Duty of Candour Annual Report 2023-2024

Duty of Candour Procedure (Scotland) Regulations 2018

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act (Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016) the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our service. This report describes how bespoke Clinical care has operated the Duty of Candour between 1st April 2023 and 31st March 2024.

1. About Bespoke Clinical Care

Bespoke Clinical Care specialise in delivering complex and palliative care for clients in their own homes. Although registered as an agency, our staff work on substantive contracts and provide care in packages, which are a minimum of 4 hours duration per shift.

Prior to taking on each package, we carry out a thorough risk and needs assessment to ensure we have the required expertise and resources to deliver the best care possible. Working in close partnership with clients, their family, fellow healthcare professionals, our legal and insurance teams, we follow local and national guidelines to ensure all risks are adequately managed and reduced to the lowest level. Staff are trained in risk assessment and each client has bespoke risk assessments carried out for activities both in and out of the home, as we recognise that there is an element of risk involved in living life to its' full potential and wish to support each client to participate safely in all their chosen activities.

At Bespoke Clinical Care, we have integrated Duty of Candour into our Adverse Events Policy, which is audited and reviewed by Senior Management monthly.

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

Between 1st April 2023 and 31st March 2024 there were 0 instances where the duty of candour applied. During this period, the senior management team carried out monthly adverse event reviews. Following these reviews, we identified 2 near misses, 7 medication errors and 6 adverse events. These events include a wider range of outcomes than those identified in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm. Through the adverse events review process, we determine if there are factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1st April 2023 and 31st March 2024)
A person died	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0

A person 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 as listed above	0
A person's life expectancy is shortened	0
Total	0

3. To what extent did Bespoke Clinical Care follow duty of candour procedure?

Although there has been no duty of candour cases identified, Bespoke Clinical Care followed the Duty of Candour procedure when addressing the adverse events identified 100% of the time.

In each case, we informed those affected, apologised to them, and offered to meet with them. Senior management carried out a full review to understand what happened and what could have been done better. Individual and organisational learning has been undertaken and subsequent action and improvement plans have been developed and completed. We ensure excellent written and verbal communication throughout the process and always share the final report with affected persons. Only by seeking continuous improvement, using the feedback and the lessons arising from adverse events, will we succeed in improving service design and delivery.

4. Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our Adverse Events Policy. Through this process, we can identify incidents that activate the duty of candour procedure. Staff are trained and updated annually on Duty of Candour at Team Meetings and through regular circulation of the Bespoke Clinical Care policies and procedures. Staff have access to all policies through the company intranet, and in the Bespoke Clinical Care Office, which they are invited to visit regularly. All client folders contain a copy of the adverse Events policy and the relevant paperwork for completion in the event of an incident occurring. We recognise that adverse events can be distressing for staff as well as those in receipt of care. As such, support is available 24 hours a day through the on-call service. Staff also have access to the employee assistance programme and can seek support from trained counsellors.

5. What has improved as a result?

Engaging with clients following review of the Adverse Events has proved beneficial to all concerned. Working collaboratively promotes participation and trust and improves outcomes for all. As a small company, we continually review and adapt our practise, for the benefit of clients and staff.

One example of improvements is the End of Shift Checklist, which has been implemented to ensure nothing is missed before staff leave and provides clients and their families an overview of the care carried out on shift. These checklists are Bespoke and developed specifically with and for each individual client, to reflect their needs and preferences. We have also introduced updated MAR charts and a 2-signature policy for administering medications (where there are 2 staff on shift). We held a training day and distributed medication workbooks for the staff to work through, in addition to their medication competencies. This has significantly reduced the medication errors and staff feel they are better supported.

Our continuous improvement has been reflected in the positive reviews from clients, staff and the Care Inspectorate, who graded us as excellent in the quality of care and support we provide.

We continue to learn and refine our existing adverse event management process to include the duty of candour outcomes.

As required, we have made this report available to The Care Inspectorate, Our Commissioning Councils, and published it on our website and Intranet. If you would like further information regarding this report, please contact:

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