Draft Duty of Candour Report
Tynewater PS
March 2022

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 Tynewater ELC has operated the duty of candour during the time between 1 April 2021 and 31 March 2022. We hope you find this report useful.

1. About Tynewater ELC

Tynewater ELC is a children's daycare service in Midlothian which is a 32 capacity setting delivering 1140 hours for children aged 3-5 at any one time. We are a local authority ELC. We aim to ensure that we care for children in a way which supports them to grow and develop.

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

In the last year, there were zero incidents to which the duty of candour applied. These are where types of incident have happened which are unintended or unexpected, and do not relate directly to the natural course of someone's illness or underlying condition

Type of unexpected or unintended incident	**Number of times this happened**
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	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
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries	0

3. To what extent did Tynewater ELC follow the duty of candour procedure?

If we were to realise any of the events listed above had happened, we would follow the correct procedure. This means we would inform the parents affected,

apologised to them, and offered to meet with them. We would review what happened and what went wrong to try and learn for the future.

4. Information about our policies and procedures

Where something has happened that triggers the duty of candour, our staff report this to the senior manager who has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, the manager and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

All new staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as people who use care and their families. We have occupational welfare support in place for our staff if they have been affected by a duty of candour incident.

Where parents or children are affected by the duty of candour, we have arrangements in place to provide welfare support as necessary.

5. What has changed as a result?

We have reviewed the way in which we provide meals and snacks to children to ensure that allergies are known to all staff and that staff are confident about how they can avoid harm arising from them.

6. Other information

Duty of Candour reporting has helped us to remember that people who use care have the right to know when things go badly, as well as when they go well.

As required, we have submitted this report to the Care Inspectorate but in the spirit of openness we have placed in on our website too.

If you would like more information about our ELC, please contact us using these details:

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