Hibiscus Housing Association Ltd

Hibiscus Domiciliary Care Agency

Inspection report

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

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hibiscus Domiciliary Care Agency is a domiciliary care agency providing personal care to people in their own homes. The service provides support to older people, people with dementia or mental health needs and those who may have physical or sensory disabilities. At the time of our inspection there were 11 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
Systems used to monitor the quality of care people received were not always effective at identifying areas of concern. Audits had failed to identify some concerns with the administration of medicines, inconsistent information about people's mental capacity, unsafe moving and handling practices, and out of date information in people's care plans.

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.

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.

People's needs were met by sufficient numbers of staff. Recruitment checks were now in place. Staff followed infection control guidance to reduce the risk of cross infection. Where incidents occurred reviews now took place to reduce the likelihood of reoccurrence.

Staff now received relevant training and felt supported in their role. People's needs had been assessed and staff understood their risks, as well as preferences. Risks associated with eating and drinking had been assessed and staff worked with other professionals to ensure people's health needs were met.

The management team had undertaken training to develop knowledge appropriate for their roles. People and staff had been asked for their views on the service provided. People, staff and professionals spoke positively about the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 3 January 2023). We imposed conditions on the provider's registration and 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 although some improvements had been made the provider remained in breach of regulations.

At our last inspection we recommended the provider should ensure the wording in care records was personalised and dignified. At this inspection we found the provider had acted on the recommendation and had made improvements to people's care plans and records.

Why we inspected
We carried out an announced comprehensive inspection of this service on 7 and 30 September 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve 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.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to consent and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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 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.

The overall rating for this service is 'requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 always 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 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 conducted by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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 not a registered manager in post. There was an acting manager, who was overseeing the service until the recruitment of a new registered manager.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 7 June 2023 and ended on 15 June 2023. We visited the location's service on 7 June 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people about their experience of the care provided. We also spoke with 4 staff, the manager and 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, these included 10 people's care records, medicines administration records, as well as governance and quality assurance records. We also looked at 8 staff recruitment files.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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

At our last inspection the provider failed to ensure people always received care and support in a safe way, which put people at risk. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation. However, further improvements were still required in some areas.

● At the last inspection there were limited assessments of risks relating to people's safety. At this inspection we found improvements had been made, however we identified 1 person who was not receiving care in line with their assessed need. Records reflected the person was not always being supported safely with their mobility. The nominated individual responded to our concerns immediately, both during and after the inspection. They took action to ensure the person was safely supported.
● People's care plans now contained information staff used as guidance to help them support people safely. Staff we spoke with were knowledgeable about people's risks and knew them well.
● Information about people's health conditions was now included in their care plans and staff were aware of what action to take in the event of an emergency.

Using medicines safely
● At the last inspection we found staff had not been consistently trained to administer medicines safely. We also found medicines were recorded as being given at the incorrect time and there was regular recording of people being overdosed. At this inspection improvements had been made; however further action was required to ensure any gaps in the recording of medicines were investigated in a timely way.
● Information about when staff should administer 'as required' medicines was now in place. However, more detail was required to ensure staff had all the information they needed to act consistently when offering people their medicines.
● Staff responsible for the administration of medicines had received training and their competency had been assessed to ensure they were safe to support people. People received their medicines as prescribed. One person told us, "[Staff] assist with medication morning and evening, no problems."

Staffing and recruitment

At our last inspection the provider failed to ensure staff were all of good character and suitable to work with

people who used the service. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation. However, further action was needed to ensure all gaps in staff employment history had been fully documented and explored.

● Disclosure and Barring Service (DBS) checks were now in place for all staff. 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 recruitment checks had been carried out to ensure staff were safe to work with people. However, we found in some cases there were gaps in employment history which the provider had not investigated. The nominated individual told us they would review these gaps and take immediate action to assess any risk.
● People told us staff were available to support them with their care needs. Staffing rotas detailed allocations and staff we spoke with knew who they were supporting each day.

Learning lessons when things go wrong
● At the last inspection we found there were no systems in place to review accidents or incidents. Checks had not been made to identify any learning, to reduce the risk of reoccurrence. At this inspection improvements had been made.
● Where incidents had occurred, there was now a record of how these had been reviewed, detailing any actions taken to reduce the risk of future harm. Where relevant, people's care plans had been updated to include any changes to their required support.
● Staff told us any learning from events was shared with them so they could take appropriate action and ensure they provided care that reflected any recent changes.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person said, "Feel safe with the staff, know them well and they know me."
● People were protected from abuse by staff who knew how to recognise and report any concerns for people's safety or well-being. Staff had received training in safeguarding and told us there were clear processes for reporting and escalating any concerns.
● The manager and nominated individual understood their responsibilities in relation to keeping people safe. Where safeguarding incidents had occurred, they had made appropriate referrals to local authority safeguarding teams, and had notified us, as required by law.

Preventing and controlling infection
● People were supported in line with infection control policies.
● People told us staff wore gloves and aprons when supporting them with personal care.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At the last inspection we found 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.

At this inspection some improvement had been made, however the provider remained in breach of the regulation.

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.

- While information about people's mental capacity to make some decisions was now included in their care plans, this was inconsistent and did not provide clear guidance to staff about how to support people in their best interests.
- One person's care records reflected their relative had consented to a restriction on their behalf. However, there was no record of the assessment of the person's capacity to make this decision, or any record of an associated best interests meeting to reflect this was the least restrictive option for the person. This did not reflect the requirements of the MCA where a person lacks capacity to make an informed decision or give consent.
- Staff, including the manager and nominated individual had now received training in the MCA. However, the nominated individual and manager were still not clear about their responsibilities to assess people's capacity. The nominated individual told us they relied on local authority social workers to assess people's mental capacity. This did not reflect the principles of the MCA.

The provider had failed to act in accordance with the MCA. These concerns were a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection the provider failed to ensure 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.

At this inspection we found improvement had been made and the provider was no longer in breach of this regulation.

● Staff had received training since the last inspection. Training areas included moving and handling, safeguarding, first aid, dignity, mental health and learning disability awareness.
● Staff told us they felt training they had completed benefited them in their roles and provided them with improved knowledge when supporting people. Staff were able to share with us information about people's individual needs, including health concerns, and knew how to respond in the event someone became unwell or was not safe.
● Staff told us they now received supervision meetings with the manager or nominated individual and any learning from incidents was shared with them for learning.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been reviewed since the last inspection and care plans reflected assessments of their needs. Care plans included known risks and offered guidance to staff about how best to support people in order to meet their individual needs.
● Professionals we spoke with shared positive examples of how staff supported people in a person centred way. They explained staff tailored their support to each individual, often going 'above and beyond' the person's planned care hours to ensure people's wellbeing was supported and promoted. One professional told us, "Hibiscus go above and beyond in terms of personalised care. They have a unique cultural way of doing things. They are like people's extended family."

Supporting people to eat and drink enough to maintain a balanced diet
● Some people required support with eating and drinking. People received food in line with their cultural needs.
● Where people had specific dietary requirements, these were included in their care plans and staff were aware. Guidance provided by healthcare professionals, for example, Speech and Language Therapists (SALT) was detailed in people's care plans to ensure staff were aware of any choking or swallowing risks.
● Some people lived in a building called Hibiscus House, this was owned by the provider. Some people had meals provided from a kitchen within Hibiscus House. People told us they liked this food and were happy with the choices available to them.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People received support with their health needs. Information about how staff should support people's health was now detailed in their care plan.
● People told us they were happy with the support they received to manage their health. One person told us, "Yesterday they had to call GP, [staff] contact medical professionals when needed."
● Staff we spoke with were aware of people's health needs and shared any changes in people's health with

the manager, who liaised with relevant healthcare professionals, including GP's, district nurses and community mental health teams.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection the provider had failed to establish and operative effective systems to monitor the quality and safety of care to people. These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection although some improvements had been made, the provider remained in breach of the regulation. This is the third consecutive inspection where this key question has been rated either requires improvement or inadequate.

● Since the last inspection the provider had established audit processes to review the quality of the service. However, we found these continued to not always be effective at identifying concerns, or areas for improvement. For example, we reviewed care plan audits that had been completed monthly. These reflected there were no changes required despite some information being out of date or no longer relevant to the person.
● The provider's systems had continued to not always identify the risks we found during the inspection. For example, 1 person received support which did not reflect their assessed needs. The governance processes had not identified the risks associated with this practice, which may have placed the person at risk.
● Information submitted by the provider prior to the inspection, to comply with their conditions of registration, reflected monthly medication audits were taking place. However, we found this was not the case as we found the most recent medicines audit was March 2023. This audit did not reflect that daily administration of medicines had been reviewed, which meant it was not effective at identifying gaps in administration records.
● Audits had not been effective at identifying information about people's mental capacity to make specific decisions was not always consistent or up to date. This placed people at risk of having decisions made for them which were not in their best interests.
● The manager and nominated individual did not have a clear understanding of their role in following the requirements of the Mental Capacity Act. This meant the service continued to be in breach of Regulation 11 as described under the effective key question.

The provider had continued to fail to establish and operate 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.

● Following the last inspection, the provider made changes to ensure the service was managed by an acting manager and the nominated individual. They had both undertaken training to improve their knowledge, however work was required to ensure this training was successfully embedded and used to ensure compliance with the requirements of the Health and Social Care Act and the Mental Capacity Act. At this inspection the service was still without a registered manager, however the nominated individual told us this role would be advertised in the weeks following the inspection.
● The rating from the previous inspection was displayed both at the registered office and on the provider's website, as required by law.

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 nominated individual had improved their knowledge in relation to duty of candour. Where incidents occurred, they were aware of the need to be open and honest and ensure relevant people were informed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● People had been asked for their views on their care following the last inspection.
● People spoke positively about the service they received. Everyone we spoke with said they were happy with the care they received. Feedback about the management team was also positive. One person said, "[Names of acting manager and nominated individual] check everything is ok. They listen."
● Staff were also positive about the management team and told us they felt supported in their role. One staff member said, "A lot of things are improving. Training, supervision meetings, we work well together as a team."
● Although not yet fully embedded the provider had established systems for learning from events. Staff told us learning was shared with them, so improvements could be made.

Working in partnership with others
● Staff and the management team worked alongside other professionals to ensure people's needs were met.
● Feedback from visiting professionals was positive. Professionals shared examples of staff and the management team going above and beyond to meet people's needs and proactively supporting people to manage their own safety.

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 had failed to act in accordance with the MCA. These concerns were a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We served a Warning Notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.