

## **Duty of Candour**

A new organisational duty of candour on health, care and social work services came into effect on 1 April 2018. The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an **unexpected or unintended incident resulting in death or harm**, as defined in the Act. The new duty applies to organisations and not individuals. It is placed upon health, care and social work organisations.

### **Candour**

Candour is the quality of being open and honest. Children and someone lawfully acting on their behalf, should as a matter of course be properly informed about all of the elements of their care and this should involve any incidents that result in harm. Scottish Borders Council sustains a culture which supports staff to be candid.

### **The responsible person:**

The Act defines the “responsible person” as: the service not an individual who provides a care service.

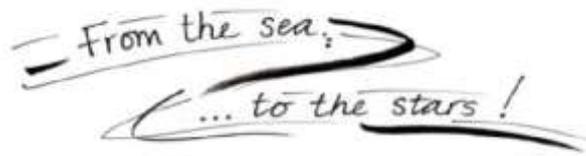
The responsible person has responsibility for:

- carrying out the procedure
- undertaking any training required by regulations
- providing training, supervision and support to any person carrying out any part of the procedure as required by regulations
- reporting annually on the duty

### **Incident which activates the duty:**

The duty of candour procedure must be carried out by the responsible person as soon as practicable after becoming aware that a child has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in or could result in:

- death of the person
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions
- an increase in the person’s treatment
- changes to the structure of the person’s body
- the shortening of the life expectancy of the person
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days
- the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days
- the person requiring treatment by a registered health professional in order to prevent
  - (i) the death of the person, or
  - (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.



## Apology

For the purposes of the Act, an “apology” means a statement of sorrow or regret in respect of the unintended or unexpected incident that caused harm or death.

An apology or other step taken in accordance with the duty of candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty.

Sometimes staff find it difficult to say sorry when something has gone wrong and harm has occurred. People may be unclear if they can say sorry and worry that the timing for doing this won't be right or that they will make things worse. The 4Rs are an easy way to remember how we can get this right:

**Reflect** – stop and think about the situation

**Regret** – give a sincere and meaningful apology

**Reason** – if you know, explain why something has happened or not happened and if you don't know, say that you will find out

**Remedy** – what actions you are going to take to ensure that this won't happen again and that the organisation learns from the incident.

It is important that an open and honest apology is provided from the outset as this can reassure the family/carer and will also set the tone for moving things forward from here. It is important to understand that by making an apology following an event that triggers the duty of candour procedure you are acknowledging that harm has been caused, a mistake has been made and you may be acknowledging emotions that are felt by the child and their family/carer. A meaningful apology can help to calm a person who has become angry or upset. An apology is not an admission of liability in a legal sense.

An apology is often the first step in putting things right and can help to repair a damaged relationship and restore dignity and trust.

## Who should apologise?

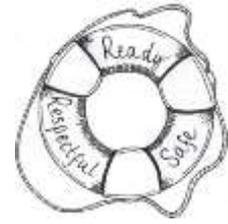
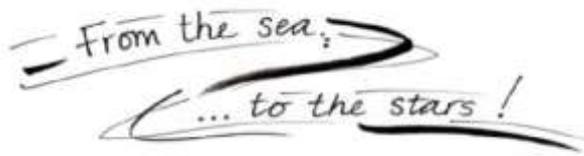
The Act states that the responsibility for the apology rests with the responsible person – this is the organisation delivering the service. Within each organisation there will be individuals with delegated responsibility for ensuring that the organisational duties (in this case providing an apology on behalf of the organisation) are met (recognising that there are likely to have been individuals who have provided individual apologies). Your organisation may have guidelines you can use.

For an apology to be effective it needs to be sincere. Sometimes you may need to apologise for an event which is not of your doing – indeed the organisationally focused apology required by the duty of candour procedure will involve this. Sometimes it is the official organisational recognition of the event that will be important to the individual and/or their family.

A more formal apology may come later as part of a meeting with the individual and/or their family but it's important to apologise immediately the event comes to light. When making your apology you should not worry about who is to blame or what has gone wrong but merely apologise for the event occurring.

**It is everyone's responsibility to make an apology**, where appropriate, and you could include some phrases such as:

'I am sorry that this has happened to you and I'm going to find out what went wrong and come back to you.'



'I am sorry that harm has occurred, let me find out what has happened and come back to you with information.'

## Annual Report

The first annual duty of candour report was due after April 2019. Even if there are no incidents to which the duty applied, a short report is still be required, as it must contain information about staff training on the duty of candour. The Care Inspectorate have amended annual returns, to ask services if they have published a duty of candour report and may ask to review services' duty of candour reports or examine them as part of an inspection.

## Training

An online learning module is available: <https://learn.nes.nhs.scot/>

New users may need to create an account to access it.

This explains more about the duty of candour and helps services and their staff understand their obligations. We strongly encourage all staff in all settings to undertake this module.

The Council's training department is currently developing an e-learn module for staff to complete. **Policy**

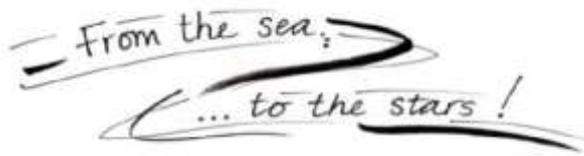
This policy sets out the appropriate processes for communicating with a child and/or family/carer following a reportable incident and should be followed in conjunction with the Duty of Candour Procedure.

This document outlines the settings policy on its statutory duty of candour and the processes by which openness will be supported. This will support the setting to meet its obligations to children and their families by being open and honest about any mistakes that are made whilst our staff care for their children.

This document is aimed at all staff working within the setting and sets out the infrastructure which is in place to support openness between practitioners and children, their families and carers, following a safety incident. Our staff will feel able to report concern or things that go wrong without fear of blame.

## Roles and responsibilities

The overall approach within the setting is one of help and support for staff involved in incidents of unintended or unexpected harm, rather than blame. Staff will feel confident that



they will be safe and supported to report duty of candour incidents so that lessons are learned and shared to improve and increase the safety of our care system for everyone.

Senior Leadership Team – Monitoring implementation of policy, activating duty of candour procedure when necessary. Supporting all staff throughout training and implantation of procedure.

Senior Early Years Officer/Early Years Officer– Prepare and publish duty of candour annual report, monitoring of training of all staff.

Early Years Practitioner – training to support personal development, reporting of unintended or unexpected incidents, that caused harm or death, to line manager.

### **Training and resources**

Training and guidance is available via <https://learn.nes.nhs.scot/>. In addition to this, the Council's training department is currently developing an e-learn module which should be available soon for staff to complete. All staff are expected to be responsible for their own professional learning and thus to complete the training module. All new staff will be supported to complete the training module as part of their induction process.

Support will be provided for all serious incidents by the Senior Leadership Team and if deemed necessary senior officers of the Council. Staff can also access confidential counselling via Occupational Health through self-referral or their line managers.

### **Monitoring**

Compliance with the implementation of this policy will be monitored and audited by the Senior Leadership Team This is dependent on staff using the system correctly to ensure the quality of data recorded provides assurance in relation to the trust's statutory requirements.

### **Procedure**

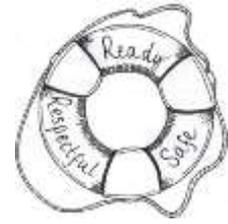
The 'duty of candour procedure' means the actions to be taken by the responsible person in accordance with regulations made by the Scottish Ministers. The regulations detail the specific actions and recording of information required by the responsible person when carrying out each stage of the procedure.

#### **The key stages of the procedure include:**

- (a) A member of the Senior Leadership Team to notify the child affected and family/carer that an unintended or unexpected incident has occurred that has resulted in harm

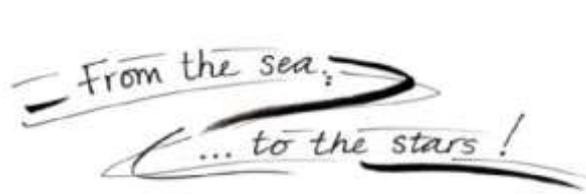


*From the sea;  
... to the stars!*



and that the duty of candour procedure will be activated. This is to happen as soon as possible after the incident has occurred.

- (b) Senior Leadership and/or staff member involved in incident to provide an apology for what has happened at this stage (see policy)
- (c) Senior Leadership Team to carry out a review into the circumstances leading to the incident, review to be carried out by an individual not involved in the incident.
- (d) Senior Leadership to offer and arrange a meeting with the family/carer.
- (e) Senior Leadership team, Senior Early Years Officer/Early Years Officer and staff involved in incident to provide the family/carer with an account of the incident and what went wrong
- (f) Senior Leadership to provide information about further steps taken
- (g) Senior Early Years Officer/Early Years Officer to make available, or provide information about support to family/carer
- (h) Senior Leadership to advise family on how the information will be stored
- (i) Senior Early Years Officer/Early Years Officer to prepare and submit an annual report on the duty of candour to the central Early Years team before the end of April each year for the previous 12 month period, (even if no incidents occur). Details of this will be included in the services' Care Inspectorate Annual returns.



## Duty of Candour Report April 2021 – March 2022 Eyemouth Primary School ELC hub

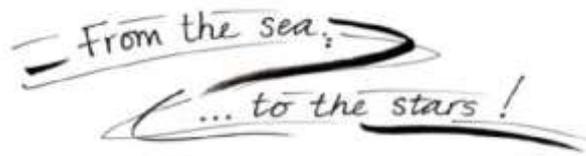
All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

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 Eyemouth Primary School ELC Hub Nursery has operated the duty of candour during the time between 1 April 2021 and 31 March 2022.

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

In the period 1<sup>st</sup> April 2021 – 31<sup>st</sup> March 2022, there have been no incidents to which the duty of candour applied. These are where types of incident have happened which are unintended or unexpected, and do not relate directly to the natural course of someone's illness or underlying condition

Type of unexpected or unintended incident	Number of times this 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
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries	0



**3. If applicable, to what extent did Eyemouth Primary School Nursery follow the duty of candour procedure? N/A**

#### **4. Information about our policies and procedures**

Where something has happened that triggers the duty of candour, our staff will report this to the nursery manager who has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to Scottish Borders Council Health and Safety Dept. through the Lexi Portal

Should an incident happen the manager and staff will 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 can access 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 can make arrangements to provide welfare support as necessary.

**5. What has changed as a result? N/A**

#### **6. Other information**

We have submitted this report to Scottish Borders Council Early Years team to include in the Corporate Duty of Candour report.

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From the sea;  
... to the stars!

