Duty of Candour Annual Report

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:	Stanely Park 35A Stanely Road Paisley PA2 6HJ	
Date of report:	20/04/2022	
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?	Pacific Care implemented the Duty of Candour Policy in May 2018. Staff were provided training via the SSSC online training course and new staff are provided written training material and discussed with providing them with an insight, understanding and discussion around the policy and the background to it. The policy is accessible for all staff from our electronic policy folder. The policy has been included in our mandatory staff training programme. There is a Duty of Candour flow chart to assist staff in the process of decision making and reporting of any potential Duty of Candour Incident. Our Clinical incident reporting form has a Duty of Candour section for staff to complete. This reminds staff to consider if a Duty of Candour incident has occurred.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	

How many times has the 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 2021 - March 2022)
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	**0**

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?	N/A
What lessons did you learn?	N/A
What learning & improvements have been put in place as a result?	N/A
Did this result is a change / update to your duty of candour policy / procedure?	N/A
How did you share lessons learned and who with?	N/A
Could any further improvements be made?	N/A
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?	We have a policy which provides clear written guidance and have provided staff training on the Duty of Candour. Our Senior Management Team can support the staff with 24 hour 7 days a week support in the event this is required.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Staff will be supported immediately by the most relevant senior member of staff on duty, and the home manager, Quality Assurance Manager, or Clinical Director will follow up and provide further support where appropriate. Individuals/families directly affected will be offered support through discussion and reflection. We will organise a team reflective practice session for all staff involved in the incident. If required staff have access to external support systems on request. This can be done anonymously.
Please note anything else that you feel may be applicable to report.	No