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.

Name & address of service:	Graham Anderson house, 1161 Springburn Road, Glasgow, G21 1UU
Date of report:	30th April 2025
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? How have you done this?	Since implementation as a service, we have – 1. Introduced Information leaflets for all staff, People we support and Families – These are made freely available in the main reception area 2. The organisation have also made "Duty of Candour" a mandatory training requirement for all staff and have also provide this via out eLearning portal 3. The organisation 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. 4. 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 organisation is compliant and transparent when following up on incidents and concerns. 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. 5. 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. Our reports are monitored within the organisation, this includes quality performance and risk and within the quality and governance committee.
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?	
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 2024 - March 2025)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A person's treatment increased	3
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 – Four reportable incidents	Four incidents reported as under duty of candour. Incident 1: A person we support fell from bed, during a night shift although staff on duty adhered to the guidance for one-to-one observations at the time and staffing levels were correct, the person we support did fall from their bed onto their head, nursing staff attended immediately, and all care and support given in the first instance, this include immediate first aid and vital observations and ensuring the person was comfortable. The nurses in charge call the emergency services at this time for additional assessment to be made due to the persons presentation at this time. The person was transferred to hospital, and it was identified that they did sustain further bleeds to the brain. This person was transferred to a different setting. **Findings from investigation** A thorough investigation was instigated because of this incident. We notified all external parties, regulators and family. The person we support who sustained injuries from this fall had not previously fell from bed, they had however recently injured their should because of a previous fall. Our Physiotherapist worked closely with this person we support and shared the new guidance with the staff team. All care plans and risk assessments were updated at that time, and the service increased this person's observation levels from one to one, waking hours to two to one, waking hours and one to one at night, this involved a 15 minute safety check.

	Incident 2: A Person we support received a higher then prescribed dose of anti-psychotic depot medication for a period of seven months this was the result of processes not being followed correctly by nursing staff and not reconciling medications as per policy on admission. **Findings from investigation** A thorough investigation was instigated as a result of this error. We notified all external parties, regulators and family. The person affected was also met with and this error was explained to them. We set actions that required to be completed by managers and nursing staff. We met with the General Practitioners to discuss a smoother process when admitting new people we support to the service. We devised a new standard operating procedure for depot medications and a depot audit tool. All registered nurses were required to complete medication competency assessments and read all medication standard operating procedures. We also included a new section into the Datix audit tool to reflect the reconciliation processes. This error was discussed with all registered nurses via line management supervision and reflective accounts. Incident 3 A person we support continued to receive a medication at a previous dose, this medication was to be titrated down as per Psychiatrists instructions, by 1mg per week. The person was prescribed an antipsychotic that was to be gradually reduced from 4mgs to zero over a four-week period, however it was identified that although the initial dose was reduced to 3mg, this was not reduced the following week and remained at 3mg for an additional period of three weeks. **Findings from investigation** A thorough investigation was instigated because of this error. We notified all external parties, regulators and family. The person affected was also met with and this error was explained to them. The reduction was again instigated and the person we support consented to the medication changes. Following this error, we took the following actions: - Meetings with registered nurses and line management supervision Reflective accounts from Nursing staff on this error **Incident 4** A person we support returned from a hospital admission and had medication discontinued, which was continued to be given in the service on their return.

	Findings from investigation As part of our duty of candour – all relevant parties where notified, Next of kin, GP, Social work, Adult support and protection and Healthcare improvement Scotland. As this error is similar to those reported before, Disciplinary processes and procedures were implemented. A Lessons Learned was devised and shared by the Ward Manager to the Nurse Team and again registered nurses were met to reflect on this error.

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	Yes – As a service, we are committed to maintaining openness and transparency at all times. This includes incidents that do not trigger the "Duty of Candour." We consistently disclose incidents, accidents, and errors to all relevant parties, engage in discussions about the incidents, and take appropriate actions. This includes offering apologies and clearly communicating the 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. Where appropriate we will invoke disciplinary action as required to managed staff. In the above incidents we have had to ensure that our registered nurses are competent and able to adhere to medication policies and procedures. We ensured that all our nurse read and understood all medication standard operating procedures, and they would be held accountable if they fail to follow the guidance in place. We have strengthened our documentation, particularly around medication procedures administration, and have added in additional checks to our medication audit tool around reconciliation for medication changes if a person we support has been treated in hospital. We have also devised a monthly depot medication audit tool, this is to further safeguard from similar incidents occurring in the future. We have learned that our current medication administering system is outdated and as such are in the process of upgrading to an electronic medication administering system, this will minimise future medication errors and will offer our staff a safer and more robust system to support them in their roles. We will devise Standard Operating procedures for the GP clinic and our Psychiatry clinic to further strengthen the processes that are required to ensure safe and consistent practice from our staff team
What learning & improvements have been put in place as a result?	We have Improved medication reconciliation procedures now in place and a further monthly audit has been devised to ensure the medication changeover is without error.

	We have implemented a new standard operating procedure for Depot medication, for staff guidance and also a new depot medication audit tool Our Registered nurse team have read and understood all medication standard operating procedures and these are incorporated into line management supervision Clear handovers given at the commencement of every shift and all staff clearly aware of their responsibilities whilst on duty. Systems in place to ensure clear recording of service user needs and observation levels
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 devised "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 de-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 incidents, 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. 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. We employ a Counsellor, who is always available to support staff following an incident, and also to support people we support and their families to discuss any concerns they may have, offering all the opportunity to de-brief. 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 Trust 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.	