Action details

Person responsible:	Andrei Joanta
Location:	Valerian Court
Due date:	01-Apr-2026
Details of action required:	An important part of Candour of duty is to provide an annual report about the duty of candour in our service. This short report describes how the Care Home has operated the duty of candour during the last year.
Closed date:	14-Apr-2026

Form - Duty of Candour Annual Report

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 Care Home has operated the duty of candour during the last year. We hope you find this report useful.

What year does this annual report relate to?: 2025

Who is completing the report: VAL132

Job Role: Home Manager

Provide a short narrative about your service: Valerian Court is a purpose built care home with a maximum capacity of 70 beds. Our Home provides care support for people with residential, dementia and nursing care in a friendly and homely environment.
Ensuring that our resident are receiving the best possible quality of care is at the heart of all our actions. We aim to ensure our residents live enriched lives supported by a friendly team of care professionals

Within the last 12 months, how many incidents have there been at the home, to which the duty of candour applied.: 3

Types of Unexpected or Unintended incidents specified within the legislation

Someone???s sensory, motor, or intellectual function is impaired for 28 days or more.

Number of people affected (just add number - no details)	3

Someone has experienced pain or psychological harm for 28 days or more.

Number of people affected (just add number - no details) 2

A person needed health treatment to prevent them from dying.

Number of people affected (just add number - no details) 1

A person needed health treatment to prevent other injuries.

No entries recorded

The structure of someone???s body changes because of harm/injury.

No entries recorded

Someone???s treatment has increased because of harm.

No entries recorded

Someone???s life expectancy becomes shorted because of harm.

No entries recorded

Someone has permanently lost bodily, sensory, motor, or intellectual functions because of harm.

No entries recorded

Someone has died.

No entries recorded

When you realised the event(s) above had happened, did you follow the correct procedure.: YES

Did you review what happened and what if anything, went wrong to try and learn for the future.: YES

When something has happened that triggers the duty of candour, do staff report this to the Home Manager who has responsibility for ensuring that the Duty of Candour procedure is followed?: YES

Does the Home Manager record the incident or accident and reports it as necessary to the CI/ CQC/CIW, the local contracting authority, the Regional Director, and the Quality Director, for the company.: YES

Do all new staff learn about the duty of candour at their induction?: YES

When an incident or accident has happened, does the Home Manager and staff set up a learning review?: YES

Please provide a short explanation of the learning from any Duty of Candours (Please do not provide any information that could identify individual residents): During 2025, there were 3 incidents where Duty of Candour applied. One incident happened on the admission day for a resident that had a fall and sustained a hip fracture. Due to complex bone health medical background, a surgical intervention was initially avoided as the risk of not surviving the intervention was too high. Due to continued deterioration and poor quality of life prognosis, the surgery took place and with the total hip replacement the resident regained the independence in mobility. The incident could not be avoided as it was an unfortunate accident but support and preventative measures were put in place on return from hospital. The care plans have been reviewed to highlight the increased level of care, mobility equipment and mobility rehabilitation. Motion sensor equipment has been put in place and external medical professional(CHSS) involved in the rehabilitation process.
The second incident involved a resident known as having a high risk of falls and the CHSS falls team previously assessed as a "risk taker" due to behaviour associated with dementia diagnosis. At the time of incident, previous actions to minimise the falls occurrence were already in place and active at the time of the incident. The resident sustained a line fracture in the left shoulder that was resolved with support in a sling and pain medication. The care plan and the risk assessment were reviewed as consequence of this event and CHSS did a reassessment with no new recommendations for falls prevention measures.
The third incident involved a resident that had a fall next to her recliner and sustained rib fractures. On the x-ray, it was evidenced that these were old fractures but now acute due to the new event. On return from the hospital, several medical professionals have been involved in the rehabilitation process with pain management reviewed with the GP, mobility assessment and rehabilitation plan done with CHSS falls team, care plan reviewed in the home and motion sensor put in place with resident agreement to ensure extra safe support with mobility needs.

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.

Do you confirm that you have made this report available to the regulator but in the spirit of openness, have also published it to share with residents and their relatives too.: YES