Care Quality Commission

Thistleton Lodge Limited

Thistleton Lodge

Inspection report

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 28 January 2015 and was unannounced, which meant the provider did not know we were coming to inspect. The last inspection of this service took place in June 2014 when we found no breaches of the Regulations.

Thistleton Lodge is a large detached property in its own extensive grounds. It is easily accessible and there is ample car parking space for visitors. The home provides care for up to 54 people with differing needs. There is a lift and access for wheelchairs throughout. The service provides care for people living with dementia. The service was supporting 46 people at the time of our inspection.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People and their relatives we spoke with all told us that they or their relative was safe and looked after well. However, our observations found that staff were stretched, and had found it difficult to provide effective care and support at busier times of the day to people living with dementia.

We found that the registered person had not protected people against the risk of insufficient numbers of staff deployed throughout the service.

We saw that robust recruitment procedures were in place and required background and identity checks had been carried out on all staff. This helped to ensure that as far as possible, staff were safe to work with vulnerable people.

We looked at procedures around medication and observed that people received their medication in a safe manner, when it was required.

People we spoke with and their relatives felt staff had sufficient knowledge to provide safe and effective care. We found the home had a good induction process for new staff which covered all mandatory training with suitable knowledge checks. Refresher and more advanced training were also available. We have made a recommendation about staff training on the subject of dementia.

We found that staff supervision and appraisal was not formally recorded and were reactive rather than proactive. The staff supervision processes did not help to identify and address any shortfalls in knowledge.

Staff had not received appropriate training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides legal protection for people who may not have the capacity to make some decisions for themselves, whilst DoLS provides legal safeguards for such people who may have restrictions placed on them as part of their care plan. We saw evidence of restrictive practices without authorisation. People in the areas of the home for those who were living with dementia were unable to exit the premises unaided or unattended and were, for the most part, under continuous supervision from staff.

We found that the registered person had not ensured that staff understood their responsibilities with regard to gaining consent from the people in their care with regard to the MCA. Peoples' liberty was being restricted without authorisation and there was no record of the discussions which took place to decide whether this was in the person's best interests.

We saw that people received enough food and drink with plenty of choice and variety on the residential unit. However, people who lived in Oak View were not offered a choice of what to eat or drink at lunchtime. Information contained within the care plans showed that people's weights and fluid intake were routinely recorded. Where concerns were highlighted, the records showed that referrals were made to the relevant professionals for help and advice.

We visited all areas of the home during our inspection and found it to be a clean, bright welcoming environment. However, more could be done to make the environment more 'dementia friendly' for people who were living with dementia. We also found storage heaters in the home were very hot to the touch, which could have resulted in injury to a person if they came in contact with them.

We found that the registered person had not protected people against the risk of unsafe or unsuitable premises.

Everyone we spoke with told us that the staff were friendly, helpful and caring. We were told staff displayed kindness and respected peoples dignity and respect. Our own observations throughout the inspection confirmed what people had told us.

Care plans we looked at were person centred, however, they lacked information about people's life histories, which would give staff more insight into how they would like to be cared for. Pre-admission assessments were completed before people moved to Thistleton Lodge which allowed the service to understand if they could meet an individual's needs. These plans were reviewed on a regular basis and changes made where appropriate. However, we found little evidence that people or their relatives were regularly involved in these reviews.

We found that the registered person had not ensured people were fully involved in reviewing their written plans of care.

Summary of findings

We found the home provided a wide ranging programme of activities for people who lived there. People told us they enjoyed trips out to the local area.

We observed a calm atmosphere within the home on our unannounced arrival. People we spoke with and staff told us the home had an open culture and the management were approachable. Staff told us they enjoyed working at Thistleton Lodge.

We saw that feedback from people their relatives and staff was obtained through surveys and regular meetings. People were able to express their views to improve the service.

We saw that a full range of audits and quality checks were completed by the management of the home in order to check on the quality of service provided and drive improvements where required. Safety checks were completed on equipment and the building itself. However, these checks had not identified the issues we found during our inspection.

We found a significant number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in respect of levels of staffing, meeting peoples' nutrition and hydration needs, unsafe or unsuitable premises, consent to care and treatment, peoples' involvement in reviewing the care provided and the operation of systems designed to assess, monitor and improve the quality and safety of the services provided. These also amounted to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe.

Staff had been trained to keep people safe, but some staff we spoke with did not fully understand what forms abuse may take.

On the day of our visit we saw that staff appeared to be stretched to provide sufficient support for people over the busy lunchtime period.

Robust and thorough recruitment procedures were in place and we found people received their medicines in a safe manner as and when required.

Is the service effective?

Requires Improvement

The service was not effective.

People told us they were supported by a competent staff team who had the knowledge and experience to carry out their role.

Staff told us they received supervision and appraisal, however, this was not recorded so we could not check whether it was effective.

Staff had little understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some peoples' liberty was being restricted without authorisation.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us and we observed that they were supported by staff in a friendly and caring manner.

However, information about people's life histories was not always available for staff and people's preferences were not always taken into account.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw people were encouraged to personalise their rooms and the home accommodated people's pets where possible.

We saw people's needs were regularly reviewed and changes to people's plans of care were mad in line with changing needs.

People told us that they were involved in planning their care at the beginning of their stay at Thistleton Lodge, but we found no evidence that people or their relatives were involved in reviewing their care on a regular basis.

Summary of findings

Is the service well-led?

The service was not always well-led.

We observed a calm atmosphere and open culture within the home. People and staff told us the management were approachable. Staff enjoyed working at Thistleton Lodge.

Feedback from people who lived at the home, their relatives and staff was regularly sought through surveys and meetings. People were able to express their views to improve the service. However, discussions with people about their care were not routinely recorded.

Regular audits and checks were carried out by the registered manager; however they had not identified and addressed the issues we found during our inspection.

Requires Improvement

Thistleton Lodge

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.

The inspection took place on 28 January 2015 and was unannounced. The inspection team consisted on an adult social care lead inspector, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert also had a nursing background.

Before the inspection we looked at information held on our own systems. This included notifications sent to us by the provider and any whistleblowing or safeguarding information provided to us. We also looked at information from external sources such as various websites where people can make comments or leave reviews about services.

During this inspection we spoke with 11 people who lived at the home and one visiting relative. We spoke with five staff, the registered manager and the company director. To gain a balanced overview of the experience of people who accessed the service we also spoke with commissioners from local authorities who commissioned services from the home, and health and social care professionals who visited the home.

We observed the care provided throughout our inspection, looked at a sample of seven care plans and three medicine administration records. We used a system of pathway tracking. Pathway tracking looks at the support people receive at each stage of their care.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home told us they had no concerns about their safety or the way in which they were treated. Comments we received included: "Of course I feel safe here" and; "Safe? There's no problems. I'm a retired nurse, so I would know if there was anything amiss".

We spoke with a visiting relative who told us: "[Relative] is very safe. They look after them very well, and me as well. [My relative] is not really able to call for assistance, so they moved them to a room where they could observe them more easily, and more frequently."

A visiting GP who we spoke with told us: "They operate to a very high standard of safety. I've absolutely no concerns whatsoever."

Safeguarding policies and procedures had been implemented by the provider and staff had easy access to contact details for reporting any concerns. Staff training records showed that staff had undertaken training in safeguarding vulnerable adults. Staff told us they would not hesitate to report any concerns with regard to bad practice or the safety of the people they cared for. However, staff were not able to confidently describe what forms abuse may take, other than physical or financial abuse apart from to tell us that this related to the home's whistleblowing policy.

Staff at the home completed individual risk assessments for each person who lived at the home. Information about how to manage these risks and keep people safe was provided to staff, to help to ensure people were protected. We looked at people's written plans of care which gave staff information on how best to support people, taking into account the risks that had been identified, for example concerning falls and pressure care.

We saw from records that accidents and incidents in the home were recorded accurately. We discussed monitoring of accidents and incidents with the registered manager who told us they keep a close eye on reports to identify any trends or themes. We saw that appropriate action was taken following incidents. For example where a person had suffered a number of falls, we saw a referral had been made to other healthcare professionals for assessment and guidance.

We looked at how the service was staffed, to ensure there were always enough suitably qualified staff on duty to provide the care and support people required. We received positive comments from most people we spoke with. However, one person told us: "They're very good, but they're always busy. I have to wait half an hour sometimes after calling them, so they could do with more people" and a visiting relative told us: "You could always do with more staff, but that's the same in any caring profession." During the inspection there were periods of time where call bell buzzers were sounding for periods ranging between 5 and 15 minutes. This meant people could be waiting for up to 15 minutes for assistance.

We observed the staffing levels in each area of the home. We saw that in the residential area of the home there were three staff to deliver care and support to 29 people. In Beech View, which was a section of the home for ladies who were living with dementia, there was one member of staff to care for seven people. In Oak View, which was a first-floor section of the home for people who were living with dementia, there was one member of staff to care for nine people. In Elm View, which was a part of the home for people with early onset dementia, there were two people, cared for by one member of staff. There was also one member of staff who provided floating support between each of the units of the home as required. The registered manager confirmed staffing levels were decided based upon people's assessed levels of dependency and had recently been reviewed.

We witnessed occasions when staff where stretched to provide the care and support people required. For example, over lunchtime on Beech View, one carer was supervising seven people and supporting two people to eat. During this time, one person asked to use the bathroom. The carer supported this person to the bathroom which left six other people, including people who required support to eat, unattended for 15 minutes in the dining room of the unit. This meant people were left without support for periods of time, because of the number of staff on duty. We also witnessed periods of time on Oak View when people were left unattended in the lounge / dining area whilst staff assisted people who chose to stay in their bedrooms.

We found that the registered person had not protected the health safety and welfare of people as there were insufficient numbers of staff deployed throughout the

Requires Improvement

Is the service safe?

service to keep people safe and meet their needs. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service operated safe recruitment practices and disciplinary procedures. We spoke with staff and looked at three staff recruitment files. We saw that the service carried out checks including obtaining references from previous employers and checks with the Disclosure and Barring Service (DBS) before staff were offered employment. These checks helped to ensure that only suitable staff were employed.

We looked at how the service managed medicines. We looked at records and spoke with staff and the registered manager. We found safe systems were in place for the ordering, receipt and storage of medicines, including controlled drugs. Controlled drugs are medicines which are subject to special legislative controls because there is a potential for them to be abused or diverted, causing possible harm.

We saw that only senior staff were allowed to administer medicines. We saw from the staff training matrix that all the senior staff had undertaken training to help ensure they were administering medicines properly. We observed a medicines round at lunchtime and saw safe practices were observed by the staff member who administered the medicines. The service had implemented suitable policies and procedures around medicines administration, including self-administration and homely remedies. Where people chose to self-administer, we saw an assessment of people's ability to self-administer and signed agreement at the front of people's medicines administration records (MARs) which gave staff guidance on how to support people with their medicines.

We did not see any guidance for medicines that were prescribed for use 'as and when required', for example for pain relief. We discussed this with the registered manager who told us that all the people for whom these medicines were prescribed were able to ask for them. We alerted the manager to the fact that some people, especially those who may lack capacity, may not be able to tell staff that they need these medicines.

We looked at all areas of the home to ensure the premises were suitable and safe for people who lived there. We found that storage heaters around the home were very hot to the touch, which could potentially have led to injury if people came into contact with them. We alerted the registered manager to this and we received assurances that they would take action to remedy this immediately.

We found that the registered person had not protected people against the risk of unsafe or unsuitable premises. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend that the provider takes steps to ensure that staff are fully conversant with the Local Authority Safeguarding Policies and Procedures, including the categories and types of abuse.

We recommend that the provider ensures guidance for staff on the administration of 'as and when required' medicines is in line with current NICE guidelines and best practice.

Requires Improvement

Is the service effective?

Our findings

People who lived at Thistleton Lodge told us they felt staff had the knowledge and experience to meet their needs. People told us: "They're quite well trained - they go for NVQ's and things" and; "Everybody I meet, I'm quite happy with. They all seem well trained". None of the people we spoke with who lived in the home expressed any concerns about the skills or knowledge of the staff team.

Staff we spoke with told us they felt they had received a good induction into the service and that the training they received enabled them to meet peoples' needs effectively. Staff told us and training records confirmed that staff had received a range of training which included safe handling of medicines, compassion and dignity in care, moving and handling, infection control and fire safety.

We found staff had completed training in dementia awareness, in order to give them knowledge and skills to support people who were living with dementia. The training was provided by an external company over half a day and staff were tasked to complete workbooks following the training which were marked by the course provider before certificates were issued. However, we found there was no monitoring, for example, observations by the manager or discussion through supervision, of how effective the training was or how beneficial it was for people who lived at the home.

People and the visiting GP told us, and records we looked at confirmed that people's general healthcare needs were met. We saw a variety of professionals involved in people's care including, dieticians, chiropodists, speech and language therapists and district nurses. People's general health was monitored by staff and where any concerns were identified, for example, weight loss, timely referral was made to the appropriate agency.

We found that the provider had made only limited adaptations to the areas of the home for people who were living with dementia. Small lettering and pictures on toilet and bathroom doors were the only adaptations we found. Doors, that should be personalised and visible to people who were living with dementia, were painted in neutral colours, as were the walls. We did not see any sensory displays around the home or personalised displays which would help people who were living with dementia to identify their own bedrooms. Likewise, tablecloths and crockery were of similar neutral colours, which made it difficult for people to distinguish between items.

Staff we spoke with told us they received regular supervision and annual appraisals, conducted by either the registered manager or deputy manager, dependant up their role. However, staff were unsure about the difference between supervision and appraisals. We discussed this with the registered manager, as well as staff, and found that supervision was conducted on an informal basis, as and when required, for example if issues or concerns arose. These supervision sessions were not formally recorded. With regard to appraisals, staff told us they had not received a copy of their appraisal documentation. We brought to the attention of the staff and the manager that it is good practice to have copies of supervision and appraisal records so that agreed actions can be followed up on.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager and staff. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We found staff and the management of the home had limited knowledge around the MCA and DoLS and were not able to describe the main principles of the legislation or how they would support people to make decisions for themselves.

Care plans we looked at contained mental capacity assessments, but these were not related to any specific decisions. We spoke with a visiting GP who told us that, where people had been assessed as lacking capacity, they were involved regularly in discussions about decisions, but we did not see any record of discussions relating to decisions that were made on behalf of the person concerned.

Requires Improvement

Is the service effective?

Staff we spoke with were unsure about the process to follow if they thought someone may lack capacity to make a decision for themselves and were unaware of the role of advocacy services.

We found that the registered person had not ensured that staff understood their responsibilities with regard to gaining consent from the people in their care with regard to the Mental Capacity Act 2005. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 11of the Health and Social Care [CD1] Act 2008 (Regulated Activities) Regulations 2014.

In the two areas of the home for people living with dementia, the majority of people were unable to move around freely or go outside unaided or without supervision. In the Beech View unit of the home, we found a pillow had been stuffed under the push bar of a fire door. We were told this was to prevent one of the people on this unit from exiting the building via the fire door. We were informed by the registered manager that no applications for authorisation under DoLS had been made.

Peoples' liberty was being restricted without authorisation and there was no record of the discussions which took place to decide whether this was in the person's best interests. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 13(1) and 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's written plans of care to see how their dietary needs were accounted for. We saw people's weights were recorded on a regular basis. Where people were observed to be losing weight, referrals were made to healthcare professionals for guidance and advice in order to stabilise their weight. We saw people's food and fluid intake was monitored appropriately. Any allergies and food preferences were recorded in people's documentation and were communicated to kitchen staff.

We asked people who lived in the home what they thought about the food provided. Comments included: "Oh aye, it's OK. You get too much sometimes!"; "I have meals in my room, which is my own choice. Before I was ill, I wasn't eating properly, but now they make sure I eat. They come round every day and ask me what I want. I have soup and a sandwich for lunch and a salad for tea. I can choose what sort of sandwich I want and what meat I'd like with my salad"; "It's good. They always ask you what you'd like and there's always something that I'm happy with" and; "It's alright. We don't think there's a lot of choice, but you get an adequate amount". A visiting relative told us: "If she's [their relative] not eating they'll help her. Communication is good so they'll let me know if she's not eating, or feeling unwell."

We observed the lunchtime period in three areas of the home. We found the atmosphere to be pleasant and relaxed and people appeared to enjoy the food that was served.

In the residential area of the home, two people required support to eat their meal. This was provided in a sensitive and unhurried manner by staff. We saw people were offered drinks and accompaniments, such as apple sauce, during lunchtime.

We saw that everyone in the Oak View part of the home was served the same meal. We were told by staff that people on this unit were not offered a choice of what they would like to eat for lunch. The support provided to people who required it was good, however, because a member of staff had to attend to a person who chose to stay in their room, the lounge / dining room was left unattended for period of time until a 'floating' member of staff arrived to assist.

In the Beech view area of the home, one member of staff was responsible for serving lunch for seven people and for assisting two people who required support to eat. The member of staff talked encouragingly to the people she was assisting. Three people did not seem to like their food and we observed the staff member offer only one of them 'something else or a pudding'. This meant the two other people were not offered an alternative. The member of staff on this unit told us "I can cope with mealtimes on my own"; however, when one person needed assistance to the toilet, this left the dining room unattended for 15 minutes whilst people were eating. During this time we observed one person taking food from another's plate.

Whilst observing lunchtime on Beech view, we noted one person did not eat or drink anything and had also refused a drink at 11:00am. This person's daily record had not been completed by the time a new member of staff came on shift and was not mentioned during the handover. We mentioned this to the staff member who had taken over and to the registered manager at the end of our inspection.

Requires Improvement

Is the service effective?

We saw that in both the Oak View and Beech view areas of the home that everyone was served weak milky tea which was tepid. This meant that people's preferences were not taken into account.

Peoples' nutritional and hydration needs were not met whilst having regard to their well-being and did not reflect their preferences. This was in breach of regulation 14(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home was clean and tidy and no bad odours were present at all. However, the environment on the two units that we were told were specifically for people who were living with dementia were not 'dementia friendly'. We saw limited signage and small lettering on doors. The layout of the building had lots of corridors which could be confusing for people to find their way around as everywhere was decorated in very similar colours. Doors that need to be visible and personalised to people who live in the home were painted in neutral colours as were the walls. We did not see any pictures or sensory displays around the home which would help to orient people. Similarly, tablecloths and crockery were both of neutral colours which made it difficult for people to distinguish between items. We raised this issue with both the registered manager and deputy manager.

We recommend that the service sources training for staff from a reputable provider, based on current best practice, in relation to the specialist needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

We asked people who lived at Thistleton Lodge whether the staff were kind, caring and knew about their preferences. People we spoke with told us: "Yes, they look after me very well here"; "It's lovely here. I wouldn't be anywhere else, they're like family"; "We're both very well looked after. They do talk to me as an equal. They do know I'm an ex-nurse, whether that makes a difference I don't know, but they're all easy to chat to. They also let Millie [their pet dog] stay with us." And; "They're absolutely fantastic, I love them all. I can't praise them highly enough, they're really good."

A visiting relative told us: "She's [their relative] definitely treated very well, with dignity and with respect."

People we spoke to told us that they had been involved in planning their care when they first moved into the home, but could not recall having been involved in regular reviews of their care. When we looked at people's written plans of care, we did not see evidence of people's regular involvement in reviewing their care. Where people were judged to lack capacity to make decisions around their care, we did not see evidence of regular involvement of people's relatives or any advocates in reviewing plans of care, other than the initial assessment and information gathering documentation. This meant that people's written plans of care may not always reflect their current preferences.

We found that the registered person had not ensured people were fully involved in reviewing their written plans of care. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time in each area of the home to observe how staff interacted with people. We saw the staff approach to people was consistently good. We saw staff were friendly and caring towards people and responded to them sensitively. Staff spoke with people politely and offered explanations and encouragement when they were assisting people. It was clear from the good humoured interactions that staff had built a good rapport and relationships with the people they supported.

We saw that people's privacy and dignity was respected and their independence promoted. We saw that staff knocked on people's doors and asked whether it was ok to enter before they went into people's rooms. Personal care was delivered in a discreet way, behind closed doors. Nobody we spoke with raised any concerns about privacy or dignity. A lot of the people who lived in the residential part of the home were independent to varying degrees. We saw that this was promoted and encouraged, for example where people required minimal support with dressing or personal care, this was provided and people were encouraged to do what they were able.

People's records were stored securely. Sensitive information could only be accessed by staff who had authority to do so.

We saw from the care plans we looked at that staff discussed people's end of life preferences with them. This included people they wished to have close to them, whether they wished to receive treatment in a hospital or at the home and any religious preferences were also discussed. We saw from staff training records that four staff had undertaken training to give them the skills and knowledge required to support someone at the end of their life.

We found that some people who lived at the home had documentation on their care plan which indicated that they did not wish 'Cardiopulmonary Resuscitation' (CPR) to be carried out, in the event of their heart stopping. These documents are known as Do Not Attempt CPR (DNACPR).

We saw from these records that where people lacked capacity to consent to this decision, the forms had been completed by the person's GP. It was evident on the forms that peoples' relatives had been consulted during the process which complied with the MCA code of practice.

Requires Improvement

Is the service responsive?

Our findings

We found that, in general, the service responded well to people's needs. People were able to exercise choice over how they spent their time and were able to personalise their rooms. For example, one person had put lots of photographs on the wall in his room and had brought his two budgerigars from home. He told us: "Lots of the staff and residents come in every day to talk to me and the budgies, and to feed them." This person appeared to be very much 'at home', happy and content. We saw various other similar examples of personalisation throughout the home. Another person told us: "They all listen to what I have to say and they take notice of my opinions."

We saw from people's written plans of care that a pre-admission assessment was completed before anyone moved into the home. This helped to ensure the home could meet the person's needs. The documentation we looked at was comprehensive, included relevant risk assessments and plans of care, which were up to date. We saw that regular reviews of these documents had taken place at least monthly and changes had been made in line with people's changing needs.

Staff we spoke with were knowledgeable about the people they cared for and were able to confidently describe people's needs and preferences. We saw a 'life history' section in each person's written plan of care. This contained information about the person's life, family, work history and significant events. However, we noted that this section of people's documentation was not always completed. Information like this helps staff to understand more about a person and their preferences in order to deliver care that is centred around them.

People we spoke with were involved in planning their care at the beginning of their stay at the home, but we could find little evidence of people being involved in formal reviews of care. The registered manager and staff told us that people's relatives were involved and kept up to date, but we could not find any written evidence of this.

Written plans of care did not always appear to be followed through by staff to the actual care delivered. For example, we read in one person's plan of care that they did not like games or puzzles, yet we observed them trying to complete a jigsaw puzzle. This showed that people's preferences were not always recorded correctly or reviewed in the event of changes.

We saw from plans of care and a visiting GP told us that the home sought guidance and input from healthcare professionals as required. The visiting GP told us that staff knew people well and cared for them well. They told us they felt people's needs were met consistently.

There were a variety of activities provided at the home. During our inspection we witnessed a 'knit and natter' session, bingo and saw people were making use of the on-site hairdressing salon. We saw from the monthly activity plan that there were usually two activities provided per day, including trips out to local areas and entertainers visiting the home. People we spoke with told us they were assisted to go shopping by staff. We saw people in the Oak View unit watching television. One person was seen to occupy themselves with 'Lego' style blocks and another with soft toys. These people appeared to take enjoyment from the activities. We were told activities were offered to people who lived in the Oak View unit of the home, but we did not witness this during the inspection.

People told us they were able to maintain relationships with family and friends and we saw a number of people visiting throughout the day. Relatives told us they were always made to feel welcome and could visit at any time. People were able to receive visitors in the communal areas or in the privacy of their own rooms.

The provider had implemented a suitable policy and procedure for dealing with complaints and concerns. A copy of the complaints procedure was given to everyone at the beginning of their stay at the home. People we spoke with told us they knew how to make a complaint and would be happy to raise any concerns if they felt they needed to. One person told us: "I could speak to any of the girls and if I needed to I could go and see [Manager]." A visiting family member told us: "I've been very happy with the care that mum has had, which has been extended to me and my daughter as well. We did have a minor complaint once. Her room carpet had a hump in it, which could be a trip hazard, we told them about it and it was sorted out straight away."

The service had not received any complaints since our last inspection, so we were unable to follow a complaint

Requires Improvement

Is the service responsive?

through the process. We did however discuss how staff would support people to make a complaint and how the manager would deal with complaints that were received. We were satisfied that complaints would be dealt with appropriately.

The home had appropriate processes in place to ensure that when people were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between other health and social care agencies. Information held within people's personal care records showed that liaison had taken place with other health professionals in a timely manner. The daily records in each person's plan of care had been completed. However, we found these entries did not provide a sufficient level of information with regard to, for example, what interactions staff had been involved in with the person, times or members of staff involved. We raised this with the registered manager during the inspection who agreed they would look into how more detail could be captured in people's records. We raised this with the registered manager during the inspection who told us they were aware of the issue and that they were working to make improvements in this area.

Requires Improvement

Is the service well-led?

Our findings

The service had a current statement of purpose. This is a document which outlines the vision, aims and objectives of the service. There were clear lines of responsibility and accountability. Staff we spoke with were knowledgeable about the people they supported and enthusiastic about providing a high standard of care and support to people who lived at the home. Staff told us they were well supported and we found the culture at the home to be open and transparent.

The home had a registered manager in post. The manager had registered with the Care Quality Commission in September 2014. They had worked at Thistleton Lodge for a number of years, working their way up to their current position. This helped with regard to continuity of care as the manager was familiar with people who worked at the home and the processes and procedures that were in place.

People we spoke with, and their relatives, all knew who the registered manager was. They told us she was approachable and supportive. They told us they could go to the registered manager with any problems and were confident that they would do their utmost to resolve the issue.

We asked people whether they thought the staff were well-led and supported by the registered manager. People told us they thought the staff were motivated and enjoyed their role. One person told us: "I can't praise them enough. You'd go a long, long way to find a better home", whilst another said; "We've only been in a couple of weeks and we've no complaints so far. It's really great - everybody's really kind".

Staff we spoke with told us they enjoyed working at the home and none of them raised any concerns about the leadership at Thistleton Lodge. Staff told us and we saw minutes of meetings which confirmed staff had regular meetings where information could be shared, and comments and suggestions made to improve the service. Staff also told us they could go to the manager with any concerns or suggestions at any time.

We looked at how people were invited to provide feedback about their experience of the service. The last resident's survey was conducted in March 2014 and another was due to be completed in the near future. The last survey did not raise any concerns. We were told by the manager that people were involved in regular reviews of their care, but we found little evidence to support that they or their relatives were involved regularly. However, people did tell us that they had good relationships with staff and that they were asked on a daily basis whether everything was 'ok'. We raised this with the registered manager during the inspection. They told us they would take action to improve how people's involvement in reviewing their care was recorded.

We looked at the minutes from 'Resident and Relative' meetings that had taken place. People we spoke with confirmed they took place, but some people chose not to attend. If people chose not to attend, they were not routinely provided with a copy of the minutes. This would help to keep people who lived at the home up to date with any discussions that take place about the service in general.

Regular audits and checks were carried out by the management. These included checks on the environment, medicines, care plans and accidents. These checks helped to maintain high standards of care and safety for those people who lived at the home. We saw that where issues were found during checks, action was taken to address these shortfalls. However, the issues raised in earlier sections of this report, for example, staffing levels and lack of protocols for 'as and when required medicines', had not been identified and addressed, which led us to question how effective the systems were.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1) & 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records which confirmed checks were carried out on the premises and equipment at the home. These included checks on fire safety equipment, such as the alarm and fire extinguishers, water temperature checks, emergency lighting and the lift. However these checks had not highlighted the concerns in the surface temperature of the storage heaters.

We saw records of accidents and incidents, and safeguarding alerts that were reported to the local authority. Our records confirmed that the home reported any incidents as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 The registered person had not ensured the involvement of relevant persons in decisions relating to the way in which the regulated activity was carried on so far as it related to peoples' care or treatment. Regulation 9(3)(f). Peoples' nutrition and hydration needs were not met whilst having regard to their well-being and preferences. Regulation 9(3)(i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not ensured they acted in accordance with the Mental Capacity Act 2005. Staff did not fully understand their responsibilities with regard to gaining valid consent from people in their care. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured the premises used were safe to use for their intended purpose and were used in a safe way. The surfaces of storage heaters were very hot to the touch which could result in injury if a person came into contact with them. Regulation 12(2)(d).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured people were protected from improper treatment in accordance with this regulation. Some people were the subject of unauthorised deprivations of their liberty. The registered manager confirmed no applications had been made under DoLS. Regulation 13(1) and 13(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes designed to assess, monitor and improve the quality and safety of the services provided were not operated effectively. Regulation 17(1) and 17(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people who used the service. Regulation 18(1).