Duty of Candour Annual Report Template

Every healthcare professional must be open and honest with service users when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the person, apologise, offer appropriate remedy or support and fully explain the effects to the person.
As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered duty of Candour within our service.

Name & address of service:

Jura Health Limited

Friarton House

Friarton Road

Perth PH2 8BB

Date of report:

20th December 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?

Jura Health's Duty of Candour policy was created, written and developed by the Directors and senior clinical and administration staff. The policy informs all Jura Health staff of their roles and responsibilities relating to the Duty of Candour, the culture of candour and their responsibilities relating to this. About being open, honest and transparent with clients. About apologising should something not be the gold standard expected by all. By taking any distress or harm caused by staff and examining what went wrong and changing policy and practice accordingly. Jura Health fully support the Duty of Candour and culture of candour as a prerequisite to improving quality and safety of service and client experience.

How have you done this?

The Duty of Candour policy is circulated to all staff and is available to the staff within the policy folder. It is included in the induction programme.

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 21 - March 31)*

A person died: ***None***

A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions: ***None***

A person's treatment increased: ***None***

The structure of a person's body changed: ***None***

A person's life expectancy shortened: ***None***

A person's sensory, motor or intellectual functions was impaired

for 28 days or more: ***None***

A person experienced pain or psychological harm for 28 days or more: ***None***

A person needed health treatment in order to prevent them dying: ***None***

A person needing health treatment in order to prevent other injuries as listed above: ***None***

Total ***Zero***

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?

What lessons did you learn?

What learning & improvements have been put in place as a result?

Did this result is a change / update to your duty of candour policy / procedure?

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?

What support do you have available for people involved in invoking the procedure and those who might be affected?

Please note anything else that you feel may be applicable to report.