Duty of Candour Annual Report

Emma J Aesthetics (Highland Medical Aesthetics Ltd)

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:	Emma J Aesthetics (Highland Medical Aesthetics Ltd) 6 Ardross Terrace Inverness IV3 5NQ	
Date of report:	March 25	
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 was formally introduced in 2019; patients suffering a significant lasting injury or side effect from treatment can expect a full and sincere apology from the organisation without any acceptance of "guilt" which will not prejudice any further investigations or subsequent legal case. Both Miss Lowe & Dr Elder have undergone specific training both in their NHS employed posts and using the on-line training module. All new staff with significant managerial responsibility will complete the module as part of their initial training	
Do you have a Duty of Candour Policy or written duty of candour procedure?	**YES**	~~NO~~

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 (January 23 – December 23)
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? 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?	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?	Either of the directors will be personally involved in any apology; Support from our clinical defence organisations on the nature & detail will always be obtained – however will not delay or inhibit the offering of apology when things go wrong.
What support do you have available for people involved in invoking the procedure and those who might be affected?	We have a comprehensive complaints policy in place – the policy points complainants who feel they are unable to complain directly to us to HIS for further help & assistance.
Please note anything else that you feel may be applicable to report.	n/a