DUTY OF CANDOR ANNUAL RETURN

1 APRIL 2019- 31 MARCH 2020

Duty of Candour

This is a legal requirement as set out in the Health, (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018, to ensure that if something goes wrong in health or social care services that the people affected are offered an explanation, an apology, and an assurance that staff will learn from this error. Learning is shared with the people affected, within the organisation, and across the sector as required.

About our Organisation

This report describes that as a small sized care at home provider, we have implemented Duty of Candour throughout the period of 1 April 2019 and 31 March 2020.

Professional Carers supports people to live in their own individual homes with a small team of carers who are matched to work for the person and provide person centred care that meets their individual needs.

Professional Carers has a Duty of Candour policy and staff guidance. All staff undertake training to help them understand the organisations policy and the process of the Duty of Candour which could affect them.

The people we work for have a variety of support needs: some have severe and challenging difficulties while others maintain some independence but require additional support.

Incident Reporting

All health and social care services in Scotland must provide an annual Duty of Candour report for their service. As a care at home provider this information is sent to our regulator the Care Inspectorate.

During the reporting period, there were no incidents that triggered the Duty of Candour.

Procedure

The purpose of the Duty of Candour is to ensure organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm.

We must activate the Duty of Candour procedure as soon as reasonably practicable after becoming aware that:

• An unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person;

• In the reasonable opinion of a registered health professional not involved in the incident: a) that incident appears to have resulted in or could result in any of the outcomes outlined in the table below; and b) That the outcome relates directly to the incident rather than the natural course of the person's illness or underlying condition.

Type of unexpected or unintended incident	Number of times this has happened
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic, or intellectual functions	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0
Someone experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them from dying	0
A person needing health treatment in order to prevent other injuries	0

No incidents triggering the Duty of Candour were reported in this period. No procedure to report.

What have we learned?

- We have continued to support staff in understanding the process

If you would like more information about this report, please contact us:

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