Duty of Candour Annual Report 2019/20

**About Bethesda Care Home and Hospice**

Bethesda Care Home and Hospice is a charitable organisation which is situated in a residential area near the centre of Stornoway, the main town of the Western Isles. The Care Home provides 21 long term care beds providing nursing care and 9 short-break care beds providing respite care. We also have 4 en-suite single bedrooms in the Hospice wing which provides specialist palliative care to people over the age of 18 years.

Bethesda aims to provide physical, psychological, social and spiritual care in a calm, peaceful and welcoming environment.

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 organisations learn how to improve for the future

Bethesda has produced this annual report following the introduction of the Duty of Candour Policy where any incidents that have happened within the previous year (April 2019/March 2020) which are unintended and result in harm, and are not related directly to the natural course of someone’s illness or underlying condition must be reported. This is to ensure an open, honest, supportive and a person-centred approach is used.

INCIDENT TABLE

|  |  |
| --- | --- |
| **Type of unexpected or unintended incident** | **Number of incidents - April 2019-March 2020** |
| A person died | 0 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| A person’s treatment increased | 0 |
| A person’s life expectancy shortened | 0 |
| A person experienced pain or psychological harm for up to 28days | 0 |
| A person needed health treatment tin order to prevent them dying | 0 |
| A patient had the potential to be harmed from a medication error. | 1 |
| **TOTAL** |  |

|  |  |
| --- | --- |
| Does Bethesda Care Home and Hospice have a Duty of Candour Policy in place? | Yes |
| How many incidents have been reported following the Duty of Candour (DoC)? | 1 |
| To what extent did Bethesda Care Home & Hospice follow the Duty of Candour Procedure | Staff followed the correct procedure as required on this occasion.  We informed the resident affected of the incident, apologised to them, and offered to meet with them or their family to discuss further. In each case, we supported the persons affected, reviewed what happened, and implemented any changes to learn from the incident.  By reviewing this medication error and the procedures surrounding it, staff have learnt from this and have refreshed their learning and made very sure all insulin pens are stored separately and clearly marked. |
| About our policies and procedures | After an incident has triggered the duty of candour, our staff report the incident to the care home manager who has responsibility for ensuring that the duty of candour procedure is followed. The one incidents was immediately reported to the manager within 3 hours.  The manager recorded the incident and reported them as necessary to the Care Inspectorate/Health Improvement Scotland. When an incident has happened the manager will investigate, speak to staff and identify and implement any necessary changes. This allows everyone involved to review what happened and identify changes for the future.  All new staff learn about 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 additional management support in place for our staff from the senior nursing staff & management, if they have been affected by a duty of candour incident.    If residents in the home/hospice and/or their relatives were affected by the duty of candour, we would arrange for them to have access to additional support too. |
| Lessons learned, and actions implemented following the review | There were no major changes to our policies due to the one incident in this past year however some storage of medication practice has been amended.  Incident 1 - required the staff responsible for the medication error to review their own practice and now practice has changed where all insulin pens are marked and stored separately. |
| How was this change in procedure communicated to staff? | Procedural changes were agreed with Clinical Team following discussion. |
| Were the persons affected satisfied with the explanation and outcome of the incidents? | Family were informed about the incident and were happy with the way in which the incident was dealt with. |

The Duty of Candour procedure has reinforced how important it is to inform families immediately after an incident to review and also to look at lessons learnt to improve practice and reduce as much as is possible the risk of a further incident occurring. .

If you would like more information about our service, please contact us on

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