

## **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:	Altruderm Minor Surgery & Aesthetic Clinic, Kirkhill House, Building 2, 81 Broom Road East, Newton Mearns, Glasgow, G77 5LL	
Date of report:	1 <sup>st</sup> May 2022	
How have you made sure that you (and your staff) understand your	Yes.	
responsibilities relating to the duty of candour and have systems in place to respond effectively?	We have a 'Duty of candour and being open' policy which is regularly reviewed.	
How have you done this?	Staff undergo NES E-Learning Module 'Duty of Candour' training.	
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	Number of times this has happened	
course of someone's illness or underlying conditions)	(May 2022 - May 2023)	
A person died	0	
A person incurred permanent lessening of bodily, sensory,	0	
motor, physiologic or intellectual functions		
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	0	
for 28 days or more		
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	0	
as listed above		
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?	NA
What lessons did you learn?	NA
What learning & improvements have been put in place as a result?	NA
Did this result is a change / update to your duty of candour policy / procedure?	NA
How did you share lessons learned and who with?	NA
Could any further improvements be made?	NA
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?	Person-centred care is at the heart of Altruderm's daily practice and is underpinned by our 'Person-centred Care' Policy which is reviewed annually.  We have a procedure in place, embedded within our 'Duty of Candour and Being Open' Policy for offering an apology to patients for any harm that has resulted from a patient safety incident occurring at Altruderm.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Clear guidance on how to trigger any duty of candour incidences and confirmation that anyone invoking the procedure will be supported in so doing.
Please note anything else that you feel may be applicable to report.	NA