HAZELWELL
CARE HOME

Duty of Candour Report 2022-2023

The Hazelwell Care Home

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 The Hazelwell has operated the duty of candour during the period from1st April 2022 to the 31st of March 2023. We hope you find this report useful.

The Hazelwell Care Home in Heswall is a care home for up to 55 residents. We provide residential and nursing care for older people who require care and support in a homely setting. 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 3 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.	0
Someone has experienced pain or psychological harm for 28 days or more.	0
A person needed health treatment to prevent them from dying.	0
A person needed health treatment to prevent other injuries.	1
The structure of someone's body changes because of harm/injury.	0
Someone's treatment has increased because of harm.	0
Someone's life expectancy becomes shorted because of harm.	0
Someone has permanently lost bodily, sensory, motor, or intellectual functions because of harm.	0
Someone has died.	2

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When we realised the events above had happened, we followed the correct procedure for all incidents. This means we informed the people affected, apologised to them in person and in writing, and offered to meet with them and their families. In each case, 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 Care Home Manager who has responsibility for ensuring that the Duty of Candour procedure is followed. The manager records the incidents and reports them as necessary to the Care Quality Commission, the local contracting authority, and the Regional Director for the company. When an incident or accident has happened, the 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 all individuals and their families, we reviewed their care and support plans, and introduced additional measures to the home.

None of the families involved in our events that triggered the Duty of Candour process wished to take part in the process. Contact was facilitated by the local authority Safeguarding Team who upheld their Section 42 Safeguarding concern but were assured that appropriate measures had been put in place to reduce the risk of this happening again.

The resident who required treatment to prevent injury did not want any further action taken and did not want to be involved in any investigation. They asked that the incident was not reported to the local authority Safeguarding Team and as part of the reporting process we made their wishes known to them. They have not progressed their Safeguarding concern as a result. We have, as a provider, continued with our own investigations and taken action to reduce the risk of this incident happening again.

This is the fifth year of the duty of candour being in operation and it has helped focus our learning and planning for improvements as a service and the company. It has

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helped us to remember that people who use care 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:

Home Manager - Simon Paul – simon.paul@thehazelwell.com

Regional Director – Kelly Walker – kelly.walker@careconcerngroup.com