

1 April 2020

Duty of Candour NUL report

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 our service has operated the duty of candour during the time between 1 April 2019 and 31 March 2020. We hope you find this report useful.

1. 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.

2. Information about our procedure relating to the Duty of Candour

Where something has happened that triggers the duty of candour, our staff report this to the registered manager who has responsibility for ensuring that the duty of candour procedure is followed. The registered 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 and sign to say that they have read and understood their duties. We know that serious mistakes can be distressing for staff as well as people who use our service and their families. We have occupational welfare support in place for our staff if they have been affected by an incident resulting in the harm of a service user as a result of our care or treatment.

Where families or children have been harmed as a result of the care or treatment they have received, we will put arrangements in place to provide welfare support as necessary.



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