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

This comprehensive inspection took place on 8 and 9 May 2018 and was unannounced.

The last comprehensive inspection was in November 2017. The service was rated 'Requires Improvement' in the key questions 'Is the service Safe, Effective, Responsive and Well Led?' and overall. We found five breaches of regulations relating to person-centred care, safe care and treatment, premises and equipment, good governance and staffing.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the rating of the key questions of 'Is the service Safe, Effective, Responsive and Well Led?' to at least good. At this inspection we found the provider had not been able to make sustained and measurable improvements to fully meet the regulations. In addition, we found three additional breaches of regulations

Telford Lodge is a care home. 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,43 people were using the service. They were mainly older people and people living with the experience of dementia. This is the only location for Telford Lodge Care Limited which is registered as a charity.

The service did not have 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. The registered manager left the service in February 2018 and a member of Telford Lodge's Committee had made an application to become the registered manager.

During the inspection we found care workers were not deployed effectively to meet the needs of the people using the service to supervise them as they go about their daily lives in the home and to help protect them from harm.

Incident and accident forms were not always completed and risk assessments were not always robust enough to minimise risks to people and others. This meant the provider was not assessing, monitoring and mitigating risks to people to help minimise their exposure to the risk of harm.

We also observed other unsafe practises that could put people at risk including a child regularly visiting the home who might not have had adequate supervision, a person using a wheelchair without the footplates and half full drinks containers that posed a risk of making people ill as it was not possible to ascertain how long they had been left out.

Medicines management was inconsistent and audits did not always identify discrepancies to help ensure people always received their medicines in a safe way.

The environment did not always meet people's needs and we saw worn furniture in the home, unused equipment sitting on the floor, broken furniture in the garden and CCTV cameras that did not have signs to alert people they were being recorded both visually and with sound. Furthermore, the provider did not follow best practice guidance for dementia friendly environments so that people lived in surroundings suitable to their needs.

Daily fluid charts were not always completed to monitor people's intake of drinks which meant they could be at risk of dehydration as records were not being maintained. Some weight charts were also incomplete which meant the provider could not effectively monitor people's weight and nutritional status to identify any risks relating to nutrition so appropriate action could be taken in a timely manner to manage the risks and to meet people's needs.

Care workers told us they had regular training but the manager did not provide evidence to confirm this. Supervisions and appraisals were not up to date which meant care workers did not always receive the support they required to develop their professional skills and knowledge.

We saw individual acts of kindness from staff, but people were not always treated in a person-centred manner. Mealtimes in particular were task orientated instead of meeting people's individual needs.

People's daily files were stored in cabinets in communal areas that were easily accessible and not secure. This indicated a lack of systems to help protect people's confidentiality and ensure people's privacy.

Care plans were not always competed in a timely manner or with up to date information. This meant there were risks that people may not have been receiving the care they required.

The home had a number of activities for people to join in, however these were not always meaningful and did not always meet their individual interests and preferences.

The service had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. However, these were not always effective. For example, record keeping was not always complete and contemporaneous, and some records were not available during the inspection.

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. Safe recruitment procedures were followed to ensure staff were suitable to work with people.

People's needs had been assessed prior to moving to the service and care plans included people's likes and dislikes. There were also records of end of life wishes and Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms completed by the GP as appropriate.

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

Care workers did not always have a good understanding of the Mental Capacity Act 2005 but the provider generally followed the principles of the Act.

Relatives were positive about the level of care provided and we saw examples of care workers being kind, patient and reassuring with people using the service.

There was a complaints procedure in place, however the service had not had any complaints since the last inspection.

The manager had submitted an application to CQC to become the registered manager and was attending a number of courses to develop their skills for managing a care home. Feedback from relatives and care workers indicated the manger was approachable and accessible.

We found eight breaches of regulations in relation to person-centred care, safe care and treatment, premises and equipment, good governance, staffing, dignity and respect, safeguarding service uses from abuse and improper treatment and meeting nutritional and hydration needs. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no longer provide a care home service lawfully.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Care workers were not deployed effectively to meet the needs of people using the service and to ensure their safety.

Incident and accident forms were not always completed and risk assessments were not always robust enough to minimise risks.

Medicines management was inconsistent and audits did not always identify discrepancies to make sure people received their medicines safely.

Infection control procedures were not always followed.

Staff knew how to respond to safeguarding concerns.

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

Is the service effective?

Inadequate

The service was not effective.

The environment was not always suitable to help meet people's needs and in some cases the layout and lack of maintenance could put people at risk of harm.

People's dietary and health needs had been assessed and recorded but were not always updated. Daily fluid charts and weight charts were not always up to date which meant people could be put at risk of dehydration or malnutrition due to the lack of monitoring of people's intake and weight.

Care workers were not always supported to develop professionally as the provider could not evidence up to date training, supervisions or appraisals.

The provider generally acted in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights. However not all care workers we spoke with understood the principles of the Act. In some case people could

have been subjected to restrictions on their liberty without the right processes being in place

People's needs were assessed prior to their move to the home which helped to ensure the provider only supported people whose needs they could meet.

Is the service caring?

Requires Improvement

The service was not always caring.

Although some individual care workers treated people with kindness, we saw that the provider did not always operate the service in a person centred manner, particularly around supporting people with their meals.

People's daily files were stored in cabinets that were not secure and therefore did not ensure people's privacy.

Care workers supported people to have choice around day to day decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always completed in a timely manner or with up to date information.

Activities for people were not always person centred or meaningful and did not always reflect their interests and preferences.

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

People had their advanced wishes for end of life care recorded so staff were aware of these and were prepared to meet these if they developed.

Is the service well-led?

Inadequate

The service was not well led.

The provider had a number of audits in place to monitor the quality of the care provided. However, these were not effective in identifying the areas where improvements were required and the risks associated with the provision of a care service so appropriate corrective action could be taken. Records were not

always complete and contemporaneous, and some paperwork was not maintained securely to ensure these were available when needed.

The manager had submitted an application to CQC to become the registered manager and feedback from relatives and care workers indicated the manager was approachable and accessible.

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

The inspection took place on 8 and 9 May and was unannounced. 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.

Prior to the inspection we looked at the information we held on the service including the provider's action plan from the 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 and placement teams to gather information about their views of the service.

During the inspection we spoke with 15 people using the service, 11 relatives, six care workers, one senior care worker, one team leader, one catering worker, three healthcare professionals and the manager. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We viewed the care records of four people using the service and seven care workers files that included recruitment, supervision and appraisal records. 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. After the inspection we spoke with the GP.

Inadequate

Is the service safe?

Our findings

At the inspection on 27 and 28 November 2017, we identified a breach of regulation relating to staffing. This was because we identified a number of instances where either the service did not have enough staff or staff were not being deployed in a way that met the needs of the people using the service. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by February 2018. During the inspection on 8 and 9 May 2018, we found the provider had not improved staffing sufficiently to meet the regulation.

Care workers told us, "We are not very short staffed but to pay attention to everyone, we need a little more staff and if staff takes someone to the toilet and two residents get aggressive, one cannot handle it", "If people are agitated and short staffed, we can't do it [provide appropriate care]" and "More service users means more appointments so staffing is pushed. It's all task orientated." The manager emailed us an incident form recording a member of staff had been hit several times by a person using the service. The care worker wrote on incident form dated 15 March 2018, "Because we were so short of staff, I was on my own in zone 6 writing the files and answering the bells with no break."

On the first day of the inspection at 9.05am we observed six people in the zone five lounge without staff for ten minutes. At 9.15am a care worker came into the lounge and supported another person out of the lounge, again leaving the lounge without staff. When we passed by the lounge at 9.55am we observed one domestic staff member in the lounge with four people.

Also on the first day of the inspection in the Osterley Lounge, between 12.55pm and 1.05pm we saw three people sitting alone without a staff presence. Between 1.15pm and1.20pm, people were again alone in the lounge as the only care worker in the lounge was going to and from the kitchen with meals for the people in the lounge.

People using the service not having adequate supervision was a safety risk as we were aware from notifications sent to CQC by the service, and from the incident forms we viewed as part of the inspection, there had been instances of people assaulting each other and of people falling. For example, we saw three different incident reports which recorded on 8, 17 and 25 April 2018 people using the service hitting other people using the service, and two incident forms recording people falling on 24 and 29 April 2018. Therefore, the assessed needs showed that this particular service user group required constant supervision to meet their needs and stay safe, which from our observations, they were not consistently receiving.

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

However, the relatives we spoke with and two members of staff said they were happy with staffing levels. Two relatives told us, "I do think there is enough staff" and "I have never been worried about staffing levels." Care workers comments included, "We have enough staff now" and "Yes enough staff."

At the inspection on 27 and 28 November 2017, we identified a breach of regulation relating to safe care and treatment. This was with regards to a lack of personal emergency evacuation plans (PEEPs), environmental checks such as an up to date gas safety certificate and medicines. Additionally, we saw evidence that incidents were recorded but there was no consistency and the analysis of incidents to identify trends was not up to date. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by February 2018. During the inspection on 8 and 9 May 2018, we found the provider had not improved how they kept people safe to sufficiently to meet the regulation.

When we viewed the incident book, we saw incidents were not always recorded correctly. For example, in the incident book, we saw body maps for one person dated 13 and 28 April 2018 who had bruising. The body map on 28 April 2018 recorded, '[Person] said that they had a fall – no fall mentioned in records.' However, there was no incident form completed to provide further information including the action staff had taken on seeing the bruises and whether measures were put in place to minimise future risk. We saw a third body map for another person dated 14 April 2018 indicating bruises, which was also missing an incident form. We saw three more incident forms where the 'details of action taken' section was not completed. Additionally, most incident forms were missing the section to be completed by the manager. This would have contributed toward the manager's overview of the service. The manager told us they were completing an incident analysis to identify trends and patterns but could not show it to us during the inspection. This meant the provider was not working in line with their accidents and incident reporting policy and procedure which included the objective, 'To ensure that all accidents are appropriately recorded and subsequent actions are managed effectively.'

On 11 May 2018, after the inspection, the manager emailed us 16 incident reports for March 2018 and nine incident reports for April 2018. These included the incomplete incident forms we saw at the inspection, but not for the body maps for people with injuries but where there were no corresponding incident records seen at the inspection. Except for one, all the incidents forms had the previously missing manager's section of the form completed and signed off on 10 May 2018. This information had been added after the inspection and for the March incidents two months after the incidents happened.

On the 11 May 2018, the manager also emailed us the accident & incidents trend analysis for March and April 2018 which they had been unable to show us on the days of the inspection. In the 'Summary of analysis, lessons learned and action taken as a result to prevent recurrence' there was no recognition of trends. For example, one person had three falls in March and a further fall in April but there was no acknowledgement of this or indication of preventative measures in the analysis. There were some lessons learned recorded such as, 'To set up bed location in such a way that resident have reduced chances of falls' and 'Refer to GP for catheter problems, not to wait for DNs'. However, there was no evidence that the manager had been made aware of the incidents at the time of occurrence or evidence to show that strategies to reduce the risks had been implemented. This meant the provider was not doing all that was reasonably practicable to assess, monitor and mitigate risks to people to help ensure they were not exposed to the risk of harm.

The provider completed risk assessments but these did not always cover relevant risks and were not always robust enough. We saw for one person the pre-admission assessment identified some risks, however apart from a personal emergency evacuation plan no risk assessments or assessments for areas such as moving and handling, nutrition and skin integrity had been completed. After the inspection the manager emailed us updated risk assessments for the person that had been completed after the inspection visit on 10 May 2018 to include risk assessments for falls, medicines side effects and 'self injury'. For the risk of self injury, under 'Measures in place to minimise the risk' and 'Risk management procedure' was recorded 'to engage in activities [person] likes' but there was no indication of what activities they liked or what to do if they began to self harm. Additionally, the assessment did not provide guidance for the staff so they could understand

why the person was self harming and the emphasis was on managing the undesirable behaviour rather than providing interventions which would reduce the person's need to do this.

For another person who sometimes behaved in a way that challenged the service and had shown aggression towards other people using the service, the risk assessment for monitoring them was not robust to help protect them and others. It suggested that staff 'kept an eye' on them, whereas they required constant monitoring when they became agitated in the company of others. Again, the provider's strategies for support were based around trying to intervene when the person presented these challenges rather than supporting them so they felt safe and less likely to become agitated.

For another person who had shown aggression to others using the service, risk assessments were in place for self harm and harm to others. There had been some recent incidents of aggression, however these documents had not been reviewed since February 2018, so did not include references to the recent incidents or evidence that the provider had learnt from these incidents to develop interventions to support this person. We saw a risk assessment for 'aggression and violent behaviour' completed in April 2018, but once again this was not robust and suggested that staff 'keep an eye on [person], staff to monitor them and not to leave them alone if they are aggressive.' This meant the risk assessments for people using the service were not always up to date and therefore not effective and not robust enough to mitigate the risks people faced. Additionally, the provider did not ensure that these assessments were followed because we identified that people were not adequately supervised or supported as stated in these.

Furthermore, the manager was bringing their pre-school aged child into work. At times the child was being cared for by a member of staff or a person using the service. There were no risk assessments around the child being in the home and it was not the role of staff to provide childcare in the home. This also removed them from the staff team for the period of time they cared for the child.

We also saw at 9.10am on the first day of the inspection in the hall by the zone five lounge, a care worker pushing a person in a wheelchair with no footplates on it which meant the person was in danger of catching their foot. When we saw the person pass by the lounge again about ten minutes later with the care worker, we saw the footplates were on the chair, indicating the care worker was aware they were required but did not use them in the first instance.

In one person's room we saw their electric toothbrush plugged in on a shelf about 20 centimetres off the floor. Beside it was a pesticide for insects and in front of the toothbrush was a bin. We asked the person if they knew what the pesticide was for and they did not. We also found surgical scissors in the person's room. The manager removed them and confirmed they did not belong to the home. We also saw a razor in an open bathroom cupboard which we alerted staff to.

When we discussed infection control with care workers, one told us, "We need to have aprons and gloves. Use separate aprons and gloves for each client. Use hand gels. Separate things into yellow and red bags." However, whilst care workers understood the need for protective equipment, we observed some poor practice with regards to managing infections. On the first day of the inspection at 9:05am two inspectors entered the lounge in zone five and saw an apple juice carton open and another drink sitting on the table. In the Osterley Lounge we saw part empty bottles of water including a plastic milk container half filled with water and an open carton of apple juice that had been left in the lounge areas. People had unsupervised access to these drinks and therefore there was a risk of infection as it was not possible to ascertain how long the items had been left out.

We looked at the systems and arrangements for managing medicines at Telford Lodge and found they were

inconsistent. Policies and procedures were in place to cover medicines related activities however we saw that these were not being followed by staff and were not embedded as part of routine practice.

Care plans contained little or no information about people's medicines. This meant staff did not have information to support them when managing high risk medicines for example warfarin or epilepsy medicines. During our visit one person's medicines had completely run out. Staff were waiting for the pharmacy to deliver the medicines however the person had missed the morning doses, which included antiepileptic medicines. Staff did not appreciate the significance of missing these medicines and there was no information in the care plan to support their decision making.

Additionally, staff did not follow the provider's policy for managing 'as required' (PRN) medicines. Policy stated that a specific plan for PRN medication should be written in the persons care plan and kept with the Medicines Administration Record (MAR) chart. We reviewed the MAR chart and care plans for four people on 'as required' medicines and saw that this documentation was not in place. For one person it had been determined that they lacked capacity to make decisions about their medicines however a note stating that the person would make it know when 'as required' pain killers were needed had been made in the care plan. This meant people were not receiving their 'as required' medicines according to their needs.

At Telford Lodge topical medicines were stored in people's rooms. However, these medicines were not being stored securely and access was not restricted. This was not in line with the home's policy and meant that people had access to substances that could cause harm if ingested. Some people in the home were living with dementia and this increased their risk of harm. Topical medicines were administered by carers during personal care. Staff told us that separate topical medicines charts kept in the bedside notes were used to record this administration and the MAR should be annotated to refer to this chart. We reviewed the previous four weeks of bedside notes, care plans and MAR for three people on topical medicines and saw that although the MAR had been completed to reference the topical chart no topical medicines charts had been completed nor had any documentation been made in the notes in reference to topical medicines. This meant we could not be assured that topical medicines were being administered as prescribed.

Medicines related audits were being undertaken on a weekly basis at Telford Lodge. We saw examples of how this audit process had identified issues with medicines and action plans to rectify these problems. Part of the audit process was the review of MAR charts. During our visit we reviewed twenty MAR charts for completeness and saw that six of these charts contained gaps. These discrepancies had not been picked up via the audit process. This meant we could not be assured that people at Telford Lodge were receiving their prescribed medicines safely.

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

There were procedures for reporting and investigating allegations of abuse and whistle blowing. Care workers we spoke with could identify the types of abuse and knew how to respond safeguarding concerns. Comments included "First I inform the team leader and then write it in the daily record" and "Straight away inform the team leader and manager. If they didn't act tell the committee or CQC." We saw an abuse awareness poster in the reception area and this included contact details for the local authority.

The provider had some checks in place regarding the safety of the environment. These included a fire risk assessment for the home completed in September 2017 and checking fire equipment such as doors and extinguishers. Maintenance checks were also completed for electrics, lifts and baths. At this inspection we saw people had individual emergency evacuation plans (PEEPs) and there was an up to date gas safety

certificate.

Records showed that the provider had systems in place to ensure support workers were suitable to work with people using the service. The files contained checks and records including, two references, identification documents with proof of permission to work in the UK if required and criminal record checks. Three references were missing when we looked at the files but the manager emailed these to us after the inspection.

Senior carer workers and team leaders administered medicines at Telford Lodge. Staff involved in medicines had received training and were subject to ongoing competency based assessments to help ensure people received their medicines safely. District nurses visited Telford Lodge to administer injectable medicines where these were prescribed.

Arrangements were in place for a local pharmacy to supply medicines and also to inform the home of any national medicines related alerts. Medicines including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. Ambient and fridge temperature monitoring was taking place daily where medicines were stored.

Inadequate

Is the service effective?

Our findings

At the inspection on 27 and 28 November 2017, we identified a breach of regulation regarding premises and equipment. This was because the age of the building was reflected in areas such as the communal bathrooms, some of which had cold water and the communal areas where there was worn and broken furniture. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by April 2018. During the inspection on 8 and 9 May 2018, we found the provider had not improved sufficiently to meet the regulation.

Feedback we received included a healthcare professional who said, "The environment is very dated. Bedrooms and bathrooms could have more adapted furniture" and a relative told us, "The décor could do with looking at."

We found a number of examples to indicate the environment was not meeting people's individual needs and that the provider did not ensure that the environment was safe or suitable. For example, the provider had not ensured that people were being supported at comfortable and safe temperatures. We were told on the morning of the first day of the inspection by the crew of the ambulance service they had just treated a person who was unwell and the temperature in the person's bedroom was 31 degrees Centigrade. High temperatures can affect people's health and wellbeing and overheating can exacerbate existing health problems such as breathing. The person was taken to hospital and the bedroom windows opened.

Some doors had small pictures on them but doors and hallways were not distinctive enough, particularly for a person living with dementia to orientate themselves to their rooms or recognise doors. The provider did not follow best practice guidance for dementia friendly environments. The National Institute for Health and Care Excellence (NICE) guidance about environments for people with dementia states in Statement 7 that care providers, 'should be aware of the value of creating homely settings that enable people to participate in day to day living activities; of having simple layouts that are easy to follow; of the impact that contrasting colours, good signage and effective lighting can have; and of the benefits that a secure garden can offer.' The government guidance on creating 'Dementia friendly health and social care environment' recommends providers 'enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.'

We saw a broken heater and television in Osterley Lounge and old newspapers had not been cleared away so they cluttered the environment. All the chairs were worn looking. Four chairs had ripped arm covers and others were missing the correct cushion seats. Also on the first day of the inspection at 9:50am, the two inspectors saw an unused incontinence pad sitting on a radiator in the Norwood Lounge, which was still there when we returned at 11:55am. This indicated the provider did not always deliver services in a clean and well maintained environment that was suitable for the intended purpose of delivering care.

There was no hot water supply in one toilet in the hall on the ground floor. The bathrooms throughout the home were worn and some of them cluttered. A shower on the second floor did not work. The manager told

us, it did but certain actions had to be completed to turn it on. The bathroom in zone five had two hoists with three slings hung over them. The bathroom on the second floor had a bath chair beside the bathtub which had a rusty plug hole and someone's shoes on the windowsill.

An unused television and fridge were stored under the stairs in the front hall. In the back garden we saw broken furniture that was accessible for people to sit on and potentially hurt themselves. This was removed by the second day of the inspection. Also in the garden was a step by the pond which was hidden by long grass. There was no visual indicator to alert people to this hazard or change of level. We saw this was in the process of being addressed on the second day.

The home had CCTVs in communal areas. However, there were no signs to indicate the CCTV cameras were recording both a visual picture and sound. The manager said they would put signs in place to alert people to being recorded. In addition, the provider's CCTV policy was clear that the home should have signs up but the policy did not include that people's verbal conversation could also be recorded. There was no explanation or rational given as to why the system needed to record sounds to help enhance people's safety and how this balanced with promoting people's dignity and rights to privacy.

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

Care workers told us they had received an induction and shadowed a more experienced care worker when they started working in the home. The Statement of Purpose stated, 'We offer new staff a comprehensive Induction programme which includes Skills for Care (Care Certificate Standards) and Social Care TV online training which need to be completed within the initial 12 weeks of employment, prior to staff being made permanent'. However, although the manager planned to contact Skills for Care to introduce the care certificate to new care workers, at the time of the inspection, new care workers were not working toward their care certificate standards. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

At the last inspection we noted not everyone had up to date supervisions and appraisals. At this inspection the manager was only able to show us one appraisal and no supervisions. The manager said although they had not formally recorded supervisions they had been meeting with care workers on a one to one basis. They planned to bring both supervisions and appraisals up to date as soon as possible.

Care workers told us they had regular training. The manager and team leaders had completed a train the trainer course and were providing moving and handling and fire safety training to new care workers. Care workers had completed first aid training in May 2018 and the manager told us all care workers were in the process of completing end of life training. However, the manager was unable to show us evidence of training to confirm when care workers had last completed training such as safeguarding adults. They noted to us in an email on 11 May 2018 the data base remained outstanding. The lack of evidence to demonstrate supervisions, appraisals and training were up to date meant that we could not be sure care workers were being adequately supported in their role or that they had the required skills to support the people they provided care for. This was highlighted by the number of areas we identified during the inspection that indicated the staff did not always follow best practice or procedures to make sure they are keeping people safe and meeting their needs.

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

During the inspection we found one person's care plan identified them as needing to have fluids encouraged to prevent dehydration and minimise the risk of urine infections. When we checked the daily fluid charts for one person we saw that there were occasions when no entries had been made from 8am until 9.30pm (20.04.18), indicating their fluid intake had not been monitored on those days. On another occasion (22.03.18) no entries had been made for a full 24 hour period. For another person there were no entries on the day time fluid check charts for six days in April 2018. We saw that drinks were available and heard staff encouraging people to drink, however staff were not adequately monitoring and recording if people had enough to drink to help protect them from the risk of dehydration where such a risk had been identified.

The provider's procedure was that people should be weighed monthly, however we saw gaps in the monthly records. For example, for one person there was a weight recorded on 1 November 2017, the next entry was 21 February 2018 and there were no further entries. The manager said that the weight list for March 2018 had been mislaid, but people had not been reweighed for that month. Changes in people's weight can indicate other problems with their health and without the correct information about people's weight, the provider was not able to effectively plan how to meet people's individual needs.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

During the inspection we observed some practices which could have been restrictions on people's liberty and there were no records to show that these were in place in the best interests of these people. On the first day of the inspection while we were in the zone five lounge, shortly after 9am we heard a person loudly banging a door in the hall as they were struggling to open it, but no care workers came to assist them. This meant the person was not being supported to move around the home and could have been restricted in accessing the lounge. At 9.15am a care worker came into the zone five lounge and tried to persuade a person who wanted to get up to sit, rather than find something to occupy them. This could have restricted the person to move and we were not assured that care was being delivered to the person in an individualised way.

Medicines were administered covertly to some people at Telford Lodge. Covert administration is the administration of medicines in a disguised format, for example in food and drink, without the knowledge or consent of the person receiving them. A policy was in place to support this practice at the home. However, this policy was not always followed. For one person we saw that there was no specific mental capacity assessment for this task. Additionally, no planned reviews were documented or scheduled to ensure the ongoing appropriateness of covert administration.
Not following procedures meant that restrictions on people's freedom, choice and control were not minimised.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most care workers we spoke with did not think they had completed MCA training and did not demonstrate a good understanding of the Act. However, with prompting said they provided people with choice. Comments from care workers when asked about their understanding of MCA included, "If people don't talk to us, we have to look at their behaviour to understand", "If they have DoLS they cannot take their decisions. We have to tell what they want from their facial expression" and "If person has DoLS we read everything about them. We do things for them and the next of kin and the team leaders have a meeting. Some clients can't make a decision and we need team leaders and managers."

Care records we viewed had copies of DoLS authorisations and the provider had a DoLS data base to identify when requests were made and when new requests were due. Where people had representatives with the legal right to act on their behalf, such as with a lasting power of attorney, copies of these documents were seen in the care files. There was a mental capacity assessment seen in one of the care file we viewed and this was reviewed every few months and indicated the person's condition was quite stable. However, there had been episodes of behaviour that challenged and although one recent monthly update had reflected this, the care plan for mental state and cognition had not been updated to reflect the changes.

We did not see a redecoration plan but the manager told us the service planned to refurbish two bathrooms with baths and the other bathrooms would have showers including two shower rooms on the second floor. They said they were also in the process of identifying someone to reupholster the chairs in the lounges and had replaced the carpets in the lounges in zones five and six since the last inspection. Additionally, bedrooms were being redecorated one by one.

People's needs had been assessed prior to coming to live at the service. We saw that a pre-admission assessment had been carried out and also copies of the local authority assessment had been obtained, which provided a good picture of the person and their needs.

People's care plans included information about nutrition and people's food preferences. The cook had a book in the kitchen that recorded people's likes and dislikes. We also saw directions for food preparation for one person from the speech and language therapist. On the daily food plan where people's meal preferences were recorded, each person had a code against their name to indicate specific needs such as whether they needed a diabetic, low fat or vegetarian meal as well as the consistency of the meal. We saw from the food orders, in addition to the planned menu, the cook was making dishes specific to people's individual tastes and cultures. She told us, "I always offer people [an alternative]" and a relative said, "The food is excellent. They have five choices of meal."

People received input from healthcare professionals such as the GP, district nurse, dentist and community psychiatric nurse. This was recorded on the multidisciplinary records within the care folder. However, we saw that when someone had a medical condition or had undergone a medical procedure, this was not always recorded in the care plans. This meant the provider was not keeping people's medical history up to date and information about people's medical conditions was not always easily available to staff.

Relatives and healthcare professionals were generally positive about the service meeting people's healthcare needs. One relative said, "I get a text message if [person] has a GP appointment." A healthcare professional told us they generally found the information they required in people's files, that staff knew the people using the service and were always friendly. Another commented that sometimes there were not enough care workers to support the healthcare professional to see people. A third healthcare professional

told us, they had no major concerns about the level of care being provided but they thought the service might benefit from understanding their medicines policies and procedures better and ensuring care workers were well trained to support people with cognitive impairments such as dementia. The GP had a dedicated afternoon clinic once a week for people using the service and met with manager to discuss any issues arising.

Requires Improvement

Is the service caring?

Our findings

During the inspection we observed that although care workers overall were caring, they were not always person centred in their approach to providing support. On the first day of the inspection in the Osterley Lounge, at 1.08pm, we observed a care worker standing in front of a person sitting in a wheelchair and supporting them to eat. At 1.10pm the phone rang and the care worker left the person to answer the phone, came back and started supporting the person to eat again. Although the care worker's manner with the person was kind, they did not explain to them that they needed to answer the phone or apologise when they returned. In addition to not being person centred, it highlighted how staff deployment was not effective as the care worker did not have time to focus solely on the person having a positive experience with lunch. We observed the practice of standing up when supporting people to eat, instead of being present with them and sitting at their level, again on the second day of the inspection at 10:05am in the zone five lounge. At this time we observed a member of staff standing up in front of a person supporting them to eat and at 10.07am in the dining room we saw another member of staff standing up and supporting a person to eat who was seated at a table.

On the first day of the inspection at 9.05am two inspectors entered the lounge in zone five and saw people's files were stored in an open and broken cabinet, so anyone could access confidential information as there were not always staff around. In the Osterley Lounge we also saw the file drawer was open and confidential files were easily accessible. This meant people's privacy was not maintained by the current set-up and approaches in regards to storing people's private information.

In another example we saw a care worker remove a person's shoes which upset the person and the care worker returned the shoes to the person's feet. There was no explanation involved as to why the care worker needed to do that and the lack of communication was not respectful. A better outcome may have been achieved if the care worker had asked the person if they could remove their shoes as they had swollen ankles and explained how this might help them to feel better.

This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above, people and relatives expressed satisfaction with the individual way their care was being provided. One person said, "I cannot fault them [staff]." Comments from relatives we spoke with included, "I'm very satisfied with the way staff look after [person]", "[Staff] treat them all as individuals. They were quick to learn what [person] does and doesn't like", "I think you have to go a long way to beat how they care for people", "I would not have my [relative] in a care home that wasn't exceptional. The home is a home from home", "They will sit and chat to people. They do take time" and "Never once have I walked out of here and felt unhappy." Healthcare professionals said, "Staff do know their residents. They try their best within their ability" and "I see very good interaction [between people using the service and care workers] here."

We saw some interactions where the staff were caring and kind towards people. We observed when someone became upset and agitated staff were gentle and patient and offered a lot of reassurance. One

member of staff was able to speak with the person in their first language and we saw that this seemed to contribute to the person becoming calmer. Staff used people's preferred term of address and we saw that staff showed people respect when speaking with them and providing support and assistance.

We carried out an observation during lunch on the second day of inspection. Staff recognised people who needed to be given their meals first, for example, someone who tended to get up and walk around, were given their meal first and sat and ate it before getting up again. A choice of drinks was offered and people were given meal choices, and staff listened to them. We saw that meals to meet people's cultural needs were provided, for example, Asian and Caribbean meals. Most people attended the dining room to have their meal and there was a good atmosphere, with staff being available to support and assist people where required. We saw the positive effect a staff member had on one person, by gently and persistently encouraging them with their meal, which they finished.

When we asked care workers how they supported people to have choice, they told us, "We have to give choice. When you put food and they don't like it, you change it. Always we have to give an option", "When we wash people, we open the cupboard and show them their toiletries and they can choose. Even their dress they choose" and "Sometimes they refuse the clothes or the food or medication. We have to give them choice of what they like to wear. If they refuse the food, we say okay what would you like. I see the team leaders [when they are administering medicines], if someone refuses medication, they come back later."

We did not see much evidence that people and their relatives were involved with the care plans, however the manager showed us documents called 'My support plan – at a glance' and told us that these were being reviewed and updated with input from people and their relatives. These documents provided a good picture of the person, their life history, interests and hobbies along with those people who were significant in their lives.

Care workers respected people's privacy and dignity when providing personal care and said, "Some people like to do things for themselves and we encourage them. With personal care we need to keep their privacy and dignity. We say good morning and close the curtains. We ask if people want a shower and what they want to dress in." and "You have to ask and get permission. Privacy and dignity, keep in mind. Close the doors and curtains and give them a choice of clothes. Respect is important. Get the permission first of all. Mentally prepare them. We are going to do this."

People had the opportunity to attend places of worship in the community according to their preferences. We saw care workers spoke a number of different languages that people using the service spoke. One care worker said they learned simple phrases such as hello in the people's own languages so they could communicate better with them. Another care worker said, "My background is [type of job] and there are one or two here who were also [in that type of job] and we have good chats." We also saw evidence of people's cultural needs being met through celebrating different holidays and having cultural evenings in the home where one specific culture's food and music were shared.

The staff welcomed relatives and we observed a number of relatives visiting. One relative said, "I come whenever I like, there's no problem."

Requires Improvement

Is the service responsive?

Our findings

At the inspection on 27 and 28 November 2017, we identified a breach of regulation regarding person centred care. This was because people's files did not have up to date information. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by April 2018. During the inspection on 8 and 9 May 2018, we found the provider had made some improvements but not enough to meet the regulation.

For one person who had lived at the service for some years we saw that although changes in their needs had been noted in the care plan reviews, the care plans had not been rewritten to reflect this. For example, they had been prescribed and supplied with glasses for the last 18 months, and although some reference had been made in the care plan reviews, the care plan still recorded that their vision was good and they did not require glasses. In another instance the care plan had not been updated to reflect changes in the person's continence care needs. For another person we saw that their care plans had not been completed until more than a month after they were admitted to the service. Therefore, staff were caring for this person without having a clear plan to tell them how they would meet this person's needs. The lack of accurate and complete care plans for these people meant that they were at risk of receiving care which was inappropriate and unsafe.

For another person the care plan for their social interests and hobbies/spiritual and cultural needs only recorded the names of people they liked to speak with and did not include any information about their interests or spiritual and cultural needs.

The service had a full time activity co-ordinator and we saw that they supported cultural evenings and taking a limited amount of people out at a time. We saw signs to tell people about activities were in small type and too high up the wall for all people to easily access. A relative said, "[The home] has something going on every day like bingo, painting, exercise, baking, arm chair exercises." They also did some ball exercises which people enjoyed but the activity options for many people were not meaningful. When asked about the activities, one person said, "Playing skittles. I'm not a child" which was echoed by another person who said, "Skittles are for children. I'm not interested." One person told us they went out for a walk because, "There's nothing here to do." On the first day of our inspection we saw people colouring but there was little option for those who were not interested to engage in this activity. For example, we saw one person who had had a stroke be given the outline of a flower to colour in. The person was not interested but was not offered an alternative so sat passively. Therefore, the provider was not always planning and providing social and leisure activities which reflected people's needs and interests.

At 11.35am on the first day of the inspection, we observed 13 people sitting in chairs in the zone five lounge. The television was showing a programme which no one was watching and there was one care worker in the lounge who was not interacting with people. As a result we observed people were either sleeping or not engaged in any activity or conversations. At 11.50am we observed when people tried to get up out of their chairs, care workers encouraged them to sit down again, but there was nothing for people to do in their chairs. Also on the first day of the inspection in the Osterley Lounge both the television and the radio were

on but the competing noise from each made it difficult to hear either one and no one was watching them.

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

Whilst there were days when there were not enough planned social activities for people, there were some occasions when people enjoyed the activities that was arranged. On the second day of the inspection we saw an entertainer with a keyboard in the dining room having a singalong which those present seemed to be enjoying.

The provider had an up to date complaints policy and procedure dated December 2017. The manager told us there had been no complaints since the last inspection. There was an easy-read poster encouraging people to raise any concerns they might have with the manager and then with the provider and the local authority if necessary. We discussed adding telephone numbers to this so they were available to complainants. Relatives confirmed they would feel confident to raise any issues they might have with the manager or with other staff so they could be addressed. Comments included, "I would go straight to the manager", "I did ask for a meeting once before and they had a form on the front desk" and "I've had no issues. If I don't like it, I would say."

Each person had a care plan for end of life wishes. Those viewed did not contain much information and referred to the people's families being the ones who would make decisions when the time came. We saw 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in the front section of two people's care records. These were completed appropriately by the GP and indicated whether the person had capacity to make decisions and who the GP had discussed the decision with.

Inadequate

Is the service well-led?

Our findings

At the inspection on 27 and 28 November 2017, we identified a breach of regulation regarding good governance. This was because 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. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by March 2018. During the inspection on 8 and 9 May 2018, we found the provider had not made sufficient improvements to meet the regulation.

During this inspection we identified multiple breaches of regulation. These included breaches we had identified at the previous inspection and where the provider had made little or no improvement. We were not assured that the provider had the capacity and the required competencies to make sustained improvements at the service which they would be able to maintain through time. We found that they did not have effective arrangements to assess, monitor and mitigate risks associated with the provision of a care service and demonstrate that they were providing care and treatment to people which was safe and appropriate. These risks included, failure to manage medicines in a safe way. In addition, there were not enough staff to support people and meet their needs. The environment was not always safe and staff did not always follow good practice to control the spread of infection.

The provider had a number of checks and audits in place which included, a monthly audit by a committee member, a health and safety audit, medicines audits, a check to ensure people's files had up to date information and health and safety checks. However, these were not always effective as we found the health and safety checks did not identify the numerous concerns that we identified during the inspection about the environment. Furthermore, the suitability and safety of the environment was an area where we identified concerns at the previous inspection. The provider had failed to implement the necessary improvements. We also saw that some of the staff practices did not demonstrate respect for people's rights, freedom or dignity. There was inadequate supervision and monitoring of the delivery of care and therefore some of these practices continued because the staff did not receive the training, supervision and support needed to improve.

People could have been unlawfully restricted by a few of the practices in the home, including the administration of medicines covertly without their knowledge and proper assessment and restricting their freedom to move. These matters had not been picked up by the management team so these could be put right.

The provider's systems for assessing, monitoring and improving the quality of the service were also ineffective and were not carried out robustly. They had not identified through their quality assurance systems that people's needs had not always been planned for and changes in their needs were not responded to. For example, people at risk of dehydration did not always have their fluid intake monitored. The provider had failed to identify this or take appropriate action. Records were not always complete and contemporaneous, as demonstrated by health charts and incident and accident forms. We also found that

the data management systems in place were not always effective as they did not identify when a risk assessment was required or if the risk assessment was robust enough to mitigate the identified risk. This meant the provider could not ensure a consistent quality of care to protect people from risk of unsafe care and treatment.

Furthermore, records in relation to the provision of a care service were not being maintained as required and were not made contemporaneously. Some of the records were not available during the inspection, for example the training data base. The manager located these documents after the inspection but a number of these had been written up after the inspection, including the manager's section of the incident and accident forms. Therefore, we could not be confident that records were contemporaneous and reflected the current situation.

The above paragraphs show that the provider did not have adequate systems and processes to ensure people were receiving a safe and appropriate standard of care and that they were protected from risks that can arise whilst they received a service.

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

The registered manager left the service in February 2018. The current manager was a member of the Telford Lodge committee and has applied to become the registered manager of the service. The manager told us they were developing their skills through attending a course called 'My Home Life Leadership Support 'programme with City University London to learn about the evidence base for best practice. They were also attending a care home manager leadership programme for northwest London CCG, were enrolled in the health and social care certificate level 5 and attending the local authority's provider and registered manager forums.

Whilst the quality assurance systems in the home were defective and we were not assured about the ability of the provider in operating a safe and quality service for people, feedback about the manager from relatives and care workers was positive and indicated the manager was available and approachable. Relatives said, "Management are very helpful. Any queries they stop and chat" and "If there's any problem, they phone me up." Care workers said, "[The manager] is supportive and understanding. She listens and arranged my timetable [to accommodate personal needs]", "[The manager] is very good. She's here from morning until night time and she asks, 'Did you have anything wrong today'. We told her so many things", "The way [the manger] treats people is very equal. All the staff work together and I can see they do they best they can" and "[The manager] is very supportive and easy to talk to. She is like a team player if anything needs done."

The provider used team meetings and meetings from people using the service to share feedback. The last residents' meeting was held in March 2018 and the last team meeting in February 2018. We saw evidence that an issue raised at the meeting was followed up by the manager. The manager told us they were having regular meetings about specific issues as they came up and planned to have monthly team meetings. However, no satisfaction surveys of people, relatives or staff had been undertaken in the last year to gain feedback that could be used for service improvement.

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 provider did not enable and support people to make or participate in making decisions about their care and treatment. They did not ensure that care was planned and designed in such a way as to meet service users' needs and preferences. Regulation 9(1) (3)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure service users were treated with respect and dignity. The provider did not always ensure the privacy of the service users. Regulation 10(1) (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 always effectively assess the risks to the health and safety of service users. The provider did not do all that was reasonably practical to mitigate such risks The provider did not always ensure that equipment was used in a safe way. The provider did not always assess, prevent and control the spread of infections. Medicines were not managed in a safe and proper manner. Regulation 12(1) (2)(a)(b)(e)(h)(g)

The enforcement action we took:

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no longer provide a care home service lawfully.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that the least restrictive practices were used to care for and support people Regulation 13(1) (4)(b)

The enforcement action we took:

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no

longer provide a care home service lawfully.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not always ensure and demonstrate that the nutritional and hydration needs of service users were being met. Regulation 14 (4)(a)

The enforcement action we took:

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no longer provide a care home service lawfully.'

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)

The enforcement action we took:

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no longer provide a care home service lawfully.'

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 operate effective systems and processes to assess, monitoring and improve the quality of the service or to assess, monitor and mitigate risks to the health and wellbeing of service users. The registered person did not 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 (1) (2)(a)(b)(c)(d)

The enforcement action we took:

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no longer provide a care home service lawfully.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not demonstrate that staff were receiving training, professional development, supervision and appraisals to carry out the duties they were employed to perform. Regulation 18(1) (2)(a)

The enforcement action we took:

On the 13 July 2018 we served a Notice of Proposal to cancel the Registration of the provider Telford Lodge Care Limited so they can no longer provide a care home service at the location Telford Lodge Care Limited. This process has now been completed and Telford Lodge Care Limited has been deregistered and can no longer provide a care home service lawfully.'