Duty Of candour April 2021 – April 2022

Name & address of service:	Nuffield Health Glasgow Hospital	
Date of report:	31st March 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? How have you done this?	Duty of Candour information available from professional bodies promoted within the theatre department Duty of candour as a consideration prompt in Datix Duty of Candour process followed and discussed as lessons learned in each department when incidents occur Feedback incorporating the principles of Duty of Candour	
Do you have a Duty of Candour Policy or written duty of candour procedure?	**YES** Nuffield Corporate Policy Reference Guide Health Improvement Scotland Duty of Candour Resource Materials	NO

How many times have you/your service implemented the duty of candour procedure this financial year April - April?	
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 – March 2022)
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	
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	1
A person needing health treatment in order to prevent other injuries as listed above	0
Total	1

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?	Medical advisory Committee discussion and review. Debrief Independent review by Resuscitation Officer Patient meeting with Hospital Director, Matron, Patient, Patients friend and Consultant Surgeon Letter sent to patient regarding Duty of Candour Apology offered by Consultant surgeon for the complications patient suffered

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What lessons did you learn?	Lack of knowledge amongst all staff groups regarding Haematology Consultant on call support service Review of major haemorrhage protocol
What learning & improvements have been put in place as a result?	Promotion of staff wellbeing link role Promotion of wellbeing materials for staff Promotion of Wellbeing Hub
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	Debrief Medical Advisory Group forum Team meetings Staff debrief Patient meeting
Could any further improvements be made?	Further staff education regarding Duty of Candour and professional responsibilities Further
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?	Debrief Transparent culture of quality improvement and promotion of lessons learned Line management support Matron support Signpost to wellbeing resources Wellbeing link practitioner support Medical Advisory Group Consultant support
What support do you have available for people involved in invoking the procedure and those who might be affected?	Occupational Health services / self-referral or line manager referral Employee Assist Programme Informal support for staff debrief and clinical supervision from CBT practitioners Onsite wellbeing support link team members Wellbeing Hub with online information and resources
Please note anything else that you feel may be applicable to report.	Consent of good quality outlining the risks of surgery which patient acknowledged during the conversations with the Consultant Surgeon regarding accepted complications of surgery experienced