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: 28 November 2013

Date of Publication: December 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Management of medicines	✗ Action needed
Records	✓ Met this standard

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

We carried out this inspection to check whether OSJCT Bartlett House had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines
- Records

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 28 November 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, talked with staff and were accompanied by a pharmacist.

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

People expressed their appreciation of the care provided. One person told us "I really enjoy being here," and another "I'm well looked after." A visitor told us their relative was "very settled here."

We saw people received the support they needed. We observed a care worker assisting a person to move who was using a frame. They did this carefully, supporting the person to move at their own pace. We met with two people who were living with dementia. Both people were calm and relaxed.

We saw people had relevant care plans in place. These were reviewed when a person's condition changed. Care workers we spoke with gave us detailed information on how they met different people's care needs. Information about people's needs was clearly documented and reflected what care workers told us about.

We observed a care worker administered medicines safely. We found appropriate arrangements were not in place for the storage and disposal of all medicines and the monitoring of expiry dates. Most supporting information for "variable dose" and "if required" medicines lacked sufficient information.

The home maintained necessary records. This included monitoring of bath water temperatures and records of general maintenance. Records relating to accidents and incidents were clear. The home also maintained records of audits relating to people who

experienced falls. Records showed this information was used to reduce people's risk of falling.

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 02 January 2014, 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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

At our last inspection on 4 June 2013, we found people did not experience care and support which met their needs and protected their rights. We asked the provider to take action to address this outcome area. Following the inspection, the provider sent us an action plan which outlined how they would ensure compliance with this essential standard. We found the provider had taken appropriate action and the home was now compliant.

People expressed their appreciation of the care provided. One person told us "I really enjoy being here," and another "I'm well looked after." A person told us they had experienced a "sore bottom" in the past and they had been seen by the district nurses about it. They said they knew they needed to stand up regularly to prevent soreness from happening again. They told us "I stand myself up but they [the care workers] also remind me in case I forget." A visitor told us their relative was "very settled here." They said they had looked at several other homes for their relative but had found "this one suits X best."

We observed a care worker assisting a person to move who was using a frame. They did this carefully, supporting the person to move at their own pace. We observed two care workers assisting a person to transfer from their easy chair to a wheel chair, using a standing frame. They explained to the person how they would be helping them throughout all the time they were with them. They also checked the person was comfortable, for example making sure the straps did not feel tight on their legs.

The home cared for several people who were living with dementia. We met with two people who showed signs of memory loss. Both people were calm and relaxed; they showed no signs of agitation or distress. We observed a lunchtime meal. Staff we spoke with told us how they were actively progressing plans to make mealtimes a positive experience for people. This was particularly in making sure people with memory loss and confusion could enjoy their mealtimes, feeling supported by staff in the way they needed. We observed a person who showed aggression towards a care worker, including physical aggression. The care worker remained consistently polite and supportive to the person

and listened to what they were asking.

We met with a person who was assessed as being at high nutrition, hydration and pressure ulcer risk. Their assessments and care plans were clear. There were records which showed the person had been assisted to move every two hours and also the amount they had been able to eat and drink over 24 hours. We spoke with six care workers about this person. They all knew about the person's current and on-going needs in detail. For example when we met with the person they told us they were not feeling well and so had not felt like eating that day. All of the care workers we spoke with knew about this. Relevant information about their condition that day was documented in their daily record. The care worker in charge of the home said they had contacted the person's GP about their current condition and were awaiting a visit from them.

Two of the people we met with were assessed as being at high risk of falling. Both of them had experienced falls during the past month. Five care workers we spoke with knew about these people's falls and how they were affected by them. They told us one of the people had hit their head during one of their recent falls. The care workers were fully aware of the risks to people if they did hit their head. They knew they needed to document if the person felt unwell, including if they felt sick or dizzy, and inform the care worker in charge of the home. They showed us the records they had kept after the person had fallen so they could monitor their condition closely.

We looked at both of these people's records and saw their assessments and care plans had been reviewed as relevant, after their falls. The care worker in charge of the home told us they identified risk factors in people who were at risk of falling and made sure they were reduced as much as possible. For example one of the people we met with had been asked to move to a room on the ground floor to reduce risk of their falling down stairs. The person's records showed they and their relatives had agreed to this move.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider does have appropriate arrangements in place to manage medicines.

This is a breach of Regulation 13.

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

Concern had been raised with CQC relating to the management of medicines within this service. Therefore, a pharmacist inspector looked at the use and management of medicines within the service.

Appropriate arrangements were not in place for the secure storage and disposal of medicines. Medicines were stored in a locked treatment room on the ground floor. The treatment room contained a refrigerator, two medicines trolleys, and a Controlled Drugs (CD) safe. Medicines were also stored either on shelving with a basket for each person or the Monitored Dosage System racks were hung from the wall. There was an accumulation of medicines awaiting disposal within this room. A person required medical oxygen therefore a few empty and full oxygen gas cylinders were kept on site, these were inadequately stored. Therefore we were not assured that the medicines could not be inappropriately accessed or disposed of appropriately.

Appropriate arrangements were not in place for medicines to be stored at the correct temperature. The current temperature for the room and refrigerator were documented. The records for November were more complete than those for August and September. However, the November records stated that the refrigerator had exceeded the recommended temperature range on a number of occasions. Therefore, we were not assured that administered medicines had not deteriorated due to incorrect storage temperatures.

Appropriate arrangements were not in place for the monitoring of "in use" expiry dates. We saw two oral liquid medicine bottles that were open which lacked either a "date opened" or "do not use after" date. We also saw two eye drop bottles that were being used beyond their in-use expiry date. Therefore, we were not assured that administered medicines had not deteriorated due to being passed their revised expiry dates.

Controlled Drugs (CD) storage is more secure than general medicines storage due to the increased risks. We undertook a balance check of the Controlled Drugs and the register which were in agreement.

We could not be assured that medicines were always appropriately administered. We observed the administration of medicines at the end of the morning medicines round and at lunch time. Most of the medicines being administered at the end of the morning round were to those people who had either refused or were asleep earlier. We shadowed the care worker, who administered medicines safely. They roused each person if required, enquired about the need for "if required" medicines, then selected the medicines the person needed. The care workers knew how each person liked to take their medicines, however we later noted that this information was not recorded. When we looked at the supporting information for "variable dose" and "if required" medicines prescribed to some people in the home, most of these lacked sufficient information. number of "rescue" or emergency medicines lacked escalation plans or maximum doses. Therefore, we were not assured that the people were receiving their medicines appropriately to their needs.

Appropriate arrangements were not in place for the recording of all medicines administration. During our visit we reviewed the Medication Administration Records (MARs) for 22 people. Only half of the MARs contained consistent supporting information relating to allergies and none contained information on how the person preferred to take their medicines. The MARs were complete for medicines taken orally, including where the quantity and frequency was variable. When a cream or ointment was prescribed a body map was prepared. The MAR would be kept with the body map in the person's room. We tracked the cream and ointment records for one person in their care records, medicines administration records and body map records. We found these to be inconsistent. Therefore, from the records we were not assured that people had received their medicines as prescribed.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At our last inspection on 4 June 2013, we found people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. We asked the provider to take action to address this outcome area. Following the inspection, the provider sent us an action plan which outlined how they would ensure compliance with this essential standard. We found the provider had taken appropriate action and the home was now compliant.

We looked at people's records. We saw where people had fallen, information in people's daily records and accident records agreed. The home maintained monthly records of when people fell, including records of factors such as times of day when people fell or places in the home where accidents occurred. These records were used in the home's audits to develop action plans to reduce risk to people. We saw there were clear records when the home had contacted the person's GP or the emergency services about a person falling. This included actions directed by these external healthcare professionals.

We looked at records relating to management and maintenance of the home. We saw there were clear, auditable records relating to bath water temperatures in each bathroom. We saw the home now maintained only one maintenance record. Records were clear and matters were ticked off as each identified area needing attention was addressed. Maintenance requests we saw included day to day matters such as a toilet flush needing attention and light bulbs which needed replacing.

We saw the home had placed a stair gate and chain on the main stair well. We were told this was to protect a person who was at risk of falling if they climbed stairs independently. The home had a clear risk assessment about this person's behaviours which showed why these barriers were needed to protect the person. The provider might like to note there was no written risk assessment about these barriers in relation to this fire escape route and safety of other persons in the event of a fire. The acting manager told us they were approaching the local fire and rescue service to develop an appropriate risk assessment about the barriers.

We saw most records were clear and completed in detail. For example we met with a

person who showed difficulty in speaking. Their care plan recorded relevant documentation about their speaking difficulty. We met with a person who was assessed as being at high nutritional risk. Their care plan stated they were to be weighed weekly. Their records showed the person was being weighed weekly. When we looked in the bath water temperatures, we saw a person was recorded as having a bath on a certain date. The person described the bath to us, telling us how much they had enjoyed it. When we looked at the person's daily record, their bath was documented, together with information on how the person had enjoyed their bath.

The provider may like to note some records needed more attention to wording. For example a person's continence care plan stated they were to be supported "regularly" with certain behaviours associated with their continence needs. We asked five care workers what was meant by the word "regularly" and they all gave us similar information. What the care workers told us was not recorded in the person's records. We talked with staff about people's preferences for baths or showers including how often they liked to have a bath or a shower. The five care workers we spoke with knew about people's individual preferences. These were not documented, to ensure all care workers could be aware of what people preferred. If full records are not made, other staff such as care workers on induction or bank care workers will not have access to relevant information about people.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Appropriate arrangements were not in place to protect the person against the risks associated with the unsafe use and management of medicine.

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 02 January 2014.

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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