Duty of Candour Report 2024-2025 Penrose Court

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 Penrose Court 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.

Penrose Court Care Home is a care home as part of Care Concern group. The home can cater for residential, residential dementia and nursing care for older people who require care and support in a homely setting. The home is over 3 floors, set in a middle of a residential area and we are closely linked to the community. We aim to ensure that our residents receive an excellent quality of care and live happy, fulfilled lives.

Within the last 12 months, there have been 14 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.	
Someone has experienced pain or psychological harm for 28 days or more.	
A person needed health treatment to prevent them from dying.	
A person needed health treatment to prevent other injuries.	
The structure of someone's body changes because of harm/injury.	13
Someone's treatment has increased because of harm.	
Someone's life expectancy becomes shorted because of harm.	
Someone has permanently lost bodily, sensory, motor, or intellectual functions because of harm.	
Someone has died.	

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 Inspectorate/ 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.

We had 8 duty of candour which have resulted in factures, all residents have falls risk assessment in place. Review of care plans and consulting with residents and their families. Review of environment, their mobility and sensors alert were in place. Staffing levels on nights on the dementia unit were reviewed and increased due to the increased risks.

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:

Mary Tolladay - manager@penrosecourt.com

Jane Prior – Jane.Prior@careconcerngroup.com