Duty of Candour

Annual Report

2019/20

1. About Inspire

Since 1988 Inspire has been providing support to local people – of all ages – with learning disabilities and additional support needs, including autism, across the North-east of Scotland.

A registered charity, we now operate over 40 services in locations ranging from Aberdeen, Elgin, Inverurie and Stonehaven to Banchory, Peterhead, Forfar and Huntly, providing support to more than 350 people.

Our vision is to empower people's life choices. This is achieved through a wide range of services across communities including on site or visiting staff support to people in their homes, respite care, innovative day services and added value activities including well-attended Supper Clubs and Activity Sessions.

Our services are commissioned by Health and Social Care Partnerships and regulated by the Care Inspectorate.

2. Duty of Candour

This is a legal requirement as set out in the Health, (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018, to ensure that if something goes wrong in health or social care services that the people affected are offered an explanation, an apology, and an assurance that staff will learn from this error. Learning is shared with the people affected, within the organisation, and across the sector as required.

The purpose of the Duty of Candour is to ensure organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm.
We must activate the Duty of Candour procedure as soon as reasonably practicable after becoming aware that:

- An unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person;
- In the reasonable opinion of a registered health professional not involved in the incident:
  a) that incident appears to have resulted in or could result in any of the outcomes outlined in the table below; and
  b) That the outcome relates directly to the incident rather than the natural course of the person's illness or underlying condition.

An important part of this duty is that we provide an annual report on any Duty of Candour incidents in our services.

3. Incident Reporting

During the period, there was one incident that triggered the Duty of Candour.

Type of unexpected or unintended incident	Number of times this happened
Someone has died	1
Someone has permanently less bodily, sensory, motor, physiological or intellectual function	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter 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 to prevent them dying	0
A person needing health treatment to prevent other injuries	0

4. Our Procedure and Processes

Where an unexpected or unintended incident occurs, our procedure requires us to:

- Inform the Chief Executive that the incident has occurred
- Notify the person affected (and/or family/relative where appropriate)
- Provide an apology
- Carry out a review into the circumstances leading to the incident
- Offer and arrange 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
- Make available, or provide access to, support to those affected by the incident

All our operational Staff receive core training in Duty of Candour.

Our Health and Safety system has an integrated checklist regarding notifications in respect of incidents. This includes stakeholders such as families, the Care Inspectorate, HSE and H&SCP's.

Staff have access to an external confidential counselling service and Inspire are committed to maintaining contact and providing assistance to affected staff.

5. Procedure Followed

Inspire's Escalated On-Call Manager was informed of the incident and contacted the Chief Executive and Director of Operations. The Care Inspectorate and Health and Social Care Partnership were notified. All Senior Managers and Trustees of the Organisation were informed.

An expression of condolence was made to the next of kin.

An internal investigation was carried out by two Senior Managers which included the background and context of the incident, the support provision relating to Inspire staff and the role of external professionals. The Investigation report was shared with the next of kin, the Care Inspectorate and Senior Health and Social Care Partnership Managers.

Regular communication was maintained with relevant parties including next of kin, the Health and Social Care Partnership and the Care Inspectorate.

As a result of the investigation, learning was captured and improvements implemented.

Staff were provided with confidential support from our Employee Assistance programme and regular contact, including wellbeing checks, was maintained by the Organisation.

6. Learning Outcomes

Whilst the staff knowledge, experience, induction and training were seen to have been appropriate in the circumstances, we nevertheless took the opportunity to review and further strengthen all relevant policies and procedures ourselves and with involvement from relevant professionals.

We have shared relevant learning across the organisation.

As part of our Risk Management approach, we have introduced a Shadow Shift Competency Checklist which strengthens the staff induction process.

We have strengthened our internal Quality Assurance in relation to Key Risks.

These learning outcomes were shared with the Care Inspectorate.

7. Other Information

If you would like further information regarding this report, please contact info@inspiremail.org.uk