

All health and social care services in the UK have Duty of Candour responsibilities. 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 organisations learn how to improve for the future.

An important part of this duty is to provide an annual report about the duty of candour in our service. This short report describes how Beaumont Manor has operated the duty of candour during the period from1st April 2024 to the 31st of March 2025. We hope you find this report useful.

Beaumont Manor Care Home is located in a seaside town in Essex, our nursing home provides dementia care, nursing care and residential care near Clacton – on Sea. The care to 70 residents is provided by a team of care professionals who have all received specialised training in dealing with all various elements and aspects of nursing and dementia care. Our care teams and Activity Coordinators are always glad to collaborate with dementia residents and their loved ones to identify activities and therapies that are appropriate for their specific needs. We always work with an open-door policy, in the sense that there will always be an open line of communication between our teams, our residents, and their loved ones.

Within the last 12 months, there have been 5 incidents at the home, to which the duty of candour applied. These are where types of incidents have happened which are unintended or unexpected, and do not relate directly to the natural course of someone's illness or underlying condition.

Types of Unexpected or Unintended incidents specified within the legislation.	The number of people affected
Someone's sensory, motor, or intellectual function is impaired for 28 days or more.	n/a
Someone has experienced pain or psychological harm for 28 days or more.	n/a
A person needed health treatment to prevent them from dying.	n/a
A person needed health treatment to prevent other injuries.	1
The structure of someone's body changes because of harm/injury.	n/a

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Someone's treatment has increased because of	4
harm.	
Someone's life expectancy becomes shorted	n/a
because of harm.	
Someone has permanently lost bodily, sensory,	n/a
motor, or intellectual functions because of harm.	
Someone has died.	n/a

When we realised the events above had happened, we followed the correct procedure. This means we informed the people affected, apologised to them in person and in writing, and offered to meet with them and their family. We reviewed what happened and what if anything, went wrong to try and learn for the future.

If something has happened that triggers the duty of candour, our staff report this to the Home Manager who has responsibility for ensuring that the Duty of Candour procedure is followed. The Home Manager records the incident or accident and reports it as necessary to the Care Quality Commission, the local contracting authority, the Regional Director, and the Quality Director, for the company. When an incident or accident has happened, the Home 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. We know that serious mistakes can be distressing for staff as well as people who use care and their families.

In response to the residents who experienced harm; in consultation with the individuals and their family, we reviewed their care and support plans, and introduced additional measures, including:

Discharge Document and MAR Chart Review: We have emphasized that it is crucial for two trained individuals to check discharge documents and clearly record all changes on the Medication Administration Record (MAR) charts. We have also learned that it is essential to discuss all findings during clinical risk meetings.

Use of Equipment to Prevent Falls: It has become evident that we must make better use of the available equipment to minimize the risk of falls. Additionally, we have realized the importance of effective communication and proper documentation during handovers to ensure all concerns or issues with any individual are addressed, and appropriate safety measures are in place. We also recognize the critical need for correct staffing levels on each floor to ensure that all residents are well-supported.

Obtaining Medical History: We have learned the importance of obtaining and maintaining all medical records, including past medical history, to ensure that we are aware of any previous diagnosis and treatments. This information will help us understand medical conditions better and communicate clearly with medical professionals to ensure the best possible outcomes for each resident.

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Clear Communication and Incident Reporting: We understand that clear and open communication is essential, and we are committed to maintaining accurate records of any incidents or accidents to eliminate any potential abuse. We have taken steps to reinforce this throughout the team.

Clear Handover Process: This helps minimize incidents and ensures continuity of care.

Duty of candour informs our learning and planning for improvements as a service, and as a company. It has helped us to remember that people who use our services have the right to know when things could be better, as well as when they go well.

As required, we have made this report available to the regulator but in the spirit of openness, we have published it to share with our residents and their relatives too.

If you would like more information about our care home, please contact us using these details:

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