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Falcon Carers

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Falcon Carers is a domiciliary care agency providing personal care to 44 people at the time of our inspection. The service provides support to people living in the Trafford borough of Greater Manchester. The registered office was in Stafford.

Not everyone who used the service 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
Risks were not assessed and managed in a safe way. Risk assessments were not always completed to support staff to keep people safe. Medicines were not managed safely. The systems in place to ensure people received their medicines safely were not robust and when errors had been identified, these had not been addressed. Staff were not always recruited safely, and we could not be assured staff had been effectively trained.

The provider had failed to report a safeguarding incident to the relevant authorities. Lessons had not been learned; the provider was unable to evidence sufficient improvement since the last inspection.

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.

The provider had a significant lack of oversight of the service. Records were not readily accessible, and the provider had little knowledge about their own systems.

People's feedback had improved since the last inspection and staff told us they felt better supported in their role.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 13 October 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. A condition was imposed on the provider's registration to restrict any further packages of care being commissioned with Falcon Carers. At this inspection we found the provider remained in breach of regulations.

Why we inspected.

This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The provider had taken immediate actions to mitigate any urgent risk.

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

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 monitor the service and will take further action if needed.

We have identified breaches in relation to regulation 11 (need for consent), regulation 12 (safe care and treatment), regulation 13 (safeguarding service users from abuse and improper treatment), regulation 17 (good governance) and regulation 18 (staffing) 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
The overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Falcon Carers

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 carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service is not required to have a manager registered with the Care Quality Commission because the provider is also the manager. This means that they are solely, legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider would be in the office to support the inspection. We needed to obtain people's contact details so we could contact them by telephone.

Inspection activity started on 19 January 2022 and ended on 3 February 2022. We visited the office location on 20th and 27th January 2022.

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. We used all this information to plan our inspection. 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.

During the inspection
We spoke with four people who used the service and seven relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, care coordinators and care staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four 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 provider to validate evidence found. We reviewed a number of quality assurance records, training and supervision records and other documentation.

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 inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Care records did not always contain sufficient information about people's specific health conditions. People with a diagnosis of diabetes did not have risk assessments and risk management plans in place to instruct staff on how they should support the person safely with this condition. People who had very specific needs as a result of health conditions, did not always receive the care and support they needed to keep them safe. For example, one person had sustained a scald as guidance and information for staff was not clear.
● Information contained within some care plans was inconsistent. For example, some care plans stated people had specific care and support needs such as wound care but there was no follow up information in the form of a risk assessment, or any other way of ensuring people were receiving the care they required. The provider was unsure as to whether people required this specific type of care.
● We could not be assured people who needed support when they experienced episodes of changed behaviour received the care and treatment required. There were no records of how people's needs had changed over time, or instructions on how staff should support people with these changes to keep them safe.
● The provider had not implemented sufficient systems and processes to learn lessons when things went wrong. The last inspection rated the service inadequate and we found little or no improvements had been made.

The provider responded immediately during and after the inspection to ensure people were safe and to mitigate the risk of harm. However, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider did not have systems in place to ensure medicines were managed safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medication was not managed in a safe and effective way. We could not be assured people were receiving their medication as prescribed.
● Medications were not always recorded on a Medication Administration Record (MAR).
● Information in care plans about people's medications did not always reflect the same information on the MAR. Some MARs we viewed had missing signatures which would indicate medication had not been administered as prescribed. This placed people at risk of being over medicated.
● There was no guidance and information for staff about application of topical creams and staff we spoke with told us they did not use MAR as a mechanism to record when supporting people with topical creams. This meant people were at risk of not receiving their topical medicines as prescribed to maintain their skin integrity.

The provider responded immediately during and after the inspection to ensure people were safe and to mitigate the risk of harm. However, systems had not been established to ensure people received their medicines as prescribed and in a safe way. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found people were not always protected from abuse and improper treatment. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● The provider failed to identify safeguarding concerns and had failed to recognise the importance of keeping vulnerable people safe.
● An incident we were made aware of during the inspection had not been referred to the relevant safeguarding authority, which meant there had not been an investigation carried out to protect the person from continued harm. We discussed this with the provider who actioned this straight away.
● The provider could not demonstrate all staff had received appropriate safeguarding training. Some staff who had worked at the service and had already been through an induction programme had been enrolled on safeguarding training but had not yet completed it. Other staff had received training with previous employers but not with Falcon Carers. We could not be assured staff training was therefore up-to-date and staff had the relevant skills and knowledge to protect people from harm.

People were not always protected from the risk of harm and abuse. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People however did tell us they felt safe when being supported by staff. One person said, "They [staff] are

kind, caring people. I always feel safe", and "They [staff] are very conscientious and very caring and I feel really safe."

Staffing and recruitment

At our last inspection recruitment procedures were not established and operated effectively to ensure that staff were suitable to work with people who used the service. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, there was still a need for improvement to assure us of safe recruitment where staff had the necessary skills and competencies. However, the provider was no longer in breach of regulation 19.

● The provider was unable to locate a risk assessment for a staff member following a Disclosure and Barring Service (DBS) check result. The DBS provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We received the information we requested from the provider following the inspection.
● Staff recruitment files were inconsistent and did not contain the required information. Some staff did not have any documentation in their staff files to evidence they had been recruited safely. For example, references were not of a high enough standard to demonstrate the prospective employee was of good character.
● Staff told us they received supervision however, the provider was unable to provide evidence to show staff received regular supervisions to monitor staff performance and development. Therefore, we could not be fully assured staff were being supervised effectively.
● People and their relatives told us staffing levels had improved, however some people were still experiencing significant inconsistencies of staff supporting them and call times could still be irregular. One person said, "I am reasonably happy with the care but they [staff] vary a lot." Another person said, "They [Falcon Carers] don't always send the same carers; it varies hugely." A relative told us, "Staff are sometimes very late for calls, but staff will phone and tell us they will get to us as soon as they can." Recruitment processes did not provide assurances staff were suitable to work with people who used the service.

Preventing and controlling infection
● We were not assured that the provider was accessing weekly PCR testing for staff which was not in line with government guidance. The provider told us they were no longer following this guidance and accessing weekly tests for their staff. However, they told us staff would access specific testing if they were symptomatic for COVID-19. Staff were mitigating the risk of working whilst being COVID-19 positive by using Lateral Flow Tests before starting their shifts to evidence a negative result. Following our feedback, the provider had ordered weekly test kits for staff to ensure staff were in receipt of a more reliable weekly laboratory test result to keep people safe .
● We were assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. A relative we spoke with told us, "Staff never come in without mask and gloves. I have watched them get PPE out of the boot of the car and put it on. I also have a box of PPE here (supplied by the Falcon Carers) just in case. They [staff] are very careful."
● We were assured that the provider's infection prevention and control policy was up to date.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection, staff did not always receive the training, development and support they needed to support people effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not always receive adequate training to support people in the most effective way.
● We could not be assured staff had received mandatory training such as moving and handling as records did not reflect this. Staff were not always able to tell us what training they had received. The provider told us staff had received training from previous employers before starting work with Falcon Carers. Evidence of these training certificates were out of date. The provider told us they did not always enrol staff on training immediately as they had other qualifications which they felt were relevant to their role as care staff for Falcon Carers. This meant people were at of receiving inappropriate and inadequate care, placing people at significant risk of harm.
● Some staff had received competency checks, but the provider could not evidence all staff had received checks to ensure staff were skilled and proficient in their role. A staff member said," I have had one observation; the care co-ordinator turns up unannounced." Records we viewed for the 'competency for the management of medicines' showed there were only eight members of staff who had received a competency check. One check identified a member of staff did not demonstrate confidence in 'storage of medication' and 'prompting was required' for the staff member to demonstrate the 'correct procedures'. The provider was unable to evidence what actions were taken as a result of this shortfall being identified.

Staff still did not always receive the training, development and support they needed to support people effectively. This was a continued breach regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff did however tell us they had received some training. One staff member said, "I had an induction and have done quite a few training courses. This is my first job in care, so I was sent out for moving and handling training; completing the Care Certificate and I have done catheter care training and infection control."

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.

- The provider did not have up to date mental capacity assessments in place where people lacked the capacity to make all of their own decisions. For example, one person who lacked the capacity to make all of their own decisions had their mental capacity assessed in 2020 by a social care professional. Some of the information within this assessment had changed and was no longer relevant. The provider had failed to re-assess the person's ability to make certain decisions for themselves which meant the person may not have consented to care and treatment being provided.
- Records which referred to capacity contained inaccurate information. A record we viewed stated a person required an Independent Mental Capacity Advocate (IMCA). The provider stated there was no IMCA appointed and the person did not in fact require an advocate. This meant this person was not supported to make decisions about their care in line with their assessment.
- Best interest decisions made on people's behalf did not always follow the principles of the MCA. One person's care record contained a signature of a family member consenting on the person's behalf. The provider could not evidence the family member had the legal authority to consent on behalf of their relative. This placed the person at risk of having decisions made that were not in their best interests.

The provider did not always follow the principles of the Mental capacity Act 2005. This was a breach regulation 11 (Need for consent) 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

- People's had their needs assessed before being supported by the agency. However, care plan documentation contained information which was either inaccurate or insufficient to enable staff to support people effectively. For example, one person's care record stated they required support with catheter care. The person did not have a catheter in place.
- The provider had not ensured people's care plans were fully reviewed after our last inspection and therefore issues had not been addressed and errors were still being made.

Supporting people to eat and drink enough to maintain a balanced diet

- Most people we spoke with did not require support with eating and drinking. However, one person's care plan stated they required support to ensure they were able to maintain an adequate dietary intake and had been prescribed liquid supplements to support with this need. There were no records about the liquid supplements being offered and accepted. The provider told us they did not have concerns about the person's risk of malnutrition and therefore did not complete dietary records for this person. We could not be assured the person had received their fortified drinks as prescribed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People did have access to health care as required. The provider was able to evidence they had consulted health and social care professionals to ensure people received support. However, all of this information was not always transferred to some people's care plans. This meant people were at risk of receiving inconsistent care because staff did not have up to date guidance to follow.

Requires Improvement

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 inadequate, at this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

At our last inspection people were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

- People and their relatives told us they felt care had improved since the last inspection.
- During our last inspection people did not always receive the care and support they needed due to staff not having a sufficient understanding of the English language which impacted on people's ability to make choices and have their preferences heard. During this inspection, some people told us they still experienced difficulties because of the language barrier. However, this was much improved overall.
- Comments we received about care received included, "The carers are always upbeat and very caring, I love every one of them," and "[Relative] is very happy with the carers and they love them coming to see them."
- Staff told us how they ensured people were treated well. One staff member said, "I will sit down, listen and talk to people. For example, [name] can tell us what they want and how they prefer things done."
- Relatives told us people were consulted about their care needs. One relative said, "If we need anything, [care coordinator] deals with it. They have been to see [name] and they know them and staff know what they are doing."

Respecting and promoting people's privacy, dignity and independence
- People also told us they felt staff supported them in a dignified way and encouraged them to be as independent as possible.
- Comments we received included, "The first thing staff do is close the blinds. Staff are very thorough and make sure I am clean and tidy. Staff encourage me to do what I can do, and they don't rush me." Another person said, "The carers help me to do things when I can. I do like to go into the kitchen and do bits and pieces and they help me to do that."
- Staff confirmed what people told us and gave us examples of how they respected people's dignity and privacy.

We could not improve the rating for caring from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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 inadequate. 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; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection, the care that people received did not always meet their needs or reflect their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● Generally, staff we spoke with knew about people's needs and were therefore able to support people with their care in line with their choices and preferences and people we spoke with confirmed this.
● However, we could not always be assured people received completely individualised care as records were not always up to date, or completed in a way which gave staff the most up to date information they needed.
● The mixed response we received about timings and inconsistency of care calls meant some people would not always have choice and control over the times they received support.
● During the height of the COVID-19 pandemic, the provider had applied for additional funding from the local authority to provide additional staff to provide companionship for people. The provider said, "We went to the local authority to seek help with funding so we could employ additional staff to provide companionship with people; to make telephone calls and help them keep in contact with their relatives."

Improving care quality in response to complaints or concerns

At our last inspection there was no effective or accessible system for managing complaints. Complaints were not always appropriately recorded and investigated, and proportionate action was not always taken in response to failures identified. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

● The provider had a complaints policy in place and most complaints had been responded to in a timely way in accordance with the policy.
● One person we spoke with highlighted to us they had not received a response from a previous complaint

they made. We brought this to the provider's attention who followed this up with immediate effect. A previous employee had begun investigating the issues raised but had not handed over their response to the provider when they terminated their employment at Falcon Carers.

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 (AIS) tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider understood their obligations in meeting the AIS.
- People and their relatives had been given access to the service's new electronic system so they could access care records. The provider said, "There is information for service users and relatives in different formats if required, such as easy read."
- The provider told us about how they supported people who required adaptations to the way they received information. For example, people with a sensory loss.

End of life care and support
- At the time of the inspection, no-one was receiving support at the end of their life.

We could not improve the rating for caring from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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 inadequate. At this inspection the rating for this key question has remained 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the provider failed to operate an effective governance system to assess, monitor and improve the quality and safety of services provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider lacked effective oversight of the service and the systems and processes in place. There were a limited number of documents available for us to view in the registered office on the days of our inspection. The provider was unable to readily access documentation held electronically. The provider could not readily access information about people's care needs, or the safety and quality of the service.
● The care notes and MAR audits we reviewed were not completed on a regular basis. A daily audit record file we viewed had only eight records in the file despite there being more people supported by Falcon carers. Only one of these eight records had been completed since our last inspection in the month of July in 2021 which showed little action had been taken to improve the service.
● Where audits had identified improvements were required, there were no clear action plans in place for managers or auditors to track when improvements had been made in response. This meant people were still at risk of receiving poor care as the systems in place were not effective in mitigating these ongoing risks.
● The provider failed to track patterns and trends, and to identify themes so that lessons could be learned from quality assurance checks.
● The provider had missed opportunities of developing their service and preventing risks to people from developing, due to ineffective governance systems. MAR audits were ineffective. Where errors had been identified, comments on the audits referred to a requirement for staff to repeat their medication training. Corresponding records did not evidence staff had been retrained following the audits.
● Where action plans were drawn up following audits, actions were not completed. For example, some audits stated issues would be addressed in staff supervision (meetings with staff regarding their performance). Supervision records we reviewed did not show the action had been taken. The provider's failure to address identified concerns failed to mitigate the risk of people not receiving their planned care.
● A staff member responsible for completing audits had identified the ineffectiveness of the audits. A

comment from the staff member regarding the auditing of care records stated, 'the daily records book has been used for a significant time without auditing, therefore some issues could not be accurately addressed.' The provider failed to respond and action their own shortfalls in governance and had been ineffective in driving improvements.

● The provider had delegated the responsibility of auditing to care coordinators. The senior care staff were not always completing audits regularly and there was no effective managerial oversight of this process.

● Care plan documentation did not always address, monitor and mitigate risks relating to the health, safety and welfare of people. This impacted on the provider's ability to improve and sustain quality and safety for people.

● The provider had no effective way of ensuring staff had received training and supervision. Training and development records were not held centrally; the provider was unaware of when staff members received training and supervision.

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 provider understood their obligations in meeting the duty of candour. However, we identified some incidents where the provider had not shared their knowledge of incidents with family members in a timely way. This meant the provider had not always acted in an open and transparent way at the time of incidents occurring. The provider responded following the inspection by ensuring people, where required, had received duty of candour responses.

The provider had not successfully developed an effective governance system to assess, monitor and improve the quality and safety of services provided This was a continued 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

● People told us they had become more involved with the service. One person said they had filled in a questionnaire, and other people and their relatives told us they were able to liaise with the provider and care coordinators as needed.

● The provider showed us survey feedback they received however, there were no measures in place to action feedback or demonstrate how the provider would ensure people's voices and opinions were heard and valued.

Working in partnership with others

● The provider had told us they received support from other agencies such as the local authority to improve the care Falcon Carers provided. However, we were unable to see evidence of this or any significant improvement since the last inspection.