Duty of Candour Policy

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Policy

The statutory duty of candour was introduced in April 2018 and applies widely across health and social care organisations, including independent healthcare providers. It requires health and social care professionals to learn from what went wrong to improve the quality of service to patients generally, and to share such learning with other health or social care organisations.

Healthcare organisations including independent health providers are subject to a statutory duty of candour. A Duty of Candour relates to all aspects of care and treatment and is defined by The National Patient Safety Agency as,

> "Any unintended or unexpected incident which could have, or did lead to, harm for one or more patients receiving 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 (a hospital stay by 4-15 days) and which caused significant but not permanent harm

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

Organisational Protocol

Veincentre's 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 shared with all our employees, highlighted at induction and reviewed annually within the organisation. All staff are encouraged to report any incidents where they feel patient safety may have been compromised. Our reporting protocols include the following reporting tools:

• SURVS – online survey tool

• Complaints recording system (Access Care Compliance)

• Complaints Guidelines

• Incident Reporting Policy

Any issue raised will be investigated by the Medical Director and shared with the clinical management team during the a weekly meeting so that learning outcomes can be shared and actioned where appropriate.

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 organisation 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. Veincentre will publish this policy on the Veincentre website. Anonymised details of the duty of candour annual report will be available on request.

Each year on completion of the Annual Report, Veincentre are asked to notify Scottish Government by email dutyofcandour@gov.scot

Resources

https://www2.gov.scot/Topics/Health/Policy/Duty-of-Candour/services