Duty of Candour Annual Report

1st April 2021 - 31st March 2022

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 37 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 2021 and 31 March 2022
A person died	11
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	14
Changes to the structure of the person's body	≤5
The shortening of the life expectancy of the person	6
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	0
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	37

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 but one case. This means we informed the people affected, apologised to them from the organisation, and offered to meet with them. Reviews have been commissioned for 37 of these events, 32 of which have been completed. In all 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 8 cases where we have not been able to feed back the outcome and learning to people involved for a variety of reasons.

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?

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 the loss of tissue samples sent out with NHS Lothian for tests; a revised standard operating procedure (SOP) has been developed to include a second person check and documentation. A review has also been undertaken to minimise types of tests which require to be performed out with NHS Lothian.

- Following incorrect internment of an early pregnancy loss, and failure to carry out laboratory tests, changes have been made to SOPs within the Laboratory and Mortuary. Processes are also being revised within early pregnancy areas and gynaecology to minimise risk of this happening again.

- Training materials were improved after an event during anaesthesia.

- Following two events involving anticoagulation; there has been a review of the current NHS Lothian guideline for the care of individuals at high risk of both bleeding and thrombosis. Structures and processes to provide perioperative anticoagulation advice and management in NHS Lothian have also been reviewed and improved.

- Following issues with reporting of CT scans processes have been reviewed to ensure more timely review of radiology reports which includes a process to track and monitor all patients who are actively on clinician's caseloads to ensure appropriate and timely follow-up and review of investigations. A referral system is in place where the receipt of the referral is acknowledged, is auditable and visible within the electronic patient record. An SOP is in place to ensure that Emergency Care notes added after the patient's initial attendance are checked by a doctor.

- As a result of a patient being discharged without appropriate medication which resulted in readmission to hospital; a reminder has been sent to all staff to complete the discharge letter timeously and of the current process of bleeping pharmacist to check and sign patient discharge scripts prior to discharge. Completion of the Trak (electronic patient record) discharge list will be added to the duties of the discharge assistant role.

- Failure to identify, escalate and appropriately manage acute confusion of a patient led to a patient absconding and injuring themselves. There will be a focus on education of the assessment and initial management of acute delirium for all Foundation doctors by the POPS (Proactive care of older people in surgery team). The Patient Engagement Policy to support decision making along with the current guidelines available relating to the detection and management of delirium will be incorporated into the education programme.

- Following residual medicine in a venous cannula which resulted in a patient receiving additional drug inadvertently, anaesthetic charts and checklists will be standardised across NHS Lothian to include check that all cannulas have been flushed or removed on arrival in recovery room. A video has been sent to all anaesthetic staff about a patient's experience of residual drugs in an IV cannula.

- Following a procedure, there was a failure to consider bleeding as a diagnosis when patient deteriorated and the failure to effectively escalate this to senior staff. A comprehensive handover is given post procedure to staff nurse from ward on collection of patient or patient is escorted back to ward following

procedure and handover given to staff on the ward. Observations are taken on arrival to ward where nurse in charge is alerted and ensures that procedure is followed and escalation to senior medics and/or Clinical nurse manager if appropriate. A more comprehensive induction process has been introduced for new starts where the escalation process is specifically highlighted. The FY1 induction booklet has been revamped and pack includes all escalation flow charts and reference to specialties.

- Following the failure to identify deterioration in a patient, the failure to administer the correct medication and a lack of medical review, improvements were introduced about the routine use of NEWS charts in all relevant outpatient areas, improved signage at all nursing stations, and education.

- Following a clinical sharps incident to a patient, speciality specific competences for the relevant staff group has been incorporated into local induction

- Additional treatment for a baby as a result of CTG escalation guideline not being followed led to review of the escalation policy to include earlier senior medical involvement and guidance incorporated into PROMPT (Practical Obstetric Multi-Professional) training.

- Following a baby being admitted to critical care and there has been a review and amendment of the relevant policy. The national neonatal network has developed national guidance on the management of neonatal critical respiratory support including guidance on referral for ECMO and it has been adopted into local guidance. Communication pathways for patients transferring between boards and services have been improved.

- Following cardiac arrest of a patient during labour due to blood loss, a revised escalation policy for obstetric anaesthesia with guidance of when a consultant anaesthetist needs to be called has been implemented and the key learning from this event has been incorporated into PROMPT (Practical Obstetric Multi-Professional) training

- Following a stillbirth of a baby where the mother moved to Lothian from another health board area during pregnancy a summary of relevant maternity information is requested for all women transferring from other boards for ongoing care and there is now a facility to visualise aspects of a Badger maternity record from another health board.

- Due to guidelines not being followed and a failure in recognition of and the management of serious maternal illness closer monitoring of results takes place. A process has also been developed by Maternity and Anaesthetics

services to support decision making on place of care for critically unwell pregnant women.

- As an alert on TRAK (patient electronic record) had not been followed, there was a delay in recognising the cause of deterioration in a patient. A process has been introduced to review TRAK alerts at least once daily on the morning ward round in the unit. Any TRAK alerts are communicated verbally and in the discharge letter to the receiving medical team when the patient is discharged. This process is being presently reviewed in a quality improvement project.

- Following the delivery of a baby who required additional treatment the pathological CTG guidance was reviewed to ensure clarity for all modes of delivery and updated to include recommendations on category of and timeline for delivery when a pathological CTG has been identified this was issued as a practice reminder to all midwifery staff.

- As a result of a patient being allocated to the incorrect pathway at booking, inappropriate outpatient induction of labour occurred. A short life working group has been established to review processes for pathway allocation and a practice reminder of the current red pathway allocation has been shared with all staff within the service.

- Following the suicide of a patient, systems have been changed so that all staff in older people's community mental health use the online risk assessment tool which is embedded in TRAK (patient electronic record). Structured care planning entries in TRAK are now used which is monitored through regular TRAK reports and electronic audits. A working group has been convened to address out of hours pathways for individuals with dementia. Training in trauma and trauma informed practice has been delivered within service.

6. Other information

We continue to learn both locally and nationally and improve implementation of processes to discharge the statutory organisational Duty of Candour. For NHS Lothian, priorities continue to be:

- 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

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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