

ITEM 7C

Duty of Candour

“Openness and Honesty when things go wrong”





Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016

2016 asp 14

Explanatory Notes have been produced to assist in the
understanding of this Act and are available separately

£6.00

PART 2

DUTY OF CANDOUR

Duty of candour procedure

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25 Interpretation

22 **Duty of candour procedure**

- (1) The “duty of candour procedure” means the actions to be taken by the responsible person in accordance with regulations made by the Scottish Ministers.
- (2) Regulations under subsection (1) may in particular make provision about—
 - (a) the notification to be given by the responsible person,
 - (b) the apology to be provided by the responsible person to the relevant person,
 - (c) the actions to be taken by the responsible person to offer and arrange a meeting with the relevant person, including asking the relevant person whether the relevant person wishes to receive an account of the incident as mentioned in section 21(2) or information about further steps taken,
 - (d) the actions which must be taken at, and following, such a meeting,
 - (e) an account of the incident as mentioned in section 21(2), information about further steps taken and any other information to be provided by the responsible person,
 - (f) the form and manner in which information must be provided,
 - (g) the circumstances in which the responsible person is to make available, or provide information about, support to persons affected by the incident,
 - (h) the keeping of information by the responsible person,
 - (i) steps to be taken by the responsible person—
 - (i) to review the circumstances leading to the incident, and
 - (ii) following such a review,even if the relevant person has advised that the relevant person does not wish to receive an account of the incident as mentioned in section 21(2) or information about further steps taken,
 - (j) training to be undertaken by a responsible person,
 - (k) training, supervision and support to be provided by a responsible person to any person carrying out any part of the procedure on behalf of the responsible person.
- (3) In this section “relevant person” means—

Scottish Government Bill

Duty of Candour (Autumn 2016)

The new duty of candour will create a **legal requirement** for health and social care **organisations** to inform people (or their families/carers acting on their behalf) when they have been harmed (physically or psychologically) as a result of the care or treatment they have received.

Context

- A professional duty of candour already exists
- An obligation to disclose and involve patients is established in NHS Lanarkshire's Adverse Event Management Policy and Procedures

Incidents that activate the duty

- Death of the person
- Permanent lessening of bodily, sensory, motor, physiological or intellectual functions
- An increase in the person's treatment
- Changes to the structure of the person's body
- Shortening of life expectancy

Incidents that activate the duty contd.

- An impairment of the sensory, motor or intellectual functions of the person that lasted, or is likely to last, for a continuous period of at least 28 days
- Pain or psychological harm experienced, or likely to be experienced, for a continuous period of at least 28 days
- Requiring treatment by a registered health professional in order to prevent death or injury, which, if left untreated would result in one or more of the above

Systems impacted by Duty of Candour

- All our clinical incidents where significant harm has occurred
- All our Health & Safety incidents where significant harm has occurred (RIDDOR)
- Complaints that conclude we have caused significant harm
- Where significant harm has been detected through other review processes e.g. M&M
- Within Claims where significant harm is recognised

Actions required



- Guidance/examples of types of incidents that should be considered under each category
- Systems for capturing all relevant incidents
- Process for identifying whether an incident triggers the formal duty of candour procedures

NHS Lanarkshire Draft Duty of Candour Guidance



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Identifying incidents – roles and responsibilities

Steps	Responsibility
1. Immediate management of event - Make person/area safe and attend to any medical requirements	Department/ Ward/Clinical Team
2. Provide Apology	Department/ Ward/Clinical Team
3. Follow Adverse Event Pathway and record on Datix	Department/ Ward/Clinical Team
4. Consider whether Organisational Duty of Candour Procedures Apply <i>(Note below)</i> <ul style="list-style-type: none"> • Category 1 (Significant Adverse Event- SAE) • Category 2 	SAE Commissioner Hospital Site or Locality Management Team Escalate to SAE Commissioner if unsure
5. If YES then follow Duty of Candour Procedures	Site or Locality Management Teams

Note: Category 3 incidents (no harm or near miss) do not trigger the organisational Duty of Candour requirements

Incidents that trigger the Duty of Candour Procedures may also be identified through Complaints, Claims or Morbidity & Mortality Processes. In these cases the Hospital Site or Locality Management Team should ensure that the event is recorded on Datix as an Incident and then follow the Duty of Candour Procedures

Duty of Candour 'procedure' in the Act

Notify the person affected (or family/relative) where appropriate

Provide an apology

Carry out a review the circumstances leading to the incident

Offer and arrange 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

Make available, or provide information about, support to persons affected by the incident

Prepare and publish an annual report on the duty of candour

Adverse Event Management Policy – Procedure 9

NHS Lanarkshire expects that patients should be provided with the following information about adverse events which affect them:

- Acknowledgement of the distress that the adverse event has caused
- A sincere and compassionate statement of regret for the distress they are experiencing
- A factual explanation of what happened
- A clear statement of what is going to happen from then onwards
- A plan about what can be done medically to repair or redress the harm

Adverse Event Management Policy – Procedure 9

If a Significant Adverse Event Review (SAER) is to be carried out, then patients and/or their families/carers should be involved as follows:

- Being informed that a detailed review is taking place
- Being invited to discuss whether and if so, how the patient and/or their families/carers will be involved
- Being made aware of the process and the purpose and logic that underpins it
- Being kept up to date with the progress of the review
- Being informed of the outcome and the actions which NHS Lanarkshire will take following the review

Actions required



- Update policies and procedures
- Clarify roles and responsibilities

All staff

- Guidance/training on Meaningful Apology

Management Teams

- Guidance/training on Implementing Procedures

Meaningful Apology

science of sorry

- Say "I'm sorry" or "I apologise"
- Name the wrong doing – be specific
- Accept/acknowledge "I got it wrong"
- Show you recognise the impact/consequences
- Agree actions and do it!

4R's
Reflect
Regret
Reason
Remedy

Reflect <ul style="list-style-type: none">• stop and think• be present• stay CALM	Regret <ul style="list-style-type: none">• say sorry• accept responsibility• sincere, real, authentic	Reason <ul style="list-style-type: none">• be honest and open• explain rather than defend• unpalatable truth	Remedy <ul style="list-style-type: none">• what will put things right• agree next steps• feedback to all involved
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Draft Procedures Checklist

Step 1:
Identifying and
Contacting the
Relevant Person

- Do you know who the relevant person in respect of this incident?
- Is their preferred method of communication already known? If not, this needs to be determined and noted.
- Has it been possible to make contact with them? If not, a note should be made of the attempts that have been made to make contact.

Step 2:
Notify Relevant
Person

- Provide the relevant person with an account of the incident and what actions are going to be taken (Note that if it is more than a month since the incident need to explain why).

Step 3:
Arrange a meeting

- Arrange a meeting - and provide the person with the opportunity to ask questions in advance of the meeting.

At the meeting (or through communication if not desired):

- Tell the person what happened.
- Tell them what further steps are being taken.
- Give the relevant person the opportunity to ask further questions and express their views.
- Tell them about any other processes that might be on-going.
- Provide them with a note of the meeting and details on how to contact a person within the organisation.

Step 4:
Carry out a review

- Start a review – remember to seek the views of the relevant person.
- Prepare a report—to include the manner it has been carried out.
- Ensure that report focus is on **improving quality and sharing learning**
- Report to include the actions taken in respect of the duty of candour procedure .
- Offer to send the relevant person a copy of the review report—remember to let them know of any further actions subsequently.
- Make sure that a written apology is offered.

Throughout
Support and
Assistance for
Relevant Person &
Staff

- Consider and give relevant person support or assistance available to them .
- Staff to receive training and guidance on all requirements of the procedure.
- Employees to be provided with details of services or support relating to their needs arising from the incident.

Support and Assistance



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Information and training

- Duty of Candour Fact Sheets
- eLearning Module

<http://www.knowledge.scot.nhs.uk/scormplayer.aspx?pkgurl=%2fecomscormplayer%2fdutyofcandour%2f>

- National events
- Communications Plan
- Training programme



Questions

Issues or concerns