Duty of Candour Annual Report 2023/24

**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 2023-March 2024) 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 23 - March 24** |
| 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. | 1 |
| **TOTAL** | **1** |

|  |  |
| --- | --- |
| 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)? | One |
| To what extent did Bethesda Care Home & Hospice follow the Duty of Candour Procedure | Staff are made aware of the Duty of Candour policy when being inducted into the service. If an incident would trigger the Duty of Candour procedure staff should know to report the incident to the manager (or most senior staff) who has responsibility for ensuring that the duty of candour procedure is followed.  In this one incident which occurred January 2024,  the correct Duty of Candour procedure was followed.  We informed the person affected of the incident, apologised to them, and offered for the Hospice Doctor/Manager/Senior Sister to meet with them to discuss further. In this case, we supported the persons affected, reviewed what happened, and implemented any changes to learn from each incident.  By reviewing this medication error and the circumstances surrounding it, staff have learnt lessons and have refreshed their learning including amending a medication monitoring chart. |
| 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. This incident was reported to senior management at 06.30 and the Hospice Doctor and registered manager as soon as they came on shift.  The manager immediately investigated and evidenced the incident and reported as necessary to the Care Inspectorate/Healthcare Improvement Scotland. All controlled drug medication errors are also 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 the people who use care services 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/patients 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 changes to our procedure due to the incident, specifically the recording of prescribed medication for the syringe pump.  DoC Inc1 –  The Staff Nurse involved was strongly reminded that under the NMC The Code, they have a duty of care to their patients and if they were unsure of instruction given by the Hospice Doctor, they should have checked with him.  It was also stressed to the Staff Nurse that they should always refer to a written instruction when administering any medication, especially a controlled drug medication. This is clearly detailed in The Code, Section 8 Work Co-operatively, under 8.2 - maintain effective communication with colleagues and 8.5 – work with colleagues to preserve the safety of those receiving care.  The Staff Nurse was also reminded of the importance of Section 10 – keeping clear and accurate records.  Reviewing the written record, the medication prescribed and written on the Prescription and Monitoring Chart for the Syringe Pump was documented on one page and the actual medication put into the syringe pump, is documented on a second page. After discussion and review with the Doctors and Nursing Team, it was agreed that the Medication prescribed, and the actual medication administered in the syringe pump should be written on the same page so that it is clear to the Nurse what has been prescribed. A new Prescription and Monitoring Chart for Syringe Pumps was designed and is being trialled.  Under section 19 of the NMC The Code, “Be aware of, and reduce as far as possible, any potential for harm associated with your practice”.  In addition, the Doctors have been requested to write a prescription as follows: If the prescription is for Morphine, to write Morphine Sulphate. If the prescription is for Diamorphine, that it is clearly written.  The learning gained from this incident was shared with all of the Nursing Team, HIS and NHS WI Accountable Officer. |
| After the incident, 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 patients-controlled drug medication. |
| Were the persons affected satisfied with the explanation and outcome of the incidents? | All family members were informed about the incident. All persons affected were satisfied with the way in which the incident was 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 a medication error as was the case with this incident reported under the Duty of Candour between April 2023 and March 2024.

Our Staff Nurses work hard to provide an excellent service at Bethesda, and this has been particularly challenging the last few years during the pandemic

This incident was 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 unsure of any aspect of their work. 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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