# Duty of Candour Report 2024-2025 The Fleet

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 Fleet 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.

The Fleet Care Home in Dartmouth is a care home for up to seventy-nine residents. We provide residential, nursing, and dementia 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 two 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. | 2 |
| A person needed health treatment to prevent them from dying. | 0 |
| A person needed health treatment to prevent other injuries. | 0 |
| 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. | 0 |

When we realised the event 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 consultation with the individuals and their family, we reviewed their care and support plans, and introduced additional measures, including the use of falls technology. We have also worked in partnership with GP practice, District Nurse Team, and other local specialists to review the multifactorial factors that can affect mobility and increase the risk of falls.

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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