



Duty of Candour Report 2022-2023

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 Woodlands Care Home has operated the duty of candour during the period from 1st April 2022 to the 31st of March 2023. We hope you find this report useful.

Woodlands Care Home is a brand new 81 bed purpose-built care facility situated in the residential area of Craigiebuckler, Aberdeen. Woodlands Care Home has been thoughtfully designed to offer first-class care for a range of care needs including Residential Care, Nursing Care, Dementia Care and Respite Care, as well as Palliative Care for older people. The care home is spacious with floor-to-ceiling windows throughout which provides a light and airy feel. Small community living is a highlight of the care home. The abundance of communal space allows for emotional wellness, increased social interaction and life enrichment. Residents on the ground floor have access to their own private garden from their own room courtesy of our extensive grounds.

Within the last 12 months, there have been no 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.	0
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 realise events above could happen, we would follow the correct procedure for all incidents. This means we would inform the people affected, apologised to them in person and in writing, and offered to meet with them and their families. In each case, we would review what happened and what if anything, went wrong to try and learn for the future.

If something had happened that triggers the duty of candour, our staff report this to the Care Home Manager who has responsibility for ensuring that the Duty of Candour procedure is followed. The manager records the incidents and reports them as necessary to the Care Inspectorate, the local contracting authority, and the Regional Director for the company. When an incident or accident has happened, the 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.

This is the fifth year of the duty of candour being in operation and it has helped focus our learning and planning for improvements as a service and the company. It has helped us to remember that people who use care 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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