



Duty of Candour Report 2023-2024

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 from 1st April 2023 to the 31st of March 2024. 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 7 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.	4
A person needed health treatment to prevent them from dying.	
A person needed health treatment to prevent other injuries.	1
The structure of someone's body changes because of harm/injury.	
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.	2



Duty of Candour Report 2023-2024

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 families. 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 and the Regional 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 one of the residents who experienced psychological harm, a full investigation was carried out and the appropriate external bodies were notified, CQC, Wirral Borough Council safeguarding team and Merseyside police.

For the other three residents who experienced psychological harm; in consultation with both individuals and their families, we put an action plan in place of what needs to be achieved within a certain time frame, measures were introduced within the home and their care and support plans were reviewed. All the actions that were introduced were met.

In response to the resident who needed health treatment to prevent other injuries involved a collaborative approach with family members as the resident lacked' capacity. An action plan was put in place and their support and care plan needs were reviewed. This was achieved with full satisfaction of the family.

Two of the residents who passed involved a full internal investigation, statements and incident forms were collected from all staff on duty. It involved external bodies such as the CQC, and Wirral Borough Council. One of the incidents involved the notification of the Merseyside police. Enquiries into both deaths have been closed.

None of the families involved in all our events stated above that triggered the Duty of candour process wished to take part in the process.

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



Duty of Candour Report 2023-2024

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:

Home Manager- Simon Paul- simon.paul@thehazelwell.com / manager@thehazelwell.com

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