Inmind Community Support Services Limited

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Inspection report

The Rock Center
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Walsall
West Midlands
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Inmind community Support Services Limited is a domiciliary care service providing personal care for people living in their own homes. At the time of inspection 81 people were receiving personal care from the service.

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 always receive safe care and support. We identified a breach of the regulations due to concerns about how some people's risks, including medicines support were managed. Risk assessments were not always in place or lacked guidance for staff to follow. Where lessons could be learned to improve the service and make the care people received safer; these were not always identified and addressed. Medicine records were not always completed correctly or clearly, and monitoring systems had not identified this. Staff understood safeguarding procedures and had been recruited safely. People and their relatives told us they felt safe and that there were enough staff to meet their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff had received some training but further training was needed. Staff felt supported by the management of the service. Additional training was needed for some staff regarding people's specific needs. People told us they enjoyed their meals and they chose what they preferred. People were supported to meet their health care needs, when necessary.

The provider's systems had not ensured the service was fully caring as people's risks had not been managed well and people's care plans did not always contain current information about people's care needs. Most people told us they felt well supported by the staff who came to provide care and that they were kind and caring but we also received some negative comments about staff. People were involved in their reviews and were supported to make choices about their care.

The provider had not ensured that people's care records contained up to date information about people's current care needs. Whilst people told us, and we saw that reviews had taken place, they had not been wholly effective in identifying inaccuracies or omissions in people's care records. There was a complaints procedure in place which people were aware of. We received mixed views about the provider's response to concerns and complaints.

The governance of the service continued to need improvement and as such the quality and the safety of the service had not been effectively monitored. Our previous inspection had identified improvements were needed in relation to care records and risk assessments. This inspection identified improvements were still needed.

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 20 August 2018)

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of choking. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the 'Is the service Safe?' sections of this full report.

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

Enforcement
We have identified breaches in relation to keeping people safe and monitoring the care provided at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Inmind community Support Services Limited on our website at www.cqc.org.uk.

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.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

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 always well-led.

Details are in our well-led findings below.

Requires Improvement

Inmind community Support 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
One inspector carried out this inspection. An Expert by Experience also spoke with people using the service and their relatives. 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection.

Inspection activity started on 28 June 2019 and ended on 5 July 2019. We visited the office location on 28 June and 2 July 2019.

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 three people who used the service and 16 relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, deputy manager and care workers. We also spoke on the telephone with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and medication records. We looked at four staff files in relation to recruitment and staff supervision. We also looked at records around the management of the service such as accidents and incidents, complaints and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information and quality assurance records.

Requires Improvement

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. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- Staff did not have all the information they needed to help manage people's risks safely. For example, some people had health conditions such as epilepsy or diabetes. There was no care plan or risk assessment in place to guide staff on what to look for and how to support the person with their condition.
- Care records we saw and discussions with the registered manager and staff did not give assurance that where people were at risk of choking the risk was effectively managed. The registered manager took action to address this when we brought this to their attention.
- Whilst people told us they were happy with the support they received with their medicines we found that improvement was needed in the recording of medicine administration.
- Medicines administration records (MAR) did not always reflect the person's current prescribed medicines. We had to bring this to the registered manager's attention who commenced action during the inspection to address this issue.
- Staff told us they had received medication training. Whilst medicine administration was checked during spot checks of staff at people's homes, medicine competency assessments had only been completed for a small number of staff. Medicine competency forms are a formal way of the provider checking staff are safe to support people with their medicines.
- One person had a Percutaneous endoscopic gastronomy (PEG) and needed staff support to take their medicines. Staff had not received competency assessments to ensure tasks associated with PEG care were undertaken safely.

Poor risk management and medicine systems meant that risks to people could not be consistently managed and left people at risk of harm. This is a breach of Regulation 12 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 felt safe when receiving care from staff. One relative told us, "'Yes we feel he's in safe hands."

● Staff confirmed they had received safeguarding training and were aware of their responsibilities to report and act on any concerns they had. Staff knew how to spot the potential signs of abuse.

Staffing and recruitment

● Recruitment processes were in place. We saw evidence of Disclosure and Barring Service (DBS) checks to ensure staff were safe to work with people.

● The people we spoke to said they had no concerns about missed calls. One relative told us, "Their times are good, and they always do the right times." However, several relatives told us that call times were often too early or too late.

● All the staff we spoke with told us they had enough time to spend with people to ensure they were safe and got the care they required.

● The provider had an electronic call monitoring system where staff logged in and out of their calls, which enabled care staff visits and punctuality to be monitored.

Preventing and controlling infection

● Staff told us they followed infection prevention and control procedures to protect people from infection.

● People confirmed staff used personal protective equipment when needed.

Learning lessons when things go wrong

● The manager had started to put in new practices and staff training in response to some recent incidents. However, where lessons could be learned to improve the service and make the care people received safer, these were not always identified or addressed. For example, the registered manager told us that following a specific incident she had audited care plans and risk assessments but had not made a record of this. The records we viewed indicated that any auditing undertaken had not been effective in identifying improvements needed.

● We identified that following a safeguarding issue the provider had agreed to undertake monitoring of people's key safes. Records did not show this was being completed effectively.

Requires Improvement

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 deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were assessed prior to them using the service. The registered manager explained that they would only provide care to those people whose needs they had assessed as being able to meet.
- Information had been sourced from other agencies such as the local authority to inform the provider in assessing whether they could provide care for the person. We found that information from these assessments about people's specific needs had not always been transferred to the person's care plan.
- Staff told us they spent time reading people's support plans to gain an understanding of people's needs.

Staff support: induction, training, skills and experience

- At the time of inspection, we identified gaps in training associated with some people's specific needs. For example, catheter care, diabetes, epilepsy and autism. Therefore we could not be assured that staff had the skills and knowledge they required to provide consistently effective care to people.
- Following our inspection the registered manager told us that staff had completed diabetes and catheter care during their induction. Additional training for staff was being arranged for epilepsy and dysphagia.
- An induction programme was in place for new staff which included shadowing experienced staff and undertaking the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.
- Staff we spoke with told us they received regular supervision and felt supported.
- Feedback from relatives about the competency of care staff was mixed. We received some positive feedback about staff but also some negative comments. One relative told us, "The carers sometimes aren't that well trained so at times I think there out of their depth."

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

- Whilst healthcare needs had been identified in care plans there was limited guidance in some care plans for staff on monitoring the healthcare condition and what action to take should the person experience a

healthcare emergency. For example, one person was recorded as having epilepsy. There was not a specific epilepsy care plan in place that would guide staff to recognise symptoms or take action should the person experience a healthcare emergency. This put people at risk of harm.

● Care staff told us if a person was unwell or experienced a fall they would call for an ambulance and would wait with the person until the ambulance or a relative had arrived.

● The registered manager and staff informed us of instances when they had worked with other healthcare professionals such as GP's and district nurses to enable people to receive the care they needed.

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

● Where staff supported with meals they were able to tell us how they supported people to make choices. One care staff told us, "If someone refused food I always leave them a sandwich in case they get hungry later."

● One person told us, "They support me and make sure I get my breakfast, I get choice of what I like." Another person told us, "They do my meals- I'm on no special diet. They offer choice."

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. We checked whether the service was working within the principles of the MCA.

● People told us that staff gained their consent before supporting them.

● Staff had received training in the Mental Capacity Act and told us how people should be supported to make their own choices. One care staff told us, "Consent is very important, we make sure we get permission before we do anything."

Requires Improvement

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 deteriorated 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

- The provider's systems did not support the service to be fully caring. For example, people could not be assured that their care plans contained accurate information about their current care needs and medicine management was not always safe.
- People told us staff were kind and caring. One person told us, "They treat me well and always ask if there's anything else I would like them to do they really go above and beyond for me." Relatives gave mixed feedback about care staff. One relative said that two carers came to attend to her family member and started talking in a language she couldn't understand, "If they start talking in a foreign language I say I don't know what you're saying, and they apologise and talk in English again." Another relative told us, "A new carer, hadn't put her glasses on and had her hearing aids in the wrong ears, so this new person didn't know her needs or hadn't been told about them. Sometimes they come in and they are working whist on their mobile phones. I would say that's the height of bad manners."
- People were supported by regular staff which helped them to develop positive relationships. One person told us, "It's nice most of the time that I have the same cares, they are all okay." One relative told us, "They try to get the same carers most of the time and we're always been happy with them."
- Staff demonstrated an understanding of people's care needs and told us the importance of respecting diversity and people's religious beliefs.

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

- People and their relatives had been involved in developing their care plans and reviewing them.
- Staff informed us how they offered choices when delivering care such as what to eat and how people wanted their care provided.

Respecting and promoting people's privacy, dignity and independence

- People told us staff treated them with dignity. One person told us, "They [carers] respect my privacy when supporting with personal care." Another person commented, "They [carers] always check what I want."

- Staff told us how they promoted people's independence.
- People's confidentiality was maintained; records were kept securely in the office of the service.

Requires Improvement

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 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

● We found that some care plans did not contain up to date information about the person's care needs. This placed people at risk of receiving unsafe care.

● We saw that when reviews had been carried out the person and their family had been involved in the review process. However, these reviews had not always been effective in identifying where people's care plans were inaccurate or where people's known risks had not been mitigated.

●One relative told us, "I'm usually present at any of the reviews and sometimes care workers are present too which is good,"

● Staff demonstrated an awareness of people's preferences for care and people received consistent carers who got to know them well.

Improving care quality in response to complaints or concerns

● People were given information about how to use the provider's complaints procedure when they started with the service.

● People told us they knew how to complain. One person told us, "I have a number I can ring if I have a complaint- has never been any serious issues. Any time I have rung about something has been sorted."

●However, some people were not satisfied with the response to their complaints or concerns. For example, one relative told us, "I've complained because sometimes there's long gaps between calls the middle of the day, ones are all over the place. They are responsive to my requests and apologise and it's okay for a week or so then it slips back again."

● Whilst complaints had been reviewed and action taken to investigate complaints, there had been no effective analysis carried out to determine any themes which could improve care quality across the service.

● Complaints and concerns were recorded in various formats and it was difficult to see a full overview of concerns and complaints received. The registered manager informed us of a new system they were putting in place to improve this although as this had only been implemented recently we did not have evidence of the effectiveness of this new system.

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.

- The registered manager told us that where needed, information was always verbally explained to people. Information was also available in large print or alternative languages if required.

End of life care and support

- No one was currently receiving end of life support from the service.

Requires Improvement

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 requires improvement. At this inspection this key question has now remained as requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Our previous inspection had identified improvements were needed in relation to care records and risk assessments. This inspection identified improvements were still needed. The provider did not always have effective systems in place to monitor the quality and safety of the service.
- Systems that were in place were not effective and had failed to identify that peoples known risks had not been mitigated and that care records were not always accurate or sufficiently detailed. This meant that people had continued to be exposed to risk.
- Systems in place had not been effective in ensuring the registered manager was aware of all safeguarding concerns. A social worker had shared the outcome of a safeguarding incident with us but the registered manager told us they were not aware of the safeguarding. They stated a member of staff had not shared this with them or recorded the outcome in the safeguard log. Following the inspection the registered manager informed us this would be addressed with the member of staff.
- People's medicines were not always managed safely. We found failings in the provider's quality assurance systems around medicines management to identify and act on shortfalls.
- The provider had failed to identify where staff had not completed training relevant to the needs of the people they were supporting.
- There were no effective systems in place to check the competency of care staff to ensure they were equipped with the skills needed and were applying their learning into practice. This was in the process of being introduced by the provider.
- We identified that the current statement of purpose for the service was not reflective of the current service or realistic in what type of support could be offered. The registered manager stated they would ensure this was reviewed.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Continuous learning and improving care

● A new nominated individual was in place. They had identified some areas of concern in relation to the service and were taking steps to address them. They informed us that the governance systems in place including audits and quality monitoring processes had identified that recording and reporting was not to the standard required. Efforts were made to actively improve the reporting with the implementation of service specific audit programme and the implementation of new electronic systems. However, at the time of our inspection systems and procedures were either newly implemented or in the process of being introduced.

● The nominated individual told us that prior to our inspection it had been identified that an additional manager was needed at the service to help implement improvements. We were informed that recruitment had commenced.

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

● It is a legal requirement that the rating from the last inspection is displayed both on the providers website and in the registered offices. The provider's rating was displayed on their website but the provider had failed to display the most recent inspection report rating at their office location. This was rectified when brought to the attention of the registered manager.

● The registered manager was aware of their registration requirements regarding statutory notifications. During our inspection we identified an incident that should have been notified to us. The registered manager told us she thought a notification had been sent.

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

● Systems were in place to seek feedback from people and their relatives. People had been involved in care reviews and feedback was also sought by telephone. Surveys had recently been sent requesting feedback. These were in the process of being returned and we were informed they would be analysed, and a report completed.

● We saw that spot checks took place to check that people were happy with their care. In addition, these were used to monitor staff performance whilst they were supporting people. Staff confirmed these checks had occurred.

● Staff meetings took place and staff told us the registered manager was approachable and willing to listen to their views.

Working in partnership with others

● The registered manager and staff told us how they worked closely with health professionals such as District Nurses. Staff told us how they worked with relatives to update them as to the person's wellbeing.

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 Service users had been placed at the potential risk of receiving unsafe or inappropriate care and support. Systems for ensuring safe medicine administration were not effective.

The enforcement action we took:

We imposed a condition of registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate an effective quality assurance system which ensured the quality and safety of the service.

The enforcement action we took:

We imposed a condition of registration.