Telford Lodge Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
•□Telford Lodge is a residential care home that provides care for up to 45 people, some living with the experience of dementia. The accommodation is provided over two floors divided into six zones. At the time of the inspection 34 people were using the service. This is the only location for Telford Lodge Care Limited which is registered as a charity.

People's experience of using this service:

•□During this inspection we found that incident and accident forms did not always provide effective guidance about what preventive measures to put in place or reflect the cause of the incident. As at the previous inspection, care plans were not always being updated to reflect incidents. Risk management plans were not always robust enough and lacked detail and effective guidance to mitigate risks. They were also reactionary rather than preventative. This meant the provider was not assessing, monitoring and mitigating risks to people to help minimise their exposure to the risk of harm.

•□Checks for the environment were not carried out consistently and the home was not dementia friendly with distinctive features to help people with dementia care needs orientate themselves.

•□The provider did not ensure medicines were always managed safely, and audits did not always identify discrepancies to help ensure people receive their medicines in a safe way. For example, when people were administered as required medicines regularly there was no evidence that referrals were made to the GP to review these medicines in accordance with the policy.

•□We saw evidence of staff training but not of how it was being monitored so staff remained up to date with their training and the provider knew when training was due.

•□The provider did not always follow the principles of the Mental Capacity Act 2005 (MCA). Information around people's mental capacity to give consent was not clear and was sometimes contradictory. Deprivation of Liberty Safeguard (DoLS) applications were not always applied for and followed up in a timely manner.

•□People's pre-admission assessments and changes in their needs were not always reflected in their care plans. Therefore, people may not have been cared for in a way that met all their needs.

•□Care plans we viewed did not always identify people's wishes or provide clear guidance to staff for the delivery of care in a person-centred manner. Key working sessions were used to involve people in planning their care. However, we saw that key working sessions were not being held regularly with all people using

the service and therefore not everyone had the opportunity to develop their care plan.

•□Activities were not always meaningful and people we spoke with did not always want to take part as the activities on offer were not ones they were interested in.

•□The provider had a system to deal with complaints. There had not been any since the last inspection.

•□The provider did not have effective systems in place to monitor, manage and improve the quality of the service delivery and to improve the care and support provided to people.

•□We saw there were procedures for reporting and investigating allegations of abuse and whistle blowing. Staff we spoke with knew how to respond to safeguarding concerns.

•□People's needs had been assessed prior to moving to the service and care plans included people's background and some personal history.

•□The service liaised with other professionals and we saw evidence that people were supported to access healthcare services appropriately.

•□We found six breaches of regulations in relation to person-centred care, consent to care, safe care and treatment, premises and equipment, good governance and fit and proper persons employed.

Rating at last inspection:
•□Previously, at the November 2017 inspection we found five breaches and rated the service requires improvement. At the inspection in May 2018 we found eight breaches. Five of those were also breaches identified in the November 2017 inspection. The service was rated Inadequate and placed into special measures.

•□The last comprehensive inspection was 3 and 4 January 2019. We found two previous breaches had been fully met, three remained, and there were three additional breaches of regulations. We rated the service inadequate overall. The report was published on 6 March 2019.

Why we inspected:
•□This was a planned inspection based on the previous rating.

Enforcement
•□We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

•□The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This is the third time the service has been rated inadequate.

•□Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

•□The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

•□If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

•□For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up:
•□We will monitor all information received about the service to understand any risks that may arise and to ensure the next planned inspection is scheduled accordingly. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Telford Lodge Care Limited

Detailed findings

Background to this inspection

The inspection:
•□We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
•□The inspection was carried out by two inspectors, a member of the medicines inspection team 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.

Service and service type:
•□Telford Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

•□The service did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
•□This inspection was unannounced.

What we did:
•□Before the inspection, we looked at the information we held on the service including the provider's last inspection, notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding team to gather information about their views of the service.

• During the inspection we observed how staff interacted with people. We spoke with five people using the service, one relative, two team leaders, four care workers, the deputy manager, the new manager, the nominated individual, the chair of the committee and the management consultant.

• We viewed the care records of six people using the service and seven staff files that included recruitment. We looked at training, supervision and appraisal records for all staff. We also looked at medicines management for people who used the service and records relating to the management of the service including service checks and audits.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

•At the inspection on 3 and 4 January 2019, we identified a breach of regulation relating to safe care and treatment. This was because incidents were not always recorded or actioned appropriately, risk assessments did not always cover relevant risks and were not always robust enough, arrangements for managing medicines were inconsistent and unsafe and we observed some poor practices regarding infection control and environmental safety. During the inspection on 2 and 3 April 2019, we found the provider had made some improvements, but several areas still required improvement and they were not fully compliant with the regulations.

Assessing risk, safety monitoring and management
•At the inspection in January 2019, incident and accident forms did not contain detailed investigations or outcomes and people's electronic Care File / Risk Assessments were not always updated to reflect the incident. At this inspection the incident forms we saw did not have information about the underlying cause of the accident/incident and preventive measures in place to help prevent the accident/incident from reoccurring.

•At the last inspection we noted under Positive Behaviour in one person's Care File/ Risk Assessment, it was recorded the person was at 'Very High Risk' of becoming 'easily agitated and aggressive'. The trigger was '[Person] does not like being told what to do.' The interventions included staff to speak with the person calmly, explain why the person needs support with certain tasks and 'Team Leader to administer medication when showing challenging behaviour.' The plan lacked any strategy to manage the person's behaviour with other people to prevent escalation, did not, as indicated in the incident form, note the person was to be supervised and did not give details of when it was appropriate to administer medicine to help manage the person's behaviour. At this inspection we saw there had been no changes to the file and it remained written up as at the previous inspection and therefore no action had been taken to mitigate potential risks to the person and others.

•At this inspection we reviewed 15 incident and accident forms completed since 10 January 2019. As at the previous inspection the action to manage behaviour that could challenge the service was not detailed enough. On 14 January 2019 a person hit a member of staff, but the only action recorded was for staff not to go too close to the person if they were aggressive. On 16 January 2019, the same person slid from their wheelchair to the floor. The action stated as the person gets aggressive or agitated sometimes, staff have to monitor them and inform the team leaders of any changes. Although the person had displayed behaviour that challenged twice in two days, there was no indication that underlying causes or triggers had been considered so preventative measures could be implemented. Information provided was general about what to do once the behaviour had occurred rather than providing proactive guidance on how to support the person and de-escalate the situation. This meant the provider did not ensure care workers had appropriate

guidance to support the person's health and wellbeing.

•□We viewed an incident and accident form for an incident on 1 April 2019 where a person fell from their bed trying to trigger the sensor mat to call care workers instead of using the call bell. The incident and accident form stated the accident was recorded in the care plan and risk assessments, but the person did not have an updated care plan and there was no record of this accident in the current care plan.

•□Another person had two incidents recorded on 9 and 13 February 2019 where they were found on the floor by their bed. On the 9 February the person was found sleeping on a floor mattress. The management report stated staff were to supervise the person at night, which was too vague to be effective. On the 13 February the person was again found on the floor with a bump on their head and the action was for staff to undertake two hourly checks. However, we saw no record of two hourly checks being carried out. The person's care plan stated they had a crash mattress next to the bed to reduce risk of injury from falls from the bed but also stated they preferred to sleep on the floor mattress and that a senor mat should be in place to alert staff to movement. During the inspection a care worker on the unit told an inspector they were not aware of the person sleeping on the floor mattress. The care worker confirmed the person was sleeping in their bed and there was no sensor mat used at night. This meant the actions identified in the incident and accident forms and care plan were not accurate.

•□The care plan also stated there should be checks undertaken at 30 minute intervals as the person was unable to use the call bell and may call out for help. The daily logs however confirmed that the care plan was not being adhered to and was therefore not effective. Of concern was that the person could not use the call bell and night checks were infrequent. We looked at daily logs for four nights and saw on 30 March checks at 2.19, 3.37 and 7.15am. On the 31 March checks were recorded at 00.26 and at 2.45am with no other checks until personal care at 7.32am. On 1 April there were two checks at 00.48 and 2.50am and on the 2 April 00.48 and 2am.

•□We saw a number of people had instructions in their care records for 30 minute checks which were not being carried out. The managers told us 30 minute checks was a default setting on the electronic records and people did not need 30 minute checks. This had not been picked up by the management during any of their checks and it was an unsafe practice as it meant it was not clear who did and did not require checks. In the previous example, the person could not use the call bell and was at risk of falling, but we found little in place to mitigate risks. The lack of clear guidance meant appropriate action may not have been taken to reduce identified risks.

•□We viewed an incident form dated 21 January for a person who fell near their washbasin. The action on the incident form was to use a sensor mat and encourage the person to use the sink appropriately. The time of the accident was recorded as 9.10am but the person was not taken to hospital until 11.45pm. They were admitted to hospital and returned home using a wheeled frame. There was no record of the accident in the care plan even though the incident and accident form stated the care plan was updated.

•□We found at the last inspection people's risk assessments were not individualised enough and risk management plans were not robust enough to mitigate identified risks. At this inspection we saw this remained the case. One person's personal emergency evacuation plan (PEEP) stated they used a wheeled trolley and could be confused and agitated. The person's bedroom was on the first floor and their mobility care plan stated they were unable to use the stairs. However, the PEEP did not include how the person could be evacuated as they were unable to use the stairs and the lift would not be available during an emergency evacuation.

•□The provider did not always take appropriate action to mitigate potential risks. A key working session for one person on 10 October 2018 recorded that the person stated they were coughing when eating but there was no record of what action was taken. During a care plan review completed with the person on 6 November 2018 it was again recorded that the person was coughing when eating. The action was a GP referral. However, there was no record of a referral being made to the GP or the speech and language therapy (SALT) team. The deputy manager told us a referral had been made to the GP but was unable to show us evidence of the referral or an outcome. Additionally, the care plan and risk assessments made no reference to the person coughing when eating and therefore there was no guidance on how to manage the potential risk of choking.

•□The provider had some checks regarding the safety of the environment, but these were not consistently carried out. At the last inspection we saw checks to keep people safe in the event of a fire included a fire risk assessment by an external company in October 2018 which recommended emergency evacuation chair training, which at the time of the inspection had not yet been undertaken. Although we specifically asked to see evidence of the training at this inspection, the provider was still not able to show it to us.

•□At the last inspection, daily fire door and exit checks were not being completed daily. At this inspection we saw they were. However, the daily checks for the fire alarm panel were not completed on March 2, 3, 9, 10, 16, 17, 18, 23, 24, 30 and 31. The fire evacuation plan was reviewed monthly, but we saw people's PEEPs were dated August 2018 and did not always reflect their current state of mobility. The weekly fire extinguisher checks were last completed 20 March 2019 and the weekly fire alarm testing was last recorded as 7 January and 20 February 2019. This meant the provider was not always mitigating identified risks. Maintenance checks were completed for the water and electric systems, lifts and baths and there was an up to date gas safety certificate.

Using medicines safely

•□At the last inspection we found medicines were not always being managed safely. During this inspection a member of the CQC medicines team reviewed 15 medicine administration records (MAR) and 10 care plans. They observed medicines administration, spoke with five staff and two people who used the service and found the provider had not made sufficient improvements for managing medicines since the last inspection.

•□At the previous inspection there were no systems to manage medicines alert. In this inspection there was a system in place to receive medicines alerts.

•□At the previous inspection we found that the provider failed to assess the competency of staff handling medicines. At this inspection we found the provider still could not confirm that all staff who administered medicines had up to date medicines training and had been competency assessed to ensure they handled medicines safely.

•□During the previous inspection we found care plans did not have guidance for staff on the side effects of medicines. In this inspection we found care plans outlined the support people needed to take their medicines. However, information was not always person specific. Care plans did not have information about people's current medicines prescribed to them and the associated side effects.

•□Staff did not follow the provider's own medicines policy. Staff transcribed on medicines administration records (MARs) without records of a second check in line with the policy. Records did not always show why people were given 'when required medicines' by staff as outlined in the providers medicines policy. When

people were administered these medicines regularly there was no evidence that referrals were made to the GP in accordance with the policy to review these medicines.

•□At the previous inspection we found staff did not administer people's medicines as prescribed. At this inspection we found that there were no systems in place to action changes to people's medicines when they were seen by other medical prescribers.

•□At this inspection we found medicines were not always stored securely when staff administered medicines to people. Medicines trolleys were left unlocked and unattended in communal areas of the home while the staff were administering medicines.

Preventing and controlling infection
•□The provider had an infection control policy reviewed in October 2018 to help protect people from the risk of infection and was completing health and safety audits with actions required. During the last inspection we saw a tick list of daily cleaning for each zone. However, when we checked the cleaning tick lists in individual toilets and bathrooms, we found they were not being completed daily. At this inspection we found cleaning lists were still not being completed daily. In addition, we found that two cleaning lists in zone 3 toilets on the first day of the inspection that had gaps in recording had been retrospectively completed by the second day of the inspection. As before, there was no cleaning schedule for the hoists or slings to monitor that these were being regularly cleaned.

All the above was a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
•□Most people using the service and their relatives told us they felt safe. One person said, "I don't feel safe, I can't lock my door" but other comments were more positive and included, "Yes I enjoy living here and I feel safe", "I feel safe, there is no interference", "I do feel safe here. I like my room it's nice and I have a key to my room" and "I think [person] is safe."

•□The provider had safeguarding adults' policies and procedures in place and staff knew how to respond to safeguarding concerns.

Staffing and recruitment
•□People using the service were generally satisfied with the number of staff available to meet their needs. One person told us that they thought the home did not have enough staff but other people said, "There is enough staff", "Sometimes too much staff" and "Every time I've been here, I've always seen plenty of staff." Care workers we spoke with said, "There is enough staff but some staff do not do as much as they should. In the morning time we are busy but after that it is good" and "Enough staff to support people with meals. Enough staff throughout the day".

•□A team leader told us they and the management consultant were working on a new allocation rota so there would always be one staff member in the dining room. In the morning, all the people who needed one care worker to support them with personal care were supported first, then two care workers supported the remaining people requiring two care staff for support. This meant most people were in the dining room at 9am for breakfast so they had time for morning activities.

•□At the last inspection we looked at the recruitment files of two staff members employed since the last

inspection and found the provider had not carried out sufficient checks of their suitability to care for people using the service. At this inspection we found sufficient recruitment checks had been undertaken for new staff including agency staff checks.

Learning lessons when things go wrong

•□As demonstrated above there were a number of areas of concerns that were identified at the last inspection that the provider had not taken action to improve, for example care plans and risk assessments.

•□Actions from incidents and accidents were at times too vague to be effective. The provider was unable to produce the incident and analysis logs during the two days of inspecting and sent analysis for November 2018 to March 2019 to us after the onsite inspection was completed. As before, analysis did not look at the underlying causes of the incidents, and the action taken and future action to prevent reoccurrence which was often not detailed, specific, measurable or targeted. For example, February 2019's analysis recorded as action, 'Continuous staff training in safeguarding and challenging behaviour. Staff becoming confident in dealing with challenging behaviour situations' and the lessons learned was recorded as, 'Staff are more vigilant and better at anticipating causative factors for falls. The number of falls has decreased.'

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

• At the inspection on 3 and 4 January 2019, we identified breaches of regulations relating to premises and equipment, need for consent and staffing. This was because we found the provider did not follow best practice guidance for dementia friendly environments and that the provider had not ensured that the environment was safe or suitable. We also found the provider did not always follow the principles of the Mental Capacity Act (2004) and that staff training, supervisions and appraisals were not always up to date. During the inspection on 2 and 3 April 2019, we found the provider had made some improvements, but we found several areas that still required improvement and where they were not fully compliant with regulations.

Adapting service, design, decoration to meet people's needs
• Telford Lodge is laid out over two floors. The ground floor has a large dining room that serves both floors with access to an enclosed garden. Each floor has two lounges and hallways with bedrooms. The home is divided into six zones. We saw, as we had at the last inspection, that the bedroom doors all had the sign of a bed and occupier's name and keyworker's name written on them. Some had pictures of flowers, butterflies or owls but these were all the same. As noted at previous inspections the doors and hallways were not distinctive enough, did not have enough clear signage and there were no noticeable landmarks to use as reference points particularly for a person living with dementia, to orientate themselves.

• People using the service were able to decorate their rooms to their own tastes, but we saw where people were dependent upon the home to support them with this, some rooms required updating.

• At the last inspection we saw examples to indicate the environment was not meeting people's individual needs and that the provider had not ensured that the environment was safe or suitable. At this inspection we found improvements were still required. The internal fire door to exit four took two inspectors six attempts to open it, which meant in the case of an emergency, people who could evacuate independently and staff assisting other people might be delayed evacuating the premises should they attempt to use that exit.

• At the last inspection we observed the hairdressing salon door to be unlocked. A brick was being used to stabilise a broken hairdryer and there were cleaning products that could have been accessible to people using the service. We also observed the staff room to be open which meant people could access the toaster and kettle. At this inspection, on the first day, we saw both rooms were open and issues we highlighted at the last inspection such as the brick and broken hairdryer had not been addressed. Therefore, people remained at risk of harm because risks associated with their environment were not mitigated and made

safe.

•□We also noted during our observations around the premises a shower room in zone 6 had three pairs of shoes and garden chairs in it. The ladies toilet on the first floor had a sign saying 'out of order' but the door was unlocked meaning anyone could still access it. At the last inspection we noted one person was using a zimmer frame to prop their door open. At this inspection we saw that person's door was closed, but another person's door was held open with a zimmer frame. Leaving the door open with a zimmer frame could pose a risk in the event of a fire.

This was a repeated breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□At the last inspection we saw the provider did not have enough tables for people to use in the lounges to place drinks and meals on. At this inspection we saw they had purchased more tables.

Ensuring consent to care and treatment in line with law and guidance
•□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.

•□We found that the provider was not always working within the principles of the MCA. Information was generalised and standard phrases were used in people's care records which meant the plans were not always person centred. Information around people's capacity to consent was not clear and sometimes contradictory. For example, one person's care plan stated the person 'may lack capacity' to make decisions about their care. It then stated the person 'does lack capacity' to make complex decisions and they are unable to make any decisions about their day to day care so they should be made in their best interests. The care plan contradicted itself again by stating the person was 'unable to sign but gave verbal consent to their care'.

•□Another person's care plan recorded the person was unable to sign that they consented to their care but they had given verbal consent. There was no metal capacity assessment available and the MCA care plan was not clear if the person did have capacity to consent to their care or why they could not sign their consent but could verbalise it. However, the care needs summary dated 28 February 2018 recorded the person did not have capacity to make informed decisions.

•□A third person's care plan stated in the same section that they had the capacity to make specific decisions about their care and treatment but three paragraphs down it stated they could not make decisions about all their day to day care, therefore decisions were made in their best interests. We did not see a capacity assessment for best interest decisions. The care needs summary was also contradictory as it stated the person may lack capacity to make decisions but went on to state they are fully able to weigh up, understand and retain information and can make decisions.

•□One person who we identified at the last inspection as having a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) transport document in place from November 2017 did not have clear information about their resuscitation status while living at the home, only for being in transit. This remained the same at this inspection.

•□When people required a DoLS authorisation to restrict their liberty, we saw a number of people did not have authorisations under DoLS and although the provider had submitted new applications, there was a delay between the old DoLS authorisation expiring and reapplying for a new authorisation. For example, one person's MCA and DoLS section of the care plan stated their DoLS was authorised 19 July 2017 and there was no record of a new application being made. A second person's DoLS had expired on the 18 March 2017. A new DoLS was applied for on 11 October 2017 but a lack of follow up meant the person still did not have a current DoLS authorisation in place at the time of the inspection. Another person's care plan indicated there was a DoLS in place but did not have the date of when it was authorised, which would have informed the provider when they needed to request a new authorisation.

•□The managers told us the contradictions were in part due to how the electronic system operated and that they had contacted the IT provider to try to resolve the situation. However, the provider's checks had not identified all of the concerns we had identified in relation to the MCA and DoLS prior to the inspection.

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

•□People who used the service told us their freedom was not restricted and that they were able to move around the home, stay in their rooms as they wished, go on outings and stay in contact with friends and family. Comments included, "I have visitors anytime", "I can go out. I go occasionally to the general store" and "My relatives can phone me."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□People's needs were assessed prior to moving to the home to confirm their needs could be met by the provider. Only two people had been admitted to the home since the last inspection. Both had initial assessments, but one person's pre-admission assessment was not reflected in their care plan. The care plan had not been reviewed since their previous stay at the home in September 2018 and an updated care plan was not completed until identified at this inspection.

Supporting people to live healthier lives, access healthcare services and support
•□People using the service were registered with the local GP and had appropriate access to healthcare services. People and their relatives told us, "I have seen the doctor here and the optician", "I usually go to the doctor and I have the chiropodist" and "[Person] sees the doctor and has chiropody and the optician."

•□However, changes in people's needs were not always reflected in the care plan. For example, we saw a letter on one person's file from the Cogitative Impairment and Dementia Services dated 15 March 2019 which directed a change in medicines dosage, but this was not reflected in the medicines administration records (MARs) and we did not see a follow-up with the GP to review the person's medicines. This meant staff were not following through on changes in the medicines regime of people to ensure they received the right dose of the medicines.

•□Another person had a discharge letter from the hospital dated 17 March 2019 requesting a review by the GP and a change in medicines dosages. However, at the time of the inspection there was no record of a GP

visit and the medicines dosages had not been changed.

•□Additionally, the person had a health condition that was not recorded in the health section of the care plan or included in the Waterlow or tissue viability assessments.

The above four paragraphs show that people were not always supported appropriately with their healthcare needs and in a way that met their needs. This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support; induction, training, skills and experience
•□During the inspection care workers told us they had an induction and shadowed a more experienced care worker when they started working in the home. Training was completed predominantly on line, and after the inspection the provider sent us a training data base. We saw three care workers shown on an employee list who were not on the training list. One care worker employed since April 2018 had only completed four courses and this did not include training considered mandatory by the provider such as safeguarding adult training.

•□At the last inspection we saw one staff member had scored less than 50% in their online training for care planning, DoLS and moving and handling in April 2018. This meant they did not have a robust knowledge in those subject areas and the provider had not taken action to address the shortfalls in the person's knowledge to ensure the member of staff had the appropriate knowledge to care for people safely. At this inspection we specifically asked for evidence to demonstrate the provider had supported this care worker to improve their skills but they were unable to provide this which meant the provider had not taken action over concerns highlighted in the last inspection report and the care worker had not been assessed as competent in the identified areas of care.

•□We also saw that for moving and handling training, four care workers had not completed the training but they had undertaken a manual handling assessment and three care workers were overdue their manual handling training which meant we could not be confident they had the skills required to carry out their roles.

This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□The managers told us that a trainer had been recruited to provide face to face training with staff and that staff would be undertaking level two and three QCF training and care certificate training every week.

•□Of the seven staff files we looked at, only one person had received one to one supervision in 2019. However, staff told us that they had been having supervision more recently and the management consultant had been undertaking supervisions jointly with the team leaders to establish a base line for training needs. One staff member told us, "We have more support and are making positive changes. [Management] have been trying recently to include the staff and have been giving a lot of feedback. They are trying to communicate. Handover was in the morning and the evening only but now includes everyone including domestic staff, kitchen staff, maintenance and care staff."

•□People we spoke with were generally positive about the knowledge and skills of the staff. Comments included, "They look after me very well", "I'm quite contented with how things are going. I hope it will continue" and "They help me with a shower."

Supporting people to eat and drink enough with choice in a balanced diet

•□Comments about the food was mixed. People and their relatives told us, "The food is alright, there is a choice", "The food is not to my liking, but I eat it anyway. I'm not fussy", "They can't cook my food [cultural dishes]. They try but it's no good", "Sometimes the food is very good, sometimes not so good" and "It's debateable the food. I know [person] eats it. The pork chops are a bit dodgy."

•□We saw that menu choices were offered in the morning and if people did not want what was on the menu, the cook provided other options of the person's choice. Since the last inspection, more people were eating in the dining room, instead of the lounges. The dining room was bright and had fresh flowers on the tables. Where required, we observed staff supporting people appropriately with their meals.

•□The kitchen had a picture menu but it was not in use. We did not see any indication of people's likes or dislikes in the kitchen. When we asked about this, staff told us when people arrived at the home, they told the cook then about their likes and dislikes and it was recorded in their care plans. The kitchen did have a record of people's specific needs such as high blood pressure or diabetes, to provide guidance on people's dietary needs. Staff told us that information around menus from relatives' meetings was fed back to the kitchen staff to act on.

•□The staff told us they bought their meat fresh from the butchers and meals were cooked from scratch but we observed there were weekly frozen deliveries. For example, on the second day of the inspection for dinner, we observed people were served chicken nuggets cooked from frozen, spaghetti hoops, ham and ready made tomato soup which were all processed foods.

•□In January 2019, the home received a food hygiene rating score from the local authority of three which meant the home's hygiene standards were generally satisfactory.

Staff working with other agencies to provide consistent, effective and timely care

•□Staff told us communication in the home was better and was improving the way staff worked together. Handovers now included catering, domestic and maintenance staff as well as care workers so all staff had an understanding of any issues to be aware of on the day.

•□We saw evidence in people's files to indicate the staff were liaising with other professionals in health and social care to meet the needs of the people using the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

•At the inspection on 3 and 4 January 2019, we identified a breach of regulation relating to dignity and respect. This was because we found care workers did not always support people appropriately at mealtimes, were not always respectful in how they shared information and the television and radio entertainment did not demonstrate consideration for the likes or dislikes of the people listening to it in the lounges. During the inspection on 2 and 3 April 2019, we found the provider had made some improvements and were compliant with the regulation.

Supporting people to express their views and be involved in making decisions about their care
•The managers told us that people were involved in planning their care through key working sessions. However, we saw that key working sessions were not being held regularly with all people using the service and the information received by staff during key working sessions was not always followed up, as in the example of the person who was coughing while eating but not referred to the GP. This meant that people may not have always been receiving the care they either required or wished.

•People's views were not always taken into consideration. One person had a cartoon picture of a cat on their door. When we asked if they had chosen this, they said no it was put there without consultation.

Ensuring people are well treated and supported; equality and diversity
•Interaction between staff and people using the service was not always positive. For example, we saw a member of staff in the lounge watching television with the residents but not interacting directly with them and on another occasion we saw medicine put down on the table in front of someone with no communication about what it was.

•Notwithstanding the above, we saw examples of good interaction between staff and people using the service. For example, one care worker in the dining room, chatting with everybody and coming down to people's level to talk if they were sitting. We saw one person make a face when they had their juice and staff responded by noting it was too sour for the person and getting them something sweeter. Staff explained to people what was on their plate when they presented it to them. We saw people were addressed respectfully by the name they preferred, for example by their first name or 'Mr' or 'Mrs'. Some staff were able to speak with people in their first language.

•People and relatives we spoke with said that generally the staff were friendly and kind. Comments included, "Service with a smile, what a bonus", "The staff are very good and caring" and "[Person] is treated like the queen. They get what they want."

•□Staff we spoke with needed prompting to provide examples of how they made sure people were supported in a non-discriminatory manner that met their individual needs. Staff told us that they met people's needs by asking what they would like but were unable to provide specific examples. One care worker told us, "Asian people like Asian food. We arrange the menu for their choice. Some people go to the temple once a week. Some residents we arrange the transport to go to church or they come here. Some Asian people need a shower early morning. You have to value their opinions."

•□People's care plans contained personal information, a work history, hobbies, activities they liked to do and religious needs.

Respecting and promoting people's privacy, dignity and independence
•□We found that people were not always afforded privacy and dignity as we saw recorded in the daily logs, that when one person refused to have their incontinence aid changed in their room, it was changed in the communal lounge.

•□However, people we spoke with reported staff were respectful because they knocked on doors and asked people if they wanted their doors left open or closed when they were in the room. One person said, "They always give my door a couple of taps [before coming into the room]."

•□Care workers we spoke with about treating people with respect and promoting independence said, "I close the door and curtain. I support them to have a strip wash. I ask if they wanted a shower or a body wash. I ask them what they would like to wear today", "We ask them first. If they give us permission then we will do. With [person] we are always asking them. Today I gave them personal care. I knocked the door and asked if they wanted to get up and they said yes so I helped them" and "We ask them first and if they like to do. We try to encourage them to play more games and create more activities, on a nice day we take them out in the garden.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:People's needs were not always met. Regulations may or may not have been met.

•At the inspection on 3 and 4 January 2019, we identified breaches of regulation relating to person centred care and receiving and acting on complaints. During the inspection on 2 and 3 April 2019, we found the provider had made some improvements and were compliant with the regulation around complaints but had not met the regulation fully for person centred care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•In terms of being involved in their care plan, one person told us, "I think I did some paperwork when I came in" and a relative said, "We sat in a quiet room and did a care plan and it was updated not long ago." However, the care plans we viewed did not always identify people's wishes or provide clear guidance to staff for the delivery of care in a person-centred manner. The electronic system recorded standard phrases about meeting people's needs and similar objectives. For example, in dementia care plans we saw a number of plans that had exactly the same action plan guidance. A standard phrase was, 'Ensure [person] has at all times any memory aids [they] rely upon'. This was a general statement and did not clarify what the specific aides were. The chair of the committee told us that since the last inspection in January 2019, they had not yet had time to make changes to the system as the new manager had only started on 1 April 2019.

•One person's care plan did not identify what their preference was for washing, for example a strip wash or a shower. Nor was the frequency of how often they would like to be washed recorded. This person's care plan also said to keep the person's mind busy or they become distressed but there was no guidance on how to keep them occupied.

•A second person had a urinary catheter and the daily records showed that they had had blood in their urine most days from 25 March 2019. We saw evidence that the person had visited the hospital on the 31 March 2019 as their urine bag was full of blood. However, this issue was not transferred to the care plan or risk assessment. The care plan provided guidance for what to do if the person pulled the catheter out but not how to respond if the person had blood in their urine.

•At the last inspection we found one person was sleeping on a chair in the lounge. At this inspection we saw the care plan had not been updated with guidance on their sleeping arrangements, even though this issue was highlighted at the last inspection. For example, where it was appropriate for them to sleep and how best to support them and make them comfortable sleeping in a chair.

•Another person's care plan recorded they liked to have a shower or strip wash but no frequency of how often. The person's continence care plan stated that they were doubly incontinent but there was no record of the person being assessed for incontinence aids.

•□Some care plans we viewed provided inaccurate or out of date guidance. For example, one person's care plan recorded they were fully continent, but their daily records stated their incontinence pads were being changed daily. The care plan also said the person required 30 minute checks during the night but they were having on average three per night.

•□The home had an activity co-ordinator. However, the only activities we observe over two days included a singer one afternoon and chair exercises such as passing a balloon or ball around. One care worker told us activities included, "Passing the balls, playing the music, dancing and watching BBC news." Another staff member said, "Activities is an aspect we need to try and improve. The board games are for children."

•□The manager told us they planned to improve the activities programme. However, at the time of the inspection, activities were not meaningful and people we spoke with did not always want to take part. People using the service said, "They come from the church in Southall", "I don't want to do the activities", "They will organise activities. I haven't taken part" and "I like the singer. I don't want to play bingo. I went up to London to see the [Christmas] lights." A relative said some people had been to Brighton but they arrived, had a sandwich on the bus and then came back home, so the outing lacked meaning.

End of life care and support

•□At the last inspection we saw care files had a section for people's end of life wishes but we did not see one that was completed. They all recorded that people were unsure and there was no record of the conversations staff had with people to explore this area. At this inspection we saw no changes to the care plans had been made and end of life wishes were mainly recorded as people being unsure of what their wishes were. Under end of life wishes for one person who had moved to the home since the last inspection it stated they did not need an end of life wishes plan. The above showed that staff lacked confidence and were not adequately supported to discuss end of life care issues with people or their relatives, so these needs could be appropriately assessed and planned for.

All of the above show a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

•□At the last inspection we found the provider was not managing complaints effectively. At this inspection we found there had been no complaints since the last inspection for us to view to see if improvements had been made. One person we spoke with about making a complaint said, "I've never had to make a complaint" and a relative said, "Any complaints I have made have been sorted in days."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

• At the inspection on 3 and 4 January 2019, we identified breaches of regulation relating to good governance because quality assurance systems to monitor the service delivery were not effective. There was a lack of experienced leadership and people's health and care needs were not monitored robustly to ensure these were met. During the inspection on 2 and 3 April 2019, we found the provider was still not meeting with the regulation.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

• During the inspection we saw that the provider did have some audits in place such as the 'Telford Lodge Providers visit' where a member of the committee checked that the service was compliant in specific areas such as medicines, finance and care plans. The provider also had an audit tick list for the deputy manager and the team leaders. However, these were not always effective as during the inspection, we identified multiple breaches of regulations including breaches of some regulations we had identified at previous inspections which the provider's checks and audits had not always identified or mitigated.

• The provider had been in breach of the regulation for premises and equipment at the last four inspections. This was also the fourth inspection that we found the provider in breach of the regulation for safe care and treatment, which meant that people were not protected against the risk of receiving unsafe care and treatment.

• The provider's checks had not always identified risks to people. Actions on incident and accident forms and some risk assessments did not always provide enough guidance for staff to be aware of triggers and to take effective action, and care plans were not always updated to reflect the incidents so staff were clear about the action to take to help prevent reoccurrence of similar accidents and incidents.

• The provider's checks did not always mitigate risks to people. For example, two people's files had information about changes to their medicines dosage, but this was not reflected in the MAR charts or care plans and the provider's audits did not pick it up. Not all PEEPs reflected people's current situation.

• Some audits made generalised statements rather than being specific. For example, the medicines audit did not indicate which people's medicines had been audited and was therefore not giving a clear overview of how medicines were being managed.

• The provider audited the MARs monthly. However, the audits had failed to identify the issues we found

during this inspection. As a consequence, corrective actions resulting from audits were not identified and there was no evidence of improvements because of audits. For example, on two consecutive months the audit identified that the times were not recorded when required medicines were administered to people to ensure the minimum times between doses were being adhered to. During the inspection, we also found examples of when required medicines were administered without records of times of administration or reasons for administration. This meant that the medicines audits were failing to ensure that people always received their medicines safely.

• We saw a health and safety audit had been completed on 28 March 2019 with actions and a completed by date. However, on the day of the inspection we identified a number of issues associated with the premises that the provider had not identified. For example, the open hair dresser's room. We also found checks regarding the safety of the environment, for example fire equipment, were not consistently carried out which meant people were exposed to potential risks in relation to the environment.

• We found some people had overdue care plan reviews and care plans that were not written in a person centred way were not identified by the provider's checks so these could be updated in a timely manner and improved.

• During the inspection the managers were not able to easily access many of the records we requested. On the morning of the first day of the inspection we provided the deputy manager with a list of required documents and records. Throughout the inspection we had to request multiple times to see the records. These records were not easily accessible and retrievable so these could be produced in a timely manner. Some were not shown to us during the inspection and others were emailed to us after we had completed the on-site visit. This shows that records were not always being maintained in an appropriate and organised way so these could easily be retrieved as necessary.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The provider had not always ensured that staff undertook training to understand their roles and responsibilities. The concerns we identified at the last inspection in relation to staff training had not been addressed by the provider. Their monitoring of training was not adequate and they had either not considered the concerns we found in relation to the training of staff or if they had considered the issues then they had not implemented an action plan to ensure all the required training was undertaken in a timely manner when it was due to be refreshed.

• The home had not had a permanent registered manager in post since February 2018, but a new manager had been employed who planned to apply to become the registered manager. Since the last inspection, the nominated individual with support from Telford Lodge's committee had been managing the service.

• During this inspection we found the service had made some improvements because they were meeting three of the nine regulations they were breaching at the last inspection, but they were still in breach of six regulations. This demonstrated that the provider had not ensured that their service was led by skilled and competent managers, who had a good knowledge and understanding of social care to help run the service so that people received safe and appropriate care at all times.

• The service was rated inadequate at the previous two inspections and continued to be rated inadequate following the inspection of 2 and 3 April 2019. This meant that there was a lack of effective leadership at the service and the provider's systems for assessing the quality of the service and making improvements had

failed to ensure any shortfalls in the quality of the service were identified and addressed promptly.

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

Continuous learning and improving care

- The nominated individual was undertaking a Health and Social Care level 5 management course and a leadership programme with the local CCG. They were also attending provider forums hosted by the local authority to help improve their knowledge and skills in managing adult social care services.

- Since the last inspection a new manager had been appointed and a management consultant employed to improve the quality of the service. Staff told us they could see positive changes since the consultant had begun working at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People using the service said the manager and deputy manager were approachable. Comments included, "The manager is quite nice and efficient" and "I've spoken to the deputy manager. He's a nice young man."

- Staff also felt the management was approachable and told us, "Management have progressed. There is new furniture and wheelchairs. They have decorated the place. These days [nominated individual] is coming now every day. If you've got anything to talk about you go and speak to her and when she is not available we go to the deputy manager", "I don't think [nominated individual] has any previous experience in the care field. They are learning. I think they need more experience and knowledge. They are improving by recruiting staff and doing face to face to face training. [The new manager] I think has more knowledge" and "[The nominated individual] helps me a lot. Team leaders are so good. I like it here."

- The provider held meetings for people using the service and their relatives. People told us, "I don't go to the meetings", "They do have meetings. I've only been to one" and a relative said, "The last relatives meeting was all about individuals. I said the next meeting needs an agenda."

- We also saw evidence of team meetings for staff. One staff member told us, "We have team meetings. If they want to make any changes to the care home, they let us know. If we have any problems we tell them, for example with residents."

Working in partnership with others

- The provider worked in partnership with health and social care professionals to ensure the well-being of people using the service where the issues were about their direct care.

- Where the provider needed to work with various agencies in the broader adult social care arena such as the local authority safeguarding adult team and the Commission, they had not always been forthcoming and the partnership relation had not always worked very well. However, following on from communication about this concern between the provider and other agencies, we found there has been an improved working relationship.