# 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.

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| Name & address of service: | Highland Hospice, 1 Bishop's Road, Inverness, IV3 5SB | |
| Date of report: | 1 April 2024 – 31 March 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?<br><br>How have you done this? | Highland Hospice published its Duty of Candour policy in June 2018 following extensive discussion with key staff. The policy is now considered and discussed at each of our monthly quality engagement group meetings and incidents are now reviewed in a weekly IPU huddle to ensure that immediate learning is taken and duty of candour responsibilities are considered, emails regarding online training and the policy have also been circulated. All clinical staff are aware that the policy follows the guidelines used for any incident affecting patients/carers i.e. informing/apologising but the need to escalate for incidents of a more serious nature is understood and accepted. | |
| 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? | |
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| 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 - March2022) |
| 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 |

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| Did the responsible person for triggering duty of candour appropriately follow the procedure?<br><br>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? | The Senior Management Team provide 24/7 on call rota. The on call member of the management team would support staff following a reportable incident and ensure follow up with staff as required. |
| What support do you have available for people involved in invoking the procedure and those who might be affected? | Our Supportive Care Team continue to provide support/counselling to staff as well as patients/families if required. Reflective sessions are arranged to include all staff involved in significant incidents, this is facilitated by one of the supportive care team and a senior member of staff. |
| Please note anything else that you feel may be applicable to report. | We have introduced weekly and monthly processes to help us consider the responsibility of duty of candour. |