Introduction

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 which result in death or harm, 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 Alzheimer Scotland has operated the duty of candour in its regulated support services during the time between 1 April 2022 and 31 March 2023. We hope you find this report useful.

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

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

Information about our policies and procedures

Incidents that may trigger duty of candour are reported and identified through our incident management and recording policy and procedures. Where duty of candour is triggered, the Executive Lead for Localities will allocate a staff member, usually a Locality Leader, to act as a point of contact and support for the person/family who have been affected, while the circumstances leading to the event are reviewed.

The Locality Leader will also identify the most appropriate mechanism to support staff who have been involved in or witnessed an incident.

The findings of any review into incidents, lessons learned, and any improvements planned, will be shared with staff involved in the incident, with the wider organisation and across the social care sector.

All incidents are recorded and where applicable reported to the Care Inspectorate. Where an incident has triggered duty of candour, this is also recorded.

All new staff learn about our incident management and recording policy and procedures at induction and all managers complete additional training in duty of candour.

If you would like more information about this report, please contact us using the following details:

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