Archangel Enterprises Limited

Heathfield House

Inspection report

318 Uttoxetter Road
Blythe Bridge
Stafford
Staffordshire
ST11 9LY

Tel: 01782393909

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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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Heathfield House is a care home for people who may have a learning disability or autism. The service was registered for up to 6 people; 6 people lived there at the time of our inspection.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support:
Care records did not always contain the accurate and up to date information required to keep people safe. Despite this, staff knew people's care needs well and people and their relatives told us they felt safe and supported.

Records did not show that appropriate action was taken in response to incidents where people had fallen. Therefore, we could not be assured that action had been taken to reduce the risk of harm from falling.

The systems in place to monitor safety and quality at the service were not fully embedded or effective. The registered manager and provider did not always report notifiable incidents to us and the local authority.

Right Care:
There were sufficient numbers of suitable staff at the service. However, improvements were needed to ensure safe recruitment processes were consistently operated.

Staff supported people in line with their individual preferences and agreed care plans. People were supported to receive their medicines when they needed them and were protected from the risk of infection as staff followed safe infection prevention and control practices.

Right Culture:
People told us they were supported to have maximum choice and control of their lives. However, the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not consistently applied. People were not always supported in the least restrictive way possible.

People were able to receive visitors without restrictions in line with best practice guidance.

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 good (published 10 August 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We planned to complete a focused inspection to review safe and well-led only. However, due to concerns identified during the inspection with regards to the application of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, we also reviewed the effective key question.

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 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 inspection reports and timeline' link for Heathfield House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified regulatory breaches in relation to; the provision of safe care, the application of safeguarding processes, the processes in place for assessing and obtaining consent to care and the systems in place to assess, monitor and improve the quality of care at the service.

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

We have made a recommendation about the processes in place to obtain feedback about the quality of care from relatives and staff.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our safe findings below.

Heathfield House

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 a CQC Operations Manager who visited the service.

Service and service type
Heathfield House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Heathfield House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 were 2 registered managers registered at the service. However, only 1 of these managers was responsible for the day to day running of the home. During our inspection we advised the provider to ensure the registered managers registered at the service accurately reflected who was responsible for the day to day running of the service.

Notice of inspection
This inspection was unannounced and included inspecting the service out of standard working hours to check how the service operated during this time.

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 3 people and a relative about their experience of the care provided. We also spoke with 3 members of care staff and the registered manager.

We reviewed a range of records, these included 2 people's care records, medicines administration records, as well as governance, training and quality assurance records. We also looked at 3 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 good. 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 and learning lessons when things go wrong
• Risks to people were not always adequately assessed, managed and reviewed to reduce the risk of harm.
• When people fell, their risk of falling again was not always reviewed which meant action was not always taken to reduce the risk of harm from further falls.
• Care plans did not always contain the information required to keep people safe. For example, 1 person's care plan did not contain the information needed relating to a long-term health condition that could place them at risk of harm.
• Care plans were not always reviewed when people's needs changed. For example, 1 person's care plan stated they mobilised independently. However, we saw and staff told us they now used a wheelchair.
• Despite this, care staff had a good understanding of people's needs and risks. However, any new or temporary staff at the home who would rely on records would not have access to the information they required to keep people safe.
• Staff reported incidents and accidents in line with the provider's policy and procedure. However, improvements were needed to ensure incident and accident forms contained the detail needed to understand their responses to incidents.

The provider failed to adequately assess, plan, and mitigate risks to people's health and wellbeing. This was 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
• Improvements were required to ensure incidents relating to falls with harm were reported in line with local and national safeguarding guidance.
• Incident and accident records reviewed showed a total of 5 incidents relating to 3 people who had fallen in 2023 where injuries obtained required first aid or emergency medical care/advice. None of these had been reported to the local authority as potential omissions of care/neglect as required.
• Following our inspection, we raised a safeguarding referral to the local authority in relation to the falls where harm had occurred for the 2 people whose care records we reviewed.

The provider failed to ensure local and national safeguarding procedures were followed to protect people from avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite this, people told us they or their loved ones felt safe at Heathfield House. Comments included, "They [the staff] are good" and, "I've no concerns".
• Staff completed safeguarding training.
• With the exception of falls, care records showed that staff identified and reported other potential safety concerns in line with local and national reporting requirements.

Using medicines safely
• We saw that medicines were mostly managed safely. This included the; ordering, storage, administration, recording and disposal of medicines.
• Improvements were however needed to ensure medicines pots (pots that staff placed medicines in to administer to people) were stored in a manner that protected people from the risk of infection.

Staffing and recruitment
• Improvements were needed with recruitment to ensure staff were safe to work with people.
• The required pre-employment checks were not always completed in a timely manner, this included obtaining appropriate references and requesting DBS checks, to ensure staff were safe to work with people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Where there were delays in obtaining references and/or DBS checks, risks assessments were not completed to ensure the risks associated with staff working without these checks had been assessed and managed.
• People told us and we saw there were enough suitably skilled staff to support people in line with their agreed needs.
• Staffing levels were adjusted when required to ensure people's individual needs were met. Staff told us and rotas we viewed confirmed this.

Preventing and controlling infection
• With the exception of the use of medicines pots, people were protected from the risk of infection as staff followed safe infection prevention and control practices.
• Staff used PPE effectively and safely.

Visiting in care homes
• People were able to receive visitors without restrictions in line with best practice guidance.

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 good. At this inspection the rating has changed to requires improvement.

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
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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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.

• Care plans did not always demonstrate that the requirements of the MCA were met. There was no evidence that mental capacity assessments had been completed to identify if people could consent to their care and support.

The provider failed to ensure the requirements of the MCA were consistently met. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Through speaking with people and staff it was evident that some people living at the service did not have capacity to make important decisions about their care and support. All of these people had restrictions upon them that would be classed as a deprivation of liberty. However, none of these people had the required DoLS applications/authorisations in place. This meant people at the service were being unlawfully deprived of their liberty.
• The least restrictive option was not always used for a person with their medicines. They routinely had a medicine administered to them covertly which was not in line with the professional advice contained in their

care records.

The provider failed to ensure people were lawfully deprived of their liberty. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite this, care staff showed they understood people's individual needs regarding making decisions about their care. They knew who could make decisions, who needed support with this and who needed decisions made in their best interests.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The falls risk assessment that was used at the service was not based on national guidance. This meant we could not be assured that the assessment was effectively identifying people's risk of falling.
• Most people who displayed behaviours of distress and/or agitation had care plans in place that were based on best practice. This included identifying and recorded people's potential triggers and how staff could best support people during times of distress and agitation.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support
• People were supported to access appropriate healthcare services. However, the advice from healthcare professionals was not always incorporated into people's care plans meaning there was a risk that professional advice would not be consistently followed.

Staff support: induction, training, skills and experience
• Staff told us the induction and training they received prepared them for their role. Training records showed that most staff were up to date with their required training.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink enough to meet their nutrition and hydration needs.
• People could choose the foods and drinks they consumed.

Adapting service, design, decoration to meet people's needs
• People told us they chose the décor in their bedrooms and communal areas.
• The service had a homely layout and design with adapted equipment available where required to meet people's individual needs.

Requires Improvement

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 for this key question has remained requires improvement.

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, understanding quality performance, risks and regulatory requirements. Continuous learning and improving care and 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 registered manager had been required to provide direct care and support to people who used the service which resulted in them having less dedicated time to complete management tasks. This included being 1 of 2 drivers at the service who could support people to access the community by car.
- There was no deputy manager or senior care worker to support the registered manager with management tasks when they were unavailable.
- The auditing systems in place to assess and monitor safety and quality were not effective and had not identified the concerns detailed in this inspection report.
- There was no effective system in place to ensure incidents and accidents were investigated and action taken to prevent further incidents from occurring.
- Incidents that required reporting to CQC and the local authority had not been reported as required.
- Care records did not always show that duty of candor requirements were followed when incidents had occurred.
- Risks associated with the delivery of care were not always identified and acted upon. For example, risk assessments were not completed and appropriate action was not taken when staff recruitment checks were delayed.
- Environmental risks were not identified and acted upon. Some carpets at the home were frayed and there was an uneven floor in a dark area of corridor increasing the risk of falls. These risks were not recorded in an environmental risk assessment or home improvement plan.
- Best practice guidance was not used to ensure risks were effectively assessed and managed. For example, the falls risk assessment in place was not based on best practice/national guidance.
- There was no service improvement plan in place to record how improvements to care and the home environment would be made.

The provider failed to ensure that effective governance systems were in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics
• People were asked for feedback about their care in the form monthly reviews. This was focused on activity provision and was used to plan future activities.
• Visiting professionals were asked to leave feedback about the quality of care. All feedback reviewed from visiting professionals was positive with regards to the quality of care.
• No staff or relatives feedback was obtained in the form of surveys.

We recommend the provider reviews the processes in place to obtain staff and relatives feedback to ensure this can be considered when making improvements to the way care and treatment is delivered.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• There was a positive and open culture at the service.
• People, relatives and staff spoke positively about Heathfield House. Comments included, "I like it here" and, "I love working here, it feels like a family".
• People told us and care records showed they were supported to do the things they enjoyed both at the service and in the local community.

Working in partnership with others
• Improvements were needed to ensure relevant agencies such as the local authority and commissioners of care were informed about incidents that had occurred at the service.
• Referrals to health care professionals, such as GPs were made in response to changes in people's health.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure the requirements of the MCA were consistently met. Regulation 11 (1) (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess, plan, and mitigate risks to people's health and wellbeing. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure local and national safeguarding procedures were followed to protect people from avoidable harm. The provider failed to ensure people were lawfully deprived of their liberty. Regulation 13 (1) (2) (3) and (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that effective governance systems were in place. Regulation 17 (a) (b) (c) and (d)