Archers Point Residential Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Archers Point Residential Home is a residential care home that provides accommodation and care for up to 33 older people, some of whom may be living with dementia. There were 21 people using the service at the time of our inspection.

People's experience of using this service
Risks were not always assessed, identified, updated and risk management plans were not always in place to manage risks safely. Records were not always completed and monitored in line with people's individual needs. Medicines were not always safely managed. There were not enough housekeeping staff deployed. The home was dirty, and people were not protected against the risk of infection. Substances hazardous to health (COSHH) namely bleach and antibacterial cleaners were left within people's reach. There was no fire evacuation equipment or strategy in place. Some equipment was not regularly cleaned or maintained. There were no systems in place to record COVID-19 vaccinations as a condition of deployment in line with government guidance for agency and permanent staff. Safeguarding notifications were not always sent to the local authority or CQC as required. Accidents and incidents were not analysed and learning from this was not disseminated to staff. Not all staff had up to date training in moving and handling people and first aid. There was a lack of activities on offer to stimulate people. There were no effective systems in place to assess and monitor the quality of the service provided.

People told us they felt safe. People told us staff were kind, caring and attentive to their needs. They also said that staff always asked for their consent before supporting them. Assessments were carried out prior to people joining the service to ensure their needs could be met. Staff were supported through supervisions. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were encouraged and supported to eat a healthy and well-balanced diet. People had access to healthcare services when required to maintain good health.

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 of the service was good (published on 31 January 2017).

At this inspection we found the service had now deteriorated to inadequate.

Why we inspected: We received concerns from the local authority in relation to lack of infection control, people's care needs not being met and lack of governance at the home. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Archers Point Residential Home on our website at www.cqc.org.uk.

Enforcement: 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 have identified breaches in relation to risks, medicines management, poor standards of housekeeping and infection control, fire safety, lack of analysis and learning lessons from accidents and incidents. As well as staff training, safeguarding incidents and injuries not being reported, premises being dirty and not maintained, lack of activities, lack of system to record COVID-19 staff vaccinations and no robust systems in place to assess and monitor the quality of the service provided.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 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**

Archers Point Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
Two inspectors carried out this inspection 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
Archers Point Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager in post. This means that they, were legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection site visit took place on 09 December 2021 and was unannounced.

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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people and five relatives to seek their views about the service. We spoke with five members of care staff and the registered manager. We reviewed records, including the care records of nine people using the service and recruitment files and training records for five staff members. We also looked at records related to the management of the service such as quality audits, accident and incident, and policies and procedures. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Safe – this means 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 deteriorated to Inadequate. This meant people were not safe and protected from avoidable harm.

Assessing risk, safety monitoring and management
• Risk to people were not adequately assessed or managed, this included when there was a change in people's needs. For example, call bell risk assessments were not carried out to establish those who could or could not summon help. We also observed that for those people who could use call bells, these were out of their reach. This meant that they were unable to call for assistance should they require it. Risks were not assessed for people requiring the use of equipment, such as mobility aids and reclining chairs and beds and guidance on the use of such equipment was not in place for staff. There were no risk assessments in place for the use of portable electric heaters that were placed within people's rooms, especially as one person was using the heater to dry wet flannels. This posed a fire risk.

• Behavioural and or monitoring tools, such as an ABC chart (an observational tool used to record information about particular behaviours) were not in place for people who displayed behaviours that may challenge. This meant that any risks associated with behaviours may not be safely managed or monitored by staff.
• There were no maintenance checks carried out on wheelchairs that people used to ensure that they were safe to use. This posed a risk to people and staff.
• People had Personal Evacuation Plans (PEEPS) in place, however, these were not person-centred and did not detail how individuals, including those on the second floor with mobility issues could safely evacuate the home in the event of an emergency.
• There was uneven flooring in the lounge that was a trip hazard, and no risk assessments had been completed to guide staff on how to keep people safe when walking within this area.

The provider had not ensured risks to the health and safety of people were effectively assessed and mitigated. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Risks regarding electrical appliances and gas were managed and records were kept up to date.

Preventing and controlling infection
• Infection control was not appropriately managed. Cleaning schedules were completed, however, we observed that communal bathrooms had dirty floors, tiles on the surround of one shower as well as toilet seats were cracked, and toilets were dirty. There was limescale on some taps and on one showerhead. We observed that a side table in one person's room was dirty with stains and a commode required cleaning. We also observed cobwebs in another person's bedroom.
• Control of Substances Hazardous to Health (COSHH) including bleach and hazardous cleaners were left in

people's reach and not securely stored in line with guidance.
• There were no records to demonstrate that equipment such as wheelchairs were regularly cleaned, and that regular maintenance checks were carried out.

• We observed that staff did not wear gloves during administration of medicines and when serving and supporting people during lunch. This posed a risk of infection.
• One relative told us, "Cleanliness is the issue here. They [staff] should clean more regularly. It's lack of attention to detail and I notice that in [relatives] room it can be dirty, with food on the floor." Another relative said, "I feel the room could be cleaner. There's certainly a hygiene issue with the carpet and in the toilet."
• There was no system in place to check staff or visitors' vaccination status which is condition of staff deployment.

The provider failed to ensure that there was an effective system in place to manage infection control. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they felt safe. One person said, "I'm safe and comfortable and it helps me feel that way because people are kind". A relative told us, "My relative is very safe; I very much feel that."

Using Medicines safely
• Medicines were not always safely managed. There were no 'When Required' (PRN) protocols in to guide staff describing what the medicine was prescribed for or details such as dose instructions, signs or symptoms about when to offer the medicine, interventions to use before medicines offered. PRN protocols and policies had not been updated since 2019.
• We observed that prescribed topical creams were not securely stored but left in bedrooms in easy reach of people. This posed a risk.
• Medicine audits failed to identify these shortfalls in practice.

We found no evidence that people had been harmed. However, systems were either not in place nor robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and their relatives told us that medicines were administered in a timely manner. One person said, "I get my medication on time." A relative told us, "My relative, receives their medicine when they should."

Systems and processes to safeguard people from the risk of abuse

• We found incidents had not always been referred to safeguarding authorities appropriately in line with best practice. We identified two incidents where people had suffered unwitnessed falls and sustained injuries that required treatment by health professionals that had not been notified. These were subsequently referred by CQC to the local authority safeguarding team following the inspection as the provider had failed to do so.
• The registered manager lacked awareness of what action they should take in response to allegations of abuse, such as physical abuse and financial abuse.

The provider failed to report incidents as required which paced people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we referred the concerns to the local authority safeguarding team and the provider advised us that they were looking into these matters.

Staffing and recruitment
• The service relied heavily on agency care staff, who did not always know people and their individual needs.
• There were not enough housekeeping staff, as the home was dirty and not clean throughout. There was no evidence of proactive attempts to cover gaps in housekeeping.
• There were not enough housekeeping staff to keep the home clean, because records showed that at times, housekeeping staff were also redeployed elsewhere in the home when there was a need to cover other staff shortages. For example, on one occasion a housekeeper was assigned to kitchen which meant there was no other housekeeper on duty.
• There was system in place, in order to establish how many housekeeping staff were needed to keep the home clean and be compliant with IPC and COVID-19 protocols.
• Appropriate recruitments checks were not always carried out before staff started work. At the time of the inspection, agency staff members' employment profiles were not available. Following the inspection staff profiles were sent to us, however, we observed that some of these were missing up-to-date Disclosure and Barring Service (DBS) records or up to date profiles.

The provider had failed to ensure safe recruitment practices were followed in line with best practice and not enough housekeeping staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Accidents and incidents were recorded, however the provider failed to carry out an analysis and no learning was disseminated to staff. We have reported on these concerns under the Well-Led section of this report.

Requires Improvement

Is the service effective?

Our findings

Effective – this means 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 that people's outcomes were not consistently good.

Adapting service, design, decoration to meet people's needs
• There were significant fire safety issues identified that have been reported to the London Fire Brigade. There was no fire evacuation strategy in place detailing how to safely evacuate people, including people on the second floor with mobility issues in the event of an emergency.

• There was no fire evacuation equipment available and staff had not undertaken any training in this area. Staff were unclear on how to evacuate people safely from the second floor or if the muster point was at the front or back of the building. This placed people at risk of harm.
• We observed that two first floor windows did not have restrictors in place. This could pose a risk to people. There was a stair gate at the top of the stairs, however this was broken and kept open, so not used appropriately to keep people safe. This meant people were at risk of falling down the stairs.

• We observed that the laundry room and back door were unlocked, and people were able to leave the premises when it wasn't safe for them to do so.
• We observed that there were cleaning schedules in place, however, they were not always checked or not signed by a manager or a senior care worker. Although, cleaning schedules confirmed that housekeeping tasks had been carried out we observed the premises to be dirty and unclean in parts.
• We observed that several radiator covers were very loose and posed a risk to peoples' safety. We observed a radiator cover that was broken. This posed a risk of burns.

The failure to ensure the environment was properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we were informed by the provider that windows restrictors had been fitted to the windows, the radiator covers had been fixed and the bolt on the stairgate had been repaired to prevent falls.

Staff support: induction, training, skills and experience

• Records showed that the majority of mandatory staff training was up to date. Mandatory training included safeguarding, medicines, moving and handling, first aid, health and safety and managing behaviour. However, not all staff had up to date training in moving and handling and first aid. This meant some staff had not received all the training necessary for them to carry out their roles.

• Records documented that staff were supported through regular supervisions and annual appraisals in line

with the provider's policy.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments of people's needs were carried out prior to them moving into the home to ensure that their care and support needs could be met.
• During these assessments, people, their relatives where appropriate, or social workers were involved to ensure appropriate information was acquired to develop care plans.

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

We checked and saw the service was working within the principles of the MCA
• The manager and staff had an understanding of the MCA and when it should be applied. People were encouraged to make all decisions for themselves and were provided with information to enable this in a format that met their needs.
• Care plans were developed with people or in their best interests following an assessment of their mental capacity for specific decisions, such as personal care and the use of equipment.
• People's rights were protected because staff sought their consent before supporting them. We observed staff seeking people's consent before supporting them.

Supporting people to eat and drink enough with choice in a balanced diet
• People had a choice in what they wanted to eat and drink. If they did not want the meals on offer, then alternatives were provided.
• Staff knew the signs to look out for if people were at risk from poor hydration and nutrition. Staff told us that they would provide additional support such as referring people to healthcare professionals if required.
• People's care files included assessments of their dietary needs, preferences, their likes and dislikes and staff knew about people's eating preferences. One person said, "I love the shepherds' pie. I think I can ask for something if I don't like what's on offer." A relative told us, "The food looks very nice and smells good."

Supporting people to live healthier lives, access healthcare services and support: Staff providing consistent, effective, timely care within and across organisations
• People had access to a range of healthcare services and professionals which included GPs, opticians, chiropodists and dentists. One relative told us, "My relative can definitely see a doctor if they need to: they [staff] are very good at that."

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to Inadequate. This meant the service was not consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

• Our findings from the safe and effective domains showed the service was not safely managed and appropriately monitored to mitigate risks and meet regulatory requirements.

• The provider had a lack of effective leadership, governance and oversight of the service. Although systems for oversight were in place, they were not robust enough to identify the issues that we found at the inspection.
• There was a lack of awareness around managing risks within the service and ensuring that PPE and infection control procedures were being managed in line with government guidance.

• Risks around topical medicines, call bells, management of behaviour's and risks and PEEPs were not being addressed safely and effectively by the provider.

• The registered manager did not always submit statutory notifications to CQC. This meant the registered manager lacked awareness of what action they should take in response to allegations of abuse, such as physical and financial abuse.
• The provider had systems in place to audit the service. Audits included care plans, infection control, staff files, water temperatures, daily pressure cushion checks and quarterly descaling of showerheads and taps. However, these had not always been completed or did not pick up the issues we found at this inspection. For example, the last care plan audit was carried out in August 2021 and failed to identify that ABC charts were not being completed and PEEPs were not person- centred. Infection control audits did not cover checking and ensuring that toilet seats were clean, rust free and undamaged. Monthly water temperature audits were last carried out in August 2021.
• The provider had failed to ensure that there were adequate housekeeping staff to ensure that people were kept safe and that the home was clean. There was no effective auditing of staff rotas which resulted, in poor management of the staffing rota and the risks around insufficient housekeeping staff being deployed on shift was not mitigated.
• The registered manager was not sure of their statutory responsibilities in relation to safeguarding and legal requirements. Statutory notifications to inform CQC of certain changes, events and incidents that affected their service or people, had not been sent in line with regulatory requirements or in a timely way.

• Accidents and incidents were logged, however the provider failed to carry out any analysis and disseminate any learning to staff on how to minimise these in the future.

The provider had failed to ensure systems for governance and management oversight were robust, safe and effective. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and understands and acts on duty of candour responsibility when things go wrong
• People did not always receive person centred care in a culture that was inclusive and empowering to achieve good outcomes. There was limited emphasis on providing regular meaningful activity to engage people, provide stimulation and promote emotional wellbeing.
• The registered manager told us they had an activities coordinator who came in four days per week for four hours. However, when asked about activities one person told us, "There's nothing to do here- I get bored. We never have trips out. A girl comes in for two hours a day- one to three and maybe does exercises. There's CDs put on to sing to but really, it's not stimulating here."
• On the day of the inspection the activities coordinator was not present at the home. The activities board documented that the activities for the day included dominoes, light exercise and letter writing. We observed that none of these activities were delivered, except for a solitary game of dominoes between one person and a carer. However, we saw that the resident was not engaged with the game, nor able to understand the activity.
• We observed that nine people were sat facing the TV and eight were asleep. In the other area of the lounge a CD played music which some people sang along with. There was in effect no stimulation for people, indicated by the numbers who were asleep or sedentary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager did not hold regular staff meetings. Therefore, the opportunity to communicate messages with staff and highlight shortfalls in staff practice was missed. There was no evidence to show that staff were encouraged to give feedback or to influence how the service was run.

• There was a lack of evidence to show the registered manager encouraged and supported staff to reflect on practice to make improvements to the service to provide individualised, safe and effective care.

• There were no resident meetings, so people did not have a regular opportunity to provide feedback to help drive improvements. One person said, "I don't ever get asked what I think about anything."

• A resident and relatives survey was sent out in June/July 2021, nine responses were received. Comments from people included, "Noticeable cobwebs on corners of ceiling", "Could be more activities – I am sometimes bored". However, there was no follow up action plan and at this inspection we observed cobwebs in people's bedrooms and that there was a lack of activities on offer to stimulate people.
• People, their relatives and the local authority told us that the provider did not communicate with them well. The local authority had reported to the provider in September 2021 that a number of healthcare professionals had not been able to get through to the home as calls were not answered and there was no facility to leave a message. The registered manager's response was that it would not be good for business to have an answerphone.
• One person told us, "I wanted to speak to my son in Australia when restrictions were on, but they said it would hold up the line if someone wanted to ring in." This meant that people were not able to contact relatives when they wanted to, and the provider was missing calls as there was no answerphone in place.

• A relative told us. "I got a call from the hospital asking me if I was aware my relative was in hospital with a chest infection…I hadn't been told." Another relative said, "Communication is not a strong point e.g., the lack of updates by phone during COVID. We have no meetings, no questionnaires and no emails.

Working in partnership with others
• The service worked with the local authority, however, feedback about the service from the local authority was not positive. Although the local authority had been supporting the service to drive improvements since September 2021, at the time of our inspection we saw that improvements had not been made.

We found systems to assess, monitor and improve the service were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 15 HSCA RA Regulations 2014 Premises and equipment The premises were not appropriately or safely maintained. Regulation 15

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always assessed, and risk management plans were not always in place to manage these safely. Regulation 12(1)(3)

The enforcement action we took:

We imposed conditions on the provider's registration

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 Safeguarding notifications were not always sent to the local authority or CQC as required. Regulation 13

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective systems in place to assess and monitor the quality of the service provided. Regulation 17

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough housekeeping staff deployed. Regulation 18

The enforcement action we took:

We imposed conditions on the provider's registration