Telford Lodge Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 27, 28 November and14 December 2017 and was unannounced. The last comprehensive inspection took place on 16 and 17 February 2016 and the service was rated Good overall. At the time we found a breach relating to consent to care in Effective. Following the inspection, we asked the provider to complete an action plan to show what they would do, and by when they would make the necessary improvements to meet the regulations. We then undertook an unannounced focused inspection on 10 March 2017 to check that improvements to meet legal requirements planned by the provider after our February 2016 inspection had been made, and found they had.

Telford Lodge is a 'care home' for up to 45 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection, 34 people were using the service.

The service had a registered manager. 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.

During the inspection we received mixed information about staffing levels, and from our observations we concluded that staffing levels were not always adequate to minimise risks to people using the service.

The provider had a number of risk plans in place for people using the service but not everybody had a Personal Emergency Evacuation Plan (PEEP) to provide guidance for reaching a place of safety in an emergency. Additionally, incidents and accidents were recorded but analysis to mitigate the risk of reoccurrence of incidents were not up to date. Therefore it was not clear how improvements were made to the service.

Medicines were not always managed safely and we found a discrepancy in one person's medicine records. Medicines audits were carried out but these were not always effective as they did not identify the discrepancies.

The provider did not ensure all premises and equipment were suitable for the purpose for which they were being used and properly maintained and there was no overall plan for improving the environment, for example upgrading the communal bathrooms.

Information recorded in people's care plans was inconsistent and based more on a medical model than a person centred model. Care plans did not always contain information about people's preferences. They were reviewed but not always monthly as per the provider's procedures.
There was a lack of effective assessment, monitoring and identified actions to improve the quality of the

service to meet the needs of the people using it which meant the service could not ensure a consistent quality of care.

The provider had procedures in place to protect people from abuse. Care workers we spoke with knew how to respond to safeguarding concerns. People had some risk assessments and management plans in place to minimise risks.

Care workers had completed training in infection control and used protective equipment as required.

Care workers had an induction, probation meeting and up to date relevant training to develop the necessary skills to support people using the service. However one to one supervision was not up to date and appraisals had not yet taken place in 2017. Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

People were supported to have maximum choice and control of their lives and care workers were responsive to individual needs and preferences. There were a number of activities available to people.

People's dietary and health needs had been assessed and recorded but monitoring records about peoples' intake were not consistently updated to make sure they were eating and drinking adequate amounts.

There was a complaints procedure in place and people and relatives told us the registered manager was approachable. Feedback from surveys was positive.

We found five of breaches of regulations. These were in relation to staffing, safe care and treatment, premises and equipment, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were not always adequate to minimise risks to people using the service.

The provider had a number of risk plans in place for people using the service to minimise the risk of harm but not everybody had a Personal Emergency Evacuation Plan.

Incidents and accidents were recorded but lacked analysis.

Medicines were not always managed safely. Audits were carried out but these were not always effective. Team leaders who were administering medicines had up to date medicines competency tests.

Safeguarding and whistle blowing policies were up to date and care workers knew how to respond to safeguarding concerns.

Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

The provider had infection control procedures in place which were followed by care workers.

Is the service effective?

Requires Improvement

The service was not always effective.

The premises were not always updated and fit for purpose for the people using the service.

Care workers were supported to develop professionally through an induction, probation and training but supervisions and appraisals were not all up to date.

The provider acted in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights.

People's needs were assessed prior to their move to the home.

People's dietary and health needs had been assessed and recorded but were not consistently monitored.

Is the service caring?

Good

The service was caring.

People using the service and relatives said care workers treated people kindly and with respect.

Care workers supported people to express their views and be involved in day to day decision making.

Is the service responsive?

Requires Improvement

Care plans were not always person centred and information was sometimes incomplete. Care plan reviews were not consistent.

People and their families were not consulted about end of life care.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of effective monitoring, analysis, documented outcomes and actions required to improve the service to meet the needs of the people using it.

There were systems in place to gather the views of people using the service and others.

The registered manager was accessible to all stakeholders.

The service had developed a number of positive relationships with other organisations and in the community.

Telford Lodge Care Limited

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 27, 28 November and14 December 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had experience of caring for an older person and someone with dementia.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. 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 experience of the service.

During the inspection we spoke with ten people using the service, six relatives, one visitor, the registered manager, three Board members, two social care professionals, one advocate and 12 staff members. We viewed the care records of 15 people using the service and nine care workers' files that included recruitment, supervision and appraisal records. We also looked at medicines management for four people and records relating to the management of the service, including service checks and audits. After the inspection we spoke with two more relatives and two medical professionals.

Requires Improvement

Is the service safe?

Our findings

During the inspection, we received mixed feedback about the staffing levels in the home. Relatives and visitors told us, "Staff change all the time", "Absolutely enough staff", "I think there is enough staff and that they do understand dementia" and "There always seems to be staff, I have never noticed the room has been left without a care worker." Care workers told us, "They don't always have enough staff but it's not a daily occurrence, today there is enough staff. If someone is sick it is hard to find cover at short notice. Will try to cover by people working longer shifts or others coming in", "Always have a team leader on shift.", "Enough staff but it is always up and down" and "We have enough staff because they are recruiting new carers."

We saw rotas that indicated there were five care workers and one team leader in the morning and in the afternoon there were four care workers and one team leader. The provider had stopped using agency staff in August 2017 and was recruiting as a number of care workers had left recently.

During the inspection we undertook observations in the home. We saw in one lounge where there were two care workers and eight people, one care worker was called out to support a person with another professional, leaving a single care worker in the room. At one point they were required to support a person to the toilet which left no staff in the lounge area.

At another time, in the entrance hall, the flooring was being repaired. When we first saw it, no one was working on it and it was therefore a trip hazard. We pointed this out to the registered manager who said that staff were monitoring people going through that area. However we sat with a person in the dining room who got up and passed by the area without any staff watching them. The floor repair was completed shortly after.

In the same hall, a person had recently fallen and CCTV cameras identified that it was several minutes before a volunteer saw the person and it took several minutes more for the volunteer to find a member of staff to assist the person.

These specific incidents were indicative of either the service not having enough staff or staff not being deployed in a way that met the needs of the people using the service, a significant number of whom had dementia or required mobility support. This was reflected by a medical professional who commented that, "Residents seem to have higher needs than what Telford Lodge can provide for." Additionally the lay out of the building meant there were areas that were not monitored, such as the entrance hall in the evening. When we discussed this with the registered manager, they said the rotas were flexible regarding staffing as the numbers of people living in the home and their needs changed. The registered manager said they would increase the staffing numbers as of the next day. However this indicated there was no clear system or tool to calculate staffing levels.

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

Some people's files did not have a Personal Emergency Evacuation Plan (PEEP) to provide guidance for staff and others to support people to reach a place of safety in an emergency. As a significant number of people were living with dementia or a disability, and unable to move to a place of safety in an emergency, it was necessary for care workers to know how to evacuate people to minimise the risks to them in an emergency. We discussed this with the registered manager who confirmed after the inspection files had been updated to ensure each person had a PEEP.

We looked at the medicines for four people using the service. One person's medicines had a discrepancy as the amount we counted differed from the amount that should have been stocked, by one tablet that could not be accounted for. Additionally, it was not clear that all the team leaders were doing a stock count as the registered manager was not able to confirm this.

The gas safety certificate was out of date and the registered manager told us although the check had been done within the last year they had not been issued a certificate. The registered manager was following this up when we pointed it out. We viewed an Electrical Installation Condition Report by an external agency completed in September 2017, stating, 'Overall assessment of the installation in terms of suitability for continued use is unsatisfactory.' The registered manager told us this work had not yet been finished, but during the inspection arranged for works to be completed by December 2017.

We saw evidence that incidents were recorded but there was no consistency in the use of standard incident reporting forms, as we saw witness statements that were not attached to incident forms. The incident forms prompted care workers about who to contact after an incident. A care worker told us, "If someone has a fall, ring the emergency bell and the team leader will assess the situation and call the emergency services. Whoever witnesses it has to fill out an incident form." We saw incident forms were completed and kept in each individual's file. The provider also had a standard accident reporting book that included the action taken and recommendations but it did not indicate lessons learned or how to improve the service as it was the care worker who completed it. The registered manager endeavoured to complete an accident and incident trend analysis, however this was not up to date. Therefore it was not clear how improvements were made to the service when things went wrong.

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

We notified the local authority of our concerns regarding medicines. On 13 December 2017, a pharmacist visited the home and completed a medicines stock check for all the people using the service and looked at how the service was recording medicines administration. They found all stocks tallied and suggested better communication, such as an effective handover would help to improve the service.

Team leaders gave routine medicines and a community nurse attended people requiring injections, dressings and catheter care. Team leaders knew which prescription medicines each person took as well as medicines they took as required (PRN). Medicines profiles were part of the health action plan. The communications book recorded which people had refused medicines and the policy was that repeated missed medicines should be raised with the GP. Medicines, both prescribed and PRN, were recorded in people's care plans and we saw evidence that the GP had reviewed some people's medicines. One person had a covert medicines plan dated October 2017 as the result of a best interests decision in July 2017 signed by the GP, registered manager, team leader and family.

Medicines were stored appropriately and controlled drugs were stored safely and securely in a wall mounted locked cabinet in a locked room. The controlled drugs book and the medicines administration

records (MAR) were signed appropriately.

The medicines policy indicated the manager should carry out medicines competency testing for team leaders administering medicines. We saw this had been completed in the last year for all team leaders. The medicines policy also stated the manager should carry out monthly medicines audits and random spot checks as a quality assurance measure. A team leader did a weekly audit and a more detailed random MAR check of three people per month, however we only saw records up to August 2017 as the team leaders had not submitted October to November 2017 audits.

The service had a fire risk assessment completed by an external agency on 29 September 2017 and no significant fire safety deficiencies were identified. We also saw evidence of ongoing risk assessments and checks for fire equipment and other equipment including baths, hoists and wheelchairs.

People we spoke with told us they felt safe. Comments included, "I am quite happy here. Two girls are very nice and I can ask them for anything in [language]", "I like to live here and I feel safe" and "It feels safe. I have never used the call bell."

All care workers had completed safeguarding adults training and policies were discussed during team meetings. Care workers we spoke with were able to identify the types of abuse and knew how to respond. One care worker said, "I would bring it straight up with [the registered manager] or I could let the committee know or social services."

Safeguarding, whistle blowing and health and safety policies had been updated within the last year. We saw completed safeguarding reports included an investigation report, summary witness statements, mitigating factors and a recommendation that was signed and dated. All safeguarding incidents had been reported to the local authority and included their report.

All the files of people using the service had completed risk assessments on admission and contained initial risk assessments for the delivery of care, and suggested strategies to manage these. These were based on assessments from the social work team or hospital. There was evidence of updating but the updates were not always in the same place as the initial assessment and old risk assessments were not archived so it was not clear which risk assessment was current. Risk assessments identified the risk, measures to minimise the risk with guidance for staff on how to achieve this and were reviewed monthly.

The provider had systems in place to ensure care workers were suitable to work with people using the service. We viewed nine employment files for care workers. The files contained a number of checks and records including interview records, a literacy assessment, a pre-employment medical questionnaire, two references, identification documents with proof of permission to work in the UK if required, and criminal record checks. The human resources manager completed a file audit in June 2017 for legal documents, pre-employment checks, interviews, inductions, supervisions, appraisals and performance records.

The service had an infection control policy dated August 2017. The communal areas were worn but clean. We saw evidence care workers managed contaminated waste safely and used personal protective equipment as required. Care workers comments included, "I wear gloves and an apron when [supporting people] with personal care", "You always have to wear aprons in the kitchen area and in the shower wear aprons and gloves. All the bathrooms have boxes of gloves. Pads, soap and everything is all stocked up. We have different bins for pads and laundry etc.", "Everybody has their own toiletries with their initials on it. Residents don't share towels or flannels" and "We have to use gloves and aprons. Always enough gloves and aprons and they come in different sizes."

Requires Improvement

Is the service effective?

Our findings

The building was not purpose built and because of the layout there were opportunities for people using the service to be in areas where staff could not physically be present at all times. One social care professional observed, "The building is not user friendly for people with dementia. Not very homey." The age of the building was reflected in areas such as the communal bathrooms. Both people using the service and care workers told us at times the showers did not work and the water was cold. One person said, "There is no hot water in the sink and the shower isn't working." We tested the water in three bathrooms and found that it took several minutes for the water to become warm. The registered manager said they had raised the possibility of wet rooms with the Board to improve people's personal care experience and showed us evidence of random water temperature checks. However the dates indicated these were not undertaken consistently. The home had a maintenance repair book that care workers used to communicate with the handyman. The furniture and décor was worn and a social care professional told us they had reported two broken chairs on the day we spoke with them.

The registered manager told us that a specific area of the building was being updated to accommodate additional people with dementia. However, there was not a renovation and decoration plan for the home as a whole. Therefore we could not be confident that improvements, for example wet rooms, would be made to the home and contribute to a more personalised service for the people living in there.

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

In addition to the local authority's assessment of people's needs, the pre admission assessment included the person's preferred name, religion, ethnicity, health needs, dietary requirements and allergies. Other care needs assessments tools were used for pressure sores, moving and handling, communication and personal care.

Care workers told us they had an induction and shadowed a more experienced member of staff when they began working at the home. We saw an induction framework and probationary reviews for care workers, however not everyone had up to date supervisions or appraisals. The registered manager told us supervisions were happening on a monthly basis until June 2017 when the team leaders became very busy. This meant, in recent months, care workers did not have the opportunity to discuss good practice and receive individual feedback from a more senior member of staff on a one to one basis.

We saw the training database was up to date with training the provider considered mandatory including safeguarding adults, Mental Capacity Act 2005 training and moving and handling. The care certificate was introduced in 2017 but care workers were not completing it independently and managers found it difficult to make time for tutorials. However, the registered manager had spoken with a representative from Skills for Care who will be supporting the service to start again in 2018.

Care plans included a section about nutrition with people's food preferences and daily fluid charts were

completed by the care worker allocated. A care worker said, "We know if people are diabetic or need soft food because they put it on the menu [for when people are choosing a meal] and the kitchen has a proper chart" which we saw. The kitchen was off the dining room and had a serving counter so people could come to the counter and tell the catering staff what foods they liked.The cook told us they would always honour people's food requests. The kitchen had a communication book that catering staff wrote messages in, for example if someone particularly liked or disliked something. In October 2017 the local authority rated the service Good in terms of food hygiene. One person said, "The food is always tasty, we do have a few choices in what we have." Relatives said, "[Person] likes the food. They eat now and have put on weight", "The food is excellent and there is a great variety. They really know their residents' likes and dislikes and make a special effort on Christmas day etc." and "[Person] loves the food."

Care workers and team leaders worked together to provide consistent support to people. There was a daily handover so care workers had a clear plan of what was required each day. A communications book was used at each handover and the information we saw recorded was clear.

We saw evidence that people were supported to access healthcare professionals, such as community nurses, the GP, community dentist, optician, mental health services and podiatrist. The care plans also recorded when people attended external appointments in hospital clinics. All the people using the service were registered at the same local GP's practice. The GP used to come to the home once a week but as that was not practical, they changed the process so that one afternoon a week, they had a dedicated surgery for people from Telford Lodge. The service had a community nurse visiting daily to administer insulin to a several people and change other people's dressings. Bedrooms had catheter monitoring charts and people's files contained a urinary catheter personal record.

Care workers told us, "We inform the team leader if someone is not well and they will assess. We write it under daily logs" and "We talk about UTIs [urinary tract infections] quite often because it's a common thing here. We're taught how to spot things like a change in mood, in case they cannot say for themselves [they are uncomfortable]. We're taught by team leaders in a daily situation" and "If someone is unwell, assess the person and call an ambulance. If not serious, we can make a GP appointment. A relative said, "[Person] had a slight bladder infection and the doctor was straight here. Before they go to dinner they empty [person's] catheter. I think they look after that side very well. The district nurse comes in to change it."

One medical professional said, "If there is a nursing need, they always contact us" and "There is enough staff. They're busy but at the initial assessment a carer always sits in if we need them." Another medical professional said, "Knowing people's needs can be variable with carers". There was mostly good communication but staff did not always follow up a fax with a phone call to ensure the information was passed on correctly. They also noted Telford Lodge had some people with very complex needs and staff were not nurses and felt some care workers were not fully trained to manage working with people with dementia.

A social care professional said when they come to the service it has "never been an issue of waiting around. They always have a care worker available and they are always able to provide the requested information. They know residents quite intimately and know a lot about them. They have good background [for people using the service] both for social and medical [needs]."

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager was aware of the need to apply for DoLS authorisations when people lacked the mental capacity to take particular decisions around restrictions on them which could amount to a deprivation of liberty, and kept a record of when applications were due and when they were applied for. Care workers demonstrated that they understood that restrictions should be the least restrictive possible and that people should receive care and treatment that is in their best interests. Regarding consent to care, care workers said, "Ask people what they want. Most people can tell you. Make sure whatever they can do, they do themselves", "We have some people who have dementia but we always give them a choice. We don't force them. They can choose their own clothes and food" and "We have clients with DoLS [authorisations]. We read their care plan and we work with the client so we see what they like or don't like and we tell the team leader of any changes."

Staff recorded when a person was unable to make a complex decision, such as agreeing to the use of sensor pads to alert care workers if the person left their room at night and to help minimise the risk of falls. The records explained the reason for the decision and who else was consulted, for example a family member. The provider had a standard form to give an overview of key legal information about the person, such as DoLS authorisations and Lasting Power of Attorney (LPA). We saw this in some, but not all files. However, applications for DOLS authorisations, capacity assessments if relevant, and the actual authorisations were seen on all the care plans reviewed. We saw that people had signed forms giving consent to night checks and bed rails where this was relevant and where they had capacity. For those lacking capacity to make such decisions, a staff member signed the forms to show they had considered people's best interests.

Good

Is the service caring?

Our findings

People spoke of being satisfied with the service and said they were well cared for. Comments included, "The staff here are very good. I am well looked after", "Some [care workers] are better than others", "I appreciate their kindness and I'm grateful that they are always well-mannered", New staff are quite nice. I have no complaints" and "[Care workers] can't do much better. They always ask if you're alright or do you want anything."

Relatives and visitors said, "They have really good staff. Always smiling and friendly and if they don't know the answer to something, they'll go ask", "I think that it is very important there is one to one contact and I do notice that the carers go up and talk to people", "I like the friendliness and the way they react to people", "A very friendly, happy place. [Person] is very, very happy here" and "I never hear staff raise their voice. They're very calm. They talk residents around and gently."

A professional from another organisation said care workers were not always available to sit and talk with people but there was positive interaction and they had never seen a person ignored by care workers. "If something is a concern, staff can always associate why they have been doing that. They have a good background in people."

We observed care interactions that were kind, patient and sensitive including appropriate moving and handling interactions when care workers were assisting people to move. We also saw that when people wanted to mobilise independently, but slowly, they were allowed to do so. We observed care workers explaining what they were going to do and asking people what they would like. Where appropriate, we saw care workers being tactile with people, putting their arm around them in a caring manner.

People using the service were given the opportunity to express their views. For example some people had started taking part in recruitment by being involved in care workers' interviews. We saw from residents meeting minutes more than 50% of the people using the service attended them. The minutes recorded that the registered manager encouraged people to raise concerns. Other areas discussed included catering, fluid intake, health and safety and personal care.

When we asked people if their views were taken into account, one person said, "Staff are very good. When I say I want to go to bed, no hesitation now" and a relative said, "Staff ask [person] what they want. They dress [person] well. They are always clean. Their clothes and bed are clean." A care worker told us, "I always ask, what language do you speak." Care workers we spoke with seemed to know people's medical needs and food likes and dislikes.

Care workers told us that people's cultural needs were met through celebrating different holidays, speaking in people's preferred language and kitchen staff catering to cultural dietary needs. People's relatives and friends were able to visit at any time of day and we saw some people had advocates who also visited.

People's care files recorded some people's preferences in relation to personal care such as whether they

wanted to have personal care from a male or female. There was evidence of relatives being involved in decision making, and where there was no family, the registered manager involved social workers and advocates. With personal care, care workers said, "Make sure they know what's going on and involve them. Ask them what they want to wear and let them do as much as possible" and "I talk to them. I make sure the water is okay. They'll say when they're happy. When I'm showering them, I tell them I am going to do your legs or your toes now." One relative told us their family member preferred a strip wash. The relative checked, and they were confident, their family member was supported to be clean. People were free to choose the time they got up and went to bed, and one resident who preferred to sleep in a chair was able to do so [in a recliner chair provided by the family].

Requires Improvement

Is the service responsive?

Our findings

We viewed nine care plans and found that the information recorded was inconsistent and based more on a medical model than a person centred model. For each identified area of the care plan, there was a long term objective, known or potential risks and a plan of care signed and dated by staff. Not all people had information about their backgrounds in their care records so staff had a good understanding about the person. Many people had a form called 'This is me' in their care plan whereas other people had several variants of personal profiles on file but there was no concise summary of a person's needs and preferences. The registered manager said they were aware the files needed to be updated and we could see at the front of the file they had placed an index page with relevant headings, but the files had not yet been audited and updated to reflect the index page.

The care plans were not based on people's life history and social circumstances. There was more emphasis in the care plans on medical needs than social needs. Where people had challenging behaviour they had an ABC chart, an observational tool to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating. The use of the tool helped staff know what the behaviour was, but it was not evident that psychosocial factors were thoroughly analysed. For example we saw one case where the person had a bereavement but there was not an acknowledgement that this might contribute to their behaviour and responses.

The provider's policy was to weigh people monthly. Measurements of weight, blood pressure etc. had been carried out monthly until August 2017. Only one of the nine files seen contained a more recent weight check. One person said to be at risk of malnutrition and dehydration had no weight record at all on their care plan. Fluid records were kept for all people using the service but they were not completed contemporaneous and were not always accurate. For example, in two cases we checked the daily summary report which indicated that the person had drunk tea or juice at several times in the day, but the fluid record showed that they had not drunk anything from breakfast to bedtime. Care plans had personal care records which were incomplete but we saw daily logs recorded how people were washed. Each person had a day and night daily log with specific headings such as personal care and activities completed daily but these were generally task orientated. A social care professional we spoke with said, "Telford Lodge have been very accommodating" regarding their customer. However they noted the care plan was generic. For example personal care was task orientated and did not say how to support the person in a holistic manner.

Most care plans contained a summary sheet to provide a brief overview of a person care for essential legal information such as Lasting Power of Attorney, DNAR and DoLS, including the date of the application, conditions attached to authorisation and whether action had been taken to meet the conditions. We did not see any completed example so for staff to obtain this key legal information entailed reading a number of documents.

We saw evidence that some staff had completed training in end of life care so they could provide person centred end of life care to people. However, a team leader said most people died in hospital rather than in the home. There was no indication in care plans that staff held discussions with people and their families

about peoples' preferences in relation to their end of life care, or where they wished to die. Most files recorded that people wanted care workers to contact their family in the event of their death. We saw no indication of end of life discussions with relatives or of funeral plans. In the files we looked at, there was only one DNAR notice signed by the GP. There was no information about discussion with the individual, family or advocate and none of the files we reviewed contained Advance Care plans.

The above paragraphs were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an up to date complaints procedure which we saw was followed. We viewed two complaints in the complaints file. One of the complaints was about medicines and we saw the outcome of this complaint was used to improve services as a new medicines record was created to reduce the likelihood or reoccurrence of the same incident.

People and relatives we spoke with felt the registered manager listened and responded to concerns being raised with them. One person said, "I complained to [registered manager] once before. She dealt with it and I've had no problem." A relative said, "We have the [registered manager's] phone number and she will sort things out. She's very good."

The home had a full time activities co-ordinator who worked five days a week and had undertaken training in activities through the National Activity Providers Association (NAPA). One relative said, "They have been doing themed evenings. Fabulous Bollywood and Caribbean nights and every month they do a trip." Another relative said the activities were good but there was a lack of exercise. However the activity co-ordinator made an effort to see all the people using the service. The activity co-ordinator said they spent about 15 minutes with each person doing one to one physical activities and they had arranged with the local authority for a ten week exercise programme to start in the home from January 2018. They also arranged outings, a music session once a week and a movie night once a month. Christian services were available at the home and the activity co-ordinator had taken people to the mosque and offered to take others to the temple. We observed people going on an outing to central London, decorations and posters for themed nights and a birthday celebration.

In people's care plans the information about participation in activities was inconsistently recorded. Records were kept in different places, making it difficult to get a picture of the activities any one individual was involved in. In most cases the daily logs recorded 'no activity' in the box for recording activity that day. However, the activity coordinator kept separate records of the daily activity by individuals. A cross check against care records for one person showed that the person had taken part in activities on many more days than the daily log recorded. In addition the daily log contained a second specific activity sheet for staff to record activities. We saw this sheet in every daily log file, but not all were fully completed for every day.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who reported to a Board of committee members. Since the last comprehensive inspection in February 2016, there had been a plan to close the service, and then a further decision was made for the home to remain open. A new manager was recruited and more recently a significant number of care workers had left the service. The registered manager had, and continues to, recruit new care workers but the level of change appears to have contributed to a period of inconsistency in service delivery. One care worker said the provider could improve on organisation. They said, "Things are hectic and there are so many changes. The organisation's training, care plans and the rota. We have to do all these things and no time to do them in."

During the inspection we found there was a lack of effective monitoring, assessments and actions being identified to improve the quality of the service to meet the needs of the people using it. The provider did have systems in place to monitor the quality of service delivery, and other audits to monitor aspects of the service such as the environment, staff recruitment and training. The registered manager was also aware of these so they had an overview of the service. However it was clear that these systems were not effective. For example monitoring on every level, from care workers not recording people's fluid intake consistently and making a complete or contemporaneous of the care they delivered, to the registered manager not analysing incidents and accidents, was not being undertaken in a consistent or effective manner. As a result it was difficult to have an overview of the quality of the service and to establish what were the areas that required improvement and what actions needed to be taken to make the improvements.

Each month there was a progress and evaluation record to be completed in the care plans but we saw that not all care plans were updated monthly. Also the level of information was inconsistent between files, some information was left unsigned, some was not dated and some not present at all. Not all information was in the correct place on the file.

Where audits took place, for example with medicines, team leaders who were auditing were not consistent with each other in how they did this. In addition, the audits were not effective as they did not identify discrepancies we identified during the inspection. The registered manager said they had begun to carry out three care plan audits per month with recommendations and actions. For 34 people, at that rate, it would take 11 months for the last person's care plan to be audited. The fact that the provider could not apply their quality assurance and governance systems in a robust and systematic manner meant the service could not ensure a consistent quality of care which meant people were placed at risk of unsafe care and treatment.

The above paragraphs were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt the registered manager was approachable and listened to them. A relative said, "[Registered manager] has her eye on the ball and has been very good for the home. If you have a problem, she knows her stuff. She's very thorough. I get an update. She tries to work with families and talks to the residents." A social care professional said, "[The registered manager] is on the ball, but staff not quite

so. It has improved since [registered manager] has taken over." Feedback forms were last completed in September 2017. Seven people using the service and ten relatives responded and were generally satisfied with the service. However there was no analysis of the feedback or evidence of how it was used to improve the service.

Care workers felt supported by the registered manager and said, "They try to support us as much as they can. They are trying to do a lot at once" and "For me I have good communication with the managers." However, some care workers were not confident that their concerns reached the Board whom they perceived as being able to make changes. We spoke with three members of the Board who said that they were planning ongoing improvements to the service, for example implementing a new electronic system to improve staffing rotas and people's care plan records.

Feedback was given to care workers through team meetings, where they also had the opportunity to provide feedback to the management. Care workers told us recently they had been asked to write down what they would like to talk about at the meetings. Feedback from care workers was mixed. One care worker said, "[Team meetings are] not helpful because issues are raised and not followed through on" and another said, "I like it because I can speak in the meeting and they take action."

We saw that the provider worked well with a number of other agencies including the local authority, district nurses and advocacy services. One advocate we spoke with said the care workers had provided everything needed and the person's application for a DoLS authorisation was completed in a timely manner by the provider. The provider also maintained links with the local community including with places of worship and a school choir so they could come to the home and to sing to people

To keep up to date with current developments in the care home sector, the registered manager attended the local authority's provider forums and training, and received emails and newsletters from the National Skills Academy and Skills for Care. They were aware of their responsibility to notify the Care Quality Commission about significant events affecting people using the service and have done so consistently.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not appropriately meet their needs and reflect their preferences. Regulation 9(1) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of the service users and do all that is practical to mitigate any such risks. Medicines were not managed in a safe and proper manner. Regulation 12(2) (a) (b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure all premises and equipment used were suitable for the purpose for which they were being used and properly maintained. Regulation 15(1) (c) and (e)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not did maintain accurate, complete and contemporaneous records in respect of each service user, persons employed in the carrying on of the regulated activity or the management of the regulated activity. Regulation 17(2) (c) and (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that sufficient numbers of competent staff were employed at all times. Regulation 18(1)