Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

NHS SCOTLAND

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:	Botanics Dental Care- 2 Southpark Avenue Glasgow	
Date of report:	3/4/20190	
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?	Duty of candour policy in place, staff training and discussed at team meeting.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	

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 2018 - March 2019)
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?	
Could any further improvements be made?	
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?	**Following identification of an incident a preliminary team discussion will be held,** in determining who will be responsible for communicating with the patient/family/carers, the individual should: • Have a good relationship with the patient and/or their carers • Have a good understanding of the relevant facts • Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to patients, carers and colleagues • Have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand • Be willing and able to offer an apology, reassurance and feedback to patients and/or their carers • Be able to maintain a relationship with the patient and/or their carer and to provide continued support and information • Be culturally aware and informed about the specific needs of the patients/relatives or their carers
What support do you have available for people involved in invoking the procedure and those who might be affected?	• Patients, their family/carers should be provided with support as is necessary during the process of "Being Open". At any face to face meeting, they should be encouraged to be accompanied by another family member/friend/representative. Where appropriate, an independent advocate or interpreter should be offered. The patient is also at liberty to request a second or independent review and this should be facilitated. Information on how patients can access additional support services and other relevant bodies should be offered. External bodies which may be able to produce support for the patient:ICAS – Independent Complaints Advocacy Services

	• CRUSE (bereavement counselling support) • Relevant charitable organisations
Please note anything else that you feel may be applicable to report.	