When things go wrong …

(Part 1)

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Practising realistic medicine

- Involving people in decisions about their care leads to safer care
- Can be difficult for patients to speak up or challenge clinician's expertise
- Doing less or no treatment can be the best option
- Evidence that clinicians choose less healthcare interventions for themselves
- Changing style to shared decision making
- Need for honesty and realism about outcomes – recognising benefits but also risks and limitation in the context of patient's life and what matters most to them

Asking the right questions!

- Health literacy
- Encouraging patients to ask the right questions
- Is this test or treatment procedure really necessary?
- What are the potential benefits and risks?
- What are the possible side effects?
- Are there simpler, safer or alternative treatment options?
- What would happen if I did nothing?

Consent has been defined as *voluntary* and *continuing* acquiescence or agreement to a proposed course of action by a competent person, which may be an examination, a diagnostic investigation or a treatment

The right of a patient under common law to give or withhold consent prior to clinical treatment is a basic principle of healthcare

Organisational Duty of Candour

Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016

- Introduced a “duty of candour procedure” in health and social care settings
- Created a legal requirement to inform patients and their families when they have been harmed, either physically or psychologically as a result of care received
- Requirement to prepare and publish reports

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The Background

- The Francis report 2013
- The Berwick report 2013
- HIS : Learning from adverse events through reporting and review: a National framework for Scotland 2013 (2nd ed 2015)
- GMC and NMC – “Openness and honesty when things go wrong”
- Professional duty of candour

Who owes a duty of candour?

- A “responsible person” –this is an organisational duty. So a Health Board or a legal person who has entered into a contract with a Health Board to provide a health service

When is the duty triggered?

- when a person is subjected to an unintended or unexpected incident which in the reasonable opinion of a registered health professional appears to have resulted in or could result in one or more prescribed outcome

- BUT

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When is the duty triggered?

- Only if the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition

To whom is the duty owed?

- Duty is owed to the " relevant person"
- Defined as a person who has received the health service which has resulted in a defined form of harmful outcome
- Or if the person primarily affected has died, lacks capacity or is otherwise unable to make decisions about the service provided, someone acting on that person's behalf.

When is the duty triggered?

When the incident comes to light:

As soon as reasonably practicable

What triggers the duty?

- **An unintended or unexpected incident where the OUTCOME is**
  - Death
  - Severe harm – defined as a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ) or brain damage

What triggers the duty?

- Harm which is not severe but results in
  - An increase in treatment
  - Changes to the structure of the body
  - Shortened life expectancy
  - Impairment of function lasing at least 28 days
  - Pain or psychological harm lasting at least 28 days

- **Where treatment has been required to prevent**
  - Death
  - Injury leading if untreated to harm

Role of the responsible person

- Duty is triggered when registered health professional considers that the incident has resulted in one of the outcomes
- Responsible person to ensure that the registered health professional was not involved in the incident
- Must initiate the duty of candour procedure

Duty of candour procedure

- Notification to be given to the patient or representative as soon as reasonably practical – good practice within 10 days – if more than a month need to give an explanation
- Meeting to be arranged and apology given
- Information gathering
- Review
- Support for affected persons
- Further apology and written summary
- Training, supervision and support

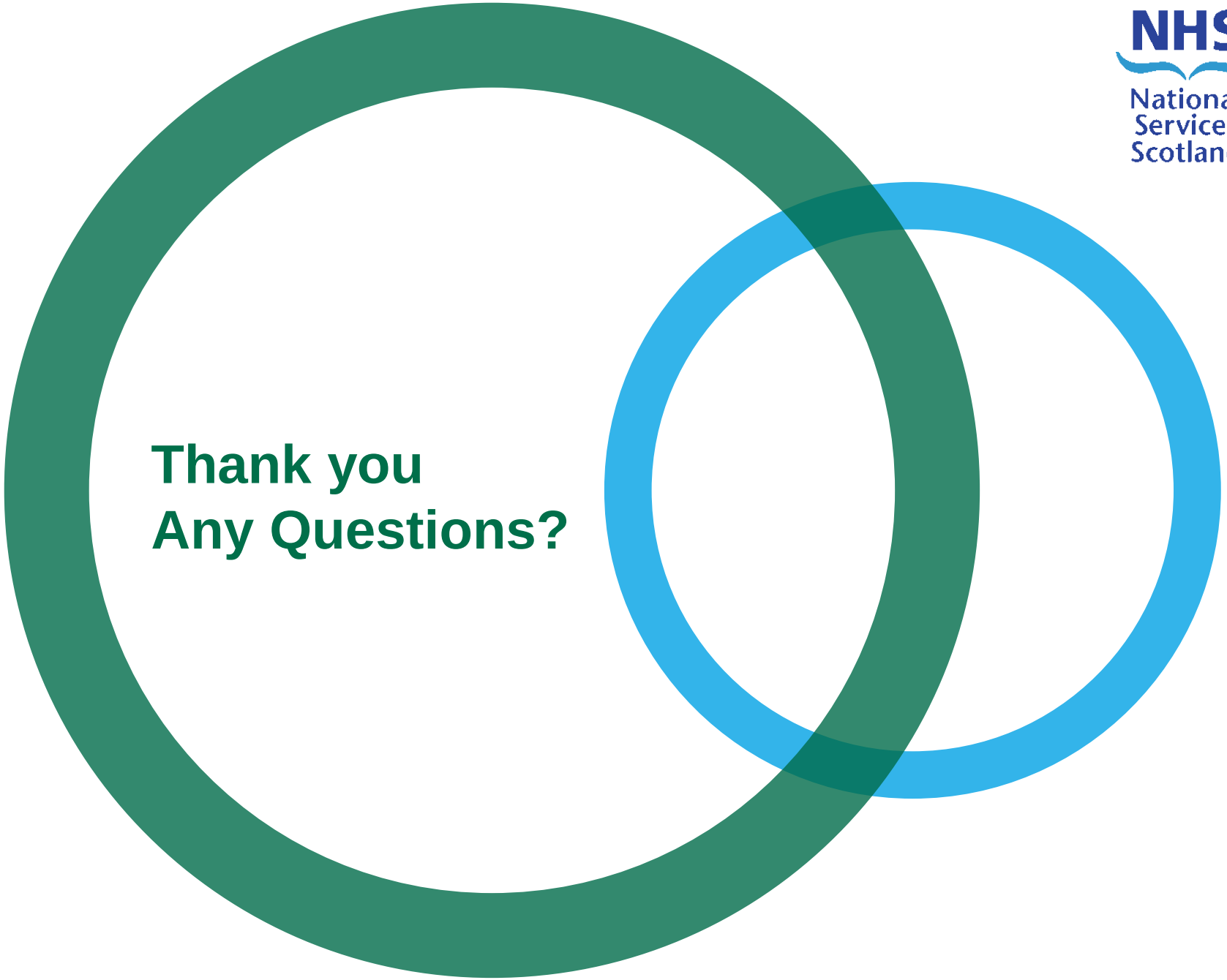
Apologies

- A statement of sorrow or regret in respect of the unintended or unexpected incident
- An apology does not of itself amount to an admission of negligence or a breach of statutory duty

Interaction with existing processes

- Complaints
- Ombudsman
- SAER (Significant adverse event review)
- Pre action protocols
- Disciplinary processes

"Wait, this one's a lawyer. We'd better wash our hands."



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