Braemar House Care Limited

Braemar House

Inspection report

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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

Summary of findings

Overall summary

This unannounced inspection took place on 19 October 2017. The home was last inspected under the provider's previous registration. This inspection was the first rated inspection under the provider's new registration.

Braemar House provides accommodation and care for up to eleven people. People living at the home have a learning disability. On the day of our inspection, nine people were living at the home. People had their own bedrooms and some had en-suite facilities. Communal space consisted of a large lounge dining area and kitchen.

There was a registered manager in post. 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.

There was a warm, friendly, family style atmosphere in the home and people were relaxed and comfortable in the company of staff. The home was well decorated and adapted to meet people's needs. The home had a homely feel and reflected the interests and lives of the people who lived there, with photos of people and staff.

People were treated with dignity, respect and kindness and were involved in the planning and review of their care and support. We saw people and staff interacting and engaging with each other in a relaxed, friendly manner.

People appeared to be happy and well supported by the home. One person told us they were happy and felt safe living at Braemar House. Relatives were very positive about the care and support provided to people. Comments included, "I am pleased with the care [name] receives. It's clear he's happy there and I would say my impression is staff genuinely like [name]."

Staff were focused on promoting people's rights and independence so that people lived fulfilling lives. People followed activities they enjoyed and were given opportunities to gain new skills and to increase their independence. Support was planned and provided to take account of each person's needs, interests and preferences. People received personalised care that took account of their abilities as well as their needs.

People told us they felt safe living at Braemar House. Systems were in place to protect people from the risk of harm. Staff were knowledgeable about safeguarding people from abuse and protecting their rights.

People were encouraged to be as independent as possible, while staff took into consideration their wishes, and any risks associated with supporting them. Risk assessments relating to people's individual care and to the safety of the home were completed and reviewed regularly. Where risks had been identified the least

restrictive options were used to manage them and keep people safe.

Care plans were extremely detailed and personalised providing staff with knowledge on how people wished to be supported and how to meet their needs. People had been fully involved in creating and reviewing their support plans. They spent time on a regular basis with staff making sure their support plan was working for them. People's preferences and lifestyle choices were clearly recorded along with excellent guidance for staff in supporting people with these.

People had an individualised timetable of activities which encouraged the development of independent skills and also provided social interaction and entertainment. We saw care plan information was available in different formats appropriate to the needs and preferences of people who lived in the home.

People received effective care from staff who had been trained and had the necessary skills to meet people's needs. Staff were supported through one to one supervisory meetings, annual appraisals and staff meetings. They were able to seek advice when necessary and had opportunities to discuss and review their work.

There were sufficient numbers of staff available to meet people's needs and to spend time with people on an individual basis. The provider's recruitment procedures ensured staff were of a suitable character to work with people who lived at Braemar House.

People were supported to have maximum choice and control of their lives and staff supported them to make informed decisions. Where a person lacked capacity to make certain decisions they were protected under the Mental Capacity Act 2005. People were supported in the least restrictive way possible and staff were insightful about how to support people who presented behaviours which may challenge others.

People were involved in planning, choosing and preparing their meals. People and staff planned weekly menus together and pictures of food or meals were used to support some people's understanding and to help them make choices. They were encouraged and supported to have a healthy diet. People's nutrition was monitored to ensure they had sufficient to eat and to maintain their health and well-being.

Medicines were stored, administered and disposed of appropriately. Staff were trained in the safe administration of medicines including those medicines required in an emergency. Their skills were observed and assessed regularly. People were supported to access a range of healthcare services to promote their health and in response to any changes in their health. These included GP's, dentists, opticians and hospital specialists.

There were effective systems in place for monitoring the safety and quality of the home. Audits identified any areas which were in need of improvement and action was taken to address these. Fire procedures were easily available, so that people were aware of action they needed to take in the event of a fire. A range of internal checks were conducted and environmental risk assessments were in place, showing that actions taken to protect people from harm had been recorded. Records showed that equipment and systems within the home had been serviced in accordance with the manufacturer's recommendations. Evidence was available to demonstrate that good infection control protocols were being followed in day-to-day practice.

Complaints were managed well and people we spoke with were aware of how to raise concerns, should they need to do so. Systems were in place to ensure that any complaints received were responded to in a timely manner and a thorough investigation was conducted.

The home was well-led. There was a relaxed, friendly and open culture at the home. Staff were valued and

supported by the registered manager and operational manager. The registered manager and operational manager were clear on the values and ethos they expected from staff. Staff worked to these values and told us they were led by example.

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.

Care plans recorded risks that had been identified in relation to people's care. Risks were being managed and processes were in place to reduce risk of harm.

People were protected by a robust staff recruitment process.

Medicines were ordered, stored and administered safely.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Is the service effective?

Good

The service was effective.

People's records showed how the principles of the MCA had been applied when a decision had been made for them or in their best interests. DoLS processes had been appropriately applied.

People received care from staff who knew them well, and had the knowledge and skills to meet their needs.

Staff received induction, on-going training, support and supervision to ensure they always delivered safe effective care.

People were provided with a choice of meals and were supported to maintain a balanced diet and adequate hydration.

People had access to healthcare and were supported to maintain their health.

Is the service caring?

Good

The service was caring.

People, relatives and healthcare professionals were positive about the home and the way staff treated the people they supported.

Staff treated people respectfully, and supported people to maintain their dignity and privacy.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's care plans were personalised and provided information of how staff should support them.

People were actively encouraged and supported to engage with their community and there was a range of varied activities available within the home.

People and their relatives felt listened to and were confident in expressing any concerns they had.

People were consulted and involved in the running of the home, their views were sought and acted upon.

Is the service well-led?

Good

The service was well led.

People, their relatives, staff and visiting professionals were extremely positive about the way the home was managed.

People benefited from staff that worked well together and were happy in their roles.

The quality of the service was monitored and the service was keen to further improve the care and support people received.

Braemar House

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 was planned to check whether the provider was 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 unannounced inspection took place on 19 October 2017 and was conducted by one adult social care inspector. As part of the inspection we reviewed the information we held about the home. We looked at previous inspection reports and other information including notifications. Statutory notifications are changes or events that occur at the home which the provider has a legal duty to inform us about. Before the inspection, 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 contacted the local authority, Quality and Improvement Team, Healthwatch and other healthcare professionals who provided information about the home. We used all of this information to plan how the inspection should be conducted.

During the inspection we looked around the home and met with everyone living there. We spoke to seven people about their experiences living at Braemar House. After the inspection we spoke with three relatives and received written feedback from three relatives. We also spoke with a visiting health care professional, the registered manager, operations manager and three staff members. After the inspection we received feedback from two health care professionals.

We looked at the care plans, records and daily notes for three people with a range of needs, and looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies, audits and quality assurance reports. We also looked at three staff files to check that the home was operating a full recruitment procedure, comprehensive training and provided regular supervision and appraisal of staff.

Good

Is the service safe?

Our findings

People told us they felt safe living at Braemar House. One person said, "The staff make me feel safe." We observed people were relaxed when speaking with staff and in each other's company. People's manner demonstrated they had trust in the staff supporting them. People said they knew who to speak to if they felt unsafe or had concerns. One person said they could talk to any of the staff. We noted staff responded to people instantly, always being sure to acknowledge when a person had spoken to them. People's relatives told us they felt their loved ones were safe at Braemar House. One relative told us, "This is the best place for [name]. She's very safe living here. She's very happy, everything is taken care of."

Staff were able to recognise signs of abuse and told us they would respond by informing their manager or contacting the local authority safeguarding team without hesitation. Staff had attended safeguarding training and had a good understanding of what it meant. One member of staff said, "If I saw anything wrong I would go to my manager or the Care Quality Commission". Another said, "We have a duty to protect them and make sure they are safe". People had access to information in an easy read format on keeping safe and how to contact outside agencies if they were concerned about their own safety. This assured us that people were protected against the risk of abuse.

Risks to people were recorded in their care plans and these had been assessed and measures had been put in place to guide staff in reducing or minimising risks to people. Staff were aware of risks to individuals, such as, risks relating to personal care, medicines, going out in the community, specific health conditions and behaviours that may challenge others. For example, there were positive behaviour support plans in place for people who needed them. Staff were clear about the strategies to reassure people and how to positively support people's behaviours that presented challenges to themselves and others.

Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. Checks included the use of application forms, an interview, reference checks and criminal record checks were undertaken through the Disclosure and Barring Service (DBS). These checks ensured new staff were of good character and had the necessary skills to work with people with complex needs.

There were sufficient staff on duty to provide safe and person centred care to people who lived at the home. People said staff were able to provide the support they asked for at any time. For example, to go out shopping, take part in leisure and recreational activities. Staff confirmed levels of staff were sufficient for them to provide the care and support to people with their preferences and in a safe and effective way. The staffing levels were flexible to meet the individual needs of the people living at the home. The registered manager told us staffing levels were kept under review as people's needs changed. Staffing rosters showed during the day there were three to four staff on duty. The registered manager and operations manager were counted in the numbers on some days and there as managerial support on others. Overnight, two care staff slept in and were available to provide support to people.

People's medicines were managed safely. Medicines policies and procedures were available to ensure

medicines were managed safely. People had individual medicine administration records (MARs). There were no gaps in the MARs so it was clear when people had been given their medicines. Medicines were stored securely. Staff had been trained in the safe handling, administration and disposal of medicines. Staff who gave medicines to people were aware of their responsibilities and understood their role. Clear records of medicines entering and leaving the home were maintained. We saw that some people were prescribed medicines that had to be taken at regular times. Arrangements were in place to ensure staff adhered to these instructions. When people had prescribed medicines on an as required basis, for example for pain relief, there were protocols in place.

Staff were aware of the reporting process for any accidents or incidents that occurred. All accidents, incidents and near misses were audited monthly to look for causes and trends and action was taken to help protect people. For example, one person had been experiencing an increase in the number of falls. Information gathered from the audit indicated the falls seemed to be happening when the person was moving from the lounge to their room and occurred when they were tired. The registered manager asked the person if they would like their chair moved to a space nearer the door to reduce the distance they had to walk to their room. This reduced the risk and resulted in a reduction in the number of falls for this person.

The home environment was suitable for the needs of the people who lived there. The communal areas were spacious and there was sufficient space for people to move around safely. We looked around the home and found it was clean and hygienic. Evidence was available to demonstrate that good infection control protocols were being followed in day-to-day practice. Staff used personal protective clothing such as disposable gloves and aprons and good infection control when carrying out personal care. This reduced the risk of cross infection. A relative told us, "The home is always clean and tidy and welcoming."

Health and safety checks and risk assessments were carried out to make sure the premises and systems within the home were maintained and serviced to keep people safe. These included checking the fire alarm, water temperatures, regular inspections and servicing of fire safety equipment, electrical installations and gas appliances. Records showed that equipment and systems within the home had been serviced in accordance with the manufacturer's recommendations.

Fire procedures were easily available, so that people were aware of action they needed to take in the event of a fire. A personal emergency evacuation plan (PEEP) was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed regularly to ensure they were up to date.

Good

Is the service effective?

Our findings

People received care from staff who had the knowledge and skills needed to carry out their roles effectively. Staff had completed an induction when they first started working in the home. This included shadowing more experienced staff, monitoring and supervision from the registered manager's and key training. These shadow shifts allowed the new member of staff to work alongside more experienced staff so they felt more confident working with people. This also enabled them to get to know people and the people to get to know them. The induction process also included introduction to policies and procedures and service specific information such as the fire procedure and maintaining a safe environment. Staff who were new to care, were supported to complete the Care Certificate. The Care Certificate is a nationally recognised certificate taken from the Care Act 2014 and is based upon 15 standards health and social care workers need to demonstrate competency in. This ensured they had the basic knowledge needed to begin working at the home.

People were cared for by staff that were supported to develop their knowledge and skills to ensure they were equipped to meet people's needs. There was a training matrix which provided details of all the training staff were required to undertake and how often it should be updated. This included training on safe working practices such as moving and handling, fire safety, infection control, safeguarding and emergency first aid. In addition to training on safe working practices, staff received training on topics to meet people's individual needs such as positive behaviour support, epilepsy, dementia awareness, diabetes and end of life care. Staff were given opportunities and supported to gain higher education in Health and Social Care.

Staff were supported by a registered manager and operations manager who worked alongside them to provide support and to ensure they followed best practice. There was a planned programme of staff supervision and appraisal. Observation, group and formal supervision took place on a three monthly rolling cycle to ensure the delivery of high quality person centred care. This helped to monitor the skills and competencies of staff and to identify any training needs they might have. Staff told us they felt well supported and they could discuss any issues with the registered manager and operations manager, who were always available.

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 so that they can receive care and treatment when this 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 (DoLS). 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 were being met.

People's care plans showed that assessments relating to people's capacity to make decisions had been undertaken and these followed the code of practice associated with The Mental Capacity Act 2005 (MCA). The registered manager identified people who may be deprived of their liberty. We saw copies of applications to the relevant local authority team in relation to Deprivation of Liberty Safeguard (DoLS). Restrictions were in place for people who were under continuous supervision and unable to leave the home unaccompanied due to risk associated with lack of capacity to make decisions.

The registered manager and staff demonstrated they understood the principles of the MCA. Care plans provided information for staff about how they should support people to make decisions. Staff told us how they supported people to make their own choices with their daily lives and their goals for the future. Staff told us people who had capacity had the right to make unwise choices. They told us how they would support people to guide them to a positive outcome, such as helping them choose a healthier food option. We heard staff asking for people's consent before they assisted them. For example, when supporting people with their medicines, preparing meals and trips out. Records showed people's ability to consent to specific things had been assessed and where it was felt they lacked the mental capacity to make a decision a best interests decision was made. For example, best interests decisions had been made involving family members and professionals regarding people's medication, their finances and invasive health care procedures such as dental treatment.

People we spoke with told us the food was good. One person said, "The food is lovely here." Another person said "the food is excellent, very nice menu." Other people answered "yes" when asked if they enjoyed the food. A relative told us "No complaints about the food. He enjoys the food, he's getting a healthy diet."

People were offered a healthy and balanced range of home cooked meals to suit people's dietary needs and preferences. Staff knew each person's likes, dislikes and alternatives were offered if people did not like the main meals on offer. Menus were planned with people and pictures were available to help people with choices. Information was displayed in the kitchen about people's food preferences with suggestions for alternative meals. We saw a poster with pictures of what items of food each individual person should take in their packed lunch. This showed that people were supported and prompted to make and prepare healthy food choices and maintain their independence.

Risk assessments were in place where people were at risk of choking. Support and advice had been sought from the speech and language therapy (SALT) team and staff had clear written guidelines on supporting people with eating. People who required support when eating their meal had staff sat next to them to help and encourage them when needed. Some people needed additional calories to maintain a healthy weight while others were following a diet plan to help them reduce their weight. Where there were risks around nutrition and hydration, people's weight and food and drink intake was monitored.

We saw people's care records included information from health professionals. There was evidence of involvement by GPs, dentists, nurse specialists, speech and language therapists and community learning disability team. Staff told us if they required advice from a health professional they would immediately make a referral. For example, staff consulted a psychiatrist and behavioural psychologist to help one person when they were displaying unusual behaviours.

A relative told us staff at the home were always very quick to contact the doctor or other health care professional if they had any concerns about people's health. One relative told us, "If it wasn't for the staff at Braemar, [name] wouldn't be alive today." They told us that when their relative became ill, staff persistently took them back to the GP and hospital until they were satisfactorily treated. They added, "They didn't give up and it saved his life." A visiting health professional told us, "They always follow any advice I give and are

very receptive. If I advise them to do something it gets done. I love coming here, it's very family orientated. It's professional but relaxed."

People had 'Health Action Plans' in place which contained information on their medical history and current health needs. People had health care document in easy read picture format with information about their health needs. This meant that health professionals could see how people wanted their healthcare provided and how the person communicated their needs and wishes. There was information available for people to help prepare them for medical appointments. These were in the form of photographs such as; a picture of their GP and the surgery building. This ensured that people's anxiety about health appointments, were reduced as much as possible.

Good

Is the service caring?

Our findings

People who lived at Braemar House appeared happy in the home, they were smiling and talkative. There was a genuine sense of fondness and respect between the staff and people. People appeared happy and relaxed in staff's company. People who were able to talk to us about their experiences said they were happy with the care and support they received. One person told us that staff were "Nice." Other comments included "I like it here and I like the staff", "They look after me well" and "All the staff are wonderful." Relatives we spoke told us the staff showed a high level of compassion towards the people they supported. One relative said "[Name] is very happy at Braemar House. There is always enough staff and they are always very kind and understanding as to [name's] needs." Another relative said "I am pleased with the care [name] receives. It's clear he's happy there and I would say my impression is staff genuinely like [name]."

Staff told us how much they liked working at Braemar House. One staff member said "I can honestly say I love my job. It's one of the best care home's I've worked in." Others said, "I enjoy the company of the residents. We have a good rapport", "It's a good team, everyone cares about people" and "It really is a home, it's a great place. The residents are really happy, they are listened to."

During the inspection there was a happy and relaxed atmosphere in the home. Staff interacted well with people, engaging and joking with them and spending time with them. Staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. We saw examples of this throughout the inspection. For example, we observed a member of staff talking to one person about their shopping they had just bought. Another member of staff was supporting one person to complete a puzzle in a newspaper.

We saw staff were familiar with the people they supported, and spoke with them about the things that were meaningful to them. Information about people's communication needs were contained within their care plans. Staff were familiar with how each person communicated and might show they were anxious or upset. Staff described how they intervened proactively when people displayed anxiety and helped them remain focused on positive activities. People were confident in the presence of staff and staff were able to communicate well with people.

Staff treated people with understanding, kindness and respected their privacy and dignity. Staff provided personal care behind closed bedroom or bathroom doors and showed discretion when helping people with their care needs. Staff were observed knocking and waiting for permission before entering a person's bedroom.

We saw people were actively involved with planning and agreeing their care and support needs and how they preferred to have these needs met. There was information in people's care plans to help staff get to know them. This included information about their communication styles, sense of humour and when they might need support or reassurance. For example, one care plan reminded staff, "Be aware when there is thunder and lightning, I may need reassuring."

People's care plans included information about how staff could help them remain as independent as possible such as details of what tasks they could perform with and without prompting. For example, one person's care plan asked staff to "encourage me to take part in daily activities especially those that help me gain more independence." We asked staff how they involved people in making decisions about their care. One member of staff we spoke with told us, "We ask them what they want to do. They all do what they want to do when they want to do it." One person's relative told us; their relative had become more independent with support from staff. We saw that staff always gave people choices and gave them time to think about the options.

Information was displayed in an accessible format to help people understand it. There were pictorial menus in the kitchen showing what choices were available for packed lunches. Pictorial information leaflets of how to complain, how make decisions and information about health checks were available around the home. When people's views were sought, questionnaires were in easy read and picture format.

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. They knew which staff responded better with certain people and who liked gender specific staff for personal care.

Relatives told us they were always made to feel welcome and could visit at any time. People were encouraged to maintain positive relationships with their families and friends through visits, phone calls, computer video link and supported and unsupported visits to social occasions. Friendships had been forged with other people who lived close by and staff told us people visited each other often and enjoyed each other's company.

The registered manager told us that the parents of some of the people at the home had passed away. They described how they helped one person through their parent's illness, passing and grieving process. They took them to visit their parent in the nursing home whilst they were unwell and supported them when their parent passed away. People's end of life wishes had been discussed with them, where appropriate, and recorded in their care plans. The care plan's contained a 'when I die' document that detailed people's choices and wishes at the end of their life. Staff received training on end of life care and how to support people at this time.

Good

Is the service responsive?

Our findings

People and relatives told us staff understood their needs and they were well cared for. One person said, "They always help me." A relative we spoke with said, "This is a brilliant home." Another relative said, "I trust them implicitly. We are absolutely confident [name] has the best care."

People received a responsive service that met their individual needs. Staff were knowledgeable about people and displayed a good understanding of their preferences and interests, as well as their health and support needs. This enabled them to provide personalised care and help people live their lives in the way they chose.

Care plans were person centred and contained very detailed information on how the person liked to be cared for and their needs. For example, one person's support plan for how they liked to be supported at night, told staff they liked to have their CD turned on at night to volume eight and the timer set. Person centred planning means putting the person at the centre to plan their own lives. The aim of the plan is to ensure that people remain central to any plan which may affect them. Care and support plans clearly stated how people wanted to start and spend their day, what they needed help with, the support needed from staff and information about the person's likes, dislikes and personal choices. This helped to ensure that people were cared for and supported in a way that they wanted to be. People and relatives told us they had been involved in making decisions about care and support and developing the care plans.

When people were unable to express their views consideration had been given to how they responded to their environment and expressed their happiness or distress. For example, one person's care plan guided staff on how to interpret their verbal and non-verbal cues such as; 'when I pace up and down, I need to go to the toilet' and 'when I say; "coffee's good for you", I want a drink.' Another person's care plan provided staff with visual and verbal clues to tell if they were happy or unhappy, such as; 'If I'm happy I smile more and I will join in with activities' and 'If I'm unhappy I will go to my room'. This helped to ensure staff built up a picture of how people communicated, what people enjoyed doing and what they engaged positively with. Their care plans recognised this providing a clear picture of what worked well for them. Staff told us they had got to know each person's individual communication needs including their specific gestures, facial expressions and behaviour by reading people's care plans.

Care plans included comprehensive guidance about how staff needed to support people in achieving personal goals and maintain people's independence by developing their skills. Staff encouraged and supported people to be involved in household tasks such as helping prepare meals, washing up after dinner and unpacking and putting the shopping away. Some people were supported to travel independently by local transport to their place of work and visit shops independently.

Staff told us they always gave people options and choices during support. For example, choice of what to wear, food or where to spend their time. Staff completed records of daily support given to each person. These provided key information on the support provided and the person's general mood. Where complex support was provided the daily notes reflected this.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, one person's behaviour became more challenging. A full review with other healthcare professionals was initiated and the person's medicine changed. The support plan and risk assessments were updated to show the changes.

The home had good systems in place to ensure smooth transition between services. People had 'hospital passports' which had all the important information to allow continuity of care. These included important information on communication, likes and dislikes, health information and allergies.

People were encouraged to lead busy lifestyles. People had access to a range of activities both within their home and in their local communities. Each person was supported to develop an activities plan which reflected their preferences and interests. These involved work days, a number of social groups and activities of their choice such as bingo, shopping, and cooking. One person enjoyed cooking and staff told us they supported this person with cooking meals for other residents. People had a schedule of activities which reflected their preferences and interests. Some people who used the service went to day centres. One person told us they liked listening to their CD's and how they liked to watch films. People regularly went out shopping, to cafés and for meals out. They also visited local places of interest as well as going further afield on day trips and on holiday. Some people were supported to take part in voluntary work. One person told us how much they enjoyed their job and looked forward to going.

Staff understood the importance of supporting people to raise concerns who could not verbalise if they were unhappy. Pictorial information of what to do in the event of needing to make a complaint was displayed in the home. For people who could not access written or pictorial procedures staff told us that they observed their interactions and body language and would report any concerns to the registered manager.

There was a complaints policy in place. The policy included clear guidelines, in an easy to read format, on how and by when, issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission. Since the last inspection the registered manager had received and responded to a complex formal complaint. The registered manager sought independent support to investigate the complaint and make recommendations. Where recommendations were made, we saw that reflective practice had taken place to discuss and resolve areas of concern and where necessary, a change of practice was instigated. We saw complaints that had been received were recorded and dealt with in accordance with the provider's complaints policy.

Relatives spoke about an open culture and felt that the home was responsive to any concerns raised. One person's relative told us, "I can complain to the manager if I have to". Since our last inspection there had been compliments and positive feedback received about the staff and the support people had received. Comments included, "I have in the past and I will continue to recommend Braemar", "Wonderful home, caring supportive staff" and "Everything is provided for [name] and we are very happy with the care provided."

Good

Is the service well-led?

Our findings

Staff described the registered manager and operational manager as very approachable and very supportive. One member of staff said the management team, "Are always here when we need them. The support is good and they are approachable" another said "I find management to be really supportive; if I come across a problem I can just ring them. I find they go out of their way to help." A relative told us "The management here is excellent."

The home was well organised and had effective leadership. The home had a statement of purpose that set out their philosophy of care and clear vision and values for the home. The aim of Braemar House was to promote the highest level of health, dignity and independence possible for each individual. Staff said they felt valued and they understood the vision and values of the home and told us they were led by example. We observed that staff had embedded these values in to their work.

There was an open and supportive culture in the home. Staff said the registered manager had an open door policy and felt supported by the managers and they all worked well as team. The staff team were caring and dedicated to meeting the needs of the people living at the home. They told us the registered manager kept them informed of any changes to the home and needs of the people they were supporting.

Staff told us they felt able to express their views and were supported by a rolling programme of monthly individual supervision, group supervision and observed practice. All staff we spoke with told us they felt happy working at Braemar House, and were motivated by the support and guidance they received to maintain high standards of care. Staff told us they were listened to by the registered manager and felt they could approach the management team with issues and concerns.

The home had systems in place to ask for and collect the views of people, their relatives and staff in order to regularly review how people experienced their care and how the quality of care and service could be improved. People's views were sought about topics including activities, decoration of rooms as well as giving people the opportunity to talk about anything they may want to talk about.

There were effective systems in place for monitoring the safety and quality of the home. The registered manager carried out a range of audits to monitor quality within the home and to ensure the safety of people who lived there. Regular audits were carried out on areas such health and safety, environment and maintenance, equipment, care plans and records audits and monthly medicines audits. Audits identified any areas which were in need of improvement and action was taken to address these.

There were strong links with the local community and staff encouraged people to go to local events. The registered manager ensured that all people living at the home were able to go out to supported work or attend social clubs as they wished.

People benefitted from a close working partnership by the registered manager and operations manager with other healthcare professionals and external agencies. This ensured people received care and support in

line with best practice. The registered manager received input from agencies such as the local authorities and organisations that specialised in needs of people with a learning disability for guidance, updates on changes to legislation and developments in the care sector. Records showed this enhanced the quality of care staff provided to people living at the home.

Policies and procedures were in place for staff to refer to. The policies and procedures were in the process of being updated and amended to ensure that staff had access to the most up to date and relevant guidance to enable them to carry out their roles safely. Records were detailed, up to date and stored securely.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know what to do if they had any concerns. Prior to our inspection the registered manager completed and returned the PIR as we requested. The PIR was accurate and reflected the evidence gained during our inspection.