Duty of Candour Annual Report

1st April 2022 - 31st March 2023

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 2022 and 31 March 2023. We hope you find this report useful.

1. About NHS Lothian

NHS Lothian serves a population of 916,310 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 41 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 2022 and 31 March 2023
A person died	11
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	25
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	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	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	41

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 30 cases. This means we informed the people affected, apologised to them from the organisation, and offered to meet with them. In the cases where we did not fully follow the process, issues included either not formally providing a key contact or failing to offer a meeting prior to the review to explain the process.

Reviews have been commissioned for all of these events, 38 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 11 cases where we have not been able to feed back the outcome and learning to people involved for a variety of reasons, including patient/family choice.

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

We are currently undertaking an improvement piece of work to improve the reliability of communication processes with patients and families where a significant adverse event has occurred, which will in turn improve our compliance with the Duty of Candour process.

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 are 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:

- As a result of the deterioration of a patient when results of blood test results not being acted on, a standard operating procedure (SOP) has been

introduced for passing information between a specialist service and prison staff to facilitate follow up where required

- As a result of failing to act on / review a CT result and therefore missing an opportunity for review of a patient with cancer, systems have been set up so that any unread results are sent to clinicians for review on a weekly basis

- Following the still birth of a baby, a risk assessment for SGA (Small for Gestational age) has been developed and introduced on TRAK (patient electronic record) with a mandatory field to ensure completion as part of the booking system. Service wide training on the SGA pathway and risk assessment has also been implemented

- A dressing of a wound involving an arterial injury was removed inappropriately in a ward environment and subsequent major haemorrhage necessitating transfusion. Processes around the assessment of wounds have now been extensively reviewed. Dressing must no longer be removed pre-operatively when there is a risk of major haemorrhage.

- Several changes have been made following the attempted suicide of a patient whilst out on pass with a family member:
    - The standard operating procedure (SOP) for escorting patients on planned time out of the ward has been reviewed and updated to ensure staff are directed to document any identified risks, with identified mitigations to support 'testing out' of patient risk factors as part of their care plan
    - The SOP also requires discussions and agreements to take place with relevant individuals who will be supporting patients during periods of authorised time out of hospital
    - The Carers Information leaflet was also updated to reflect discussion regarding pass arrangements.

- Several changes and clarifications to the foetal monitoring guidance have been made following a delayed review and inappropriate response to an abnormal foetal monitoring result and a resulting brain injury. The new guidance includes additional information on foetal physiology to aid decision making about timing of delivery. A competency test has also been introduced for all staff working on labour ward.

- Following the fall of a patient resulting in a fracture from a shower/commode chair where the wheels had not been locked, all staff were made aware of the safe storage and management of this equipment and that all wheels have to

be stored in locked position when not in use. This reminder is included in the cleaning schedule daily sign off.

- Changes have been implemented across all vaccination facilities following a clinical sharps event when carrying out immunisation. A standard operating procedure (SOP) has been developed detailing that shared stations and shared vials of vaccine should not be used. This will reduce the risk of needlestick injury as re-sheathing will not be required to transport the vaccine.

- As a result of the wrong tooth being drilled during dental treatment, Local Safety Standards for Invasive Procedures (LOCSSIP) were introduced to the team including a pre-operative safety huddle for every case. This will address the issue of tooth identification and will empower all team members to speak up if they have concern of a potential error.

- Several improvements have been introduced to reduce the likelihood of similar errors occurring after a patient had a significant hypoglycaemic event which was caused by changes in a patient's other medications. A more robust protocol for multi-speciality handovers has been introduced and a change has been requested to the electronic patient record system (TRAK) to allow for a reminder to be set to review patient's blood glucose levels.

- Following the death of a patient as a result of intracerebral bleeding which was contributed to by a high dose of an anticoagulant drug, the NHS Lothian anti-thrombotic guidelines have been amended. Additionally, a shortcut has been added to electronic patient record system (TRAK) to allow for clearer recommendations regarding certain drugs including anticoagulants.

- Several improvements to the staffing arrangements have been made to address issues of nursing cover, following an incident when a patient disconnected themselves from a haemodialysis machine and suffered a cardiac arrest. Additionally, a formalised support system is now in place to support more inexperienced nurses caring for patients in this area. A thorough testing and review programme of the equipment in question also took place.

- Patients at risk of pressure ulcer development are highlighted on the ward handover sheet and verbally discussed at handover time after a patient developed a Grade 4 pressure ulcer. Posters have also been displayed around the ward highlighting pressure damage and the importance of regular care rounding and checking.

- A number of changes have been made following the inappropriate administration of a drug to a patient who had a known allergy:

- All patients now wear wrist bands, including red allergy bands where indicated
- Education sessions for staff on allergy and anaphylaxis have also been developed and a roll out programme devised
- The Safety brief and handover tool has been revised to include allergy status of patients
- A Standard Operating Procedure (SOP) for escalation, along with appropriate educational support has also been developed.

- Following necrosis to a patient's digit caused by a dressing applied too tightly, a database has now been established to allow staff to seek support for the care of patients with such dressings in place.

6. Other information

We continue to learn both locally and nationally and to 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 of adverse event reviews
- Improving reliability of communication with patients and families at all stages of the review process, including clarity of roles and responsibilities all those involved

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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