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 cause, 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 triggered duty of Candour within our services.

Name and address of services	**Cygnet Healthcare** Trinity House – Lockerbie Ranaich House – Dunblane Thistle Care Home – Dundee Lindsay House – Dundee Ellen Mhor – Dundee Wallace Hospital - Dundee	
Date of report	25/01/22	
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?	The values and attitude of Care, Respect, Empower, Trust and Integrity underpin the founding principles of Cygnet Healthcare. Staff are aware of the importance of their duty of Candour through the development, training and implementation of Cygnet Healthcare policy. Duty of Candour underpins our communication with service users, families, local authorities, regulators and guardians, following every incident, whether it requires implementation or not. Staff complete the Duty of Candour module on Achieve and are introduced to the process from the moment of induction to the organisation, additionally the Care Inspectorate provide an online training module for all staff to complete. Cygnet has an online web-based Incident Management System (IMS) for the reporting and management of incidents. Within IMS, Duty of Candour is also embedded.	
Do you have a Duty of Candour Policy or written Duty of Candour procedure?	Yes	No

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 (January 2021 – December 2021)
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 in any under or over reporting of Duty of Candour?	N/A - there have been no instances of implementing Duty of Candour in the above-noted circumstances. However, all healthcare professionals have a professional responsibility to report incidents, be honest and communicate effectively when things may go wrong.
What lessons did you learn?	N/A – there are no incidents to report. However, following any incident a review is completed on IMS and where applicable an investigation is carried out. As an outcome of incident reviews, the risk assessments and care plans are updated as appropriate
What learning and improvements have been put in place as a result?	N/A – Where applicable continual learning from each incident is shared within services and corporately to ensure improvements are made
Did this result in a change/update to your Duty of Candour policy/procedure	N/A – All policies are reviewed and updated regularly and as required
How did you share lessons learned and who with?	N/A - All lessons learned are shared within each service during staff meetings, there is a wider care governance meeting for all managers of the services, there is also a lesson learnt meeting for corporate learning and larger governance meetings for Directors and the board. The information is cascaded through e-mail and internal communications. Cygnet has a Lessons Learnt site within the Cygnet intranet for all staff to access and view recent and historic lesson learnt bulletins, videos and lessons learnt emails.
Could any further improvements be made?	None that has been raised or proven a barrier to the care delivery of service users
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 policy, the person providing an apology and the investigation is a qualified nurse, this person is supported by their line manager through supervision both clinical and managerial. The Nursing and Clinical Directorate also provides support throughout the process. There are templates in place to assist the investigating officer to ensure the person is kept at the centre of the Duty of Candour investigation. Investigators are also trained in RCA methodology and a part of this training includes Duty of Candour responsibilities.
What support do you have available for people involved in invoking the procedure and those who might be affected?	The people involved in the process will be provided with a person to contact for questions and updates, this includes support. The service user and their families would be signposted to support networks both within the company and externally for example advocacy services
Please note anything else that you feel may be applicable to the report.	The process will continue to be reviewed and updated. Lessons' learnt will continue to be shared and the training and development of the staff involved in the Duty of Candour process will continue to ensure Cygnet Healthcare are providing a high level of quality care and support to the individuals they are trusted to care for