Ardach Health Centre Duty of Candour Annual Report 2018/19

1. Introduction

All health and social care services in Scotland have a duty of candour (D of C). This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the regulations, the people affected understand what has happened, receive an apology, and are informed by the organisation what has been learned and how improvements for the future will be made.

An important part of this duty is that we publish an annual report which describes how Ardach Health Centre has operated the duty of candour procedures during the time between 1 April 2018 and 31 March 2019.

2. About Ardach Health Centre

Ardach Health Centre serves a population of 9200 people across the Buckie Locality ranging from Spey Bay to Cullen .

Our aim is to provide high quality care for every person who uses our services.

3. How many incidents happened to which the duty of candour applies?

Between 1 April 2018 and 31 March 2019, there were no incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition. Ardach Health Centre sought to identify these incidents through our Significant Event management procedures. Over the time period for this report we carried out and concluded several significant event analyses. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm. Significant event analyses (SEA) are also undertaken where there is no harm to patients or service users, but there has been a significant impact to service or care delivery; in some cases, this may be a positive impact that we seek to exploit formally through a process of change.

We identify through the SEA process if there were factors that may have caused or contributed to the event, which helps to identify D of C incidents.

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Type of unexpected or unintended incident (not related to the natural course if someone's illness or underlying condition)	**Number of times this happened (between 1 April 2018 and 31 March 2019)**
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A persons treatment increased	0
The structure of a person's body changed	0
A persons life expectancy shortened	0
A persons sensory, motor or intellectual function was impaired for 28 days or more	0
A person experienced pain or psychological	0

harm for 28days or more	
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

4. To what extend did Ardach Health Centre follow the duty of candour procedure

As is often the case, the practice learns about any event above via a complaint or feedback, rather than identifying an incident independently; such as, it doesn't fall completely within the scope of duty of candour but will be included in this Annual reporting for transparency. When we are informed about any event, we follow the correct procedure. This means we would inform the people affected; apologise to them; offer to meet with them; review what happened and what could have been done better and feedback any findings to the people affected if this was their wish.

5. Information about our policies and procedures

Every SEA event is reported through our local reporting system as set out in our management procedures. Through these procedures we can identify incidents that trigger the duty of candour procedure.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning.

Recommendations are made as part of the adverse event review, and Senior Partner takes action to implement these recommendations. These are followed up until conclusion.

Staff receive training on adverse event management and incident reporting as part of their induction. Duty of Candour training has taken place at a practice educational meeting which highlighted the procedures for escalating cases which have the potential to meet D of C.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our Practice Manager.

6. What has changed as a result?

We would consider a number of changes following review of adverse events which have been identified as meeting the criteria of Duty of Candour. For example these could include SEA process changes to force consideration of Duty of Candour at an early stage alongside briefing/ education of all or specific teams.

7. Other Information

This is the first year of Duty of Candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the organisational duty of candour requirements. Initially, we understood it to be a secondary care (Hospital) requirement but as the year progressed we got a better understanding of primary care (Community) responsibilities. We have taken steps to address any shortfall and in particular create procedures to proactively report / record events that may occur, rather than waiting for a complaint or an incident or take place.

If you would like more information about this report, please contact

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