North Lanarkshire Health and Social Care Partnership

Duty of Candour Report: 2022-2023

Introduction

North Lanarkshire Health and Social Care Partnership recognises that when adverse events occur during the provision of treatment or care, openness and transparency is fundamental. The duty of candour arrangements which we have implemented reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. When harm occurs the focus must be on personal contact with those affected; support, and a process of review and action that is meaningful and informed by the principles of learning and continuous improvement.

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 was implemented on 1st April 2018 placing an organisational duty (Duty of Candour) on health, care, and social work services to be open and honest with people in their care.

The overall purpose of this duty is to ensure organisations are open, honest, and supportive when there is an unexpected or unintended incident resulting in death or harm as defined in the Act. All health and social care services in Scotland have a duty of candour, a legal requirement which means that when things go wrong and mistakes happen, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

A key part of this duty is that Health and Social Care publish an annual report about the duty of candour in our services. This short report describes how the services we commission, and our own services have operated the duty of candour during the time between 1 April 2022 and 31 March 2023.

Information about policies and procedures

All social care organisations have a Duty of Candour policy. All staff who are employed in the sector should be aware that all instances that necessitate implementation of Duty of Candour must immediately be reported. In such instances, a manager will then take the appropriate action, ensuring relevant bodies [depending on the sector] such as Social Work and Care Inspectorate are notified of the event. Where an incident occurs that triggers the duty of candour, managers have responsibility for ensuring that the duty of candour procedure is followed. Information on Duty of Candour and reportable incidents is described in detail within Appendix 1.

82 commissioned organisations were asked to provide information in relation to Duty of Candour activity in the reporting period. Of the 34 [41%] that responded, there were six reported incidents. All North Lanarkshire Council social work in-house services - home support, integrated day services, locality support services and children services were also asked to provide information. There were no Duty of Candour incidents reported from any of the council provided services. Reporting of Duty of

Candour incidents are an integral part of our Contract Monitoring Framework and all should be reported on quarterly contract monitoring returns.

How many incidents happened to which the duty of candour applies?

In the reporting period, six incidents have been reported to which the duty of candour applied, one in relation to maladministration of paracetamol, and five where a person fell and sustained physical harm. All incidents reported were from a care home service. No Duty of Candour incidents were reported by North Lanarkshire Council in-house social work services.

The low number and type of reported incidents indicate that there may be some uncertainty over situations where Duty of Candour responsibilities should be invoked. Refresher sessions on Duty of Candour duties will be offered to all of our in-house providers over the course of 2023-2024. Reminders and information slides will be sent to all of our contracted providers to ensure that they are fully sighted on the duties that the Act imposes upon them.

Details of incidents where Duty of Candour applied

Nature of incident: Duty of Candour raised for accident where resident fell and fractured his femur. Incident fully investigated and reported. Relative invited to a Duty of Candour meeting but declined to attend.

Nature of incident: Duty of candour raised for incident whereby a resident received an overdose of Paracetamol. No lasting harm occurred. Incident fully investigated and reported. Relative invited to Duty of Candour meeting but declined to attend.

Nature of incident: Duty of Candour raised for an incident where a resident had staples to a wound in her head following an unwitnessed fall. No lasting harm occurred. Incident fully investigated and reported. Relative declined invite to attend Duty of Candour meeting.

Nature of incident: Duty of Candour raised for incident where a resident had sutures to head wound following a witnessed fall. No lasting harm occurred. Incident fully investigated and reported. Family were invited to attend a Duty of Candour meeting but declined to attend.

Nature of incident: Duty of Candour raised for incident concerning a resident who sustained a fracture due to witnessed fall. Incident fully investigated and reported. Family were invited to attend a Duty of Candour meeting but declined to attend.

Nature of incident: Duty of Candour raised for incident concerning a resident who sustained a fracture due to an unwitnessed fall. Incident fully investigated and reported. Relatives were invited to a Duty of Candour meetings but declined to attend.

Unfortunately, there were incidents where Duty of Candour duties should have been invoked but didn't. Reasons for failure were inexperienced management and lack of familiarity with Duty of Candour procedures. Police involvement was also a factor in two serious incidents where it was thought that their involvement superseded Duty of Candour.

Conclusion

There were no Duty of Council incidents from in-house social work services within the reporting period and only six from care homes, of which none of which had lasting consequences for the person to whom the duty applied. Appropriate actions were taken, lessons were learned, procedures and training were revised, and where applicable, families were informed, and were invited to meet to discuss in more detail. If in the future, if any incidents occur that invoke Duty of Candour proceedings, there will be a review process to identify any lessons learned and the result of any such review will be shared with the relevant person/persons. This approach will minimise the impact on the organisation and the vulnerable people that we strive to support.

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Appendix 1 – Definition of Harm and appropriate level of response

Grading of Harm	**Definition of Harm**	**Level of Response**
No harm, incident prevented	Any service user safety incident that had the potential to cause harm but was prevented.	These incidents are outside of the scope of the duty of candour. Social work professionals may however feel it is appropriate to inform the person involved if it is in their best interest.
No harm, incident not prevented	Any service user safety incident that occurred but no harm was caused to the person involved.	These incidents are outside of the scope of the duty of candour policy. Being open in a discussion between staff involved and the service user and their family is usually undertaken locally.
Low Harm	Any service user safety incident that led to the extra observation or minor treatment such as first aid or additional medication for the person involved.	These incidents are outside of the scope of the duty of candour policy. Being open in a discussion between staff involved and the service user and their family is usually undertaken locally.
Moderate Harm	A level of harm that is not permanent but has led to a moderate increase in treatment or prolonged psychological harm of more than 28 days. For example, a return to theatre, an unplanned readmission to hospital, unexpected admission to critical care, a prolonge hospital stay or additional out service user visits.	Duty of candour is a statutory requirement. Notification should be given to the person affected or their representative in person including an explanation of the incident, the process for investigation and an apology. This will be followed up in writing and on conclusion of the investigation the findings and outcome will be available to the service user of their representative.
Serious Harm	Any service user safety incident that has resulted in permanent harm that is directly related to the incident and not the natural course of an illness or the underlying condition of the person affected. Examples of severe harm are permanent lessening of bodily functions, sensory, motor, physiological or intellectual function, removal of the wrong organ or limb or brain damage.	Duty of candour is a statutory requirement – see above.
Death	Any service user safety incident that directly resulted in the death of a person and is not related to their illness or underlying condition.	Duty of candour is a statutory requirement – see above.

Appendix 2

Organisations who provided a response: all but one returned a nil response.

All New Beginnings
Angels
Aspire
Beechwood Care Home
Capability Scotland
Care One Professional
Care Solutions
C-Change
Cera Care
Cornerstone
Deanston Care Home
Enable Scotland
Enhance Supported Living Services
HRM
Inclusion Scotland
Invercare
Keane Premier Support Services
Key Housing
Lanarkshire Association for Mental Health
Lanarkshire Care Partners
Local Lanarkshire Care
Lochside Manor
Love
Partners in Play
Penumbra
PHEW
Potential Living
Quarriers
Scottish Autism
Support for Ordinary Living
The Richmond Fellowship Scotland
Thera Care
Turning Point Scotland
Wheatley Care