



Complaints/Duty of Candour Policy

This policy was adopted at a meeting of:

East Craigs Playgroup

Academic Year 2022/23

Signed: Caroline Wilkinson

Designation: Manager

Statement of Purpose

East Craigs Playgroup is committed to providing a high quality service and maintaining good relationships with parents. It is important that staff and parents work together in the best interests of the children. At times, however, things can go wrong, or misunderstandings may occur. Complaints will be dealt with fairly and confidentially and every effort will be made to resolve the complaint within 20 days. Throughout the guidance, the term parents is used to include all main caregivers.

2. Complaints Process

2.1 Open Access

Staff have a duty to inform parents of their right to make a complaint, including a right to appeal. A written copy of the complaint's procedure will be supplied on request to ensure parents are aware of their own roles and responsibilities regarding complaints. All complaints will be investigated thoroughly, and any necessary action will be taken where failures have been identified. Things can often be resolved quickly once we are aware of the problem and we can agree how it will be solved. We encourage this wherever possible, however alternatively a complaint can be made using our complaints procedure. A copy of the complaints policy or where to find it will also be on display for service users

2.2 Procedure

Complaints can be made to the setting both informally and formally. We will acknowledge receipt of a complaint within three working days and will endeavour to investigate and resolve it within 20 days of receipt of the written complaint. We will let you know if we think there will be a delay and give you the reasons for the delay. Complaints will be investigated by Caroline Wilkinson, manager, however if the complaint involves the management, East Craigs Playgroup committee will investigate by emailing Sarah Wylie: **ecplaygroupmanagement@gmail.com**

2.3 Informal Procedure

The initial approach made by the parent will be listened to carefully. After discussion, agreement should be reached as to whether the complaint has been resolved satisfactorily. If a delay is unavoidable the complainant will be informed, the reason for the delay will be stated and a revised timescale given. If there has not been a satisfactory outcome, then the formal complaint process should be initiated.

2.4 Formal Procedure

If a parent wishes to make use of the formal procedures the complaint should be put in writing to the manager. Receipt of the complaint will be acknowledged in writing within three working days. Following investigation, a meeting will be arranged. The parent will have the right to have the assistance of a friend, relative or representative present throughout the process. The issues or concerns raised in the complaint will be investigated thoroughly and a confidential written record of the meeting will be noted in addition to actions agreed. If the complaint remains unresolved, the appeals process will be invoked.

2.5 Appeals Process:

A parent has the right to appeal if they are not satisfied that the complaint has been resolved. The parent should contact, in writing, the same person the original complaint was sent to. If an agreement cannot be reached an external mediator, acceptable to both sides, will be invited to listen to the complaint and offer advice. The mediator has no legal powers but can help to clarify the situation by defining the problem, reviewing the actions and suggesting further ways which the complaint might be resolved. If requested, a meeting can be arranged between all those involved in the formal process. All discussions will be confidential, and a written record will be kept of all meetings held and any advice given.

3. Care Inspectorate

The Care Inspectorate is the national organisation which regulates and inspects care services. The Care Inspectorate has a complaints procedure for dealing with any complaint regarding regulated services. If you are unhappy about a care service you can, at any time, contact the Care Inspectorate directly with your complaint. In certain circumstances, in addition to the Care Inspectorate, it may be necessary to involve other agencies, such as the Local Authority, Scottish Social Services Council or the police. If you wish to complain to the Care Inspectorate, you can choose to do so anonymously. Further information can be found in the complaints section of the Care Inspectorate website:

<http://www.careinspectorate.com/index.php/complaints>

You can choose to complain directly to the Care Inspectorate by either:

- Filling in their complaints form online
- Contacting them on 0345 600 9527
- Writing to them at: Care Inspectorate, Compass House, 11 Riverside Drive, Dundee DD1 4NY

4. Duty of Candour

4.1 [The Duty of Candour Procedures \(Scotland\) Regulations 2018](#) underpins our commitment to openness and transparency, which is vital to the provision of safe, effective and person-centred health and social care. Honesty, trust and effective communication can be difficult to maintain and easy to lose when things have gone wrong. If this should happen, then we would like to have the opportunity to try and resolve any issues or concerns you may have. The organisational Duty of Candour procedure is a legal duty.

4.2

Procedure:

- When an unintended or unexpected incident that results in harm or death occurs, we will be open and accountable.
- We will apologise, without delay, if there are any misunderstandings or if something goes wrong.

- Our lead person will meet and discuss this with you, as soon as possible, when we are aware that an event has happened, or harm has been confirmed.
- We will listen and respond positively to your complaints and discuss what actions will be taken to reduce the risk of this type of incident happening again to anyone else.
- We will provide an annual duty of candour report.
- All staff will be trained on our organisation's duty of candour procedure, so that they are able to:
 - Identify harm whether it is unintended or unexpected
 - Understand what has gone wrong
 - Know who to speak to, to discuss concerns/issues.

4.3

The legislation requires care services and social work services to publish their own duty of candour reports. Even if there are no incidents to which the duty has applied during the reporting period, a short report is still required, and must contain information about staff training on the duty of candour. We will produce a report on meeting the duty of candour annually.

4.4

The Care Inspectorate has a recording system on their e-form site. One of the key questions that requires to be answered is "Does this incident trigger the duty of candour?". A designated member of staff will be asked to collect data on how the duty is being implemented and help embed awareness. We will, in turn, annually report and record these findings.

This report will include an assessment of how the duty was carried out and provide:

- A record of the number of unexpected incidents that have resulted in death or harm;
- The nature of the incident; and
- A review of any policy and procedures reviewed and any changes made as a result of the incidents reported.

The Duty of Candour sets out a range of things that need to happen when unexpected or unintended harm has occurred. You will find the online training resources information here:

www.careinspectorate.com/index.php/duty-of-candour

www.gov.scot/Resource/0053/00533470.pdf

5. General Data Protection (GDPR)

5.1 Statement of Purpose

We are required to gather particular personal data and information in order to comply with legislation relating to early learning and childcare in Scotland. We will gather and process all personal data and relevant consents, both verbal and written, which is in line with GDPR guidance. Data will be treated confidentially and will uphold the rights

of all individuals involved in the service, including children, parents, staff, students and volunteers. We are required to hold information about our children and families, as well as staff working within the setting, again ensuring compliance within the regulation. Processes will be in place to ensure the safe and secure storage of all data belonging to our service users; the detail of this storage is as follows XXXX. General Data Protection Regulation (GDPR) came into effect on 25 May 2018 and expands on the current regime established by the Data Protection Act 1998 (DPA).

Monitoring of this Policy

It will be the responsibility of Caroline Wilkinson, , manager to ensure that all staff are aware of this policy and implement it consistently. Parents will be made aware of the policy and their role regarding complaints through the parents' handbook and the enrolment procedure. This policy will be reviewed annually to ensure that it is relevant and up to date.

See also:

Confidentiality Policy
Equal Opportunities Policy
Participation Policy
Whistleblowing Policy
Recruitment Policy
General Data Protection Regulation – Privacy Policy

Links to national policy

When reviewing your policy, please reflect on the 'Health & Social Care Standards: My support, My life' <https://www.gov.scot/publications/health-social-care-standards-support-life/> Standards 2.3, 2.4, 3.22, 3.24, 4.4, 4.18, 4.19, 4.20, 4.21, 4.22, 4.23

www.gov.scot/Resource/0052/00520693.pdf

www.gov.scot/policies/healthcare-standards/duty-of-candour/

www.gov.scot/publications/organisational-duty-candour-guidance/

<https://learn.nes.nhs.scot/2654/elearning-nmahp/duty-of-candour>

Duty of Candour

The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them in a review of what happened.

When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement.

They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen.

The duty of candour procedure provisions reflect our commitment to place people at the heart of health and social care services in Scotland.

We recognise that when unexpected or unintended incidents occur during the provision of treatment or care, openness and transparency is fundamental. This promotes a culture of learning and continuous improvement.

2021/2022

In the last year there were 0 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.

Duty of Candour Record

Type of unexpected or unintended incident	Number of times this happened
Someone has died.	
Someone has permanently lost bodily, sensory, motor, physiologic or intellectual functions.	
Someone's life expectancy becomes shorter because of harm.	
A person needing health treatment in order to prevent other injuries.	
A person needed health treatment in order to prevent them dying.	

When we realised the above incidents had occurred, our policy and procedures were followed correctly on occasions. This means we informed the people affected, apologised to them and offered to meet with them. In each case, we reviewed what happened and what went wrong to try and learn for the future.