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| **DUTY OF CANDOUR REPORT**  **FEBRUARY 2024 TO MARCH 2025** |

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| **Version**: As dated | **Author**: Dr Heather McCallum |
| **Issue Date**: As dated | **Review Date**: Annually |

**1.0 Introduction**

This is the annual Duty of Candour report by SkinGenius Private GP and Medical Aesthetics Limited, “SkinGenius”.

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or if care causes, or has the potential to cause, harm or distress.

Accordingly SkinGenius must:

1. Tell the patient;
2. Apologise;
3. Offer appropriate remedy or support; and
4. Fully explain the effects to the patient.

As part of our responsibilities, SkinGenius must produce an annual report to provide a summary of the number of times we have triggered a Duty of Candour (DoC) within our service.

**2.0 The Report**

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| Name and Address of Service: | SkinGenius Medical Aesthetics, Kirkcaldy. |
| Date of Report: |  |
| 1. How have you made sure that you (and your staff) understand your responsibilities relating to the DoC and have systems in place to respond effectively? 2. How have you done this? | * DoC is written within section 6.11 of the reporting and management of incidents policy. |
| Do you have a DoC Policy or written DoC procedure? | Yes |

**How many times have you/your service implemented the DoC procedure this financial year?**

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| **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**  **(Feb 2024 - Mar 2025)** |
| 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** |

**Organisational Learning**

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| Did the responsible person for triggering DoC appropriately follow the procedure?  If not, did this result is any under or over reporting of DoC? | N/A |
| What lessons did you learn? | N/A |
| What learning and improvements have been put in place as a result? | N/A |
| Did this result in a change/update to your DoC 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? | * We have not had any incidents or issues that have involved DoC. * Our reporting system picks up if any incidents are reportable and this cascades into our quality governance reporting. * DoC is part of our overall approach to managing incidents and integral to our approach and builds on our being open framework. * Staff would be supported by a senior manager and all apologies would be offered verbally and in-person and ideally involve the clinician if appropriate. |
| 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. | N/A |