Falcon Care Agency Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Falcon Care Agency Ltd is a domiciliary care agency providing personal care. The service provides support to youngers adults with dementia, physical disabilities and long-term mental health conditions. At the time of our inspection there were 28 people using the service. The registered manager advised inspectors that all these people received personal care.

People's experience of using this service and what we found
Service users were not protected from abuse and improper treatment. One person was found to be restrained by staff without legal authority, or consent from the person. Risks to people using the service were not assessed or mitigated. Medicines were not managed safely. Staff were not recruited safely.

Staff did not have the training and skills to support the people they worked with. There was a lack of training delivered to staff. Staff did not receive regular competency assessments or supervision meetings with the registered manager. Care plans were not always in place for people.

Where people were deemed to lack capacity, formal assessments had not been carried out to assess whether they needed support with decision making. This meant staff had no guidance in place, and risked staff restricting people by making unnecessary decisions on their behalf.

The service was not caring. As a result of our inspection, 9 referrals were made to the Local Authority to safeguard people from harm and abuse. There were widespread concerns found during the inspection, and these did not demonstrate that caring and respectful care was provided at all times to people.

People's care was not personalised. People were not always supported with their communication needs which meant the provider could not be assured that people were always heard or understood by staff. The service did not always support people appropriately in the pursuit of their own activities, and hobbies.

The service was not well-led. There were widespread shortfalls in the day to day running of the service, leading to multiple breaches of regulation.

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. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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 8 December 2021).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, training, medicines, and quality of care. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Falcon Care Agency Ltd on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to person centred care, consent, staffing, recruitment, safety, protecting people from abuse, and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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
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?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Falcon Care Agency Ltd

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 Health and Social Care Act 2008.

Inspection team
The inspection was completed by 4 inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before 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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 members of staff, including the registered manager.

We reviewed a range of records. This included 8 people's care plans and associated documents. We reviewed 18 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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; Learning lessons when things go wrong

- Service users were not protected from abuse and improper treatment. During this inspection, we identified significant concerns with the care people were receiving. As a result of these serious concerns, we shared 9 safeguarding alerts with the Local Authority.
- One person was found to be restrained by staff without legal authority. A staff member told us the person gets angry when they are restrained, indicating restraint caused the person distress. The provider was also unable to demonstrate staff had received training in safe physical restraint techniques. This placed the person at risk of significant abuse and improper treatment from potentially unsafe restraint practices.
- The provider was unable to evidence that all staff had received safeguarding training. This lack of training was demonstrated when staff failed to recognise and respond appropriately to abuse such as the unauthorised restraint described above.

The provider's systems and processes placed people at increased risk of avoidable abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people using the service were not assessed or mitigated. For example, a person was at high risk of falls. The registered manager advised inspectors that the person fell most days. However, there was no falls risk assessment in place to guide staff on ways to mitigate the risk of the person falling. Additionally, care records demonstrated the person fell in front of staff and injured themselves, however, no medical attention was sought, and the incident was not shared with other healthcare professionals.
- Additionally, the person was known to self-harm. Daily records record staff being unable to gain access to the person's property on 20 occasions. Staff did not follow the provider's non access policy, and the registered manger did not follow this up. This meant the provider could not be assured the person was safe and well, and not seriously harmed or injured.
- Risks associated with diabetes were not managed safely. One person who had been diagnosed with diabetes had no diabetic care plan or risk assessment in place. Whilst the person managed their own diabetes medicines, staff were responsible for the preparation of meals suitable for diabetics. This meant staff did not have adequate information to support the person appropriately with their diabetes, or how to recognise warning signs of high or low blood sugar. This meant the person was at increased risk of becoming unwell with undetected changes in their diabetes.
- Catheter care plans and risk assessments had not been completed for people who had a catheter. Staff were responsible for daily catheter management. This meant staff lacked guidance on how to safely provide catheter care and how to identify the signs and symptoms when there was an issue such as a blockage or

infection.
● The provider had failed to identify risks associated with other areas of care delivery, such as pressure area care, enteral feeding, fire safety and environmental concerns. This meant they could not be assured people received care and treatment in a safe way.
● One person suffered with low mood, self-harm and suicidal ideations. Staff were aware, however, had failed to take action. There was no care plan in place to guide staff about how to support this person during calls with their mental health or provide any guidance about who and how to escalate concerns about a deterioration in the persons health. This left the person at serious risk of harm to themselves.
● One person was unable to weight bare and needed staff support with moving and handling. There was no guidance in place for staff on how to move the person safely, and 73% of regularly visiting staff failed to receive moving and handling training. This placed the person at high risk of avoidable injuries if staff moved the person inappropriately.

The provider failed to identify and mitigate serious risks to people's health, safety and wellbeing. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely. The registered manager advised inspectors that no one received support with medicines, and they did not administer medicines or applications of creams for any person. However, daily care notes evidenced staff regularly administering medicines and applying creams to people. One person's care plan also stated they required staff support with managing their medicines. A member of staff also confirmed they administered medication and had done for the entirety of their employment with the provider.
● None of the people being supported with medicines had Medicine Administration Records (MAR) Charts in place. This placed people at significant risk of harm as it was not clear for other staff which medicines had been administered to the person at the previous care visit. One staff member told us the lack of MAR charts also meant they would be unaware if the person's medicines were changed. People were at risk of overdose as staff did not have enough information to administer these safely.
● Prescribed creams were being applied to people with no MAR chart or guidance in place. This meant staff were unclear on where the cream should be applied. This was not in line with national guidelines for managing medicines in care settings. This meant people were at risk of having the cream applied to the incorrect area of the body, rendering it ineffective.
● Some people received 'as required' medicines. There were no protocols in place to provide guidance for staff on how and when to administer this medicine. The protocol should also describe how much time should be left between doses. This placed people at risk of receiving their medicines incorrectly.

The provider failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited safely. At the time of the inspection, the provider was employing 38 staff members. On the day of inspection, the provider was unable to provide evidence of Disclosure and Barring Service checks for being completed for 22 staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● A total of 18 staff recruitment files were reviewed as part of the inspection. None of the 18 staff members had evidence in their file of references, application forms, interview questions or any employment history.

This meant the provider could not be assured of the person's background and whether they were suitable to work with vulnerable people.

The failure to ensure staff were safely recruited was a breach if Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was unable to evidence the effective deployment of suitably qualified staff for scheduled calls. The registered manager informed the inspection team that not all staff used the electronic call monitoring system correctly, with staff often failing to log in and out of calls. This meant the provider could not be assured that all care visits had been completed, and risked people missing care visits.

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

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always have the training and skills to support the people they worked with. This included some staff failing to have received training in areas such as first aid, adult and child safeguarding, moving and handling, and medicines. For example, one member of staff admitted to giving medicines without a MAR chart in place. This demonstrates a clear lack of understanding with regards to medicines administration.
- Some staff competency assessments had been completed, however, they failed to evidence how the member of staff had demonstrated competence in each specific area.
- The provider was unable to demonstrate that all staff had completed induction training.
- The provider was unable to evidence that they were regularly supporting staff through supervisions, appraisals and spot checks. This meant, staff did not have a formal process to review their workload, monitor and review performance, and identify any learning and development opportunities.

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 MCA 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.

- Where people were deemed to lack capacity, formal assessments had not been carried out to assess whether they needed support with decision making. This meant staff had no guidance in place, and risked staff restricting people by making unnecessary decisions on their behalf.

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

● Care plans did not always describe the full scope of people's needs. The registered manager had not ensured people's needs were assessed fully, prior to staff providing care. This meant staff did not have a full assessment of people's needs to provide effective support.
● People who were known to express emotional distress did not have proactive behaviour strategies in their care records. This meant there was no specific actions staff should take to support the person through their period of distress, and to ensure staff practices were the least restrictive to the person.

Supporting people to eat and drink enough to maintain a balanced diet
● Some care plans provided conflicting information regarding people's eating and drinking needs. Several care plans stated eating and drinking support was required. However, when safety concerns were raised with the registered manager in relation to these people, the registered manager advised inspectors that staff did not support these people with eating and drinking. This conflicting information meant it was difficult for inspectors to be assured that people were receiving safe support with eating and drinking.
● Other people could make their own food and drinks independently, without staff support.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The provider could only demonstrate limited evidence of working with some healthcare providers.
● The service did not always work well with other agencies to provide effective care. For example, a person who had been diagnosed with diabetes had been refusing to eat. However, the diabetic nurses had not been consulted in relation to this.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- The service was not caring. As a result of our inspection, 9 referrals were made to the Local Authority to safeguard people from harm and abuse. There were widespread concerns found during the inspection, and these do not demonstrate that caring and respectful care was always provided to people.
- People were not always treated with respect. One person's care plan recorded inappropriate language used. This meant staff would apply a punitive approach when dealing with the person. Neither staff nor the registered manager had identified this in the care plan, which meant the provider could not be assured staff were treating people with kindness and compassion.
- The provider was unable to demonstrate robust systems in place to seek views about the quality of the service from people, or their relatives.
- People's care plans lacked information to help staff get to know people well, including people's preferences, personal histories and backgrounds.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was not personalised. Care plans often provided very minimal information. This meant guidance for staff was not always available to help them to support people's preferences.
- One person's care plan was out of date, as advised by the registered manager. However, they were unable to provide a care plan which was in date and contained accurate information about the care the person required. This meant people could not receive person-centred care.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People were not always supported with their communication needs. Some people did not use words to communicate. Staff had not been trained to understand how to communicate effectively, and people's care plans did not give enough information about how they communicated. Therefore, the provider could not be assured people were always heard or understood by staff.
- Information contained in 1 person's care records showed they had sensory impairment. However, there was no further information to tell staff how to communicate with them. The registered manager was unaware of their responsibility of making information accessible in a format that would assist the person and promote their independence.

Improving care quality in response to complaints or concerns

- The registered manager advised they had received 1 complaint regarding a task which had not been completed during a person's care call. The registered manager advised they had spoken with the staff member and liaised with the relative who had made the complaint in order to resolve the matter.

End of life care and support

- At the time of the inspection, no one was receiving end of life care.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- There were widespread shortfalls in the day to day running of the service, leading to multiple breaches of regulation. There was a lack of oversight by the registered manager and provider.
- There was a lack of order in record keeping and some documents, audits and checks we asked for could not, or were not, made readily available to us. When we asked the provider for this information, they were unable to produce it.
- We found a lack of robust systems and processes within the service to monitor and review the quality of service people received, along with a failure to effectively respond to and record improvements. This led to some people receiving an ineffective or potentially unsafe service.
- The provider could not demonstrate an effective call monitoring system in place and was not able to accurately evidence staff attendance at care calls. The registered manager acknowledged that staff were not using the system effectively but was unsure how to improve compliance. There was no management monitoring, oversight or audits in place for the electronic call monitoring system. The provider was unable to evidence any call monitoring issues had been addressed with individual staff members, such as during staff supervisions.
- Staff were not adequately trained, competency checked, appraised, or supervised. There was a lack of reflective practice, which meant the service was unable to learn, evolve, or drive improvements.

The provider's failure to ensure effective oversight and governance of the service was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A closed culture was prevalent within the service. A closed culture means people are more likely to be at risk of deliberate or unintentional harm. Examples of this closed culture included the workforce comprising of family members or close friends, restrictive practices being used within the service, unsafe staff recruitment practices, and the failure to identify improper treatment of people.
- The provider's systems and processes failed to ensure consistent information was recorded in people's care plans and risk assessments. This made it difficult for staff to ensure people's needs were met.
- Engagement with people involved with the service was minimal. Poor communication plans for people who had communication needs, impacted on the provider being able to involve people in the service.

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

● The registered manager failed to understand their duty to be open and honest when things went wrong. Multiple safeguarding incidents had occurred within the service however, these were not shared with both the CQC, and external healthcare professionals.

Working in partnership with others

● There was some evidence of working with the local authorities.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm due to risks not being identified and mitigated.

The enforcement action we took:

We took urgent action and suspended the provider's registration for a period of time.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment.

The enforcement action we took:

We took urgent action and suspended the provider's registration for a period of time.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well-led.

The enforcement action we took:

We took urgent action and suspended the provider's registration for a period of time.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not recruited safely.

The enforcement action we took:

We took urgent action and suspended the provider's registration for a period of time.