DUTY OF CANDOUR report 2024

This report covers the period January 1st 2024 -31st December 2024. During this period there were no instances when this duty was required.

Corbenic Camphill Community aims to create a culture that supports a safe environment, which encourages workers to report concerns or when something has gone wrong. We believe that an atmosphere of openness, honesty and transparency will enable those involved in care provision or other roles of responsibility to expect support rather than blame, and will help to develop good relationships between all who live or work in Corbenic. Incidents and situations are reflected upon and viewed as opportunities for learning and improvement. This is inline with the values and aims of the organisation as well as policies and procedures stemming from current legislation. In the event of an unintended or unexpected incident that results in serious harm or death, we believe that how we respond to such an incident will make a real difference to people's experience, and that people want to be told honestly what happened and what will be done in response, and to know what actions will be taken to reduce the risk of the same thing happening again to someone else in the future. These conversations should happen as soon as possible after an event happening or harm being confirmed.

Therefore, in the event of any incident that is unexpected and has resulted in death or serious harm and is not related to the natural course of the person's current condition or illness for which they are receiving care, we will follow our Duty of Candour Procedure, as soon as it is clear that this has been triggered (APPENDIX A).

Any incident triggering duty of candour (APPEDIX B) will be reported promptly and appropriately and will highlight that the duty of candour procedure has been triggered.

There have been no changes to our policy or procedure detailed below during this time.

DUTY OF CANDOUR PROCEDURE

- Corbenic Camphill Community will identify a lead person for communicating with the person affected and/or their family and for communication within Corbenic.

- That lead person will straight away notify the person affected and/or their family that an unintended or unexpected incident has occurred that has resulted serious harm.

- They will apologise to the person and/or their family and express the Community's sincere regret that the incident has happened.
  (This does not imply legal responsibility.)

- They will tell them that we will look into the details of what happened and how and why it happened and will inform them of this will be treated as a matter of urgency. Also, that we will tell them what we will do in response, and what actions will be taken to reduce the risk of the same thing happening to someone else in the future.

- The Community will provide support to each person involved, both the person affected and their family and the workers involved in the incident.

- The Community will report the incident through local systems by completing incident records and incident management reports as standard, and will carry out a review of the incident and ensuring that as far as possible the person and/or their family are included in a way that meets their needs, (the review should be undertaken by a person not involved in the incident).

- The lead person will arrange the next meeting with the person and/or their family to explain what went wrong and the actions that will be taken.

- They will provide a written account to the person and/or their family should they wish for this. (Whilst they may not wish for this, it should always be offered.)

- The lead person will ask how the person and/or their family want information to be provided to them and tell them how we will store their information.

- The Community will record each action or meeting and all associated correspondence, whilst continuing to monitor and report on developments as appropriate, and ensuring that lessons are learned and shared.

- An annual incident analysis and report will include and detail any incidence whereby Duty of Candour has been triggered (APPENDIX C).

Date: 31st December 2024

APPENDIX A

Events that would trigger the Duty of Candour Procedure

An unintended or unexpected event that has resulted in one of the following:

a) the death of the person

b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions.

c) harm which is not severe but results in;

  i) an increase in the person's treatment.

  ii) changes in the structure of the person's body.

  iii) the shortening of life expectancy of the person.

  iv) an impairment of the sensory, motor or intellectual functions of the person which has lasted or is likely to last for a continuous period of at least 28 days.

  v) the person experiencing pain or psychological harm which has been or is likely to be experienced by the person for a period of at least 28 days.

d) the person requiring treatment by a registered health professional in order to prevent:

  i) the death of the person or

  ii) any injury to the person which if left untreated, would lead to one or more of the outcomes mentioned in b) or c).

APPENDIX B

Ways that the Duty of Candour Procedure can be triggered

A regulated health professional, not involved in the incident, confirms that an unintended or unexpected incident has occurred and has resulted in serious harm or death.

Or

A complaint, feedback received or a significant event which may lead to a review.

Or

A disclosure under the Whistleblowing Policy or our policy about raising concerns.

<u>APPENDIX C</u>

The Annual Report should include the following:

- The number and nature of incidents to which the Duty of Candour has applied (without names of those involved).
- How the duty was carried out.
- Information about our policies and procedures in relation to the Duty of Candour, including information about procedures for identifying and reporting incidents and support available to all persons involved or affected by incidents.
- Information about any changes made to policies, procedures or practice as a result of the incident, i.e. learning identified and shared, and improvements made.
- Support that was made available to the person affected by the incident and to the worker involved.