Duty of Candour Annual Report 2021/22

Every healthcare professional must be open and honest with residents when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the residents or their families.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered duty of Candour within our service.

Name & address of service:	Lower Johnshill New Trows Road South Lanarkshire ML11 0JS	
Date of report:	1st April 2022	
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? How have you done this?	MHA has a Duty of Candour Policy which sets out the requirements under The Duty of Candour Procedure (Scotland) Regulations 2018 (alongside the associated regulations in England and Wales). The policy sets out the circumstances under which the Duty of Candour applies and the requirements which must be met when an incident which meets the criteria of Duty of Candour has occurred. The policy also includes a checklist which our staff can use to support them to ensure the Duty of candour process is followed correctly. The Duty of Candour Policy is updated on a three yearly basis, unless changes in legislation require it to be updated more often. The policy is available on our intranet to all staff and updates or changes to the policy are sent to staff via our monthly policy update emails. All relevant staff (Home / Scheme Managers; Deputy Managers; Registered Nurses) within our Scottish homes and schemes complete duty of candour training, via the web training available on the Scottish NHS website.	
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 this financial year?	
Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Unwitnessed or witnessed falls resulting in fractures of limbs lasting more that 28 days.
A person died	Nil
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	Nil
A person's treatment increased	3
The structure of a person's body changed	Nil
A person's life expectancy shortened	Nil
A person's sensory, motor or intellectual functions was impaired for 28 days or more	Nil
A person experienced pain or psychological harm for 28 days or more	Nil
A person needed health treatment in order to prevent them dying	Nil
A person needing health treatment in order to prevent other injuries as listed above	Nil
Total	**3**

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	As part of our review of incidents in order to complete this report we identified incidents which, on review, should have triggered the duty of candour process to be initiated but this did not occur. The figures reported above reflect the actual number of incidents where the duty of candour procedure should have been implemented based on the results of our review.
What lessons did you learn?	As a result of the findings noted above, we have identified that the process around when duty of candour is triggered is not as well understood as we had considered it to be.

	All management staff (Home / Scheme Managers; Deputy Managers; Registered Nurses) alongside some of our others staff (including Senior Carers, Supervisors and Domestic staff) working in MHA's homes and schemes in Scotland have completed training in Duty of Candour requirements, via the Scottish NHS online training course. As a result of the findings of the above we are now considering whether this needs to be refreshed for all relevant staff members or whether more specific training on the requirements should be made available to these staff members.
What learning & improvements have been put in place as a result?	As noted above, we have identified that there is an additional training requirement for the duty of candour procedure and we are in the process of identifying how this can be best addressed.
Did this result is a change / update to your duty of candour policy / procedure?	Not at the current time, but should this be required as a result of our further work relevant updates to our duty of candour policies and procedures would be made and circulated to homes and schemes in Scotland.
How did you share lessons learned and who with?	See above, this process of improvement is ongoing.
Could any further improvements be made?	See above, this process of improvement is ongoing.
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	Where there has been a serious incident, the manager is supported by the Area Manager to complete an investigation, the outcome of which is then shared with the resident and/or nearest family member with any associated learning. Going forward, MHA is reviewing the training that we give to managers regarding investigations to enable greater core fact finding and investigation skills to include root cause analysis. The Quality Improvement Managers provide support and advice when a serious incident occurs and escalate this to the Safeguarding Lead and the Head of Quality Improvement where it is felt that additional support is needed both in terms of investigation, liaising with external authorities and communicating with residents and their families. We encourage honesty relating to all incidents not

	just those that sit within the Duty of Candour reporting requirements.
What support do you have available for people involved in invoking the procedure and those who might be affected?	All MHA staff have access to a support network which includes Area Managers and Regional Directors and staff are encouraged to raise any concerns or issues with these individuals. Outside of line management, staff have access to a range of other managerial level individuals which include a Safeguarding Lead, Quality Improvement Manager and to local and regional Chaplains. These individuals are often present in the homes/schemes under normal circumstances who staff do not report to, but can approach should they require support. We also have counselling available to all staff members through MHA's Employee Assistance Program. For any non-staff members who may be affected (such as residents and / or family members) we encourage all residents and families to approach home / scheme management with any concerns they have. They also have access to an MHA Customer Services Manager if they want to raise a concern or a complaint or the Chaplaincy Team if they want to see support outside of the management structure.
Please note anything else that you feel may be applicable to report.	n/a