

Action details

Person responsible: Ben Co

Location: Longbridge Deverill

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: 13-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?: 2026

Who is completing the report: LDH12

Job Role: Home Manager

Provide a short narrative about your service: Longbridge Deverill Nursing Home is a home that provides nursing and dementia care for up to 70 older people. We sit in the wonderful grounds of old Longleat estate with beautiful views. We aim to ensure that our residents receive an excellent quality of care and live happy, fulfilled lives.

Within the last 12 months, how many incidents have there been at the home, to which the duty of candour applied.: 4

Types of Unexpected or Unintended incidents specified within the legislation

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

No entries recorded

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

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

4

A person needed health treatment to prevent them from dying.

No entries recorded

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): 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, 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 response to the residents who experienced harm; 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, PIR infrared motion sensors, falls mat and chocking preventive devices in each units.

This is the seventh 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 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.

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