Duty of Candour – Allowing a Constructive Use of Error in Learning and Improvement in Acute Medicine using Measurement & Monitoring of Safety Framework (MMSF)

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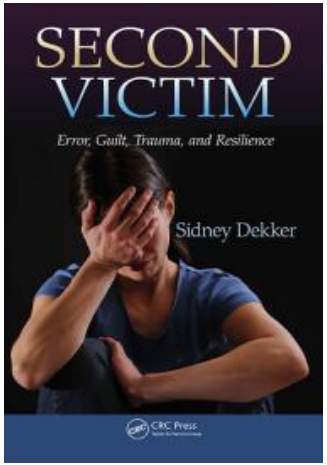
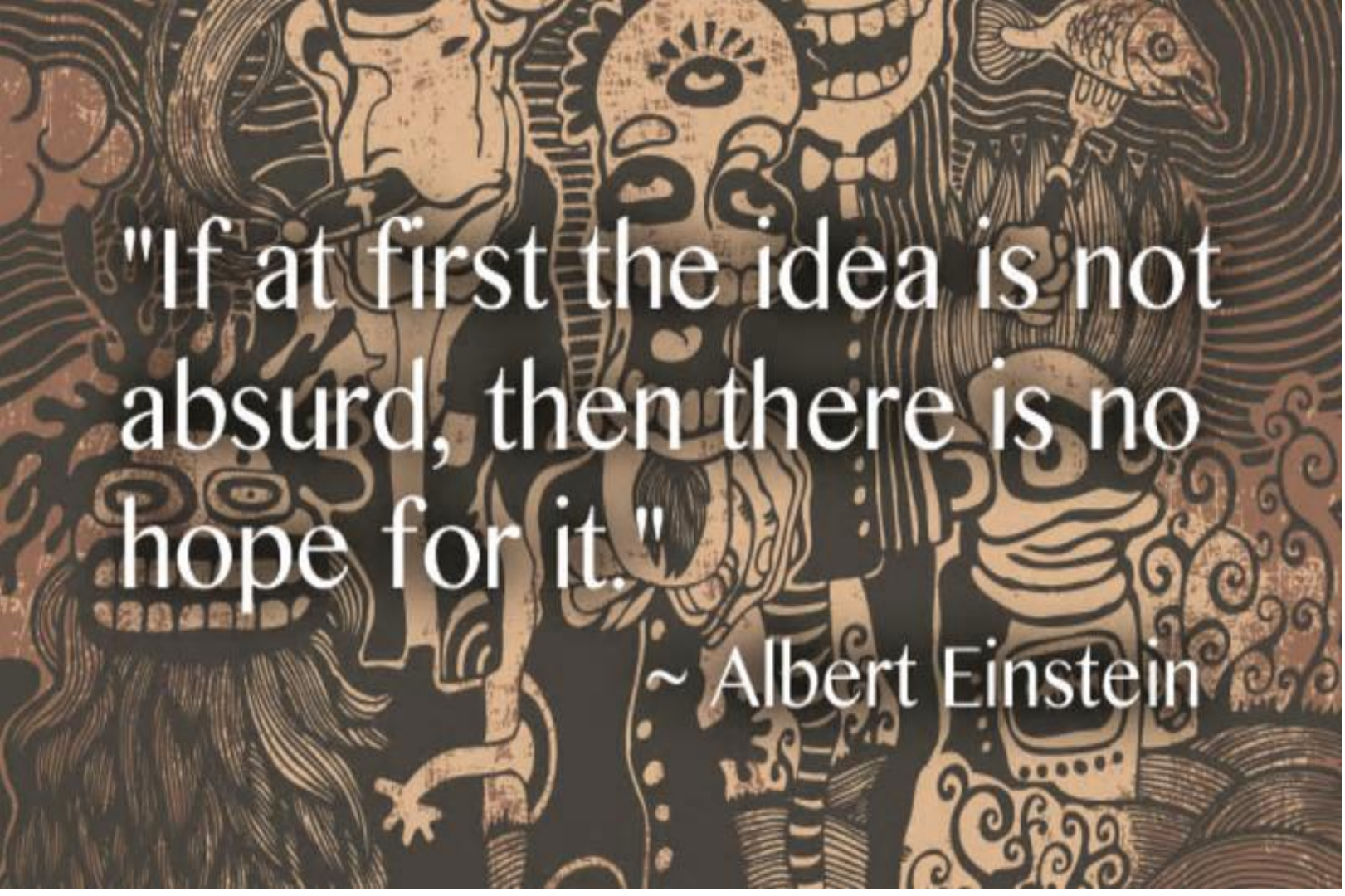
Scottish Medical Education Conference EICC 4nd May 2017

Triangulation





NHS
Greater Glasgow and Clyde

Overview of this Session

NHS Greater Glasgow and Clyde

- What is Duty of Candour ?
- Measurement & Monitoring of Safety Framework (MMSF)
- Developing a Duty of Candour Meeting in the Acute Medicine Department using MMSF
- Demonstration of a Typical Duty of Candour Meeting and the System Learning from the meeting
- Group discussion on an Example of Error/Harm & Use of MMSF to facilitate system learning

Francis Inquiry Report

NHS Greater Glasgow and Clyde

- Openness
- Transparency
- Candour

What is Duty of Candour ?

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

- Duty of Candour aims to help patients receive accurate, truthful information from health providers

Good medical practice (2013) paragraph 55

General Medical Council

Regulating doctors
Ensuring good medical practice

NHS Greater Glasgow and Clyde

You 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.

Duty of Candour Categories

- Professional Duty of Candour
- Contractual Duty of Candour
- Statutory Duty of Candour

Threshold of Notifications – NHS Body

Something unintended or unexpected in the patient's care that, in the reasonable opinion of a health care professional, could result in or appears to have resulted in:

- their death (not relating to natural progression of an illness or condition)
- them suffering severe or moderate harm, or prolonged psychological harm

Threshold of Notifications – Non NHS Body

Something unintended or unexpected occurring in the care of a patient that, in the reasonable opinion of a health care professional, appears to have resulted in:

- their death (not relating to natural progression of the illness or condition)
- impairment of sensory, motor or intellectual function, lasting or likely to last for 28 days
- changes to the structure of the body (eg, amputation)
- prolonged pain or psychological harm (defined as experienced or likely to be experienced for at least 28 days
- shortening of life expectancy
- the need for treatment to prevent death or the above adverse outcomes

Definition of Harm

Severe harm

Moderate harm

Prolonged psychological harm

Scottish Law

The Statutory Duty of Candour is governed by the Health (Tobacco, Nicotine and Care etc.) (Scotland) Act 2016.

The provisions of this Act are not yet in force and regulations have yet to be made by government.

Is there a risk that being open and honest with some groups of patients or service users could be counterproductive ?

- It is ethically and morally the right thing to do.
- It reduces litigation costs.
- A vehicle for winning back patient confidence
- It is what patients want.

Key Messages

- Ethical duty applies to all doctors, in all parts of the UK, in all circumstances.
- Statutory duty applies to organisations, not individuals - but individuals should co-operate as necessary.
- Patients should be told of a notifiable incident as soon as practical.
- If something has gone wrong, apologise. It's the right thing to do, and isn't an admission of negligence.
- Keep written records of discussions and correspondence with patients.
- The thresholds for notification depend on different factors. If in doubt, it's safer to assume it applies.

Questions for you

- To what extent do you think providers are already candid? Do they inform service users of harm and investigate appropriately?
- Are external reporting of social care harm incidents well-developed and comprehensive?
- Do you think further duty of candour reporting systems would be beneficial or un-necessary?
- Do you have any other views to report relating to candour?

Healthcare Improvement Scotland

Measurement and Monitoring of Safety Programme

Thursday May 4th 2017
Edinburgh International Conference Centre

Dr Jonathan Kirk, National clinical lead
@JonathanKirk42 **#THFSMP**

decision

noun

a choice that you make about something after thinking about several possibilities

REALISING REALISTIC MEDICINE

'REALISTIC'

1. HAVING OR SHOWING A SENSIBLE AND PRACTICAL IDEA OF WHAT CAN BE ACHIEVED OR EXPECTED.
2. REPRESENTING THINGS IN A WAY THAT IS ACCURATE AND TRUE TO LIFE.

CREATING CONDITIONS

COMMUNICATE

CONNECT

COLLABORATE

CULTURE

THE VISION

BY 2025, EVERYONE WHO PROVIDES HEALTHCARE IN SCOTLAND WILL DEMONSTRATE THEIR PROFESSIONALISM THROUGH THE APPROACHES, BEHAVIOURS AND ATTITUDES OF REALISTIC MEDICINE

candour
noun

- ‘the quality of being open and honest; frankness’.

- synonyms: frankness, openness, honesty, candidness, truthfulness, sincerity, forthrightness, directness, lack of restraint, straightforwardness, plain-speaking, unreservedness, bluntness, outspoken, ‘telling it like it is’, ‘call’s a spade a spade’.

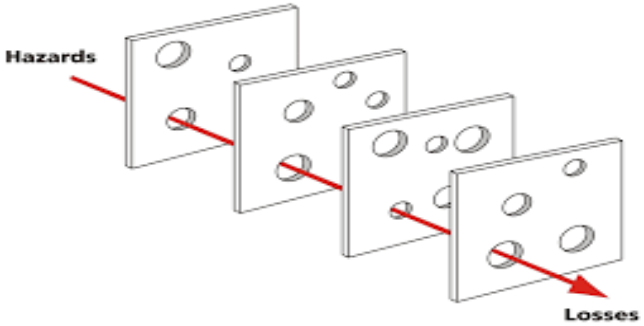
‘The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.’

Dr. Lucian Leape

Professor, Harvard Medical School of Public Health

Testimony before Congress on Health Care Quality Improvement

Psychological safety



blame less, understand more.

Measuring and monitoring safety

http://www.health.org.uk/publication/measurement-and-monitoring-safety

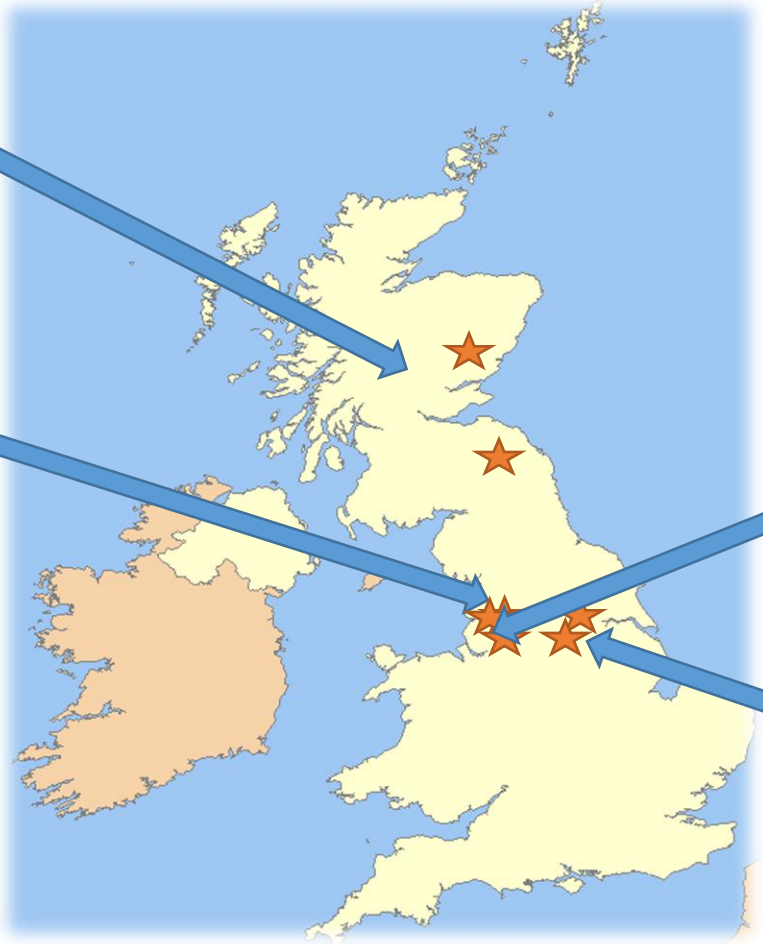
Global impact of the report

USA
Canada
Hong Kong
UAE
Oman
Brazil
Australia
New Zealand
Trinidad & Tobago

UK
Ireland
France
Netherlands
India
Myanmar
Ghana
Zambia
South Korea

Healthcare Improvement Scotland

AQuA
Advancing Quality Alliance

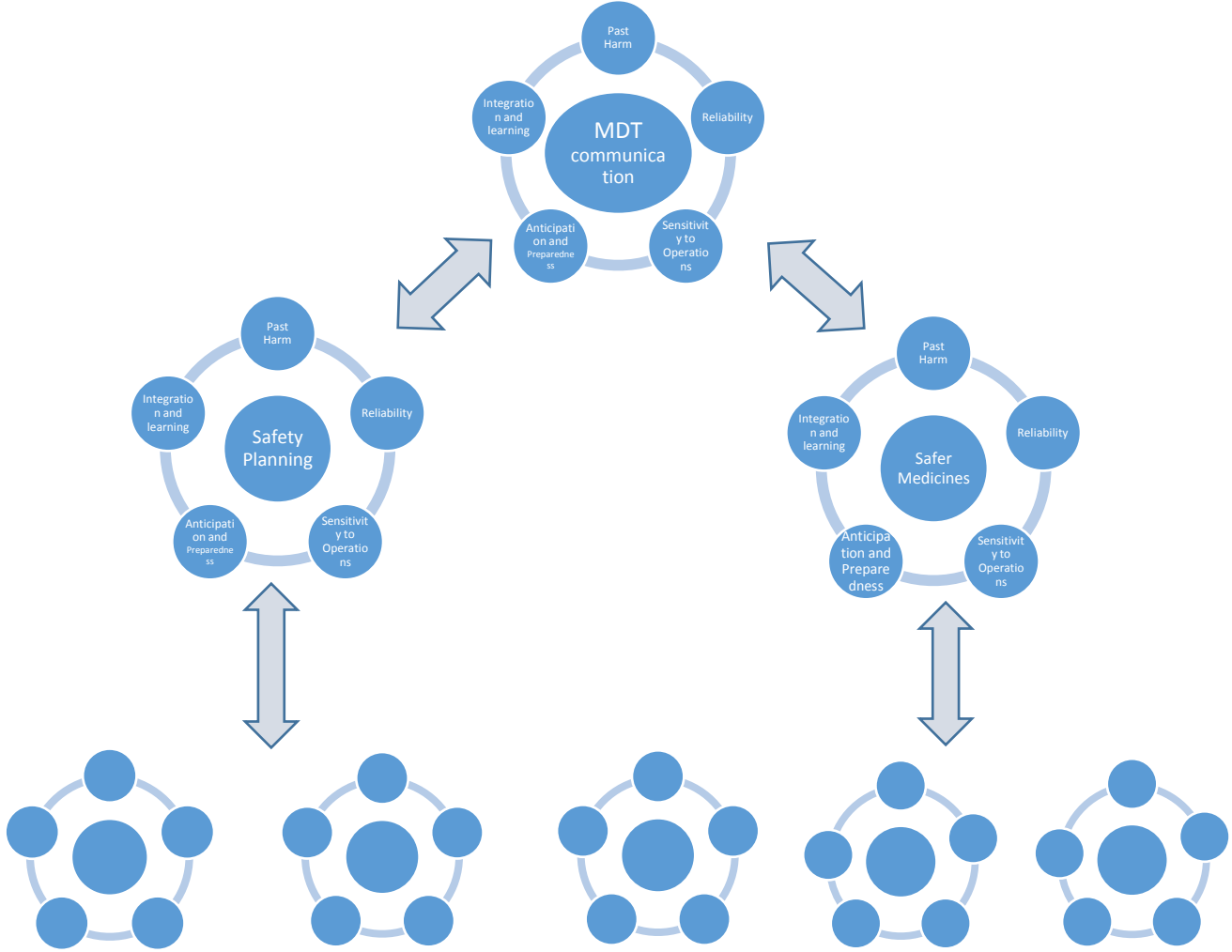


haelo

Improvement Academy
Part of the Yorkshire & Humber AHSN

★Test sites

- Image https://commons.wikimedia.org/wiki/File:Uk_outline_map.png


Past Harm
Integration and learning
MDT communication
Reliability
Anticipation and Preparedness
Sensitivity to Operations
Past Harm
Integration and learning
Safety Planning
Reliability
Anticipation and Preparedness
Sensitivity to Operations
Past Harm
Integration and learning
Safer Medicines
Reliability
Anticipation and Preparedness
Sensitivity to Operations

https://youtu.be/w14Imowxptg

https://youtu.be/iUvu2Fdy38c

Switch Gear from Past

Indicators

Prediction

↑

Leading

↑

Lagging

- Broaden our understanding of ‘why things go wrong’.

- Apply it to an adverse event.
- Apply it to our interaction at a learning meeting.
- Blame less, understand more.


Past harm
Has patient care been safe in the past?
Reliability
Are our clinical systems and processes reliable?
Sensitivity to operations
Is care safe today?
Anticipation and preparedness
Will care be safe in the future?
Integration and learning
Are we responding and improving?
Safety measurement and monitoring

Absence of harm

Presence of safety

- Structure conversations about safety
- Surface gaps in understanding
- Identify barriers to improvement
- Enable **learning**

If you want to do some testing or find out more……

Jo Thomson,
Senior programme manager

e: JoThomson@nhs.net

@JoThomsonQI

t: 0131 623 4350

Further information

- **www.howsafeisourcare.com**
- **Monthly calls** open to all
- (register at www.howsafeisourcare.com)
- Next call Wednesday 10th May
- **Interactive pdf**
- (coming soon)

Setting up a Duty of Candour Meeting – Our Story

- Acute Medicine Unit – fast paced area with high turnover.
- Stressful Environment for staff particularly junior doctors
- Healthcare professionals must support and encourage each other to be open and honest

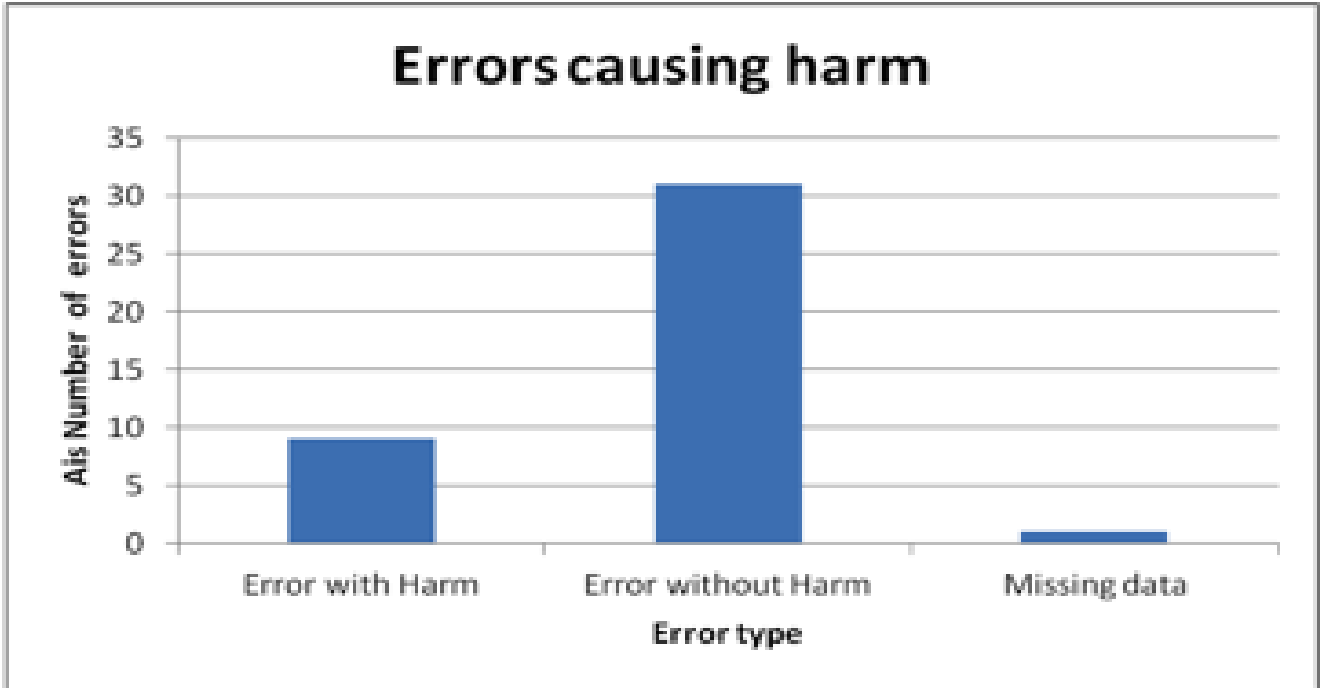
Recognised Second Victim Phenomenon

- An awful chain reaction can occur resulting in poor performance
- Stress → Distress → Fragile → Breakdown
- Isolation, guilt, fear, anxiety, embarrassment (perceived or actual), insomnia can result

A Baseline Audit

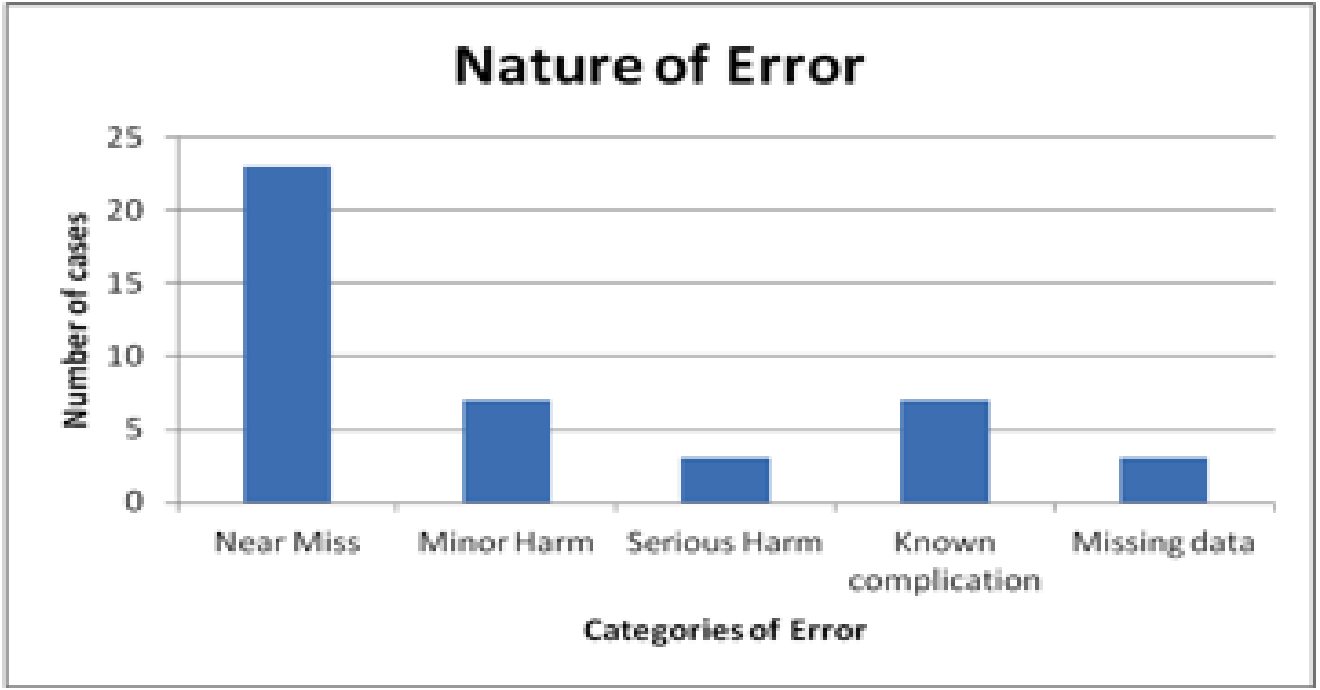
- To determine experience of all levels of medical staff in Acute Medicine Department regarding making medical errors
- To raise awareness of GMC Duty of Candour
- Find out if staff will feel confident to present errors they were involved in at an open forum

Error Causing Harm

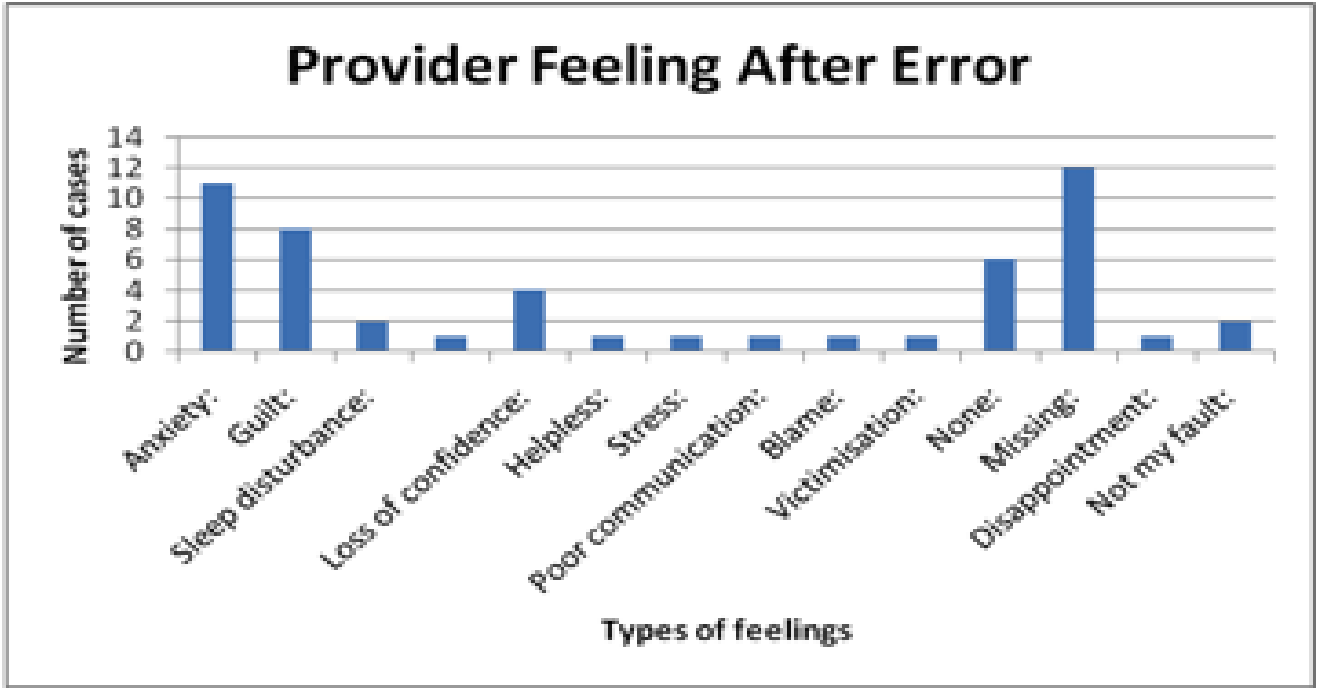


Time Since Recent Error

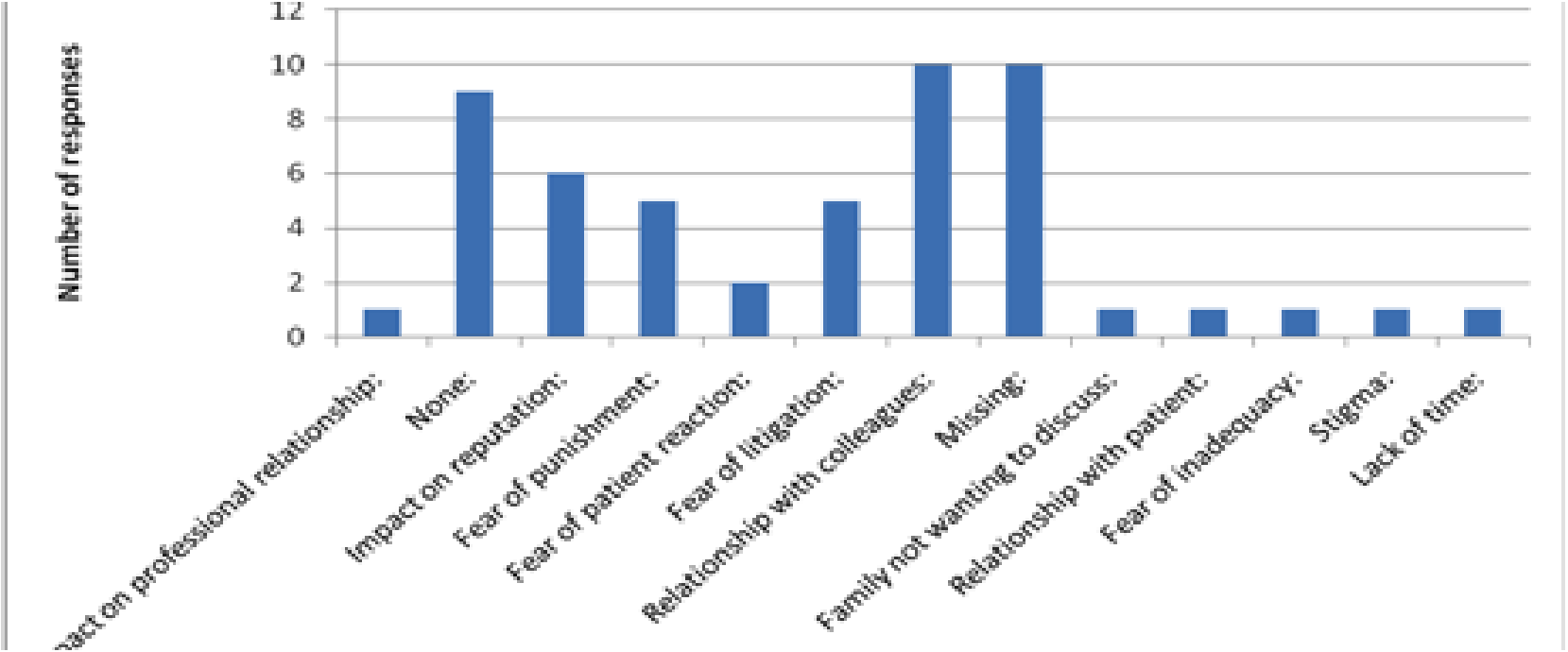
Nature Of Error



Feeling After Error

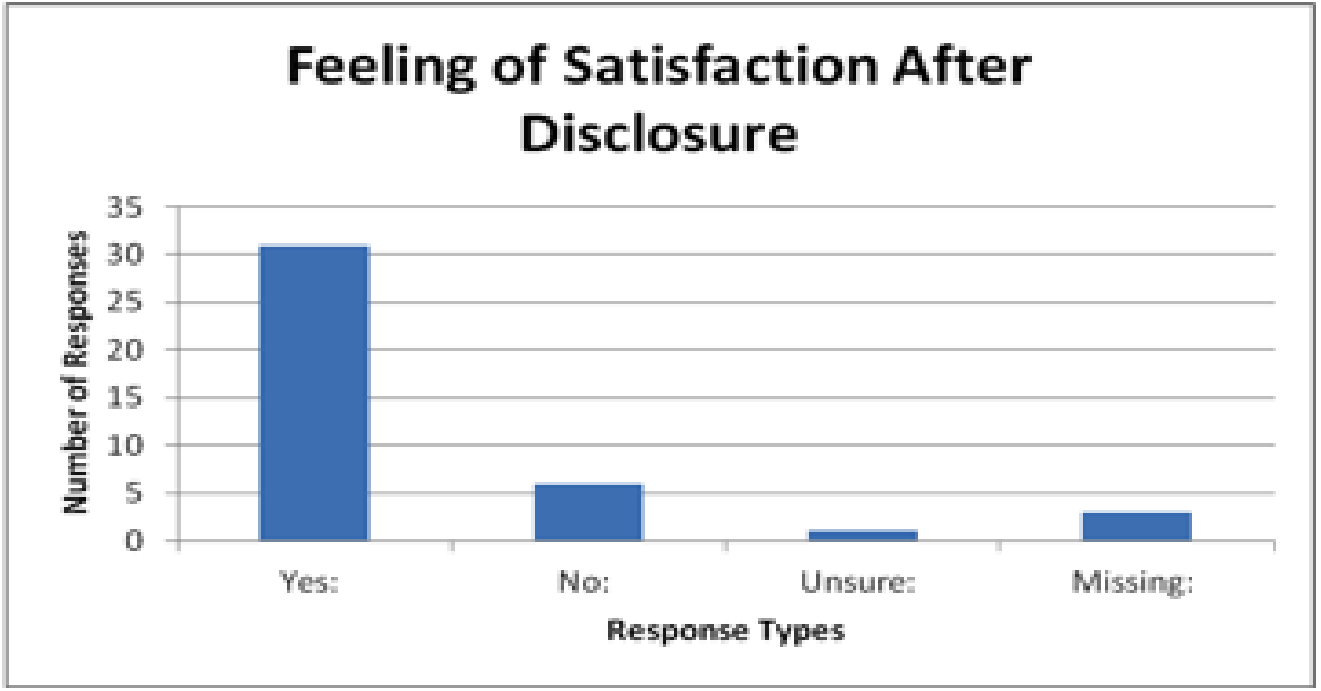


Reservations Regarding Disclosure

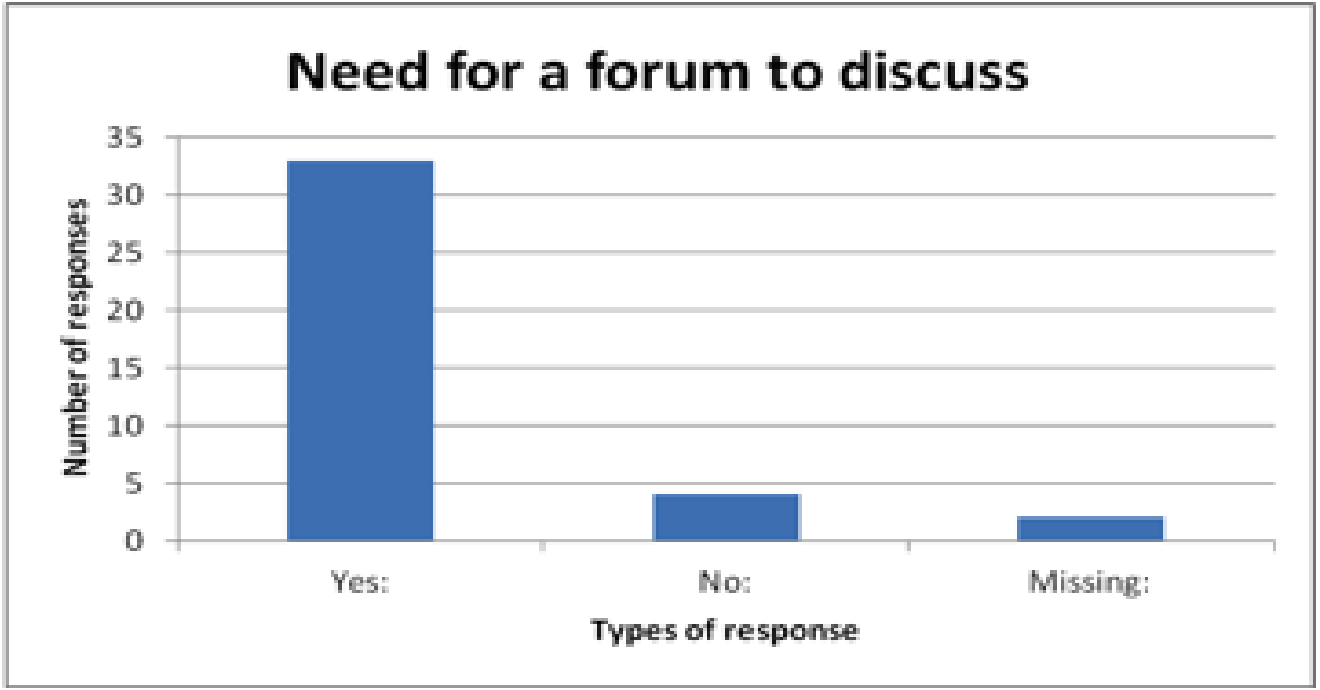


Error Discussed With

Satisfaction After Disclosure



Appetite For Forum



Key findings from the Baseline Audit

- Majority of staff members had been involved in a medical error in past 1 year
- Anxiety, guilt and loss of confidence common feelings after an error
- One in four errors not disclosed to patient or relatives
- 75% disclosures done satisfactorily by individuals.
- Large appetite for a regular forum for disclosure of medical errors

Using the IHI Model of Improvement

NHS Greater Glasgow and Clyde

- **What are we trying to establish ?**

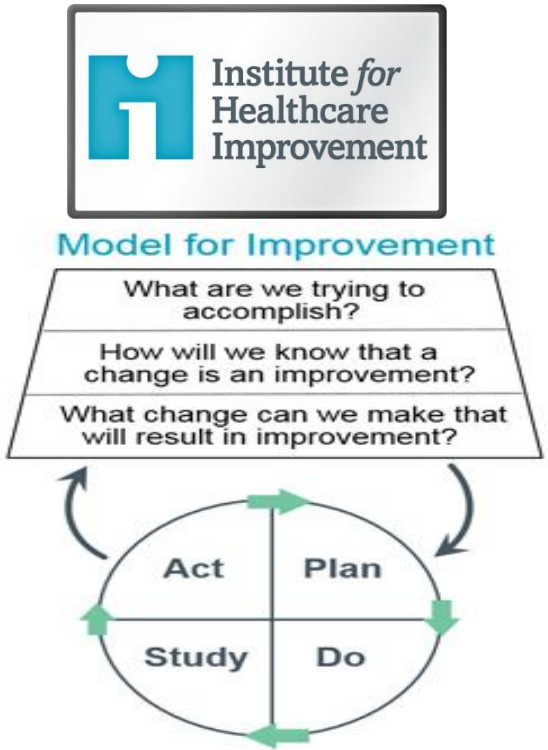
  Trying to improve the negative feeling of acute medical staff after an error or harm

- **How will we know that change is improvement ?**

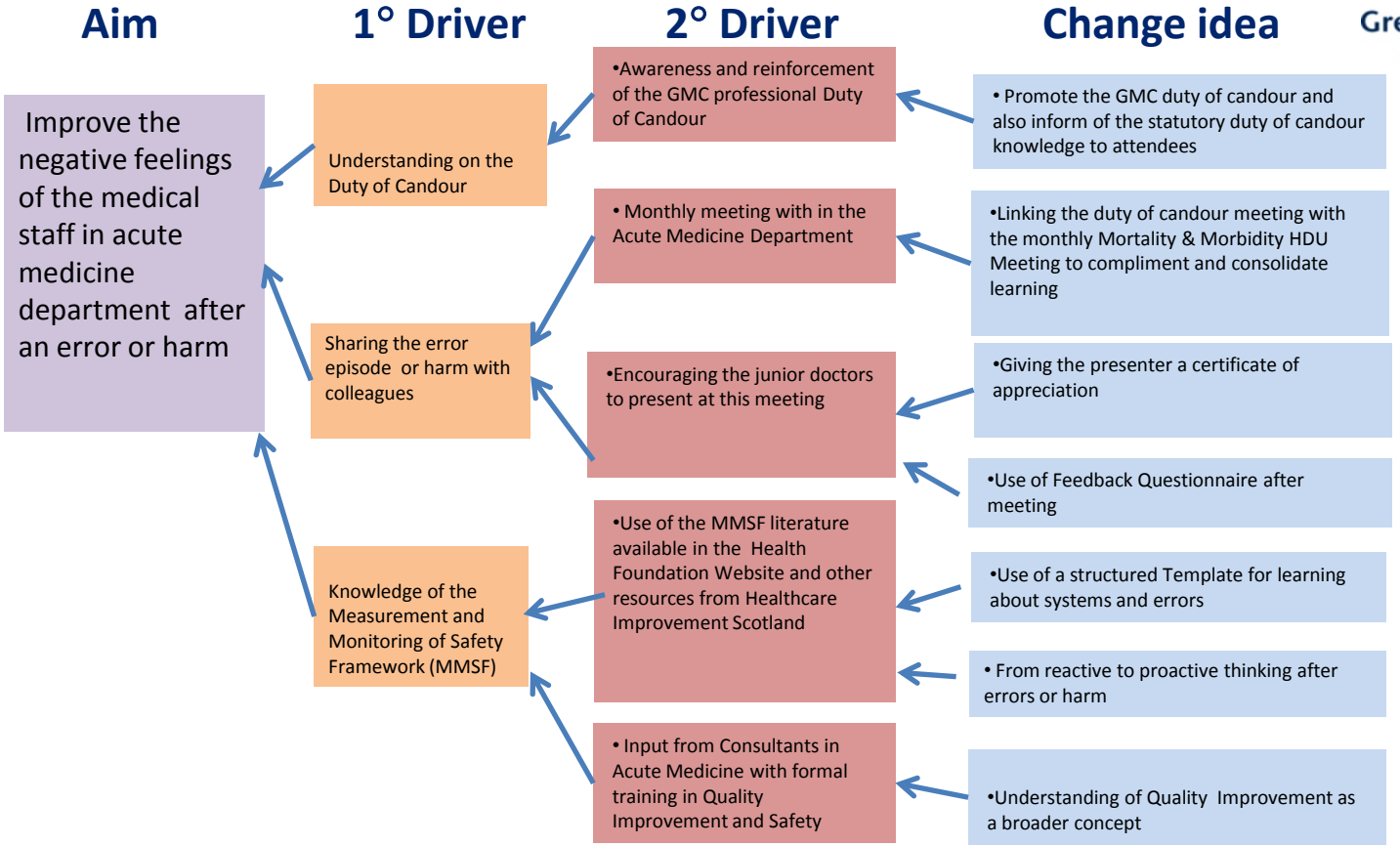
  By measuring the satisfaction rate or positive feelings after discussing about a recent error or harm

- **What change can we make that will result in improvement ?**

  Having a monthly open forum where staff can candidly discuss about their errors or harm.

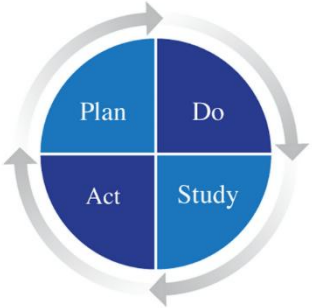


Driver Diagram

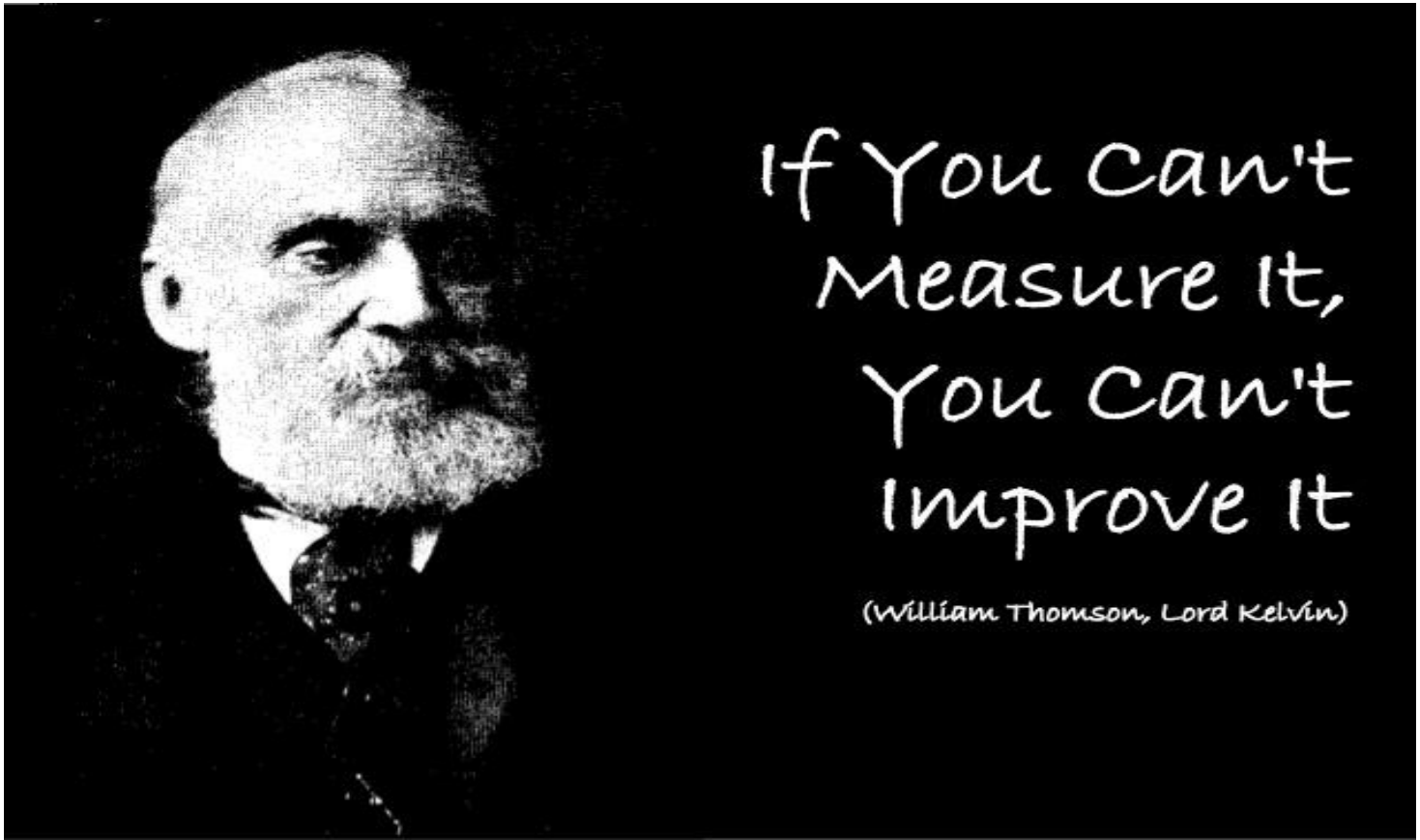


First Meeting

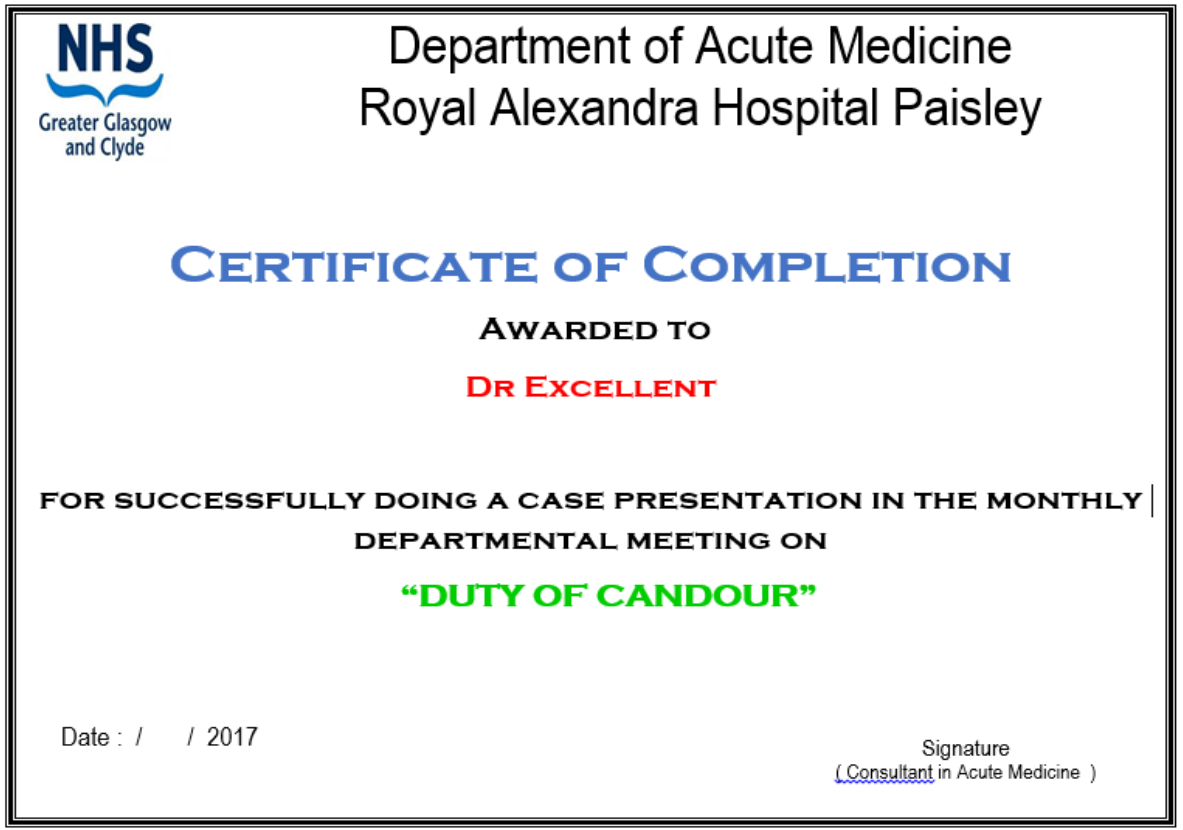
- Lunchtime monthly meeting along with the unit M&M
- Attended by 12 mixed grades of doctors
- Personal case example of high INR due to warfarin not chased over weekend
- Group discussion of how this fit in to MMS framework
- Using small PDSA cycles from audience feedback and evolving the meeting
- All attendees having awareness of the DOC and MMSF



Qualitative Data



Certificate given to presenter



NHS
Greater Glasgow and Clyde

Department of Acute Medicine
Royal Alexandra Hospital Paisley

CERTIFICATE OF COMPLETION

AWARDED TO

DR EXCELLENT

FOR SUCCESSFULLY DOING A CASE PRESENTATION IN THE MONTHLY DEPARTMENTAL MEETING ON

"DUTY OF CANDOUR"

Date : / / 2017

Signature
(Consultant in Acute Medicine)

Picture of our meeting room

Case: A good death

- 76 year old sudden collapse
- GCS 8 on arrival to a busy A&E department
- End of a 12.5 hour shift (FY2)
- CTB: massive intra cranial haemorrhage with mass effect
- On warfarin: beriplex, vitamin K
- Phone calls to haematology/radiology/neurosurgery. Some indecision
- GCS 4
- Decision made to palliate. DNA CPR discussed and agreed with family
- Side room in Medicine vs A&E short stay unit
- Referred to Medical Registrar and accepted
- Patient transfers to AMU and arrests < 1 min after arrival
- Receives approx. 1 minute of CPR
- No DNA CPR Form. Handover between Nursing staff ? Still for active treatment

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Outcome

Futile, inappropriate resuscitation vs supportive death with family present

Harm to patient, family, staff

Resolution: Acknowledging failings, apology, Datix

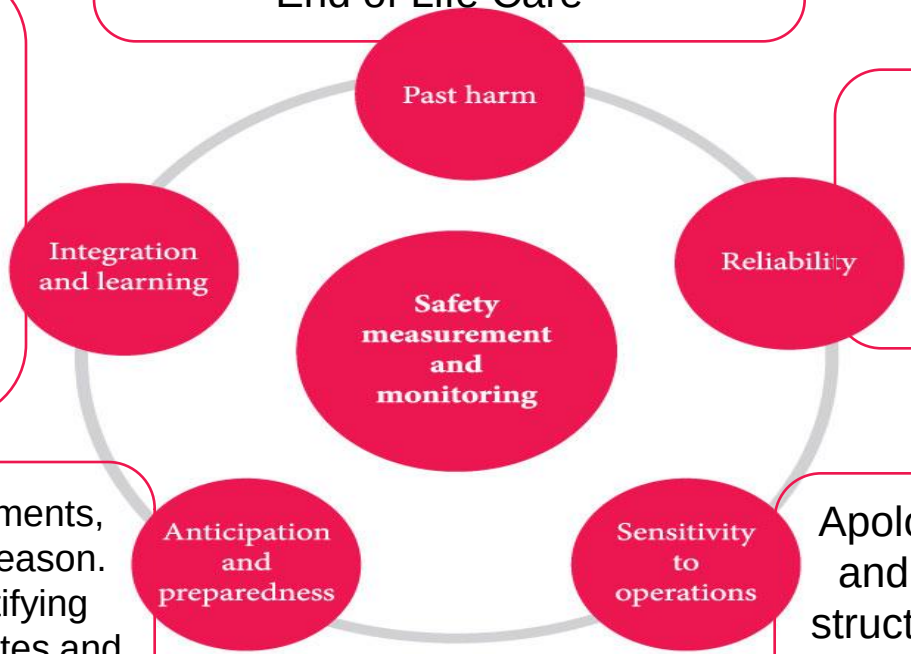
A framework for the measurement and monitoring of safety

The Health Foundation

Gaps in communication with transfers, handovers, DNACPR decisions and End of Life Care

Key issues from this case applicable to other units. Share and learning in M&M meetings, huddles.

SBAR System of feedback to units, waiting time reporting of adverse events



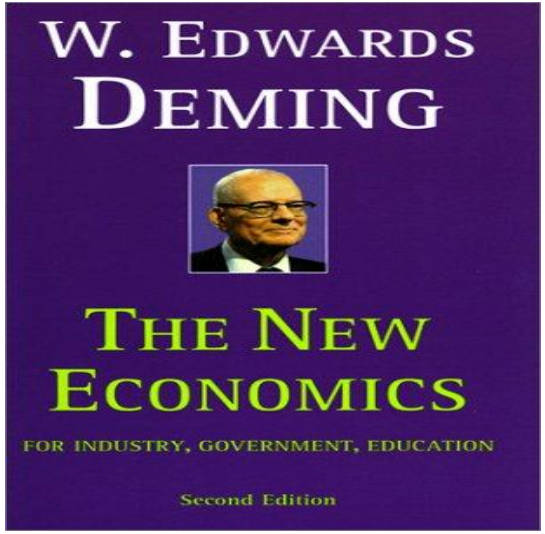
Knowledge of other departments, high risk hours, days and season. Familiarity with staff. Identifying high stake patients, clear notes and full documentation

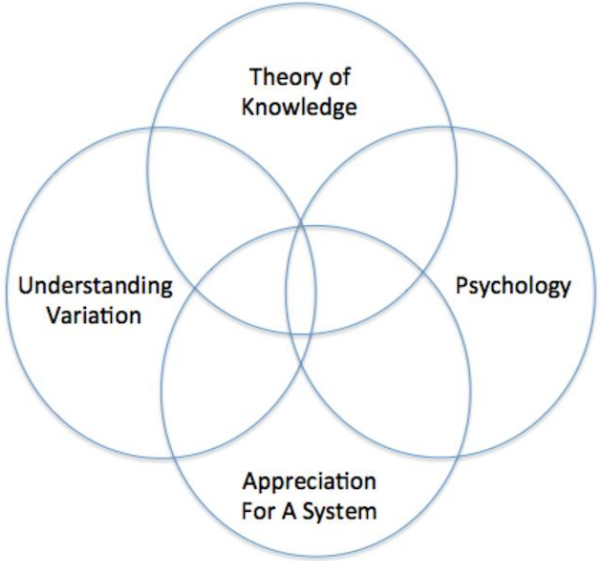
Apology. Speak to family and explain, Handover structure – working within hours, junior to senior handover

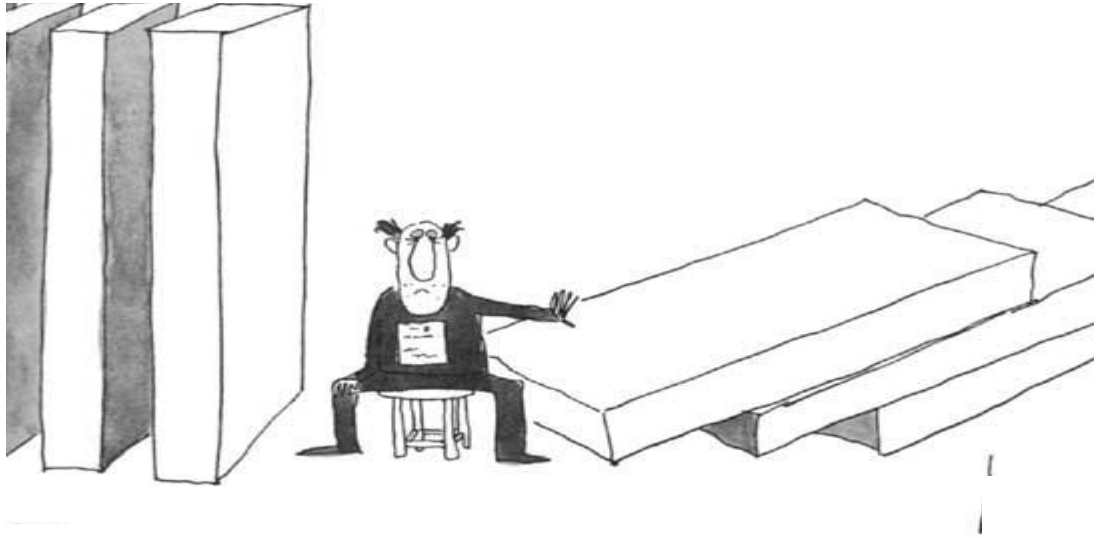
Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety.* The Health Foundation, 2013

System of Profound Knowledge

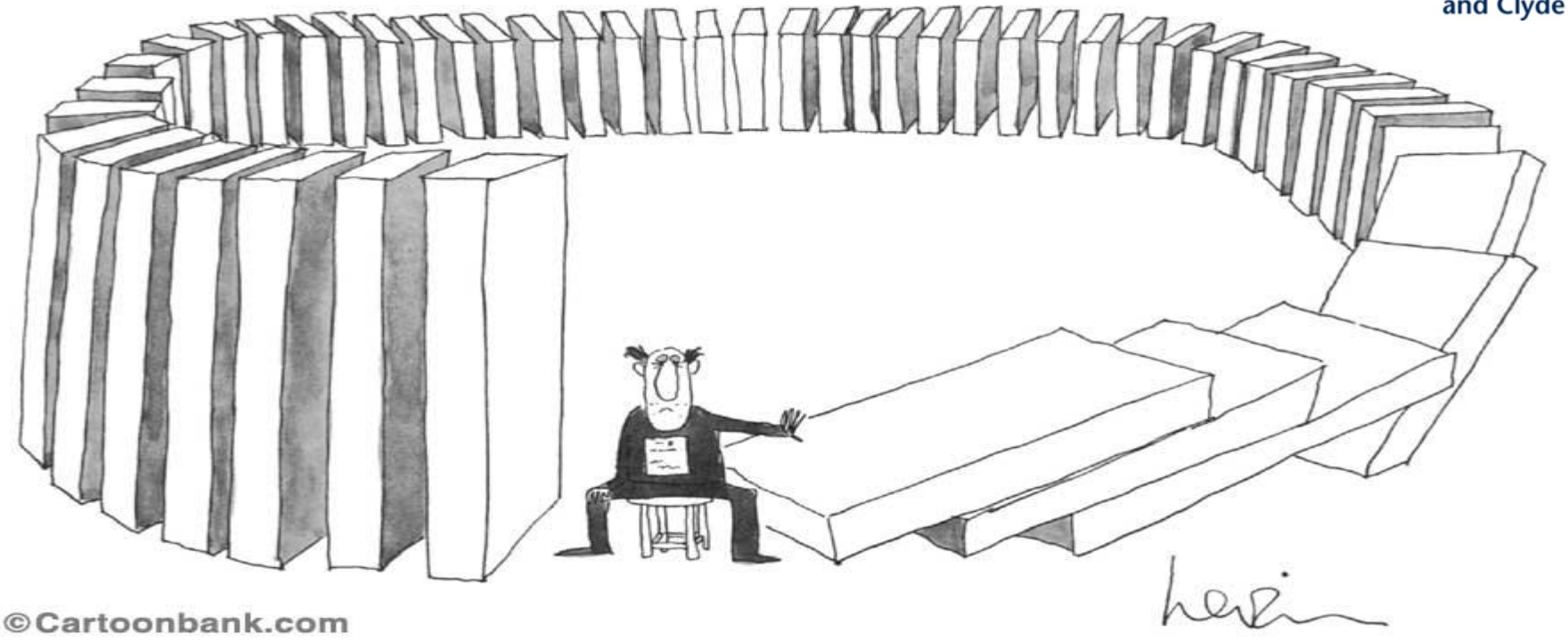
- Need to look at systems in the fashion of an applied science
- Developed the ‘System of Profound Knowledge







“Maybe pushing on that wall to the right will give some space.”



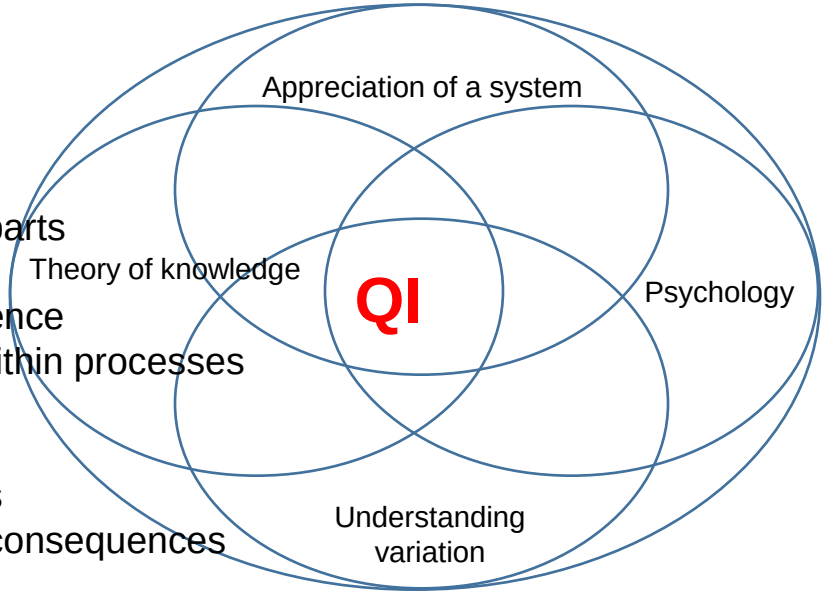
"Oops!"

When an error occurs

- What will you do?
- Will you use the MMSF Framework?
- How will you implement the duty of candour in your practice ?

System of Profound Knowledge

Constituent parts
Dynamicity
Interdependence
Processes within processes
Aim
Complexity
Stakeholders
Unintended consequences



System of Profound Knowledge
Understanding Variation

Theory of Knowledge

Psychology

Variation is to be expected

Motivation – extrinsic and intrinsic

Understanding common and special cause variation

The human side of change

Prediction of outcomes

Operational Definitions

Analysing the data

Dealing with barriers

Learning from experimentation

Developing theories

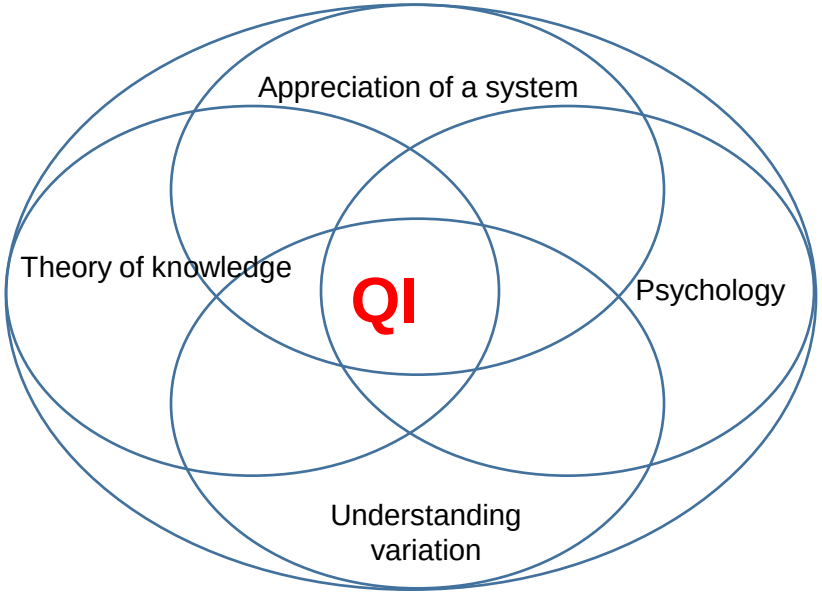
Developing change

The PDSA cycle

Levers

Force functions

System of Profound Knowledge



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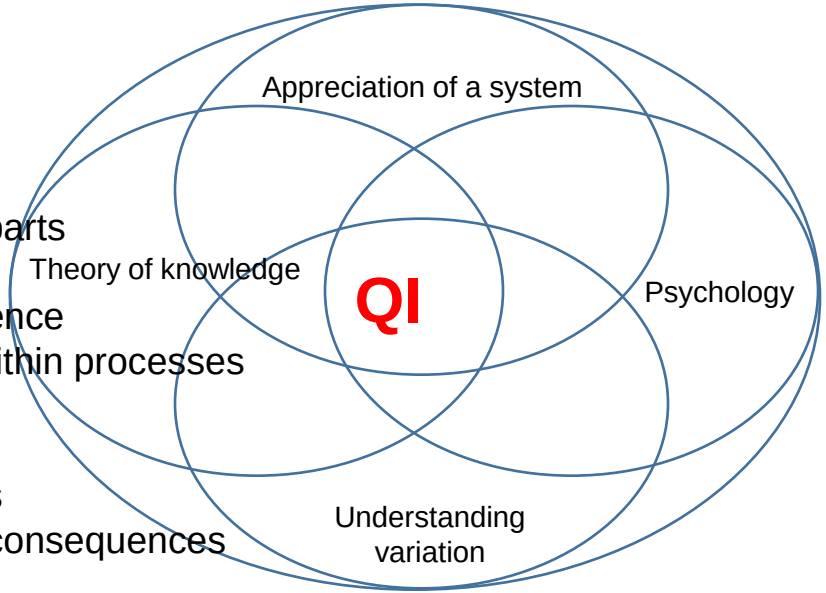
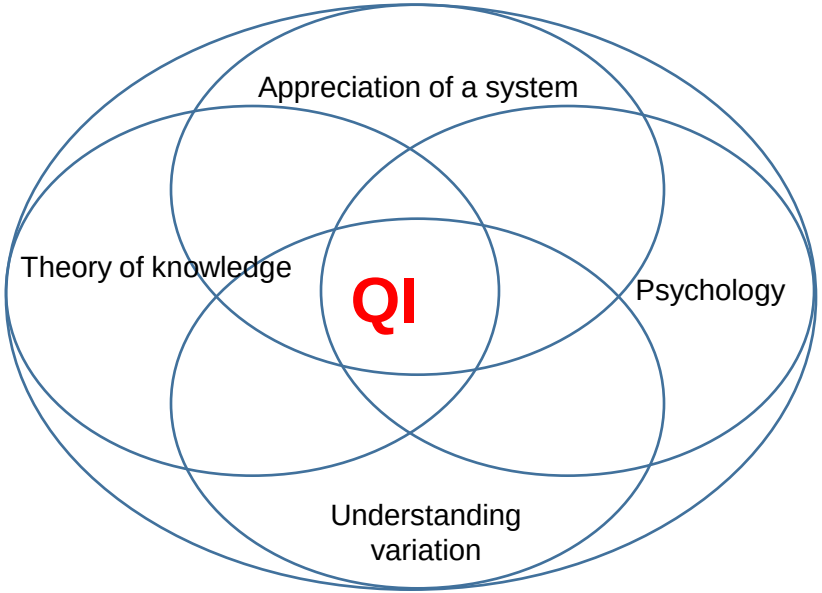


System of Profound Knowledge



Case Discussions

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