

South Ayrshire Council- Educational Services

Duty of Candour for services registered with the Care Inspectorate– Draft

The new duty of candour came into effect on 1 April 2018. It affects all health & social care services except child minders. It means that services must take specific steps to carry out their duty of candour when an unintended or unexpected incident has occurred and that has resulted in harm. Services will need to let those affected know, offer to meet with them, and apologise. This is an important part of being open with people who experience care, and also learning from things that go wrong.

Starting from next year, April 2019, health and social care services must, by law, produce a short annual report showing the learning from their duty of candour incidents that year, publish it, and notify Care Inspectorate that it has been published. That means the first annual report your service produces will cover the period April 2018 to April 2019. (Appendix A – sample Report format)

Regulations and guidance about the duty of candour process has been issued by the Scottish Government and you can find it here: <http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour>. It has also issued a guidance letter, which you can read here: http://www.careinspectorate.com/images/Duty_of_Candour_Guidance_Letter.pdf. An online learning module is available now. This explains more about the duty of candour and helps you and your staff understand their obligations. All staff must undertake this module here: <http://www.knowledge.scot.nhs.uk/scormplayer.aspx?pkgurl=%2fecomscormplayer%2fdutyofcandour%2f>.

Nominated person in each service to support the duty of candour process

Each service area should have a nominated person to support the Duty of Candour process and provide staff with advice and guidance.

Aligning duty of candour with existing procedures

Within registered social care services, providers must make notifications to the Care Inspectorate when certain events occur. These include:

- accidents, incidents or injuries to a person using a service
- all deaths of a person using a care service
- adverse event involving a controlled drug.

Notifications are made electronically using the eForms system within a set number of days and providers are required to provide certain details when making a notification. The statutory basis for these notifications is set out in The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011. The Care Inspectorate is required to publish guidance to set out the details. Notifications contribute to the risk and intelligence base used to inform regulatory responses.

Appendix A

Duty of Candour Report

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 ~~XX service has~~ Heathfield Early Years Centre operated the duty of candour during the time between 1 April 2020 and 31 March 2021. We hope you find this report useful.

1. About Service

1.

Heathfield Early Years Centre is registered with the Care Inspectorate to provide places for 50 children, aged 3-5, for term time provision. Provide brief details of your service.

2. How many incidents happened to which the duty of candour applies?

In the last year, there has been 0 incidents to which the duty of candour has applied. These are where the types of incident have happened which are unintended or unexpected, do not relate directly to the natural course of someone's illness or underlying condition.

If you have no incidents you can stop here and display only Part one and first part of Part two – as far as I am aware this should be all services for the past year.

Type of unexpected or unintended incident	Number of times this has happened
Someone has died	
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	
Someone's treatment has increased because of harm	

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The structure of someone's body changes because of harm	
Someone's life expectancy becomes shorter because of harm	
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	

3. To what extent did the service follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure. This means we informed the parents/ person affected, apologised to them, and offered to meet with them. We reviewed what happened and what went wrong to try and learn for the future.

4. Information about our policies and procedures

Where something has happened that triggers the duty of candour, our staff report this to the service 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 and staff set 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 people who use care and their families. We have occupational welfare support in place for our staff if they have been affected by a duty of candour incident. Where parents or children are affected by the duty of candour, we have arrangements in place to provide welfare support as necessary.

5. What has changed as a result?

We made a change to our policies and procedures as a result of the duty of candour. We have reviewed the way in which we XXXXX

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