DUTY OF CANDOUR

ANNUAL REPORT

1st April 2018 - 31st March 2019

NHS Lanarkshire	
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DUTY OF CANDOUR REPORT

The Duty of Candour (DoC) legislation became active from the 1st April 2018. This placed a statutory obligation on health organisations to follow the subsequent regulations which stipulate a number of actions to take place if certain circumstances occur. These are as follows:

If a patient suffers **death** or **serious*** harm as a result of an **adverse event** that the **organisation is responsible** for, the following should occur:

- An apology is offered to the patient or their relative.
- The patient / relative is informed that there will be an investigation.
- The patient / relative is given the opportunity to ask questions to be answered as part of the investigation.
- The result of the investigation is shared with the patient / relative and a meeting is offered.
- The organisation learns from the investigation by implementing the recommendations/ actions.

During this first year of Duty of Candour legislation being live, NHS Lanarkshire has reported five events. These were all unintended or unexpected incidents that resulted in death or harm as defined in the Act and did not relate directly to the natural course of illness or an underlying condition.

The table below shows the number of duty of candour events recorded for NHS Lanarkshire grouped by Operational unit -

	CATEGORY 1
HAIRMYRES	3
MONKLANDS	0
WISHAW	1
MATERNITY	1
NORTH	0
SOUTH	0
CORPORATE	0

The events noted above were assessed for compliance with the following elements of the regulations recognising if the patient died and there were no relatives to contact or following an attempt, relatives would not engage, this would still count as compliance.

- Patient or Relative **informed** of the adverse event **% compliance.
- **Apology** given **% compliance.
- Adverse event robustly **reviewed** and recommendations made **% compliance.
- Patient or Relative **informed** of the results of the review **% compliance.

Compliance with regulations are shown on the table below –

	%
% where Patient or Relative informed of the adverse event	*100*
% where Apology given	*100*
% where the Adverse event was robustly reviewed and recommendations	*100*
% where Patient or Relative was informed of the results of the review	*60*

Reasons for non-compliance -

For the % where Patient or Relative was informed of the results of the review –

- One of the incidents the SAER has a level of technical complexity and the patient was kept advised of its progress whilst having regular clinical review, they were content with that involvement.

- The other incident is still ongoing.

When carrying out the adverse event review process, the factors listed below are considered to support the decision making on whether any of these have caused or contributed to the adverse event, which can then identify if these are duty of candour incidents or not.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2018 and 31 March 2019)**
A person died	0
A person's treatment increased	3
The structure of a person's body changed	0
A person's sensory, motor or intellectual functions was impaired for 28 days or	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	1
A person needing health treatment in order to prevent other injuries as listed above	1
TOTAL	5

WHAT HAVE WE LEARNED / CHANGED AS A RESULT OF REVIEWING THESE EVENTS?

A significant learning point has been the need for contemporaneous data collection and regular review of that by the Adverse Events team centrally. Variation in coding and compliance with completing all data fields has made completion of this first annual report very resource intensive. However we are now confident that future reporting to our Board's Governance Committee on a quarterly basis will be both accurate and complete.

NHS Lanarkshire has made a number of changes following review of the duty of candour events. Examples of these are detailed below –

Duty of Candour Event	Changes made
Following a theatre equipment incident where it was noticed at the end of a hip replacement procedure that one of the trays housing the hip instruments did not have filters, this should have been highlighted when the set was opened at the beginning of the procedure.	NHS Lanarkshire have agreed to carry out a review of the receipt, storage and checking of incoming instrument trays and have regular meetings with the service provider.
Following an appointments problem incident where a young diabetic patient listed for urgent laser treatment to their left eye in June 2018; the patient had excellent vision in their left eye at that point but had a proliferative diabetic retinopathy that would need urgent laser treatment. An appointment scheduled for August 2018 but was cancelled and was rescheduled for October 2018, 6 months after being listed for urgent laser treatment. The patient's vision in their left eye had fallen to 'counting fingers' and they also had a bleed in the eye with extensive new vessels on the retina in their left eye.	NHS Lanarkshire have agreed to make changes to laser clinic profiles, development of a Standard Operating Procedure and carry out customer care training for administrative and nursing staff.
Following a medication prescribing incident a patient admitted with NSTEMI attended the Cardiac Catheterisation Laboratory and had a coronary angiogram but stenting was unfortunately not possible. It was decided patient should be for medical management and was commenced on apixaban and clopidogrel and aspirin and ticagrelor were stopped; however, fondaparinux was not stopped and patient also received this. The patient was reviewed the following day but clinician failed to notice the error that patient was prescribed both apixaban and fondaparinux and patient received a further dose of these. Patient then had a haemorrhagic stroke.	NHS Lanarkshire involved in reviewing this incident, still ongoing.

Following a treatment problem incident where a young patient was referred to ICU at approximately 0700hrs with cardiogenic shock of unclear origin. Haemodynamic instability worsened and the patient was referred to a hospital out with Lanarkshire. A request made from the specialist centre for formal cardiology review and echocardiogram prior to transfer, however the only cardiologist in NHSL was in the Cardiac Catheterisation Laboratory and not immediately available. The cardiology review was eventually carried out at approximately 1630, but the patient became increasingly unstable and by the time the patient was transferred they were in multi-organ failure and died shortly after arrival.	NHS Lanarkshire have agreed that all medical emergency patients in ED now have a manual check of the heart rate rather than relying on pulse oximetry and cardiology cover across Lanarkshire is being reviewed by the board.
Following a maternal delivery incident a patient attended their GP on day 9 complaining of feeling sore with pressure PV. The GP performed a PV speculum examination and located swabs, all of which were removed.	NHS Lanarkshire have reviewed and updated SOP accordingly.

NHS LANARKSHIRE POLICIES, PROCEDURES AND GUIDANCE

All adverse events are recorded on the incident management recording system (Datix) and reported through the organisation's governance structures as set out in the adverse event management process. NHS Lanarkshire has put in place some trigger questions that can identify incidents that should activate the duty of candour procedure.

There is a separate Guidance document on Duty of Candour which provides information on the procedure and steps to follow when a potential duty of candour incident is identified. Staff have access to information on the intranet via the dedicated duty of candour page.

All staff are encouraged to complete the NHS Education Scotland Duty of Candour e-learning module, which is also available on the organisation's intranet.

All adverse events are reviewed to help us understand the situation of the event and what caused this to happen, allowing for changes to be implemented to improve the process and healthcare for all patients.

The type of review carried out is dependent on the severity of the grading of the adverse event e.g.: a significant adverse event review includes recommendations at the end of the report; these are all taken into account and an improvement action plan is also developed at the end of every review. These actions are taken forward by the operational units who nominate the most suitable staff to be responsible for taking the actions forward and making the changes for improvement.

IMPLEMENTATION OF DUTY OF CANDOUR LEGISLATION

In preparation for the legislation and subsequently, NHS Lanarkshire have developed guidance on Duty of Candour which is available for all staff via the intranet page on First Port including documentation and tools, and to support staff there are training and education sessions planned.

NHS Lanarkshire have realised that we need to change the way information on Duty of Candour is being collected on the Datix system to allow recording of more accurate information. We have therefore reviewed and updated the dataset with additional questions to allow complete capture of all information, these changes were introduced from February 2019.

OTHER INFORMATION

This first year of Duty of Candour legislation has been a learning exercise for all involved and we have taken this as an opportunity to review our current process for reviewing adverse events and capturing the information required to evidence duty of candour, with many changes and updates made to our adverse event management policy and procedures ensuring inclusion of duty of candour where applicable.

This report has been submitted to Health Improvement Scotland (HIS) and shared within NHS Lanarkshire structures and with all stakeholders.

For any further information regarding this report, please contact:

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