Durham Road Medical Group
Report compiled by: Dr Mills
Date: March 2024

Duty of Candour Annual Report

1st April 2023 - 31st March 2024

Duty of Candour Report

All health and social care services in Scotland have a duty of candour as an organisation. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report describes how Durham Road Medical Group have operated the duty of candour during the time between 1 January 2023 and 31st of December 2023. We hope you find this report useful.

1. About Durham Road Medical Group

Durham Road Medical Group have a practice list of 6100 patients. 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. Number and nature of Duty of Candour incidents

We regret to inform that we have had one incident identified in this period where the duty of candour applied. This was an unexpected event that resulted in death or one of our patients.

Durham Road Medical Group identified this incident through a complaint received.

Our practice identifies these incidents principally through our adverse event management process although these can be highlighted through other routes such as a complaint, but it would then be processed through the adverse event management process.

We review and consider all adverse events where the patient outcome was either moderate or major harm or death for application of Duty of Candour. The inclusion in our review of events where there was moderate harm was used to capture instances which did not result in severe harm, but harm which resulted in one or more of the criteria as set out in the legislation.

We identify through the adverse event review process if there are factors that may have caused or contributed to this event, which helps to identify Duty of Candour incidents.

Nature of unexpected or unintended incident where Duty of Candour applies	Number of events identified between 1st of April 2023 and the 31st of March 2024.
A person died who was on warfarin. He was prescribed antibiotics. Following his course of antibiotics, he died before his appointment to get his INR checked. He died from a catastrophic brain haemorrhage.	1
Total	1

3. To what extent did Durham Road follow the Duty of Candour procedure?

- We were made aware of event via our complaints process and contacted the patient's wife to offer our apologies and acknowledge her complaint. We informed her that a review would take place. When we were aware there was going to be a delay, we informed the wife. Once the review was completed, we sent a letter giving feedback of the review and offered to meet to discuss at a time convenient to her.

- A total review of the event has been carried out and a significant event analysis written up. We reviewed what happened, what went wrong and what we could have done better. Individual and organisational learning has been considered in this case.

4. Information about our policies and procedures

Every adverse event is reported through our local reporting system procedures. This may be retrospective if an adverse event is identified through a claim, complaint, or other means. Through our significant event management process, we can identify incidents that trigger the Duty of Candour procedure.

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 relevant management teams develop improvement plans to meet these recommendations.

All clinicians receive training on an adverse event management and implementation of the Duty of Candour.

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 our occupational health service.

5. What has changed as a result?

We considered what actions we needed to take to try to prevent a repetition of this adverse event. We have made the following changes.

The current practice protocol for warfarin suggests that INR is monitored when specific medications are started. There are no specifics in this, such as when this should be done. We have reviewed the NICE guidelines and updated our practice protocol for interactions with other medications and given more specific guidance on when to check the INR.

We also ran a search for everyone in the practice on warfarin to add an alert to the system. To say ‘ON WARFARIN – please consider when to next check INR when prescribing new medications’ as an additional prompt.

6. Other information

We continue to learn both locally and nationally and to improve implementation of processes to discharge the statutory organisational duty of candour for Durham Road Medical Group,

Our priorities continue to be:

- Ensuring that a plan for communication with patient and family is clear and included as part significant adverse event reviews.
- Improving reliability of communication with patients and families at all stages of the review process, including clarity of roles and responsibilities all those involved.

As required, we have notified the Scottish Ministers that we have published this report on our website.

Reported by: Dr. Catherine Mills, Durham Road Medical Group