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**ANNUAL DUTY OF CANDOUR REPORT**

**2023-2024**

**Duty of Candour Report for Randolph Hill Nursing Homes Group**

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 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 the duty of candour in our services. This short report describes how Randolph Hill Nursing Homes Group has operated the duty of candour during the time between 1 April 2023 and 31 March 2024.

**Randolph Hill Nursing Homes Group**

Randolph Hill Nursing Homes Group operates seven nursing homes across Edinburgh, the Lothians and Dunblane. Six of our homes provide care and accommodation for up to 60 residents, and one for 50 residents. Our residents are older people who find it very hard to live at home. We aim to ensure these people receive an excellent quality of care and live happy, fulfilled lives.

**Information about our policy and procedure**

The company has a Duty of Candour Policy and guidance for staff. This is available at all times on the company’s intranet.

All staff receive training during their induction period about what Duty of Candour means, and the importance of being honest and open.

Senior staff receive more detailed training on the requirements of duty of candour, the company policy, and the procedure to follow.

Senior management are available on call, 24 hours a day, to give advice where needed regarding duty of candour incidents.

**How many incidents happened to which the duty of candour applied?**

In the past year there have been three incidents which impacted on residents in which the duty of candour applied.

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| --- | --- |
| **Type of incident** | **Number of times this has happened** |
| Someone has died | **0** |
| Someone has had permanent loss of bodily, sensory, motor, psychological or intellectual functions | **0** |
| Someone’s treatment has increased because of harm | **1** |
| The structure of someone’s body changed because of harm | **1** |
| Someone’s life expectancy became shorted because of harm | **0** |
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|  |  |
| --- | --- |
| 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 | **1** |
| A person needed health treatment in order to prevent them dying | **0** |
| A person needing health treatment in order to prevent other injuries | **0** |

One incident involved a resident who fell from a wheelchair and sustained a fractured arm.

One incident involved a resident who was caused distress by the action of a member of staff.

One incident involved a delay in escalating concerns about a wound to a specialist nurse.

**To what extent did Randolph Hill Nursing Homes Group follow the duty of candour procedure?**

In each case, our procedure for recording accidents and incidents identified that these were duty of candour incidents.

Senior management was made aware as part of our regular reporting procedures.

The Care Inspectorate were notified through eforms, as part of the normal notification procedure.

An explanation of our findings and an apology was offered to the resident or their nominated representative.

In each case, consideration was given to what could be learned, both at an individual and at an organisational level. Where necessary, improvements were made to the way care was provided to residents. Staff were reminded of company policies and procedures, and the importance of following care plans.

**What has changed as a result?**

* In response to the incident involving the wheelchair, the home reviewed the use of lapstraps for all residents who use wheelchairs, to make sure that safety straps were being used appropriately.
* In response to the incident where a resident was caused distress by the action of a staff member, we followed our company policy and procedures in investigating and addressing the concerns with the staff member.
* In response to the delay in escalating concerns about a wound to a specialist nurse, we ensured that the resident was seen by the specialist nurse and an appropriate plan of care put into place. We also made sure that the incident was reviewed with the staff involved, so that it would not be repeated in the future.

Whilst the focus of any investigation following a duty of candour incident is to highlight learning and improvement, staff are supported to understand the role their practice played in the incident.

Where wrongdoing is identified, the company’s normal disciplinary procedures will be applied, and statutory regulatory bodies notified as appropriate.

**Other information**

If you would like more information about this report, or about our care homes, please contact us via our website randolphhill.co.uk or by contacting 0131 523 0440.