Action details

Person responsible:	Preet Hundal
Location:	Ashton
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:	15-Jun-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: ASH'0034

Job Role: Home manager

Provide a short narrative about your service: The Ashton Care Home is able to provide care and support for 72 residents. We provide residential, dementia and nursing care for older people who require care and support in homely setting. We aim to ensure resident s care is provided in safe, comfortable environment offer excellent quality of care and living happy and fulfilled lives.
Within the last 12 months, there have been 2 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.

Within the last 12 months, how many incidents have there been at the home, to which the duty of candour applied.: 2

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.

No entries recorded

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.

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

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

Number of people affected (just add number - no details)	1
Number of people affected (just add number - no details)	2
Number of people affected (just add number - no details)	3

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): 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 e.g., the use of falls technology, and impact reducing aids low profile beds and crash mats. We increased our measures for monitoring for e.g. more frequent comfort checks, and clinical oversight daily through flash meetings. We requested external multi agency support for more guidance and support on managing treatment for individuals and we ensured to reflect and share lessons learnt by communicating with the team e.g Nourish updates, clinical risk meetings, staff notices and meetings.

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