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:	28th April 2026
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, Service Users and Families – These are made freely available in the main reception area 2. The organisation provide "Duty of Candour" as 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 system 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 PSIRF aligned incident form/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
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES – Last reviewed ate March 2025

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 2025 - March 2026)
A person died	0
A person incurred permanent lessening of bodily, sensory,	0

motor, physiologic or intellectual functions	
A person's treatment increased	1
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 saw one incident that resulted in a person's medication increasing for a 2-week period, due to a staff transcribing error. This person was not harmed, though we viewed this error as very serious and took all appropriate action required. We also saw a further two medication transcribing errors, resulting in too low a dose than prescribed. Although again these errors did not result in any harm or adverse effects to the people. We also saw one medication error where a person received another person's prescribed medication – again all appropriate actions were taken and the person was not harmed or suffered any adverse reactions as a result. We also see incidents; however, they do not fit the above criteria. When this occurs 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 coaching, supervision and where necessary consider 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 Whenever we do see incidents that we should have managed or were avoidable, that resulted in harm, we do and will always offer apologies for what went wrong. Apologies will be offered to the person affected and family members.

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 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 Learning from incidents at staff meeting and 1:1 line management sessions, to reduce the risk of this type of incident reoccurring in the future
What learning & improvements have been put in place as a result?	We have an internal QA team who review all incidents on a daily M_F basis and when needed report safeguarding incidents and notify the regulator. These processes strengthen our response to incidents to ensure we minimise risk of a similar event occurring again. In this case the staff members were supported and an internal disciplinary process was identified as an appropriate response. Clear handovers given at the commencement of every shift and all staff clearly aware of their responsibilities whilst on duty. We ensure all our registered nurses are familiar with all medication policies and procedures, and ensure all competencies are undertaken and up to date. Following any medication error we ask nursing staff to complete a reflective account, as to how this happened and what they personally have learned from the incident in order to share this learning we
Did this result is a change / update to your duty of candour policy / procedure?	Not on these occasions.
How did you share lessons learned and who with?	We have reinstated "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 can be 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 system has been built in to/aligned to the PSIRF. Incident management system supports records of huddles/de-briefs and therefore generic lessons learned can be shared wider with other services in the organisation.
Could any further improvements be made?	All staff will receive PSIRF training to the relevant level appropriate to their job roles. Some of this PSIRF training has already been rolled out, others are planned to complete this by end June 2026. As part of our governance process which includes the Duty of Candour, we seek to drive continuous improvement 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 the team to provide an apology as we recognise that this can be a difficult emotional and traumatic experience for some individuals following an incident. As a management team we would be happy to discuss any concerns with staff team on how best to manage and approach this with empathy for the situation for both the individual patients/relatives affected or colleagues.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Yes- the organisation has an 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 1:1 staff supervision. We do look at reflective practice and devise lessons learned from incidents where appropriate. Staff have access to our Employee assistance line, patients and relatives have access to advocacy services.
Please note anything else that you feel may be applicable to report.	