TLC Care Management Ltd

Scissett Mount

Inspection report

Busker Lane
Scissett
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Scissett Mount is a care home registered to provide residential care to a maximum of 85 people. At the time of our inspection, the provider was providing accommodation for older people and those living with dementia. On the first day we inspected this service, 69 people were living in the home. On day 2, this number was 71.

People's experience of using this service and what we found
Risks to people were not fully assessed and recorded in sufficient detail in care records. Senior staff responsible on each floor were aware of individual risks to people. Some people were without access to call bells which meant we were not assured they could alert staff if they needed assistance.

A wide selection of audits were being carried out, although these were of a variable quality. Audit scores were not fully reflective of the issues identified. Audits identified that some people needed risk assessments for behaviour which may challenge others and falls, although the timescale for these actions did not reflect the urgency associated with the risk. The home manager's daily walkaround had not been recorded for approximately 6 weeks and this task had not been delegated to anyone else. There had been insufficient monitoring of maintenance checks.

The management of medicines was not always safe. Some medicines for 2 people were signed for on the wrong day and risks to another person were not sufficiently recorded in their 'as required' protocol. Medicines administration was safe, and staff were trained and had their competency checked.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, mental capacity assessments were not in place for some people. Action was being taken to address this. People were given choice in different aspects of their daily living.

People and relatives consistently told us they felt safe and protected from harm. Safeguarding systems were used to record concerns, which we could see were followed up.

Staffing levels were sufficient to meet people's needs. Staff were recruited safely as relevant background checks had been completed. A small group of people were part of the interviewing panel when the role of home manager was being recruited to in 2023.

People and relatives provided positive feedback about Scissett Mount. Staff we spoke with reflected positively on the management team and said they felt supported. Meetings for people, relatives and staff were taking place and opportunities to feedback were available.

The provider developed strong working relationships with partners in the community. Weekly clinical

meetings were effective in discussing people's changing needs. An inter-generational reading event received positive feedback.

The management team were eager to make the necessary improvements in the service and were working with the local authority as well as a registered managers' network.

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

Rating at last inspection
The last rating for this service was good (published 25 March 2023).

Why we inspected
We received concerns in relation to the safe management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'All inspection reports and timeline' link for Scissett Mount on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to the safe management of medicines, management of risks to people and systems of governance and oversight.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Scissett Mount

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
On day 1 of our inspection, an inspector and an Expert by Experience visited this service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day 2 of this inspection was carried out by 2 inspectors.

Service and service type
Scissett Mount is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Scissett Mount is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The home manager was in the process of applying to become registered with us.

Notice of inspection
The first day of our inspection was unannounced. We gave the provider 48 hours' notice in advance of day of 2 of our inspection.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with the home manager, deputy manager, a care unit manager, 3 senior care workers and 3 care assistants, a housekeeper, a handy person, a cook, an activities coordinator, a visiting healthcare professional and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 10 people who lived at this home and 5 relatives. We looked at multiple medication records and specific sections of care plans for 6 people. We looked at quality assurance and other records following the inspection.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• Risks to people were not always identified and written into care records.
• Staff in charge of the 3 floors in the home were able to demonstrate a good understanding of risk. However, the same detail was not contained in people's individual risk assessments. For example, a person's choking risk and drink thickener was not recorded in their eating and drinking risk assessment. Another person's dietary risk was not recorded in their eating and drinking risk assessment.
• Some people were found to be without call bells in order to alert staff when they needed assistance. Some of these were found stored in drawers. Following our inspection, these were made accessible to people who needed them, and technology was purchased to allow sensor mats and call bells to be plugged in and operate at the same time.
• Personal emergency evacuation plans held in the reception area for staff to access were undated and were not the most up-to-date available. These were updated immediately on day 1 of the inspection.
• The electrical wiring certificate expired in mid-December 2023. Following our inspection, the provider arranged for this to be renewed at the beginning of February 2024.
• Fire drills were taking place, although these were in response to fire doors unexpectedly being opened by a person. Fire drills did not contain a review to show action taken and lessons learned.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people had not been sufficiently assessed and recorded.

Using medicines safely
• Medicines were not always managed safely.
• Medication administration records (MARs) were checked by 2 trained staff members. However, we found 2 examples of medicines being administered correctly, but signed for on the MAR in the wrong daily column.
• There was insufficient information in the PRN protocol about the care needs of a person and administration of their 'when required' medicine, which put them at risk of harm.
• Staff had not confirmed the time of day a person's medicine should be given with the prescriber or pharmacist when the instruction around timing changed from one month to the next.
• MARs did not indicate whether medicines prescribed before food were given at the right time. Medicines were stored securely. However, thickening agents were not kept safely and where this product was used, it was not recorded.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medication risks to people had not been sufficiently reduced.

• All other PRN protocols were in place and found to be detailed in describing the safe use of these medicines.
• Staff administered people's medicines in a safe and respectful way.
• All other PRN protocols were in place and found to be detailed in the use of these medicines.
• Medicines were kept at the right temperature in the clinic room. Staff administering medicines were assessed to check their competency. Medicines training had recently been provided.
• Medicine audits were effective in identifying where some improvements in medicines management were needed.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• There were gaps in the recording of people's mental capacity.
• Whilst people were offered choices and staff were able to identify whether people had capacity or otherwise, there was an absence of mental capacity assessments to support this for some people. The deputy manager had identified these gaps which were due to be addressed by the end of January 2024 by way of updating care plans.
• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
• People who needed a DoLS authorisation had these in place. Conditions imposed by the local authority were known and were being met.

Staffing and recruitment
• Sufficient numbers of staff were in place to meet people's needs.
• People told us there were sufficient numbers of staff and where they had to wait, this was for a relatively short, manageable period of time. People told us, "There's enough staff, there's always someone you can ask [for help]" and "The staff come when you press (for assistance)."
• Recruitment records for 3 staff members showed relevant background checks had been completed before employment commenced.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse through suitable safeguarding systems.
• People and relatives consistently told us the service protected people from abuse. People commented, "[Scissett Mount] suits me fine. I feel very safe" and "I feel safe. It's because I trust the staff."
• Safeguarding incidents were recorded and these were reviewed by the management team to ensure action had been taken.

Preventing and controlling infection
• Infection prevention and control was suitably managed.
• The premises were clean and tidy and staff were seen wearing PPE where needed.
• Infection control audits were being completed, which helped to monitor and measure cleanliness in the home.

Visiting in care homes
Shortly before our inspection, an infection control outbreak had been dealt with and cleared. During this period, it had been assessed that it was safe for people to have a nominated visitor who was allowed to safely visit their loved ones.

Learning lessons when things go wrong
• Examples of lessons learned were noted during the inspection.
• In response to concerns about medication errors prior to our inspection, the provider invested in an external professional who looked at reasons these occurred and preventative action needed.
• The nominated individual told us they introduced 'flash meetings' from mid-January 2024. These were daily meetings to discuss key updates with department heads. They added that at the end of the month, they would hold a monthly governance meeting to review this information.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Risks were not robustly managed through systems of governance.
• The home manager's daily walkaround showed a gap in these checks not having taken place from mid-November 2023 until the beginning of January 2024. This gap had been identified by the provider, but this task wasn't passed to anyone else to complete. The home manager told us this would be completed by the deputy manager in their absence in the future.
• The urgency needed for action in response to specific events was not reflected in timescales given to these tasks. For example, a person had 3 behaviour related incidents in October 2023. They were identified as needing a behaviour care plan by 31 January 2024. Four people experienced 2 falls in October 2023 and the deadline recorded for completing falls risk assessments was 31 January 2024.
• Audit scores were not fully reflective of action needed. For example, the November 2023 mental capacity and Deprivation of Liberty audit scored as 92% compliant. This did not reflect feedback from the management team who told us there were notable gaps in these records. A care file audit from November 2023 scored as 99% complaint. This asked, 'Is there a decision specific mental capacity assessment' with the response recorded as 'Yes, fully met'. This did not reflect the gaps in MCA recording seen at this inspection. This meant we were not sufficiently assured of the effectiveness of governance checks.
• There was insufficient oversight of maintenance checks. The electrical wiring certificate had expired in December 2023, hot water temperature checks in people's rooms had not been checked since the end of October 2023 and personal emergency evacuation plans were not up to date when the inspection started.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems of oversight had not identified and responded appropriately to risks.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The management team were open with us throughout the inspection.
• The provider routinely ensured that notifiable events were reported to us, although on our review we found 2 incidents which we were not told about. These incidents were reported to us after this inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The culture in the service was found to be positive.

• The home manager started in October 2023 and felt they knew people well. They were introduced to people and relatives at an event with a singer and food provided.
• One staff member said they felt supported and listened to, adding, "They leave me to do my thing." Other staff feedback included, "I'm very happy here. They've [management] told me I can go to them anytime" and "There's been an improvement in the wellbeing of staff."
• A select group of people were part of the interview panel when the home manager role was advertised in the summer of 2023. They were empowered to inform the successful manager of their offer of employment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Opportunities were provided to people, relatives and staff to be engaged and involved in the running of the home.
• A relative told us how impressed they were that the home manager supported their request to enable their loved one to go back home with their family for Christmas, even though additional staff support was needed. One person commented, "If I approach [home manager] about anything, they always get back to me."
• Regular meetings for people, relatives and staff were taking place. The minutes from the December 2023 resident meeting showed this was led by people living in the home. Since the home manager joined the home, they introduced a resident committee. One person told us, "I'm on the committee. We've had 1 meeting where we talked about things, and I felt they [management] listened to me." A newsletter provided updates, puzzles and useful information for people and relatives.
• The provider and staff supported people with their protected characteristics. For example, appropriate storage of food for one person which was linked to their religious beliefs was carefully managed.

Working in partnership with others
• Effective partnership arrangements were found during the inspection.
• We listened to a weekly catch up call between the deputy manager, senior leaders from each floor in the home and a GP from a local surgery. This was a well-run meeting which focused on people's changing needs and any related medication matters.
• An inter-generational reading event saw 80 students visit the home as part of a project set up with a local college. This was very positively received by everyone who participated and was expected to continue in the future with reminiscence sessions also planned. A local choir attended practices in the home and they put on a concert for people living in the home and relatives.
• The provider was beginning to work in partnership with a registered managers' network in the district to share ideas and obtain support.

Continuous learning and improving care
• The provider was committed to making improvements to the service.
• Examples of improvements were shared with us throughout the inspection. Feedback showed that sometimes staff and people didn't know what the meal choices were, so a menu board was put on display. The home manager purchased lifting equipment for each floor which meant staff no longer had to borrow this equipment between different floors in the home.
• Dining room assistants had been introduced to support people's mealtime experience. This helped free up time for care workers and meant they could sooner meet people's needs. Dining room assistants helped to encourage people with fluid intake.
• The provider successfully applied for funding for 2 large screen tablets. We saw this equipment used to good effect during the inspection. A group of people were doing a word search, and a member of the activities team said they had used 'Google Earth' to zoom in on places of interest as a way to help people reminisce.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been sufficiently assessed and recorded. Risks associated with the management of medicines had not been sufficiently reduced. Recording of medicines administration was not sufficiently robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems of oversight had not identified and responded appropriately to risks.