Brough Manor Care Home Limited

Brough Manor Care Home

Inspection report

33 Station Road
Brough
HU15 1DX
Tel: 01482 668382
Website: Not applicable.

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection of Brough Manor took place on 15 May 2015 and was unannounced. At the previous inspection on 30 July 2013 the regulations we assessed were all being complied with.

Brough Manor provides care and accommodation for up to 26 older people some of whom may be living with dementia. The service offers support with personal care, and provides activities and pastimes to help enable people to remain as independent as possible. Rooms are mainly single occupancy with en-suite toilets but there is provision for shared use as well. There are two lounges, a dining room and a garden courtyard for people to use.

There is access to local train and bus transport close by. At the time of our inspection there were 23 people using the service and approximately 10 people were living with dementia.

There was a registered manager in post who had been managing the service for the past three years. 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.

Summary of findings

We found that people were protected from the risks of harm or abuse because the provider had effective systems in place to manage issues of a safeguarding nature. Staff were trained in safeguarding adults from abuse and understood their responsibilities.

People that required support with mobility, transferring and postural changes were safely cared for by staff that followed good practice guidelines and were trained in moving and handling techniques and the use of hoists. All safety issues were covered by risk assessments that were regularly reviewed.

We found the premises to be safe and well maintained. Contingency plans and risk assessments were in place for emergency events such as utility failures or inclement weather.

There were sufficient numbers of trained, skilled and competent staff on duty and staff had been safely recruited following effective use of recruitment procedures, which ensured staff were vetted for their suitability to work with vulnerable people.

We found that the management of medicines was safely carried out and while there was a need to improve the infection control equipment in the service, the overall infection control and food hygiene practices were safely carried out and managed.

People told us they were happy with the effectiveness of the service. Staff were appropriately inducted, trained, skilled and supervised to carry out their roles.

Staff use of equipment was seen to be effective, for example, in assisting people to transfer and there was good communication when doing so. The service effectively used the Mental Capacity Act and Deprivation of Liberty Safeguards legislation to ensure people's rights were adhered to and consent in all things was obtained.

Nutrition and hydration for people was adequately provided and people's choice/preferences played a part in this. The service was proactive in accessing health care professional's support.

The environment was suitable for older people, but not entirely suitable for meeting the needs of people living with a diagnosis of dementia.

People we spoke with said the staff were kind, considerate and caring and we observed a caring approach from all staff. Relationships between people and staff were seen to be good. Activities were appropriate to people's needs and preferences and they made for eventful days.

We were told by people that their privacy and dignity was respected and we saw for ourselves that staff were discreet. People's physical and emotional well-being was considered and they were supported to achieve good outcomes.

We found that a different approach to supporting people living with dementia at the end of their lives had been discovered and used to ensure their last days were as comfortable and stress free as possible.

We found there were well written care plans in place to reflect people's needs and to show staff how best to support pole. The complaint system in place showed issues were responded to appropriately and resolved as quickly as possible.

There was a variety of activities provided for everyone. People's choice and preferences were respected as much as possible.

There was consistency in the running of the service because the registered manager had been registered for the last three years. They were open, transparent, focussed and inclusive in their management style. We found there was a strong and effective system of quality assuring in place: auditing and surveying, which provided feedback to people and their relatives. Records were well maintained throughout the service.

Summary of findings

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.

People that used the service were protected from the risks of harm or abuse because the provider had ensured staff were appropriately trained in safeguarding adults from abuse and the provider had systems in place to ensure safeguarding referrals were made to the appropriate department.

People were safe because whistle blowing was appropriately addressed and investigated, the risks to people in the service were reduced, staffing was in sufficient numbers to meet people's needs and staff recruitment followed safe policies and practices. Medication management was safe and infection control practices were suitably carried out.

This meant people that used the service were safely cared for.

Is the service effective?

Good

The service was effective.

Staff were appropriately inducted, trained, skilled and supervised to carry out their roles. Equipment was effectively used and there was good communication when using it. The service effectively used the Mental Capacity Act and Deprivation of Liberty Safeguards legislation to ensure people's rights were adhered to.

Nutrition and hydration for people was adequately provided and people's choice/preferences played a part in this. The service was proactive in accessing health care professional's support.

This meant people that used the service received effective support.

The environment was suitable for older people, but not entirely suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

People said the staff were kind, considerate and caring and we observed a caring approach from all staff. Relationships between people and staff were good. Activities were appropriate to people's needs and preferences.

People's privacy and dignity was respected and we saw for ourselves that staff were discreet. People's physical and emotional well-being was considered.

Support to people living with dementia at the end of their lives was based on best practice and ensured their last days were as comfortable and stress free as possible.

People were well cared for.

Is the service responsive?

Good

The service was responsive.

Summary of findings

There were well written care plans in place to reflect people's needs and to show staff how best to support people. The complaint system showed issues were responded to appropriately and resolved as quickly as possible.

There was a variety of activities provided for everyone. People's choice and preferences were respected as much as possible.

The service responded well to people's needs.

Is the service well-led?

Good

The service was well led.

There was consistency in the running of the service. The registered manager was open, transparent, focussed and inclusive in their management style.

There was a strong and effective system of quality assuring the service, which provided feedback to people and their relatives. Records were well maintained throughout the service.

This meant people had the benefit of a well-run service.

Brough Manor Care Home

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.

This inspection took place on 15 May 2015 and was unannounced. The inspection was undertaken by one lead inspector. Before we carried out our inspection we looked at all of the information we already held for this service from having received notifications, at the 'provider information return' (PIR), which had been sent to us in advance and at the information sent to us by the local placing authorities. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We spoke with four people that used the service, one relative, four staff, the registered manager and the area manager. We looked around the premises, viewed four people's care files including their care plans, three staff files and other documentation relating to the running of the service. We looked at the medicine management systems and assessed whether or not the service was adhering to good infection control practices.

We observed interactions between people and staff and saw some of the service's planned activities taking place.

Good

Is the service safe?

Our findings

People we spoke with expressed the view that they felt safe living at Brough Manor. They said, "I'm happy here, the staff are very nice" and "The staff are very kind and look after us well."

Staff we spoke with told us they had completed safeguarding training with East Riding of Yorkshire Council (ERYC) and they demonstrated a good understanding of safeguarding awareness when we asked them to explain their responsibilities. Staff knew the types of abuse, signs and symptoms and knew the procedure for making referrals to ERYC. Staff explained they had a flow chart in the office to follow regarding any suspected or actual safeguarding allegations. We saw from the staff training record and individual training certificates that care staff had completed safeguarding training in the last two years. This meant people that used the service were protected form the risk of harm or abuse.

We saw from the information we held on our system that there had been no safeguarding referrals and that we had received no notifications that required a safeguarding referral. The registered manager told us they had not sent any notifications as any issues that had arisen had not met the criteria for making notifications.

We saw there were at least two sling hoists in use for people that used the service. Staff explained that there were only two people that used the service requiring assistance to transfer using lifting equipment. They said both people had been assessed as requiring this support and they had risk assessments in place to ensure the equipment was used safely.

We saw examples of risk assessment documents in peoples care files and these covered the areas of mobility, falling, weight, nutrition, skin integrity and where there was any tendency to want to leave the building. They had been reviewed regularly to make sure staff were aware of and following the latest information when supporting someone.

We also saw that the service had generic risk assessments in place for staff working on the premises and for if visitors or contractors are in the building and need to be kept safe.

When we looked round the premises we saw there were some safety features in place: window restrictors, radiator covers and a new emergency call bell system, which was portable so that people could carry the activators around with them. This gave people better opportunities to call for assistance if they had a fall.

We found the premises to be safe, comfortable and suitable to meet the needs of older people. We looked at documentary evidence of regular maintenance checks, for example, on the fire safety system, emergency lighting, electrical installations, passenger lift and portable hoists, electrical portable appliances, thermostatic control valves on hot water outlets and waste management. All of these had been checked and maintained since December 2014. A routine weekly fire alarm test was carried out on the day we visited and we saw that staff responded appropriately. It was recorded appropriately.

The service had emergency contingency plans in place for action to take in the event of flood, fire or utilities shortage. Staff were aware of these and there was accessible information for staff regarding contacting engineers should the service have a problem.

When we spoke with staff they told us they were aware of the whistle blowing policy and that they would not hesitate to use it. Staff said they had used the whistle blowing system in the past in other employment. Staff felt they were very well supported by the registered manager and they said they could make any concerns known to her without fear of being ridiculed or disbelieved.

We saw there were clear accident and incident procedures in place and staff told us they were aware of what to do. Accident records that we looked at were well maintained and used to highlight, for example, where a change in care approach or a change in medicines taken might be needed. This had happened for one person where they had experienced two falls. A GP had been requested and a certain medicine had been reduced. This meant people were protected from the risks of further injury and showed that the service responded to their changing needs.

When we spoke with staff they expressed the view that they had sufficient numbers of staff on duty to be able to meet peoples' needs. They said that agency staff were never used as any absences or vacancies were always covered by the staff team. They expressed that they worked as one big team and found that the service had a family approach to caring for people.

Good

Is the service safe?

We looked at the staffing rosters and we saw that the staff on duty were the staff named on the roster that day. We observed that people that used the service received the care and support they required and that staff were appropriately deployed to ensure this happened. There were no people receiving one-to-one care and staffing levels were set according to a dependency tool that the service used.

The registered manager told us they used thorough recruitment procedures to ensure staff were right for the job. They ensured job applications were completed, references taken and Disclosure and Barring Service (DBS) checks were carried out before staff started working. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw this was the case in all three of the staff recruitment files we looked at. Files contained evidence of job application forms, DBS checks, references and people's identities and there were interview documents, disciplinary information, correspondence about job offers, records of inductions completed, shifts completed while 'shadowing' other staff and there was a staff handbook.

We saw that staff had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

There were staff grievance and disciplinary procedures in place and these were also written in the staff handbook. Staff understood their rights and responsibilities with regard to their roles and meeting people's needs.

There were systems in place to manage medicines safely. Only senior staff trained to give people their medicines did so. We assessed the medication management systems used by the service and saw that medication was appropriately requested, received, stored, recorded, administered and returned when not used.

We looked at the medicine administration record (MAR) charts and saw they contained clear details of when and how medicines were to be given and that they had been completed accurately by staff. Each MAR chart was accompanied by a picture of the person the medicine was intended for so that staff knew who to administer the medicines to. There were patient information sheets held with the MAR charts. These are instructions on how to take medicines, their side effects and ingredients they contained.

There was a returns system in place and used and all medicines were safely recorded. We saw there was an over-large stock of food supplement drinks. When we asked about this they told us that people were prescribed them, but once they recovered or improved in health they did not want them and so they sometimes 'piled up'. The service had not ensured repeat prescriptions had been stopped quickly enough regarding these supplements.

We saw that only one controlled drug (CD) was administered. CDs are medicines with a higher classification that require specific management systems to ensure they are handled extra safely, are stored and recorded separately and are checked and signed for by two staff. There were no people that self-medicated.

We looked at some of the infection control systems in the service and saw there were no paper towels in use in communal toilets. We discussed this with the registered manager, who explained they were previously used by people who inappropriately disposed of them and so the service had stopped providing them. The registered manager said they would look at managing this differently. We saw that hoist slings did not have individual storage bags, but were hanging together in a space by the toilets. Best practice would be to store these in people's bedrooms or in protective storage bags. There were hand sanitizer dispensers around the premises, washable fabrics on some chairs and bed headboards and where necessary there were protective covers on duvets and mattresses. Staff used appropriate personal protective equipment: gloves and aprons. We saw that good hygiene standards were followed. Staff had an infection control policy to follow and there were instructions on good hand washing techniques.

The premises were clean and staff had cleaning schedules to follow, which were also accompanied by cleaning records. Staff told us they had completed training on infection control and/or food hygiene, which we verified in their training records. This meant people that used the service were cared for and supported in a premises and an environment that was safe for them to live and socialise in.

Good

Is the service effective?

Our findings

We spoke with people that used the service about the effectiveness of the care they received and people told us they were happy with everything. The said, "I am satisfied with the way staff look after me. I am immobile but the staff have made sure I get to my meals in the dining room by loaning me a wheelchair until I can get my own" and "Oh the girls are lovely here and I relate very well to them. I couldn't want for better support."

The registered manager told us that staff completed training necessary for their roles and responsibilities. Staff told us they had completed various training as opportunities to do so at Brough Manor were good. They had completed courses in safeguarding adults from abuse, management of medicines, first aid, moving and handling, fire safety and dementia care for example. When we looked at staff training records we saw they had also completed courses in infection control, food hygiene and health and safety. We saw other evidence in the form of copy certificates in staff files of the training staff had completed.

The registered manager had recently completed some training in 'communication' level 1 and 2. The registered manager explained the service had been completing training with the East Riding of Yorkshire Council (ERYC) and had set a mission to achieve the council's bronze award in staff training and competency: to have a minimum of 40% staff working in the service fully trained to ERYC standards.

We observed staff providing appropriate care, using equipment where necessary and ensuring care was delivered safely and effectively. Staff spoke with people and told them what they were doing and what they wanted people to do in return. Staff also obtained people's consent to provide care and support whenever possible.

We saw from recruitment files that staff completed an induction programme produced by the service provider and according to the provider's expectations. The induction reflected Skills For Care Common Induction Standards. All staff undertook a probationary period during which time they completed induction and training to enable them to carry out their roles skilfully.

Staff told us they received three or four supervisions per year, had a cascade system where the registered manager supervised senior care staff and senior care staff supervised care staff. We saw evidence of this in supervision records. We also saw evidence of annual appraisals in the form of a new style of record, which had been recorded using a new style format; targets, objectives, additional comments, development and training needs. The format followed the SMART principles; specific, measurable, achievable, recorded and time bound, which ensured staff had a fair system of appraisal.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. The registered manager told us there was one DoLS application pending in respect of restricting a person's freedom of movement as they were at serious risk of being harmed if they left the premises unescorted. The service was awaiting an outcome.

We heard staff seeking people's consent to care before they undertook to assist them. People were glad to accept help from staff and we saw that for some people it was reassuring that they had staff to help them. When we spoke with staff they demonstrated an understanding of MCA and DoLs and spoke about the importance of obtaining people's consent in all things.

The registered manager told us there had been best interest meetings held for people whenever they were required. A best interest meeting may be needed where an adult lacks mental capacity to make significant decisions for themselves and needs others to make those decisions on their behalf. It is particularly important where there are a number of agencies working with the person, or where there are unresolved issues regarding either the person's capacity or what is in their best interest and a consensus has not been reached.

We saw there were menus on display around the service, which we were told by staff were changed seasonally or if the quality monitoring system highlighted any specific wishes or requests. We saw the cook asking people what they wanted for their lunch and tea that day and we heard that they were given a choice of two options. People told us they found the food to be absolutely acceptable. They said, "The food is quite good as we have a marvellous cook. The cook has a stand in on her day off and she has cooked for us today," and "The food here is very good, I get plenty and if there is something I don't like I can have an alternative."

Good

Is the service effective?

We saw in people's care files that they had nutritional risk assessments in place that had been regularly reviewed. Staff also kept a check on people's body mass index scores to ensure they were not losing weight for any reason (unless for weight reducing due to health issues). All of this was appropriately recorded in care files and staff told us they weighed people regularly especially if there were any concerns regarding their diet or nutritional intake. We saw that there were food intake charts in use for those people that required them, which were held in people's bedrooms.

The kitchen at Brough Manor was organised, clean and well equipped. The cook told us they had the entire food budget they required, that equipment was working satisfactorily and there were no concerns about supplying a balanced diet to everyone at the service. The cook was aware of people's individual needs and their likes and preferences as this information was made available to her.

We saw that people had information in care plans about their health care needs. There were records of visits from GP and district nurses and there were details about people's medication needs. There were medication administration record sheets for people's topical creams and lotions that needed to be administered and turn charts to monitor people's skin integrity. People were regularly weighed by staff if there was an assessed need to ensure their weight did not fluctuate and as an indication their health was not deteriorating. There were weight risk assessments in place to show who was at risk of deterioration. Anyone demonstrating poor mental health was supported to access mental health services and anyone requiring support to see a consultant was accommodated. Where possible people were informed about their deteriorating or improving health so that they could make decisions about treatment.

We saw from care files that one person had been referred to the 'continuing health care services' so that additional funding could be obtained. This was to ensure the person had sufficient staffing support to offer more individualised care at their end of life.

Where necessary files contained information about referrals to 'continence services' and one person had recently had samples sent for laboratory testing to determine whether or not infection was present in their bladder. Health care needs were well monitored.

Décor and furnishings were appropriate with the exception of a low settee in the main lounge which we felt was unsuitably low and that older people would have difficulty getting up from sitting on it.

We found one area that was in need of an upgrade. This was the toilets off the main lounge. The area manager and registered manager acknowledged these toilets were in need of refurbishment and said it had already been factored into the next maintenance plan.

For those people that used the service who were living with dementia, approximately one quarter of the whole group, we found that there could have been some improvement in the signage and the colour/pattern schemes of the décor and carpets to enhance their quality of life by nurturing a better environment. Environment incorporates design and building layout, colour schemes, textures, experience, light, sound, smell. However, the premises were well maintained and provided a very homely atmosphere for people that used the service.

Good

Is the service caring?

Our findings

We observed staff being considerate, kind and thoughtful towards people that used the service. We saw all staff demonstrating their compassion for and sensitivity towards people they supported. We saw the activities coordinator spending time with one person looking through a book with them. We were told by staff that one person liked to stay in bed and refused all support with personal care until after lunch, which was always respected.

One person that received end of life care at the time of our visit also stayed in bed, slept a lot and only ate and drank whenever they wanted to and this was completely respected by staff as well. Staff took food and drink to the person whenever they needed it and not just when meal times were in progress. The dietician and GP had both visited the person several times and were also involved in their end of life care. The person had spent some time in hospital but it was their wish and that of their family to remain at Brough Manor now, as the staff were so caring and gentle.

We heard staff explain their intentions to people when they assisted them with care and support and we heard staff ask for people's cooperation and consent. People were asked their views about their care and fully included in decision making whenever possible. We heard staff ask people how they were and check their moods and states of wellbeing as well as their physical comfort. Staff asked people whether or not they needed emotional support as well as physical assistance.

People we spoke with told us they only ever received personal care in the privacy of their bedrooms or the bathroom, that staff knocked on doors before entering their bedrooms and did not disclose any personal information about them to other people. People felt staff were respectful, caring, helpful and loving.

We found there was a core of staff that had worked at Brough Manor for many years. This included the registered manager. The registered manager and all the staff knew people well and understood their needs, because they took the time to speak with people and find out about their wishes and fears.

We saw good relationships between people that used the service and staff and there were some good relationships between the people that used the service as well. People and staff enjoyed a little banter when it was appropriate, worked out problems when they arose and talked through their low moments. One person felt down about the failing in their general physical ability and staff took time to speak with them and reassure them they were doing very well. Staff offered alternatives to their usual routine to invoke a sense of there being plenty of new things to get into and to divert them away from feeling down. Staff were seen to be compassionate and comforting towards people.

We saw from care files that people had signed the documentation whenever possible, such as their care plan, to provide formal consent to care and support. When we asked them if they knew about their care plans some of them said they had been involved in putting the information together. One person said they were unaware of the document, but that they were not really bothered about seeing it. Other information in care files showed that people were asked about their views regarding activities and given the opportunity to be involved in setting these up.

We saw that people were given good explanations about the care staff were offering. When one person expressed some anxiety about wishing to leave the building staff were not judgemental about their determined behaviour, but withdrew and allowed the person space to make up their own mind about things. Staff then gave them privacy within their bedroom to consider their wishes. Staff returned to offer the person some realistic information about the likelihood they would be able to go far. The area manager expressed to the staff team that the solution was to allow the person to 'actualise' their need and be accompanied by a staff member out of the building, when those situations arose. However, this did not need to take place at that time as the person realised they were physically unable to venture far using their walking frame and settled down to eat some ice-cream. The area of enabling people to 'actualise' their needs was one the service was exploring.

We saw the service had received an abundance of thank you and compliment cards from relatives of people who previously or still used the service, in acknowledgement of the very kind and considerate care and support staff had given to people.

People told us they felt well cared for. They said, "Staff look out for us and take time to check that we are okay. Not just physically", and "Staff check we are happy with everything."

Good

Is the service caring?

We saw from the way staff approached people that staff were concerned for people's overall wellbeing as they might be concerned for that of a relative. Staff described the service as being a 'family home'.

We were told by the registered manager that there were no people requiring the support of external advocacy services as everyone living at Brough Manor had family of friends to speak up for them if they were unable to represent themselves. The registered manager was aware of the advocacy services available to people and there was information about these posted on the notice board.

We saw from the approach staff had to people that staff respected people's privacy and dignity in every way. There was a family attitude and approach to knowing information about each other, but this was on an appropriate level and did not breach the more confidential aspects of caring for people that were vulnerable. All information we saw in documents was confidentially held. We saw that care plans made reference to ensuring people were supported with personal care in a way that considered their privacy and dignity.

When we spoke with the activities coordinator about activities they planned for people they also told us about a seven day 'end of life' care programme they had discovered and researched. It was especially for people living with dementia. It was based on a Hindu approach to 'honouring the spirit within' at the end of a person's life and it was called 'Namaste Care'. It was from the Hindu religion and based on the power of loving touch with the intention of 'honouring the spirit within'. It involved touch, smell and stimulating other senses that reflected a caring and soothing approach: like stroking a person's hands, brushing their hair, playing calming music or rubbing scented oils into their skin.

The basic principles were that people living with dementia at their end of life stage were afforded spiritual care that involved the senses: touch, sight, sound, smells and tastes. These senses were considered important to people living with dementia as they were heightened due to cognitive impairment. Simple care practices like brushing a person's hair with a soft brush, stroking their hands with scented cream, smiling at them and talking kindly, or playing soothing music to them in a loving way was thought in the Hindu religion to be a way of 'honouring a person's inner spirit'.

This meant people experienced pleasant senses in their last days of life and felt 'loved' so that their death took place in the company of another human being, wherever possible and when they were in a relaxed and comforted state. It also used continuous hydration to aid with reduction in urinary tract infections and regular nourishment in small portions to help those people with reduced appetite. The activities coordinator had adopted this as a programme that staff would use for people living with dementia, being cared for in bed or at the end of their lives. This was not based on a religious approach, but used the principles of respect, kindness and compassion.

We saw that two people living with dementia that received the majority of their care in bed were very well cared for. Their positional changes were considered and carried out regularly, they were supported with their nutrition and given supplements as well and they were visited regularly to ensure they had contact with the staff. They were offered the opportunity to alternate between listening to the radio, watching television or chatting to staff on a regular basis. They were assisted to get out of bed each day and sit in an armchair, particularly to have their midday meal and to have nails painted, hair brushed etc.

Their shared bedroom was in a part of the house close to the main entrance and opposite a busy corridor and so they had sight and sound of people, staff and visitors coming and going. Throughout the day time they liked their bedroom door secured open with a 'door guard' (linked to the fire safety system so it would automatically close in the event of the fire alarm activating), which meant they were not isolated. Any personal care was provided only after closing the door and curtains. While these two people had a less active life than others using the service they were still included in the day to day provision of the service and offered some one-to-one activity from the activities coordinator.

The service had a good approach to ensuring people felt 'cared for' regarding both their physical and their emotional needs.

Good

Is the service responsive?

Our findings

We saw from the case files held that there was a person-centred approach to care planning within the service. Care plans were devised from individual assessments of need and care support that people required was fully planned for. Care plans were reviewed monthly and yearly in conjunction with the placing local authorities. The service used a colour coded system to denote particular needs that people had and this was both noted in care plans and on people's bedroom doors beside a sign stating their name.

Of the three care files we looked at all three contained care plans. Care plans contained 13 different areas of care/ support need including, for example, personal support, physical wellbeing, mobility and communication, mental capacity decisions, mental health and social interaction. Care plans had been reviewed monthly and there was a six monthly summary review of needs as well. Care files contained information about peoples' admission, a 'do not attempt resuscitation' form if appropriate, a key details form, a patient passport (key information about the person for passing to healthcare professionals on admission to hospital so that healthcare staff know how to support the person), a current life history, their preferred daily routine, diary notes, activity planner and a record of any 'magic moments' in their lives.

Files also contained records of health care professionals visits, time spent with the person's key worker, an advanced end of life care plan if appropriate and a copy of the placing authority assessment and support plan for moving into care. Which meant people's needs were thoroughly assessed and planned for so that staff knew how to meet them.

We saw evidence of activities on offer in the form of an activity plan for the week and it was displayed in the dining room. It included a list of the week's activities for each morning and each afternoon. There were posters of activities advertised around the service in case anyone did not come to the dining room for their meals. We saw, for example, that each Friday an entertainer came to play a guitar and sing and this person was seen on the day of our inspection.

We were told by the activities coordinator that the service had held a Victory in Europe day celebration recently when people ate fish and chips from out of the paper they were delivered in and listened to an entertainer singing songs form the second world war. There were other activities advertised; pet therapy, music, birthday celebrations, nostalgia nights, theatre afternoons, puzzles, 'tea time' (which was often combined with a version of a television game – million pound drop – where chocolate was used instead of money). The activities coordinator told us they also carried out one-to-one sessions with people on occasion to complete a 'memory box' perhaps or a 'life story book'.

People could also engage in magnetic fish to which a quiz was attached, carpet bowls and skittles and general current affairs or reminiscence discussions.

The activities coordinator told us they were trained as a 'counsellor' and had signed up for a project with York University regarding a 'research and care course', which looked at and used different approaches to each individual that might wish to engage in an activity. We were told that activities at the weekend were also being incorporated into the activities plan.

We saw people making craft items, listening to and singing along with or dancing to a visiting entertainer, dong jig-saws and playing skittles on the day of our visit. Some people preferred to watch television in their bedrooms or listen to the radio and their preferences were respected.

We saw no one in a situation of social isolation, because everyone was included in the meal time arrangements or was offered a chance to engage in an activity or pastime. The activities coordinator made a point of checking every person in the service to ask if they wanted to join in with the planned entertainment that day. If they didn't she went back to them later to just chat or check they had all they required.

People we spoke with told us they had every opportunity to make choices about when they rose or went to bed, where they sat for the day, who they spoke with and what they joined in with. They said they could choose what meals they wanted and we saw the cook passing among people to ask about and record their meal choices for the day.

When we asked people about making complaints they said, "I would go straight to the manager, or to a staff member I related well to", and "The girls are all so lovely I could speak

Good

Is the service responsive?

to anyone of them. There's a couple of male staff that are approachable too." We saw there was a complaint procedure posted in the service, which was accessible to people and their relatives.

The service had a policy and procedure for complaint handling and people we spoke with demonstrated their awareness of what to do in the event they wanted to raise a complaint. There was a record held of complaints made and these were filed in a dedicated ring binder file. The records showed the service was accountable and that people's complaints were taken seriously and resolved wherever possible. There were copies of formal complaints forms available but none had been completed for some years, we were told by the staff. There were five 'niggles' recorded in the file and we saw that they had been addressed and resolved.

Good

Is the service well-led?

Our findings

We found that the culture at Brough Manor was one based on a family approach to sharing tasks and responsibility. Staff told us they all worked well as a team and no one displayed any attitudes that implied they considered themselves above everyone else. Staff said, "It is a friendly place where people come first" and "I think we pass the 'mum's test'. We work for each other to make it good for the people that live here."

The registered manager involved people in decisions, choices and how the service was run. They accommodated people's views when planning service delivery. Staff told us they were appreciative of the leadership in the service that they experienced from the registered manager. Staff described the registered manager as 'A trouper who does a fantastic job" and they said, "The first two hours of the registered manager's day are always spent helping us supporting people that use the service." They said, "The registered manager leads by example but also delegates responsibilities to us" and "If the manager doesn't know something they make it their job to find out and pass the information on to us."

The service has been consistently managed by the registered manager for the last three years. There has been no changes to the management structure in that time which meant people have known consistency and stability in the running of the service.

We found the registered manager to be open and transparent, willing to take on tasks they asked the staff to complete and capable of 'stepping up' whenever necessary to ensure the service was well managed and well-led.

We saw that the service had been awarded a score of 5 (on a rating of 1-5 with 5 being the highest) for their environmental health food hygiene (food safety) inspection in November 2014. We saw that checks had been carried out regularly by the cook within the kitchen regarding safe fridge temperatures, cleaning schedules and safe equipment.

We were told by the registered manager that the service had a written visions and values statement that included the need to focus on further development and improvement in 'the quality of care, support and hospitality', 'staff performance', 'the environment', 'practice and the use of quality monitoring' and 'meaningful partnerships with people they support, commissioners and stakeholders'. We saw that the services values, which were written in the visions and values statement included 'integrity, trust, kindness, dignity, compassion and respect'.

There had been no changes to the registration conditions of the service in the last four years.

We saw there was a yearly planner for the quality monitoring carried out in the service. The planner included the use of audits. These were in the format of a 'quality and compliance audit' which included an audit on care plans: 36 questions that were analysed to achieve a percentage score for compliance against the Health and Social Care Act 2008 requirements. We were told by the registered manager that a new audit tool on the same lines was being developed for checking infection control and medicines management.

We saw evidence that weekly audits were completed already on infection control in people's bedrooms, the kitchen, general cleaning and medicines management. We saw evidence of monthly audits carried out on care plans, communal area cleanliness, deep clearing of showers and bathrooms, accidents, staff meetings, 'service user' meetings and staff files. We saw evidence of quarterly (four times a year) audits on water temperatures, relatives' meetings, fire safety and health and safety issues.

The service also gave out six monthly quality satisfaction surveys and completed audits on the premises, waste management, policies, activities and GP medication reviews. There were yearly audits on staff appraisals and using optician and dental services. All audits had been completed regularly and in line with the yearly planner.

We discussed with the area manager and registered manager the large extent of quality audit checks and suggested that they may have repeated themselves in some areas, which may not have been necessary. We also discussed the possibility of reducing the frequency of some of the audits to enable the registered manager to move their focus to other management tasks.

We saw that there was a satisfaction analysis report on the quality satisfaction surveys that had been returned and this had been used to produce an overall action plan. The surveys received from relatives in March and April 2015 had been collated, a specific action plan had been devised and

Good

Is the service well-led?

there was evidence in the form of a feedback sheet on the communal notice board to show people and their relatives the action that had been taken from the information in surveys.

Staff surveys had also been issued and feedback from staff had requested that the service provided them with a policy/procedure summary guide that was easier for them to work with. This had been produced.

There were two types of surveys for people that used the service, one for commenting on general issues and one for activities offered in the service. Some comments for the activities survey included, "There are activities suitable for people living with dementia", "There is a fantastic activities programme in place" and "The lady in charge of the activities is very enthusiastic." Some of the questions on the general satisfaction survey included 'Are you happy with the décor?, the cleanliness? personal care?, timings of your support?, medical attention, the atmosphere?, information regarding making complaints and food provision?' The people that had replied to these were generally very satisfied with the overall service at Brough Manor.

The service held meetings for people that used the service, relatives and staff to enable everyone to make contributions to the quality of the service provided. Discussions carried out in these meetings were recorded, which meant they cold be followed up and any changes to the service made as necessary.

We saw that records regarding the care to people that used the service were well maintained and gave staff good indication as to how best to support people. Care plans and risk assessment documents were reviewed regularly and staff maintained good accounts of the support people received in diary notes, monitoring charts and, for example, GP and other health care professional visits and medicine administration records. People's care files were uniform, consistently updated and safely stored.

Other records relating to the running of the regulated activity, for example, staffing records (recruitment, training and rosters) and equipment maintenance checks were well maintained.

We were told by the registered manager and staff that they worked in close partnership with other organisations and bodies, for example, the East Riding of Yorkshire Council, Hull City Council, GPs, district nurses and other providers. We had received no information prior to our inspection to indicate this was not the case.