Barchester Healthcare Homes Limited

Thistle Hill

Inspection report

Thistle Hill
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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**

Summary of findings

Overall summary

This inspection of Thistle Hill took place on 26 and 27 July 2016 and was unannounced. The inspection was carried out in response to some serious concerns we had received regarding the care and support provided at Thistle Hill. An investigation into these concerns is underway and we will report on any action once completed.

Our previous inspection report was published in December 2015. The service was given an overall quality rating of 'Good,' with a rating of 'Requires improvement' for the key question 'Is the service well led?' A recommendation was made regarding the approach of management and how a more open and responsive culture could be developed, where staff and others would feel confident their feedback was listened too.

Thistle Hill is registered to provide nursing care for up to 85 younger adults or older people, who may be living with dementia or a physical disability. The home is divided into three units. One provides care for up to 41 people who may be living with dementia and is called the Deighton unit. One provides care for up to 24 older people who require general nursing care and is called the Ripley unit. The third provides care for up to 20 younger adults with disabilities and is called the Farnham unit.

The service had a registered manager, who registered with us in July 2016. 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.

The registered provider used a dependency based tool to determine what staffing levels should be. However, we found the deployment of staff was not always effective and that on-going, regular use of agency staff had impacted on the care and support people received. People who used the service and their relatives told us they had experienced times when staff had not been available to meet people's needs and that this was a recurrent issue they had raised with the registered provider. We also observed this during our visit, when we saw staff struggle to provide the care and support people needed during a lunch time meal. We have required that the provider make improvements.

We received variable feedback from staff about the training and support provided. Some staff did not feel that their training and support and supervision needs were well met and the limited records available to us supported this. People who used the service and relatives were complimentary about the dedication and approach of permanent staff, but told us there were too many agency staff working at the home who were not sufficiently familiar with people's needs. This meant people did not experience a consistent quality of care. We have required that the provider make improvements.

There was a recruitment procedure in place, which included checks on staff to ensure they were suitable to work with people who may be vulnerable. However, some staff records did not contain full employment histories, or explanations of gaps. In the absence of adequate documentation, we have recommended that

the registered provider review their internal selection and recruitment arrangements and take steps to improve the maintenance of staff records.

People did not receive a consistent quality of person centred care. Some people and relatives were satisfied with their care, while others expressed frustration, describing a lack of involvement and consistency. The safety and quality of people's care varied depending on which staff were on duty and how well they knew people's needs. We found examples where people had not received safe care and treatment. Some of these matters were still under investigation by CQC together with the police and Local Authority. We have required that the registered provider make improvements.

A complaints procedure was in place and a record of concerns and complaints showed what had been done in response to concerns raised. However, people were not confident that concerns and complaints were listened or responded to effectively by the registered provider. We have recommended that the provider review their own internal arrangements to communicate and respond to people who use the service and their representatives in order to improve communications and confidence.

There was a registered manager in post and a deputy manager had been recruited to provide additional management support. People who used the service, relatives and staff were generally positive about the local management at the home and the efforts they were making to improve the service. However, we found that there was a disconnect between the views of the registered provider's senior management and what people who used the service, their relatives and staff told us about their experience of living and working at Thistle Hill. Relatives expressed frustration with "head office" and the "hierarchy in Barchester," and did not feel that they were open or listening to their concerns. Staff said they did not feel valued. We have required that the registered provider make improvements.

Activity coordinators were employed to provide activities and social stimulation. People spoke highly of the input from these staff and there was evidence of some activities taking place and some focused individual interactions taking place. However, we received feedback from people suggesting that a more person centred and individual approach to activities was needed, particularly for people who spent the majority of time in their rooms.

Staff knew how to report any concerns about people's welfare and safeguarding alerts had been made.

Procedures were in place to guide staff on the safe administration of medicines. Staff could explain how medicines were managed safely and we saw safe storage arrangement in place. The records we checked showed that people had received their medicines as prescribed.

We received positive feedback from three health care professionals who regularly visited the service. They told us they were involved appropriately in people's care and felt that good arrangements were in place to enable people to access their services. They felt the service was improving and staff were trying hard to ensure people were well care for.

The service had policies and procedures to guide staff on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Deprivation of Liberty Authorisation requests had been made if staff felt that someone lacked capacity to consent to their care and treatment at Thistle Hill.

Audits and checks had been completed by senior management and the manager and deputy manager. Resident and relatives meetings had commenced on a three monthly basis and records of these evidenced frank discussions around the issues and concerns that people had raised. The deputy manager was able to

show us the clinical governance arrangements they had put in place and the actions arising from these to make improvements.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of the full version of this 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?

Inadequate

The service was not safe.

The service struggled to recruit and retain permanent staff and relied on agency staff to cover staffing shortfalls. People had experienced times when staff were not available to meet their needs or the available staff did not know their needs well enough to provide safe and consistent care.

Recruitment procedures included checks to ensure staff were suitable to work with vulnerable adults. However, some of the required information was not available in all staff files.

Staff knew how to report concerns. Safeguarding alerts and notifications about incidents had been made when needed.

Medicines were stored safely and the records we viewed showed that people had received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service required improvement to be effective.

Training was being provided to cover training gaps, but training records were incomplete and some staff did not feel sufficiently competent or trained to fulfil their job roles.

Staff support had not been consistent. Staff had not received regular supervision and some did not feel sufficiently valued and supported by the organisation.

People were supported to maintain their nutritional wellbeing, but improvements were needed to ensure that people received good quality food and timely support with their meals.

The service was working within the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service required improvement to be caring.

Staff approach was inconsistent, with some very good and some poor interactions being evident.

Some people were involved in planning and reviewing their care and making decisions about their lives. However, some people told us they were not adequately involved.

Staff were respectful of people's privacy and dignity and ensured personal care was carried out in private, but staff availability and ability to respond to people impacted on people's dignity

Is the service responsive?

Requires Improvement

The service required improvement to be responsive.

Staff worked hard to respond to people's needs, but people had experienced staff not having sufficient knowledge of their support needs and interests.

Systems were in place to assess and plan people's care needs, but opportunities to provide person centred care had been missed.

Some people had access to the local community and were supported to take part in activities that interested them, but other people would benefit from a more person centred approach.

Is the service well-led?

Requires Improvement

The service required improvement to be well led.

There was an apparent disconnect between senior management and people who used the service and their relatives. People who used the service, relatives and staff told us the registered provider did not effectively involve them or listen and act on their concerns and feedback.

Our inspection findings, including breaches of regulation, showed that effective systems to monitor and improve the service were not in place.

A registered manager was in place and supported by a new deputy manager. There was evidence of actions being taken to improve the service, including regular clinical governance reviews and meetings with staff and relatives.

Thistle Hill

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 registered 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 inspection took place on 26 and 27 July 2016 and was unannounced. The inspection team on the first day of inspection was made up of two adult social care inspectors and an expert by experience. An expert by experience is someone who has experience of using care services or caring for someone who uses care services. On the second day, the inspection team was made up of two adult social care inspectors.

Prior to the inspection we looked at information we held about the service. This included notifications that the registered provider had sent to the CQC about specific events. We contacted the local commissioners and reviewed information we had about on-going safeguarding investigations and complaints. We also reviewed feedback we had received about the service and documentation the registered provider had sent us in relation to questions we had raised with them since our last inspection.

We contacted Healthwatch which is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch did not have any information to share with us about Thistle Hill.

During the inspection we spoke with six people who used the service and nine relatives. We spent time observing people in the communal areas, as some people had complex needs and were not able to express their views about the service. We spoke with three visiting health and social care professionals during our visit.

We spoke with the area clinical lead nurse, deputy manager, the training organiser, two unit leaders, four nurses, five care staff and the property manager. We were able to speak with some of the care staff via pre-arranged telephone calls after our visits. The registered manager was on leave at the time of our visit, but the deputy manager, although relatively new in post, was supportive and able to assist us with most elements of the inspection. Senior management visited the service to support their staff during the

inspection visits. This included the divisional and regional directors and divisional clinical lead nurse.

During the inspection, we looked at a selection of five people's care records, including monitoring tools and medication records. We also looked at employment and training files for six staff and other records relating to the running of the service. These included policies and procedures and maintenance records.

Inadequate

Is the service safe?

Our findings

We received a consistent theme of concern from people who used the service and relatives regarding the use of agency staff and the numbers and availability of staff on duty. One person told us, "I've had to chase up my own medication and remind agency staff of the number of pills that I take. Some don't even know how to make up your bed; you have to tell them everything. I have had to wait 20 minutes for a response to my call button. Some staff don't speak English well and that makes communication and understanding difficult." Another said, "There are too many agency staff and a consequent lack of continuity of care."

Relatives told us they were concerned about how the staffing situation had impacted on the care their loved ones received. Two relatives told us about experiences when they had visited and found that staff were not available or that loved ones had apparently not received the support they needed. Feedback we received regarding part of the Deighton unit, referred to as 'North Deighton,' was particularly poor in this regard. For example, a relative described what they thought was, "Skeleton staff[ing levels] at the weekend." Relatives also told us they were worried that agency staff did not know people as well as the permanent staff. For example, one relative commented, "When I know who is on and it is 'our' staff [permanent staff employed by Thistle Hill] I'm relieved."

At the time of our inspection there was an on-going safeguarding and police investigation involving agency staff where concerns had been raised over suspected delays in seeking appropriate medical assistance.

Staff told us that the home relied heavily on agency staff and that this could cause difficulties. For example, one staff member told us they often worked alongside agency staff, which they found to be difficult, as they sometimes did not do what was expected of them meaning the staff member had to direct them much more often than the regular staff.

We spoke with the deputy manager and other senior staff about staffing at Thistle Hill. A dependency based tool was used to determine safe staffing levels and an 'all hands on deck' approach was used to help deploy staff where they were most needed at meal times. Senior staff described how they were working hard to recruit permanent staff and reduce the numbers of agency staff that were used. This had resulted in a large reduction in the use of agency staff over the last year, although records showed that the home still relied on agency staffing to cover shifts. For example, records provided to us showed that over a 24 hour period on 22 July 2016 two agency nurses and five agency care workers were on duty on the Deighton unit.

During our inspection, we observed occasions when the staff on duty were not able to meet people's needs effectively. This was particularly the case on the North Deighton unit at lunchtime on the second day of our inspection. We observed two staff struggling to provide the care and support for eight people, whilst also serving and supporting people with their lunchtime meal. For example, one person was calling for assistance in their room, but no-one was available to hear or check what they needed. Staff had not started serving the lunchtime meal until 13:15 because they had been busy assisting someone with personal care. Staff told us that six of the eight people on the North Deighton unit required help to eat their meal. We saw that the two available staff were stretched and rushed, resulting in delays in people receiving the help and

assistance they needed.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Staffing.

People's care records included risk assessments and management plans. However, we identified that these were not always effective, because some staff on duty were not sufficiently familiar with them. For example, we found that one member of agency staff was unaware of the safe position someone needed to be in while eating, despite being directed by a permanent member of staff. They gave this person their meal in their bedroom, but failed to ensure they were sat up in a safe position, as directed by the person's care plan and written risk assessments. This put the person who used the service at risk of choking and demonstrated that people who used the service did not always receive safe care and treatment. We had to ask a permanent member of staff, who was more aware of the person's needs, to intervene to ensure that the person was able to eat comfortably and safely.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safe care and treatment.

We informed the deputy manager and senior staff of these concerns and our observations during our visit and asked them to visit the North Deighton unit so that they could observe the situation for themselves. They took immediate action to ensure that people were safe and arranged for an additional member of staff to be available.

We looked at the employment files for three staff. The files contained evidence of checks obtained through the Disclosure and Barring service (DBS). The DBS assists employers in making safer recruitment decisions by checking if prospective staff members have criminal records or are barred from working with vulnerable people. Records also included application forms and references, evidencing that some checks had been completed before staff started work. However, two of the records we looked at did not contain a full employment history or evidence that employment gaps or questions about conduct in past employment had been adequately explored. We were unable to access any staff interview records to see what had been discussed in relation to gaps or a relevant health issue declared by one member of staff. We asked senior staff on duty for this information during our visit, but were told it was not available.

We recommend the registered provider review their internal selection and recruitment arrangements and take steps to improve the maintenance of staff records.

Staff we spoke with had received training in safeguarding vulnerable adults and were aware of their responsibility to recognise and report concerns. Safeguarding and whistleblowing [telling someone] policies were available and the deputy manager knew how to make alerts to the local safeguarding authority. Notifications about safeguarding concerns had been made to us in line with notification requirements and showed that staff had made safeguarding alerts in response to incidents and concerns.

We looked at how people were supported to take their medicines. The medicine policy and procedure was available in the nurse's office and the nurses we spoke with were able to talk through the process for ordering, booking in and disposal of medicines. Daily checks of the fridge and room temperatures were carried out and were within acceptable range. Medicines were stored safely. We checked a sample of controlled drugs and the controlled drugs record book and found stock levels to be correct. Controlled drugs are medicines that require increased monitoring because of the risk of misuse. We randomly stock checked a sample of medicines and found these were accurately recorded and stored. All of the medication

administration records we looked at were completed correctly with stock balances recorded. Where staff had handwritten medicines, there were two staff signatures against the documented information to show these had been checked.

We found that medicines that were no longer required were not disposed of in a timely manner on the Farnham unit. We saw that there were six green bins which were full of medicines waiting to be disposed of and staff had started to put other unwanted medicines into two black boxes on top of the bins. These were not secure as medicines could easily be removed from the boxes. The nurses said the bins were usually picked up every month, but recently this had not taken place. We informed the area manager and deputy manager that this needed doing as soon as possible and they agreed.

During our visit we saw that standards of cleanliness and hygiene varied throughout the home. Some parts of the home were clean and tidy, but we saw examples where hygiene standards had not been maintained. For example, a chair cushion had been left without a protective cover, there was clutter in the corridors of the Deighton unit amongst which someone had hidden a half-eaten pudding, and unlabelled toiletries, combs and a nasal trimmer were seen in communal bathrooms. The staff told us that there were sufficient manual handling slings for each person to have their own, that these should be stored in the person's bedroom when not in use and clean slings were kept in the linen rooms. However, we saw slings hung over hoists in store rooms and behind doors in bathrooms, including slings that were trailing on the floor. This increased the risk of slings being dirty or not used for the right person. Staff told us this should not be happening and was an example of poor practice, which would be put right immediately.

We recommend that the registered provider reviews and implements advice and guidance regarding effective infection control practices.

We saw gloves and aprons available around the home and in use during our visit. We also saw housekeeping staff on duty and spoke to the home services manager, who described how cleaning schedules were kept on cleaning trolleys to record that cleaning procedures had been undertaken.

We spoke with the property manager who described the arrangements in place to ensure the safety and maintenance of the premises and equipment. The registered provider had a fire risk assessment which had been completed by a specialist company. The most recent fire drills had been undertaken during May and July 2016. Records showed that regular maintenance testing took place to ensure fire equipment was in safe working order. Routine inspection and servicing of equipment had also taken place, including gas appliances, electrical installations, manual handling equipment and legionella testing. There was a meeting planned for the week following our inspection to discuss the on-going maintenance plan for the next five years.

Systems were in place to report accidents and incidents. The deputy manager described these systems and showed us examples of the actions that had been taken in response to incidents. For example, they had undertaken detailed assessment and analysis of what had happened in relation to specific incidents. This included their explanation of why things had gone wrong and the subsequent action plans which had been implemented to reduce the risk of any reoccurrence.

Requires Improvement

Is the service effective?

Our findings

We spoke with the training manager and other staff and looked at training records for four nurses, three care staff and an agency nurse who regularly worked in the home. We found that individual training records were not comprehensive or up to date and did not evidence that staff had completed the specialist training they needed to do their jobs effectively. The agency nurse's profile and four nurse's training records evidenced only mandatory training and not the specialist skills that were relevant to the unit they worked on. For example, training for tracheostomy, percutaneous endoscopic gastrostomy (PEG, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach), use of syringe driver and palliative care.

Feedback we received from staff about their training varied, with staff confirming that basic mandatory training was available and taking place, but also indicating that there were some gaps where specialist training was needed. For example, nurses told us they needed more in-depth training to meet the needs of people on the Farnham unit and that care staff had a lack of knowledge of specialist needs, with some care staff only having basic care skills. One member of care staff described how they had recently requested training on PEG and urinary catheter care, as they were now caring for people with these medical devices in place, but did not feel fully equipped to manage them. Another member of care staff was now working with people living with dementia, but told us they felt ill equipped to care for people with challenging behaviours.

When we asked management and training staff about the training records, they acknowledged that they were not in order and that some information could not be found. They were able to describe a thorough induction processes that included training and support for new staff and nurses, including staff working alongside more experienced staff until they felt competent working alone. We could see no evidence of an established mentorship programme and management confirmed that this was not yet in place. The management team were able to provide evidence that specialist training had recently been provided to some staff, with further training planned. However, despite these actions by management, staff dissatisfaction with their support and development remained.

Records of staff supervisions and appraisals were incomplete or unavailable. This included the supervision of qualified nursing staff, where there was no evidence of clinical supervisions in their files and staff told us that these were not taking place. We could see that some forms of supervisory support had taken place. For example, the deputy manager told us they had held two clinical governance meetings recently to discuss roles and responsibilities and that this had been classed as supervision. Staff feedback on their supervision and support at Thistle Hill varied. Some staff said they had received recent one-to-one supervision and felt well supported. Other staff said they did not receive supervision sessions and felt there were few opportunities to have a 'voice' in the service as staff meetings did not take place.

We were provided with an overview of staff supervisions and appraisal together with the provider's own policy and procedural guidance. This confirmed that although the manager and her deputy had initiated improved staff support there was still a lot to do in order to establish a consistent and fully operational staff

supervision programme.

Overall we found that staff were not sufficiently competent, skilled or supervised. This was further evidence of a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Staffing.

We spent time observing people's lunch time experiences on both days of the inspection. We found that experiences varied, depending on the unit they lived on and the staff available to assist with meal times. For example, on the Deighton unit we observed lots of staff assisting with meals and the 'all hands on deck' approach appeared to work well. On other units, such as Farnham and North Deighton, we observed staff who found it difficult to provide the support people needed. Some meals went cold as people struggled to manage and had to wait before they were offered assistance. Feedback from people about the meals provided also varied. One person said, "The food is awful sometimes." Another person told us, "I tend to eat in my own room and the meals are often late. They just say that they are terribly busy." Someone else said, "I can be left unattended in the dining room for ages."

We received feedback from relatives that specialist diets were not always well catered for. For example, one relative described how their loved one did not receive what was on the menu because they needed finger foods and subsequently received repetitive meals. During our visit we observed what this person was given for lunch and found that it was not related to the meals described on the menu and was not an appetising, well balanced meal. It also closely resembled what the relative described them eating the day before. On the same unit, we saw one person being served a jacket potato with tinned tomatoes and another lasagne with no vegetables or side dish. The food served during this meal time did not look appetising. We showed these meals to the deputy manager and clinical development nurse at the time, and they agreed that they were not of the quality they expected.

People had not received person centred care that was appropriate and met their individual nutritional needs. This was evidence of a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Person centred care.

The care records we looked at included nutritional assessments and weight monitoring. We saw that professional advice had been sought on how to meet people's needs and that fortified diets were provided if people were at risk or losing weight. Fluid and food intake was being monitored where this had been assessed as necessary. One person whose records we looked at had been identified as at high nutritional risk earlier in the year. They had received increased monitoring and a fortified diet as a result, and had put on enough weight to now be considered low risk. This evidenced that their nutritional needs had been effectively met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The service had a policy and procedure on the MCA and DoLS. The deputy manager was aware of the process for seeking DoLS Authorisations when needed and we saw evidence that DoLS Authorisations were

in place or had been sought appropriately. Staff we spoke with understood that people had the right to make their own decisions whenever possible. We saw evidence of capacity assessments and records of decisions and choices about care. For example, one person's care plans clearly documented that the risks related to a particular health need had been explained. We also noted the inclusion of the person's own choices and their right to make decisions that others may think unwise.

During our visit, we spoke with three visiting healthcare professionals who supported people who lived at the home. All three were complimentary about the way medical cover was organised with Thistle Hill and how they were involved in people's care. There was one named general practitioner (doctor) who acted as the first point of contact for the service, with deputy cover when needed. They provided a weekly visit to the service, coordinating their visit regularly with members of the community mental health team and the community matron, to help provide people with the specialist medical support they needed. One professional told us, "We get to know the patients very well and it works well," and "They [staff] respond appropriately and listen to advice and follow it through." Feedback from the community mental health team included that Thistle Hill dealt well with people with very complex and deteriorating needs, that regular staff dealt with people living with dementia very well and that, from the health professional's point of view, they felt people were getting the care they needed.

Thistle Hill provided people with a comfortable place to live, with suitable general decoration and furnishings in place. A decorator was in the process of painting one of the corridors during our visit. However, we saw that more could be done to adapt the Deighton unit to the needs of people living with dementia and to take account of best practice guidance in this area. Management staff assured us that they were planning new colour schemes and better signage for this unit, with redecoration planned imminently. This was confirmed by the decorator who was working on site at the time of our visit.

Requires Improvement

Is the service caring?

Our findings

We saw that there was warmth and positive familiarity between some members of staff and people who used the service. We observed some good interactions where staff engaged with people positively and in a caring and attentive way. For example, staff speaking calmly and patiently with residents, listening to them and explaining what they were doing. We also saw occasions when staff joked and had fun with people who used the service, enjoying some laughter together. One person told us, "The permanent staff are good and nice." A relative told us, "I am very pleased with the staff and care here. They are gentle with my wife and explain everything – I have observed them."

However, this quality of interaction was not consistent. Our observations showed that some staff on duty clearly displayed a high degree of engagement and commitment, while others appeared disengaged and as if they were going through the motions. For example, not interacting or giving people their full attention whilst assisting them, or interacting with other staff rather than people who used the service. A relative told us, "Some staff are better than others, it's sort of 'good enough'."

We asked people if staff were kind and caring. Some people told us that staff were caring and kind, but this was not universally felt to be the case. A person using the service told us, "I don't like the staff much," and "There needs to be a more individual and personalised approach to care." One relative told us, "There are some good staff who will just muck in, but others keep strictly to their own role and are not helpful." Another relative told us, "They didn't even remember [Relative's] birthday, though they were reminded the day before…. [Relative] gets little to no individual attention, though we have raised this a number of times and made constructive suggestions," and "I bring in plants and they don't get watered." People who were unhappy felt that there was not enough consistency in staff approach and attributed this mainly on the home's staff recruitment and retention difficulties.

Visiting healthcare professionals acknowledged the difficulties the home had recruiting and maintaining a permanent staff team and the impact this had on the consistency of care, but they also spoke highly of the permanent staff who worked in the home and their approach. One told us, "They are very kind, caring and comforting to their residents." Another said, "[Member of staff] and [member of staff] are very good and deal with people with dementia very well."

Staff assisted people in a way which maintained people's dignity and privacy. We saw staff knocked on doors or sought permission before entering people's bedrooms and ensured that personal care was carried out in private. For example, shutting bedroom doors and curtains. Staff we spoke with were aware of the importance of maintaining people's privacy and dignity and able to describe how they did this. However, we also saw that staff were not always available when people called out for assistance/reassurance or needed help with their meals. This had an impact on people's dignity.

People's wishes and choices around privacy and dignity were recorded in their care files. For example, we saw one person had asked staff to inform him about any visitors before bringing them to their room, so that they could decide if they wanted to see them or not. The person confirmed to us that this happened in

practice.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people who used the service and their relatives about the responsiveness of the care people received. Some people were happy with their care and support at Thistle Hill. For example, one relative told us, "They [staff] seem dedicated to their job and visiting arrangements are really flexible." Another said, "I have nothing to complain about, staff are communicative and provide feedback."

Other people were not happy with their care. For example, one person told us, "I am not always informed or involved," and "I am not that happy here. There needs to be more going on and more stimulation and a more individual and personalised approach to care." Another person said, "I don't have enough to do." A relative told us, "There are too few staff who know my wife's specific needs well enough, so I come in every day." Another relative told us how they visited very frequently to make sure their relative ate, drank and had company. Some people lacked confidence in Thistle Hill responding to their needs. This was mainly perceived to be due to the difficulties the home had in maintaining a consistent staff team.

Each person living at Thistle Hill had their own individual assessments and care plans, which were based on the registered provider's formal assessment and care planning paperwork system. The care files we looked at were written in a person centred way and included up to date risk assessments, which were reviewed monthly or as people's needs changed. We saw examples where people had been part of the assessment process and included in the planning and delivery of their care. For example, one person's care plan recorded their activities and interests and the person told us they were supported to retain their independence as much as possible. For example, they were able to join in activities when not in bed and usually attended a session of their choice each week. They also went out weekly into Harrogate using the home's transport bus or a local wheelchair taxi. They told us they were able to maintain their own interests and spoke about their involvement in the community.

However, this involvement and person centred approach was not consistent throughout the records we viewed or in the care some people had experienced. For example, one relative described how putting on a train DVD could help limit the distress their loved one experienced during personal care interventions. They had made staff aware of this, but in their experience this hadn't been put into practice. We also saw that this information hadn't been included in the person's care plan or risk assessment, which provided staff with information and guidance on how to meet their personal care needs. Another relative told us about their frustration regarding the lack of individualised care their relative received, despite their suggestions and requests to staff. They told us, "I have had to ask for care planning meetings and I just hope they start listening and actually doing things now."

Activities coordinators were employed at the service and we received positive feedback about the approach and input from these members of staff. There was evidence of some individualised activities and support being provided to people. However, we also received feedback that what was currently provided did not meet the needs of everyone who lived at the home.

There was a variation in the quality of person centred care people received and how staff responded to

individual wishes and needs. This was further evidence of a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Person centred care.

The service had a complaints procedure, which provided people with information about making complaints and how these would be handled. We saw information about making complaints was displayed in the home's reception area. A complaints record was available and showed what had been done when concerns were raised and how these had been responded to. However, before and during the inspection we received negative feedback from relatives about the way the registered provider responded to complaints, concerns and requests for information. People told us they did not have confidence that their concerns would be listened to or responded to effectively. This particularly related to people's concerns about staffing at Thistle Hill and people's experiences when trying to escalate concerns higher up the organisation. They described a perceived lack of openness in how issues were dealt with by the registered provider and that 'lip service,' rather than lasting improvements, had been made in response to their concerns.

We recommend that the provider review their own internal arrangements to communicate and respond to people who use the service and their representatives in order to improve communications and confidence.

Requires Improvement

Is the service well-led?

Our findings

We found example's where the registered provider's quality assurance systems had not been effective in recognising and rectifying issues at Thistle Hill. Concerns remained which were similar to those identified at our last inspection, regarding the lack of an open and responsive culture within the organisation, where staff, people who used the service and their relatives lacked confidence as to whether their feedback was being listened too.

We received a large variation in feedback from people who used the service, relatives and staff, which was validated by our own observations and findings. People had mixed experiences of care and were not experiencing a consistently good quality and safe service. The majority of people we spoke with, including some members of the management team, felt that this was down to difficulties in maintaining a consistent and well-led team of suitably skilled and experienced staff.

People also felt that there was not enough emphasis on the involvement of people who used the service and their relatives or the importance of effectively listening and acting on their feedback and concerns. People told us they did not have confidence that their concerns would be listened to or responded to effectively and were frustrated by this. For example, one person told us, "We just have to put up with agency staff who don't know us and we don't know them. There just aren't enough of them – with management it just goes in one ear and out the other…They are only interested in profit and satisfying their investors." A relative said, "They say they have the DICE tool [used to determine staff levels] and are trying to recruit, that's all we ever get, not an effective response." Another relative told us, "There has been too little engagement with relatives and residents – though this has started to change recently."

We found evidence of poor management and leadership through staff dissatisfaction with their support and development. Many staff we spoke with did not feel valued by the establishment, saying there was a lack of investment in staff retention and they lacked a voice in decision making within the service. We could see the new management team was taking steps to address this, but there remained a strong feeling of dissatisfaction within parts of the staff team.

The registered provider's representative was aware of the staffing situation and the challenges this posed at the service. However, during our feedback we found them reluctant to accept the full impact that staffing issues were having on people's care experiences, stating that the care provided was not 'usually like' what our findings showed . We found a disconnect between the views of senior management and what people who used the service and their relatives told us about their experience of living at Thistle Hill. This had also been apparent in a recent relative's meeting, where relatives had acknowledged the efforts of local management, but expressed frustration with 'head office' and the 'hierarchy in Barchester.'

The management team explained the actions they had taken and were continuing to take to try and address the staffing situation and could evidence that improvements had been made. For example, there had been a large reduction in the number of agency staff used, due to on-going recruitment and retention initiatives. They maintained that the changes that were needed could not be achieved quickly, but they were taking

appropriate actions to make improvements at the service.

We found that some record keeping at Thistle Hill needed to improve. Up to date and full records relating to staff recruitment, training and supervision were not available. Staff were not receiving sufficient one-to-one supervisions and opportunities to share their concerns and ideas for the service. We found examples where care records were of inconsistent quality. For example, fluid intake charts and positional change charts were completed well on some days and had unexplained omissions and poor recording keeping on others. Care plans had not always been updated to reflect changes that were recorded within monthly evaluations or evaluations were missing.

A nutrition and fluid intake audit had been completed in January and February 2016, which had identified poor outcomes for people living on the Deighton units. Since then improvements had been made and we saw evidence that overall people's nutritional needs were being met. However, we also saw that people's experiences still varied, with examples where people did not receive good quality food or timely, person centred support with eating.

Our findings during this inspection, including breaches of regulation, evidence that effective quality and governance systems were not in place. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Good governance.

Since our last inspection a new registered manager and deputy manager had come into post, to help provide consistent management and leadership. Feedback we received about the registered manager and deputy manager and their efforts was generally positive and we saw evidence of their efforts to tackle issues and make improvements. One staff member told us, "I find [registered manager] very, very approachable, very supportive, she listens to what I say, lets me have my little moan and her door is always open."

The three health care professionals we spoke with recognised that the service still faced challenges around the recruitment and retention of staff, but that everyone was working very hard to make improvements. They felt care and nursing staff were trying their best and needed support. Comments included, "I can't praise the regular staff enough," "I think Thistle Hill is on the up," and, "It really does seem that the manager and deputy are turning things around."

Meetings for relatives and residents were now taking place and had been planned three monthly for the rest of the year. The records of these meetings showed frank discussions between the registered manager, deputy and relatives about the service and its challenges. Records were also available of recent meetings held with staff, including heads of department meetings.

There was a monthly clinical governance meeting between the deputy manager and unit representatives. This meeting took into account the monthly clinical governance report that was based on information about accidents, incidents, tissue viability, nutrition and other clinical aspects of care in the home. The meeting record we viewed showed that relevant training and practice improvement points had been considered and discussed. Daily 'stand up' meetings helped with communication and the 'resident of the day' scheme helped to focus on the individual needs of a particular person. The regional director and clinical development nurse had also undertaken quality audits at the service, to support the local management staff. Records of these were available and included plans of action to address issues the audits had identified.

During our inspection we observed that the provider was displaying the CQC rating given during the last inspection on their website. Displaying a regulated service's CQC rating is a legal requirement. We had also

received formal notifications about events at Thistle Hill, in line with legal requirements.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate or adequately reflected the needs and preferences of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users, because persons providing care and treatment did not have the competence, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems or processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed.