Hibiscus Housing Association Ltd

Hibiscus Domiciliary Care Agency

Inspection report

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West Midlands
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Website: www.hibiscus-housing.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hibiscus Domiciliary Care Agency is a home care service providing personal care to people living in their own homes in the community and in a single building where people had their own flats, but shared communal facilities. The service provides support to older people, people with dementia or mental health issues and those who may have physical or sensory disabilities. They were also supporting people who had a learning disability and autistic spectrum disorder. At the time of our inspection there were 18 people receiving support with personal care.

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
There was a lack of quality assurance systems in place. There were no audits being undertaken so risks to people and concerns had not been identified. There was a lack of robust recording so poor audit trails. The provider had failed to recognise their own action plan was inaccurate. The provider failed to be compliant with multiple regulations. People and their relatives were not asked for their opinion, so the provider could not continuously learn and improve the service. The nominated individual was not fully aware of the duty of candour.

People were not protected from the risk of harm as risks were not assessed and planned for. Staff were also unaware of some risks to people. Medicines were not managed safely. The provider had failed to fully consider the infection control measures in place with staff. Lessons were not always learned when things had gone wrong; there was no process for reviewing and acting on learning following accidents and incidents. Staff were not recruited safely. Staff understood their safeguarding responsibilities and people told us they felt safe.

The provider had failed to ensure staff had enough training to be effective in their role. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's health needs had not always been fully assessed and guidance was not always in place for staff to follow.

We could not be sure people were always supported to be involved and make their own decisions about care as they were not asked for their opinion. Care was not always personalised, and care plans lacked detail. People had not been given the opportunity to discuss their end of life wishes.

There were enough staff to support people in a timely manner. People were supported to have food appropriate to their cultural needs. People felt well-treated and staff treated people with dignity and

respect. People generally had a stable staff team so they could get to know one another. People had access to information in a way that suited them. People were supported to engage in activities, if they wished to. Professionals were complimentary of the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

The provider had failed to ensure the management team were aware of and following best practice guidance. No staff had received training in relation to learning disabilities, which is now a requirement for all services.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 July 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made, the quality and safety of care had deteriorated, and the provider had breached more regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the death of a person who used the service. A decision was made for us to inspect and examine those risks.

This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

We found concerns about the management of risk to people at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches at this inspection in relation to managing risks to people, the safe management of medicines, infection control, lack of governance systems, lack of training for staff, poor recruitment practices and failure to display their previous inspection rating. There was also a breach about supporting people to make decisions and following the Mental Capacity Act 2005.

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.

We have also made a recommendation in relation to ensuring the wording in care records is personalised and dignified.

Follow up
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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Hibiscus Domiciliary Care Agency

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector 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. This service was also providing care and support to people living in a 'supported living' setting, so that 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. We have asked them to add the supported living service type to their records.

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

At the time of our inspection there was no registered manager in post; the last registered manager had left in July 2020 .

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and we wanted to be sure there would be management available to assist us. Inspection activity started on 7 September 2022 and ended on 30 September 2022. We visited the location's office/service on 7 September 2022.

What we did before the inspection
Due to technical problems, the provider was not able to complete a Provider Information Return (PIR). A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We asked the local authority and Healthwatch for feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not have any information to share. We also reviewed the information we had received about the service. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and six relatives. We spoke with five care staff. We also spoke with the acting manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also had feedback from two professionals who were involved in supporting people who used the service.

We reviewed six people's care plans, records and medicine records. We reviewed five staff recruitment files. We also looked at records relating to the management of the service, such as action plans.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
- People were not always protected from the risk of harm.
- There were limited or no risk assessments in place and limited or no details in people's care plans about risks to people's safety.
- For example, some people had health conditions which meant if they became unwell, staff needed to know how to respond swiftly to help them. There was no guidance in place for staff to know how to recognise symptoms or know what to do in an emergency.
- In another example, one person had fallen and sustained a minor injury. Whilst this fall had happened when staff were not present, the provider had failed to recognise this as a risk to the person and ensure staff were aware of this.

Using medicines safely
- At the last inspection we made a recommendation about medicines as they were not being managed safely. At this inspection we found medicines were still not safely managed.
- Whilst we did not find anyone had specifically come to harm, Medication Administration Records (MARs) had multiple unexplained gaps in recording, medicines were recorded as being given at the incorrect time and there was regular recording of people being overdosed.
- Staff had not been consistently trained to administer medicines safely. Staff had failed to recognise, and report concerns with medicines recording.

Preventing and controlling infection
- We were not assured that the provider was using PPE effectively and safely. Care staff did not always wear appropriate PPE masks in the presence of people, and we could not be sure masks were always of the appropriate quality.
- We could not be assured that the provider's infection prevention and control policy was up to date as they were not consistently following PPE guidance.

Learning lessons when things go wrong
- Lessons were not always learned when things went wrong.
- There were no systems in place to review accidents or incidents. No checks were made to see if there were any trends, or anything which could be learned to reduce the risk of a reoccurrence.

The provider failed to ensure people always received care and support in a safe way, which put people at risk. These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited safely which could put people at risk.
● The required checks on staff suitability to work with people who used the service were not always completed. For example, some staff had no evidence their Disclosure and Barring Service (DBS) records checked. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Other checks had also not always been completed, such as staff employment history, identity checks and on references from previous employers.
● When concerns had been identified about a staff members suitability, this had not been explored further and no risk assessments were carried out to ensure they were suitable to support people.

The provider failed to ensure staff were all of good character and suitable to work with people who used the service. These concerns were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to support people. Staff had a consistent rota, so they generally supported the same people regularly. One person told us, "They [staff] are on time."

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse by staff who understood their safeguarding responsibilities and knew to report concerns. We saw some safeguarding concerns were reported and investigated and people told us they felt safe.
● However, we could not be sure concerns would always be identified and reported as there was a lack of systems in place to review people's care, so there was an increased risk concerns may be missed.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff had received enough training which had placed people at risk of harm. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there had been no improvement and the provider remained in breach of regulation 18.

- Staff did not receive enough training to be effective in their role. The provider had no way of tracking the training staff had received, such as a training matrix.
- Staff confirmed, other than one specific course, they had not consistently received training. Staff told us they had generally not received training whilst working for Hibiscus Domiciliary Care Agency, but at previous employment at other care companies. This meant the provider had failed to ensure staff had received consistent training and could not verify the quality of training staff had previously completed.
- The provider had failed to ensure staff knew how to respond if a person was to become unwell as a result of their health conditions and staff had not had training in these areas. Staff had also failed to recognise multiple, ongoing issues with medicine records and the provider failed to identify that additional training was required for their staff.
- The provider was supporting some people who had a learning disability. No staff had received training in this area, which is now a regulatory requirement for all services supporting people with a learning disability and/or autism.

The provider failed to ensure that all their staff received the required training to support and care for people effectively. These concerns were a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not working within the principles of the MCA and people were not protected.
- The provider had failed to recognise they needed to carry out assessments of people's capacity, when it was thought a person may struggle to make decisions due an impairment. The acting manager and nominated individual had not had any training in relation to the MCA, therefore could not ensure these assessments were required or undertaken.
- One person was being unlawfully restricted and had been for a prolonged period of time. The provider had not assessed the person's ability to consent to this, despite them restricting the person. There had been no applications to the Court of Protection to get the legal authorisation to restrict the person.
- Another person had it documented in their care records that family had decided about a medical procedure on their behalf. The person's ability to decide themselves and the relative's legal right to make such a decision had not been checked.

The provider had failed to get consent for care and treatment from the relevant person and failed to act in accordance with the MCA. These concerns were a breach of Regulation 11 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; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People did not always have their needs assessed in line with guidance.
- People had various health conditions which staff needed to be aware of and have guidance about. This guidance was generally not in place and not all staff were aware of people's needs, despite caring for them.
- One person had a recommendation made by another health professional for their GP to follow up on. The service had failed to follow up on the outcome of this, despite the person continuing to experience symptoms of the issue they were referred for.
- Staff and management told us of one person who needed their food cutting into smaller pieces and would eat a softer diet. None of this had been assessed or detailed within their plan. This meant there was a risk they may not always been supported appropriately as the guidance was not available.

The provider failed to ensure people always had risks to their health and wellbeing assessed and planned for, which put people at risk. These concerns were also a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not always assessed and did not always have robust plans in place for their eating needs.
- People were supported to have food appropriate for their cultural needs.
- Some people lived in a building called Hibiscus House. There was a catering kitchen which staff cooked and provided meals to people, for those who chose to have these meals. People told us they liked this food. People who did not want to have meals provided to them had access to microwaves in their flats or in small

communal facilities. Other people lived out in the community and would buy their own food directly.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to be involved in and make their own decisions about their care.
- People were not asked for their views, there was no evidence of review of people's care and people could not always make their own decisions.

Ensuring people are well treated and supported; respecting equality and diversity
- People felt well treated. One person said one of their staff, "was a princess." Another person said, "There are no carers I don't like." Another person said, "We get on very well."
- People's equality and diversity needs were respected and supported. People were supported with culturally appropriate food and staff could easily communicate with people.

Respecting and promoting people's privacy, dignity and independence
- People felt treated with dignity and had privacy. One person said, "Staff knock on the door before coming in; they ask to come in and say why they are coming in."
- A professional told us, "From my observations of staff interacting with people, they do treat people with dignity and respect." Another professional told us, "[Person] are very pleased with the care and support received from staff. They are treated with respect and dignity at all times."

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- People had basic care plans in place, but these did not cover all aspect of people's needs or risks. People did not always have individualised care.
- People and relatives were unaware if they had a care plan or not. For example, one relative said they had, "never seen a care plan."
- Two people had bowel monitoring charts put in place, which were later stopped. There was no explanation as to why they had been started or stopped. Therefore, we could not be sure they were being supported in line with their needs. When we asked the acting manager about this, they said they had put them in place for everyone. This shows a lack of individualised care as not everyone would need these.
- People generally had regular staff which helped staff get to know people better.

Meeting people's communication needs

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

- People had access to information in a way that suited them. The nominated individual explained they could provide information in large print or could explain things to people in a way they understood.

End of life care and support

- There were no end of life care plans in place and people had not been given the opportunity to discuss their end of life wishes, should they have chosen to.
- No one was considered needing palliative care at the time of our inspection.

Improving care quality in response to complaints or concerns

- People and relatives did not always know how they could complain about the service they received. However, one person told us they would go to the acting manager or nominated individual and felt they would be listened to.
- The nominated individual was aware of the providers responsibility to investigate and respond to concerns. They were able to explain to us the action taken when recent feedback had been received from a relative.

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

- People were supported to avoid social isolation and the service was tailored to support people's cultural heritage.
- Staff were able to engage with people effectively.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to recognise that robust quality assurances systems needed to be in place in order to monitor the quality and safety of care. The provider had failed to continuously learn and improve. People had been exposed to risks to their health and well-being and this was being left undetected until our inspection.
- There were no audits in place for care plans, daily care records or medicine records. Therefore, concerns and areas to improve had not been identified and the provider had failed to ensure continuous learning.
- The provider had an action plan in place following the last inspection. However, this was not being updated or reviewed on a regular basis to ensure improvements followed.
- There was a lack of robust recording. There were multiple unexplained gaps in medicines records, and some people's daily notes did not record the times calls took place so there was no audit trail.
- The provider had failed to ensure they were following guidance for people with learning disabilities, despite supporting people with those needs.
- There was a lack of a robust system to ensure staff were trained to a good standard. There was no system in place to ensure staff were safely recruited. The provider had failed to follow the principles of the MCA.
- The service had been without a registered manager for a significant period of time. The nominated individual and acting manager were completing training to improve their practice.
- The provider had failed to ensure an experienced staff member was managing the service until such time as the nominated individual and acting manager had completed their training and had developed their experience. They also failed to ensure good governance processes were being undertaken and overseen.

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

- People and relatives had not been engaged to gain their opinions about the service, so their feedback was not gathered and acted on to improve the service.
- There were regular staff meetings, however these were not recorded so there was no audit trail of what had been discussed or actions agreed.
- Staff did not have supervisions so were not given the regular opportunity to discuss their opinions on a private basis.

The provider had failed to establish and operative effective systems to monitor the quality and safety of care

to people. These concerns were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, people were generally aware of who the management team were and felt they were 'approachable.'

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 previous inspection rating was not being displayed at the registered location or on the provider's website, which is a regulation.
● The nominated individual was not able explain to us what duty of candour meant. They were unaware of the details of the fundamental standards on which the regulations are based.
● Once we explained this to them, they confirmed they would not deny if something had happened and would take 'full responsibility' if they had 'done something wrong.'
● Systems and processes were not in place, so we could not be sure they would identify when things had gone wrong and be able to respond accordingly.

Working in partnership with others
● The nominated individual was open to inspection feedback and recognised they needed additional support. They engaged an external consultant to support the service to help them establish systems and processes to recognise concerns and make improvements.
● Professionals were complimentary about the service. One professional said, "The management are approachable, willing to listen and act on any information/feedback received." Another professional said, "The management and staff have been approachable, caring and helpful in addressing any queries."

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 11 HSCA RA Regulations 2014 Need for consent The provider was not working within the principles of the Mental Capacity Act 2005 (MCA) and people were not protected.

The enforcement action we took:

Notice of proposal to impose conditions.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not have risks to their health and well being assessed and planned for. Medicines were not managed safely. Effective infection control measures were not fully in place.

The enforcement action we took:

Notice of proposal to impose conditions.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective quality assurance measures to monitor to safety and quality of people's care were not in place which had put people at risk.

The enforcement action we took:

Notice of proposal to impose conditions.

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

The enforcement action we took:

Notice of proposal to impose conditions.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

People did not have risks to their health and well being assessed and planned for. Medicines were not managed safely. Effective infection control measures were not fully in place.

The enforcement action we took:

Notice of proposal to impose conditions.