Marie Curie Hospice Glasgow & Scotland North & West Community Services

Duty of Candour Annual Report April 25- March 26

What is Duty of Candour?

Marie Curie has always been committed to being open and honest with patients and families about all aspects of their care and treatment and to work in partnership in all decision making.

Duty of Candour is a legal duty for all healthcare providers. It means that when something goes wrong with treatment or care which leads to harm or distress, or has the potential to do so, we have a duty to be open and honest with patients and where appropriate their families.

When something goes wrong which leads to harm or distress, we will:

- Take time to tell the patient about what has happened at the earliest opportunity and offer an apology
- Explain any anticipated effects and answer any questions
- Take all possible steps to remedy any impact
- Investigate the incident so that we can learn from it
- Offer a meeting where we can share the outcome of the investigation and address any outstanding issues
- Offer a written summary of the events
- We will involve family/significant others in this process where this is the patient's wish

As part of our responsibilities, we publish an annual report in order to provide public assurance and demonstrate a commitment to learning and improvement. The report will include:

1) information about the number and nature of incidents to which the duty has applied

2) an assessment of how effectively the duty of candour has been carried out

3) information about organisational processes for identifying and reporting incidents

4) the support available to the patient, families, staff and others affected by any incidents.

5) other information e.g. learning and improvement from incidents and how the learning has been disseminated

Marie Curie is a registered charity in England and Wales (207994) and Scotland (SC038731).
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Registered Office: One Embassy Gardens, 8 Viaduct Gardens, London, SW11 7BW.

Name & address of service:	**Marie Curie Hospice Glasgow** & **Marie Curie Nurse Agency & Care at Home North & West Scotland** (Argyll & Bute, Grampian, Greater Glasgow & Clyde, Highland & Islands) 133, Balornock Road Glasgow G21 3US
Date of report:	24th April 26
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 requirements are embedded in our operational policies, including incident reporting and management policy. All clinical staff are required to complete Duty of Candour e-learning module which includes- Describes what Duty of Candour is, identifies incident which are covered by Duty of Candour, how to give an effective apology when needed, Marie Curie Duty of Candour policy and procedures if staff are involved in a Duty of Candour incident. All managers are required to complete a face-to-face Incident Investigation Training Workshop which includes Duty of Candour training and processes. All senior managers are required to complete external Patient Safety Incident Response Framework training or equivalent. Incident monitoring and analysis is undertaken by North & West/ Scottish clinical governance groups. Organisational oversight and shared learning via Safety Learning Panels. Monthly learning through incidents and complaints sessions open to all Marie Curie staff across Scotland to ensure learning is cascaded effectively. Duty of Candour embedded in Scotland clinical training and education programme.
Do you have a Duty of Candour Policy or written duty of candour procedure?	Yes

Marie Curie Glasgow Hospice

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 25 - March 26)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0

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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**

Marie Curie Nurse Agency & Care at Home Services North & West Scotland	
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 25 - March 26)
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	1
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	**1**

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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?	Apology given and Duty of Candour letters issued. Incident was reported to regulator and full investigation completed. Learning discussed at Marie Quality oversight group

What lessons did you learn?	Patient fell from bed, reviewed by paramedics however not transferred for investigations due to phase of illness. Fracture suspected due to slight rotation, no increased analgesic requirements following the fall, Patient and family had requested staff member was not present in the patient's bedroom overnight. Marie Curie staff member sat in an adjacent room and monitored the patient every 15minutes. Care and support was clearly documented, and risks in relation to falls was discussed and documented and person-centred care was delivered.
What learning & improvements have been put in place as a result?	All risk assessments completed, challenging to balance patient choice and patient safety. Ongoing risk-based conversations utilising realistic medicine framework to ensure risks are fully understood by patients and families.
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	Clinical & Operational Governance Groups. Report Summary of Learning shared at team meetings. Scotland wide Learning via team meetings. Clinical Update Days.

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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?	E-learning regarding How to apologise well. Communication Skills and Advanced Communication Skills Training. Fall reductions training Career Development and Progression Framework and Personal Development Plans including shadowing opportunities.
What support do you have available for people involved in invoking the procedure and those who might be affected?	For patients and their families, we have written information and resources available. Patients and families also have access to a range of Marie Curie healthcare professionals for support. A lead clinician would be identified in the event of a Duty of Candour incident to support patient and families affected. For our staff and volunteers, we have a range of support available including policies and procedures, accessible line management, HR support, occupational health, clinical supervision, and staff counselling.
Please note anything else that you feel may be applicable to report.	N/A

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