**Annual Duty Of Candour Report – period ending 31st March 2022**

**The duty of candour**

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) set out a new Duty of Candour.

The Act and the Regulations require organisations providing health services, care services and social work services in Scotland to follow a formalised procedure when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The purpose of this duty is to ensure that providers are open, honest, supportive and providing a person-centred approach.

**1. Duty of Candour Procedure**

As a provider of an independent social care service, we are required to develop and implement a duty of candour policy that describes how we/our staff will act in the event of an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The key stages of the policy must include:

* Notify the person affected (or family/relative where appropriate);
* Provide an apology;
* Carry out a review into the circumstances that led to the incident;
* Offer a meeting with the person affected and/or their family, where appropriate;
* Provide the person affected with an account of the incident;
* Provide information about further steps taken;
* Provide support to staff notifying the person affected by the incident;
* Prepare and publish an annual duty of candour report (see below).

Further guidance on when the duty must be implemented can be found in the Scottish Government Duty of Candour Guidance ([Organisational duty of candour: guidance - gov.scot (www.gov.scot)](https://www.gov.scot/publications/organisational-duty-candour-guidance/)) and the dedicated webpage ([Duty of Candour - Healthcare standards - gov.scot (www.gov.scot)](https://www.gov.scot/policies/healthcare-standards/duty-of-candour/))

**2. About our organisation**

LOVE Care is a socially conscious and compassionate provider of residential and home care services across Scotland. We cater to individuals of all ages with varying needs.

LOVE Care specialises in delivering enhanced care packages that make a real difference. We offer home care services that are combined with compassion, kindness and love, and provide mental health crisis support, end of life palliative care, personal care and domiciliary services.

As part of our residential care offering, LOVE Care provides 24/7 tailored care services to children with social, emotional and behavioural needs for whom residential care is the only option. We complement our residential services with educational support to provide children the best available opportunities.

**3. Duty of Candour Incidents**

In the period 1 April 2021 – 31 March 2022, there were no incidents to which the duty of candour applied

|  |  |
| --- | --- |
| **Type of unexpected or unintended incident where Duty of Candour applies** | **Number of times this happened** |
| A person died | 0 |
| A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| An increase in the Service User’s treatment | 0 |
| Changes to the structure of the Service User’s body | 0 |
| The shortening of the life expectancy of the Service Use | 0 |
| An impairment of the sensory, motor or intellectual functions of the Service User which has lasted, or is likely to last, for a continuous period of at least 28 days | 0 |
| The Service User experiencing pain or psychological harm which has been, or is likely to be, experienced by the Service User for a continuous period of at least 28 days | 0 |
| The Service User requiring treatment by a registered health professional in order to prevent –  the death of the Service User, or  any injury to the Service User which, if left untreated, would lead to one or more of the outcomes mentioned above. | 0 |

**4. Information about our Incident policies & procedures**

Incidents that occur in our services are reported through the organisation’s Incident

reporting process. This ensures that the Senior Management and Executive Teams have the opportunity to examine, discuss and determine if an incident should be classed as a duty of candour.

Where something has happened that triggers the duty of candour procedure, this is

identified through our incident reporting process by staff. The Registered Manager works in conjunction with the Heads of Service who reports the incident to the Care Inspectorate.

When a duty of candour incident has happened, the manager and staff will set up a learning review. This allows everyone involved to review what happened and to identify changes for the future.

All new staff learn about the duty of candour procedure during their organisational

induction training. We know that serious mistakes can be distressing for staff as well

as people who use our services and their families. We have support in place for our staff if they have been affected by a duty of candour incident.

**5. Additional Information**

We also review all formal complaints for potential duty of candour incidents and may

initiate a significant adverse event review following receipt of a complaint.

Love @ Care continues to monitor and review its policies and procedures, to include risk management and training for staff. Such a proactive approach has supported us in meeting the challenges of the ongoing COVID19 crisis which through our proactive planning and processes has minimised the impact on the organisation and the vulnerable people we support

If you would like more information about this report, please contact us using the contact details found on our website.

**Lynn Black**

**Chief Executive Officer**