. A SOP for observation to intervention has been implemented. A SOP and new form for handover has been implemented across acute inpatients wards. The SOPs for the roles of shift coordinator and key workers explicitly outlining their individual responsibilities has been reviewed and all staff have confirmed they have read and understood it. Off duties are now monitored bi-weekly by Clinical Nurse Managers and Senior Charge Nurses. Reflective practice for staff is in place, delivered by the psychotherapy department on a weekly basis.
- Following an incident, a policy for missing persons from acute hospital has been implemented, and the policy for missing persons in non-acute facilities has been amended to include patients on transfer to acute hospitals. An SOP for the transport of patients between facilities, including guidance to aid decision making on escorts has also been implemented. The nursing notes in the patient information record system within acute wards will now include text to include risk assessments and this information is audited every two weeks.
- Following an inpatient fall, there has been improved usage of assessment tools that are available on TRAK and improvements have been made to the multi-disciplinary team (MDT) review tool. This is monitored by the senior charge nurse on the ward and a falls group has commenced. Medical to medical handover when transferring between hospitals has also been promoted.

6. Covid-19 Pandemic

Guidance was provided to all services and review teams at the start of the pandemic on reporting and managing adverse events, given the significant demands on the service at that time, acknowledging that it may not always be possible to fully implement current processes. Local governance was maintained around reporting,

managing and communicating about adverse events to ensure patient and staff safety, acknowledging that reviews may be delayed.

Senior management teams continued to:

- Seek assurance that any immediate safety issues had been addressed
- Agree level of review required
- Consider whether organisational DoC applied to events
- Contact patient/family to inform them of the review process and explain there may be a delay to the conclusion of the review
- Complete commissioning documentation if decision was for full SAE review (HIS level 1), capturing any specific questions and stating that the review is on hold if necessary.

Senior management teams also took stock of current SAE reviews and decide whether they should formally be put on hold, communicating any delay to patients and families.

The length of time taken to progress reviews was generally longer than we would have liked due to availability of staff and our wish to ensure that all relevant information was gathered to inform the review so that clear information was provided to patients and families. There have been no cases this year when the duty of candour procedure was activated which have been directly attributable to Covid-19.

In several cases, communication with the patient/family has not been in person but has taken place either via the telephone or video calls.

Existing processes were followed with the exception of contact via telephone or video call as above.

7. Other information

As expected, there is learning at both a national and local level which is being shared and explored further at national and local Forums. For NHS Lothian, three key priorities are listed below.

- Ensuring that a plan for communication with patient and family is clear and included as part of commissioning reviews
- Clarify roles and responsibilities in relation to communication with patients and families (management role in statutory DoC process vs professional DoC conversations)
- Ensure appropriate early communication with patient and families where it is unclear whether the statutory duty of candour applies at the outset

Following on from last year's report we have also made amendments to the information we record to evidence the completion of key steps in the procedure.

As required, we have notified the Scottish Ministers that we have published this report on our website.

If you would like more information about this report, please contact us.

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