

# Duty of Candour Report 2025/26



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# Eildon Housing Association

## Duty of Candour Report

### Duty of Candour

The Duty of Candour is the obligation for any registered service to be open and transparent when there has been an unintended or unexpected incident that results in death or harm (or treatment is required to prevent death or harm). There is a legal requirement to ensure that when things go wrong, the affected people are offered an explanation, an apology, and assurances that lessons will be learned from the error.

Reporting on Duty of Candour is incorporated into our Statutory Reporting Procedure which underpins our approach to monitoring and reporting across our care services.

### About Eildon

Eildon Housing Association provides housing, care, and support services to people across the Scottish Borders – serving nearly 50 communities in Borders towns, villages, and rural areas.

All staff working in our care services undertake training on Duty of Candour through our Learning Management System online, and our induction process includes our policies and procedures for Incident Reporting. In the event of incidents which may trigger Duty of Candour reporting requirements (or are otherwise significant) we offer additional support to staff, to reflect and debrief, and external counselling and support is also available to all staff through Westfield Health.

As an organisation, we are committed to transparency, continuous improvement, and the professional development of our staff teams.

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## Period April 2025 – March 2026

All Health and Social Care Services across Scotland must provide an annual Duty of Candour report. This report will note any instances where Duty of Candour has been triggered within the reporting period, describe the actions taken because of the incident, and outline the lessons learned and how these lessons will be incorporated into our daily practice.

Between the reporting period of April 2025 to March 2026, there were no incidents which met the criteria for Duty of Candour reporting.

### **Type of unexpected or unintended incident and how many times it occurred across our care services**

Someone has died	0
A person has permanently lost bodily, sensory, motor, physiological, or intellectual function	0
A person experiences a permanent physical change because of life-altering harm	0
A person's life expectancy was reduced because of harm	0
A person's sensory, motor, or intellectual function was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed treatment to prevent death	0
A person needed treatment to prevent further injury	0

## Other Incidents and Accidents

All incidents, accidents, and errors are recorded, discussed, and analysed as part of the operational management of our services. Actions taken as a result are noted and reported to our regulators and commissioners as appropriate.

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During the reporting period, there were other notifiable events (that did not meet the criteria for Duty of Candour reporting) through our care services. We have reviewed each event and taken appropriate actions identified.

## Learning From Incidents

For each notifiable event we consider any steps that should be taken to minimise the likelihood of the event recurring, either within the same service, or elsewhere in our organisation. Where actions are identified, we aim to communicate with affected people what we are doing and why, to demonstrate transparency and reflective practice.

We also discuss all serious medication-related incidents within our Care Services management team structures regularly to agree and have oversight of any changes to our practice that may be needed in response to these. We will also increase service audits to ensure changes in practice are implemented.

All non-notifiable incidents, near misses, and errors are also discussed within each service by the Senior Team to identify potential causes or patterns and take any required action. This may include additional support from external partners such as Social Work, Public Protection, or referral on to health professionals or third sector organisations.

Learning from these discussions is then shared widely across our care services teams and embedded into our approach through procedure review and staff development.

## How to Contact Us

We're always happy to help - give us a follow or get in touch for more information.



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