CCS Homecare Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

About the service
CCS Homecare Services Limited provides a range of care and support services. At the time of our inspection, the service supported approximately 334 people. People had diverse needs, including younger adults with learning disabilities, people with mental health needs, older people and people living with dementia.

Some people received personal care in supported living accommodation. At the time of our inspection, support was provided at 16 supported living sites. Accommodation ranged in size, from single person flats to a development of 16 one-bedroom flats, with shared facilities such as a communal lounge and garden. Most sites supported around five to seven people living with learning disabilities, and some people also required mental health support.

The service supported individuals at four extra care housing sites within the London Borough of Hillingdon. People using the service lived in flats, with access to care support. The size of these buildings ranged from 47 to 88 flats. One of the buildings contained a six-flat unit, used to provide short term care support for people discharged from hospital.

The service also supported people living in their own homes. Some people received support as part of discharge to assess arrangements, meaning they received short-term care following hospital discharge. Other people received care support on an ongoing basis.

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
We spoke with people and families about their experiences of the discharge to assess pathway. People received a welcome letter but did not receive a copy of their care plan. Care was arranged quickly to help people return home at short notice. This meant the service could not provide set visit times. Some people were unhappy with not knowing what time staff were turning up which impacted on their meals and medication. A relative told us, "There was inconsistency with times carers came. My relative felt trapped and stressed because of erratic times." Another person commented, "They are kind but don't always stay the right amount of time and turned up at different times."

Most people felt safe whilst receiving discharge to assess support. Some people provided positive feedback. One relative told us, "It was an excellent transition from hospital to home. She feels safe with the carers who come as they help her confidence and trusts them to do a good job." Another person advised, "I felt safe with the carers as whatever I asked them to do, they did it. They reminded me of the risks with walking and how to use the zimmer frame."

We also spoke with people and families in relation to long-term care and support at home. Most people told us they felt safe with the care and support they received. One person told us, "The carers inspect me for sores as it is part of my plan, I self-medicate and I'm treated with dignity and respect". Another person added, "I feel safe and comfortable when carers are here".

We heard varying feedback about the consistency of people's support, particularly regarding punctuality of staff. One person told us, "Lunchtime can be anywhere between 11.00am and 2.00pm. They have never missed a call but won't give me a time." Other comments included, "they are fairly punctual", "carers are often late" and "schedules given to carers don't seem to correspond with what has been agreed."

People we spoke with did not know the name of the manager, but there was generally positive feedback about communication with the office. One person told us, "The staff and carers are pleasant and friendly… I'm happy with the office." Another person told us, "If I have concerns, my relative deals with the office for me. A lady comes out and asks me questions about the support I'm getting and if I need anything from my plan changing". People also confirmed they were contacted for feedback as part of quality assurance monitoring.

We also gathered feedback from people and families using extra care services. People told us they felt safe and spoke positively about the support they received. People used an alarm system to call for assistance when staff weren't present. We heard staff responded promptly to the alarm. People received support from regular staff, and we heard staff understood people's needs and preferences. One person told us, "They do everything they are supposed to do for me, I like all the girls." At one site we visited, people knew there was a new manager and one person said, "She pops in to see me". Another person at the same site told us the manager acted quickly when they requested an earlier morning visit, to ensure they received pain relief medicines at the right time.

People spoke positively about safe care received within supported living settings. This helped people achieve good outcomes. People felt there were enough staff to support them and told us they felt supported in relation to medicines and managing the risks associated with COVID-19 infection. Some people's routines and preferred activities had been impacted by the pandemic, with one person commenting, "It's difficult to set goals. College finished early." However, people told us the service had supported them during this period. One relative told us, "[person's name] used to go to a day centre. They definitely get one to one support three days a week and since he's been in hospital, he needs extra help. They've done really well." Another person described the activities they now access and enjoy, advising, "I like shopping, television and music. I go to college to do maths, English and cookery."

We found risks in relation to people's care and support were not always clearly identified within records. We also identified concerns in relation to the recording of medicines support. We made recommendations the service develop their approach in relation to risk assessments and medicines recording. The service responded to our feedback immediately to confirm they were taking action to address the concerns we found.

We found records in relation to people's care and support were not always person-centred. Some records contained contradictory or incorrect information. The language used within care plans was not always person-centred. The service was responsive to our feedback and immediately confirmed they would work to make improvements. This included plans to revise staff training and review the content and wording of all care plans and risks assessments.

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.

This service was able to demonstrate how they were meeting the underpinning principles of right support and right culture. We did not look at the component of right care as part of this inspection.

Right support:
• Model of care and setting maximises people's choice, control and independence.

Right care:
• We did not inspect the Caring domain as part of this inspection and did not look at all the components in relation to right care.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

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 29 June 2019).

Why we inspected
The inspection was prompted in part due to significant expansion of the service since our last inspection. We were aware of increased numbers of safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service remains Good. This is based on the findings at this inspection.

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

The service responded immediately to our feedback and commenced action to address the issues we identified. This included updating policies, revising staff training materials and reviewing how medicines administration, care plans and risk assessments were recorded. The service improved information given to people receiving discharge to assess care, to include a summary of the care support in place and approximate visit timescales.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

CCS Homecare Services Limited

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 team included five inspectors, an inspection manager, an assistant inspector and three Experts 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
CCS Homecare Services Limited provides a range of services which include domiciliary care. It provides personal care to people living in their own houses and flats.

The service also provides care and support to people living in 16 supported living settings, so they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

In addition, CCS Homecare Services Limited provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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

Notice of inspection
We gave a short notice period of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 19 April 2021 and ended on 7 May 2021. We visited the office location on 20 April 2021 and 21 April 2021. We also undertook visits to two extra care sites and three supported living homes between 21 April 2021 and 23 April 2021. From 26 April 2021 to 7 May 2021 we continued to review evidence remotely and spoke with staff and managers.

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 sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 38 people who used the service and 23 relatives about their experience of the care provided. We spoke with 48 members of staff including the nominated individual, two registered managers, five service managers, one medication officer, field liaison supervisors, team leaders and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received feedback from 21 members of staff electronically, either by email or using CQC's 'Give Feedback on Care' online feedback form.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 45 people's care records including a sample of people's medicines records where they received support with this task. We looked at 23 staff files in relation to recruitment, induction 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 review records shared electronically and continued to seek clarification from the provider to validate evidence found. We viewed a wide range of records including safeguarding enquiry evidence, training records, medicines audits, service audits, meeting records and policies. We also contacted several professionals for feedback and received nine responses.

Requires Improvement

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 Requires Improvement.

Requires improvement: This meant some aspects of the service were not always safe and there was an increased risk that people could be harmed. Some people's records did not clearly outline how identified risks should be managed by staff.

Assessing risk, safety monitoring and management

- The provider did not do all that was reasonably practical to mitigate risks. This was because some people's risk assessments lacked personalised detail, particularly for people using extra care housing or receiving care in their own homes. This meant information about identified risks and how they should be managed was not always comprehensive. Risk assessments were lengthy, but information was not always relevant to the person. For example, a detailed risk assessment was completed in relation to abuse people had experienced over their lifetime. This was completed for all people using the service. It was not clear what the purpose of this was and if this was necessary or appropriate if no other risks had been identified.
- One person's care plan stated they were at medium risk of dehydration and drinks were to be left in reach at the end of each visit. However, the care plan only mentioned this for the lunchtime call and not the other three daily visits. Despite the gaps in these records, staff spoken to knew people well and were taking action to manage the risks identified.
- One person using the service was a smoker, with significant fire risks associated with this. Staff checked on this person frequently and the person used a fire-retardant blanket, due to the risks associated with drinking alcohol and smoking in their flat. This detail was not included within their support plan. The risk assessment included with the support plan advised staff to 'Teach regarding immediate and long-term fall risk due to dulling of neurological capacity from alcohol'. The person's personal emergency evacuation plan (PEEP) asked staff to check the ashtray was not over filled and the fire blanket was in use. These instructions were not included within the daily task description given to staff for each visit.
- Another person was at high risk of falls if left unattended in a chair, because of a history of falls whilst walking unaided. We were advised the person was only hoisted to a chair if staff or family would be present to supervise. This critical information was not recorded within the person's support plan or risk assessment. The falls risk assessment instead advised staff 'Care workers to ensure that the mobility equipment is left within close reach at all times.' We were advised the person felt anxious when their walking aid was not close by, however the risk assessment did not highlight the person would be at risk if left unattended with their walking aid.

We recommend the service develop their approach to ensure risk assessments are person-centred, proportionate and appropriately updated when people's needs change.

The provider was immediately responsive to our feedback. Individual risk assessments were updated, and

the provider outlined planned actions to review and develop their approach to risk assessment documentation. This included a review of the risk assessment process and staff training to ensure care plans and risk assessments presented relevant and person-centred information. The provider shared updated templates, staff training materials and example documents to evidence their approach.

● Staff undertaking risk assessments received training and we reviewed training materials in place. A staff member told us, "Part of my role is to carry out risk assessments. I look at the surroundings, observe people, talk to them and try to pick up as much information as possible."
● People had Personal Evacuation Emergency plans (PEEPs) in place which outlined the support they required to evacuate the building in the event of a fire.
● Environmental risk assessments were in place and health and safety checks were carried out which included water temperature checks and regular fire drills. Other risks to staff safety were robustly considered, including animals present, moving and handling and use of equipment.
● Within supported living settings, we found systems were in place to mitigate risks to people. Risks associated with moving and handling, choking, tissue viability, behaviours that challenge and medical conditions such as epilepsy and diabetes were identified and mitigated. The service had worked closely and collaboratively with other health professionals to support a person which had resulted in positive outcomes for the individual.
● Staff at one supported living site told us they felt care plans and risk assessments contained enough information for them. Staff comments included "I would learn about specific risks and how to handle them by looking in the service user's care plan and reading everything that is in there."
● Staff were trained to support people with behaviours that challenged as well as being trained in breakaway techniques to keep themselves safe. Staff knew people well, the risks they presented with and the level of support required. This enabled them to be responsive to changes in individuals to prevent a situation escalating.

Using medicines safely
● Some medicines have recognised instructions for safe administration. Some people using extra care services were prescribed Levothyroxine and Alendronic Acid. If these medicines are not administered on an empty stomach the person may not get the benefit of the full dose. Additionally, when taking Alendronic Acid, the person is advised to sit or stand for 30 minutes, because if the tablet gets stuck, it can irritate the lining of the oesophagus and cause dysphagia, heartburn, pain or ulcers. The sample of extra care records we reviewed did not evidence the safe administration of these medicines. These people's support plans and medicine administration records (MAR) lacked detailed instructions for staff and daily records did not evidence in which order a person had received their medicine and breakfast. Due to potential risks of harm, we advised the manager to raise a safeguarding alert to the local authority. The service provided feedback to the local authority about action taken and the alert was closed. Staff we spoke with in relation to specific individuals confirmed correct administration practice was followed, and we were advised staff received information about time sensitive medicines during induction.
● One person receiving extra care support was prescribed two creams which were not documented on a MAR chart. A staff member told us it can be "hit and miss" as to whether creams are added to MAR charts and advised they bring discrepancies to the attention of a supervisor. The person's MAR chart was updated immediately in response to our feedback.
● Electronic MAR charts did not accurately reflect when people were administered as and when required (PRN) pain relief such as paracetamol. MAR charts showed insufficient gaps between the doses administered for some people, but a separate handwritten record showed there were appropriate gaps between the doses administered. We heard this was a known issue due to internet access which meant electronic records can refresh and upload data later.

● Systems were in place to audit medicines practice. Within extra care sites this included daily checks, weekly audits and quarterly audits conducted by the registered manager. We provided feedback regarding the daily audit forms used at one extra care site, which showed several blank gaps. The manager confirmed they would implement an improved form where staff could avoid blank entries, for example, to note if a person was in hospital, or the flat was unoccupied.
● Some people were prescribed transdermal patches. When visiting a supported living site, staff confirmed these were rotated on each use and the previous one removed. However, there was no transdermal patch record in place to ensure this practice was promoted. The service agreed to put one in place and a template was provided after the inspection visit.

We recommend the service develop their approach to medicines recording, to ensure staff can evidence people have received safe support with prescribed medicines.

The service was immediately responsive to feedback. The service identified individuals prescribed levothyroxine and alendronic acid and contacted GP surgeries to ensure any specific instructions were included on medicines labelling. The service also improved the function of the electronic recording system to enable staff to accurately record when medicines were given and where on the body medicines such as patches, had been applied. Additional information about time-sensitive medicines was shared with staff to improve awareness.

● Staff had received training in safe medicines practice. Staff had their competency to administer medicines assessed prior to supporting people. We observed a workbook completed by staff as part of their first supervision. This highlighted some key information about medicines, including blood thinners, food contraindications and risks associated with paraffin-based creams.
● Controlled medicines were managed appropriately, and protocols and guidance were in place around "as required" medicines and seizure protocol medicines for people with epilepsy.
● Records were maintained of medicines ordered, received and we observed medicines stored appropriately. Some parts of the service benefited from dedicated medication officers to maintain medicines records and act as a point of contact with families and healthcare professionals.
● The provider acknowledged an increased level of medicine errors. Following this, a full review of medicine practices was made. The managers cascaded further guidance to staff on how to reduce errors. In addition, the electronic medicine record (MARs) alerted staff to potential errors. For instance, if a member of staff entered two tablets onto the record when only one should have been administered a warning indicator appeared. One member of staff told us, "It really does help".

Staffing and recruitment
● Staff were safely recruited. We found DBS checks were conducted, two references were taken, and applicants attended for interview. A DBS check is a record of a person's criminal convictions and cautions carried out by the Disclosure and Barring Service.
● During the inspection we found some isolated instances where recruitment procedures were not consistently followed. We saw a job application and noted approximately six weeks discrepancy in relation to when they started working for their most current employer. The service was responsive to our feedback. The service reviewed all staff files, updated the audit tool in use and provided updated training to auditing and recruitment staff.
● Staff spoke positively about recruitment, training and ongoing development opportunities. A structured induction programme based around the Care Certificate was in place, and staff benefited from a period of shadowing. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of staff working in social care. One staff member told us, "The training was quite

intense…but you are not left to fend for yourself and work alongside experienced people who know what they are doing." A second staff member added, "The training is very comprehensive and informative, and refresher courses are good too."

● Registered managers evidenced how safe staffing levels were determined within services. A planning tool was used within home care services to anticipate when additional recruitment would be necessary throughout the year.

● People receiving discharge to assess care did not receive set visit times. This was because care was arranged at extremely short notice to facilitate hospital discharges. Supervisors monitored new referrals and assessments were undertaken as quickly as possible. A medication officer ensured medicines records were available to care workers. A service manager closely monitored the levels of service demand in relation to staffing capacity.

● People receiving ongoing care at home raised concerns regarding consistency of care staff, visit times, lateness and occasional missed visits. One family member told us, "There never seems to be a set time for the visits and times vary a lot…different people go in and don't get to know him. I feel they rush him." Another person told us, "sometimes they are very late and at weekends the times vary a lot."

● Staff were given a 30-minute leeway, to consider factors such as transport delays. We found a very small number of missed visits over a six-month period which had been appropriately investigated by the service. We identified concerns in relation to the wide variation in punctuality across the staff team. The overall percentage of punctuality was 80%, however 10 care workers had a visit punctuality of less than 50% and three care workers had a punctuality of less than 30%.

● The service was responsive to our feedback and recent quality assurance had found similar concerns and identified required actions. The nominated individual informed us carer punctuality would now be monitored by the provider using KPIs (key performance indicators) to ensure better oversight. An initial analysis completed by the service identified factors such as public transport issues, visits overrunning, emergencies and scheduling issues. The service explained the COVID-19 pandemic had resulted in an adverse impact on staff attendance due to restrictions in public transport, self-isolation instances and staff shielding. The service had shared this feedback with people using the service and the local authority to highlight the challenges they had faced.

● People using extra care services told us there were enough staff and that staff always responded promptly when they called for support. One person said, "I only have to press the button and they come". Staff were deployed in a way that meant people had regular staff who supported them to provide continuity.

● Within supported living services, we observed, and staff told us there was enough available staff to support people. One member of staff told us "There is always enough time to support the service users with their activities and appointments."

● People using supported living told us support was provided by existing and sometimes new staff. One person told us, "There are quite a lot of different staff but they're really helpful…they tell me in advance of changes." Another family member commented, "There's some regular staff and some new. One to one staff are always the same and they know him."

Preventing and controlling infection

● People were protected from the risk of infection. Staff informed us they had access to COVID-19 test kits and sufficient supplies of personal protective equipment (PPE). PPE stock levels were monitored across all sites.

● Staff had received training in relation to infection control. One staff member told us, "We had PPE

training…We learnt to wash hands properly…and ensure everything is wiped down with antibacterial spray."

● Staff told us they were encouraged to take the COVID-19 vaccine. The nominated individual joined a national campaign to promote the COVID-19 vaccine within the adult social care sector.

● Weekly meetings were held to discuss the service's response to the pandemic. We observed detailed business continuity plans provided managers with clear guidance if someone presented with suspected symptoms of COVID-19 infection.

● Within extra care services, staff were observed wearing appropriate PPE to protect people and communal areas were cleaned throughout the day to mitigate the risks associated with COVID-19. People told us staff wore PPE, one person said, "They all wear masks, gloves and aprons."

● People had been informed about the risk of COVID-19 and how they could protect themselves. In one supported living scheme we observed people getting ready to leave the building either by public transport or a taxi. Without prompting each person ensured they had a face mask ready to use. One person we spoke with was able to tell us why this was important.

● Some people receiving care at home expressed concerns regarding how PPE was used. One family member told us, "PPE isn't always worn correctly, I observed a carer who wore the mask round her chin, and another kept her outside coat on [whilst delivering care]." Another family member commented, "They don't always wear aprons." Feedback varied, with other people indicating staff had worn appropriate PPE. The service was responsive to our feedback and advised they would continue to monitor the use of PPE.

● Spot checks to monitor use of PPE were in place. Staff received reminders in relation to infection control good practice through supervision, team meetings and weekly memos.

Systems and processes to safeguard people from the risk of abuse

● Most people told us they felt safe being supported by the service. People's comments included, "They are always close making sure I don't fall" and "They are not rough, and they are polite."

● People were protected from abuse. Staff received training on how to recognise signs of abuse and were confident to raise concerns to the office or external parties such as the local authority. One staff member told us, "I learnt about what triggers to look out for and how to report safeguarding". A second staff member informed us, "I will report…who is being harmed, where, when...but I maintain confidentiality and inform the victim and gain their consent. In some cases, consent may not be possible so it will be my legal and ethical duty to inform the relevant people."

● There was management oversight of all safeguarding concerns. Concerns were not closed until the local authority communicated an outcome, and we noted many recent concerns were found to be unsubstantiated.

● The service worked in partnership with the local authority to support the safeguarding enquiry process. A professional working with the service advised, "Whilst there has been some complaints and safeguarding cases, CCS have always sought to resolve the issues. When a case has progressed to safeguarding, CCS have contributed and participated in all processes to ensure a positive solution."

● We observed a safeguarding meeting, where a service manager engaged cooperatively with partner agencies to discuss a recent incident. The service had already completed an internal investigation and explained how they would implement any areas of learning.

Learning lessons when things go wrong

● Staff understood their responsibility to report incidents of concern. Staff used an electronic system to escalate concerns whilst working remotely.

● Throughout the inspection we were provided with examples of how the provider worked with professionals to reduce harm to people and ensure they had the right level of support. This included social services, district nurses, GPs and other healthcare professionals when required.

● Systems logged concerns and complaints, accidents and incidents and safeguarding issues. Reports were accessed by supervisors and managers to ensure appropriate action was taken. Daily meetings were held to discuss immediate risks and agree any further actions required.

● Systems were in place to identify learning from single incidents and consider any wider themes or trends. The service held daily, weekly, monthly and quarterly meetings where risks and any emerging trends could be explored. Learning was identified both within individual services and across the organisation.

● Learning was shared with staff in several ways. This included supervisions, meetings, memos, and awareness raising campaigns. At the time of our inspection a medicines campaign was underway. The campaign was developed following a trend of medicines errors. A management briefing showed training was initially targeted for services with the highest numbers of errors. The service planned future campaigns such as diabetes awareness, and nutrition and hydration.

Good

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 remained the same.

Good: This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

At our last inspection we recommended the service followed good practice in fully demonstrating the duty of candour requirement. The provider had made improvements.

● The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The provider understood their responsibilities.
● A duty of candour policy was in place. This provided staff with clear and detailed guidance.
● We observed evidence in relation to duty of candour processes across the organisation. We found people were given detailed feedback and an apology as part of the organisation's duty of candour responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Some people receiving care in their own homes expressed concern about continuity of care and staff approach. We received mixed feedback, indicating people did not consistently receive person-centred care. One relative told us, "When they gave her a bed bath I had to ask one carer to cover up my relative's exposed top half when they were washing her lower body. It was for privacy, dignity and so she didn't get cold." A second person added, "I do feel safe with the carers but different carers treat me differently…some of the carers aren't sociable and don't talk much." Feedback was variable and other people provided positive feedback, with one relative advising, "They try to keep to the same two carers and I can hear them joking and laughing with him." The service monitored people's support through regular quality assurance, and we found evidence concerns raised directly with the service had been appropriately addressed.
● Where people received care at home or extra care support, some care plans and risk assessments lacked person-centred detail; at times information was task focused or incorrect. One person's care plan described them as having a catheter; this was not the case. Another person's support plan described them as using a walker however their risk assessment, and our conversation with the person, confirmed they could not walk and used a wheelchair. Some care plans referred to people by the acronym 'SU' meaning service user, which was not respectful or empowering language. The service was immediately responsive to our feedback and

updated records containing incorrect information. We also found examples of detailed, person-centred documentation, particularly within supported living services, which demonstrated good practice.

● Staff were aware of the service's values and mission. There was a focus for the organisation to be outcome focused, innovative and quality driven. One staff member told us the values of the company had first attracted them to the role, as this included the importance of "genuine care and putting people first".

● Within supported living services, we found there was a commitment from staff to support people to maximise their independence and achieve good outcomes. One person told us how they desired to be a security guard at a supermarket and go horse riding. These goals and aspirations were detailed in the person's care plan. One staff member told us "I enjoy trying to make a difference to the [service users] and making them safe and happy". A second staff member advised, "When we see our efforts are helping people to achieve their goals that makes us proud." People's achievements were shared within a newsletter to celebrate their success.

● Staff provided examples of supporting and empowering people in relation to their protected characteristics. One staff member told us, "One person worships his own religion which we respect." Some people with learning disabilities were supported in relation to their understanding of relationships and sexual health, including the importance of consent.

● Most staff told us they felt supported by the management of the service and enjoyed good team working. Comments included, "We have a good team who support each other", "The management are approachable and supportive" and "I can call her [manager] anytime and she will listen." Staff member protected characteristics were supported. For example, during our inspection some staff were observing prayers and fasting during Ramadan. Prayer rooms were made available.

● Within extra-care services, people told us having their own flat with access to care support enabled them to retain their sense of independence where possible. We also found the service received several compliments in relation to a short-term care unit within extra care services. One family member told us, "I have never encountered a team that demonstrated such care, compassion and understanding…they arranged a surprise Eid celebration, which brought tears of joy."

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

● We identified concerns regarding the lack of person-centred detail within some care plans and risk assessments. This was variable and some records, particularly within supported living settings, contained a good level of detail. We observed audits completed across extra care and long term care services. Audits identified individual records which required more person-centred detail, such as choices of food and drink, but did not fully identify the wider concerns we found. The service responded to our feedback and explained some aspects of auditing had been impacted by the COVID-19 pandemic, when auditors moved to virtual working to minimise the risk of infection to people using the service. The provider planned to increase staffing. We heard two auditors had been recruited to join the quality assurance team and further recruitment was planned.

● Registered managers understood CQC regulatory requirements and submitted required notifications to CQC. Registered managers told us they were closely and effectively supported by the provider. The nominated individual took a proactive role in supporting the organisation and attended key meetings to ensure oversight of risks, trends and quality matters. This enabled the provider to provide appropriate advice and resources, including extra staffing when required.

● Staff were clear about their roles, responsibilities and lines of accountability. Staff accessed a standard operating procedure booklet which set out clear expectations and required performance standards in relation to daily work tasks. This helped ensure a consistent approach where staff teams operated across several sites.

● Registered managers retained a good oversight of services. This was supported by daily telephone calls to

maintain close contact with services based in different locations. The electronic systems also enabled registered managers to have full oversight of risks including accidents, incidents and safeguarding concerns. Registered manager also demonstrated a good knowledge of staff and people receiving support. One manager told us, "I do like to be a hands on manager…I'm happy to do whatever I'm asking other people to do…I'm proud of my managers… and they know they can come to me at any time."

● There was a robust approach to the security of confidential information. We observed records stored securely across all sites we visited. Safeguards were in place within electronic systems to lessen the risk of a data breach occurring. Staff visiting people in their own homes accessed care plans for people they supported that day but could not search or access information relating to other service users. Access to external email was limited to senior staff to ensure information was shared securely.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they were able to raise feedback at team meetings or had direct contact with their managers. A staff member commented, "We are always listened to, for example if I wanted to increase or decrease hours, management are thinking about our wellbeing as well as the service users." Another staff member told us they had been supported after voicing concerns, advising, "I challenged the behaviour of the manager when I felt discriminated, I emailed the head office…and things were addressed."

● We reviewed the results of a staff survey undertaken which included an analysis of findings and planned actions. Some staff indicated they were not aware or had not participated in this process. Quarterly audits included conversations with a sample of staff to ask if they had any concerns or suggestions of improvements for the service.

● Quality assurance systems were in place to gather feedback from people using the service. We reviewed the most recent survey results and analysis across each part of the service. This included planned actions to address any themes identified.

● Spot checks undertaken for staff working in the community also gathered feedback from the person about their experiences of receiving support.

● Some extra care sites held residents' meetings to gather feedback.

● We found links were in place to encourage regular communication with key stakeholders via regular meetings.

Continuous learning and improving care

● The service used bespoke information technology systems to monitor the quality of people's care and support. Electronic records including people's daily care, medicines administration and accidents and incidents could be accessed centrally by supervisors and managers. This enabled new issues to be identified and discussed as part of daily team calls across each part of the service. This approach meant learning from individual incidents or concerns could be quickly shared with team members.

● Staff told us the service used different communication methods to support their continuous learning. One staff member told us, "Lessons learnt are shared at staff meetings and training is arranged." A second staff member added, "Staff are kept updated through emails." A third staff member advised, "After every incident we discuss outcomes with our manager and lessons learnt are shared with colleagues during handover and notes via our mobile phones."

● Information was collated and analysed as part of the service's quality management approach. A series of meetings were held within services and across the organisation to discuss risks, identify learning and agree actions to drive improvement. At the time of our inspection the service had identified a trend of medicines errors and was rolling out an awareness raising campaign as part of efforts to minimise future errors. The service had also identified a trend of falls and developed a falls awareness campaign.

● The service identified staff who had excelled in their role through schemes such as staff of the month and

management excellence award. Their achievements were documented, and they received a cash prize.

Working in partnership with others

● The service worked closely with a key local authority stakeholder. At the time of our inspection, the service had successfully managed a period of expansion to incorporate four extra care sites. We observed evidence of close working with the local authority to monitor the progress of this and other joint working projects. In addition, we found evidence of regular partnership working with healthcare professionals, to provide people living in extra care more joined up support. In relation to the transfer of extra care services, a professional commented, "The transitions of these services were extremely smooth considering the size of them and the amount of people involved."

● Staff working with people who lived in supported living schemes ensured they referred people to external health and social care professionals in a timely manner. We observed evidence of close partnership working to support people with complex needs associated with their behaviours or medical conditions.

● We found there was good communication about people who attended college or work placements.

● We received positive feedback from professionals regarding their experiences of partnership working. A professional involved with quality monitoring on behalf of a local authority advised, "they co-operate and engage well when QA Officers carry out their monitoring visits. They have been open and responsive to the findings from these visits and provided all requested information and implemented any actions plans from recommendations on where improvements can be made to improve services to residents."

● One extra care site contained a short-term care unit to support people following hospital discharge. The service worked closely with health and social care professionals in relation to referrals, people's care and discharges from the unit. A professional advised, "They have provided regular detailed situation reports that show where the patient is and how they are getting on, they will highlight any issues or areas of concern to the care management team; ensuring that they have reviewed and tried to resolve any issues."

● The service also worked closely with health and social care teams to provide discharge to assess (D2A) short term care in people's own homes. Clear referral processes and regular joint meetings were in place to promote effective partnership working. A professional told us, "In my experience CCS have also sought to learn, develop, and adapt to the requirements of the D2A model."