

Consensus Support Services Limited

Smugglers Barn

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

About the service

Smugglers Barn is a residential care home providing personal care to nine people at the time of the inspection. The service can support up to nine people. The home is comprised of two separate houses in close proximity, Smugglers Barn and Little Smugglers, these are both under the same registration with CQC.

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

Risks to people's health had not always been properly assessed to ensure they remained safe. Staffing levels were inconsistent and not always sufficient to meet people's needs. People's positive behaviour support was not always adequately managed.

People were not always supported with meaningful occupation and activities. Some people were supported to follow interests close to them and measures were in place to encourage people to access the community, although many were unoccupied and lacked structured routines. We have made a recommendation about the organisation of activities for people at the home.

Feedback about the management of the service was mixed. Staff and relatives said that communication was poor and lacked a willingness to work together. One staff member said, "We have not had consistent leadership." Quality assurance systems were in place but had not always identified issues that were found at the inspection.

People's medicines were administered safely and infection and prevention control procedures were well managed.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Safe, Responsive and Well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture

Right Support

Some people's needs had not always been properly assessed to ensure they were protected from avoidable harm. The model of care and setting did not maximise people's choice, control and independence. People were not receiving person-centred care due to the systems in place and staffing issues. Some people's specific support needs were not always clearly identified and met.

Right Care

People's needs and preferences were known by caring staff, but consistent shortfalls in staffing levels meant

that people did not always have access to meaningful occupation or receive the amount of support according to their assessed need.

Right Culture

People did not receive planned and coordinated person-centred support that was appropriate and inclusive for them. Leaders were not always transparent and did not promote an open culture at the service. People were supported by staff who followed systems and processes to administer, record and store medicines safely. Staff ensured that people were protected from infection throughout the COVID-19 pandemic. People's communication needs had been assessed, and their care plans included information and guidance on how staff could communicate with them effectively. Staff and management worked with other professionals and specialists to support people's care when required.

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 10 December 2019).

Why we inspected

We received concerns in relation to an increase in safeguarding issues, management of people's distressed behaviours and the governance of the service. As a result, we undertook a focused inspection to review the key questions of Safe, Responsive and Well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We also undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

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, responsive and well-led sections of this 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 Smugglers Barn on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and governance at this inspection. 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

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our safe findings below.

Requires Improvement ●

Smugglers Barn

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 Care Act 2014.

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

Two inspectors attended on the first day of the inspection. One inspector attended the second day.

Service and service type

Smugglers Barn 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. Smugglers Barn is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information we require providers to send us with key information about their service, what they do well and improvements they plan to make.

This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service and four relatives about their experience of the care provided. Some people were unable to communicate with us directly, so we undertook a number of observations to see how staff supported and interacted with them. We spoke with six members of staff including the acting manager, area operations manager, deputy manager and four support workers.

We reviewed a range of records. This included six people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We contacted two professionals who have a working relationship with the service.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- Risks to some people's care was not always monitored and managed safely. For example, one person had previously been observed by staff as having seizure activity in April and May 2021. Staff had made appropriate referrals for support, although documentation showed that an epilepsy diagnosis was still being investigated. There was no care plan or risk assessment to guide staff with any potential subsequent seizure activity. There was no advice on how to support that person safely and effectively, should they experience any further seizure activity.
- One relative said, "I don't think they (staff) fully understand his epilepsy. There are various types of seizure. The one that he has is absences - he has a lot of those. Last year one staff member said he doesn't have many at the service, but he does at home, but I don't think they recognise them. The staff should be more aware about these things."
- Other risks had been identified but not appropriately monitored or managed. One person had been identified as being at risk of choking. There was no record of an appropriate Speech and Language Therapy (SaLT) assessment or that a referral had been made. Although staff had been instructed to cut the persons food up, the failure to seek specialist support meant that choking risks to the person remained. The operations manager stated on the second day of the inspection that staff had made contact with the person's GP to request a referral to the SaLT team.

The provider has failed to do all that was reasonably practical to mitigate the risks people's health and safety. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other potential risks to people's health and daily living activities had been assessed and staff had guidance to mitigate the risk. For example, risks associated with people's mobility had been assessed and measures put in place to mitigate these.
- Risks to the environment had been considered and were monitored with regular checks. People had personal emergency evacuation plans (PEEPs) in place. PEEPs are used to help the emergency services know how to support people to evacuate in emergency situations.

Staffing and recruitment

- There were not always sufficient levels of staff to meet people's needs. Feedback from staff and relatives was poor regarding the level of support people received due to staffing. One staff member said, "When I started, we never used agency and had enough staff. Three months after, staff started leaving one after another. We felt the effect. We started getting agency in. There were different faces every day, three times a

day. We do get regulars now and the guys are getting used to them. The weekends are the worst though. It can go from one end to the other."

- The lack of permanent staff and consistent staff numbers had impacted on staff's ability to effectively support some people. One staff member said, "The only concern is about the staffing, they (people) are being limited in what they can do. This has been a big challenge. They have hours of 1:1 which most of the time they don't get. If there's two on shift and there should be three staff it doesn't work out. Those people need support with 1:1 which is sometimes not possible. (The manager) has failed us and we have raised our concerns and nothing has been done about staffing and other issues." Another staff member said, "We are short staffed here now. Sometimes you get days where it gets on top of you. There is so much pressure with staff." One relative said, "I think they are having staffing problems at the moment. I don't know what they are doing about it."

- We looked at eight weeks of staff schedules. The acting manager stated that schedules were in the process of being transitioned from separate rotas for each house in Smugglers Barn to a combined schedule for consistency. Rotas showed that there were often fewer staff than planned on many weekends. The service used agency staff frequently to address shortfalls in permanent staff members.

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems were in place to protect people from the risk of abuse, although these were not always effective.

- Some people displayed distressed behaviours and were a risk to themselves and others without the presence and intervention of staff. Staff told us that they received Positive Behaviour Support (PBS) training to support people when they were distressed or agitated, but some staff said that challenges with staffing meant that people were not always effectively supported.

- Another staff member said, "At Smugglers Barn its acted on well and they are supported properly. The challenge is at Little Smugglers. There are a lot of incidents and challenges. Most of the staff resigned and they end up in a situation where they can't manage them well. They are very vulnerable and need 1:1. They got some injuries in the process." One professional said, "There appears to be a real lack of understanding of [person] needs as a person with severe learning disability and autism by the service."

- The registered manager did not always effectively manage safeguarding concerns when they were raised. Concerns were raised on how one investigation into potential abuse was managed and how information was shared. One professional said about the highlighted concern, "It took the service over four months to share the summary of their internal safeguarding investigation report, which the family felt was incomplete and did not fully explain the investigation process or outcomes. There did not seem to be a robust policy in place about how internal investigation outcomes linked to safeguarding concerns were disseminated to all relevant parties."

- We asked one staff member how new staff or agency staff were given guidance about care needs and how to support distressed behaviour, but the staff member was unclear about how this was done. One staff member said, "PBS plans are effective. At the moment we are really short staff and we have agency staff. Permanent staff who knew them have left. It's a big challenge and most of the time they change staff and people can't get used to them. Every day they see new faces. Its takes time for people to get used to them and for them to get used to. They might not get time to read support files. This is where the problem sometimes comes from."

- Staff were aware of their responsibilities under safeguarding, were able to describe how they would recognise signs of abuse and knew how to report any concerns that they had about people's safety.

- Incidents were regularly reviewed to make any appropriate changes. For example, incidents where people had exhibited heightened anxieties and behaviour were reviewed by the providers Positive Behaviour

Support practitioner. Recommendations were made to guidance to help staff support those with anxieties and mitigate future occurrences.

Using medicines safely

- People were receiving their medicines safely.
- People were supported by staff who followed systems and processes to administer, record and store medicines safely. Staff who administered medicines were fully trained and assessed.
- During the inspection we identified administrative errors in relation the recording and auditing of medicines. One person's medicine chart indicated that they were still receiving a medicine to support them with anxieties although we were informed that they were no longer receiving this. We highlighted this with the management of the service and the error was immediately addressed.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- 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

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now changed to 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

- People, staff and relatives told us that while some people's interests and activities were supported and facilitated by staff, there was a lack of emphasis on providing occupation and activities at the home.
- The manager explained that the Covid 19 lockdown had had an impact on people's confidence to go out in the community. Staff had been proactively working with a professional to support one person with strategies to improve their confidence to access the community. However, our observations during the inspection was that there was limited organised occupation for people within the service. One staff member said, "We encourage them to get out. Part of it is the lack of staff, we can't do much. The only activities they would really do is get up and go out." One relative said, "I would personally like to see more. As a parent I would like to see his days filled with activities."
- Staff and peoples loved ones told us that while Covid had an impact on some, the issue with staffing was now impacting on their ability to provide meaningful occupation and access to the community. One relative said, "If there isn't the level of staff on duty, they can't provide the level of 2-1 to go out. So it may limit outdoor activities." Another relative told us, "They definitely don't put any activities on. They blame Covid. They have big area there. There's nothing stopping staff supporting people outside and there's no activities inside either." Another relative commented, "No I don't think they keep him occupied. He spends most of the time in his room watching DVDS. There's not much routine, not like when he first went there when they had a proper programme. They don't do much in the way of activities. He looks forward to his visits home here." One person said, "We are low on staff at the moment, we are short. You can't do so many activities it does affect this. They are trying."
- People were regularly supported to maintain relationships important to them. Where possible, staff supported people with visits to their family homes to maintain contact, while people kept in touch with loved ones when at Smugglers Barn. One relative said, "I talk to him very regularly on the phone. We are always at the end of the phone. He will tell staff if he wants to ring and they will always help him or leave a message."

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) 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

- People's care plans were detailed, and person centred, and staff we spoke with were knowledgeable about people's needs and preferences. However, there was considerable volume of documentation and guidance which made it difficult to identify which information needed to be followed and used. One staff

member told us that the degree of information could be overwhelming for agency and new staff to absorb effectively.

- Relatives told us that staff knew their loved ones well and worked proactively to support them with any changes and adapt to their needs. One family member said, "He has a schedule but it's very difficult to work with autism. He likes to be in control so it's what he wants to do and when, so staff have to work around him."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs had been assessed, and their care plans included information and guidance on how staff could communicate with them effectively. We observed people communicating with staff effectively.
- Staff described a good knowledge of peoples' communication needs and how they communicated with them. One staff member said, "It's about showing them options of things, using the now and next board. With (person) he used a little bit of sign language and I can relate to him." Another staff member said, "Most people can verbally communicate. For those who don't, we use pictures to support them. Identify their likes and dislikes, and interests e.g. Pubs, aeroplanes, like going to the airport, or pictures of a picnic." Another staff member said, "We communicate with them effectively, if you've been there for some time, you can understand their language. There's no one we can't understand."

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure in place.
- People we spoke to told us they would speak to staff if they had any issues or complaints and would feel comfortable doing so.
- Feedback from relatives was mixed on how the registered manager dealt with any issues or complaints they raised. One family member said, "I did have to make a complaint with the previous manager and it wasn't addressed and went to her line manager as I didn't feel it was being dealt with. When I've raised things with (current registered manager) which happens from time to time, she is very good at dealing with them and keeping me informed." Another said, "I don't have any problems there."

End of life care and support

- No one was receiving end of life support at the time of the inspection.
- People's end of life wishes had been discussed with them and their families. Not everyone wished to discuss this area of support and staff took a careful approach to care planning
- Peoples wishes and preferences were recorded within 'My Thinking Ahead' advanced care plans. These detailed any advanced legal decisions, the persons preferred place to receive end of life support and wishes that were personal or important to them.

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 the last inspection this key question was rated as good. At this inspection this key question has now 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.

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

- The service had a registered manager who was not working at the time of the inspection. The day-to-day oversight of the home was being undertaken by a peripatetic manager employed by the provider. They were supported by the area operations manager who visited the service weekly.
- People and staff all spoke of an inconsistency in leadership, stating that improvements in management support and communication were needed. One person said, "Management is ok, could be better." One staff member told us, "We do a lot for the management to get things resolved. The provider could do more. They could listen to us. I haven't had an incident or problem at work, but other people have. We talk to each other. The things I've heard that management haven't done. It would be nice to be filled in with what is happening rather than keep us waiting." Another staff member said, "The permanent staff numbers are low. They left because of the management. Sometimes you have a manager who is known to not be supportive to the staff and this is passed on to the supportive individual. If you don't communicate with staff when there is a problem or concern or listens to what staff are saying, this will cause a problem. Staff don't see themselves as valued."
- Staff spoke of the lack of communication around people's needs and getting response and feedback to issues they had raised. Another staff member said, "We are the frontline, but I'd appreciate for the people there we are supporting, we don't really get listened to. I just feel like they don't really listen. Management sit in their office, busy, but not listening."

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

- Although the provider has quality assurance systems in place, they were not always successful in identifying the issues raised in this inspection. Audits although completed regularly, had not identified issues or changes required and no actions had been taken forward to show learning and ongoing improvement.
- One professional commented on the registered manager's failure to effectively monitor and review essential guidance for one person's behavioural support. They said, "Sensory support strategies are integral to their ability to self-manage and a missing document with essential information stating daily support

strategies should have been picked up by the manager months before their behaviour started to deteriorate. This flags up the fact that his PBS plan was not adhered to or reviewed by the manager and the staff, and instead (the person) was supported using ad-hoc strategies, which did not always lead to favourable outcomes."

- Staff were positive about the care they provided to people but indicated that their roles required support and clarity from management to undertake them successfully. One staff member said, "To me the management has been poor. In areas of coordination between support workers and the management, there's hasn't been a good relationship. If that's not there, then a lot of things don't work. People can't be open. Communication of information about support we are to give is passed on well, but if there's a concern you want management to iron out, you may not get a good response."
- Although the provider was aware of their responsibilities around duty of candour, we received concerns from some relatives that the registered manager had not always been forthcoming and open when communicating with them when things went wrong. One relative we spoke to stated that they felt they weren't provided with the full information or feedback regarding safeguarding concerns they had raised, while another relative said of the registered manager, "She just sweeps things under the carpet, but they have a new deputy manager and they are trying their best."

The provider had not ensured that effective systems were in place to monitor and improve the quality and safety of the services provided. There were not effective communication systems in place to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff and people's loved ones were more positive about the impact of the manager currently overseeing the home. One staff member said, "It's been nice having [current manager]. They've done a lot more than anyone. Things that we wanted. Since they entered our building things have started to happen. We've had more information. If anyone wants advice, they are always there with an answer."
- People were involved in their support. People had meetings with their keyworkers to provide feedback on their support, while relatives were often involved in annual reviews or provided feedback through provider surveys.
- A range of quality assurance audits were undertaken to assess the quality of the care provided. These included checks on health and safety and the environment. The provider completed regular checks on the service.
- Staff knew the whistleblowing processes and confirmed that they would use this if they needed to report concerns.
- The management had ensured that they informed CQC of any significant events, such as when there had been suspected abuse or when someone had suffered a significant injury. This ensured that CQC could monitor that the correct actions had been taken.

Working in partnership with others

- Staff and management worked with other professionals and specialists to support people's care when required. For example, joint working was completed with local Community Learning Disability Teams.
- One professional said, "The staff are always prepared for my visit and have been following my advice with regard to the work we are supporting resident (name) with. They have demonstrated knowledge about their needs and how best to support them to access healthcare. They have implemented the strategies I have suggested. The current manager/temporary team leader also has contacted me about medical queries

when requiring additional support."

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 The provider has failed to do all that was reasonably practical to mitigate the risks people's health and safety.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that effective systems were in place to monitor and improve the quality and safety of the services provided. There were not effective communication systems in place to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's needs.