Duty of Candour Policy

Kirkvoe Medical

Date Effective:	1/3/24
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Version No:	1
Policy Owner / Author:	Dr Zoe Shepherd

1. Reason for Policy / Purpose of Policy

The duty of candour requires registered providers and registered managers to act in an open and transparent way with people receiving care or treatment from them. Within Scotland provisions for Duty of Candour are legislated via the Health (Tobacco, Nicotine etc. and Care)(Scotland) Act 2016.

"Good Medical Practice" published by the GMC advises – a doctor must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

- put matters right (if that is possible)
- offer an apology
- explain fully and promptly what has happened and the likely short-term and long-term effects

The MDU advise the key principles of duty of candour are:

1. Care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout an organisation.

2. The statutory duty applies to organisations, not individuals, though it is clear from Scottish Government guidance that it is expected that an organisation's staff cooperate with it to ensure the obligation is met.

3. As soon as is reasonably practicable after becoming aware of a notifiable patient safety incident, the organisation must tell the patient (or their representative) about it in person.

4. The circumstances that give rise to a requirement to tell the patient or their representative about something that has gone wrong are the same as those that are required to be notified without delay to the Regulator (Healthcare Improvement Scotland perform this role for Kirkvoe Medical). This notification is separate from and in addition to the statutory duty of candour which requires the organisation to keep copies of correspondence with the patient.

5. The organisation has to give the patient a full explanation of what is known at the time, including what further enquiries will be carried out. Organisations must also provide an apology and keep a written record of the notification to the patient. Failure to make that notification may amount to a criminal offence.

6. A notifiable patient safety incident has a specific statutory meaning: it applies to incidents where something unintended or unexpected has occurred in the care of a patient and appears to have resulted in:

1. their death, where this relates to the incident and is not simply due to the natural progression of the illness or condition;
2. impairment (of sensory, motor or intellectual function) that has lasted or is likely to last for 28 days continuously;
3. changes to the structure of the body (for example, amputation following arterial occlusion);
4. prolonged pain or prolonged psychological harm. The pain or psychological harm must be, or likely to be, experienced continuously for 28 days or more;
5. shortening of their life expectancy;
6. or where the patient requires treatment by a healthcare professional in order to prevent death, or the adverse outcomes listed above.

7. There is a statutory duty to provide reasonable support to the patient. Reasonable support could be providing an interpreter to ensure discussions are understood, or giving emotional support to the patient following a notifiable patient safety incident.

8. Once the patient has been told in person about the notifiable patient safety incident, the organisation must provide the patient with a written note of the discussion, and copies of correspondence must be kept. Following the initial notification the patient must be given written notification including details of any further enquiries into the incident and their results and an apology.

It is important to note that Dr Zoe Shepherd's ethical duty to identify incidents (any harm or distress caused to the patient) has a lower threshold than statutory Duty of Candour requirements therefore incidents are likely to be identified through this means as well as Duty of Candour procedures.

2. *Policy Statement and Aims*

The intent of this policy is to inform practice actions should an incident be identified where care has Scope
This policy applies to all patients treated by Kirkvoe Medical.

3. *Procedure*

An incident in Kirkvoe medical could be identified through a variety of means - a patient complaint or feedback, clinical audit, feedback from another service (e.g. the patient's employer) or a national body such as Healthcare Improvement Scotland.

Should an incident be identified the standard of care will be examined by Dr Zoe Shepherd with advice taken from her defence union if there is any uncertainty as to whether it meets the threshold for duty of candour.

Should an incident be felt to meet this duty of candour threshold Dr Zoe Shepherd will contact the patient to offer a full explanation of events and an apology for any distress suffered. Any episodes felt to meet duty of candour will be recorded in Dr Zoe Shepherd's

appraisal to discuss at her annual review and also used to inform future practice to ensure they are not repeated.

4. *Responsibilities*

As a sole trader Dr Zoe Shepherd is responsible for implementing this policy.

5. *Enforcement / Compliance*

Non-compliance with the policy may result in intervention from regulators including Healthcare Improvement Scotland and the General Medical Council.

6. *Related information*

Duty of candour in primary care and independent practice - The MDU
The professional duty of candour - ethical guidance - GMC (gmc-uk.org)
Organisational duty of candour: guidance - gov.scot (www.gov.scot)
https://www.legislation.gov.uk/asp/2016/14/part/2/enacted (Health (Tobacco, Nicotine etc. and Care)(Scotland) Act 2016