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Consultations by Appointment Only

Cove Bay & Kincorth Medical Practice

Duty of Candour Annual Report – April 2022

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, 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 the duty of candour in our services. This short report describes how our care service has operated the duty of candour during the time between 1 April 2021 and 31 March 2022. We hope you find this report useful.

1. How many incidents happened to which the duty of candour applies?
In the last year, there has been 1 incident to which the duty of candour applied. We feel that our responsible persons carried out all the required elements of the duty which included a full internal review and a subsequent written summary to the patient involved. We offered our sincere apologies to the patient both verbally at the time the mistake was discovered and also consequently in writing. A meeting was also offered to the patient to discuss things further. As result of this incident, we initiated a quality improvement exercise to remind all administrative staff of the standard operating procedures for dealing with results. This includes doing a monthly audit of a random selection of results to check that results have been actioned appropriately. We also shared our experiences with NHS Grampian to encourage wider shared learning.

2. Information about our policies and procedures
Where something has happened that triggers the duty of candour, our staff report this to the Practice Manager or Executive GP Partner who have responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to NHS Grampian. When an incident has happened, the manager and team members involved set up a learning review. This allows everyone involved to review what happened and identify changes for the future.
All new clinical staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as people who use our services and their families. We have occupational welfare support in place for our staff if they have been affected by a duty of candour incident.

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If you would like more information about our practice, please contact us using the details above and ask for the Practice Manager.