



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 Trinity House Care Home has operated the duty of candour during the period from 1st April 2024 to the 31st of March 2025. We hope you find this report useful.

Trinity House Care Home in the centre of Edinburgh is a care home for up to 55 residents. We provide residential, nursing, palliative care and dementia care for older people who require care and support in a homely setting. We aim to ensure that our residents receive an excellent quality of care and live happy, fulfilled lives.

Within the last 12 months, there have been 2 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.	
Someone has experienced pain or psychological harm for 28 days or more.	2
A person needed health treatment to prevent them from dying.	
A person needed health treatment to prevent other injuries.	
The structure of someone's body changes because of harm/injury.	
Someone's treatment has increased because of harm.	
Someone's life expectancy becomes shorted because of harm.	
Someone has permanently lost bodily, sensory, motor, or intellectual functions because of harm.	
Someone has died.	

Duty of Candour Report 2024-2025 Trinity House Care Home



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 family. We reviewed what happened and where things went wrong we put measures in place to ensure learning 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 Inspectorate, 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 or injuries, we ensured a full review of their care and support in consultation with the individuals and their families. Care and support plans were reviewed, professional input sought and additional measures introduced, including the use of falls technology and review of equipment in use.

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.

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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