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| Name & address of service: | Kilbryde HospiceMcGuinness Way East Kilbride G75 8GJ  |
| Date of report: | 1/4/23  |
| 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 Kilbryde Hospice senior nursing team attended training facilitated by NES in readiness for the new legislation on 1st April 2018. All registered nursing staff completed Duty of Candour on-line education as core mandatory modules. Duty of Candour policy initially drafted in April 2018, reviewed in Dec 2022 and again in Dec 2023. All registered nursing staff and senior managers sign off they have read and understood the policy via People HRMaster Clinical Incident Reporting Form Appendix 1 explains Duty of Candour process and when to trigger. All registered nursing, medical and AHP staff have awareness of when the process is triggered.  |
| Do you have a Duty of Candour Policy or written duty of candour procedure? | YES |  |

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| 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 22 – March 23) |
| A person died |  |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic, or intellectual functions |  |
| A person’s treatment increased | X 2 (Nov 22)  |
| The structure of a person’s body changed |  |
| A person’s life expectancy shortened |  |
| A person’s sensory, motor or intellectual functions was impaired for 28 days or more |  |
| A person experienced pain or psychological harm for 28 days or more |  |
| A person needed health treatment to prevent them dying |  |
| A person needing health treatment in order to prevent other injuries as listed above |  |
| **Total** | 2 |

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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? | YES  |
| What lessons did you learn? | Duty of Candour incident 1 (Nov 22). Fall sustaining a laceration. * Staff to remain with agitated patient and request assistance rather than leave patient alone.
* Reminder to all staff to complete NHS Lanarkshire Falls Awareness Learnpro module.
* All risk assessment and documentation completed accurately and appropriately and in a timely manner.

Duty of Candour incident 2. (Nov 22). Ungradable pressure ulcer acquired on admission. * PURA to be completed within 8hr of admission.
* Training to be provided to help recognise deep tissue damage as patient was admitted on the 16/11/22 and pressure ulcer was noted 23/11/22.
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| What learning & improvements have been put in place as a result? | As above  |
| Did this result is a change / update to your duty of candour policy / procedure? | More explanation added to the Duty of Candour categories on Clinical Incident Reporting Forms  |
| How did you share lessons learned and who with?  | Duty of Candour investigations reported externally to Healthcare Improvement Scotland, South Lanarkshire Health & Social Care Partnership and internally to Kilbryde Hospice Board of Directors and Clinical Governance Committee (Feb 23)  |
| 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? | Explanation is given of Duty of Candour process in Clinical Incident Reporting form as below. |
| What support do you have available for people involved in invoking the procedure and those who might be affected? | Peer support following incident, debrief if required, support from Band 6 & 7 nursing staff, support from spiritual care team and access to PAM Assist (Employee Assistance Scheme)  |
| Please note anything else that you feel may be applicable to report.  |  |