Duty of Candour Policy

Hebridean Aesthetics

Date Effective:	31/05/2021
Review Date:	31/05/2023
Version No:	1
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1. Reason for Policy

Hebridean Aesthetics has a duty to be open and honest with patients when something goes wrong with their treatment or care.

2. Policy Statement and Aims

In order to minimise the risk of something going wrong the owners will fully discuss the proposed treatment, explain the risks and provide information as to whether the risk occurs often or a very low risk of complication. Patients will also be offered an alternative treatment and the risks of this will also be explained.

3. Scope

This policy applies to all service users.

4. Procedure

In the event that something goes wrong with a patient treated at Hebridean Aesthetics, at the time of treatment or as a result of treatment the owners will:

- Tell the patient something has gone wrong and discuss what has happened; this will be occur as soon as possible after it is clear something has gone wrong and all information regarding what has happened and why and what the expected consequences are will be explained.
- Apologise to the patient that something has gone wrong: when apologising to the patient the owners will give the patient the information they want or need in a way that they understand; the information will be given sensitively and in private.
- Explain and discuss the long and short-term effects of what has happened.
- Where possible offer a solution to rectify the problem; if it is not possible for the practitioner to provide a solution the patient will be referred to a fellow professional for consultation and support for both the patient and practitioner.

5. Reporting

Hebridean Aesthetics have a duty to report incidents if something has gone wrong with a patient's treatment. Following an incident, the owner will document and self-reflect on the incident and seek further peer review, advice and support in order to manage, resolve and learn from the experience. If indicated, a plan shall be implemented in regards to learning outcomes and further care planning and or management.

If the incident is as a result of an adverse drug reaction or a medical device this will be reported to the MHRA using the yellow card system. The date, time and nature of the incident will be documented in the patient's notes.

6. References

References: Nursing and Midwifery Council(2015) The code: Professional standards of practice and behaviour for nurses and midwives available at www.nmc.org/code sections 4.2,14, 23

Scottish Patient Safety Programme; www.scottishpatientsafetyprogramme.scot.nhs.uk

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