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**DUTY OF CANDOUR – single incident**

October 2023

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 details how our care service has operated the duty of candour during the time between ***1st April 2022 and 31st March 2023.***

We hope you find this report useful.

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

There was a single incident where a student broke his arm during game of Street Soccer, medical intervention sought and parent’s spoken with. No lasting injury or impact and student returned to site following week.

**2. Information about our policies and procedures**

Where something has happened that triggers the duty of candour, our staff report this to the Head of Operations, or another 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 or via RIDDOR process. 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 and through our Employee Handbook. We know that serious mistakes can be distressing for staff as well as people who use care and their families. We have support in place for our staff if they have been affected by a duty of candour incident.

If you would like more information about our duty of candour policy, please contact us at [info@upmo.org](mailto:info@upmo.org)

Claire Farquhar

Head of Operations