The 'duty of candour'

The duty of candour

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) set out a new Duty of Candour.

The Act and the Regulations require organisations providing health services, care services and social work services in Scotland to follow a formalised procedure when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The purpose of this new duty is to ensure that providers are open, honest, supportive and providing a person-centred approach.

Our legal obligations

1. Duty of Candour Procedure

As a provider of an independent health care service, we are required to develop and implement a duty of candour policy that describes how we/our staff will act in the event of an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The key stages of the policy must include:

- → Notify the person affected (or family/relative where appropriate);
- → Provide an apology;
- → Carry out a review into the circumstances that led to the incident;
- → Offer a meeting with the person affected and/or their family, where appropriate;
- → Provide the person affected with an account of the incident;
- → Provide information about further steps taken;
- → Provide support to staff notifying the person affected by the incident;
- → Prepare and publish an annual duty of candour report (see below).

Further guidance on when the duty must be implemented can be found in the Scottish Government Duty of Candour Guidance and the dedicated webpage.

Preparing the duty of candour procedure:

We will consider the following points when preparing the duty of candour procedure and annual report:

- How we will identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21 of the Act?
- We are satisfied our staff understand their responsibilities and we have systems in place to respond effectively?
- Who do we need to engage with to satisfy ourselves we can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?
- What systems we have in place to support staff to provide an apology in a person-centred way and how we support staff to enable them to do this?
- Do our current systems and processes provide the information required to report on the Duty of Candour?
- How we will align our duty of candour annual report with other reports we are required to provide, such as feedback and complaints, significant events reviews, case reviews etc.?
- What training and education we have at present that will support the implementation of the Duty? This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations. We also participate in national training which is available freely to our staff such as Learnpro.
- What we have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?
- How we currently share lessons learned and best practice around incidents of harm? Could this be improved in any way?

**Please refer to the Duty of Candour Guidance for more detailed guidance.*

2. Duty of candour annual report

We must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where we have applied the duty of candour. This annual report will be published on our website.

NB: *Even if you do not implement the duty of candour procedure in a given year, you are still required to produce a short report that contains information about staff training on the duty of candour obligations.*

Duty of Candour Annual Report

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered duty of Candour within our service.

Name & address of service:	St Margaret of Scotland Hospice, East Barns Street, Clydebank, G81 1EG	
Date of report:	12 April 2021 (for period 1 April 2020 – 31 March 2021) This report encompasses the period from the start of the COVID pandemic and includes an outbreak in December 2020.	
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?	The values and attitudes of the Hospice team is underpinned by our Mission Statement which is founded upon the principles of honesty, openness, transparency and integrity. Staff are aware of the importance of candour through the development and implementation of Hospice Policy. We have had given a multi-disciplinary meeting on the subject of Duty of Candour to various staffing groups. Duty of Candour underpins our communication with patients and families following every incident, whether it requires implementation or not. Staff complete the Duty of Candour module on Learnpro and are introduced from the moment of induction to the organisation.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	~~NO~~

How many times have you/your service implemented the duty of candour procedure this financial year?	
Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened (April 20 - March 21)
A person died	1 – COVID Part 1 10 – COVID Part 2
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	3
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	0

Document based on IHC Duty of Candour Template for Providers, Version 1.0, dated 19 February 2019 prepared by IHC team

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over reporting of duty of candour?	Yes, all healthcare professionals have a duty of candour and a professional responsibility to be honest and communicate effectively when things go wrong and to follow the terms of the Duty of Candour Policy. The Policy was reviewed in May 2020.
What lessons did you learn?	Following any incident, whether Duty of Candour is implemented or not, an immediate investigation is carried out by the Senior Nurse on duty, risk assessments are created or updated as appropriate, named nurse is put in place if necessary. If appropriate information is added to the safety brief shared at each handover report. Any incident or accident or medication error, is recorded on DATIX.
What learning & improvements have been put in place as a result?	COVID outbreak – Duty of Candour was implemented for every patient in the Hospice. On 24 December 2020, we wrote to each family to advise of the Hospice outbreak and the potential consequences on their loved ones. We provided a named person to contact for any further information. Letters were sent to all patient families, by email where possible and followed up with a telephone call made by the Director of Clinical Services. We worked closely with Public Health to maximise communication efforts. We voluntarily requested an Infection Control Audit be carried out by an NHSGGC Infection Control Specialist to ensure all systems in place were appropriate and adequate – confirmed no improvements identified. Weekly staff PCR testing commenced. Please see COVID Policy for detailed information on COVID specific learning and improvements. The importance of accurate documentation, photographs where appropriate and named nursing where necessary. Patient risk assessments undertaken, updated and reviewed. Information shared at handover and in safety brief.
Did this result is a change / update to your duty of candour policy / procedure?	No change required.
How did you share lessons learned and who with?	Lessons learned were shared at the weekly Senior Nurse Management meeting, ward handovers, Multi-disciplinary meetings by way of a case study and education session (if appropriate), and medical meetings. Any slips, trips and falls, including those which have not resulted in harm as defined under Duty of Candour, are discussed at the Senior Nurse Meeting and the Health & Safety meeting.
Could any further improvements be made?	Not that we are aware of at present.
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	In terms of our policy, the Senior Nurse manager on duty takes responsibility for ensuring any apology is delivered when necessary. The senior nurse managers are supported by their colleagues and the Chief Executive.

What support do you have available for people involved in invoking the procedure and those who might be affected?	There is always a Senior Nurse Manager on duty and if necessary, the Chief Executive can be contacted for advice/guidance. All staff have access to the Hospice policies.
Please note anything else that you feel may be applicable to report.	Nothing at this time but we will continue to review, monitor and develop our policy.