Duty of Candour Annual Report 2020/21

**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 2020-March 2021) 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 20 - March 21** |
| 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 in order to prevent them dying | 0 |
| A patient had the potential to be harmed from a medication error. | 3 |
| **TOTAL** | **3** |

|  |  |
| --- | --- |
| 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)? | Three |
| To what extent did Bethesda Care Home & Hospice follow the Duty of Candour Procedure | Staff followed the correct procedure on all three occasions.  We informed the persons affected of the incidents, apologised to them, and offered to meet with them to discuss further and we also spoke to each person’s General Practitioner. In each case, we supported the persons affected, reviewed what happened, and implemented any changes to learn from each incident.  By reviewing the three medication errors and the circumstances surrounding these, staff have learnt lessons and have refreshed their learning and also reviewed a procedure. |
| 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 has been followed. In all three incidents they were reported to senior management within 3 hours.  The manager evidenced the incidents and reported them as necessary to the Care Inspectorate/Healthcare Improvement Scotland. All medication errors are reported to the NHS Western Isles Accountable Officer. 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 incidents however some procedural changes have been implemented.  DoC Inc1 - The Student Nurse must ask for instructions to be repeated if they do not clearly understand what is said. In turn the Staff Nurse mentoring must ensure they give clear concise instruction to students. A significant event analysis was carried out by Sister Macsween in order to discuss, reflect and learn from the incident.  DoC Inc 2 – The staff nurse was strongly advised to follow the Medicines Policy of preparing one controlled drug at a time.  The death of a patient in Room 4 of the Hospice on the same shift was also discussed with the Staff Nurse who was reminded to ask for assistance and support if this was required, and not to try to do everything by herself.  All Nursing Staff will be reminded to ask for help and/or support if they feel this is required during very busy times in the Hospice.  The learning gained from this incident was shared with NHS WI Accountable Officer.  DoC Inc 3 - The manager severely reprimanded the Senior Staff and both Staff Nurses and informed them they must be extra vigilant when administering medication under the NMC The Code, Statement 18.  Two other Staff Nurses were commended for their diligence and attention given, to the correct dosage of medication & for noticing the error.  All nursing staff were strongly reminded of the seriousness of any medication error and the importance of care & attention to detail when administering medication. |
| After Incident 2, how was the Medicines Policy communicated to nursing staff? | The Clinical Lead is meeting with all Staff Nurses to refer them to the Medicines Policy documentation to ensure they follow Bethesda Hospice Policy of administering one patients controlled drug medication at a time. |
| Were the persons affected satisfied with the explanation and outcome of the incidents? | All family members were informed about the incidents, one family member asked for an investigation, which would be normal practice for such an incident. All persons affected were happy with the way in which each of the three incidents were dealt with. |

The Duty of Candour Policy ensures all incidents which occur out-with normal care are dealt with appropriately and with the knowledge of the resident/patient and their family/next of kin. It is good practice to look at lessons learnt from any occurrence particularly medication errors as was the case with all three incidents reported under the Duty of Candour between April 2020 and March 2021.

Our Staff Nurses work hard to provide an excellent service at Bethesda and this has been particularly challenging this last year due to Covid-19.

All three errors were felt very deeply by our staff and through showing honesty and openness we are reminded that when things go wrong that people who use the service have a right to know and lessons must be learnt.

Staff must ask for help/support when feeling overwhelmed. Also, being reminded to regularly read and be aware of policies can only preserve the excellent standard of care at Bethesda Care Home & Hospice.

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

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