Autism TASCC Services Limited

Collinson Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Collinson Court is a residential care home made up of individual apartments with their own communal spaces and bathrooms. The service provides personal care to a maximum of 9 people who have a learning disability and/or autism. There were 9 people residing there at the time of the inspection, although 1 person was on holiday so was not present during our site visits.

People's experience of using this service and what we found

Right Support:
Risks were not always assessed and planned for so we could not always be sure people would always be kept safe. There were enough staff to support people in line with their commissioned care and support plans. However, staff did not always have all the necessary skills and knowledge to effectively support people. Medicines were generally safely managed, but improvements were needed. Staff were recruited safely. People were protected from the risk of abuse by staff. Where abuse had been identified action was taken by the provider to safeguard people. People were protected from the risk of infection.

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.

Right Care:
People's social activity needs were not always met. People had varying levels of access to the community. No one was nearing the end of their life. Some practical arrangements had been made if someone was to pass away, however personalised plans about people's choices had not been put in place. People were supported to communicate in a way that suited them. Relatives felt able to raise concerns, if needed.

Right Culture:
There were culture concerns at the service. There had been numerous management changes over a long period of time, so staff had not always had consistent leadership in place. The provider had failed to ensure sufficient oversight of the service had been maintained during periods of change. The registered manager and deputy manager were person-centred and were working on making improvements with the culture of the service. Quality assurance system to monitoring and improve the quality and safety of the service were not always effective. The service worked in partnership with external professionals and organisations.

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 overall, but requires improvement in well-led (published 23 July 2022).

Why we inspected
The inspection was prompted in part due to concerns received about staffing and staff culture and lack of activities. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of an incident following which a person using the service was allegedly abused. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people's support in the community and staff culture. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive, and well-led 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 reports' link for Collinson Court on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to managing risk, supporting people appropriately and in-line with their needs and the oversight and monitoring of the quality and safety of care.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Collinson Court

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.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector.

Service and service type
Collinson Court 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. Collinson Court 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We asked Healthwatch if they had any information to share about the service; they did not. Healthwatch is an independent consumer champion that 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
We spoke with 5 relatives as part of the inspection. We spoke with 6 care staff, including both permanent and agency staff. We also spoke with the registered manager, deputy manager, a quality improvement lead from the provider, a peripatetic manager and a regional manager. We also spoke or got feedback from 4 professionals who worked with the service. Due to the complex needs of people who lived at the home we were unable to talk with them. However, we observed interactions between people and staff.

We reviewed a range of records. This is included four people's care plans and various medicines and medicines records. We looked at two staff files in relation to recruitment and multiple agency staff profiles. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 good. At this inspection the rating has changed to 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; Learning lessons when things go wrong
- Risks were not always assessed and planned for, and lessons were not always learned when things went wrong.
- Staff had noted 1 person had pain and discomfort. However, a referral to an appropriate health professional was not made for 4 days, leaving the person in discomfort and at risk of it worsening.
- One person needed specific pillows on their bed due to their health condition. These pillows were not in place, which left the person at risk of suffocation while experiencing symptoms of their health condition. Following our feedback, these pillows were put in place.
- Staff had recorded on a couple of occasions 1 person had sun burn. We also observed the person to have tan lines. There was no action following this to reduce the risk of this happening again and no plan in place to prompt staff to protect the person in these circumstances. Multiple people in the service may be at risk of sun burn as they would not always be able to reliably let staff know they were in discomfort.

People were left at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks were made on building safety, such as checks on gas, electrical and fire alarm systems to ensure they remained safe for people and staff to use.
- The care plans and risk assessments which were in place, were detailed and personalised to each individual.
- Other mechanisms, such as staff de-briefs following incidents, were in place to review incidents which had occurred to reflect and share learning.

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)

- 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.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse by staff. Where abuse had been identified action was taken by the provider to safeguard people.

● Relatives consistently told us people were happy to return to the service when they had been out and did not have safeguarding concerns. One relative said, "My relative is cheerful, they never refuse to go back which is good."

● Staff understood the different types of abuse and their responsibility to report concerns. Staff had felt able to come forward to whistleblow with their concerns and the provider responded by investigating concerns and considering whether action was needed.

● Safeguarding referrals were made to the local safeguarding authority as needed.

Staffing and recruitment

● There were enough staff to support people in line with their commissioned care and support plans. However, staff did not always have all the necessary skills and knowledge to effectively support people.

● There were a number of staff absences which had meant there was a reliance on agency staff or recruitment of new staff. Therefore, new and agency staff did not always know people as knew as regular staff, as they had not worked with them for long. However, to mitigate this agency staff were blocked booked so they would become more experienced in supporting people. Information about each person they were supporting was provided to them to assist them to get to know people. Regular and agency staff we spoke with were all able to tell us about risks to people.

● Staff were safely recruited. Checks were made on their suitability to support people who used the service. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Checks were also made on agency staff to ensure they were also appropriate.

Using medicines safely

● Medicines were generally safely managed, but improvements were needed.

● One person had their bowel movements monitored so staff would know if the person needed medicine to help them go to the toilet. Records showed there were multiple occasions they had not opened their bowels, but the medicine had not been given. No harm came to the person as they had since been to the toilet, however staff had failed to recognise this.

● There had been numerous medicines errors. These had been identified and appropriate action taken following these and additional measures were being put in place to reduce the ongoing risk of reoccurrence.

● One 'when required' medicine had a missing Medicine Administration Record (MAR). This medicine had not been given since there was last a MAR in place so there were no missed doses, however all medicines should have a MAR in place. This is so there was a clear record of when medicines had or had not been administered. This was immediately put in place following our feedback.

● Despite this, medicines stock levels all matched records, so we could be sure these were given as prescribed.

Preventing and controlling infection

● We were assured that the provider was supporting people living at the service to minimise the spread of infection. There was some furniture in poor condition so it would not be able to be kept hygienically clean. However, replacement furniture had already been ordered and was awaiting delivery.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions on visiting.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's social activity needs were not always met. People had varying levels of access to the community. There had also been an absence of specific activity staff, however they were returning to the service.

● One relative said, "They could do more [activities], I think. I used to get cakes and stuff I could bring home, like arts and crafts but not now. It's all seem to have gone. Sometimes my relative is just sitting there." Another relative said, "My relative doesn't seem to be doing much, or not going out. They're not stimulated in Collinson Court and sitting around and not doing many activities." Another relative told us, "I am being told my relative is doing things but there is never any evidence they have done it."

● One staff member said, "It depends on whether we have enough drivers, it can be tough when there's not enough." Another staff member commented, "I don't think there is enough activity, its hard considering the amount of vehicles we've got as we have to say no [to people going out as not enough drivers or vehicles]."

● While staff were supporting people in the community, they sometimes had to complete tasks for other people, so it meant the activity was not always focused on the person they were supporting at the time. For example, while supporting someone to go shopping, they bought cinema tickets for someone else which led to the shopping trip being cut short. This was not person-centred support.

● Activities were recorded on the provider's electronic recording system. However, there was not always clear detailed evidence people were supported with meaningful activities regularly.

● The service was going through a period of difficulty as there had been some staff absences, meaning there was an increase in the use of agency staff to support people. Not all staff knew people well enough to be able to support them out in the community and not all staff had the ability to drive a vehicle in order to enable people to access the community.

The above shows people did not always receive appropriate support. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● No one was nearing the end of their life; however, some practical arrangements had been made for those in the event of their passing.

● There was a template in place to help guide conversations about what people may want in the event of them becoming very ill and may die. However, we did not see people, or their relatives, had been given the opportunity to discuss this, should they wish to.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People were supported to communicate in a way that suited them.
● Some people were able to verbally communicate. For those less able to verbally communicate, staff knew their physical cues – such as pointing at items, handling items or taking staff to what they wanted. A communication board had been developed for 1 person to they could tell staff what they wanted to do that day.

Improving care quality in response to complaints or concerns
● Relatives felt able to raise concerns if needed.
● One relative said, "If there are hiccups, if I bring it to their attention, they deal with it." We were given examples by relatives of interactions they'd had with the registered manager and they felt they were approachable.
● The registered manager shared examples of complaints they had received and acted on, recently.

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 requires improvement. The rating for this key question has remained 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were culture concerns at the service. There had been numerous management changes over a long period of time, so staff had not always had consistent leadership in place. The provider had failed to ensure sufficient oversight of the service had been maintained during periods of change.
- A relative said, "There's 1 or 2 of the staff who are friends, and they seem too cliquey with one another, and I don't think that is a good thing. Work is work, personal should be separate from work. I get the feeling if you're not in that clique you are shunned a bit. I think that's wrong."
- Relatives also told us they felt communication could be improved. Relatives felt they did not receive much proactive communication about how people were on a regular basis, unless there was an issue they needed to be informed of. One relative said, "It wouldn't hurt for a phone call to hear what my relative is doing. A phone call wouldn't go a miss. Communication could be a lot better."
- A professional who worked with the service stated, "They've struggled with getting stable management over last few years. It's difficult to know who to contact and who is in charge."
- One staff member used 1 word which was not kind when referring to working with people. Another staff member did not follow a person's care plan while supporting them. This did not put the person at risk but it was not thoughtful.
- We found a concern with confidentiality outside of working hours.

The above shows people did not always receive appropriate support. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite this, the registered manager and deputy manager had a person-centred outlook and had support from some staff to improve the service.
- Relatives and professionals were complimentary of the registered manager and management team. A relative told us, "I can absolutely speak to the registered manager, and the deputy manager, they both seem on the ball." One professional said, "I have a lot more confidence in this service going forward. Since the registered manager has been there it has improved." Another professional said, "The management team is very approachable."

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

regulatory requirements; Continuous learning and improving care
● We could not be sure there were effective quality assurance systems in place to monitor and improve the service. The registered manager, deputy manager and the provider were responsive to feedback. However, as there were several areas where necessary improvements and omissions had not been identified, we could not be sure there was continuous learning.
● It was not clear what oversight there was of people being supported in the community and what activities were being undertaken. Concerns had been raised about activities in the community and it was not evidence what action had been taken to reduce the risk of further concerns occurring.
● Handover processes were not always effective. Staff had recorded concerns about a person but the delay in seeking advice about this was delayed. Information was recorded in handwritten notes and in different parts of the electronic recording system so this was not picked up.
● One person's plan stated they should be weighed weekly, but they were not being weighed at this frequency. The person was not at risk of being ill due to weight loss, however systems in place had failed to recognise their care plan was not being followed.
● Another person's care plan stated staff should keep a certain item with them at all times when supporting the person in the home. However, staff did not have it with them whilst in the home. The registered manager explained the reasons why it was not with staff, but the care plan had not been updated to reflect this change.
● An action plan was in place which was not always robust. However, this had identified some actions had been marked as complete which we continued to find concerns about. Also, areas we found for improvement were not always identified on their action plan.

Systems were not always effective at identifying areas for improvement or omissions which could leave people at risk. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, there were other areas which had been reviewed and action was being taken to make improvements. For example, it was recognised the menu needed improving which more variety and fresher, homemade meals. We observed this had been implemented.
● Staff training was monitored, and work had been undertaken to increase the level of compliance. Staff were being asked to complete training again to ensure it was effective and staff were competent.

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 registered manager was aware of their duty of candour. Relatives gave us examples of when something had gone wrong, and they had been informed about it and told what action had been taken to reduce the ongoing risk.
● There was one incident we were considering in relation to duty of candour; however, we are investigating this outside of the inspection process.
● The previous inspection rating was being displayed and notifications were submitted to the CQC, as necessary.

Working in partnership with others
● The service worked in partnership with external professionals and organisations.
● One professional said, "I have regular communication with the team there. The team are responsive and regularly flag up any concerns or queries." Another professional said, " I never get diverted away from visiting the service, they're always happy for me to come."
● There were collaborative meetings lead by the local authority which the registered manager and provider

attended to discuss and monitor the service and the registered manager acted on feedback.

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 People did not always have their needs met and their preferences catered for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient oversight and robust systems in place to effectively monitor the quality and safety of care.

The enforcement action we took:

Warning notice