Barns
MEDICAL PRACTICE

DUTY OF CANDOUR POLICY

Duty of candour relates to all aspects of care and treatment and is defined in the Robert Francis' Mid Staffs report as –

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made"

The National Patient Safety Agency defines a Patient Safety Incident as –

"*Any unintended or unexpected incident which could have, or did lead to, harm for one or more patients receiving NHS care*"

Definition of Levels of Harm

No Harm

- Impact prevented – any incident that had the potential to cause harm but was prevented and resulted in no harm to staff or patients
- Impact not prevented – any incident that occurred, but resulted in no harm to people receiving care

Low Harm

An incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care

Moderate Harm

An incident that resulted in a moderate increase in treatment (eg increase in length of hospital stay by 4-15 days) and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care

Severe Harm

An incident that appears to have resulted in permanent harm to one or more persons receiving care

Death

An incident that directly resulted in the death of one or more persons receiving care

Practice Procedure

Barns Medical Practice' approach to candour demonstrates a commitment to providing high quality care for our patients, even when things go wrong. Our staff are committed to ensuring that patients are fully involved in their care, that they are communicated with if there are issues and that any problems are fully investigated.

By understanding the root causes that lead to an incident, and sharing lessons learned, we can help to ensure that similar incidents do not happen again. This is both good practice, and gives our patients confidence that we are a learning organisation.
The Duty of Candour Policy is included in the Staff Handbook, highlighted at induction and reviewed annually within the Practice.

All staff are encouraged to report any incidents where they feel patient safety may have been compromised and the following reporting tools are available -

- Accidents Incidents and Near Misses Reporting Template
- Comments Concerns and Complaints Recording Template
- Complaints Guidelines
- Incident Reporting Policy
- Significant Event Analysis Template

Any issue raised will be investigated by the Senior Partner and Management Partner, and discussed with the clinician(s) involved. Where appropriate, details will be discussed at the regular Practice Meeting so that learning can be shared.

Patients will be informed and a review period set if appropriate.

Reporting

As per the terms of The Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016, the Practice is expected to produce and publish an annual report of unintended or unexpected incidents that have occurred during the year – even if there have been zero events. Only incidents where significant harm has been caused need shared.
The Practice will publish this Policy on the Practice website, and anonymised details of the Annual Report will be available on request.
Each year on completion of the Annual Report, the Practice are asked to notify Scottish Government by email dutyofcandour@gov.scot

Resources

Scottish Government – Services to whom the Duty of Candour applies
https://www2.gov.scot/Topics/Health/Policy/Duty-of-Candour/services

The Knowledge Network – Adverse Events
http://www.knowledge.scot.nhs.uk/adverse-events/duty-of-candour.aspx

General Medical Council -
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong

Nursing and Midwifery Council -
https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/

Gov. UK - Francis Report on Mid Staffordshire enquiry
https://www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations

National Patient Safety Agency – Seven Steps to Patient Safety
http://patientsafety.health.org.uk/resources/seven-steps-patient-safety