# KILDRUM MEDICAL PRACTICE

## Kildrum Health Centre

Lochlea Road

Cumbernauld G67 2ES

**Duty of Candour Report 2019**

All health and social care services in Scotland have a duty of candour. In addition to a professional duty of candour, this is a legal requirement which means that when unintended or unexpected adverse events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report describes how Kildrum Medical Practice has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

**1. About Kildrum Medical Practice**

Kildrum Medical Practice serves a population of 5434 people in Cumbernauld. The practice has 3 partner GPs, an ANP and Practice Nurse and are supported by a loyal hardworking admin team, a part time pharmacist, centralised treatment room and phlebotomy we also have SAMH input. Our aim is to provide high quality care for every person who uses our services, and where possible help people to receive care at home.

**2. 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. Such incidents are unintended or unexpected events 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.

|  |  |
| --- | --- |
| Type of unexpected or unintended incident (not related to the natural course of 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 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** |

**3. To what extent did Kildrum Medical Practice follow the duty of candour procedure?**

We actively sought out cases to which a Duty of Candour might apply but did not find any. To this extent we were fully compliant with the duty of candour procedure.

**4. Information about our policies and procedures**

Where something has happened that has the potential to trigger duty of candour, our staff report this to the Practice Manager who has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, the manager sets up a learning review. This allows everyone involved to review what happened and identify changes for the future.

All new staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as patients and their families.

Kildrum Medical Practice identifies such incidents through our adverse event management process. We regularly carry out significant adverse event reviews. 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.

We would hope to identify through the significant adverse event review process any factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

**5. What has changed as a result?**

We have not identified any Duty of Candour events this year and so there are no resulting changes to report.

**6. Other information**

This is the first year of the 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 duty of candour outcomes.

As required, we have submitted this report to Scottish Ministers and we have also placed it on our website.

If you would like more information about this report, please contact us using these details:

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