Voyage 1 Limited

Barley Close

Inspection report

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Date of inspection visit:
12 May 2023

Date of publication:
19 June 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Barley Close is a care home for up to 10 people with a learning disability and autistic people. At the time of our inspection there were 8 people living in the home.

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

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting all the underpinning principles of right support, right care, right culture.

Right Support
People had not always received the care they needed to live safe, fulfilling and happy lives. There had been a strong focus on improving these areas in recent months.

People had not always been supported with their medicines in a safe, consistent and effective way. Medicine administration had improved and was the focus of ongoing improvements.

Risks to people were considered and planned for. People's risk plans had not always been followed by staff. Risks to people had therefore been focused upon and staff practice was improving and being monitored.

People were supported to make as many of their own decisions as possible.

Recruitment processes were safe. The provider was taking active steps to recruit, mentor and retain staff.

Right Care
Staff had not always protected people from poor care, errors, abuse or neglect. The service was currently working with other agencies to ensure people's safety and to improve the quality of care and support provided.

People who spoke with us said they were happy living at Barley Close. People told us, and we saw, they were treated respectfully and with compassion by staff. People clearly trusted staff; they were happy and relaxed in their company.

Right culture
People had not received high quality care and support. There had been a significant decline in the quality of

the service. There had been a lack of clear, consistent leadership which had contributed to the decline and lack of structure, support and guidance for staff.

People's quality of life had not been enhanced by a culture of learning and improvement. Neither the provider nor the various managers had effective oversight of the quality of care, staff practice or risk management. This had led to people receiving poor or unsafe care.

People, and those important to them, were working with the acting manager and staff to develop and improve the service. Confidence in the service and in how it was managed was returning as improvements were made and sustained.

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

Rating at last inspection and update
The last rating for this service was good (published 25 January 2019).

Why we inspected
We received concerns in relation to safeguarding, risks to people, medicine administration, staffing levels and management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

The provider had taken action to mitigate the risks and these were effective. A new management team had been brought in by the provider to stabilise and improve the service. There was current ongoing support from the local authority to ensure the service remained safe whilst improvements were being made. Staff had been given improved support, guidance and mentoring. The provider's oversight of the service had been improved to ensure people received safe and effective care.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Barley Close on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, medicine management and governance at this inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Barley Close

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors carried out the inspection.

Service and service type
Barley Close 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. Barley Close is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 3 May 2023 and ended on 24 May 2023. We visited the home on 12 May 2023.

What we did before inspection
We reviewed all of the information we held about the service, including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We sought feedback from the local authority safeguarding team who were working with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We met 7 people using the service; 3 people were able to talk with us about living at Barley Close. We also spent time observing staff supporting, interacting and communicating with people in communal areas of the home throughout the day. We spoke with 9 members of care staff, the acting manager and the provider's operations manager.

We viewed all parts of the home and reviewed people's medicine records and medicine storage facilities. We also looked at the senior's medication book, the doctor's book, at a selection of staff rotas and the staff communication book.

The acting manager sent us 4 people's care records, the most recent medicine audit, learning from accidents and incidents including actions taken, details of current safeguarding issues, the latest update of the service's action plan and copies of minutes from recent staff meetings.

They also provided contact details for people's relatives. We spoke with 3 relatives to gain their views of the care and support provided to their family members; 3 relatives shared their views by email.

Requires Improvement

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse
• People had not always been kept safe from avoidable harm or fully protected from abuse or neglect.
• The service had been placed in a 'whole service safeguarding' process by the local authority. This meant there were significant ongoing concerns about people's safety and other agencies, such as the local authority safeguarding team, were actively supporting the service to ensure people remained safe whilst the significant improvements needed were made.
• One relative had recently moved their family member to another service operated by a different provider. They told us, "I wanted [name] out of there as soon as possible and that took a lot of work. My [relative], in the past 6 months, has been unsafe and unfulfilled. [Name's] safeguarding incidents were in the first 3 months of the year when the company were aware [the service was] failing."
• Record keeping had been poor. For example, when people had unexplained bruising, it was unclear if this was a result of an accident, an incident or if something more serious had occurred. Many people had 1 to 1 support so staff should have known why the bruising may have happened. There were examples where unexplained bruising had not been investigated to find out the cause. This placed people at risk.

The provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There had been a strong focus on improving safeguarding in recent months. People who spoke with us said they were happy living at Barley Close. One person said, "I am fine; I am happy here." We saw warm, kind and respectful interactions between people and staff. People clearly trusted staff; they were happy and relaxed in their company.
• Relatives told us they felt their family members were currently safe. One relative said, "Yes, I do think it is a safe place for [name] to live. She is really settled there and thinks of it as her home." Another told us, "Yes, I do think it is a safe place for [name]. Staff are generally all lovely, they all mean well."
• Staff were being supported and mentored to ensure people were cared for in a safe way. Record keeping had been improved and this was ongoing. This was supported and monitored by the provider and the area operations manager. One staff member told us, "I want to get it right, I want the home to be better. We definitely have direction now. All the external people that have come in have been helpful. It's good to have the extra knowledge."
• Staff had training on how to recognise and report abuse and they knew how to apply it. None of the staff spoken with raised any new concerns with us about people's safety. One staff member said, "People are safe. I have never had to report anything here. I would report if I needed to."

Using medicines safely
• Staff had not always followed effective processes to provide the support people needed to take medicines safely. This had led to numerous errors being made over a sustained period of time. This meant people did not have their medicines when they needed them, received the wrong dose or had been placed at risk by poor staff practice. In one instance this had led to a very poor health outcome for the person. Another person had been left with an item overnight which could have caused them harm.
• One relative said, "There have been mis-medications in the past 6 months [for their family member]. Paperwork was poorly kept, had many inconsistencies and many instances of medication not being signed off."
• Staff had not always followed systems and processes to accurately record medicines people needed. This had contributed to the errors made. For example, staff had not recorded stock levels of medicines. This had led to one person not receiving their medicines because they had run out and staff had not noticed.

The provider had failed to consistently support people with their medicines in a safe and effective way. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There had been a strong focus on improving medicine administration in recent months. The errors had significantly reduced; there had only been one error made in the last month. Staff who made errors were retrained and reassessed before they could support people with medicines again. One senior member of staff now oversaw medicines administration and mentored staff. They were also updating and adding to people's medicine guidelines to ensure these were clear and comprehensive. The acting manager also carried out a thorough medicines audit to ensure staff practice was consistent and the systems in place were safe.
• People who could express a view confirmed they had the right medicines at the right time. Whilst we spoke with one person, they explained to staff they were in pain and asked for painkillers which staff then gave them.
• The service had ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and would ensure any medicines taken now or in the future were reviewed by prescribers in line with these principles.

Assessing risk, safety monitoring and management
• Risks to people and to staff were assessed and plans put in place to reduce or eliminate risks where possible. These plans had not always been followed by staff. For example, one person had been left unsupported whilst using the bath; this directly contradicted their risk assessment. Another person was at risk of choking and had a plan in place to enable them to eat and drink safely. This had not been followed by staff and had therefore placed them at risk of choking.
• Risks to people had been focused upon and staff practice had improved. All plans were now being followed. Improvements were also being made where possible to better ensure people's safety. One relative said, "I was concerned about [a particular risk to their family member]. A new alarm has been fitted which I feel will make a huge difference."
• Staff told us their practice was monitored and they were being supported to improve in this area. One staff member said, "We are aware of risk assessments and eating and drinking plans; people have their own protocols. It has dramatically changed here. More things in place, more structure. From where we were, we have had a big leap."
• People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible.
• Staff recognised signs when people experienced emotional distress and knew how to support them. There

were care plans for emotional distress in place which staff understood and followed.

Staffing and recruitment
• People often formed close relationships with staff. People spoken with told us they liked the staff who supported them. One person said, "I like them [staff]. I've been for a long walk with [staff name] today and we went to the shop as well and to the church." Another person said "yes" when we asked if they liked the staff who worked here.
• The service had experienced the national care sector challenges in both recruiting and retaining care staff. There had been a very high turnover of staff in the last year which had clearly affected people, the quality of care and morale within the staff team. Recruitment was ongoing.
• Relatives commented on staff changes and the detrimental effect this had. One relative said, "Constant changing of staff has been an issue for many years and because of this lack of continuity I visit twice a week and take my daughter to her medical appointments. I can only think that pay, support and time might help this issue and I know [the acting manager] is working hard in this area."
• The service currently had enough staff for the support people needed, including when people needed 1 to 1 or 2 to 1 care. Regular agency staff were used when necessary to ensure consistency of staffing. Experienced staff had also been brought in from other services run by the provider to support and mentor the staff team. Staff spoken with felt staffing levels and consistency had recently improved. One staff member said, "When there wasn't enough staff it was stressful; more often than not we have enough staff. We have regular agency staff; they feel like part of the team. Regular staff mean the residents trust them. I think there is a good rapport."
• New staff were recruited safely. All required pre-employment checks were carried out including criminal record checks and obtaining satisfactory references from previous employers before new staff started work. Staff had a formal induction to the home. One staff member said, "It's a really good job. I really like the people. Staff have been really nice. It's a very diverse team and I have learnt a lot. They [staff] were welcoming and I fitted in quickly."

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People were supported to make as many of their own decisions as possible. Staff knew about people's capacity to make decisions through verbal or non-verbal means, and this was well documented.
• One person told us they decided what they did each day and how staff supported them. It was clear their choices were respected. We saw other people being offered choices; people responded using their preferred method of communication. A relative told us, "They do involve [name] and try to do what she wants. [Name] is now planning a holiday and she does lots more things she wants to do."

• Staff demonstrated good practice around assessing mental capacity, supporting decision-making and best interests decision-making. When people had been assessed as lacking mental capacity to make a certain decision, staff clearly recorded assessments and any best interests decisions. Relatives were consulted when best interests decisions were needed.
• Where necessary, applications to deprive people of their liberty had been made to the appropriate legal authority and had been authorised.

Learning lessons when things go wrong
• People had not always received safe care because there had been a lack of review and learning from any accidents, incidents or errors which occurred. This was being improved.
• There was a system in place where the acting manager reviewed accidents, incidents and errors. This was to prevent recurrence, share any learning with the staff team and improve the service wherever possible.
• Recent examples of this process included reflective learning by staff who had made medicine errors; 2 staff now checked and administered medicines to reduce the risk of errors. Care plans and risk assessments for 3 people had been updated. Agency staff now only provided 1 to1 support to 2 particular people when they had been assessed as competent and confident to do so through observations by senior members of the staff team.

Preventing and controlling infection
• We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was clean and hygienic. Specific parts of the home needed redecoration; some areas needed to be made more homely. This issue was discussed with the acting manager and operations manager. They were already in discussions to ensure improvements were made.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was 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
• The provider was facilitating visits in accordance with the current guidance.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

• The home had been through a period of significant change in management. There had been 4 home managers since 2022, each of whom had only stayed for short periods of time. This lack of clear, consistent leadership had contributed to the decline in the quality of the service and lack of structure, support and guidance for staff. One staff member said, "We didn't have a manager stay long enough. We had 4 managers and each manager changed things. That caused confusion; no one knew what they were meant to be doing."

• Relatives also commented on the effect numerous managerial changes had. One relative told us, "No administration has settled, with manager appointees staying for only days, weeks or months before [the current acting manager], with her deep experience, was bought in to sort the service out. I have been concerned that higher management could be questioned regarding the appointment of managerial staff, and more worrying is that the support and mentoring seems insufficient to persuade new appointees to stay."

• The quality assurance systems in place had been ineffective. They had not identified issues within the service, reduction in the quality of service, poor care, poor practice or other areas of concern. This led to a reactive quality assurance process rather than a proactive system. Where an issue had been picked up it had not been resolved so the service had deteriorated, not improved. This meant people had not been protected from abuse, neglect, poor care or harm.

• Relatives told us the provider had not acted quickly and effectively when they knew there were serious issues in the service. One relative said, "I was never reassured..[there was a] lack of progress, movement, care or concern in bringing about rapid change."

• Serious concerns had also been raised by visiting health and social care professionals. This had led to the home being placed in a 'whole service safeguarding' process by the local authority.

• The initial improvement plan put together by the new management team had identified over 150 improvement actions. The latest update on this plan provided as part of our inspection showed a majority had been completed; 42 actions were either 'in progress' or being monitored. There were no actions where work had not yet been started.

The provider had failed to ensure effective governance and oversight of the service. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The current acting manager had the skills, knowledge and experience to perform their role and a clear understanding of people's needs and the improvements which were needed in the service. They were supported by the operations manager and by other staff employed by the provider. The acting manager said, "Everything needed looking at and staff needed a lot of support and guidance. What we have done really is gone back to basics and started again from there. It has been hard work, but things have really improved."
• People, relatives and staff did have confidence in the new management team, or confidence in them was growing. A relative told us, "[The acting manager] always takes time to talk to me and values my feedback, which I really appreciate. Issues that I raise with her are acted upon and gradually my daughter's quality of life improves."
• Staff told us the service was improving and people were safer and happier than they were. One staff member said, "The new structure helps everyone know where they are meant to be. We are still learning." Another staff member told us, "It's definitely improving. Everyone is getting on board, we are building a new team. Things were not being done properly before. To improve, we need to make sure everyone is definitely on the same page."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People, and those important to them, were working with the acting manager and staff to develop and improve the service. People were happy and comfortable in their home and interacted and communicated confidently with staff.
• Staff encouraged and supported people to be involved in their service as much as they were able to be. We saw staff listened to people and acted on what they said. Staff told us they had built, or were building, good relationships with people and felt they put their needs and wishes first. One staff member said, "We want to make their lives as good as possible, enriching lives, give them the best life they can, promote their independence and keep them safe."
• Relatives told us they were involved with the service. Some felt they had not always been kept informed or listened to; others felt differently. Comments included: "I called an emergency meeting to discuss many serious concerns about care at Barley Close but also engagement. This was followed up 6 weeks later and there was no change" and "I do have a lot of contact with [the acting manager]. It seems like lots of things are getting better since she arrived. She gets things done."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People had not received consistently high-quality care and support. Relatives spoke about the decline over a period of time. One relative said, "They [the service] used to be rated outstanding a few years ago. Things went massively downhill. We tried to escalate our concerns, we did escalate them. Lots of things were promised but nothing ever happened and that was disappointing." Another relative told us, "Voyage Care promise a client led service. [However, the service had become] a stale and stagnating environment to be in whilst also being chaotic and lacking routine."
• The acting manager and operations manager had worked hard to initially stabilise the service and then steadily improve the care and support people received. They were leading and developing a culture in which staff valued and promoted people's safety, individuality, protected their rights and enabled them to develop and flourish.
• Relatives were confident the service would improve if the right staff, support and resources were available. One relative said, "Overall, I am much more positive about the future and that's important. I'm much more hopeful it can get back to what it was." Another told us, "I do feel [it was and could again be] a caring home. The staff work hard to give the residents a happy, fulfilled lifestyle."
• Staff were positive about recent changes and improvements. They spoke openly about the care they

provided and about the service more generally. Comments included: "Things are starting to go the right way in the last couple of months. Things are starting to get better. I like coming to work, see people happy and doing what they want to do," "I can see improvements. Our goal is to give the guys what they want. We had a low patch. Morale is definitely getting better" and "From when I first came to now, there is a vast improvement. The home seems calmer, and staff are working more cohesively."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The service apologised to people, and those important to them, when things went wrong. Staff gave information and suitable support and would apply the duty of candour where appropriate.

Working in partnership with others
• The service worked in partnership with other health and social care organisations. There was current ongoing support from the local authority to ensure the service remained safe and the quality of care and support improved. This was to promote people's wellbeing and enhance their quality of life.

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 had failed to consistently support people with their medicines in a safe and effective way. This was a breach of Regulation 12(2) (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13(2) (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective

governance and oversight of the service.

This was a breach of Regulation 17(2) (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.