Duty of Candour Annual Report 2025

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have trigger duty of Candour within our service.

Name & address of service:	Eaton Aesthetics; Crombie Road, Crombie House, AB11 9QP	
Date of report:	19/09/2025	
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?	We have ensured that all practitioners working with Eaton Health Services are aware of their responsibilities under the Duty of Candour through induction, policy documents, and regular governance discussions. The Director and clinical team review incidents openly and use reflective practice to embed learning. A Duty of Candour policy is in place, supported by clear reporting procedures, and staff are encouraged to be transparent and proactive in communicating with patients when something goes wrong.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	~~NO~~

How many times have you/your service implemented the duty of candour procedure this financial year?	
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 (April XX - March XX)
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	1
Total	0

Did the responsible person for triggering duty of candour appropriately follow the procedure?	Yes

If not, did this result is any under or over reporting of duty of candour?	
What lessons did you learn?	I learned that systemic barriers still exist between private aesthetics and NHS services, which can delay escalation of complications. I also recognised the importance of always having a reliable backup prescribing method, and that even small refinements in aseptic technique can further reduce risk.
What learning & improvements have been put in place as a result?	□ Introduced paper prescription pads alongside digital prescribing to avoid delays. □ Updated aseptic practice to include pre-treatment mouthwash rinses for lip and marionette procedures. □ Established formal contacts with local ENT/plastics and Glasgow colleagues for escalation.
Did this result is a change / update to your duty of candour policy / procedure?	No — this incident did not result in a change to the Duty of Candour policy, but it reinforced the importance of continuing to follow the existing procedures, which already support openness, transparency, and patient-centred communication.
How did you share lessons learned and who with?	Lessons were shared with colleagues in aesthetics during reflective discussions. I also discussed the case with the treating nurse to ensure consistent learning and future preparedness.
Could any further improvements be made?	Yes — further advocacy is needed for a bridging system between private and NHS services, so that complications can be escalated safely without adding burden to emergency care.
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?	Staff are guided to use clear, compassionate communication and to explain what has happened, what is being done, and what support is available. We emphasise empathy, listening, and ensuring patients feel cared for throughout.
What support do you have available for people involved in invoking the procedure and those who might be affected?	□ Staff support is provided through debrief discussions and reflective supervision. □ Patients are given ongoing access to the director or treating nurse, regular reviews, and clear escalation options. □ Where needed, referral to specialist services is arranged promptly.
Please note anything else that you feel may be applicable to report.	This case reinforced patient trust in our service, as the patient expressed confidence in the way her care was managed despite challenges. It also strengthened our governance systems, creating reassurance that lessons are actively learned and improvements embedded.