The Orders Of St. John Care Trust

OSJCT Bartlett House

Inspection report

Old Common Way
Ludgershall
Andover
Hampshire
SP11 9SA

Tel: 01264790766
Website: www.osjct.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Bartlett House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bartlett House is registered to provide accommodation and personal care for up to 36 older people. At the time of our inspection there were 27 people living in the home. People lived in three different units in the home, 'Up Red' and 'Down Red' were mostly people living with residential care needs. 'Down Blue' was a secure unit for twelve people with a diagnosis of dementia.

The inspection took place on 13 and 14 November, and 4 December 2018. The inspection was unannounced on the first day. We provided feedback to the registered manager and area operations manager at the end of the second day. We returned for a third day to gather further evidence and where actions had been taken in response to our feedback, this has been included in the report.

Care plans were not always up to date or reflective of people's current assessed risks. In addition, some information was missing regarding the assessed risks, to enable staff to provide effective and safe support. This was despite care plan reviews and audits taking place.

Not all staff adhered to the organisations infection prevention and control policy regarding hand hygiene. Some areas of the home also had unpleasant odours, which indicated people's continence needs were not being supported. However, the rest of the service was mostly maintained to be clean and tidy.

Falls were recorded and monitored, however there were some areas for improvement in the quality of the monitoring. We provided feedback to the registered manager regarding this and saw that when we visited on the third day of the inspection, the improvements had been implemented.

At times, staff were not deployed effectively. This resulted in people seeking assistance and staff not being available to help. There was a dependency calculation tool being used, however this did not account for the layout of the building.

There were safe staff recruitment processes in place.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Access to outside areas was restricted, despite there being adapted flower beds and a raised fishpond for the enjoyment of the people living at the service. The large garden space had not been creatively designed

to maximise opportunities for people's independence to be promoted.

The Down Blue, dementia unit, was not designed to support the needs of the people living there. The lounge space in the unit was a converted bedroom, with only six chairs, despite twelve people living there.

Medicines were stored and managed safely. However, medicines were not always administered with dignity. On two of the three days we inspected, we saw that medicines were administered by a staff member who lacked a person-centred approach.

Staff felt confident they could report any safeguarding concerns to the registered manager and that action would be taken. They also felt supported to raise any queries they had with regards to their work.

We saw safe transfers taking place. People were comfortable and appeared confident in the procedure. We also saw measures to support people's dignity during transfers were being used, including placing a blanket over people's laps to prevent their legs being exposed.

There were gaps in the registered manager and senior staff member's knowledge regarding the Accessible Information Standards 2016 (AIS) and the Mental Capacity Act 2005 (MCA). This meant that procedures to meet the legislative requirements were only partly implemented.

The quality of care interactions varied between different staff members. We saw examples of undignified and abrupt engagement, as well as positive, kind and polite interactions.

People were joined at lunch by staff who sat with them throughout their meal. There was a positive atmosphere in the dining room, with people choosing where they wanted to sit, and staff encouraging conversation.

There was no always a clear managerial vision for how the service could improve and develop. Effective support had not been provided by the organisation to ensure that the service could maintain their previous CQC rating of good; also, to help the service better support the needs of the people who live there, in accordance with up to date practice and national guidance.

We identified breaches of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014. Details of these and the action we have asked the provider to take have been recorded at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Care plans were not always up to date or reflective of people's current risks.

Staff were not consistently deployed effectively.

Some areas of the home had unpleasant odours.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not consistently meet the principles of the Mental Capacity Act 2005.

The environment had not been adapted to suit the needs of the people living at the service.

People's healthcare needs were not monitored on a reflective basis to identify if the service could improve.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw lots of undignified interactions and the quality of care varied significantly between different members of staff.

The medicines round was task focussed and lacked personal interaction.

We saw abrupt and rushed engagement.

There were plans to develop the quality of the life histories in people's care plans.

Is the service responsive?

Good

The service was responsive.

People's accessible information needs were identified, but there no examples of how the service had responded to this.

The activities programme was not always designed around meeting the needs or interests of people.

Complaints were responded to in detail.

Staff spoke with enthusiasm about wanting to provide a good standard of end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We identified breaches in regulation.

We raised concerns about shortfalls that had not been picked up through the quality monitoring processes.

There were gaps in the registered manager's understanding and confidence regarding the Mental Capacity Act 2005 and the Accessible Information Standard 2016.

OSJCT Bartlett House

Detailed findings

Background to this 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 was planned to check 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.

This comprehensive inspection took place on 13 and 14 November, as well as 4 December 2018 and was unannounced. The inspection was completed by two inspectors and one assistant inspector. Prior to the inspection we reviewed information we held about the service, such as statutory notifications and information the provider had sent to us in their provider information return (PIR). The PIR tells us what the provider feels the service is doing well, as well as any areas they have identified for improvements.

During the inspection, we gathered information by reviewing documents relating to people's care, including care plans and daily records for nine people. We also looked at information relating to the management of the service. This included audits completed by the registered manager and the organisations quality team; falls analysis, and meeting minutes. We spoke with seven people who use the service and two visiting relatives. We also spoke with the registered manager, the area operations manager, and eight members of care and ancillary staff, either through formal interview, or informal conversation.

After the inspection, we wrote to four of the service's community contacts, as well as three health and social care professionals. We received feedback from two professionals and two community contacts.

Requires Improvement

Is the service safe?

Our findings

Care plans were not always maintained and up to date to reflect current risks. One person's care plan stated that the person 'locks their door at night.' There was no risk assessment for this to explain for example, how access could be sought in the event of an emergency. The monthly reviews had not stated that this assessed risk had changed. We raised this with the registered manager and were advised by the second day of the inspection that the care plan had been re-written. They told us, "She no longer locks her door." It was not clear from the care plans as to what risks were present to then identify how these should be managed.

For another person, their care plan stated that they should only mobilise with the support of a staff member, however we saw them moving independently. Although staff completed monthly updates in the care plans, these did not consistently include whether the risks to this person had changed. The registered manager told us to check the handover notes regarding the person's up to date needs. The handover notes did not contain the appropriate details to replace the out of date information written in the care plan. The registered manager explained that the person no longer needed one to one support while mobilising, because their mobility had improved. However, their care plan did not reflect improvements in their mobility. People were at risk of receiving inconsistent support in relation to their assessed risks because the care plans were not up to date. The registered manager updated the care plans during the inspection process, to reflect the up to date needs for the people we had identified.

In addition to some risks not being assessed, or being out of date, there was also an inconsistent level of detail. The fire risk assessment for one person stated that they would require the use of an 'evacuation aid', however the assessment did not state what aid they would require. For another person, in their epilepsy care plan, the recorded information was general and not specific in stating the steps that staff should follow to provide support. The lack of clarity in some risk assessments and care plans regarding risks meant that staff did not have access to specific guidance that may be required in the event of an emergency.

Not all staff adhered to the infection prevention and control policy. We saw staff with long or painted fingernails. The policy explained that staff fingernails should be short and clean, free from nail polish. This presented risks to cross infection and when protecting people's skin integrity.

Staff were not consistently deployed effectively. At times, people were unable to locate staff for assistance. We saw one person walking through the dining area quietly asking for help and appearing disorientated. A staff member walked past the person, asked "alright?" as they passed but were unaware of the time and attention the person needed. As the staff member had not stopped to consider that the person may require assistance, one inspector asked the person what help they would like. They told us they wanted to know where the bathroom was located. On two other occasions we had to request staff assistance on behalf of people in communal areas, because the staff were not accessible to them. There were risks to people's dignity and safety because of ineffective staff deployment.

Staffing numbers were calculated using a dependency tool, however this did not account for the layout of the building. There were people who had been assessed as not being able to use their call bell, as well as

those who verbally called for staff instead of alerting them via the electronic system. Staff told us, and rotas showed that frequently there were only three staff members working after 9pm. They said that if a person required the support of two members of staff for personal care, this only left one member of staff to oversee the rest of the people in the service. Due to the layout of the building not being taken into consideration in the dependency calculation, the staffing numbers at night meant there was a risk that staff may not be present or able to respond promptly.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The monitoring and analysis of people's falls was not always completed to a consistent standard. It did not look at the wider picture for that person, beyond the month being reviewed. There were monitoring systems in place, overseen by the registered manager and falls lead. The registered manager had acted upon this feedback and when we visited for the third day of the inspection, they had implemented more detailed falls analysis for each person.

We received mixed feedback about people's opportunities for independence outside of the home. We were told by one staff member that "only a few people tend to go out, usually three. It is because the others might need medication or might not be able to use the taxi safely." Most medicines can be taken outside of the home, with appropriate risk assessment processes in place and trained staff to manage these. However, there was an overriding risk averse culture amongst the staff, who spoke about who would and could spend time outside of the service.

Some communal areas of the home had unpleasant odours, particularly in one corner of the main lounge and at points in the corridor of Down Blue. Other than this, we saw that the communal areas were mostly clean and tidy. People told us that their bedrooms were kept clean and one person said theirs was "spotless".

Maintenance records were up to date. These evidenced that health and safety checks of the building were completed. The maintenance person was appointed as the health and safety champion.

Medicines were stored and managed safely. We completed stock checks and found these to all be present and correct. We also reviewed record keeping documentation and protocols for medicines administration and found these to be up to date and detailed.

Staff felt confident in identifying and reporting any safeguarding concerns. They were aware of the different types of abuse and who they could contact within and external to the service. Staff knew about whistle-blowing and how to raise anonymous concerns if needed with the CQC.

There were safe staff recruitment and selection processes in place. The registered manager explained that they valued staff's life experiences and personalities, as well as looking at if they have worked in care before. We checked recruitment files and found there to be character and employment reference checks. New staff were also subject to a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Records relating to people's healthcare needs were not always followed up or monitored. We saw that daily records identified health concerns, but no further action or follow up was recorded. Records for one person showed they had passed only a small amount of urine and expressed discomfort. This had been forwarded to the head of care and the registered manager. There was nothing recorded to acknowledge that the registered manager or head of care had received and evaluated the information. There was also nothing recorded to show that this had been logged in any wider monitoring of the person's condition. Therefore, information of importance regarding the person may not be up to date in the event of needing to consult with a healthcare professional in the future.

Another daily record entry referred to a person having a "vacant moment" and stated that the person was not responding. Staff recorded that the person "became more alert after approximately 10 minutes". There were no notes following up on this, or to advise if the person was seen by their GP following the incident. The registered manager told us that the persons' GP had advised that they could go for up to 10 minutes of being unresponsive before they would need to seek medical advice. This was not recorded anywhere in the person's care plan. There was also no monitoring of the frequency of these incidents, which could help staff in identifying wider health concerns for the person.

Records for people who had their dietary intake monitored were only up to date until 5pm; after this point the records did not show if any food was offered. Records for one person showed that they had eaten a cooked meal at lunch time. They had then declined their evening meal option four hours later. We were advised and observed that there was a tea trolley in the evening and people were offered snacks at that time. This however was not recorded to evidence if the person may have had or declined additional food after 5pm. Records monitoring their intake may not be reflective of what they had received throughout the whole day. The total amounts recorded risked being inaccurate when considering how the service was meeting people's nutritional needs.

There was no overview or analysis of infections within the home. These were managed in the present, rather than analysing trends and evaluating practice, particularly for people who had frequently occurring urinary tract infections (UTI). The registered manager stated that the action would be to liaise with the GP in response to a suspected UTI. This action was reactive, rather than proactive in looking to reduce the likelihood or frequency of infections occurring. Having a monitoring system could identify if there was something the service could do or improve upon. The potential connection between the infection and the care that the service provided was not being made.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The management team had submitted DoLS applications where they had completed capacity assessments. We saw that mental capacity assessments had been completed for people who had a diagnosis of dementia, regarding their capacity to consent to receive care and treatment.

The registered manager and a senior member of staff told us they wouldn't complete a mental capacity assessment unless the person had received a "formal diagnosis" of dementia. They told us they would still make decisions for people, even if they had not been formally assessed to lack capacity regarding that decision, for example, not allowing a person to leave the premises. The MCA does not require people to have a diagnosis only of dementia before an assessment can be made. Assessments should be completed if the service has indication that the person may lack capacity regarding a decision. This meant that the legal process to deprive someone of their liberty was not always being followed.

There was no evidence that specific decisions for invasive care interventions outside of the care provided by staff at Bartlett House were being assessed in accordance with the MCA. For example, one person who had been assessed as lacking capacity to consent to receiving care and treatment at Bartlett House had been offered the flu vaccination. The records relating to this stated, "[The Doctor] has asked [person] if they would like to have the flu jab. [The person] declined." There was no evidence to indicate that the person had been assessed regarding their capacity to consent to this decision, or how they were supported in the decision-making process. The service could not confirm if the GP had completed a separate capacity assessment, as they had not obtained copies of this. If the person had lacked the capacity to consent to the decision, but had declined, there was no evidence to show that it was in their best interests to not receive the treatment.

Training and competency checks regarding the MCA were ineffective. We were advised by the registered manager that staff completed an online module for the MCA. The registered manager explained that the module did not test what staff have learned, to ensure that the training was understood.

When we spoke with staff, we found that most understood how the principles of the MCA related to their role. However, staff were not always confident in knowing when best interest decisions should be made and if they were legally depriving someone of their liberty. We asked different staff, practice-based questions about the MCA and DoLS to gauge their understanding. They were not always clear about supporting people who had capacity to make decisions. Staff said they would make certain decisions for people, regardless of if the person had the mental capacity to make these themselves, such as leaving the building alone.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Access to outside space was restricted. There was an enclosed patio area, which was initially only accessible with a member of staff due to the door being locked. We were told that this was because of "safety". However, when we returned to the service for the third day of the inspection, we saw that a pictorial notice had been added to the door that led to the patio. The sign instructed people that they could use the door to go outside and that they needed to use the lever to do so. The opportunity to spend time beyond the patio was then further restricted by a locked gate. The patio had a tall fence restricting the view for some people and limiting their opportunity to access the adapted garden features, such as raised flower beds and a raised pond. The risk averse culture was not being challenged from the staff team or management prior to our inspection feedback.

The Down Blue dementia unit did not provide a stimulating and independence promoting environment. The

door to the rest of the home remained locked with a secure key coded system in place. Only staff knew the key code. There were tactile and interactive displays on the corridor walls, but staff told us that these were not used. The tactile wall displays were outside people's bedrooms and in a busy corridor often being used by staff with the laundry or medicine trolleys, wheelchairs and transfer equipment. There was also a life size sticker on the wall of a red-letter box. This was positioned up high on the wall. It could be confusing to people with dementia and those with visual impairments, but also there was no evidence of this being of any positive impact to people.

There was a bedroom sized space that had been converted into a lounge in Down Blue, which only had six chairs, despite twelve people living there. The large communal areas were inaccessible to people without staff assistance. Each staff member we asked, told us that Down Blue was not providing the most suitable environment for the needs of people living with dementia. Staff said that the converted lounge area was too small and when people were in there with their mobility aids, there was difficulty to mobilise. They also said that the enclosed area caused some people to have negative interactions with others and that this was at times difficult to manage.

Toilets were not always easy for people to find or identify. We saw that the sign for some toilets were on the wall, next to the toilet door, but the signs were easily lost amongst the volume of posters and other notices also there. This could be confusing for people where their dementia affects their orientation and perception, or for those with visual impairments. There were plans in place to re-paint the bathroom doors to create uniformity, and we were advised that signs would be added to the doors, rather than next to them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were snack bowls and jugs of drink available throughout the home. We queried why the chocolate bars had been taken out of their wrappers and cakes out of their cases in Down Blue. The registered manager said that this was because some people were at risk of attempting to consume the items with the wrappers still on. However, one staff member told us, "If people want a snack, we will happily help them to take the wrapper off. I'm not sure why the wrappers have been removed. It doesn't seem quite right." The peripatetic manager explained that they had not seen this practice in any other service and suggested that the service look to introduce more person-centred approaches, such as rice paper cake cases.

People were visited by the GP and health or social care professionals when required. We saw staff supporting a person who communicated that they were in pain, to make the decision to see the GP later in the day.

People who require regular assistance to reposition were supported at timely intervals, based on their assessed care needs. We saw that repositioning records were maintained and up to date. Regular repositioning supports people who are unable to reposition themselves in maintaining their skin integrity, reducing the risk of skin breakdown.

Staff told us they felt they could request more training if needed. Different staff told us they would like to receive more training around dementia and end of life care. They explained that they received training from the organisation and that when starting employment, they were required to complete the Care Certificate. The Care Certificate is an agreed set of standards based on the requirements of specific roles in the health and social care sector. The registered manager told us that a lot of training was online. They explained they could request face to face training and would do so regarding the MCA after this gap in knowledge had been identified at the inspection.

Requires Improvement

Is the service caring?

Our findings

The afternoon medicines round on the first two days of the inspection were not person-centred, it was task focussed and impersonal. People were not greeted, instead they were handed a pot of their medicines, or had them put on the table next to them. The staff member didn't explain what medicines they were offering, because people were compliant. The staff member only acknowledged the person once they handed back their medicine pot. On the first day of the inspection this was done while people were eating, and their meals were interrupted for their medicines to be given. The interactions during the afternoon medicines round were more dignified on the third day, because of a different member of staff.

There were examples of undignified care observed during the first two days of the inspection. We also saw some interactions where staff were abrupt in their approach. For example, we saw one person who required the use of a mobility aid, being sternly told to "jump up". We had alerted the staff member discretely that the person had spilled their drink and it may have gone on their trouser leg. The staff member didn't speak to the person prior to instructing them. The person may not have understood or known why they were being told and not asked, to move to another seat. The trouser leg could have easily been checked while the person was seated in their preferred chair.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Person-centred interactions varied between different staff members, including those responsible for leading staff teams and shifts. We observed kinder and more dignified interactions on the third day of the inspection, where some different staff were present. For example, we saw one person was receiving one-to-one support during their lunch, we saw them leaning in to the member of care staff. They shared smiles and staff explained that the person responds well to tactile interactions. Also, the medicines were given just before lunch, but by a staff member who conversed with people and shared a smile with them. Staff appeared more attentive to people's needs.

People were joined at their lunch table by staff from different roles and we saw some person-centred interactions during this time. For example, we saw one member of ancillary staff sat next to a person who had chosen to eat in a lounge chair away from the main tables. The staff member's approach was kind and attentive, and together they were discussing where they had grown-up, and spoke about their families. Prior to this, the person had been repeating their words and was disorientated as to where they were. The interactions helped to orientate the person into the present. There was a positive change in their body language and verbal tone. Staff told us they valued having this "quality time" to spend with people during lunch. Staff knew that joining people for lunch was to support the dining experience and worked together as a team to contribute to this.

Staff told us how they promoted people's dignity. They told us, and we saw that staff always knocked on people's bedroom doors before entering. Staff said that they made sure people's bedrooms were made private during personal care, including closing curtains, or locking doors to prevent other people entering.

We saw people being transferred between chairs and wheelchairs. People wearing skirts had a blanket placed over their legs, to ensure that the process was as respectful as possible.

We received positive feedback from people's relatives. Their comments included, "The staff are really caring here." Also, "[Person] is definitely well looked after here." The service had received compliment cards from relatives of people who had received care at the service or had spent time there for respite.

Some staff explained that they had known some of the people prior to them living at Bartlett House. They spoke with enthusiasm about being able to continue the community spirit that people had enjoyed living in the local village. Staff told us that people had regular visitors.

Most people either had a document entitled 'All About Me', or a one-page profile in place. These contained details of what was important to the person, how they liked to spend their time, as well as what people liked and admired about them. For one person we saw that their one-page profile explained how they had met their wife, and about their career choices. These provided talking points for staff and could be used when considering activities that the person may like to engage in. The registered manager explained that they would like to further develop the documents to build a more detailed picture of the person's life history.

There were 'Personal Place Mats' for each person and these explained their dining preferences. For one person this included, "I will choose where I want to eat, most of the time I go to the dining room." These gave additional insight into the usual choices the person may make.

Staff had received training in data protection. We saw that care plans and information containing people's data was stored in key coded offices, which remained locked when not in use.

Good

Is the service responsive?

Our findings

Information was not provided to people in an accessible format, despite people being assessed to identify how they would prefer to receive information. It is a legal requirement for social care services to comply with the Accessible Information Standard 2016 (AIS). This is to ensure that people with a disability or sensory loss are given information in a way they can understand. In the care plan for one person, there was a document regarding their requirements for accessible information. This included stating that the person wore glasses and that they would like information in an easy read and large print format. There was no evidence to show that the AIS was being met in supporting this person's sensory needs. Information held and recorded about the person in their care plan was not in an accessible format. We also asked the registered manager if the complaints policy would be accessible to this person and were advised that there was not a large print or easy read policy available.

We recommend that the service reviews the Accessible Information Standard 2016.

Daily records varied in quality, with some entries identifying that the person was in discomfort or unhappy, but nothing recorded to evidence how staff supported them. For example, the daily records for one person stated, '[Person's name] wasn't happy this evening. Bowels open. [Person's name] was supported with all care and settled into bed.' This didn't show how staff had supported the person's emotional wellbeing. Other entries did include observations around people's mood, the choices they made, and the support that was provided. For example, the entries for one person included that they had requested a 'full English' for breakfast and that this was provided.

The activity programme was not always based around options that would offer stimulation and be of positive impact to those who chose to be involved. 'Napkin folding' was advertised as a weekly activity session. We saw two people sat without engagement from a staff member, taking one napkin from a pile, folding it in half and placing it next to them, before repeating this exercise. We asked one of the people involved why they were doing this, they told us, "Because I was told to." We discussed this with the registered manager and area operations manager. They both felt that while this might be an activity someone might do to pass time, it was not suitable for the main activity programme.

We observed a reminiscence quiz, where people were actively engaging with the activities coordinator. The coordinator ensured that different people received their attention and that everyone was encouraged to be involved.

We contacted community organisations linked to Bartlett House for their feedback. One representative said, "We are always welcomed and feel our visit is of benefit to our children and the residents of Bartlett House. We visit yearly at Christmas to perform our nativity." The activities coordinator told us that there were links with the local military and that they visited to attend coffee mornings and interact with people. There were plans for introducing a garden shed, where people could be part of projects and spend time outside. The registered manager felt their biggest achievement was to increase the community involvement at the home, with regular visitors such as the local military.

There were emotional well-being care plans in place. For one person their care plan stated, "Care staff to encourage [person] out of their room, so they do not become isolated. [Person] enjoys chatting with staff, so whenever staff are assisting with anything they need to make sure they chat whenever they get the chance." 'Well-being checks' were being completed every 30 minutes, for people who spent most of their day in their bedrooms. We saw that these were completed half hourly and staff were prompted to check if the person had been offered a drink or if they needed anything. One staff member said, "It is our way of showing that she is not left."

Where complaints were received, these were responded to with each point of the complaint acknowledged and addressed. Meetings took place for people and their relatives to share their feedback and there was an annual survey sent to relatives. The service was awaiting the results of their most recent survey at the time of the inspection.

Care reviews took place every five to six months for each person. During the reviews people were asked if they would like anyone else present, and relatives were given the opportunity to attend. If relatives were unable to attend, their feedback obtained over the telephone was recorded as part of the review. There was positive feedback from people who were quoted in their reviews explaining that the service felt like home. People said they were happy living at Bartlett House and that they felt safe and cared for. Some of the comments included, 'I am quite happy living here, my room is comfortable, and I have no complaints. The food is good, the carers are good. No-one nags me to sit with everyone else because I like my own company and people seem to respect that.'

Staff spoke with enthusiasm about wanting to provide the best end of life support to people that they could. Their comments included, "It is so hard, but so rewarding, people become like your family and you want to do your best for them, especially when they are at end of life." Staff understood that it was important to maintain providing people with company during their end of life care. We saw that an acute care plan was in place for a person whose condition had deteriorated. This directed staff as to how the person should be supported, their pain relief, and the involvement from the GP. Staff told us that they felt well supported by their team and the registered manager when providing end of life care. The registered manager explained that in team meetings and handovers they would discuss end of life care with the staff team. These conversations were to reflect on what was being done for the person and how the staff were feeling.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, in April 2016, we rated the service as good overall and good in all domains. At this inspection the rating for four domains and overall has changed to requires improvement. Based on the findings at this inspection, the service had not maintained their good rating because they had not adapted or progressed in accordance with changing expectations and practice in the care sector.

There was a registered manager in post, and they were available throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were some shortfalls in the registered manager's knowledge and confidence about how to implement legislative requirements regarding the Accessible Information Standard 2016 (AIS). Their own audit stated that, 'The home manager can evidence that they are aware of the AIS and Trust Policy and the ways in which they can demonstrate this.' The registered manager had assessed themselves as having 'Met' that requirement in their October 2018 audit. We asked the registered manager for evidence about how the service was meeting the AIS and they told us, "We have the forms in the care plans." The form is an initial assessment and is not evidence of how the service is meeting people's AIS needs.

The registered manager and a senior staff member did not fully understand how to apply the principles of the Mental Capacity Act 2005 (MCA). They were responsible for completing the mental capacity assessments. Assessments were not completed for people they told us lacked mental capacity to make certain decisions but did not have a diagnosis of dementia.

Care plan reviews were not being overseen effectively throughout the auditing process to identify that some information was out of date. We raised concerns regarding the care planning for risks and were told that the plans were out of date. Action was only taken to address this once it had been discussed at the inspection and had not been brought about through the auditing process.

Good practice from other services within the organisation was not being shared effectively. Where other services had more thorough monitoring processes in place, these were not being shared with Bartlett House. We were advised by the area operations manager that the care plan audits had been introduced five months prior to the inspection. We were told that there had not been enough time for these to be fully embedded, despite us raising concerns about how risks were documented in care plans and there only being 27 people living at the service.

The managerial vision for how the service could develop was at times unclear. However, they were able to tell us that they had different projects in mind as part of this, such as the introduction of a "man shed". This was intended to be a place where men living at the home could meet and socialise. When discussing their vision for the service, the registered manager referred to things that had previously happened, such as the

patio fencing. They referred to pre-existing community relationships with the military and said, "They are going to come in and start talking about building raised flower beds for next summer." There were already raised flower beds, and these had been in place for some time. We asked a staff member if people enjoyed gardening. They told us, "Not really". There were no timescales in place for plans to adapt the environment, as these were waiting on head office approval in the upcoming months. This meant that action regarding the environment had only started to take place in recent months. Action had not been identified as a priority before this, despite some areas being outdated and not promoting independence.

There was a risk averse culture, without creative thought as to innovative ideas that would promote independence while keeping people safe. This was present throughout the service and when questioned, staff referred to keeping people safe as justification for not promoting independence. The service lacked creative leadership from the organisation to address where staff had restricted people's independence due to not having a suitable and safe alternative available.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The organisations quality team completed a whole home audit and the area operations manager requested that registered managers complete their own copies of this as well. There were some differences in the audit results. The registered manager explained that they had assessed themselves as not meeting one requirement because they had plans to develop people's existing life history documents. The registered manager explained, "The quality team put it as met, but we put it as not met, as we want to work on it. We need to get a nice life history. We met the criteria in their audit because we have something in place."

The registered manager explained that the head of care was responsible for overseeing the service in their absence. Staff told us they felt supported by the registered manager and the head of care. They told us they could contact either of them if they had concerns or wanted to ask for advice. The registered manager said they meet with the head of care each day and have discussions to ensure they are up to date with what is taking place at the service. They said, "[The head of care] has in depth contact with the care leaders and will communicate with them." Also, "I hope I am a manager with an open door and that staff can talk to me if they have anything they need to discuss."

There were Key Performance Indicators (KPI's) for the registered manager and Bartlett House. The registered manager said they received a monthly email from their head office, providing analysis of how the KPI's are being met. This information included the occupancy levels, the number of falls and infections. The registered manager told us, "We are looking at having the full capacity of 36 [people at the service]. With higher numbers of people comes higher need of staff. A safe happy home is more important to me than beds completely full."

We raised concerns about the staffing numbers at night in relation to the layout of the service. The registered manager told us they received feedback from the night care leader. They explained, "We look at the number of falls and emergency situations we have at night, there's no alarming numbers." The response did not address that there was always a staff member in Down Blue, which then left only two members of staff supporting the remainder of the service, despite some people requiring the support of two staff for personal care. Staff told us they tried to make sure as many people as possible were in their bedclothes before 8pm when the night staff began their shift. We could not see records in all care plans reviewed, relating to when people's preferred bedtimes were, to know if this action by staff was because of people's choice, or because of staffing levels.

The registered manager explained that they felt their biggest challenge moving forward would be making the dementia unit more accessible and brighter. They said, "The whole environment and seating and relaxing areas need to be looked at to see what can be adapted. We need to make the dementia unit more accessible to the outside garden space."

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 9 HSCA RA Regulations 2014 Person-centred care People's independence was not promoted. The facilities in Down Blue were not sufficient to meet people's dementia care needs. Toilets were not easily identifiable. There were many undignified and task focussed interactions from staff when supporting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Training for the MCA was not sufficient, it did not test staff competencies and knowledge gained. Mental capacity assessments were not being completed for people who staff told us lacked capacity, but did not have a dementia diagnosis. Leadership at the service lacked understanding around consistently implementing the principles of the MCA. People's consent was not always sought prior to care interventions.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

Systems to monitor care plan updates, risk assessments, people's healthcare needs and incidents related to these were insufficient and ineffective.

Staff did not adhere to the organisations policy regarding hand hygiene.

Staff were not consistently effectively deployed and the dependency calculation tool did not take into account the layout of the building.

Dietary monitoring records only recorded until 5pm.

The organisation had not supported the service by sharing best practice and investing in service improvements in a timely manner.