DUTY OF CANDOUR
ANNUAL REPORT
2022-23

NHS Ayrshire & Arran Duty of Candour Annual Report 2022-23

All health and social care services in Scotland have a Duty of Candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death / harm or intervention is required to prevent death / harm as defined in the Act and does not relate directly to the natural course of someone's illness or underlying conditions, the people affected understand what has happened, receive an apology and that our organisation learns how to improve for the future.

An important part of the Duty is the provision of an annual report detailing how the Duty of Candour has been implemented across the organisation and the number of times the Duty of Candour has been triggered. This report describes how NHS Ayrshire & Arran has fulfilled its' responsibilities in the triggering of Duty of Candour for adverse events which occurred between 1 April 2022 and 31 March 2023.

1.0 About NHS Ayrshire & Arran

NHS Ayrshire & Arran serves a population of around 376,000 people and employs in the region of 10,500 staff. The Board provides a full range of primary and secondary clinical services covering the mainland of Ayrshire and the islands of Arran and Cumbrae and three Local Authority areas of North, South and East Ayrshire.

The Board currently operates over two Acute Hospital sites, University Hospitals Ayr and Crosshouse, and 70 community based healthcare settings including GP practices.

Our aim is to provide high quality care for every person who uses our services and where possible help people to receive care at home or in a homely setting.

2.0 Number and Nature of Duty of Candour incidents

Of the 8788 reported adverse events which occurred between 1 April 2022 and 31 March 2023, 473 were escalated for Duty of Candour consideration through our adverse event management process. 187 (2% of total annual adverse events) were determined by the relevant Directorate Adverse Event Review Group (AERG) to be Duty of Candour applicable. 21 resulted in the commissioning of a Significant Adverse Event Analysis and Review (SAER) and 166 Local Management Team Reviews (LMTR). Table 1 below provides a breakdown of the number and nature of Duty of Candour application:-

Nature of unexpected or unintended incidents which triggered Duty of Candour	**Number**
Death of the person	10
A permanent lessening of bodily, sensory, motor, physiological or intellectual functions	1
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	30
Changes to the structure of the person's body	6
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	3
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.	136
The person required treatment by a registered health professional in order to prevent:	
The death of the person	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	1
Total	**187**

Table 1: Number and Nature of Duty of Candour Application 1 April 2022 – 31 March 2023

3.0 To what extent did NHS Ayrshire & Arran follow the Duty of Candour procedure?

NHS Ayrshire & Arran has a robust process for the identification and management of adverse events where Duty of Candour is triggered; this process is integrated within the Adverse Events Policy.

Once an adverse event has been identified as potentially triggering Duty of Candour by the Reviewer/Final Approver, an escalation is generated within the local reporting system and an Adverse Event Review Level Decision Making Form is submitted to the relevant Directorate Adverse Event Review Group who will determine whether or not Duty of Candour is triggered and the level of review to be undertaken. This decision is based on the:

- adverse event,
- content of the Decision Making Form
- NHS Ayrshire & Arran's agreed 'Never Events' list
- NHS Ayrshire & Arran's Adverse Event Policy
- specialist knowledge of the advisors of the AERG

Where Duty of Candour is triggered, all necessary action will be taken in accordance with the Duty of Candour procedure. The key stages of the procedure include the requirement to:

- Notify the person affected (or family/relative where appropriate);
- Provide an verbal apology with follow up in writing;
- Carry out a review into the circumstances leading to the adverse event;
- Offer and arrange a meeting with the person affected and/or their family, where appropriate;
- Provide the person affected with detail of the review findings;
- Provide information about improvement actions; and
- Make available, or provide information about, support to persons affected by the adverse event.

NHS Ayrshire & Arran has committed to commissioning a minimum of a LMTR where Duty of Candour has been triggered. Both the LMTR and SAER processes include the

steps indicated above and a formal report is produced to identify and implement any learning.

A defined guidance for application of Duty of Candour in relation to unavoidable Grade 3, Grade 4, Suspected Deeper Tissue Injury and Ungradable pressure ulcers, acquired under our care was implemented in alignment with Healthcare Improvement Scotland's Pressure Ulcer Standards.

4.0 Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our Adverse Event Policy. Through our adverse event management process we can identify events that trigger Duty of Candour. Our Adverse Event Policy contains a section on implementing the Duty of Candour. A stand-alone Duty of Candour Policy was being considered however following consultation it was agreed that the Duty of Candour section within the Adverse Event Policy will be reviewed and developed during the 2023 policy review.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning.

Recommendations are made as part of the adverse event review and improvement plans are developed to meet these recommendations.

Patients and/or families are allocated a Family Contact (who is a member of the Review Team) who provide regular contact with the patient / family to share information and updates on the progress of the review. The Contact person has the required skills to respectfully disclose sensitive information and answer questions or concerns the patient / family may have. The NHS National Education for Scotland : Duty of Candour training module is available to all staff via the NHS Learn Pro System which provides guidance and supportive tools around providing a person centred apology and planning and preparing for subsequent discussions.

All staff who review and finally approve adverse events receive training on adverse event management and the implementation of the Duty of Candour prior to being given access to the adverse event reporting system, so that they understand when it applies and how to trigger the Duty. In addition, NHS Ayrshire & Arran have robust governance arrangements to monitor all reported adverse events to provide further assurance that any events which may have triggered Duty of Candour are identified.
We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through Occupational Health and Staff Care.

5.0 What has improved as a result?

We have identified a number of learning and/or improvements following review of the Duty of Candour events.

There are three key examples of learning below that we would like to highlight following review:-

Example 1
An inpatient was prescribed an incorrect higher dose of an antiviral medication. Supportive care was initiated as per Toxbase Guidance (for management of drug overdose). The patient subsequently sadly passed away.

Learning Identified
The review team identified this drug prescribing error was a slip made when prescribing an unfamiliar drug. There were several distractions during the completion of this task, in part related to the management of this unwell patient. As such, an action plan was developed with the following recommendation:-

- Prescribing of this particular antiviral medication should be reviewed by the Safer Medicines Group (subgroup of Area, Drug and Therapeutics Committee). This Group will be able to access and review any other adverse events involving the use of this Intravenously (IV), in the wider context of medications, which are weight-based prescriptions. They will be able to plan any practical interventions to mitigate risks of prescribing this medication in future.

Example 2
Deterioration of a superficial sore to Grade 4 pressure ulcer related to a patient with a number of co-morbidities and very limited mobility.

Learning Identified
An action plan for service learning was developed which addressed lack of record keeping training, ensuring staff have the right information available to support decision making, the introduction of a robust system for ordering appropriate dressings and reviewing systems to ensure concerns are escalated in a timely manner.

- The service will ensure a robust system for carrying out record keeping audits is implemented, ensuring that staff adhere to their professional and organisational responsibilities;
- Outputs from the service review, such as referral routes, new models of care and workforce planning will continue to be implemented across the service;
- The service will move to PECOS (electronic procurement system) ordering for non-medical prescribing which will increase the availability of appropriate dressings at a local level and reduce waits for patient prescriptions;
- Staff will be provided with National Association Tissue Viability Nurses Scotland Pressure Ulcer Tool to ensure appropriate grading of pressure ulcers and literature regarding appropriate dressing choices to be obtained from Tissue Viability Nurse and circulated to staff.

Example 3
Incorrect reporting of x-ray following fall at home leading to Acute admission. Patient had subsequent falls within Acute setting and sadly passed away with fall being a contributory factor.

Learning Identified

The Review Team considered all the evidence and made the following recommendations which were addressed through an action plan:

- Communication and training on the guidance and process for staff on the assessment, escalation and documentation for supervision levels, including if there is insufficient staff to cover the required supervision level and what alternative arrangements are in place;
- Ensure all staff are aware of the referral criteria and process to the Falls Team, including for advice and support with patients at risk of falls and those patients who have had falls with significant harm;
- Additional training and support for staff within the two wards that the patient was nursed on the completion of the Falls for All Bundle, 4AT, Care and Comfort Round Chart and Bed Rail Risk Assessments in line with current guidance;
- Structured written handovers when a patient transfers between wards should be completed and saved into the patient's record; a review and update of the current inter-hospital transfer form is recommended with guidance and education for staff on its use;
- Develop the use of a post fall debrief, which should occur promptly after any significant fall, bringing staff together quickly, allowing prompt investigation and action, and including all staff directly involved in the incident to prevent time lapse affecting staffs' recollection of events.

6.0 Other information

This is the fifth year of the Duty of Candour being in operation and it has been another year of learning and refining our existing adverse event management process to include the Duty of Candour outcomes. Our learning continues to be refined in terms of application of Duty of Candour. As required, we have published this report on our public website.

If you would like more information about this report, please contact us using these details: Jennifer Wilson, Nurse Director. Telephone 01292 513674 or email Jennifer.Wilson2@aapct.scot.nhs.uk