Healthcare Improvement Scotland | Inspections and reviews To drive improvement

NHS SCOTLAND

# Duty of Candour Annual Report Template

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have trigger duty of Candour within our service.

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| Name & address of service: | Graham Anderson house, 1161 Springburn Road, Glasgow, G21 1UU |
| Date of report: | 9th April 2024 |
| How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively?<br><br>How have you done this? | Since implementation as a service, we have –<br>1. Introduced Information leaflets for all staff, Service Users and Families – These are made freely available in the main reception area<br>2. The Trust have also made "Duty of Candour" a mandatory training requirement for all staff and have also provide this via out eLearning portal<br>3. Provided online training on "Duty of Candour" which was recommended by the Care Inspectorate – All existing staff have completed this and this training is now part of our induction process for new staff.<br>4. The Trust has devised and published a Policy and Procedure for "Duty of Candour" for all staff to follow – staff are currently required to read this Policy and a copy of confirmation of their understanding will be kept in their personnel file.<br>5. All staff have received DATIX training on how to report any accidents, incidents, concerns or allegations – reports are accessible to managers, senior managers, HR, QA and directors to ensure the Trust is compliant and transparent when following up on incidents and concerns.<br>The Duty of Candour is part of the Datix reporting system and therefore allows incidents which are covered by the regulations to be monitored and provide assurance that they are effectively managed and follow the policy and procedure.<br>6. We conduct a quarterly Safeguarding audit – again this monitors the staffs' knowledge on "Duty of Candour" and if concerns are raised we will action accordingly |
| Do you have a Duty of Candour Policy or written duty of candour procedure? | YES – Dated April 2022 |

| How many times have you/your service implemented the duty of candour procedure this financial year? | |
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| Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions) | Number of times this has happened (April 2023 - March 2024) |

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| A person died | 0 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| A person's treatment increased | 0 |
| The structure of a person's body changed | 0 |
| A person's life expectancy shortened | 0 |
| A person's sensory, motor or intellectual functions was impaired for 28 days or more | 0 |
| A person experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment in order to prevent them dying | 0 |
| A person needing health treatment in order to prevent other injuries as listed above | 0 |
| **Total** | We do see incidents however they do not fit the above criteria however we will always treat as reportable under duty of candour. As a service we will always manage incidents via our Lessons learned or internal systems such as supervision and disciplinary processes. As part of our duty of candour – all relevant parties will be notified, Next of kin, GP, Social work, Adult support and protection and Healthcare improvement Scotland |

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| Did the responsible person for triggering duty of candour appropriately follow the procedure?<br><br>If not, did this result is any under or over reporting of duty of candour? | Yes – as a service we are open and transparent at all times, including incidents that do not trigger "Duty of Candour" and will always disclose incidents, accidents and errors to all relevant parties, meet and discuss incident further and take appropriate actions including offering apologies and making explicit what actions we have taken as a result of the incident. |
| What lessons did you learn? | As a service team, we continue to learn from incidents, errors and improve on our practice. - we also discuss at staff meeting and 1:1 line management session, to reduce the risk of this type of incident reoccurring in the future |
| What learning & improvements have been put in place as a result? | Systems in place to ensure clear recording of service user needs and observation levels – In this case the staff member was managed via internal disciplinary process.<br><br>Clear handovers given at the commencement of every shift and all staff clearly aware of their responsibilities whilst on duty.<br><br>Clear staff allocations of tasks and duties provided to all staff at commencement of shift. |

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| Did this result is a change / update to your duty of candour policy / procedure? | No |
| How did you share lessons learned and who with? | We devise "Lessons Learned" bulletins and these form agenda items for our various staff meetings including the management team meeting and multi-disciplinary team meeting. Lessons learned are discussed as a reflective practice exercise and give staff especially those involved in the incidents the opportunity to de-brief. We find these to be beneficial to staff development through supervisions and Professional Development Reviews. The Datix incident management system supports records of be-briefs and therefore generic lessons learned can be shared with other services. |
| Could any further improvements be made? | As part of our governance process which includes the Duty of Candour, we seek to drive improvements in the quality of our care, support and treatment and ensure that we promote openness and transparency when incidents occur.<br>We can always improve and strive to be continuous in providing the highest care and support possible to those in our care. |
| What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this? | As a management team we fully support any staff member to provide an apology as we recognise that this can be a difficult emotional and traumatic experience following an incident.<br><br>– we would be happy to discuss any concerns with staff on how best to manage and approach this with empathy for the situation |
| What support do you have available for people involved in invoking the procedure and those who might be affected? | Yes- the organisation has devised a new audit tool to discuss staff's understanding of "duty of Candour" and we are happy to offer support to any staff member and look at where learning and training is needed. We have regular staff meetings within the service and also 1:1 staff supervision. We do look at reflective practice and devise lessons learned from incidents where appropriate. |
| Please note anything else that you feel may be applicable to report. | |