Mr Amarjit Singh Sehmi

Destiny Care Support

Inspection report

Crowhurst Care Home
Old Forewood Lane, Crowhurst
Battle
East Sussex
TN33 9AE

Tel: 01424830754

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Destiny Care Support is a supported living service providing personal care to nine people with a learning disability at the time of the inspection. The service can support a maximum of 10 people. The service is located in a large residential building set on a quiet rural lane.

At the time of our inspection everyone living at Destiny Care Support received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Systems to protect people from abuse and neglect had not been safely implemented. Risks to people were not being managed as safely as possible. Medicines were not being managed effectively or safely and this put people at risk of not having prescribed medicines when they needed them or as directed. Lessons had not always been learned when things went wrong.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People had not been supported to understand restrictions, or to ensure any decisions to keep people safe were the least restrictive measures.

People were at risk of not having their health needs met. For example, some health conditions had not been care planned effectively. Risks around peoples eating and drinking needs had not been mitigated, so people may not have had enough to eat or drink for good health.

Staff had not always had the correct training they needed to carry out their roles safely. Staff supervisions had not been carried out as planned.

Quality audits were not effective in identifying shortfalls in the service. The registered manager and provider had not completed sufficient audits to identify where improvements were needed. Statutory notifications had not been sent to CQC and we found multiple breaches of Regulations.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting did not always maximise people's choice, control and independence.
• The service was located in a rural setting on a secluded lane and accessing the community often required staff support, which meant some people had to wait to access activities or shopping. Other people could access the community independently via taxis or local transport links.

Right care:
• Care was not person-centred and failed promote people's dignity, privacy and human rights.
• People did not always receive their care in a way that empowered them or promoted their independence.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives.
• The culture in the service was not always positive. People sometimes felt not listened to and lessons were not learned to improve service delivery.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection The last rating for this service was Good (published 12 July 2018).

Why we inspected
We received concerns in relation to safeguarding concerns and the safe management of risk. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to consent, safe care and treatment, safeguarding people from abuse, good governance, staffing and notifying CQC of significant events at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Destiny Care Support

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We reviewed recent safeguarding incidents and spoke to professionals involved in the service. We used all of this information to plan our inspection.

During the inspection-
We spoke with six people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager, team leader, and care workers.
We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the registered manager to gain assurances about concerns. We looked at training data and quality assurance records. We spoke with staff who worked at the service. We met with the registered manager and received assurances about actions taken to ensure the safety of people.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes to keep people safe from abuse had not been effectively implemented. There had been incidents where a person had been threatened online and raised this with staff. However, this had not been responded to as a possible allegation of abuse.
- The registered manager and provider had failed to ensure action was taken to keep two people safe when an incident occurred at night-time. This incident involved a known risk to one person but was not safely followed up to reduce the risk of abuse recurring
- People were not being supported to understand what keeping safe meant for them and were not being positively encouraged to raise concerns. There had been a known risk in the service but people, some of whom had communication needs, had not been empowered to raise concerns. The service had not ensured that people knew what might constitute abuse or tailored this information to people's communication needs.
- One person had been subject to a safeguarding enquiry but their risks had not been proactively managed to ensure other people were not at risk. There was a lack of preventative action following the incident. There had been occasions when Statutory Notifications should have been made to CQC relating to safeguarding issues but these were not sent. We have reported on this in the Well led section of this report.

People had not been sufficiently protected from the risk of abuse because systems to safeguard people were not effective. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management, and learning lessons when things go wrong

- Risks to people were not being safely mitigated and monitored. This left people at risk of harm.
- One person had known behaviours of concern. Their behaviour support plan did not describe actions staff needed to take to keep the person safe. There was no understanding from staff as to why the person engaged with these behaviours, or how they could help the person. This left the person at risk of repeatedly exposing themselves to harm.
- A second person had a known behaviour that could result in physical and verbal aggression to staff and people living at Destiny Care Support. Their support plan had a lack of preventative strategies for staff to use to support the person. Strategies suggested were only very briefly described and were reactive, meaning the person, and others, would be at risk of repeat distress or injury. Staff were working ad hoc to support the person when they were distressed.
- A third person had a care plan that spoke about high risk behaviours that were developed over many years. However, the person did not have a positive behaviour support plan (PBSP). A PBSP would help staff to understand the reason for inappropriate or challenging behaviour and direct them how to support the

person to reduce the behaviours. The lack of positive behaviour support approaches left people at risk of repeat incidents of concern.

● Choking risks had not been managed safely. One person had a choking risk that was known and recorded in an old care plan. This risk had not been managed safely or carried over to new care plans. The person had some risk assessments but these did not mention the risk or how to reduce it. We spoke with staff about how they would manage this risk and they could only tell us they would monitor the person. However, staff also said the person could be on their own and described incidents in their bedroom where they had been at risk.

● Two other people were at risk from choking and both had speech and language therapy (SaLT) guidance to set out how they need their food and drink to be given. Both people had risks assessments and care plans for eating and drinking but these did not set out how to keep them safe or what action staff should take if the person was choking.

● Staff we spoke with were not confident when describing the actions they would take in the event of a person choking. Following our site visit we asked the registered manager to arrange training for staff and to write risk assessments for choking for each person at risk and send these to us, which they did.

● Risk mitigation measures that had been identified to keep people safe had not been effective. One risk had led to CCTV being installed. However, the images were not accessible to staff working in the service. The registered manager and staff agreed this did not reduce the risk to people.

● Following our site visit we requested that the registered manager re-assessed the risk. The registered manager confirmed that following our inspection they had access to CCTV images and were able to reduce risk.

● Other risks were not being managed proactively. There was a lack of active risk management around one person's known risks. Measures to keep people safe that had been in place in other care settings had not been carried over to Destiny Care Support and no other measures had been implemented.

● One person who was diagnosed with epilepsy had a special treatment for any seizures. Their care plans and risk assessments did not make clear how this treatment should be given or where staff would find it. We spoke with staff who gave different answers as to what they would do in the event of the person having a seizure. This left the person at risk of not receiving the care they needed with their epilepsy

Using medicines safely

● Medicines were not being managed safely. People had been prescribed some medicines to be used as and when required (PRN). These medicines need PRN protocols to explain their use and how much to give, or when to use the medicine. Some PRN medicines did not have PRN protocols which left people at risk of not receiving their medicine when they need it or in the way it was prescribed.

● Other 'as required' medicines had a PRN protocol. However, the PRN protocol did not give all the information that staff administering medicines would need to know. For example, one person's PRN protocol for epilepsy medicine did not give information about seizure type, how the person presented during a seizure, or the duration and frequency of seizures prior to giving the medicine. It failed to outline the specific risks related to the medicines use, how long to monitor the person after administration, if more than one dose can be given, or what to do if the first does was ineffective.

● Medicines were being recorded on a medicine administration chart (MAR). MAR charts did not have the running balance recorded so it was not possible to confirm if the physical stock of medicines was correct, if any have gone missing, or any had been administered incorrectly. There were further concerns with stock checks of medicines.

● Staff we spoke with gave different accounts of how medicines were stored and whether there was a system for returning medicines that were unused. There was no system to separate stock of medicines in use and medicines to be returned. In addition, we found out of dates medicines. This put people at risk of not having medicines available if they run out, or of receiving medicines that are passed their use by date.

People had not been kept safe from risks and did not have safe access to medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Deployment of staff was not effective. A large number of incidents had occurred at night-time when there were fewer staff on shift.

● We received mixed feedback about staffing levels at the service. One person told us, "There are enough staff around or I'll wait. There's always enough staff, even at weekends and evenings." During our inspection we saw that staff were able to support people with their needs.

● However, we were also told by staff that there are times when there were not enough staff, particularly at night. We discussed this with the registered manager who told us about the funding that people have for support in the daytimes and the various things that staff may need to support people with at night times.

We recommend the provider considers the deployment of staff so that day and night-time support needs are equally provided for.

Preventing and controlling infection

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. PPE was being disposed of in a domestic bin without the proper safety precautions. We have also signposted the provider to resources to develop their approach.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not have the skills and competencies they needed to fulfil their roles effectively. Some people living in Destiny Care Support had behaviours that may challenge others. Staff required training in how to manage people's behaviours to reduce the impact on people. The registered manager confirmed that staff had not received this training. The lack of PBS plans and guidance meant that staff could not be sure of what they should do to help a person in distress. This left people at risk of repeat distress and staff at risk of personal injury or harm.
- Other people living at Destiny Care Support were at risk from choking. Staff we spoke with were not confident in how they would manage a choking episode. When asked how they would support a person choking one staff told us, "I'd try the Heimlich manoeuvre if I had to do it I would do it; but I haven't had training for a while so would be wary."
- One person had a special device for epileptic seizures. A staff member told us they thought they knew how to use the device but said they had not had training on how to use it.
- We checked the training records and staff had not been trained to know what actions to take in response to a choking incident
- Staff supervisions had not been happening regularly. The registered manager told us that staff supervisions had, "…got behind". This meant that staff may not have a formal place to discuss any issues or concerns, or feedback about performance was not shared in a structured way.

The lack of supervision and training meant staff did not have the skills and competencies to deliver effective care and support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was

working within the principles of the MCA.
● The principles of the MCA were not being followed. There had been a decision taken to install CCTV to some areas of the building. Although some people with assumed capacity had consented, there had been no MCA assessments or best interest meetings for people who may lack capacity.
● We spoke with the registered manager about one person who was found to lack capacity to make a decision whether to receive a flu vaccine. The registered manager confirmed this person would very likely not have capacity to consent to the CCTV. The registered manager also highlighted other people who would be unlikely to have capacity to consent to CCTV.
● One person raised some issues with the registered manager. The registered manager then relayed these and discussed them with the person's relatives. The registered manager confirmed with us that the person's relatives did not have lasting power of attorney or authority under the Court of Protection.

Consent to care and treatment was not always being sought in line with legislation. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support
● Not all people had their day to day health and wellbeing needs met effectively. One person was diagnosed with a health condition that was linked to increased epileptic seizures. Their choking risk assessment mentioned this risk but this was not carried across to other care plans. This condition was diagnosed in June 2021 was not in correct care plans and not all staff were not aware of the condition or the action they should be taking.
● The same person had a very serious health condition for which they were receiving treatment. However, there was no care plan or risk assessment in place for this treatment. Staff were working outside of their usual working hours to support the person to access treatments but this was not being planned effectively and if different staff were on shift there is a risk the person would not access their treatment. The registered manager told us they had not got around to writing the care plan for this serious condition and treatment.
● Another person with epilepsy was experiencing regular seizures and required their staff to record the type and frequency of seizure so health professionals can ensure they are receiving effective treatment. However, seizure records were poor in detail and often did not record the type of seizure, or whether the person needed to use a special device to treat the seizure. Multiple entries on seizure charts just state, 'seizure' with no further information.
● We spoke with staff about the same person and their epilepsy management. Staff outlined to us several measures they followed to keep the person safe when they were in the community. None of these were included in the person's care plans. This put the person at risk of not receiving the correct support if different staff supported them.

Supporting people to eat and drink enough to maintain a balanced diet
● Not everyone living at Destiny Care Support had the correct support they needed with eating and drinking enough to maintain good health. People were not being supported to have a balanced diet that promoted the correct nutrition. Staff told us that one person had a nutrition milkshake drink because their weight was a concern. This supplement was added to the person's lunches. However, there was not an effective monitoring of the person's weight to identify any further risk or improvement.
● The Malnutrition Universal Screening Tool (MUST) is a tool that helps manage risk for people at risk of being under or overweight. Destiny Care Support used a MUST to track people's weight. However, for the person with nutrition supplements the MUST had not been completed since one entry in June 2021. The MUST should be completed every month.

● The same person needed to drink a restricted amount but staff were not able to tell us what this amount should be and gave different responses. The person's care plan was unclear about the safe amount they should drink. Fluid charts for the person had not been completed accurately. This meant staff had no way of knowing how much the person had drunk.

We found no evidence people had suffered ill health, dehydration or malnutrition, but there were not effective systems to demonstrate health needs were safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● It was not clear that people's needs had been assessed in terms of their physical, mental, and social needs to give effective support outcomes. Peoples needs were not always identified in care plans and staff had given different information when speaking about people's conditions. We have reported on this in more detail in the Safe section of this report.

Staff working with other agencies to provide consistent, effective, timely care

● The registered manager was able to describe the process by which a person had moved into the service. People had been supported by social workers to use a social story to explain the process of moving and had stayed for visits building up their time at the service until they were ready to stay and staff knew their needs better.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager did not demonstrate that they fully understood their responsibilities. CCTV had been installed to some communal areas of the service. Under data protection law a company using CCTV must let people know they are using CCTV by putting up signs saying that recording is taking place, and why. We spoke with the registered manager about this and asked if there were any signs up about CCTV? The registered manager told us, "No. It's something I needed to put in to place."
- The registered manager and the registered provider had failed to send Statutory Notifications to CQC. Regulations of the Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service, or the people using it, are notified to CQC. There were four incidents between March 2020 and September 2020 where an incident was reported to or investigated by the Police. The registered manager or registered provider had not notified CQC of any of these.
- Some of these incidents were related to safeguarding concerns. Had we known of these we may have inspected sooner or requested further assurances. All registered providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The failure to Notify CQC of incidents without delay is an offence.

Statutory Notifications had not been sent to CQC. The failure to notify CQC of significant incidents is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

Continuous learning and improving care

- Quality assurance and governance systems were not effective in driving improvement or learning from performance. Quality monitoring systems were not effective in highlighting or improving shortfalls in service delivery. In this inspection we found breaches of Regulations 11, 12, 13, 17, and 18. These relate to concerns with consent, safe care, safeguarding people from abuse, good governance and staffing. We also found a breach of Regulations 18 of the Registration Regulations for failing to notify CQC of significant events. Quality audits had either not been completed or had not identified these shortfalls.
- Care plans did not ensure people had their needs met. Staff told us of one person's care plan, "His care plan is very vague at the moment in terms of keeping him safe." This was relating to a risk that was known for over a year. A second staff member told us about another person's care plan, "It is the basics, gives you an understanding but could be more detailed."
- Another person had known risks that had been highlighted in a previous review from the local authority.

These risks had not been transferred to their current care plan. There was no strategy for staff to keep the person safe if the risks reappeared. Audits had not highlighted this or the need for a care plan review.
● Incidents were not being audited effectively. The registered manager was able to collate incidents and download these to a file, However, there was no analysis being done, and learning from incidents was not evident.
● We spoke to the registered manager and asked them why issues we found during the inspection had not been identified in audits. The registered manager told us it was because they hadn't audited them, as they hadn't realised they needed to audit these areas. The registered manager was sourcing audits systems to use from a registered managers network group.
● The registered provider had not made sufficient improvements to the environment. One person was at risk of choking from eating non-food items related to a poor physical environment. However, the building remained in a poor state of decoration.
● The provider did not have sufficient oversight of the service. The registered manager told us that the provider had not been able to visit the service as often as previously, due to Covid restrictions. However, there had not been any remote review of documents or performance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not always a positive culture that empowered people or achieved good outcomes for people. One person's incident charts, on multiple occasions, showed a reactive and sometimes punitive response from staff. There was no record of a review or any information from staff about how these incidents were analysed to help improve the person's support. We spoke with the person who told us that they were unhappy with staff support and felt no action was taken when they raised issues.
● Some incident charts recorded the person was told that staff were fed up listening to the person's 'moans and groans'. Other incident charts were also written in a dismissive way. One incident showed the person was worried about their personal care. Staff did not address these concerns in a person centred or empowering way.
● Staff we spoke with suggested the person's behaviours were down to them wanting things done in a certain way. However, staff had not made the link to the person's needs and how they should adapt their approach to support them positively to manage incidents.

Quality audits had not been effective in making improvements. People were not supported in a person-centred culture and the registered manager and provider did not always understand the requirements of their roles. This placed people at risk of poor care outcomes. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff had been encouraged to share ideas when supervisions had been held, about how to improve the service for people. The registered manager told us, "They have added lots of suggestions to the home." Staff had sourced and enacted activities such as bingo or cycling groups.
● People had been encouraged to communicate with their families. During the pandemic people had access to skype to stay in contact with their families and were helped by staff where appropriate.

Working in partnership with others
● The registered manager and staff had been working in partnership with the local authority and funders for people's care. The registered manager described the close working relationship the service had with the local doctor's surgery, including making double appointments for people with a learning disability so they

did not feel rushed.
● Not all possible safeguarding incidents had been reported correctly and we have reported on this in the Safe section of this report.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● When something went wrong this was reported to people's families. The registered manager understood their responsibilities under duty of candour to report things openly to people and their families.