Ultrasound Direct Aberdeen

Duty of Candour Annual Report
1st January 2024-31st Dec 2024

Ultrasound Direct Clinic:	Aberdeen
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DUTY OF CANDOUR REPORT

Overview

All health and social care services in Scotland have a duty of candour. This is a legal requirement, which means that when unintended or unexpected events happen that result in death or harm as defined in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

The regulation makes it a statutory requirement that health service providers act in an open and honest way to patients, and their families or carers, should their care not go to plan, and harm was caused to the patient as a result.

An important part of this duty is that Ultrasound Direct Aberdeen provides an annual report about how the duty of candour is implemented in our services.

Report

This report describes how Ultrasound Direct Aberdeen has discharged the Duty of Candour approach during the time between 1st January 2024 to 31st December 2024.

It is worthwhile noting that Ultrasound Direct Aberdeen may often only play a small part in the patient's full journey of care. While impact or outcomes are not always known, where opportunities for learning and improvements are identified through our adverse event process or following feedback from other health and social care services, these will be addressed.

Background - Ultrasound Direct Aberdeen

Ultrasound-Direct Aberdeen is a private ultrasound service provider. We provide clients age 16+ with access to private self-referral scanning and

blood services. Clients can access our services 24/7 via our webpage, www.Ultrasound-Direct.com or by calling us during business hours.

How many incidents happened to which the Duty of Candour applies?

Between 1st Jan 2024 to 31st Dec 2024 we had 0 incidents where the duty of candour was applied.

What processes are in place to identify and report unexpected or unintended incidents that may require activation of the duty of candour procedure?

As soon as a patient safety event is identified where harm has occurred, the priority is to ensure appropriate clinical care is provided and action taken to prevent further harm. All adverse events and near misses are reported.

Adverse events are sometimes picked up through our complaints process or through communication from the NHS or the client. Our Duty of Candour policy along with any associated procedures contain guidance on activating the organisational Duty of Candour where applicable.

Compliance with any adverse event is recorded, and the level of review applied depends on the severity of the event as well as the potential for learning.

All events (including near misses), are reviewed to understand what happened and how we might learn from and improve the care and services we provide in the future. However, beyond the Duty applied within the Act, we apply the principles of open, honest and transparent communication when reviewing clinical events and incidents. This means that although an event may not trigger the formal Duty of Candour, we still invoke the "spirit" of the Act when communicating with patients and their families.

Recommendations are made as part of all adverse event reviews and the local team develops improvement plans to meet these. Duty of Candour cases are subject to a more formal review.

What support is available to staff who are involved in unintended or unexpected incidents resulting or could result in harm or death?

Ultrasound Direct Aberdeen has a commitment to all staff who are involved in an adverse event to ensure that they are offered support at a time and in a way that meets their needs. Staff involved in an adverse event may be physically and / or psychologically affected by what has happened. Line managers have a responsibility to check in with their staff and help to identify appropriate support for individuals and teams. This may include:

- protected time for a staff member to prepare information as part of an adverse event to discuss any ongoing concerns they have.
- Access to their peer group to discuss any issues they may be experiencing.
- Counselling via our Employee Assistance Program
- Additional training via the Regional Managers

What changes, learning and/or improvements to services and patient outcomes can you identify as a result of THE "NEAR MISS"?

Some examples of the LEARNING OUTCOMES are highlighted below:

- If we were to identify a near miss or have learning outcomes as a result of an incident then the learning outcomes would reflect on what did not go well and how we can prevent it from occurring in the future.
- We may implement change where necessary to our service, clinic or staff training
- We may offer further training or additional support to staff via outsourcing a training module or through our Ultrasound School

Ultrasound Direct Aberdeen is an ever learning an evolving business that puts its clients at the forefront of all it does.