



Duty of Candour Annual Report

1. Introduction

On 1 April 2018, a statutory organisational duty of candour came into force for all health and social care services in Scotland.

The duty of candour is a legal requirement to be open, honest and transparent when things go wrong.

HC-One operate 56 care homes in Scotland and we aim to always provide safe, effective and the highest quality care. However, there are occasions where unexpected or unintended incidents happen, which may result in significant harm or death. When these events happen, we ensure our commitment to openness and transparency is fundamental, informing people of what happened, what we have done in response, and what actions will be taken to ensure shared learning and to reduce the risk of recurrence.

We recognise that any incident, but particularly one where the duty of candour applies, can have devastating emotional and physical consequences for Residents, their families and Colleagues. Being open about what happened and discussing incidents promptly, fully and compassionately provides supportive opportunities for all to ensure positive wellbeing and learn lessons.

We, at HC-One, are wholeheartedly committed to the principles of duty of candour and welcome this opportunity to report and learn from incidents and experiences.

A requirement of the statutory duty of candour is to provide an annual report about the duty of candour in our care homes. This report outlines how HC-One operated our duty of candour during the time between **1 April 2018 and 31 March 2019**.

2. What is a duty of candour incident?

A duty of candour incident is an incident which occurred because something went wrong with the care and treatment provided and results in harm or death, as defined in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

The unintended or unexpected incident must, in the reasonable opinion of a registered health professional (who was not involved in the incident), have resulted in or could result in any of the following levels of harm:

- 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 which has lasted, or is likely to last, for a continuous period of at least 28 days
- person experiencing pain or psychological harm which has been, or is likely to be, experienced for a continuous period of at least 28 days

- death
- the person requiring treatment by a registered health professional in order to prevent:
 - the death of the person, or
 - any injury to the person, which, if left untreated, would lead to one or more of the outcomes mentioned above.

The harm caused must relate directly to the incident rather than to the natural course of the person's illness or underlying condition.

3. How many incidents happened to which the duty of candour applied?

There were 29 incidents across 19 of our care homes to which the duty of candour applied.

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	22
The structure of someone's body changes because of harm	7
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor or intellectual function 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 dying	0
A person needing health treatment in order to prevent other injuries	0

Category of incident	Number of times this happened
Pressure Sore – Grade 3 or above	19
Slips, Trips & Falls, including found on the floor	7
Incidents occurring whilst moving or handling	1
Person trapped by objects or equipment	1
Distress incident	1

4. To what extent did HC-One follow the duty of candour procedure?

For every duty of candour incident, we investigated what happened and what went wrong to enable us to take appropriate action to prevent a similar incident happening again.

As soon as we were made aware of the events listed above, we informed the people affected, apologised to them and offered to meet with them in 25 of the 29 occasions (86%). In each case, the relevant person (i.e. the Resident themselves, or in certain circumstances the person acting on their behalf) was notified verbally of the incident and the next steps we would take. At the conclusion of each investigation, a letter was sent to the relevant person providing a detailed written account of the incident, an apology, details of the investigation and the actions taken to make necessary improvements.

A meeting with the relevant person was held in 12 of the 29 occasions (41%).

We identified that on 13 occasions, an opportunity for a meeting was made via the conclusion letter. There was no documented evidence of a verbal invitation to meet with the relevant person and no evidence of a meeting being held. We have reviewed this process and implemented a more effective way to ensure opportunities to meet with those involved are offered, facilitated (if wished) and records maintained to evidence this communication and engagement.

There were four occasions where the relevant person was notified of the incident and the reasons for it, however on all of these occasions, the Resident sadly passed away (unrelated to the injury sustained) prior to a written account being provided. Each case was considered on its merits and a decision was made not to send the written account to avoid any further distress. We are reviewing this process to ensure a written account is always offered to the relevant person.

5. Information about our policies and procedures

Our Incidents policy states that we will adopt an open and transparent approach to all incidents by ensuring the Resident's next of kin is informed and that incidents are fully investigated and documented. If any significant injury or death is caused because something went wrong with the care and treatment provided, we will fulfil our duty of candour.

Any unintended or unexpected event, which could have or did cause harm or injury to a Resident, is reported as an incident on our local reporting system. It is the responsibility of every Home Manager to ensure each incident is investigated to understand what happened, how it happened, why it happened and what action is needed to keep people safe and to minimise the risk of recurrence.

If the investigation identifies any factors that may have caused or contributed to the event, then this will trigger the duty of candour procedure. Our Standards and Compliance team, along with our Clinical Quality Team and operation teams, have visibility of all incidents and provide support to our homes in identifying duty of candour incidents and discharging the duty.

All Colleagues receive training in relation to incident investigation. Our Incidents policy and Duty of Candour procedure are accessible to all Colleagues, so they can refer to and understand when the duty of candour applies.



We are able to offer support to all people affected by a duty of candour incident. We know that duty of candour incidents can be distressing for Colleagues, as well as the people who receive care and their families. We have developed and implemented responsive support facilities for all Colleagues at all times through our line management structure, as well as our employee assistance programme. This programme provides opportunities for Colleagues to make contact to a confidential telephone line to discuss their concerns with trained counsellors independent of HC-One. We are also committed to offering the same levels of support for Residents and their relatives, when needed.

Duty of candour logs/documents are included in our home based quality assurance system, Cornerstone. Cornerstone is fundamental to ensuring high quality care and continuous improvement is achieved and consistently maintained. Cornerstone supports the Home Managers with diarising key activities, including systematic audits and quality checks to ensure they meet expected standards of care and support at all times.

At HC-One, we have skilled and experienced senior management and operation teams who undertake regular audits and inspections of our homes, which includes reviewing duty of candour incidents.

Incident trends and specifics are discussed quarterly at our Quality Governance Group and lessons resulting from this scrutiny are shared across the organisation.

6. What has changed as a result?

After every incident, action was taken to minimise the risk of reoccurrence. Examples of such action include care plans and risk assessments being reviewed, assessing the use of appropriate equipment, review of training and additional training and learning opportunities for staff to ensure competence skills and knowledge.

We are committed to ensuring duty of candour is firmly embedded in all of our homes and action always taken to maintain the safety of our Residents.

7. Other information

We have placed this report on our website and shared it with our Residents and their relatives via the noticeboard in each of our homes.

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

HC-One
Standards and Compliance
Southgate House
Archer Street
Darlington
DL3 6AH

standards@hc-one.co.uk