Duty of Candour Policy

Your World Nursing - Scotland
Duty of Candour Policy

General obligations

Every organisation covered by the duty of candour legislation is regarded as a 'responsible person' with the definition as set out in section 25 of The Act.

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.

A 'relevant person' is the person who has been harmed during the incident, or where that person has died, or is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided, a person acting on behalf of that person. This is set out in section 22(3) of the Act.

There are already a number of professional duties of candour such as those required by the Scottish Social Services Council, the Nursing and Midwifery Council, the General Medical Council, the General Dental Council, and the General Optical Council. This statutory organisational duty has been developed to be in close alignment with the requirements of these professional duties and will be mutually supportive.

Your World Nursing Ltd (YWN) supplies agency nurses to the NHS boards, independent healthcare services and prisons and will follow their local reporting systems and processes.

Notifications are made electronically using the eForms system.
These include:

- Serious injury or complication to a service user
- A drug error
- Controlled drug incident
- The unexpected death of a service user
- Accidents, incidents or injuries to a person using a service
- All deaths of a person using a care service
- Adverse event involving a controlled drug

Duty of candour procedure

The below describes how YWN/YWN workers 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).

Duty of Candour Policy

When must the duty of candour procedure be activated?

Organisations (as responsible persons) must activate the duty of candour procedure as soon as reasonably practicable after becoming aware that:

- An unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person
- In the reasonable opinion of a registered health professional not involved in the incident
  - » that incident appears to have resulted in or could result in any of the outcomes mentioned below
  - » that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition

It is important to note that where the duty of candour procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for this must be provided to the relevant person.

The relevant outcomes are as follows:

- The death of the person
- Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm")
- Harm which is not severe harm but which results in one or more of the following criterion
  - » An increase in the person's treatment
  - » Changes to the structure of the person's body
  - » The shortening of the life expectancy of the person
  - » 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
  - » 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

The person requires treatment by a registered health professional in order to prevent:

- The death of the person
- Any injury to the person which, if left untreated, would lead to one or more of the outcomes

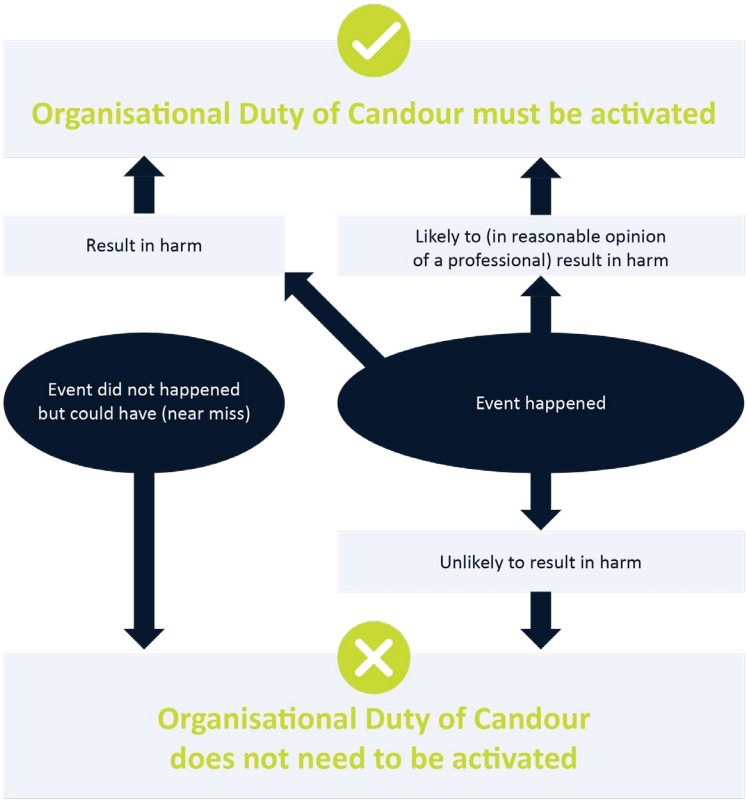
What is the procedure start date?

The procedure start date is the date that the YWN receives confirmation from a registered health professional that, in their reasonable opinion, an unintended or unexpected incident appears to have resulted in, or could result in an outcome listed above and that relates directly to the incident rather than to the natural course of the relevant person's illness or underlying condition.

Duty of Candour Policy

What does 'could result' mean and how is that decision to be made?

If the registered health professional thinks that it is unlikely that harm will occur, then the duty of candour procedure need not be activated for that incident. The diagram below sets out the decision-making process in more detail.



Duty of Candour policy key stages

- Notify the person affected (or family/relative where appropriate)
- Provide an apology
- Carry out a review into the circumstances that led to the incident; it is likely that health professionals will require organisations to provide them with the following core information in the first instance: (What was the incident? What was the outcome? What illnesses and underlying condition did/does the person have?)
- 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

Organisations who have difficulties in identifying a registered health professional can also contact Healthcare Improvement Scotland or the Care Inspectorate for advice on routes to be considered.

Duty of Candour Policy

Notification

The duty of candour legislation states that the relevant person should be notified as soon as reasonably practicable, but it should be considered good practice to notify the relevant person within 10 working days of the procedure start date.

This notification can be by various methods including telephone, face to face or by letter. It is important to remember that where a duty of candour procedure start date is more than a month after the incident, the organisation must provide the relevant person with an explanation of why this is.

Before having the conversation at the point of notification, YWN may wish to consider:

- Who from the organisation is already in contact with the relevant person?
- What discussions or information exchange has already taken place?
- What is the relevant person's current understanding of the incident and organisational response to this?
- Where the conversation takes place?
- Who should be part of, and who should lead that conversation?
- What support should be available to the relevant person during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the relevant person?

The notification must include:

- An account of the incident to the extent that the organisation is aware of the facts at the date the notification is provided
- An explanation of the actions that the organisation will take as part of the procedure
- In the case where the procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for the delay in starting the procedure

When YWN has published a report, we will notify:

- Healthcare Improvement Scotland, in the case of a report published by an organisation which provides an independent healthcare service (within the meaning of section 10F(1) of the (Scotland) Act 1978). This can be submitted via the eForms system
- The Scottish Ministers, in the case of a report published by any other organisation which provides a health service
- The Care Inspectorate, in the case of a report published by an organisation which provides a care service or a social work service. The Care Inspectorate will ask for information about whether or not care services have published their duty of candour report in the first set of Annual Returns following the end of the financial year after which the report must be published

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

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, YWN prepare and publish a duty of candour report at the end of each financial year, providing information about when and where we have applied duty of candour.

Duty of Candour Policy

Duty of candour annual report template		
Name & address of service:		
Date of report:		
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?		
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 XX - March XX)**
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions was impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	
A person needing health treatment in order to prevent other injuries as listed above	
Total	

Duty of Candour Policy

How many times have you/your service implemented the duty of candour procedure this financial year?	
Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	
What lessons did you learn?	
What learning & improvements have been put in place as a result?	
Did this result is a change/update to your duty of candour policy / procedure?	
How did you share lessons learned and who with?	
Could any further improvements be made?	
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?	
What support do you have available for people involved in invoking the procedure and those who might be affected?	
Please note anything else that you feel may be applicable to report.	

References

https://www.gov.scot/publications/organisational-duty-candour-guidance/