NHS
Golden Jubilee

Duty of Candour Annual Report

2021 - 2022

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1. Introduction

All health and social care services in Scotland have a Duty of Candour (DoC), which is a legal requirement. 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 between 1 April 2021 and 31 March 2022.

2. About Golden Jubilee University National Hospital

NHS Golden Jubilee has always aimed to ensure that we support the delivery of NHSScotland'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. COVID-19 Impact

During the COVID-19 pandemic, non-urgent services were paused in line with government guidelines. This had a significant impact on the activity within the hospital. All elective activity was paused and during this time clinical governance activity was also temporarily paused until it was known what level of support was manageable, taking into account clinician availability. Any open Significant Adverse Event Reviews (SAERs) were placed on hold and the patients/families were contacted and advised of this.

It was acknowledged that adverse events still had the potential to occur and normal processes for reporting them were encouraged. However, a revised assessment process for SAERs was implemented, which involved the development of a Brief Assessment Tool that was adapted from our SAER initial assessment tool and our SAER report template to support prompt review and investigation of any immediate issues and actions required. This tool also identified if any subsequent review was required when COVID-19 restrictions were eased and business as usual (or as close to this) resumed.

During the reporting period, the Initial Assessment Tool was used for 47 adverse events, with 32 of these progressing to a SAER investigation when appropriate to do so. The Duty of Candour procedure was applied in 22 of these events.

NHS Golden Jubilee has not triggered the Duty of Candour procedure for any events directly attributed to COVID-19.

During the period, no families requested to meet to discuss the findings of a SAER investigation.

4. 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 and guidance have been updated to reflect the introduction of DoC.

The decision on DoC is built into the SAER process. All severity 4 and 5 adverse events are automatically escalated as potential SAER. Legislation requires that a clinical person must make the final decision on Duty of Candour. The Initial Assessment Tool (IAT) which supports review of SAERs is completed by the Clinical Governance Lead and/or Clinical Nurse Manager, depending on the type of event. This includes a specific question relating to the DoC status. The completed assessment and recommendation of DoC is then approved by the Division Management Team (DMT), which includes an Associate Nurse and Medical Director. Any IATs that do not progress for review are discussed at the service Clinical Governance Forum, with multi-disciplinary representation, to ensure learning is captured whilst offering further opportunity for any challenge on the level of review and DoC status.

Each adverse 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 via the corporate induction e-learning package. More in depth training is delivered to those responsible for reviewing incidents on Datix and a programme of investigation training is being refreshed for staff who could potentially take part in a Significant Adverse Event investigation. This will take the form of blended learning utilising webinars, MS Teams sessions and in-person training where possible.

We know that being involved in a significant adverse event can be difficult for staff as well as those affected by the event. We have support available to colleagues through 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. Further to this, patients/families are offered the support of our Spiritual Care Lead and clinicians where required.

5. Significant Adverse Event (SAE) Activity 2021-2022

Between the period 1 April 2021 and 31 March 2022, there were 32 SAEs reported - an increase of 3 events compared to the previous year.

Of these SAEs, 22 events triggered the organisational Duty of Candour; table 1 below shows the breakdown of these in relation to the outcome of the event.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	7
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	14
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	0
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	0
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.	0
The person required treatment by a registered health professional in order to prevent:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	**22**

Table 1: Duty of Candour rationale

Regardless of DoC status, when adverse events occur, the appropriate clinician makes contact with patients and/or families to advise of an event and the investigation process.

6. Duty of Candour Events

Of the 22 events that triggered the organisational DoC, 12 reviews remain open at the time of reporting; these reviews are projected to breach timeframes, however, effective communication will continue with those involved in the process. In all of the DoC cases, relevant parties were advised a review was taking place and they were also given a copy of the final report and an offer made to meet to discuss the content of the report.

Of the 9 reviews that have concluded, 2 fully met the DoC process requirements including meeting the 90-day timescale for completion of the review process.

7. Learning

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

- Lockable storage facilities should be explored for the Critical care bed spaces, which will include a separate compartment for controlled drugs.
- A refresh of the staff induction guidance booklet should be undertaken to include commonly used medications and their administration and preparation guidance.
- Marks on the patient's body to identify the site of surgery must always be as close to the surgery site as possible and be as big as possible.
- A policy for the delivery of steroid injections must be developed and ratified via the Drugs and Therapeutics Committee.
- Education around the hospital-wide protocol for the Management of Hyperkalaemia is required within the Cardiology wards. The panel acknowledged that this is now printed and displayed in CCU drug cupboard, but wider education around the policy, it's content and accessibility of this is required.
- A group of nursing staff will be trained to undertake and interpret blood gas analysis. The existing competency training from Critical Care will be rolled out to this small group by the Clinical Educators.
- Clarification will be sought from the Labs team regarding adding ranges for abnormal venous blood gases to the system to enabling automatic flagging of abnormal results.

It is acknowledged that meeting the timescales for DoC has been challenging during this period. The Clinical Governance team works closely with the Divisional Management Teams to improve compliance with timeframes and will monitor this throughout the year making necessary amendments where indicated.

8. Conclusion

This is the fourth year of the DoC being in operation. The organisation continues to learn and refine processes to ensure adherence to the DoC process.

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.

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