Voyage 1 Limited

Barley Close

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

The inspection took place on 12 and 18 April 2016 and was unannounced. We previously inspected the service in August 2013 and found no breaches of regulations in the standards we looked at.

Barley Close is registered to provide accommodation with personal care and support for up to ten adults. Seven people lived there when we visited, whose ages ranged from 23 to 65.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived at Barley Close had profound and complex learning disabilities, several people had autism, physical disabilities and were unable to verbally communicate with us. The service recognised the individuality of each person regardless of their level of disability or support they needed.

Staff developed exceptionally positive, kind, and compassionate relationships with people. People's care was individualised, staff put them first and knew them really well, such as what made a good day for them. There was a relaxed, calm and happy atmosphere at the home with lots of smiles, good humour, fun and gestures of affection. People were relaxed and comfortable with staff who were attuned to their needs. Staff could recognise how a person was feeling from their non-verbal cues such as body language, gestures and vocal sounds and they responded appropriately. Staff spoke with pride about the people they cared for and celebrated their achievements.

A detailed communication plan identified each person's preferred communication methods. Staff used a variety of non-verbal communication methods to help people to communicate effectively. For example, using a picture exchange system, Makaton (a form of sign language), and sensory objects. A 'smiley face' system was used to monitor people's enjoyment of food and activities, so staff could be change and improve their approach in response to their feedback.

People enjoyed spending time in a newly developed sensory room, a special room designed to help them develop their senses through special lighting, music, and objects. One person looked relaxed listening to music and watching a light show, and another picked up their musical toy, held it to their ear, listened intently and smiled.

Each person had a support plan developed with the person, a relative or others who knew them well, which highlighted their positive attributes. Support plans identified family and friends important to the person's emotional and psychological well-being. Each person had a key worker who took a lead role in the person's care and was the main contact for relatives.

People received a consistently high standard of care because staff were led by an experienced, and proactive team. Staff were highly motivated and enthusiastic, and were committed to ensuring each person had a good quality of life. There was a clear management structure in place, staff understood their roles and responsibilities and were accountable.

The culture at the service was open and honest and encouraged staff to see beyond each person's disability. Staff demonstrated the provider's values of 'passion for care, positive energy,' and used their initiative to help people to succeed. The registered manager led by example, set high expectations and provided staff with a high level of support. They had an 'open door' policy, worked alongside staff using a coaching style of leadership and challenged them to continuously improve people' s care and their quality of life. Professionals and staff consistently gave us positive feedback about the registered manager's leadership, which they described as "brilliant."

People's rights and choices were promoted and respected and staff explored new ways to help people make more choices and decisions for themselves. Staff understood the Mental Capacity Act (MCA) and used it confidently, its principles were embedded in the provider's assessment framework and in day to day practice. Comprehensive records of 'best interest' decisions were kept including a register of decisions for each person.

The service had enough staff to support each person's assessed needs and organised people's care flexibly around their wishes and preferences. People pursued a range of hobbies, activities and individual interests. For example, baking, music workshops, arts and crafts, and swimming. The service had a wheelchair accessible minibus, car and some people used local buses and enjoyed trips to farms and animal sanctuaries, the cinema and the theatre. People were well known in their local community where they visited local cafes, shops and restaurants. Relatives said they appreciated that people were stimulated, enjoyed a range of activities, went out regularly and had holidays.

Staff treated people with dignity and respected their privacy, they were discreet when supporting people with personal care. The service had a 'dignity' advocate who championed dignity issues within the staff team. They raised awareness of best practice by making resources available, and encouraged staff to raise dignity issues and identify creative solutions at staff meetings.

Each person had a comprehensive assessment of their health needs and support plans had detailed instructions for staff about how to meet those needs. People were supported to improve their health through good nutrition and a healthy lifestyle. Staff encouraged people to eat a well-balanced diet, make healthy eating choices and be active. People improved their mobility through a regular exercise programme, and some people were on weight reducing plans, which could further improve their mobility. People enjoyed their meals and ate well and the food served looked appetising and smelt delicious.

Staff worked closely with local healthcare professionals such as the GP, local learning disability team and specialist professionals to improve people's care. Each person had a health action plan and mobility plan, through which staff encouraged them to improve their health. Health professionals consistently praised staff and told us how people's health had improved. They said staff were proactive, sought their advice and implemented it.

The provider used a quality and compliance audit tool based around CQC's fundamental standards, to monitor the quality of care at each service. Regular audits of care records, medicines management and health and safety checks were carried out with action taken on areas that needed improvement. Quality monitoring reports demonstrated the service was consistently high performing within the provider group.

The registered manager said the provider's policies and procedures and quality monitoring systems were "excellent." This was because they said they measured the right things and helped them identify areas for further improvement.

The service had a comprehensive training programme to ensure staff had the right knowledge and skills relevant to the needs of people they supported. For example, the service used positive behaviour support training, to support people with behaviours that challenged the service. The provider also employed a behaviour therapist, staff could access advice from to to help with meeting people's emotional and behavioural needs. This increased staff skills and confidence to promote people's freedom because staff felt more confident to support them to go into the community.

The environment of the home was bright and airy, with a calm and relaxing colour scheme and lots of interesting pictures and artwork. All ground floor areas of the home were accessible for people with physical disabilities, including wheelchair access to an enclosed garden. Relatives particularly commented positively on the facilities available.

People who lived at the home were not able to verbalise their feelings or thoughts in order to raise a concern or complaint. Day to day staff used 'smiley face' charts to check and record what they enjoyed and found difficult. Relatives knew how to raise concerns which were listened and responded to, with actions taken in response. The service had received no complaints and had several compliments from relatives.

The service continually reviewed evaluated and improved people's care. People, families and visiting professionals were surveyed each year to get their feedback about the service. Responses showed they consistently reported positively about all aspects of care provided. An annual service review report was compiled to inform people and families them about further actions being taken to improve the service. For example, improving the garden for people by adding sensory planting and a vegetable patch.

People appeared happy and content in their surroundings. Relatives said they felt people were safe at the home because staff knew how to look after them. Personalised risk assessments balanced risks with minimising restrictions to people's freedom. Equipment was regularly serviced and tested as were gas, electrical and fire equipment.

People received their medicines safely and on time from staff who were trained and assessed to manage medicines safely. Accidents and incidents were reported and included measures to continually improve practice and reduce the risks of recurrence.

Staff understood the signs of abuse and knew how to report concerns, including to external agencies. They completed safeguarding training and had regular updates. Where a safeguarding concern was raised, the registered manager took robust action to improve staff practice and safeguard the person.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise signs of abuse and how to report suspected abuse. Any concerns reported were acted on.

Risks to people were managed to reduce them as much as possible, whilst promoting people's freedom and independence.

People were supported by enough staff to receive care at a time and pace convenient for them.

People were supported to take their medicines on time and in a safe way.

Accidents and incidents were reported and actions were taken to reduce risks of recurrence.

Is the service effective?

Good

The service was effective.

People were offered choices and staff supported people to make as many decisions as possible, using a range of communication methods.

Staff understood the Mental Capacity Act (MCA) and its principles, which was embedded in day to day practice at the home. Comprehensive records of 'best interest' decisions were kept for each person.

People's health and mobility were improved by staff who worked with a range of professionals They were supported to lead a healthy lifestyle and have access to healthcare services.

People's health and mobility had improved and health professionals were consistently positive about the skills of staff and their impact on people's health and wellbeing.

Staff were skilled at meeting people's complex health and communication needs using evidence based approaches. Staff had regular training relevant to the needs of people they

supported, and regular support and development through supervision and appraisals.

Is the service caring?

Outstanding ☆

The service was caring.

Staff developed exceptionally positive, kind, and compassionate relationships with people. People's rights and choices were promoted and respected.

Staff demonstrated person centred values, which placed an emphasis on respect for the individual being supported. People were treated with dignity and a 'dignity' advocate promoted and championed dignity issues within the team.

The service used a wide range of non-verbal communication methods in innovative ways to enable people express their views, and make choices and decisions. This helped them increased their independence.

Staff protected people's privacy and supported them sensitively.

Is the service responsive?

Outstanding ☆

The service was responsive.

People received care that recognised the individuality of each person, regardless of their level of disability or the level of support they needed.

People's social skills had improved and they were part of their locally community. Staff supported people to pursue a wide range of activities, and health action plans helped people be more active by improving their mobility.

People who lived at the home were not able to verbalise their feelings or thoughts. Staff used innovative ways to consult and involve people and respond to their needs .

People's support plans were detailed and comprehensive and described positive ways in which staff could support them. These were regularly reviewed and updated as people's needs changed.

Relatives knew how to raise concerns which were listened and responded to, with actions taken in response.

Is the service well-led?

Outstanding ☆

The service was well led.

People received a consistently high standard of care because the registered manager led by example and set high expectations about the standards of care.

The culture was open and honest and focused on each person as an individual. Staff put people first and were committed to continually improving each person's quality of life.

People experienced care and treatment that improved their health and promoted their well- being. The provider promoted best practice and people benefited from the skills and knowledge of staff.

The provider had robust quality monitoring arrangements through which they continually reviewed, evaluated and improved people's care. The provider's quality monitoring showed the service was consistently high performing.

Barley Close

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 and 18 April 2016 and was unannounced. The inspection team included an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we looked at all the information we had about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at previous inspection reports, feedback from questionnaires, records of our contact with the service and any notifications received. A notification is information about important events, which the provider is required to tell us about by law.

People living at the service were unable to verbally communicate so could not comment directly on their care and experience of living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We met with all seven of the people who lived at the service and spoke with three relatives. We looked in detail at three people's care records. We met with the registered manager, operations manager and with nine staff who worked at the service. They included care and support staff. We looked at four staff records which included recruitment, staff training, supervision and appraisal records. We looked at the provider's quality monitoring systems which included audits of medicines, health and safety and infection control audits, provider quality monitoring visit reports and details of any actions taken in response. We sought feedback from commissioners, the GP practice, specialist therapists such as speech and language and physiotherapists, as well as members of the local learning disability team and received a response from three of them.

Good

Is the service safe?

Our findings

People appeared happy and content in their surroundings. Their demeanour and body language around the home showed they felt safe and secure. They were safely cared for by experienced staff, who were observant, and were aware of individual risks for people and how to minimise them. Relatives said they felt people were safe at the home because staff knew how to look after them.

Staff understood the signs of abuse and knew how to report concerns. They completed safeguarding training and had regular updates. The registered manager had recently attended a local authority practitioners safeguarding training day to update their knowledge. Staff said they would have no hesitation in reporting any concerns to a senior member of staff, and knew how to report concerns to external agencies. The registered manager responded to a concern raised with the local authority about potential abuse, and had taken robust action to improve staff practice to safeguard a person. There were robust systems in place to support people with their monies and account for all expenditure. These measures reduced people's risk of financial abuse.

The provider had a whistleblowing policy in place, known as 'See something, say something.' This meant staff were aware they could raise any concerns in 'good faith' without fear of recrimination. A staff member told us about their experiences of doing so and confirmed the concerns they raised were investigated and responded to, which meant the person's care improved.

Personalised risk assessments promoted people's safety and reduced risks for people as much as possible. For example, a person was assessed as at increased risk of choking by a speech and language therapist (SALT) because of difficulties chewing and swallowing their food. The person's support plan had detailed information about how to reduce risks for that person. This included advice about preparing the person's food to a soft consistency, supervising them at mealtimes and encouraging them to chew and swallow each mouthful before eating again. At lunchtime, staff followed this advice which minimised the person's choking risk.

Staff balanced risks for individuals with the freedom to have new experiences. A number of people living at the home had epilepsy and experienced regular seizures. Staff were very aware of each person's safety in relation to their epilepsy and the need for close monitoring. However, they were skilled in managing these risks and made sure people's condition didn't restrict their lifestyle. For example, staff carried a person's rescue medication wherever they went and said they felt confident to deal with any seizures. Another person had health risks which made swimming a more risky activity for them. Their risk assessment was detailed about how to keep the person safe and get them out of the pool if they showed any signs of becoming unwell.

People were supported by staff to receive their medicines safely and on time. The service used a monitored dosage system on a monthly cycle for each person. Staff were trained and assessed to make sure they had the required skills and knowledge to administer medicines safely. Medicines administered were well documented in people's Medicine Administration Records (MAR), as were records of prescribed creams

applied.

Medicines were checked and medicine administration records were audited regularly and action taken to follow up any discrepancies or gaps in documentation. Annual medicine reviews were completed for each person with their GP and an epilepsy specialist, if appropriate. This meant health professionals were checking regularly that people's medicines were still relevant and effective for their health needs.

Accidents and incidents were reported and included measures to reduce risks for people. For example, any slips, trips or falls were reviewed to identify any avoidable factors, so they could be addressed to reduce the risk of recurrence. For example, by reviewing the layout and environment in a person's bedroom to further reduce trip hazards.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. A detailed assessment of each person's needs included a calculation about their staffing support needs. The registered manager monitored staffing levels to ensure each person's funded staffing levels were still appropriate and were being maintained.

Staff met people's needs at a time and pace convenient to them. The atmosphere in the home was calm and organised, staff worked in an unhurried way and were able to spend time with each person and respond to their needs and wishes. For example, when a person needed help to eat or drink or have help with personal care, a staff member was available to help them. Where people's care records showed a person needed two staff for personal care or one to one support to go out, staff confirmed this was provided.

During the day the staffing numbers varied from four to seven depending on people's activity plans. At night, there were two staff on duty, which meant there was support available in case of emergencies. There were no staff vacancies at the service. The registered manager said they were continuing to recruit bank staff and did not use agency staff. This was because they wanted to increase the number and quality of bank staff, so all staff had the right skills to support people. They were committed to this approach because they did not want people to miss out on opportunities or experiences due to staff leave, or sickness This meant people benefitted from continuity of care by staff who knew about their care needs and preferences.

Environmental risk assessments were completed for each room and showed measures taken to reduce risks. For example, in response to a falls risk identified in the garden, a gate was recently installed at the top of a flight of steps. The provider had systems in place that staff used to monitor the safety of the environment such as checks on health and safety, infection control, medicines management, and fire prevention measures. These were up to date and showed repairs and maintenance of the building was regularly undertaken. Equipment was regularly serviced and tested as were gas, electrical and fire equipment. Regular checks of the hot water system, fire alarm and fire extinguishers, smoke alarms, and fire exits were also undertaken.

In the provider information return, the registered manager said they had worked with the local fire safety officer to develop a personal emergency evacuation plan for each person. This took into account the individual's mobility and the support they would need from the emergency services to be evacuated in the event of a fire. There were regular unannounced fire drills carried out including simulated evacuation using the equipment. This meant staff were confident they could respond to a fire emergency at any time.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had access to hand washing facilities and used gloves and aprons appropriately. Housekeeping staff had suitable cleaning materials and equipment. Soiled laundry was appropriately segregated and

laundered separately at high temperatures in accordance with the Department of Health guidance.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Staff had police and disclosure and barring checks (DBS), checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Good

Is the service effective?

Our findings

People's needs were met by staff who had an in-depth knowledge of their care and treatment, and were skilled and confident in their practice. A relative said, "Staff are experienced, they understand her needs and moods."

The provider had a comprehensive staff training programme to ensure staff had the right knowledge and skills to meet people's individual needs, which benefited the people living at the home. A training matrix showed all staff undertook regular training and updates on topics such as safeguarding adults, health and safety, moving and handling and infection control. The provider also had a comprehensive range of staff training, relevant to the needs of people they supported. In the provider information return, the registered manager said staff had recently undertaken update training about epilepsy and the use of rescue medicine, on autism, learning disabilities and non-verbal communication methods, such as Makaton, (a form of sign language). Most staff had qualifications in care or were working towards them.

When staff first came to work at the home, they undertook a period of intensive induction for one to two weeks. This included working alongside the registered manager and other experienced staff to get to know people, including their care and support needs. All new staff had a probationary period to assess they had the right skills and attitudes to ensure good standards of practice. New staff were undertaking the national care certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life. A newer member of staff said they felt very well supported by other staff who checked they were carrying out their roles and responsibilities to the standard expected. They were about to have their six month probation review to check they had the required competencies to become a permanent member of staff.

Staff received support through regular one to one supervision, group supervision in handover and at staff meetings. Supervision also included senior staff monitoring staff practice around the home, and providing constructive feedback. Staff had an annual appraisal and regular performance review meetings, where they had an opportunity to discuss their practice and identify any further training and support needs. All staff training, supervision and appraisals were monitored and showed staff were up to date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff understood the Mental Capacity Act (MCA) and used it confidently. MCA principles was embedded in day to day practice at the home.

People were offered choices, in every aspect of their day to day decision making, such as what time to get up, what to wear, choices at mealtimes and about what activities they wished to do. Staff sought people's consent for all day to day support and decision making, using a variety of way appropriate to their individual communication needs.

Staff understood the Mental Capacity Act (MCA) and its principles, which were embedded in their day to day practice. Each person's capacity to make day to decisions about their care and support had been assessed. Staff using a range of communication methods to supported people with decision making. For example, staff offered a person several different coloured balls so they could choose which colour they wished to choose for an activity, and they selected a blue one. To help a person prepare for an activity, a person's support plan advised staff to 'ask her if she would like to take part and show her an object of reference such as a swimming costume for swimming.' Another person's support plan said, 'Give me a choice and I will let you know which one by smiling.' Support plans also indicated to staff how they would recognise when a person was withholding their consent such as through their body language, and facial expressions.

Where a person indicated they did not wish to do something staff suggested, their choice was respected. For example, staff tried to encourage a person to come to the dining room for meal times to prevent them becoming isolated. The inspection meant there were visitors in the home the person didn't know, so they were more reluctant to come to the dining room. So, staff offered this person lunch in a quieter area. However, when the person indicated they didn't wish to do this by deciding to return to their room, their choice was respected.

Where people lacked capacity, staff consulted with families and health and social care professionals in making 'best interest' decisions, which was confirmed by the relatives. Where a person had no close relatives, staff arranged for an independent mental health advocate to represent them. A register of significant decisions made in in each person's best interest was recorded in their care records. For example, a 'best interest' decision about the use of a standing frame at mealtimes, to help a person with their mobility. Other 'best interest' decisions examples included the use of monitoring equipment for a person with epilepsy, and the introduction of a modified diet for a person with swallowing difficulties.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. None of the people who lived at the home could safely go outside without the support and supervision of a member of staff. The registered manager said everyone who lived at Barley Close had been assessed as lacking capacity, and were under staff supervision to meet their day to day needs. There were appropriate security systems in place on the front door, garden door, emergency exits and windows, so that people couldn't accidentally leave the building, without staff being alerted. The registered manager had submitted Deprivation of Liberty applications to the local authority DoLS team for all seven people, and were awaiting their assessment. This was in accordance with the relevant MCA and DoLS legislation and codes of practice.

Each person had a comprehensive assessment of their health needs and had detailed instructions for staff about how to meet those needs. Staff worked closely with the local GP, and members of the learning disability team as well as an occupational therapist, speech and language therapist and a physiotherapist. Health professionals said staff were proactive and sought their advice appropriately about people's health needs and followed that advice. One said, "People with high needs are managed well." A GP said they were particularly impressed that staff made appointments for people to visit them at the surgery, for routine health checks, rather than requesting home visits, despite people's complex needs.

A 'hospital passport' provided key information about each person, their communication and health needs, in the event they needed a stay in hospital. Where a hospital stay was needed, staff would accompany the person and liaise with the learning disability liaison nurse at the hospital.

We followed up concerns raised with us about how one person was moved. The person had a detailed

moving and handling risk assessment which instructed staff how to carry out transfers, including details of equipment needed. When the person went into the kitchen, during a busy period, staff encouraged them out again for their safety. Had the person been unwilling to do so, staff said they would use a sliding sheet, which was in accordance with the person's moving and handling plan.

We also observed two staff helping a person to transfer in a communal area using hoist equipment. Throughout the transfer, staff were reassuring and instructing the person to gain their co-operation. The person looked relaxed and calm throughout because of the way staff supported them. The junior member of staff was explaining to a more senior member of staff what they were doing and why. This was so the senior staff member could check they understood the principles of their moving and handling training, and were using the equipment competently and correctly.

The service had a plentiful supply of moving and handling equipment such as stand aids, hoists and hoist slings in various sizes, so people didn't have to wait. They also had spares in various sizes, so soiled slings could be regularly laundered. People had specialist equipment to meet their individual needs. For example, monitoring devices to alert staff if a person with epilepsy was experiencing a seizure. Furniture was especially chosen to ensure it was appropriate for people's needs. For example, one person was able to sit comfortably at the table in their specialist chair.

People were supported to improve their health through good nutrition. People seemed to enjoy their meals and ate well. The food served looked appetising and smelt delicious. Two support staff were passionate about cooking food from scratch using fresh ingredients and local seasonal produce. For example, homemade soups, stews and roast dinners. There was a four week menu which was changed regularly and a choice of two meals at each mealtime. Where a person indicated they disliked their lunch and pushed their plate away, an alternative meal was offered.

Staff offered people who needed it one to one support, in accordance with their meal plan, and copies were kept in the dining room for staff to refer to. Some people had adapted cutlery and crockery to enable them to eat independently. Throughout the day people were offered regular drinks and snacks to ensure their nutrition and hydration needs were met. At lunchtime, staff joined people at the dining table and made it a sociable occasion. Staff provided one to one prompting and encouragement to people who needed additional support to eat and drink. They were patient and allowed each person as much time as they needed to eat their meal.

In the provider information return, the registered manager highlighted the strong emphasis placed on the importance of people eating and drinking well for their health. Staff encouraged people to eat a well-balanced diet and make healthy eating choices. Some people were on weight reducing plans, as the registered manager explained being overweight would further reduce the mobility of a person with a physical disability. Staff were aware of people's specific dietary needs and each person's food was prepared in accordance with their support plan. For example, where a person's food needed to be of a softer consistency, to help a person swallow it.

People's nutritional needs were assessed and a daily record of each person's eating and drinking was kept. Their weight was monitored regularly so staff were alerted to any changes which might need further action. At handover and team meetings staff discussed people's nutrition and hydration needs and made suggestions for improvement. For example, discussing strategies to improve a person's nutrition by offering them regular snacks, and by leaving the food with the person so they could eat it when they wanted, rather than staff trying to give the person their food. Staff also discussed high fibre foods they could try for another person.

The environment of the home was bright and airy, with a lovely calm and relaxing colour scheme and lots of interesting pictures and artwork. A relative said they particularly liked the environment of the home. They said, "It's a great place, there is so much space, as [person] likes to wander." People moved freely around the home pursuing whatever task or activity they had chosen to do. Staff used pictorial images to help some people identify where they wished to go, so they could assist them to do so.

All ground floor areas of the home were accessible for people with physical disabilities, including wheelchair access to an enclosed garden. The corridors were wide so people could move around on specialist chairs, and mobility equipment and there was a living room and large conservatory. People who liked cooking were supported with meal preparation in a dedicated kitchen area with height adjustable counters, so they could work at a height suitable for them.

Outstanding ☆

Is the service caring?

Our findings

Staff developed exceptionally kind, positive and compassionate relationships with people. They demonstrated person centred values, which placed an emphasis on respect for the individual being supported. People's care was individualised, staff put them first and knew them really well, such as what made a good day for them. For one person, this was a trip to Sidmouth for tea and cake with a walk along the beach to feel the wind in their hair.

There was a relaxed, calm and happy atmosphere at the home with lots of smiles, good humour, fun and gestures of affection. We watched how a person got the giggles because of the playful way a staff member was interacting with them. The staff member said, "They have a wicked sense of humour." A visiting professional said, "There is an excellent atmosphere in the home, staff are so caring and people enjoy a good quality of life."

Each person had a key worker who took a lead role in the person's care and was the main contact for relatives. Staff said key workers were particularly close to the people they supported, because they knew and understood them really well. Relatives said the service was "homely", and one said, "[Person] has a good quality of life, they love the attention. Their care worker keeps in touch and we are consulted and involved in decisions about her." Another relative said, "I'm very pleased, staff are very caring, they know her, understand her needs well, and encourage her to be independent, and they keep me up to date." Staff told us how they had re-established contact with another person's relative, who now visited them regularly, which they were delighted about. A member of staff said, "This home is a really happy place, it's so rewarding, we have great job satisfaction." Another staff member doing their first job in care work said, "It's the best job I've ever had."

People were supported to keep in contact with friends and make new friends. For example, two people went to a youth club one evening a week, where they met up with friends and enjoyed dancing to their favourite music.

Each person had a support plan which had been developed with the person, a relative or others who knew them well. People's care records identified family and friends important to the person's emotional and psychological well-being. Relative's views and opinions were sought in developing the person's support plan and they participated in people's annual reviews. Support plans highlighted people's positive attributes, including a section called, 'What others like and admire about me.' For one person this was their infectious laugh, determination and independence.

People who lived at Barley Close had profound and complex learning disabilities. Although they could understand what staff were saying to them, they could not verbally respond. Despite this, staff spoke with people them in a conversational tone, using simple, short sentences and making good eye contact to get their attention.

Staff understood and recognised what people might be trying to convey through their non-verbal

communication. They watched people's facial expression and body language closely, so they could gauge reactions, recognise any mood changes and respond to them. This was because they were trained and experienced in using a range of tools to support people to express their views. This meant people could be actively involved in making decisions about their care, treatment and support.

For example, when a person wasn't enjoying the activity a staff member was doing, the staff member noticed and offered them a hand massage instead. When another person's vocal sounds became louder, this indicated to the staff member the person wanted their attention, so they responded immediately and engaged with the person who then became quite happy and settled.

Staff successfully used a range of communication methods to help people communicate effectively. These included using a picture exchange communication system (PECS – which helps people initiate communication by handing out picture cards to convey what the person wants). Other tools used included Makaton (a form of sign language) and objects of reference (these are objects which have special meanings, such as a cup to indicate when a person wants a drink). These communication methods help people with a sensory impairment. This is because providing information through touch, pictures and symbols can be easier for a person with cognitive difficulties to interpret their meaning.

For example, when a person moved from a sitting position on the sofa to a kneeling position on the floor, the staff member wasn't sure what the person was trying to convey. They encouraged them to use their picture cards, so the staff member then understood the person wanted to go to the bathroom.

Each person had a detailed communication plan which identified their preferred communication methods. Records also included helpful explanations of what people's individual behaviours might indicate. For example, if a person showed a staff member a toy, it meant they wanted staff to play a game with them. Another person had an activity planner using the person's own bespoke version of Makaton, which helped the person choose which activities they wished to undertake.

Staff were motivated and worked tirelessly to identify new ways to help people make choices, express their views and make as many decisions as possible. For example, staff experimented with introducing picture communication to expand a person's communication. Staff used pictures with the person to help them ask for a drink and to indicate which room they wanted to go to within the home. After a trial period, staff concluded the person actually responded better when they were offered objects of reference, so they updated the person's communication plan to reflect that. This ethos meant staff were always striving to find new ways to enable people to make decisions and choices.

Where people had no close relatives, staff acted as an advocate for the person to uphold their rights. For example, when external professionals suggested a person shouldn't go swimming because they felt it was too risky for them, the registered manager intervened. The person loved swimming and really benefitted from it. They sought support from other professionals and demonstrated to them how staff safely supported this person swimming, and minimised any risks. The professional agreed the person should be allowed to continue swimming and wrote a letter to confirm this was their professional opinion.

The service had information about advocacy services and contact details, which they could use if they needed someone independent to speak up for people. This included lay advocates or statutory advocates, such as Independent Mental Capacity Advocates ('IMCAs'), a service they had used recently to represent the person's interests with a 'best interest' decision.

Staff treated people with dignity and respected their privacy. They were discreet when supporting people

with personal care, respected their choices and acted in accordance with the person's wishes and preferences. For example, using a light scarf around a person's neck to catch any excessive moisture from their mouth. Another person liked to change their clothes regularly, sometimes several times a day, which staff patiently supported them to do. People's clothes were protected from spills and staff didn't fuss if food was spilt on the table, floor, or on them. They helped the person clean their hands and face and change any soiled clothing after their meal and wiped up any spills. Mealtimes were sociable and people were encouraged to eat as a 'family' at lunch and dinner. However, some people with autism often chose to eat in their own time, and this was respected.

The service had a 'dignity' advocate who championed dignity issues within the staff team. They raised awareness through make 'best practice' resources available to staff, and by raising dignity issues at staff meetings and encouraging them to identify creative solutions. For example, minutes of a staff meeting showed staff discussed how to protect a person's dignity, and agreed on using long vest tops to protect their modesty.

People were supported to maintain and develop their independence. For example, a person living upstairs needed supervision and assistance coming down the stairs because of their mobility needs. Equipment alerted staff when the person left their room, so staff reacted quickly and met the person at the top of the stairs so they could support them to come downstairs. However, staff managed this sensitively and unobtrusively which enabled the person to retain their independence. They stayed nearby and waited patiently, and only intervened when necessary with gentle prompting and to remind the person to use the techniques they had been taught.

In the provider information return, the registered manager said they were just starting work on developing advanced directives, starting with two older people. Advance directives are legal documents that allow a person and their representatives to make known any wishes about a person's end of life care and treatment to help staff and health care professionals caring for them.

Outstanding ☆

Is the service responsive?

Our findings

Care was personalised, staff knew about people's lives, their families and what they enjoyed doing. The service recognised the individuality of each person regardless of their level of disability or the support they needed. Staff spoke with pride about the people they cared for and celebrated their achievements. They worked flexibly and organised their day around the needs and wishes of people.

Relatives appreciated that people were stimulated, enjoyed a range of activities, went out regularly and had holidays. A relative said the person particularly loved swimming, music and singing. Another relative said what they particularly liked about the home was how the person enjoyed a range of trips out. They said, "[Person's name] likes to be out, they take people out on so many trips; bowling, the pictures, and on holiday to Butlin's."

People's support plans described positive ways in which staff could support them. They were detailed and comprehensive about all aspects of each person's care, staff confirmed they were accurate and up to date. They included people's likes and dislikes, preferred routines, how they liked to be supported with their personal care, preferred clothing, activities, and food.

For example, staff kept a food diary for a newer person for over six months to help them their preferred food choices by using 'smiley face' feedback charts. From this they compiled detailed information about this person's food habits, likes and dislikes. One person's sensory support plan showed they liked any activities that involved music or water, another person's showed they liked to crumple the pages of a magazine because they liked the sound. A section of another person's support plan about 'How to support me well' advised staff to, 'Always greet me with a smile, make me laugh and let me know what is happening.' Another section, 'What people like and admire about me', gave us a real sense of each person, for example that a person had, 'a lovely smile, sense of humour and was really friendly.'

Each person had a health action plan about the things they could do to remain healthy and active. For example, an individual mobility plan, through which staff encouraged people to remain active. This included a regular exercise programme and details of any specialist equipment needed. The registered manager explained that a person's mobility had "massively improved" since they started using a standing frame. This helped the person by strengthening their leg muscles and increasing their bone strength. They explained there were other benefits as well, such as reducing the person's problems with constipation through their improved posture and movement. A health professional who visits the home regularly said, "This is no ordinary home, staff are dealing with residents with lots of challenges. I am amazed at by the quality of the service provided, I can't fault it." Another professional speaking about improvements to people's health said, "It's difficult to imagine how it could be any better."

Ceiling hoists were fitted in all the ground floor rooms at the home, which enabled staff to support people to move easily around their room. During our visit, a piece of specialist mobility equipment for a person broke. The registered manager immediately contacted the specialist company and the person's relative, and arranged for it to be repaired, as the person used it every day. The equipment was repaired and back in use,

when we returned to the home on the second day.

Where another person's mobility had decreased, they had been moved downstairs, as there was no lift access to the first floor of the home. This meant people could only be accommodated in the upstairs rooms if they were sufficiently mobile to use the stairs. The relative of a person whose mobility was decreasing said, "Ideally, I would prefer him to be on ground floor, although staff manage his mobility well. At the last review meeting we made the decision staff would accompany him going downstairs." In the provider information return, the registered manager said the provider was considering making further adaptations to the upstairs rooms to meet people's mobility needs. This included exploring the possibility of having a lift installed.

People's quality of life had improved because staff felt confident to support people with behaviours that challenged the service to access the community. Staff used Positive Behaviour Support (PBS) which is based upon the principle that if you can teach a person a more effective and more acceptable behaviour than the challenging one, the challenging behaviour will reduce. This approach had increased staff skills and confidence and reduced the use of restrictive practices.

For example, staff described how a person might clap repeatedly when they were becoming anxious and could hit out at staff or a passer-by if they were unhappy. They said the person disliked waiting, so when they went to a restaurant or coffee shop they had learned to pay for any drinks or food straightaway. This meant the person could leave the restaurant whenever they were ready to go, which was in accordance with their support plan. This demonstrated staff were attuned to behaviour 'triggers' for this person and used this information positively, so the person could enjoy going out without incident.

The provider employed a behaviour therapist, who gave staff specific advice to help them meet people's individual emotional and behavioural needs, and manage specific aspects of people's behaviours. For example, a person had a tendency to pinch others when they were in close proximity with them. Staff were alert to this danger and whenever the person ventured too close to another person, they caught the person's attention, distracted them and moved them away quietly and without fuss. Although the person pinched staff sometimes, the registered manager confirmed there were no incidents, where this person had pinched other people. This showed staff managed this person's behaviour positively, and without incident using the techniques recommended by the behaviour therapist.

Staff kept daily records which documented details of how people had spent their day, about their mood, meals, snacks and drinks. At the end of each month, key workers collated a summary report about each person, which highlighted their achievements and any challenges. They made plans and set goals for the forthcoming month. Each person had an annual review which involved the person, their care manager, staff and families. In the provider information return, the registered manager highlighted how some people's social skills had improved tremendously since they moved to Barley Close, which they said families and care managers were particularly pleased about. For example, a person who was previously quite anxious and withdrawn was now more relaxed around other people. This meant they spent more time in communal areas of the home, rather than in their room.

People were supported to pursue a range of hobbies, activities and individual interests. For example, cooking and baking, music workshops, arts and crafts, going bowling and enjoying a massage. A person proudly showed us their amazing craftwork which was displayed in their room. Each person had an individual activity planner that showed what they liked to do each day and staff worked flexibly to support each person with their preferred activities. A named staff member was allocated to each person, morning and afternoon who took responsibility for making sure the person did their chosen of activity.

Staff tried a variety of activities with people and used 'smiley faces' to document, monitor and review what each person enjoyed. Several people enjoyed swimming and sometimes they visited the local swimming pool, although some people preferred the provider's hydrotherapy pool, as it was quieter for them. Staffing numbers varied each day to meet people's individual needs and their planned activities. For example, as part of their individual support plan, a person liked to go out every day. Sometimes, they went for walks in the local area, other times for coffee or a drive with a member of staff. Other people enjoyed going on shopping trips, to restaurants, or helping staff with the grocery shopping.

Two people particularly enjoyed and benefitted from spending time in a newly developed sensory room. A sensory room is a special room designed to help a person develop their senses through special lighting, music, and objects. It is used as a therapy for people with limited communication skills. The registered manager explained that staff used sensory rooms in other Voyage homes, and had noticed two people in particular really enjoyed them. They suggested Barley Close had a sensory room, although as a small home, there wasn't sufficient funding to purchase the full range of sensory equipment. Instead, staff prioritised and gradually developed a bespoke sensory room by using some of the activities budget to buy the equipment they knew people liked best and used most often. For example, one person liked banging a drum, twinkling lights and listening to sensory music.

When we visited, a person sat for a long time in a little booth. They looked relaxed and were quietly absorbed listening to gentle music and gazing at a light show, with various colours were moving across the ceiling. Later, the person went into the booth again and this time they enjoyed banging their drum vigorously. Another person also particularly enjoyed spending time in the sensory room, playing noisily and enthusiastically with their sensory toys. They selected their favourite musical toy, held it to their ear and smiled as they listened to the music. The development of the sensory room showed staff were creative and used available resources in innovative ways to meet people's individual sensory needs.

Several people living at the home were particularly interested in cooking and liked to sit near the kitchen, when meals were being prepared, although it was not safe for them to be in the kitchen during these times. Instead, the service had a separate training kitchen where staff involved people in cooking and baking activities, such as cake making and decorating, which they really enjoyed.

People accessed their local community and were well known in local cafes, pubs and restaurants. The service had a wheelchair accessible minibus and a car to transport people, and some people used local buses. Trips included visits to farms and animal sanctuaries, to the cinema, theatre and meals out. The registered manager said they were planning to arrange a small afternoon tea party during the summer and invite local villagers to attend. Photographs were used to capture what people had been doing and show what each person particularly enjoyed.

Staff were flexible and adapted their approach according to each person's changing needs. For example, one person chose to play the drums during a music activity. However, their interest in this waned quite quickly and they indicated they wanted to go to their room and change their clothes. The staff member immediately responded to support the person with this instead. Some people preferred to undertake activities in their room, and staff spent one to one time with them assisting them to do so. This meant those people were stimulated and interacted with staff in a way they were comfortable with, which also prevented them from becoming socially isolated.

Staff at the home were always pursuing ideas and thoughts to widen people's experiences. For example, in the provider information return the registered manager was exploring introducing some animals or pets into the home, by pursuing a regular visit from 'Pets as Therapy' for people at the home. When we visited, they

were bringing their own dog to work with them, who was placid, friendly and wandered freely around the home. When we asked staff about people's interaction with the dog, they said people were comfortable around the dog. Although so far, no one had shown any particular interest in petting or interacting with them or in helping to care for them.

Staff were also working on planning this year's holidays for each person; some people were planning a trip to Butlin's. Others didn't like to be away from home, so staff were planning special treats for them such as garden party, day trips to visit local attractions and meeting up with friends at another of the provider's homes in Somerset.

People were encouraged and supported to keep in contact with friends and family. Several people went to their family home for short visits, or their family visited them at the home and relatives said they were made welcome at any time. A relative, who lived a long way from the home, said they particularly appreciated staff meeting them halfway, when the person went home to visit, which reduced their travelling time. When we asked another relative what the best thing about the home was for the person, they said they were pleased the person had friends of their own age there. Key workers and the registered manager kept in regular touch with families by telephone and email to update them about the person's progress and any new developments.

People who lived at the home were not able to verbalise their feelings or thoughts in order to raise a concern or complaint. Day to day staff used 'smiley face' charts to check and record what they enjoyed and found difficult. The chart also has a sad face to indicate what the person didn't enjoy, and a straight face to indicate a neutral response. Staff used these to evaluate people's responses to see if any trends were emerging. For example, these might indicate changes needed to a person's activity programme or food likes or dislikes. Also staff said these helped to indicate whether the person was just having an 'off' day.

People and relatives had no concerns or complaints about the home. Relatives knew how to raise concerns, which were listened and responded to, with actions taken in response. Whenever they had any concerns, they felt happy to raise these with the person's key worker or the registered manager and said they were dealt with straightaway. For example, on one occasion, relatives of a person expressed concerns about the professional health advice given about a person's dietary needs. This was because they felt the recommended food preparation of a soft consistency unnecessarily restricted the person's food choices and freedom to try different textures. As part of the 'best interest' decision making process, the registered manager listened to their views, and sought the opinions of other relevant professionals in order to decide what to do. From this the registered manager arranged for the person to have a second assessment, and negotiated with the therapist to ensure the person's updated support plan incorporated some aspects of the family's wishes, where it was safe and in the person's best interest to do so. This showed they listened and acted in response to the feedback received.

People, families and visiting professionals were surveyed each year to get their feedback about the service. A 'smiley face' survey tool was used to ask people five key questions about choice, decision making, support with care, quality of food and dignity and respect. Responses showed people consistently reported they were happy with all aspects of their care. The service had also received several compliments from relatives. A relative said, 'I am well informed about what is happening.' Another said, 'I am made to feel welcome whenever I visit,' and a third said, 'Thank you for taking [person's name] on holiday.'

Outstanding ☆

Is the service well-led?

Our findings

The culture of the service was open and inclusive and encouraged staff to see beyond each person's disability. The provider had clear values which the registered manager promoted to staff. Staff demonstrated the provider's values of 'passion for care, positive energy, and using their initiative' to help people succeed and celebrated their success.

People received a consistently high standard of care because the registered manager led by example and set high expectations for staff. They put people first and continuously looked for new ways to further improve people's care and their quality of life. Staff were highly motivated and enthusiastic, and were committed to ensuring each person had a good quality of life. Staff trusted and respected one another, worked well together and with other professionals to deliver evidence based care that met people's individual needs.

The Voyage mission was, 'To provide world class outcomes for people with disabilities in the highest quality residential homes by providing innovative, flexible and individual support.' The provider was a national learning disability specialist, which meant staff could access relevant advice and support on managing people's complex needs, on equipment and the environment of care. They promoted best practice through membership of a number of national organisations. For example, the provider was a member of the British Institute of Learning Disabilities (BILD), through which they accessed a range of evidence based training for staff. At Barley Close, staff used the positive behaviour support methods to help a person become more independent and go out each day, which they really enjoyed and benefitted from.

Staff continually developed their skills, and followed best practice guidance in providing people's care and treatment. For example, by promoting people's dignity and human rights through the use of evidence based positive behaviour support methods. They enabled people make as many choices as possible by using a wide variety of non-verbal communication methods, so people could express their views. The provider also had an Investors in People award, this is an accreditation system which recognises best practice in people management standards. Staff also had access to a computer and could access the provider's website to help them keep up to date with changes in practice.

The service had a registered manager, who had been in post for 18 months. They encouraged staff, relatives, colleagues and visiting professionals to continually question and challenge practice. Staff said people had really benefitted from the skills and knowledge of the registered manager, who was a qualified learning disability nurse. For example, that people had more freedom and choice through the increased use of non-verbal communication methods, and were undertaking a much wider range of activities and interests. One staff said, "All the people who live here have really blossomed since she came, she's so committed to giving people choice and freedom, it's their home. She is very knowledgeable about how things should be done." Other staff also described how the registered manager had improved people's quality of life by standing up for their rights.

Staff consistently gave us positive feedback about the registered manager's leadership, which several staff

described as "brilliant." All staff said they felt able to ask for advice or raise an issue. One said, "She is always there when you need her." Another staff member, who had worked at the home for four years, said things were operating much better because staff had a clear idea what they needed to do. Other staff described the home as, "well organised and well run." One staff commented, "It was too rigid in the past, now it's flexible for people and staff really like it." Another staff member appreciated how the registered manager had been flexible in accommodating them to do their job, whilst continuing to fulfil their family caring responsibilities. Health professionals also consistently commented positively on the registered manager's leadership of Barley Close. One health professional said, " [Manager's name] is the best manager that Barley Close has had since the service opened, she stands up for residents and she is measured in her approach."

The registered manager worked with people alongside staff, and acted as a role model. They had an 'open door' policy and used a coaching style of leadership. This provided staff with a high level of support and challenged them to continuously improve people's care and quality of life. For example, by encouraging staff to enable people to experiment and try out new things. The service continually reviewed, evaluated and improved people's care. Staff experimented with trying different approaches with individuals to see how they responded, in order to maximise their potential and ability to participate in decision-making.

Relatives gave us similarly positive feedback about their leadership at the home. One said, "The home has certainly improved under her leadership." Another commented, "We are very happy with the current manager, she is very efficient, and things seems to be running quite smoothly." Relatives confirmed the registered manager kept in regular contact to update them and consulted and involved them in decision making.

People benefitted because Barley Close was well led by an experienced, qualified and proactive team. There was a clear management structure in place, with a senior member of staff on duty at all times, organising, supporting and leading the staff team. There was excellent communication within the team, through which staff were made very aware of any recent changes to people's health and care needs when they came on duty. There was a staff handover meeting three times a day and a written handover record was kept in the staff communication book for staff to refer to. Staff worked well together, for example, when one staff member was unsure what a person was trying to communicate, another staff member, who knew the person well, noticed and helped out. This meant together they were able to provide appropriate support to the person.

The registered manager held senior staff and team meetings every month. These included discussing and reviewing in detail the care of each person, what was working well and any changes needed. Staff were consulted and involved in decision making about people's care and treatment, shared good practice ideas and were praised for their achievements. Staff meeting minutes showed lively discussions and debates and that staff ideas and suggestions were encouraged and implemented.

Staff understood their roles and responsibilities and were accountable. They were supported to improve through clear expectations of the standards expected, goal setting and positive role modelling. Staff were being developed to take on more roles and responsibilities. For example, each member of the staff team had a lead role through which they were developing their expertise in a key area of practice. They shared this knowledge with the rest of the team to help promote excellent standards of care. For example, the lead for communication had developed small Makaton reference cards for staff to carry in their pockets to help remind them about most commonly used sign language. Other lead roles included a lead for medicines management and for health and safety. Where any concerns about staff attitudes or performance were identified these were dealt with quickly, robustly and fairly in accordance with the provider's policies and procedures.

The registered manager was committed to their continuing professional development. They were undertaking a leadership and management development programme to further develop their skills. The registered manager said they felt well supported by their operations manager, who visited the home regularly and kept in touch by phone. The provider had networks through which they met with other managers and had opportunities to share good practice ideas. They kept up to date with regulatory changes via the CQC website, and the provider's website and the monthly newsletter.

The registered manager said the provider's policies and procedures and quality monitoring systems were "excellent." They said this was because they measured the right things and helped them identify areas for further improvement. The provider used a quality and compliance audit tool based around CQC's fundamental standards, to monitor the quality of care at each service. This tool identified indicators of the five key questions about safety, effectiveness, caring , responsiveness and leadership at the home. A numerical scoring and a visual red, amber, green system highlighted and prioritised areas needing improvement.

The provider's information return, showed the provider's quality and compliance team had visited the service 14 times in the past year. The quality monitoring reports produced showed Barley Close had achieved consistently high scores of over 90%. In their latest audit they had achieved the highest score in the company of 96.8%. This demonstrated the service was consistently high performing. An external audit by a local pharmacist described staff practice in medicines management at the home as 'exemplary.'

Regular audits of care records, medicines management and health and safety checks were carried out, with positive action taken on areas that needed improvement. Accidents, incidents and complaints were monitored and reported to the provider, so any risks were highlighted and followed up and any themes or trends identified. People, families and visiting professionals were surveyed annually to get their feedback about the service and the latest survey results showed consistently positive feedback. An annual service review report was compiled to inform them about further actions being taken to improve the service. Examples of improvements included the development of the garden to provide sensory planting, herbaceous beds and an allotment area in order to encourage people to enjoy the garden more.

The registered manager met their legal obligations to submit statutory notifications when certain events occurred, such as when injury to a person occurred. They provided additional information promptly when requested, and worked in line with their conditions of registration.

In the provider information return, the registered manager identified further improvements they wished to make to the home when further funds became available. For example, replacing the carpet in corridor areas with hard flooring to make it easier for people with mobility equipment to move around more easily. They also wanted to have the outside of the home re-decorated to improve its 'kerb appeal.' A staff member was working on developing a newsletter as another way to celebrate people's achievements and provide further feedback. These were examples of their commitment to on-going improvements within the service.