Scotstown Medical Group

Organisational Duty of Candour report 2018-2019

This report is the Practice's first under the Organisational Duty of Candour Regulations which came into force on 1st April 2018. Under the regulations the report should cover the areas set out below.

Information about the number and nature of incidents to which the duty has applied:

One (1) incident resulting in delayed diagnosis and treatment of bone metastases from prostate cancer.

The patient presented in August of 2018 with myalgia, and comment made by duty doctor in September querying possible recurrence of prostate cancer. The GP missed this comment and investigated another path.

The patient's treatment could have been started sooner if the earlier comment had been acted upon, so effectively there was a delay to treatment during which time the pain and discomfort grew, while the disease went untreated for this period. The patient has since responded well to treatment.

On reflection by the Practice, it was felt the Duty of Candour procedure was appropriate for this incident.

Assessment of the extent to which the responsible person carried out the elements of the duty:

The GP called the patient to explain the error and gave a verbal apology. He then invited the patient to see him, and followed up with a written meaningful apology.

As this was the first incident under the Practice protocol, the duties were carried out appropriately, but it was felt following review that there was room for improvement.

Information about the Practice's policies and procedures:

Practice policies and procedures, both clinical and non-clinical, are readily available to all staff via the Practice computer system.

A clinical protocol, however, was not written to cover these circumstances. This was a clinical judgement to be made by a doctor, and sadly on this occasion the result was missed. This has now been rectified and a written protocol has been added to the practice systems.

Procedures for identifying and reporting incidents:

Procedures are clear and have been made available to all staff, having been presented to staff and GP Principals at Practice training events. Staff are aware of the path to follow when reporting incidents or raising concerns, and are in-keeping with the key principles of openness, transparency and candour as discussed in the regulations.

To assist the Practice in maintaining a robust culture of informing and educating our staff, a new process for ensuring staff have read and understood policies and procedures is currently under development.

Support available to staff and to persons affected by incidents:

The practice provides management and peer support, though on reflection following this incident there may be a need for a more formal counselling structure.

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Information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty has applied:

A Significant Event Analysis report conducted by the Practice suggested two improvements to current systems, which were adopted in full.

Other information

Overall, as a first learning exercise in the practice's Organisational Duty of Candour this went well. The patient was notified quickly once the error was found and a formal verbal and written meaningful apology given. However, improvement in the process is required to make it run more smoothly, and a greater understanding by clinical staff of the nature of the regulations is needed. The Practice will be conducting further learning events for both clinical and non-clinical staff to ensure that it continues to meet its obligations.