ANDERSON'S

A VOLUNTARY SECTOR CARE HOME FOR OLDER PEOPLE

Duty of Candour Annual Report

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 the duty is that we provide an annual report about the duty of candour services. This short report describes how Anderson's has operated the duty of candour between April 2020 and March 2021.

1. **How many incidents happened to which the duty of candour applies?**

In the last year there have been zero 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.

Name & Address of service:	Anderson's Care Home, 2 Institution Road, Elgin, Moray, IV31 1RP
Date of Report	7th February 2024
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively?	The values and attitudes of Anderson's team is underpinned by our Mission/Purpose and Vision Statement which is founded upon the principles of trust, openness and transparency and supportive. Staff are aware of the importance of candour through the development and implementation of Anderson's policies.
How have you done this?	Duty of Candour underpins our communication with patients and families following every incident, whether it requires implementation or not. All staff complete the Duty of Candour module on SSSC e-learning.
Do you have a Duty of Candour Policy or written duty of candour procedure.	YES ~~NO~~

How many times have you/your service implemented the duty of candour procedure for this financial year?

Type of unexpected or unintended incident	Number of times this happened (April 2022 to March 2023)
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 are 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 dying	0
A person needed health treatment in order to prevent other injuries.	0
Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over reporting of duty of candour?	N/A as there have been no instances of implementing the Duty of Candour in the above-noted circumstances. However, all care staff have a duty of candour and a professional responsibility to be honest and communicate effectively when things go wrong.
What lessons were learnt?	N/A as there are no incidents to report for this period. However, following any incident and immediate investigation is carried out by management, risk assessments are created and updated as appropriate. If appropriate information is added to the communication book to share at each handover report.
What learning & improvements have been put in place as a result?	N/A
Did this result in a change/update to your duty of candour policy/procedure?	N/A Our Duty of Candour policy was created in July 2018 and reviewed in October 2020, April 2022.
How did you share lessons learned and who with?	N/A Any lessons learnt would be shared in meetings between Care Management Team, during handovers by shift leaders, by way of team meetings by way of example scenario and education session (if appropriate). Any slips, trips and falls, including those that have not resulted in harm as defined under Duty of Candour, are discussed by Senior Care Management and Health & Safety meetings.