



2022 - 2023

Annual Duty of Candour Report



Introduction

Duty of Candour was introduced at the beginning of April 2018 as the second part of the Health (Tobacco, Nicotine, etc and Care) (Scotland) Act 2016. The act effects all Health, Social Work and Care Services (except childminders) based in Scotland. This means that these services must take specific steps (Duty of Candour) when a serious adverse event happens. The Act sets out how the service must inform people of the event, offer to meet them and also apologise. It allows us to be open with the people who experience our care and also to learn from things that go wrong.

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The Scottish Government states that-

"The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them in a review of what happened.

When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement.

They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen.

The duty of candour procedure provisions reflect our commitment to place people at the heart of health and social care services in Scotland.

We recognise that when unexpected or unintended incidents occur during the provision of treatment or care, openness and transparency is fundamental. This promotes a culture of learning and continuous improvement."

Duty of Candour Incidents

Between 1st April 2021 and the 31st March 2022, there have been 0 incidents where Moore House Group have had to apply Duty of Candour.

These are incidents that are unexpected or unintended and result in harm or death as defined by the Health (Tobacco, Nicotine, etc and Care) (Scotland) Act 2016. These incidents do not relate to the natural course of a service users ilness or underlying condition.

Type of Unintended or Unexpected Incident (not related to the natural course of a service users illness or underlying condition)	Number of Incidents
The death of a user	0
Permanent lessening of bodily, sensory. motor. physiologic or intellectual function	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions were impaired for 28 days or more	0
A person experienced pain or psychological harm 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 as listed above	0
Total	0

Continuous Development and Improvement

Moore House Group have not had to apply Duty of Candour during this year and therefore there are no direct lessons to be learned, however, as per our policies for continual improvement, we continue to review our collective practice and improve on the services we provide.



Organisational Policy

Moore House Group have produced a "Duty of Candour" policy which every member of staff has access to via our secure computer systems.

Training and Development

All Moore House Group staff have access to, and are required to complete, online Duty of Candour (Scotland) training along with their induction programme. The training is provided by Azilo Training and takes around 20 minutes to complete.

Procedures for Reporting Incidents

As per The Care Inspectorate's guidelines, Moore House Group must state whether Duty of Candour was triggered with each submission to the "E-Forms" system used by The Care Inspectorate.

Further Information

If you would like to know any further information to how Moore House Group deal with Duty of Candour incidents, please contact -

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