Duty of Candour Annual Report

2019 – 2020

1. Introduction

All health and social care services in Scotland have a Duty of Candour (DoC). This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the DoC is implemented in our services. This report describes how we have operated the DoC during the time between 1 April 2019 and 31st March 2020.

2. About Golden Jubilee National Hospital

Golden Jubilee Foundation has always aimed to ensure that we support the delivery of NHS Scotland's national health priorities. Our focus since our establishment has been to meet NHS Board demands and deliver equity of access to high quality healthcare for as many patients as possible so that they benefit from our clinical expertise and excellent facilities.

3. Our Policies and Procedures

Each Adverse Event is reported and reviewed via the Datix system. The procedure for reviewing each level of incident is set out in the Adverse Events Management policy. The Adverse Events Management policy and supporting tools/ guidance have been updated to reflect the introduction of DoC. The decision on DoC is built into the SAE review process. Legislation requires that a clinical person must make the final decision; this process is led by the appropriate Division CG lead and approved by the Division DMT.

Each event is reviewed with a focus on learning from what has happened, regardless of the level of harm. If there is potential to learn from an error this should be harnessed and taken forward. On completion of an adverse event review actions are identified and these are monitored to completion via the Clinical Governance reporting framework.

All staff receive training regarding adverse event reporting and the implementation of DoC at corporate induction. More in depth training is delivered to those responsible for reviewing incidents on Datix and a programme of Root Cause Analysis training has been launched for staff who could potentially take part in a Significant Adverse Event investigation.

We know that being involved in a significant adverse event can be distressing for staff as well as those affected by the event. We have support available to staff in the form of the formal line management structure. In addition to this we have the Spiritual Care and Diversity Lead and the Occupational Health team who are available to provide staff support in different forms following significant adverse events, where required.

4. Significant Adverse Event (SAE) Activity 2019-2020

Between 1 April 2019 and 31 March 2020, there were 44 SAE's reported; this is an increase of 9 events compared to the previous year. The table below shows the breakdown of these in relation to type of investigation. As outlined in our policy events may be investigated as Significant Adverse Event Reviews (SAE) or if more complex escalated for further review via Root Cause Analysis (RCA). As shown we have had 7 DoC events in this 12-month period:

Type of Review	No of events
RCA	7
RCA - DoC	7
SAE	30
SAE – DoC	0

Appendix 2 details the rationale for the SAE reviews that did not trigger the DoC.

There were 7 events that were reviewed as an RCA event that did not trigger the DoC. Three of these events were reviewed as specified in the Adverse Events Policy (transplant death, death in theatre and MCS death). There were no immediate concerns relating to the patients care and on commissioning of these RCA's it was agreed not to trigger the DoC however the families were advised of the reviews with the opportunity to receive the report and meet to discuss the events.

The other events were reviewed as RCA's as there was potential for good learning to improve processes.

Regardless of DoC status, contact with patients and families to advise of an event and investigation is undertaken.

5. DoC Events

Of the 7 events that triggered the DoC, 3 followed the DoC process including meeting the 90 day timescale for completion of the review process. Each party was advised a review was taking place and 2 patients/families were also given a copy of the final report and one report has still to be sent. This is partly due to the inability to meet face to face with families due to the current situation. The patient/families were kept updated throughout the process and received a copy of the final report along with an invitation to meet with staff involved to discuss the report. To date, none of these offers have been accepted.

All of the patients/families involved in these DoC events were advised of the process from the initial stages and were given the opportunity to contribute to the Terms of Reference for the investigation.

The 4 events that did not follow the DoC process were complex and sensitive cases. One of these events is still to be completed as this was temporarily placed on hold due to the current COVID situation; this was also communicated to the family. Of the other 3 events, two breached the timescales by 7 – 10 days however this was mainly due to arrangements to sign off the reviews. The remaining event breached timescales due to the time taken to secure an appropriate panel date for the investigation.

6. Learning

Further to the review of the events that triggered the DoC various learning points were identified. Some of this learning currently being implemented includes:

- Development of a process for transferring patients from Critical Care to a ward setting.
- The escalation of identified complications highlighted following routine review of imaging for orthopaedic surgery formalised and communicated.
- Review of pacing settings at least once every 24 hours incorporated into ward round. SOP updating accordingly.
- Development of donor vetting checklist to ensure process is structured, formalised and documented.
- The process for reviewing patients currently on the waiting list for cardiac surgery has been updated to ensure changes in patient status are captured and acted upon e.g. level or urgency and overall patient health.
- Development of a high risk MDT process for discussion and planning of complex cardiac cases.

7. Conclusion

This is the second year of the DoC being in operation. The organization continues to learn and refine processes to ensure adherence to the DoC process. We have demonstrated the ability to achieve the timescales (or very close to the timescale) in the majority of cases.

This report will be disseminated via the Clinical Governance reporting structure for internal information and will also be published on our public website as per the DoC legislation. The Scottish Government will be made aware of the publication of this report and we are aware that they may, for the purposes of compliance with the DoC provision, request information regarding the content of this report.

Appendix 1 – DoC Criteria

Incident which activates the duty:

The DoC procedure must be carried out by the responsible person as soon as practicable after becoming aware that an individual who has received a health, social care or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in or could result in:

- death of the person
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions
- 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 requiring treatment by a registered health professional in order to prevent –
    - the death of the person, or
    - any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.

Appendix 2

The following table details the rationale for those events that did not trigger the DoC.

Ref	Description	Rationale not to invoke Duty of Candour
DW-5200	Two patient deaths in theatre.	Patients family aware of the investigation and have been called by the Medical Director and have received a copy of the report. Does not come under DoC criteria.
DW-4771	Patient procedure completed in an unsterile environment.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4613	Cardiac Physiology out of hours cover.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4655	Incorrect discharge prescription.	No harm to patient - error identified prior to any incident occurring. SAE being conducted for learning purposes in relation to dispensing process and discharge process.
DW-5053	Patient deaths while on waiting list for Cardiac Surgery.	Did not trigger DoC criteria. Investigated through RCA process.
DW-4959	Patient fall resulting in fracture.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4498	Air embolism.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4513	PICC line removal complication.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5389	Review of Mechanical Circulatory Support patient death.	Did not trigger DoC criteria.
DW-4826	Issues with Carestream (Radiology reporting system) resulting in missing reports.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5264	Clinical enquiry regarding decision not to accept patient for Cardiac Surgery.	Did not trigger DoC criteria. Investigated through RCA process.
DW-4777	Patient given penicillin despite having allergy alert on case record.	Near miss - patient did not come to harm.
DW-5048	Potassium infusion device overdose.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5424	Immediate Discharge Letter completed on Clinical Portal with information relating to another patient.	No harm to patient, systems event. Does not trigger DoC criteria. Investigated through SAE review.
DW-5158	Bile duct complications following surgery.	Dose not fit DoC criteria, known complication for this procedure.

Ref	Description	Rationale not to invoke Duty of Candour
DW-5400	Medication prescribing error.	No significant harm to the patient
DW-5274	Research & Development project process review.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5096	CALS reopening process review.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4501	Contaminated clinical instruments.	No harm to patient as other instruments sourced from donor hospital.
DW-4800	Anaesthesia equipment event.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5411	Turn down of potential donor organ due to communication error.	Did not trigger DoC criteria.
DW-4708	Discharge prescribing omission.	No significant harm to patient, system error. Does not trigger DoC criteria. Investigated through SAE review.
DW-5544	Patient absconsion from ward area.	Did not meet criteria for DoC
DW-4807	Balloon pump complications on removal.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4707	Incorrect selection of reversal anaesthetic agent.	No patient harm - no prolonged hospital stay. Patient advised of event in writing as full explanation of event not given at the time.
DW-4623	Missed pneumothorax on imaging.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5565	Cardiac patient death in theatre.	DoC status remains unclear; will be agreed on review of case.
DW-4954	Carestream image viewing issues.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-5480	Booking process within General Surgery for complex patients cared for at GJNH due to complex morbidities and illnesses.	No significant harm to patient, system error. Does not trigger DoC criteria. Investigated through SAE review.
DW-5539	Review of death of transplant patient.	All transplant deaths reviewed as per Adverse Event policy. DoC to be determined if investigation suggests this.
DW-4661	Patient suffered VF arrest whilst pacing.	No significant harm to patient, does not trigger DoC criteria. Investigated through SAE review.
DW-4672	Cardiac patient called late at night for next day surgery.	Did not come under DoC criteria, no harm to patient.
DW-5523	Complication of blood transfusion during patient transfer between clinical areas.	No significant harm to patient, does not trigger DoC criteria. Being investigated as SAE review - still ongoing.

Ref	Description	Rationale not to invoke Duty of Candour
DW-5717	Patient fall resulting in fracture.	Appropriate patient care and assessment. Does not trigger DoC criteria. Being investigated as SAE review - still ongoing.
DW-5724	Complication following implantable cardioverter defibrillator (ICD) procedure.	No significant harm to patient, does not trigger DoC criteria. Being investigated as SAE review - still ongoing.
DW-5596	Known complications following laparoscopic cholecystectomy.	No significant harm to patient, does not trigger DoC criteria. Being investigated as SAE review - still ongoing.
DW-5684	Known complication following angiogram.	No significant harm to patient, does not trigger DoC criteria. Being investigated as SAE review - still ongoing.