Duty of Candour Report April 23- March 24

Name & address of service:	Kilbryde Hospice McGuinness Way East Kilbride G75 8GJ	
Date of report:	4/4/24	
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 HR Clinical Incident Reporting via Datix signifies Duty of Candour trigger Kilbryde Hospice Incident Escalation Policy evidence Duty of Candour 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	

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 23 – March 24)
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic, or intellectual functions	
A person's treatment increased	
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	Zero

Did the responsible person for triggering duty of candour appropriately follow the procedure?	N/A

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If not, did this result is any under or over reporting of duty of candour?	
What lessons did you learn?	N/A
What learning & improvements have been put in place as a result?	N/A
Did this result is a change / update to your duty of candour policy / procedure?	N/A
How did you share lessons learned and who with?	N/A
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?	N/A
What support do you have available for people involved in invoking the procedure and those who might be affected?	N/A
Please note anything else that you feel may be applicable to report.	Nil