

Craigshill Health Centre – Duty of Candour

Summary

Duty of Candour is part of the Scottish Government’s commitment to openness and learning within health and social care. This is legislation as from 1st April 2018:

‘The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow 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).’

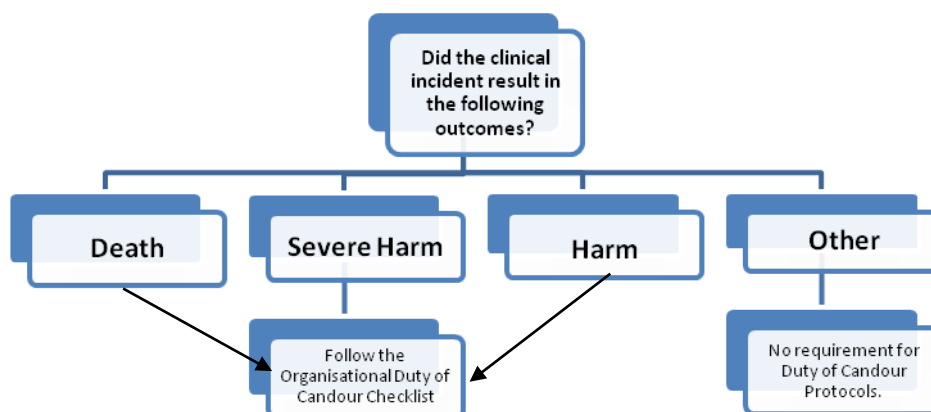
Scottish Government [Web] dated 30th May 2018

[The Duty of Candour Procedure \(Scotland\) Regulations 2018](#) sets out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been **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).

Triggering Duty of Candour in the practice

The practice identifies three origins of identifying a clinical incident under Duty of Candour.

1. Death
2. Severe Harm “A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ) or brain damage.”
3. Harm:
 - a. an increase in treatment
 - b. changes to the structure of the body
 - c. shortened life expectancy
 - d. impairment of function lasting at least 28 days
 - e. pain or psychological harm lasting at least 28 days



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Timeframes

Craigshill Health Centre has weekly meetings held each Tuesday between 12:30 – 13:30. These meetings include all health professionals attached to the practice.

There is protected time set aside in these meetings to discuss Significant Events Analysis and as part of the discussion of SEAs we will all take into consideration if the event comes under the Duty of Candour guidelines.

The Duty of Candour is triggered when the event comes to light:

- As soon as reasonably practicable
- May be immediately apparent
- Following review of an unexpected outcome e.g. unexpected death, unexpected worsening of an existing condition
- During investigation of a complaint
- Through Medicine Management review

The practice will notify the patient / family that the Duty of Candour process is being followed within **10 working days of the event**.

A response to the findings of the Duty of Candour will be made within **28 days*** of the event. The response will be of the following:

- Verbal apology given to the patient / family by the relevant senior person.
- Explanation as to why the Duty of Candour process has been triggered.
- Arrange a personal meeting with the patient / family and allow questions to be submitted prior to the meeting.
- If meeting is arranged outside the 28 day period, a full explanation will be provided to patient / family.

**Legislation states '1 month'; Craigshill Health Centre will define a month as 28 days to ensure full compliance and best practice.*

Documentation and Reports

The Practice will report annually on Duty of Candour findings. Reports will be anonymised and published on the website.

Minutes from meetings will be in a summary format, but the practice will use its discretion to produce more detailed minutes when appropriate.

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Name of Patient _____

Date of Birth _____

Date of Incident _____

Responsible Person _____

► The Organisational Duty of Candour Checklist

Step 1:

Identifying and
Contacting the
Relevant Person

- Do you know who the relevant person is 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 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):
- Apologise, if not already happened.
 - 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.

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Craigshill Health Centre will prepare a written report of the review, which will include:

- a description of the manner in which the review was carried out;
- a statement of any actions to be taken by the organisation for the purpose of improving the quality of service it provides and sharing learning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services;

and

- a list of the actions taken for the purpose of the procedure in respect of the incident and the date each action took place.

Where possible, Craigshill Health Centre will provide written reports on reviews in a manner that minimises the need for extensive redaction.

Craigshill Health Centre will offer to send the relevant person:

- a copy of the written report of the review;
- details of any further information about actions taken for the purpose of improving the quality of service provided by the organisation or other health, care or social work services;

and

- details of any services or support which may be able to provide assistance or support the relevant person, taking into account their needs.

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Name of Patient		Address	
Date of Birth		Postcode Contact Tel No	

Date of Incident	Date Identified	Date Patient Contacted	Date of Meeting	Description of Incident

Summary of the Review conducted by Craigshill Health Centre

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Actions taken by Craigshill Health Centre as a result of the review

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Details of third party support offered to assist patient / family

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