Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

OSJCT Bartlett House

Old Common Way, Ludgershall, Andover, SP11 9SA

Tel: 01264790766

Date of Inspection: 04 June 2013

Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Management of medicines	✔ Met this standard
Safety, availability and suitability of equipment	✔ Met this standard
Staffing	✔ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Orders of St John Care Trust
Registered Manager	Mrs. Sandra Caroline Burrows
Overview of the service	OSJCT Bartlett House is registered to care for 49 older people who have residential care needs, these may include dementia needs.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

Some people told us they liked living in the home. One person said "I'm very content" and another "staff are very good." A person told us "I get help with my personal care when I want." A person described how they experienced pain at times and care workers let them decide when they wanted their painkillers. Another person said they would not be without their recliner chair which was provided by the home.

We observed two care workers assist a person to move, using an aid. They assisted the person in a safe manner. We observed systems for giving out medication and saw medicines were given to people in a safe manner and were securely stored. A member of staff told us "we're getting there" about changes in staffing levels.

Observations of care, discussions with people, and a review of records showed staff were not consistently assessing people's needs or up-dating assessments when relevant. Some people's care plans did not inform staff on how to meet their individual needs and were not reviewed following changes in their condition. This included people's personal care and dementia care needs. We observed some staff did not consistently follow people's care plans.

Some records including people's records and records relating to management of the home had not been completed, although staff we spoke with knew the information. Other records were not completed in such a way as to enable audit of health, safety and quality of service provision.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 24 July 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care and support which met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our inspection of 28 May 2012, we found people did not consistently experience care and support which met their needs. Care was not always planned and delivered in a way which ensured people's safety and welfare and did not reflect relevant research and guidance. At our inspection of 3 January 2013, we found the provider had taken action to ensure it complied with this outcome area.

During this inspection, some people told us they liked living in the home. One person said "I'm very content" and another "staff are very good." A person described when they had fallen and how staff had heard them when this happened "so I had help." Another person told us there was "lots to do during the day", describing the "lady" who "arranges things," giving examples of a concert and hairdressing. A person told us "they get to know you and what you want help with."

We observed two care workers assist a person to move, using an aid. They assisted the person in a safe manner, explaining how they were going to assist them and checking on their safety throughout the time they were with them.

We found some people did not have assessments of their care needs completed when needed. This included one newly admitted person who had very limited written information about their care needs. Two care staff we met with were not able to tell us about how to meet this newly admitted person's needs. They reported this was because the person had only been admitted recently. The person had a family who had been involved with the person's admission. Information from them had not been used to develop assessments of the person's needs.

Three people we met with had a history of falls. All three of them had experienced recent

falls. During the inspection, we observed specific risk factors for two of these people. Staff and a relative also told us matters about all three people's risk of falling. These had not been included in the people's updated risk assessments. The three people's care plans had not been up-dated with such information to ensure risk for them was reduced. A different person had a care need which we observed and staff told us about, which affected their daily life. They had not had an assessment made of this need. Their care plan did not reflect what we observed, or what staff told us. It also did not follow what the district nurse, who was visiting the home at the time of our inspection, described as a usual intervention for such a condition.

Another person's records showed they had sustained some tissue damage. Their care plan had not been revised to include the information which was documented in their records or what staff told us about. There was no written evidence to show this person had been referred to the district nurses following their recent skin damage. The district nurse we met with told us they were always ready to take referrals for such matters.

We saw a person had long fingernails, which were unclean underneath. They had a medical condition which could place them at additional risk of infection. There were no directions in the person's care plan about how this aspect of their personal care was to be met. We asked a care worker about meeting the person's care needs. They suggested we discussed the matter with a senior care worker. When we did this and showed the senior care worker the condition of the person's nails, they agreed this aspect of the person's care needed attention. They reported nail care was the responsibility of the person's key worker.

A person's records showed they were loosing weight and their care plan directed that they should be weighed weekly. We saw this was not taking place and they continued to be weighed once a month. We observed at lunchtime the person was not supported to eat in a supportive way or in accordance with what was documented in their care plan.

We observed two people who showed behaviours associated with dementia, including shouting and swearing. We talked with care workers about these people's needs. Care workers knew about these people's behaviours and reported for one of the people about advice they had been given by external professionals. We saw there was a long document in the person's records which outlined how the person's behaviours were to be managed. This had been put in place six months prior to our inspection. There was no evidence on this person's file to show it had been reviewed since then.

The behaviours we observed had not been documented in the person's records by the end of the day of our inspection. We asked a senior care worker about this. They told us what we observed for the person was normal behaviour for them. They told us care workers were expected only to document behaviours which were outside the person's normal daily behaviours. Information on what was the person's normal behaviours and what was to be documented was not included on the person's care plan.

The second person had a care plan but it did not detail how the person was to be supported when they showed complex behaviours apart from they needed "support" and be "distracted". It did not provide any detail as to what this "distraction" involved. When we performed our observation we saw staff ignoring the person's complex behaviours, apart from one occasion when a care worker asked the person to discontinue what they were doing. This was despite observations of the person shouting and being aggressive to other people and staff, including physical contact. The person's care plan evaluations did

not include what interventions were effective for the person.

Both of these people's behaviours had the potential to disturb other people in communal areas. This had not been considered in their care plans. When we talked with staff they did not report on different actions they took to prevent these people's behaviours from affecting other frail and vulnerable persons.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were generally protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We met with people who told us staff supported them in taking their medicines. One person told us they experienced pain from arthritis. They said the care workers gave them their painkillers regularly, saying "oh yes, they help" about their painkillers. Another person who also told us they experienced pain at times from arthritis, said care workers let them decide when they wanted painkillers and when they did not. They said this depended on how they were feeling at the time.

We observed a care worker administering medicines. They were doing this in the dining room at lunchtime, which was a busy time. We saw they wore a red tabard which alerted people that they were administering medicines and were not to be disturbed. We saw the care worker concentrated on medicines administration and did not become involved in other roles, such as giving out meals. They carefully read each prescription, then dispensed the person's prescribed medicines and gave it to them individually, prior to signing the medicines record.

We saw medicines were securely stored in a room designated for that purpose. A fridge was provided for medicines which required cold storage. The temperature of the fridge was regularly monitored, to ensure it remained correct.

The home stored Controlled Drugs in a safe way and the care worker we spoke with was aware of which drugs needed to be stored in the Controlled Drugs cupboard.

We looked at medicines administration records. We saw records had been completed in full. Where the home accepted a verbal prescription, for example for a skin cream, the record was signed and countersigned by a second care worker to confirm the prescriber's wishes.

We asked the care worker who had administered medicines if people could self-medicate if they wished. They said there was no one self-medicating at the time of the inspection. They confirmed the home supported people in self-medicating where they wished to, after completing a risk assessment and discussion with relevant persons, for example the person's GP.

We observed the home had a tablet cutter. The care worker performing mediines informed us that this was because occasionally people were admitted who were prescribed half a tablet. The provider may like to note the tablet cutter showed deposits of white dust, particularly in its crevices, which probably related to tablets. The care worker agreed to dispose of the tablet cutter at once and order a new one.

We looked at records where people were prescribed a medicines on an "as required" basis. The senior care worker told us the home were in the process of developing protocols to direct staff on the reasons for and when people were to be supported in taking such medicines. The provider may like to note we saw some of the people had protocols about administration of such medicines, but others did not. For example one of the people with dementia we met with was prescribed painkillers on an "as required" basis. They did not have a protocol or care plan about when they needed to be supported in taking such medicines. The provider may also like to note that some people's protocols did not reflect information in their records. For example one person's protocol stated they needed to be given painkillers to manage their "aches and pains", however their care plan stated they had arthritic pain in a specific joint of their body and not general aches and pains. Clearer protocols would support care workers in informing people's GPs of the effectiveness of medicines in managing people's conditions.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

At our last inspection we found people were not protected as some of the sanitary and cleaning equipment was not suitably maintained and other equipment was not available in sufficient quantities. Following our inspection, the provider sent us an action plan which detailed how they would meet this outcome area.

At this inspection people told us they had the furniture and equipment they needed. One person said "I'm sort of comfy here" when showing us the recliner chair the home had provided them with. They told us "I wouldn't be without it."

We talked with domestic workers. They showed us the new equipment they had been supplied with since the previous inspection. This included new mops and buckets and trolleys for distributing people's clothing and linen after it had been to the laundry. One domestic told us how pleased they were with the new equipment.

One room had been designated for the storage of equipment. We saw this equipment included a range of hoists and sit-on scales. We saw all this equipment had been regularly serviced to ensure its safety.

We saw furniture had been placed in parts of the home which were used as small sitting areas, such as the ends of corridors by windows. The furniture in these areas was domestic in style and made the corridors look more homely.

The provider may like to note we showed the home manager a cloth covered chair which was placed in one of the disabled shower rooms. The cloth of this chair was stained. The fabric did not enable the chair to be effectively wiped down when used after a person had showered.

The provider may also like to note all of the radiator covers in toilets and bathrooms we looked at showed visible deposits of dust both in the fret-work and on the radiators underneath. Cleaning of these items of furniture was not included in the home's cleaning schedules. We did not see any equipment for dust removal from such furniture on domestic workers' trolleys. The home manager told us all of the radiator covers were due to be replaced in the next financial year.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

At our last inspection we found there were not enough skilled and experienced staff to consistently meet people's needs, including at weekends. The provider sent us an action plan after our inspection to outline how they would meet this outcome area.

We talked with people about what they thought about staffing levels. We received a range of replies. One person said "there's always someone around if I want to talk." Another person told us "I get help with my personal care when I want." Some people said they felt staffing levels varied, with occasions when there were not enough staff on duty. One person told us they liked to have a care worker with them when they walked but that was "not always possible." They told us "the longest I've waited is 20 minutes."

We talked with staff about their opinion of staffing levels. Staff varied in their responses. Several staff told us about an occasion recently when the home had been short of staff. All the comments we received all related to the same incident. A care worker who told us they had been in charge at the time of the occurrence said they always made a report about such short-falls and were confident the home manager took relevant action. One member of staff told us "we're getting there" about staffing levels.

We performed observations of care and support during the morning and at lunchtime. We saw during the morning that people in sitting areas were not left without support, as there was always a member of staff in the vicinity. At lunchtime there were sufficient staff to serve the meals and support people who needed assistance. For example we observed a care worker taking a meal to a frail person in their room who asked the care worker to help them to eat. The care worker informed the other care workers they would be supporting the person and which of the other people still needed to be taken their meals. We saw the other people were given their meals promptly.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our inspection of 28 May 2012, we found people were not protected from the risks of unsafe or inappropriate care, as the home was not maintaining appropriate and accurate records about them. At our last inspection on 3 January 2013, we found the provider had taken action to meet this outcome area.

We asked people about their care plans. The home manager told us they now kept people's care plans in their rooms to enable them to access them when they wanted and to support care workers in providing individualised care. One person told us they did not have a care plan. We saw and were told about a person who had a recent fall. Their records did not show their GP or relative has been informed about this fall.

We observed a person who touched their face near an eye on more than one occasion and showed an expression on their face which indicated they were in pain from the area. We spoke with three care workers, two of whom reported on the person's specific condition, which they reported could make them uncomfortable. One of the care workers told us the person's "eye is playing them up again." Both of the care workers told us the person's GP had been consulted and there was no treatment for their condition. The third care worker we spoke with did not know about this condition. We looked at the persons' records and saw none of the information told us by the care workers was documented. One of the care workers described the person's past life, preferences and what was important to them, in detail. We looked at the person's records and saw their "life history" document in their notes was uncompleted throughout. We also saw in this person's records that they had been involved in a safeguarding incident during 2012. Following the incident, there were no outcomes for this person documented in their records.

We asked a care worker how they checked on stock levels of items such as skin creams which were stored in the medicines room. They told us they regularly checked expiry dates and rotated stocks. These checks were not documented.

We looked at the Controlled Drugs register and saw while records were accurately

documented, the index to the register was not up-to-date. The care worker therefore had to look through parts of the register page by page to identify the person's record they were checking.

We looked at the record for day to day maintenance of items in the home. We were shown two separate records. The records were not signed off or dated to indicate when the maintenance request had been completed. We observed a recent repeated request for maintenance to one area of the home in one of the two records we were shown. There was no indication to show if action had been taken.

We looked at records of hot water temperatures in one bathroom. Such records enable a provider to assess water temperatures between regular maintenance. This is because mixer valves have been shown to fail over time, particularly in areas of high limescale. We saw one bathroom had three separate paper records. A review of these records showed staff had been variably using all three to record temperatures from 2011 to the time of the inspection. As dates had been documented variably over three records, review of changes in hot water temperatures would be complex in-between regular maintenance visits.

We saw the home maintained cleaning schedules for rooms and other areas. The manager also performed spot checks on the quality of cleaning and maintained a record of their checks. We visited a person's room during the inspection and noted it showed an unpleasant odour. We asked a domestic worker about the room and they agreed about the presence of the odour. They told us they were aware of the issue for the person and the carpet was shampooed regularly, but the odour remained. The cleaning schedules and spot checks record did not note any issues relating to the presence of odour in this person's room.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider was not taking proper steps to ensure each person was protected against the risks of receiving care which was inappropriate or unsafe, as assessments were not consistently carried out or reviewed when needed and the planning and delivery of care did not meet people's individual needs and ensure their welfare and safety.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider was not ensuring people were protected against the risks of unsafe or inappropriate care arising from a lack of information about them and other records relating to management of the home.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 24 July 2013.

This section is primarily information for the provider

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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