

Action details

Person responsible:	Yanti Beament
Location:	Silverleigh
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:	23-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: SL513

Job Role: Registered Manager

Provide a short narrative about your service: Silverleigh is a welcoming care home for up to 65 residents. We provide residential, nursing, and dementia care for older people who need support in a safe, homely, and compassionate environment. Our dedicated team works closely with residents and their families to ensure that everyone receives personalised care that promotes wellbeing, dignity, and independence. We strive to create a nurturing environment where residents can enjoy fulfilling, happy lives surrounded by warmth, respect, and community.

Within the last 12 months, how many incidents have there been at the home, to which the duty of candour applied.: 6

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) 0

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

Number of people affected (just add number - no details) 0

A person needed health treatment to prevent them from dying.

Number of people affected (just add number - no details) 0

A person needed health treatment to prevent other injuries.

Number of people affected (just add number - no details) 4

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

Number of people affected (just add number - no details) 4

Someone's treatment has increased because of harm.

Number of people affected (just add number - no details) 0

Someone's life expectancy becomes shorted because of harm.

Number of people affected (just add number - no details) 0

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

Number of people affected (just add number - no details) 0

Someone has died.

Number of people affected (just add number - no details) 0

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 resident(s) who experienced harm, and in consultation with the individual(s) where possible, and their families or legal representatives, we reviewed their care and support plans and introduced additional measures where appropriate. These included enhanced monitoring, updated risk assessments, and adjustments to care routines to better meet residents' needs. Staff were reminded of best practice guidance, and additional training was provided to support safe, person-centred care.

We also reviewed our internal reporting and communication procedures to ensure incidents are identified promptly, addressed openly, and families or representatives are informed in a timely and transparent manner. These measures reinforce our ongoing commitment to providing high-quality, safe care for residents, including those with dementia or reduced capacity, while maintaining trust and transparency with families and representatives.

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