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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?	**Inadequate**
Is the service responsive?	**Inadequate**
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 79 people at the time of the inspection. Most people supported lived in the Trafford area of 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
People did not feel safe when being supported by the service. Risks to people were not always assessed and managed and staff were not always well trained to respond to people's risks.

Medicines were not safely managed. Medicines records were poor, and issues had not been identified by the provider, despite them checking the medicines records.

People did not feel staff were competent and the provider could not be sure all staff had the correct training to deliver effective care. Safe recruitment practices had not always been followed.

People were not always 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's privacy and dignity was not always respected. People felt staff rushed them. People told us about a language barrier that made communication with staff difficult and people could not always make their needs known. This meant people did not receive personalised care and their communication needs were not met.

The provider, who was also the manager had little oversight of the service. Records were disorganised which meant there was a delay in accessing some documents and records. People's complaints were not dealt with appropriately, so people had lost confidence in sharing their concerns or feedback with the service. People did not feel involved in their care and support.

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 30 April 2019).

Why we inspected
We undertook a focused inspection of safe and well-led to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about poor

moving and handling practices from staff which resulted in a person falling and injuring themselves. The decision was made for us to inspect and examine those risks.

We commenced telephone calls to people and relatives and found there were other concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all key questions.

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 improvements.

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

The provider took action to mitigate some of the most serious risks we found including those in relation to medicines practices and staff training.

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 dignity, safe care, governance, handling of complaints, staff training and recruitment and notification of incidents at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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 Care Act 2014.

Inspection team
The inspection was carried out by three 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.

Service and service type
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 24 hours' notice of the inspection because we needed to be sure that the provider would be in the office to support the inspection. We also needed to gather people's contact details and consent to contact them by telephone.

Inspection activity started on 30th June 2021. We visited the office location on 1st and 6th July.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and six relatives about their experience of the care provided. We spoke with seven members of staff including the provider, office manager, care coordinator and care staff. We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at multiple staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training data and medicines audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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.

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

- Risks to people's safety were not always managed and people did not always feel safe. One person, who needed support from staff and equipment to move said, "No, I don't feel safe with them, they've injured me a couple of times. I've got very delicate skin and it's split twice."
- Risk assessments were not always followed, for example, when undertaking moving and handling. The same person said, "[Staff] yanked the sling and it ripped the dressing on my leg. It had taken a long time for it to start healing and was doing well, it started to bleed."
- We found there were no accident or incident forms completed regarding these injuries and no action had been taken to reduce the risks to the person or reduce the risk of reoccurrence.
- People and relatives told us about a language barrier that was impacting upon them communicating with staff. One person said, "The other day, one carer spent a time looking for something for me, they couldn't understand what I'd asked for, so just kept guessing what I wanted and just kept bringing things in to me from the hallway, just hoping they were the right thing." This meant care could not always be provided in a safe way, because staff were unable to understand people's needs and risks or follow a care plan and risk assessment. The provider confirmed that some staff did not speak fluent English and stated they were put on calls with another carer who spoke good English.

Using medicines safely

- Medicines were not managed and administered safely which placed people at significant risk of harm.
- One person was prescribed a controlled drug for pain relief. This drug was not clearly recorded on the Medicine Administration Record (MAR) and the provider and care-coordinator were unsure about whether this medicine was still prescribed. Records did not clearly show whether the medicine had been administered as prescribed and it was not clear for staff to see how, why and when it should be administered. This meant there was a risk the person could be left in pain, because staff were not clear about their medicine regime.
- When medicines were prescribed 'as and when required' (PRN) there was not always a clear protocol for staff to follow to know how, when and why the medicines should be administered. This meant there was a risk people may not get medicines when they needed them.
- Some people's medicines needed to be administered at a certain time, with a certain time period in between doses to ensure they were effective. We found the medicines were not always being administered at the required times. There was no system in place to ensure staff would be available to administer the medicines at the correct times. This had the potential to have a serious impact on people's health.
- There were no clear records of topical medicines administered. For example, one staff member recorded, 'cream applied' in the daily notes but there was no corresponding MAR, so it was not clear what cream had been applied where.

● MARs were handwritten and incomplete. They did not contain all the information required to administer medicines safely including the medicines full name, dosage and frequencies. They also did not include details of any allergies, despite one person having a penicillin allergy. Staff had signed MARs using only one initial, not their full name or initials so it was difficult to track who had administered medicines. MARs had been audited by the provider who did not recognise the issues we found and therefore no action had been taken to make improvements, leaving people at risk of harm.

People were at risk of harm because care was not always provided in a safe way and medicines were not managed safely. 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
● The provider could not demonstrate safe and effective recruitment procedures were being operated to ensure staff were suitable to work with people who used the service.
● One staff member told us, "[The service] asked me for ID documents and references when I was about to leave, not when I started the job."
● Some important information such as evidence of interview and reference checks were not available so the provider could not be sure staff were safe and suitable to work with people.

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.

Systems and processes to safeguard people from the risk of abuse
● People told us they did not feel safe when being supported by the service. One person described how they had been injured whilst being supported by staff. They said they reported their concerns about the competence of care staff to the manager and the manager responded, "I'll speak to them." There was no action taken to protect the person from risk of reoccurrence.
● People and relatives told us about multiple examples of staff leaving doors or key safes open when they left. One relative said, "[Staff] left the key safe open and key exposed." Another relative said, "I noticed the front door was open, so I walked over and found both [my relatives] asleep, no-one was in the house." This left people at significant risk of harm.
● Whilst some safeguarding referrals had been made to the local safeguarding authority, neither we nor the provider could be sure that all incidents were being reported as required because records were poor. For example, there was no record of a skin tear that one person told us about.
● The provider could not be sure that all staff understood their roles in protecting people from abuse and avoidable harm because they could not evidence that all staff had completed training. One staff member said, "I have had safeguarding training but not with Falcon Carers."

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.

Preventing and controlling infection
● People and relatives told us that staff wore suitable Personal Protective Equipment (PPE). One person said, "[Staff] wipe everything down afterwards when they wash me, it all seems very clean."
● However, one person said, "I have to tell them umpteen times that you don't put a wet [continence] pad on the table, it's the same table I have my drinks and food. It's clear they aren't trained."

● Staff told us they had PPE available and that they knew how to use it safely. A staff member said, "The director comes to see us. She always brings PPE and we fill every car. We wear a mask, aprons and gloves and blue plastic shoes when going into someone's home to deliver care."

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 good. 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 always receive adequate training to ensure they could meet people's needs effectively. One staff member told us, "The only training I have done with Falcon was medication, I didn't have any moving and handling training with them. I did support people who needed hoisting." The provider could not evidence a full list of staff employed and their training.
- Staff did not always receive a full induction prior to providing care to people. One staff member said, "[Falcon Carers] didn't give me an induction. I didn't have training or induction but was put with someone who knew the client." The provider was unable to evidence all staff employed had an induction.
- Staff were not competent and skilled enough to provide safe and effective care to people. One person required specific equipment to meet their needs. The provider confirmed that all staff had not been trained to use this equipment and the person told us staff did not appear competent.
- Staff did not receive regular supervision. The provider told us that most supervisions took place informally and were not documented. We saw no evidence of regular supervisions taking place. We saw that competency checks had only been carried out for a limited number of staff. Therefore, the provider could not be assured that all staff were competent to provide safe and effective care.

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.

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

- People's needs were assessed but were not always reviewed to ensure information was up to date. This meant staff did not always have up to date information to allow them to deliver the care and support that people wanted and needed.

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

- People were not always supported by staff who understood how to meet their dietary needs. For example, a relative told us a person had been encouraged to eat food that was not consistent with their dietary needs. Staff had not received training in how to support people with these particular needs and the care plan was not clear for staff to follow.
- People and relatives said staff did not always provide the support they would like in relation to eating and drinking. A relative said, "[My relative] wanted egg on toast recently, that's not much to ask. [Staff] couldn't use the stove so [my relative] only had toast. [Staff] don't seem very competent."

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

● Staff told us they worked alongside other professionals including occupational therapists and physiotherapists.

● However, we found that referrals to professionals were not always made when required. For example, a person's falls risk assessment indicated a high level of risk that should have been referred for support but there was no evidence of a referral being made. Another person's daily notes stated they complained of pain in their legs, but no medical attention was sought.

● Some relatives said staff worked alongside professionals to ensure people got the healthcare they needed. One relative said, "Staff have alerted us before when [my relative] has needed a district nurse to look at a sore, it's so helpful."

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.

● We found some examples of relatives giving consent on behalf of a person, without the legal authority to do so. The service did not always seek evidence that relatives had the power to make decisions on behalf of people. This meant the service was not always following the MCA to ensure people's rights were protected.

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 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 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

- People and relatives said that some staff were pleasant, but they didn't feel well treated. One relative said, "They're not very good or caring to be honest. This morning [my relative] had two lovely carers. I could hear them laughing their heads off, suddenly it went quiet. It turned out that [my relative] was on the toilet when one of the carers got a phone call saying she had to go elsewhere, to [care for someone], somewhere else. So [the service] sent a new [staff member] who didn't speak a word of English. [My relative] was still on the loo while all this was happening, it was upsetting for [my relative]."

Supporting people to express their views and be involved in making decisions about their care

- Some staff were employed who did not have sufficient understanding of the English language to keep people safe and understand their needs. People described how this impacted on their care and meant they were unable to express their views because they couldn't make themselves understood. One person said, "I'm fed up with them all. [Staff] don't understand what I'm talking about."
- A relative said, "[Staff] couldn't understand [my relative] and [my relative] couldn't understand them. Sometimes I felt they just walked into the job because it was a job, but they didn't really care. "I'd say [staff] had no knowledge of dementia and didn't really try to understand [my relative] and if they can't speak English how can they recognise what [my relative]'s needs are?"

Respecting and promoting people's privacy, dignity and independence

- One person described how staff did not respect them or their home. They said, "Some carers don't drive so they can wait half an hour for a driver to pick them up. They will sit in my house sometimes after my call has finished, just waiting for their driver. I don't want that. I tell them they shouldn't be waiting in my home, but they don't understand because of their English."
- Another person said, "Their phones constantly ring while [staff] are looking after you, it's usually telling them it's the driver outside." This was disrespectful and did not make people feel valued.
- A relative said, "[My relative] told me [staff] come in sometimes and clap their hands at [my relative]. [My relative] said, 'I'm not a baby'. It really upsets [my relative]." This was not a dignified and respectful way to support a person.
- Some people said staff did not always cover them up when providing personal care, which was undignified and did not respect their privacy. One person said, "Once, [staff] left the front door open, I was in the conservatory washing. I was expecting a lift from an ambulance. Suddenly the ambulance crew walked in on me, I was naked, I couldn't get off the commode, they said the front door was wide open."
- Some people said staff rushed a lot and this meant the care they provided was not always dignified. One

person said, "They rush all the time, so I end up banging my leg on the trolley. The other day [staff member] went to shower me, they were in such a rush they sat me on the toilet and just washed me, it's happened quite a few times." This meant the person did not get the shower they needed, just a wash. They were not given a choice. This was disrespectful and undignified.

The evidence above shows that 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.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

- People told us they did not feel confident to raise any concerns or complaints as when they had previously, nothing changed. One person said, "I've raised about the time-keeping. The last time was just the other week. The manager always says the same but nothing changes, there's little point raising anything."
- Another person told us about poor care they received. When we asked if they reported it to the service they said, "There's no point, nothing changes."
- People told us they did not always get an appropriate response or resolution when they raised a complaint. A relative said, "[The manager] just kept saying she understands, at this moment I'm not confident she does though."
- Another person said, "They did investigate, and the manager contacted us to say sorry. They were very apologetic and said they were still looking into it. They said they'd email me but never did, I've heard nothing since."
- We found that not all the complaints people told us about had not been appropriately recorded and responded to. Complaints records were poor and disorganised.

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.

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

- Care plans contained some personalised information, including life history information and preferences so that staff had access to the information they needed to provide personalised care. However, these care plans were not always regularly reviewed and updated.
- People told us their care calls were often earlier or later than the agreed times. One person said, "The evening call should be 9pm but it can be 8:30pm or 9:45pm, it's impossible to settle when you don't know, it doesn't aid recovery." This meant people did not always have choice and control over the times they received support.
- People and relatives said staff didn't always stay for the full, agreed amount of time and that staff were often rushing. A relative said, "[Staff] should give [my relative] the full half hour they're entitled to and take their time. [My relative] shouldn't feel rushed."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were not always met, as they could not always make their needs known to some staff who did not have a good understanding of English.

● One person said, "[Staff] should speak the same language as their clients. This is care work after all and what about people who struggle to communicate themselves, this must be impossible for them." Another person said, "I get the impression [staff] haven't read my care plan. They can't if they don't have the language. Most don't know what they're doing when they get here. I have to remind them what needs doing, like I have to point to my leg and say it needs the cream."

● A relative said, "[The language barrier] really is a barrier to care. Some [staff] are very poor at English and with [my relative]'s speech difficulties they don't understand [my relative] so they treat [my relative] like a baby instead."

● A staff member said, "It is very true that some carers don't speak enough English to communicate with people."

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

● One person described how the language barrier between people and staff, impacted on staff's ability to understand and meet their needs in relation to their culture and diversity. They said, "If [staff] knew what you were talking about, they might respect your culture. I'm Irish catholic and was married to a Punjabi but they don't have a clue."

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.

End of life care and support

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

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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and relatives did not feel engaged and involved with the service. A relative said, "I never had a call from them to ask how things were going."
- People did not feel valued, or that their feedback mattered. Another relative explained, "I find communication at this (management) level not the best. I got an email back from [the manager] saying there were rota issues. She apologised then for being harsh but said the lack of regular carers was down to COVID-19. Then the next part of the email was a copy and paste job from a generic COVID-19 email."
- Another relative said, "To do better, they need to recognise there are problems. Then they need to act on it, not just give a bland generic response."

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

- The provider, who was also the manager, had little oversight of the service. They did not have prompt access to all records and documentation required, despite being notified in advance of our inspection. Systems were chaotic which meant there was a delay in accessing vital information in relation to the safety and quality of the service.
- Care plans were not audited or reviewed. This meant the provider was unaware of some of the issues we found during the inspection. Some care plans were out of date and had not been reviewed but the provider had not identified this as they had not checked any of the care plans.
- The provider completed audits of medicines administration records (MARS). However, they did not identify the significant concerns we found with medicines administration including that MARS lacked vital information such as the medicines dosage and frequency. The provider's audit had therefore been ineffective in identifying areas for improvement and driving those improvements.
- People's daily records were returned to the office when the paper book was full. No logs were in the office from 2021 on the first day of inspection, indicating no full audit checks of the logs had been taken for at least six months. The provider did evidence some audit checks that had been undertaken but they were sparse, and few errors were not identified and followed up. This meant people's daily records were not regularly audited or reviewed to ensure people were receiving the care and support they needed.
- The provider could not evidence all staff had received the required training. Only 17 out of 39 staff members employed were registered on the provider's training site. This showed gaps and out of date training. Neither we, nor the provider, could be assured that staff were trained adequately to meet people's

needs and provide safe care.
● The provider had recruited staff who were unable to understand people's needs effectively due to being unable to speak fluent English.

The provider failed to operate an effective governance system to assess, monitor and improve the quality and safety of services provided. They failed to seek and act on feedback in order to improve the services provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider is required to notify CQC of certain events that occur at the service such as allegations of abuse, serious injuries and deprivations of liberty. This is required by law.
● We found there were 10 allegations of abuse that had been recorded in a safeguarding folder at the service. The service had not notified CQC.

The above evidence demonstrated that the provider had failed to notify CQC of allegations of abuse. This was a breach of regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

● The provider was not displaying their rating on their website. However, the provider took immediate action to display their rating, when we bought this to their attention.

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 could not demonstrate they understood their responsibilities in relation to duty of candour. When things had gone wrong, we found that people did not always receive an apology and appropriate investigations were not always carried out.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of allegations of abuse.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care that people received did not always meet their needs or reflect their preferences.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not maintained.

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

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no effective system to receive and investigate complaints, ensuring appropriate

action is taken in response to any failures. People were unhappy with complaints responses.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate an effective governance system to assess, monitor and improve the quality and safety of services provided.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that staff were suitable to work with people who used the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive the training, development and support they needed to support people effectively.

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's risks and medicines were not safely managed. This left people at significant risk of harm.

The enforcement action we took:

We took urgent enforcement action to impose conditions on the provider's registration.