Aberdeenshire COUNCIL

# Fishermoss Nursery
# Duty of Candour Policy

This policy outlines how Fishermoss Nursery meets the obligations introduced by the Health (Tobacco, Nicotine etc.) and Care (Scotland) Act 2016 and Duty of Candour Procedure (Scotland) Regulations 2018.

## What is duty of candour?

The duty of candour is about what happens if there is an unintended or unexpected incident within an organisation that results in death, severe harm, or other serious consequences specified in the act.

The focus of the duty of candour legislation is to ensure that early years settings take specific steps when a serious adverse event happens. They will need to let the people affected know, offer to meet with them, and apologise. This is an important part of being open with people who experience care, and also learning from things that go wrong.

Settings must, by law, produce a short annual report showing their learning from any incidents that year, publish it and notify Care Inspectorate that it has been published.

## When is duty of candour activated?

Early Years Settings must activate the duty of candour procedure as soon as reasonably possible after becoming aware that an individual has been subject to an unintended or unexpected incident occurred in the provision of the nursery care, 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 expectance 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 continuous for a period of at least 28 days
- 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.

It is important to note that where the duty of candour procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for this has to be provided to the relevant person.

## Systems and Procedures at Fishermoss Nursery

If the nursery staff believe that an incident has occurred which may trigger the duty of candour, they will report it to the Head Teacher or designated staff member in their absence immediately, or as soon as they realise it may be such an incident, who will inform their QIO and the Central Early Years Team.

The Head Teacher shall be responsible for managing the duty of candour from that point. They will:

Obtain a viewpoint from a registered health professional as to the incident and its relationship to the harm that was caused. The Head Teacher should ensure this viewpoint covers the following questions:

- What was the incident?
- What was the outcome?
- What illnesses and underlying conditions did/does the person have?
- Does it appear that this incident resulted in or could result in the death or harm, caused?
- Does the natural course of the person's illness or underlying condition directly relate to the death or harm described?

If the registered professional's view is that the incident appears to have resulted in, or could result in the harm caused, the Head Teacher will:

- Record the date this view is given as the procedure start date
- Notify the parents/carers of the child as soon as reasonably practical, and ideally within 10 working days of the procedure date. The notification should include
  - An account of the incident and all the facts the school is aware of
  - An explanation of the actions that the school will take as part of the duty of candour procedure
  - An apology for the incident
  - An invitation to meet the person or their parents/carers if they want to ask any questions.
- Meet with the parents/carers of the child to discuss the incident. Provide a note of the meeting which should include when and where the meeting took place, a record of the apology, and any timescales that were agreed.
- Co-operate fully with a review of the circumstances which led to the incident, led by an Aberdeenshire Council Officer, within three months of the procedure start date. A written report of this review will be sent to the parents/carers of the child.
- Inform Care Inspectorate about the report and actions from this.

An annual report will be written at the end of March which includes information about the number of nature of incidents to which duty of candour applies (ensuring anonymity).

Appendix A – examples of annual reports

Appendix B – Factsheet 1, 2, 3 NHS Education for Scotland

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Revised by all staff (DA, LS, BP, LM, LG) – Nov 19

Scottish Social Services Council

Aberdeenshire COUNCIL

# Fishermoss Nursery
# Duty of Candour Report
# April 2019 – March 2020
*(Change Date as applicable)*

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 and apology, and that organisations learn how to improve in the future.

An important part of this duty is that we provide an annual report about the duty of candour in our service, **Fishermoss Nursery**. This short report describes how our care service has operated the duty of candour during the time between **1st, April 2018** and **31st March, 2019**. We hope you find this report useful.

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

In the last year, there has been one incident 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 changed because of harm | 0 |
| Someone's sensory, motor or intellectual functions 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 needed health treatment in order to prevent other injuries | 1 |

**2. To what extent did Fishermoss Nursery follow the duty of candour procedure?**

When we realised the events listed above had happened, we followed the correct procedure. This means we informed the parents affected, apologised to them, and offered to meet with them. We reviewed what happened and what went wrong to try and learn for the future.

**3. Information about our policies and procedures**

Where something has happened that triggers the duty of candour, our staff report this to the Senior Leadership Team who has responsibility for ensuring that the duty of candour procedure is followed. A member of the Senior Leadership Team records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, a learning review will take place. 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 have 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 have arrangements in place to provide welfare support as necessary.

**4. What has changed as a result?**

Complete to include specific information relating to incident.
*e.g. We made a change to our policies and procedures as a result of the duty of candour. We have reviewed the way in which we provide meals and snacks to children to ensure that allergies are known to all staff and that staff are confident about how they can avoid harm arising from them.*

**5. Other information**

This is the first year of the duty of candour being in operation and it has been a learning experience for our nursery. It has helped us to remember that people who use care have the right to know when things go badly, as well as when they go well.

As required, we have submitted this report to the Care Inspectorate but in the spirit of openness we have placed in on our website and shared it with our parents too.

If you would like more information about our nursery, please contact us using these details:
XXX

Scottish Social Services Council

Aberdeenshire COUNCIL

# Fishermoss Nursery
# Duty of Candour Report
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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 and apology, and that organisations learn how to improve in the future.

An important part of this duty is that we provide an annual report about the duty of candour in our service, Fishermoss Nursery. This short report describes how our care service has operated the duty of candour during the time between 1st, April 2018 and 31st March, 2019. We hope you find this report useful.

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

   In the last year, there have been no incidents to which the duty of candour applied.

2. **Information about our policies and procedures**

   Where something has happened that triggers the duty of candour, our staff report this to the Senior Management Team who have responsibility for ensuring that the duty of candour procedure is followed. The management team records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, the senior management team and staff 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 have 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 have arrangements in place to provide welfare support as necessary.

   If you would like more information about the duty of candour in Fishermoss Nursery please speak with a member of staff.

Scottish Social Services Council

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Appendix 1

**Incidents that trigger Duty of Candour**

| Type of unexpected or unintended incident | Number of times this happened |
|---|---|
| Someone has died | |
| Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions | |
| Someone's treatment has increased because of harm | |
| The structure of someone's body changed because of harm | |
| Someone's sensory, motor or intellectual functions is impaired for 28 days or more | |
| Someone experienced pain or psychological harm for 28 days or more | |
| A person needed health treatment in order to prevent them dying | |
| A person needed health treatment in order to prevent other injuries | |

FACTSHEET No.1

NHS Education for Scotland | Healthcare Improvement Scotland | Scottish Social Services Council | care inspectorate | Scottish Government Riaghaltas na h-Alba

# The Duty of Candour Procedure

The **Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016** received Royal Assent on 6 April 2016 and introduced a new organisational duty of candour on health, care and social work services. The implementation date for the duty of candour provisions to come into effect is 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 responsible person:

The Act defines the "responsible person" as:

(a) a Health Board,
(b) a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service,
(c) the Common Services Agency for the Scottish Health Service
(d) a person (other than an individual) providing an independent health care service
(e) a local authority,
(f) a person (other than an individual) who provides a care service,
(g) an individual who provides a care service and who employs, or has otherwise made arrangements with, other persons to assist with the provision of that service
(h) a person (other than an individual) who provides a social work service

This means that the new Duty applies to organisations and not individuals. It is placed upon health, care and social work organisations.

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 an individual who has received a health, social care or social work service 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.

## The 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 regulations will be available at: **www.gov.scot/Topics/Health/Policy/Duty-of-Candour**.

The key stages of the procedure include:

(a) to notify the person affected (or family/relative where appropriate)
(b) to provide an apology
(c) to carry out a review into the circumstances leading to the incident
(d) to offer and arrange a meeting with the person affected and/or their family, where appropriate
(e) to provide the person affected with an account of the incident
(f) to provide information about further steps taken
(g) to make available, or provide information about, support to persons affected by the incident
(h) to prepare and publish an annual report on the duty of candour

## Duty of Candour – organisations covered by the Act:

- NHS Boards
- Scottish Ambulance Service
- State Hospital
- National Waiting Times Centre
- GP services
- Dental surgeries and services
- Glasgow Dental Hospital
- Pharmacies
- Optometry services
- Independent hospitals and hospices
- Private psychiatric hospitals
- Independent clinics
- Independent medical agencies
- Independent ambulance services
- Care home services
- School care accommodation service
- Nurse agencies
- Child care agencies
- Secure accommodation services
- Offender accommodation services
- Adoption services
- Fostering services
- Adult placement services
- Day care of children
- Housing support services
- Social work services offered by or on behalf of local authorities
- Social care support services
- Day care services
- Care at home services

For further copies please contact:
NHS Education for Scotland on 0141 223 1435

FACTSHEET No.2

NHS Education for Scotland | Healthcare Improvement Scotland | Scottish Social Services Council | care inspectorate | Scottish Government Riaghaltas na h-Alba

# Duty of Candour - 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 clinical and care 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 an individual and/or their family 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 individual and/or their family. 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.

## What is a meaningful apology?

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

To make an apology meaningful you should:

- Acknowledge what has gone wrong
- Clearly describe what has gone wrong to show you understand what has happened and the impact for the person affected
- Accept responsibility or the responsibility of your organisation for the harm done
- Explain why the harm happened
- Show that you are sincerely sorry
- Assure the individual and/or their family of the steps you or your organisation have taken, or will be taking to make sure the harm does not happen again(where possible)
- Make amends and put things right where you can

## How should I make an apology?

Your apology will need to be based on the individual circumstances. There is no 'one size fits all' apology, but there are some general good practice points.

1. The timing of the apology is very important and should be done without delay
2. To make the apology meaningful do not distance yourself from the apology or let there be any doubt that you or your organisation accept the wrongdoing
3. The language you use should be clear, plain and direct

4. Your apology should sound natural and sincere
5. Your apology should not question the extent of harm suffered by the person affected
6. Your apology should not minimise the incident
7. It is very important that you apologise to the right person or people.

## 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.'

## Further sources of support

Little Things Make a Big Difference, Power of Apology e-learning module
**www.knowledge.scot.nhs.uk/making-a-difference.aspx**

Scottish Public Services Ombudsman, Guidance on Apology
**http://www.spso.org.uk/sites/spso/files/communications_material/leaflets_buj/2011_March_SPSO%20Guidance%20on%20Apology.pdf**

Healthcare Improvement Scotland, Being Open
**http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4058625/20150113%20Being%20Open%201.0.pdf**

Scottish Social Services Council - Codes of Practice
**http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/37-about-the-sssc/information-material/61-codes-of-practice/1020-sssc-codes-of-practice-for-social-service-workers-and-employers**

Scottish Government, Duty of Candour and FAQs
**www.gov.scot/topics/health/policy/duty-of-candour**

Care Inspectorate
**www.careinspectorate.com**

Healthcare Improvement Scotland
**www.healthcareimprovementscotland.org**

For further copies please contact:
NHS Education for Scotland on 0141 223 1435

FACTSHEET No.3

NHS Education for Scotland | Healthcare Improvement Scotland | Scottish Social Services Council | care inspectorate | Scottish Government Riaghaltas na h-Alba

# Duty of Candour - Monitoring and Reporting

The purpose of the duty of candour procedure is to support the implementation of consistent responses across health, social work and social care providers when there has been an incident that has resulted in unintended or unexpected harm that is not related to the course of the condition for which the person is receiving care.

In order to ensure consistency in applying the duty of candour procedure, it is important that unintended or unexpected incidents triggering the duty of candour procedure are monitored, recorded and reported by all relevant organisations.

The duty of candour procedure can be aligned with adverse events (also known as incidents), case reviews, notifications, complaints processes or disclosures through relevant 'whistleblowing' mechanisms. These processes will already be well established within organisations. Your reporting should include information regarding how you have met the various steps within the duty of candour procedure and what you have learnt from the review and how the learning has been shared.

To enable learning and improvement across organisations appropriate information needs to be gathered throughout the process. It is important that this is an ongoing process and not left until the end of the procedure to do this.

You should be able to identify and implement improvements to your practice or area of work as a result of the learning identified from the duty of candour incidents.

Remember at the heart of this process is an individual and their family who have experienced harm and you should make sure that they are offered the opportunity to be involved in the learning and improvement too.

## Notifications to the monitoring bodies:

There are already well established reporting processes for certain types of events within health, social care and social work. The statutory basis for these notifications is set out within other legislative regulations.

**Within independent healthcare services**, registered providers must make notifications to Healthcare Improvement Scotland when certain events occur.

Notifications are made electronically using the eForms system within a set number of days and providers are required to provide certain details when making a notification.

**Within registered social care services**, providers must make notifications to the Care Inspectorate when certain events occur.

Notifications are made electronically using the eForms system within a set number of days and providers are required to provide certain details when making a notification.

**Within social work services** (i.e. mainly the functions of a local authority social work department, as opposed to a registered care service), there are a variety of reporting processes for specific types of adverse events including social work criminal justice serious incident reviews (SIRs) and the death of a looked after child.

**Within independent contractors to the NHS**, there are a variety of reporting processes. Adverse events should be reported to the NHS Board to which the independent contractor is providing services.

**Within the NHS**, there is an existing national approach for managing adverse events. A **national framework** for learning from adverse events was first published in 2013. All NHS boards have local reporting systems

and processes in place to manage adverse events, which includes being open with all those involved in the event.

Organisations covered by the Act should align, where possible, their notification and reporting responsibilities in relation to the duty of candour procedure to existing local reporting systems and processes. This will enable organisations to identify when the duty of candour procedure has been invoked, what notifications are required and when, and ensure they maintain adequate records to allow an annual report to be prepared.

## The annual report:

The Act states the responsible person must publish an annual report. The Act provides clarity on certain matters which must (or must not) be in the report. The report is directed at supporting learning, rather than merely collecting quantitative information.

The primary purposes of the report should be:

- to demonstrate learning which has taken place following the harm being identified
- to provide public assurance that the duty of candour is being embedded in the sectors to which it applies
- to encourage responsible persons to self-reflect on how the duty is being embedded and how the quality of operation can be continually improved
- to contribute to the Care Inspectorate's, Healthcare Improvement Scotland's and the Scottish Government's wide evidence base about the provision of social care and health services.

The Act specifies certain things that should be in the report:

- information about the number and nature of incidents to which the duty has applied
- an assessment of the extent to which the responsible person carried out the elements of the duty
- information about the responsible person's policies and procedures including information about:

- procedures for identifying and reporting incidents
- support available to staff and to persons affected by incidents

- information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty has applied
- such other information as the responsible person thinks fit.

A report **must not** mention the name of any individual or contain any information which is likely to identify any individual.

The monitoring bodies – Care Inspectorate, Healthcare Improvement Scotland and the Scottish Government – are empowered to obtain further information from responsible persons if necessary.

For registered care and health services, the Care Inspectorate and Healthcare Improvement Scotland have aligned the harms in the Act within existing eForm notifications and style template annual reports are available.

## How can I find out more?

**www.gov.scot/Topics/Health/Policy/Duty-of-Candour**

**www.careinspectorate.com**

**www.healthcareimprovementscotland.org**

For further copies please contact:
NHS Education for Scotland on 0141 223 1435