Duty of Candour Report April 2024 – March 2025

DEE VIEW COURT
NEUROLOGICAL CARE CENTRE

This short report describes how Dee View Court Neurological Care Centre has operated the duty of candour during the timeframe between 1 April 2024 and 31 March 2025.

1. About Dee View Court:

Dee View Court is a Sue Ryder specialist neurological care centre based in Aberdeen, caring for people aged 18 and over with a range of neurological conditions such as Huntington's Disease and multiple sclerosis. During the period of this report, a maximum of 43 adults with physical and sensory impairment were resident at this Service.

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

In the last year, there have been 2 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	2
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 experienced pain or psychological harm 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 as listed above	0

3. To what extent did Dee View Court follow the duty of candour procedure?

We followed the correct procedure for incident reporting through our system, Datix, Adult Support Protection referrals and e-form notifications to our regulator are submitted and a full investigation undertaken. The Senior Clinical Management informed the person affected, Next of kin/Power of Attorney of the outcome of the investigations, and apologies were made. We reviewed what had happened, what we can improve and shared the learning and actions both with all relevant people including staff to minimise the risk of reoccurrence happening in the future.

4. Information about our policies and procedures:

Staff record all incidents and near misses on our incident reporting system- Datix. All Datix's are reviewed by the Head of clinical services and Service Director. Where an incident triggers Duty of Candor the Head of Clinical Services will submit all pertinent reporting forms to our regulator the Care Inspectorate, Adult Support and Protection Team and any other relevant parties. A full investigation is undertaken and shared with all parties including Sue Ryder Quality and Governance team. Our best practice after any significant event is to complete a team debriefing this allows everyone involved to review what happened, identify potential root causes and set actions and procedural changes for the future. The findings are then shared at a local quality improvement meeting, and can be shared across Sue Ryder services, if appropriate.

If investigation shows staff misconduct we follow our Disciplinary process and would complete any professional referrals to appropriate bodies.

Duty of candour is covered within our induction process, where staff undertake our eLearning module to ensure a full and robust understanding. We know that serious incidents can be distressing for staff as well as people who use care and their families. We have staff confidential support systems in place for our staff that can access this when the need is identified, together with support from line managers and senior management.

5. What has changed as a result?

Incident 1

The physio reassessed the bedroom to re-configure and install another sensory mat to ensure the sensory mat was present on both sides of bed. These sensory mats were reprogrammed to sound as an emergency when activated (previously mats sound an alarm but not emergency alarm).

The bedrail risk assessment was repeated together with the falls risk assessment. A change to a high low bed with crash mats at both sides. The Sensory mat was set to the emergency alarm whenever

activated. The physio provided revised instructions for positioning of the residents with photos to support this.

Incident 2

All staff have had been reminded of the fundamentals of ensuring resident safety when supporting personal care needs, especially where hair tools are being used.

6. Other information

Both incidents have been closed by Adult Support Protection and the Care Inspectorate with no further actions required.