Autism TASCC Services Limited

Collinson Court

Inspection report

56 Longton Road
Trentham
Stoke On Trent
Staffordshire
ST4 8NA

Tel: 01782658156
Website: www.prioryadultcare.co.uk

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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?	**Inadequate**

Summary of findings

Overall summary

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.

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

Right Support:
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 experience to effectively support people. Risks were assessed and planned for, and staff knew people's health conditions and risks to their safety. However, we identified some incidents staff had recorded had not always been reviewed by quality assurance systems in place and considered for any learning to reduce the risk of them happening again. Medicines were safely managed. 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 not always supported to have maximum choice and control of their lives as there were staffing difficulties which meant people did not always have the range of choices they have previously had. 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 continued to not always be met. People still had varying levels of access to the community. No one was nearing the end of their life, although relatives had been offered the opportunity to discuss people's end of life wishes if they wanted to. People were supported to communicate in a way that suited them. Relatives felt able to raise concerns, if needed, although there was mixed feedback about the response to these concerns.

Right Culture:
There had been numerous management changes over a long period of time, and a new manager had started since the last inspection. The relatives and staff were positive about the new manager and continued to be positive about the deputy manager. Quality assurance system to monitor and improve the quality and safety of the service were not always effective, although some improvements had been made. The service

worked in partnership with external professionals.

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 requires improvement (published 10 November 2023).

Why we inspected
We carried out an unannounced inspection of this service on 17 and 21 July 2023. Breaches of legal requirements were found. We issued a warning notice on the provider. The provider completed an action plan after the last inspection to show what they would do and by when to improve managing risk, supporting people appropriately and in-line with their needs and the oversight and monitoring of the quality and safety of care.

We undertook this focused inspection to check they had complied with the warning notice and followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, responsive and well-led which contain those requirements.

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 continued breaches in relation to supporting people appropriately and in-line with their needs and the oversight and monitoring of the quality and safety of care. We also found an additional breach regarding staff skills and experience.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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.

Inspection team
The inspection was carried out by 1 inspector and 1 regulatory co-ordinator, who both made telephone calls to relatives.

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 no registered manager in post, however a new manager had recently started.

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 used all this information to plan our inspection.

During the inspection
We spoke with 8 relatives as part of the inspection. We spoke with 9 care staff, including both permanent and agency staff. We also spoke with the manager, deputy manager, a quality improvement lead, an operations director and a managing director. We also spoke or got feedback from 4 professionals who worked with the service. Due to the complex communication 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 4 people's care plans, daily care notes and various medicines and medicines records. We looked at 2 staff files in relation to recruitment and 2 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 requires improvement. At this inspection the rating 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; Learning lessons when things go wrong
At our last inspection the provider had failed to robustly mitigate the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12, although further improvements were still needed.

- Lessons were not always learned when things went wrong.
- Staff had recorded in daily notes about 1 person becoming agitated and injuring themselves on multiple occasions. However, these had not been reviewed to ensure the circumstances were learned from to reduce the risk of them occurring again.
- People had specific detailed care plans and risk assessments in place to guide staff about how to support people which contained personalised details. However, as there was not always clear learning following incidents, we could not be sure these would also be up to date to incorporate learning and the best way to support people.
- Despite this, both permanent and agency staff knew people's specific health conditions and risks to people to help keep them safe. One professional told us, "I feel the residents are safe with the current team."
- We observed there was unsafe practice about the propping open of fire doors using unsuitable items, so they may not close in the event of an emergency. Once we fed this back, action was taken to remove the need to prop open the fire doors.

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)

- 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. The provider had acted when abuse had been identified.

● Relatives continued to consistently tell us people were happy to return to the service when they had been out. One relative said, "From my point of view, [my relative] is happy to go back into Collinson Court. It gives me the overall feeling they are happy."

● Staff understood the different types of abuse and their responsibility to report concerns and could explain this effectively to us.

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

Staffing and recruitment

● There were enough staff to support people in line with peoples' commissioned hours. However, staff did not always have all the necessary skills and knowledge to effectively support people. We explore this further in the responsive key question.

● There continued to be a reliance on agency staff, although many new permanent staff had been employed.

● Checks were made on agency staff to ensure they were appropriate to support people. One agency staff member had an error on their profile, and this had not been identified or questioned. Following our feedback, this was rectified.

● 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.

Using medicines safely

● Medicines were safely managed.

● The fridge used to store medicines had been recorded as being outside of the safe temperature range for an extended period of time. However, this had been identified after a number of weeks and a replacement fridge was put in place following our inspection.

● Medicines stock levels all matched records, so we could be sure these were being given as prescribed.

● 'When required' medicines had clear protocols in place to guide staff when to give these.

Preventing and controlling infection

● People were protected from the risk of cross infection.

● There was an ongoing replacement of furniture or items if they became damaged to ensure they could be kept hygienically clean, and some items were awaiting delivery.

● We observed staff wearing appropriate Personal Protective Equipment (PPE) when necessary and the home environment was free form malodours.

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 requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

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

At our last inspection the provider had failed to ensure people were always supported in a way that met their needs and reflected their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

● People's social activity needs continued to not always be met. People had varying levels of access to the community and staff did not always engage effectively in hobbies and activities in the home. Relative and staff feedback overall was consistent that they felt people were not engaged in regular and meaningful activity.
● One relative said, "There is a whole lack of activities and no stimulation, I don't know what they [staff] think they are there for, do they think they are just babysitters?" Another relative told us, "My relatives needs to have a quality of life. My relative needs lots of activities to keep them busy to enjoy their life. I think my relative's life is limited now. There is so much potential staff could do with them that doesn't get done."
● Multiple relatives gave us examples of ideas they had suggested and activities and items they had provided for people, and multiple relatives told us they felt these had been 'ignored' or not utilised by staff.
● One staff member said, "Agency staff don't interact [with people], they don't know how to. People are not being stimulated." Multiple staff also gave us examples of missed opportunities to engage in activities and encourage people with daily living tasks to increase people's independence.
● Activities were recorded on the provider's electronic recording system. However, these records sometimes lacked detail, had gaps or indicated people were not able access the community due to a lack of staff able to drive.
● The provider explained they were going to explore the use of taxis and public transport, dependent on people's needs, however this had not yet happened and the lack of consistent staff able to drive had been an ongoing issue for a number of months.
● A professional we received feedback from confirmed they continued to have concerns about the lack of varied activities.
● Staff told us they had been asked for their ideas about activities for people and they were hopeful this would mean more activities would take place. However, we have not seen this change embedded and sustained.

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Staff did not always have the skills and experience to be able to support people in a personalised way and to enable people to have choice and control to support their preferences.

● A relative commented, "Staff are not well trained, it's just mandatory training, you would expect staff to have higher awareness on [learning disabilities and autism], I see them just milling about with no purpose." Another relative said, "They need people with experience with [learning disabilities and autism]. Not someone who just sits. It was a specialised [learning disability and autistic] care unit. Everything has been watered down. If you ask staff what autism is, I don't think they are specialised."

● A staff member told us, "They [new staff] do shadow first, but they are shadowing agency and not shadowing the right people. They are employing bodies for bodies." Another staff member said, "They [new staff] might care but they have no common sense." We discussed this with the provider and one of their staff said, "Rather than just going and getting staff, it's getting the right staff. We've been on a journey, we're still on the journey and on the right path. I'd rather have sustainability than a quick fix."

● Staff had received training in their roles, however for some staff this was only an 'awareness' of learning disabilities/autism. Staff worked with people on an individual 1-1 basis, and they had not all received more in-depth training appropriate to their role.

● There was also a lack of staff who had the skills and confidence to support people to access the community and sometimes there was a lack of staff able to drive to take people out. Staff would not consistently use their skills to offer people alternatives if people couldn't go out. Records confirmed feedback from relatives, as it would be recorded people could not go out due to a lack of drivers or clear alternatives being offered.

● One relative said, "Often it is because there is not a driver [that my relative cannot go out]. My relative is bored a lot of the time. I wish the staff would use their imagination." Another relative commented, "My relative is meant to go out but doesn't go out as much as they should. There's no car [or driver available] for them to go out."

● Multiple relatives and staff fed back their concern with some staff ability to communicate effectively due to English not being their first language, which they felt impacted on people's ability to communicate with those supporting them.

The above shows staff did not always have the appropriate skills and experience to support people in a personalised way. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above concerns, relatives felt staff were caring. It is acknowledged there were some capable staff, both permanent and agency staff who were skilled at supporting people. However, this level of support was not always consistent.

● The provider had recruited more permanent staff and had further staff due to start. The provider explained they were changing the induction process to improve this for new starters.

● We acknowledge recruitment processes can take time and national pressures on the recruitment of social care staff impacted the service.

Improving care quality in response to complaints or concerns

● Relatives told us they felt able to complain if needed. However, there was mixed feedback about the response to feedback.

● One relative said, "Relatives are making complaints and suggestions, but you're never listened too. After years of repeating myself, am I stupid?"
● Another relative said, "We've sent in official complaints, but nothing has happened and there's no feedback. We are all picking up on the same things they said would look into, we're still waiting for responses from years ago."
● Despite, this relatives still felt able to raise concerns and consistently felt the manager and deputy manager were approachable to discuss their concerns with.

End of life care and support
● No one was nearing the end of their life; however, relatives confirmed they had been given the opportunity to discuss people's end of life wishes, should they choose 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.
● Staff were aware of people's communication needs.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality 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

At our last inspection the provider had failed to ensure there was a positive culture at the service, to ensure people's care reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9. This breach is also explored in the responsive key question.

- There had been further management changes since the last inspection, which added to the numerous management changes over a long period of time. The provider had been swift in appointing a replacement manager.
- One relative said, "They seem to get through managers quite quick, you get to know one, then they are gone." Another relative commented, "Collinson is going through another transitory period, staff have gone, there's a new manager. It's stable and not stable. The awful thing is the instability."
- Relatives overall told us they felt communication needed improving and felt they were not always listened to.
- One relative said, "We are still fighting for the same things. In the end you get fed up of asking. Nothing has changed." Another relative told us, "I get no reply [following a phone call] on a regular basis" and they went on to say, "I want to know what's happening every week not 3 weeks later being told what my relative has not done."
- Relatives gave us examples of times they had not been called back or poor communication, such as a missed appointment or missed activities.
- Multiple relatives told us they would move their relative out of Collinson Court, however as they were unaware of other suitable places for their loved ones to move to, they felt they had to remain there. One relative said, "If there was a service within 30 minutes, I would move my relative, but my relative is settled and happy where they are, but [another service] could offer my relative more." A different relative said, "I would move my relative tomorrow if we could find somewhere better, my relative is there by default, which is a shame."

People continued to not always be supported in line with their preferences. This was a continued breach of

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us how they planned to improve communication, both internally with staff, and with relatives.
● Despite the concerns noted above, relatives were universally complimentary of the deputy manager and the new manager. Relatives still felt staff were caring.
● A relative said, "[Deputy manager] is an absolute asset, they have been amazing." Another relative said, "[The new manager] is very approachable. They seem very hands on and committed to Collinson. The manager is interacting [with staff and people] a lot more."
● A staff member told us, "The new manager is nice. I feel able to report concerns." Another staff member said, "The management is positive now and they are focused on improving the lives of residents."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure there were effective systems in place to effectively monitor the quality and safety of people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● The provider had not made enough improvement to ensure people received good quality care which consistently met their needs and their systems were not always effective. Improvements which had been made were not always sustained.
● A relative told us, "Managers think it's all good but as soon as they go, it goes back to how it was. They should see the pattern when they step back as it always goes pear-shaped again."
● Staff had recorded in 1 person's daily care notes multiple incidents of self-injurious behaviour. The provider had systems in place to review and analyse these type of incidents. However, these incidents had not been identified and therefore had not been included in any analysis. Therefore, we could not be sure there would be continuous learning from incidents in order to improve people's care.
● Handover processes were still not always effective. At the last inspection there was a handover process in place which had not been fully effective. At this inspection there was a mixture of ways information was being handed over, so it meant it was not always consistent and it was not always recorded. A staff member said, "Communication doesn't happen – things don't always get handed over to me." The manager and deputy manager had started a new handover process to improve this, but this was not yet fully embedded and was not being consistently used. We will check this has been sustained at the next inspection.
● The provider had an action plan was in place, but this had not yet ensured people's care consistently improved, so actions taken had not all been successful yet.

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

● Despite this, we found possible triggers for another person's agitation had been identified and action commenced to try and address this.

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 manager was aware of their duty of candour.
● Relatives told us they were made aware if something had gone wrong, such as medicines errors.
● Notifications were submitted to the CQC, as necessary.

Working in partnership with others
● The service worked in partnership with external professionals and organisations.
● Professionals were positive about the management team and felt they were approachable their professional advice was followed. One professional told us, "The staff listen and action our advice and speak up if there are issues to the advice. The Management team is approachable and seems more settled to me." Another professional said, "There has been a recent change in relation to the manager, but the Deputy Manager has always been available to correspond and discuss issues with."

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 18 HSCA RA Regulations 2014 Staffing Staff did not always have the appropriate skills and experience to support people effectively.

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 9 HSCA RA Regulations 2014 Person-centred care People were not always supported in a personalised way that reflected their preferences and met their needs.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not always effective at identifying areas for improvement or omissions which could leave people at risk.

The enforcement action we took:

Warning notice