The 'duty of candour': your legal obligations

The duty of candour

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.

Your legal obligations

1. Duty of Candour Procedure

As a provider of an independent health care service you are required to develop and implement a duty of candour policy that describes how you/your staff 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).

The key stages of the policy must include the procedure you will follow to:

- → Notify the person affected (or family/relative where appropriate);
- → Provide an apology;
- → Carry out a review into the circumstances that led to the incident;
- → 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 (see below).

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

Guidance: points to consider when preparing your duty of candour procedure and annual report

Preparing your duty of candour procedure*

- How will you identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21?
- Have you satisfied yourself that you (and your staff, if you employ staff) understand your responsibilities and have systems in place to respond effectively?
- Who do you need to engage with to satisfy yourselves you can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?
- 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?
- Do your current systems and processes provide you with the information required to report on the Duty of Candour?
- How will you align your duty of candour annual report with other reports you are required to provide, such as feedback and complaints, significant events reviews, case reviews etc.?
- What training and education do you have at present that will support the implementation of the Duty? This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations. You should also consider national training that is available freely to your staff such as e-learning opportunities.
- What support do you have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?
- How do you currently share lessons learned and best practice around incidents of harm? Could this be improved in any way?

**Please refer to the Duty of Candour Guidance for more detailed guidance.*

2. Duty of candour annual report

You must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where you have applied the duty of candour. Your annual report should be published on your website, if you have one, or make other suitable arrangements to communicate the duty of candour report to people who use your services.

Your first annual report must be prepared in April 2019, so it is important to start planning for this now. To help you we have provided a report template (below) for you to use/adapt.

NB: *Even if you do not implement the duty of candour procedure in a given year, you are still required to produce a short report that contains information about staff training on the duty of candour obligations.*

Duty of Candour Annual Report Template

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, we must produce an annual report to provide a summary of the number of times we have trigger duty of Candour within our service.

Name & address of service:	Graham Anderson house, 1161 Springburn Road, Glasgow, G21 1UU	
Date of report:	30th April 2020	
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?	Since implementation as a service we have – 1. Introduced Information leaflets for all staff, Service Users and Families – These are made freely available in the main reception area 2. The Trust have also made "Duty of Candour" a mandatory training requirement for all staff and have also provide this via out eLearning portal 3. Provided online training on "Duty of Candour" which was recommended by the Care Inspectorate – All existing staff have completed this and this training is now part of our induction process for new staff. 4. The Trust has devised and published a Policy and Procedure for "Duty of Candour" for all staff to follow – staff are currently required to read this Policy and a copy of confirmation of their understanding will be kept in their personnel file. 5. All staff have received DATIX training on how to report any accidents, incidents, concerns or allegations – reports are accessible to managers, senior managers, HR, QA and directors to ensure the Trust is compliant and transparent when following up on incidents and concerns. The Duty of Candour is part of the Datix reporting system and therefore allows incidents which are covered by the regulations to be monitored and provide assurance that they are effectively managed and follow the policy and procedure.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES – Dated 5th March 2019	

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 2019 - March 2020)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0

A person's treatment increased	2
The structure of a person's body changed	2
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	3
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	3
Total	10

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?	Yes, on all occasions – as a service we are open and transparent at all times, including incidents that do not trigger "Duty of Candour" and will always disclose incidents, accidents and errors to all relevant parties, meet and discuss incident further and take appropriate actions including offering apologies and making explicit what actions we have taken as a result of the incident.
What lessons did you learn?	As a service team, we continue to learn from incidents, errors and improve on our practice. Based on the ten incidents reported above, some of the lessons learned have been in relation to improved staff supervision to ensure service user safety and improvements
What learning & improvements have been put in place as a result?	Improved staff coordination for service user safety – where we now ensure communal smoking areas and lounges are supervised at all times – staff are now allocated to these areas/tasks and use of 1:1 when appropriate to decrease incidents between service user Systems in place to ensure clear medication documentation - All staff managing medication have completed their training and competencies. We also - Ensure the reconciliation is completed and clarified at time of admission Ensure GP registration is completed at time of admission Ensure where Methadone is part of a prescription that links are made with appropriate community prescriber to ensure prescription is available on day of admission. All nurses are aware of the policies/procedures in relation to medication management Ensuring that medication care plans are in place and staff are familiar with them Ensure that medication changes are highlighted at handovers. All nurses are aware of their own responsibility & accountability surrounding Medication management
Did this result is a change / update to your duty of candour policy / procedure?	No

How did you share lessons learned and who with?	We devise “Lessons Learned” bulletins and these form agenda items for our various staff meetings including the management team meeting and multi-disciplinary team meeting. Lessons learned are discussed as a reflective practice exercise and give staff especially those involved in the incidents the opportunity to de-brief. We find these to be beneficial to staff development through supervisions and Professional Development Reviews. The Datix incident management system supports records of be-briefs and therefore generic lessons learned can be shared with other services.
Could any further improvements be made?	As part of our governance process which includes the Duty of Candour, we seek to drive improvements in the quality of our care, support and treatment and ensure that we promote openness and transparency when incidents occur. We can always improve and strive to be continuous in providing the highest care and support possible to those in our care.
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?	As a management team we fully support any staff member to provide an apology as we recognise that this can be a difficult emotional and traumatic experience following an incident. – we would be happy to discuss any concerns with staff on how best to manage and approach this with empathy for the situation
What support do you have available for people involved in invoking the procedure and those who might be affected?	Yes- the Trust has devised a new audit tool to discuss staff’s understanding of “duty of Candour” and we are happy to offer support to any staff member and look at where learning and training is needed. We have regular staff meetings within the service and also 1:1 staff supervision. We do look at reflective practice and devise lessons learned from incidents where appropriate.
Please note anything else that you feel may be applicable to report.	