**Dr Roz Aesthetics Duty of Candour Annual Report 2021**

 Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, 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 trigger duty of Candour within our service.

Name & address of service: Dr Roz Aesthetics, Tribune Court, 2 Roman Road, Bearsden, G61 2SW

Date of report: September 2021

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? As a sole practitioner in this service it is vital I have a thorough understanding of the Duty of Candour. In my other full time role I am a Principal GP Partner and responsible for the teaching and training of undergraduate Glasgow University Medical Students and trainee GPs. Through the process of being responsible for clinical governance in this role and then having to educate others in it I have developed a good understanding of the process and responsibilities relating to duty of candour.

How have you done this? As a doctor I have been involved in audit, complaints, significant/learning event analysis, QI projects, appraisal and revalidation. I am an Education Supervisor for GP trainees. I have also read *Good Medical Practice* which outlines the duty of candour and the *Raising and acting concerns about patient safety* and used them as topics for tutorials to educate GP trainees.

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 20 - March 21)** |
| 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? N/A

If not, did this result is any under or over reporting of duty of candour? N/A

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? I would share the lessons with my network of other practitioners in cma collaboration and with other practitioners I have working relationships with. I would also discuss it with my indemnity providers the MDDUS.

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? The patient would be contacted and asked if they could come into the clinic (presuming there are no restrictions due to the pandemic). They would also be given options of a video call, phone call, email or letter. If they are coming into the clinic they would be offered to have a friend or family member present. They will be have the opportunity to ask questions after an apology and a thorough explanation given.

What support do you have available for people involved in invoking the procedure and those who might be affected? I would seek support from my professional network and MDDUS.

The patient would be offered written information about the incident and reassured there is always opportunity to come back and ask questions. The complaints procedure will be discussed with them and information on how to call HIS if they wish to report the event or involve them.

Please note anything else that you feel may be applicable to report.