Brierley Care Ltd

High Brake House

Inspection report

129 Chatburn Road
Clitheroe
Lancashire
BB7 2BD

Tel: 01200443680

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out on 20, 21 and 22 December 2017. The first day of the inspection was unannounced.

High Brake House is a care home which is registered to provide care and accommodation for up to 35 older people, including older people living with a dementia. The service does not provide nursing care. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. High Brake House is an adapted building in a residential area in Clitheroe. At the time of the inspection there were 34 people accommodated at the service.

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

At our last inspection on the 4 and 5 May 2016 the overall rating of the service was 'Good'. However there were breaches of the regulations relating to staff recruitment and medicines management. We asked the provider to make improvements on these matters. We received an action plan from the provider on 19 June 2016 indicating how and when they would meet the relevant legal requirements. At this inspection we found sufficient improvements had been made and the service remained Good.

During this inspection we found there were no breaches of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. However we found there were some shortfalls with the management of complaints. We have therefore made a recommendation about improving complaints processes.

There was a warm and friendly atmosphere at the service. We found there were good management and leadership arrangements in place to support the day to day running of the service.

Arrangements were in place to promote the safety of the premises, this included maintenance, servicing and checking systems. We found the service to be clean in the areas we looked at.

People were happy with the accommodation. We found there was a good standard of décor and furnishings to provide for people's comfort and wellbeing. People had personalised their rooms and had been asked for their choice of colour schemes.

People told us they felt safe at the service. Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns about people's wellbeing and safety.

Arrangements were in place to ensure staff were checked before working at the service. We found some

checks had not been properly completed. But the registered manager took swift action to make improvements. There were enough staff available to provide care and support. There were systems in place to ensure all staff received regular training and supervision.

People's needs were being assessed and planned for before they moved into the service. People were supported with their healthcare needs and received appropriate medical attention. Changes in people's health and well-being were monitored and responded to.

Each person had a care plan, describing their individual needs, preferences and routines. This provided guidance for staff on how to provide support. People's needs and choices were kept under review.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems at the service support this practice.

There were some good processes in place to manage and store people's medicines safely. We found some improvements were needed and these were put right during the inspection.

People made positive comments about the caring attitude of staff. During the inspection we observed staff interacting with people in a kind, friendly and respectful manner.

There were opportunities for people to engage in a range of group and individual activities. Progress was ongoing to provide more meaningful activities and engagement. People were keeping in contact with families and friends. We found visiting arrangements were flexible.

People were happy with the variety and quality of the meals provided. We found various choices were available. Support was provided with specific diets. Drinks were readily accessible and regularly offered.

People spoken with had an awareness of the service's complaints procedure and processes. They indicated they would be confident in raising concerns.

Arrangements were in place to encourage people to express their views and be consulted about High Brake House, they had opportunities to give feedback on their experience of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service has improved to Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service has deteriorated to Requires Improvement.	**Requires Improvement**
Is the service well-led? The service remains Good.	**Good**

High Brake 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 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 20, 21 and 22 December 2017. The inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring and safeguarding teams.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit, we spent time with people, observing the care and support being delivered. We talked with a visitor and seven people living at High Brake House about their experiences at the service. We talked with three care workers, the deputy manager, team leader, a cook, a housekeeper, the registered manager and the nominated individual.

We looked round parts of the premises. We looked at a sample of records, including three care plans and other related care documentation, two staff recruitment records, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Good

Is the service safe?

Our findings

We looked at the way people were supported with the proper and safe use of medicines. At our last inspection we found the provider had failed to ensure people's medicines were managed safely. At this inspection we noted sufficient improvements had been made. People spoken with told us they received their medicines appropriately and on time. One person told us, "I get my morning tablets after breakfast, then after tea. I get them on time. They stick to the times." During the inspection we observed people being sensitively and safely supported with their medicines.

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. The process included staff having sight of repeat prescriptions for checking prior to them being sent to the pharmacist. This was to ensure all the required items were included on the prescriptions. Processes were also in place to check and record the numbers of medicines received at the service, this was to ensure people had been given their medicines properly.

There was information in the care records we reviewed; of people's preferences to manage or be involved with their medicines. This meant there was some information to show how decisions around people choosing not to self-administer their medicines had been made. One person told us, "I have quite a lot. I know what they all are." We discussed with the registered manager the value of ensuring these reasons and decisions were justified and kept under review. Processes were in place to assesses and manage the risks should people choose to administer their own medicines. The medicines administration records (MAR) included a basic medicines profile. This included any known allergies and a photograph of the person to assist with identification. The registered manager told us a new medicines profile was in the process of being introduced, this was to promote a more person centred approach to supporting people with their medicines.

The MAR provided clear information on the name and strength of the medicines and dosage instructions. The records we looked at were clear, up to date and appropriately kept. Processes were in place for care staff to sign in confirmation of the application of people's external medicines, such as topical creams. There were recording charts with 'body map' diagrams for care staff to refer to and complete. We found there were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols were important to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered, in response to the person's specific needs. We found some protocols were slightly lacking in specific detail however, action was taken to make improvements during the inspection.

We looked at the arrangements for the safe storage of medicines. There was a monitored dosage system (MDS) for medicines. This is a storage device provided and packed by the pharmacy, which places tablets in separate compartments according to the time of day. We found medicines were being stored safely and securely. Room and fridge temperatures were monitored in order to maintain the appropriate storage conditions. Processes were in place to manage the appropriated disposal of medicines, including returns to the pharmacy. Arrangements were in place for the safe management and storage of controlled drugs; these

are medicines which may be at risk of misuse. We checked one person's controlled drugs and found they corresponded accurately with the register.

Staff had access to a range of medicines policies and procedures which reflected nationally recognised guidance. Information leaflets were available for each of the prescribed items. Records and discussion showed staff responsible for medicines management had received various levels of training. We looked at records which showed staff had been competency assessed in undertaking this task. We found some assessment records were unable to be located; however the registered manager assured us they had been completed and were in the process of being updated. There were weekly checks, monthly and six monthly audits of medicine management practices.

We checked if the staff recruitment procedures protected people who used the service. At our last inspection we found the provider had failed to operate safe and robust recruitment and selection processes. At this inspection we found sufficient improvements had been made. We reviewed the recruitment records of two newest recruits. The recruitment process included candidates completing a written application form and attending a face to face interview. Character checks including, identification, obtaining written references, health screening and evidence of any qualifications had been carried out. An appropriate DBS (Disclosure and Barring Service) check had been completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We found full employment histories and the reasons for leaving previous employment had not always been properly checked. However during the inspection the registered manager proactively took action to rectify these matters and prevent any recurrence. Arrangements were in place for new employees to undergo a probationary period to monitor their conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct.

We reviewed how the service protected people from abuse, neglect and discrimination. The people we spoke with indicated they felt safe at the service. Their comments included, "I feel safe," "Oh absolutely," "Yes I definitely feel safe" and "I was frightened on my own in my house, they really take care of me here."

There had not been any recent safeguarding incidents at the service. However, we discussed and reviewed safeguarding processes with the registered manager. The local authorities revised and updated guidance for responding to safeguarding concerns was available. Processes were in place to record the actions taken in response to safeguarding concerns. Staff spoken with expressed an understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse, including physical abuse, psychological harm and potential discrimination. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. We noted information was available from the local authority on adults at risk and keeping people safe.

We looked at how risks to people's individual safety and well-being were assessed and managed. Individual risks were considered as part of the care planning process. There were specific risk assessments in response to individual needs, which included, skin integrity, mobility, oral health, malnutrition, behaviours, falls and moving and handling. Strategies had been drawn up to guide staff on how to manage and respond to identified risks. There were also additional risk screening assessments on various matters, including people spending time alone in their rooms, having hot drinks and accessing the 'nurse call' systems. We noted the risks assessments were dated and kept under review. Each person had a 'personal emergency evacuation plan' in the event of emergency situations.

Records were kept of any accidents and incidents that had taken place. Processes were in place to monitor any accidents and incidents. We discussed with the registered manager their responsibilities to monitor any safeguarding concerns, accidents and incidents at the service, to ensure there was a proactive 'lessons learned' approach. Staff spoken with were aware of the accident and incident procedures and their responsibilities to record and appropriately report such matters.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. Most people spoken with thought there were enough staff at the service. During the inspection we found there were sufficient numbers of care staff on duty to meet people's needs. We observed staff responding to people's requests and providing support, in a safe and timely way.

There were five care staff on duty throughout the day and three at night with on call management support. Care staff were allocated specific people to work with and designated responsibilities at the start of each shift. There were housekeeping, cleaning and catering staff available each day. All the staff spoken with considered there were always enough staff on duty. We looked at the staff rotas, which showed arrangements were in place to maintain consistent staffing levels. The registered manager said staffing reviews were carried out in response to people's changing needs and as part of the assessment process of new people using the service. We noted a 'dependency assessment' had been carried out to assist with identifying safe staffing arrangements. We discussed the value of developing this approach to take into account people's lifestyle choices and the layout of the building.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. We looked around the premises. The areas we viewed were well maintained and did not present as a risk to health and safety. We found health and safety risk assessments had been carried out and kept under review. There were accident and fire safety procedures available. There were contingency arrangements to be followed in the event of emergencies and failures of utility services and equipment. Records showed arrangements were in place to check, maintain and service fittings and equipment, including electrical and gas safety, water temperatures, fire extinguishers, hoists and the passenger lifts. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out.

There was CCTV in operation in communal areas including the lounges, dining areas, corridors and grounds. The system did not operate in people's private rooms. The management team told us the system helped them to monitor people's safety and the care and support provided. There was information about the surveillance system in the service user guide on display for visitors.

We reviewed how people were protected by the prevention and control of infection. People spoken with said, "The place is cleaned, they are very good" and "My room is cleaned every day." The areas of the service we looked at were kept clean. Suitable cleaning equipment, laundry facilities and a sluice room were provided. Protective personal equipment, including gloves, aprons and anti-bacterial hand wash was available. Guidance on effective hand hygiene was displayed in bathrooms. There were cleaning schedules and associated recording systems to maintain hygiene standards. Records and discussion indicated staff had completed training on infection control. There were processes to audit, monitor and respond to infection prevention and control measures at the service. This meant arrangements were in place to check, maintain and promote good hygiene standards.

Good

Is the service effective?

Our findings

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. The people we spoke with indicated they were satisfied with the care and support they experienced. Their comments included, "Let's just say I am very happy here," "Oh yes, I'm really looked after" and "Everything is fine here."

We looked at the way the service assessed and planned for people's needs, choices and abilities. The registered manager and deputy described the process of initially assessing people's needs and abilities before they used the service. This involved meeting with the person and completing a needs assessment, by gathering information from them, their families and any relevant health and social care professionals. There were policies and procedures to support the principles of equality and diversity. This meant consideration would be given to protected characteristics including: race, sexual orientation and religion or belief. People were encouraged to visit the service, for meals and short stays. This was to support the ongoing assessment process and provide people with opportunity to experience the service before moving in. The registered manager said the process included taking into consideration the person's compatibility with people already using the service.

We looked at how consent to care and treatment was sought in line with legislation and guidance. During the inspection we observed staff consulting with people on their individual needs and preferences. There were instances where staff involved people in routine decisions and sought their consent to provide care and support. Staff spoken with told us how they routinely consulted with people about their care and support. One staff member said, "I always ask if I can do things. Then I explain and talk them through the steps." We noted examples in the records we reviewed of people signing consent to care agreements. Where people had some difficulty expressing their wishes they were supported as appropriate by family members. During the inspection we discussed with the registered manager, best interest approaches around consent including arrangements for night time monitoring.

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. 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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw there were processes in place to screen and monitor people's capacity to make decisions. There was information to demonstrate appropriate action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. Records had been kept to monitor and review the

progress of pending applications. We discussed with the registered manager the possibility of future applications which may need to be assessed and submitted. Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and monitor their capacity to make their own decisions. The service had policies and procedures which aimed to underpin an appropriate response to the MCA 2005 and DoLS.

We looked at how people were supported to live healthier lives, the access they had to healthcare services and ongoing healthcare support. The people we spoke with indicated they had access to health care professionals when needed. This included GP's, district nurses, mental health professionals and chiropodists. One person said, "If I wanted a doctor I would ask the staff." Records were kept of healthcare visits and appointments. People's medical histories and conditions were included in the care planning process. Their healthcare needs were monitored and considered as part of ongoing reviews. Five staff had been trained and assessed in checking people's vital signs. There were regular routine GP visits from local practices. The service was also signed up to a system whereby they could access remote clinical consultations; this meant staff could access prompt professional healthcare advice at any time. People were offered the opportunity for physical exercise, including 'wheelchair football' and further options were being arranged. One person told us, "[Registered Manager] was saying a lady is coming in after Christmas to do exercises."

We checked how people were supported to eat and drink enough to maintain a balanced diet. People made positive comments about the meals provided at the service. They told us, "I had fish pie today, I love it," "The food is good" and "I've had no complaints about my food the bacon is similar to what I buy at home."

Individual dietary needs, food likes and dislikes were included within the care planning process and shared with the catering staff. People's general dietary intake was monitored and their weight was checked at regular intervals. This helped staff to monitor risks of malnutrition and support people with their diet and food intake. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary. Specific diets could be catered for, including fortified diets and pureed meals.

We talked with the chef on duty and looked at the three week rotating menus which had been devised to include people's known likes and preferences. There were choices offered at each meal, including a choice of desserts. People were asked each day to select their choice of meals. The days' menu was also available in the dining room for reference; this aimed to remind people of the choices on offer and gave them the opportunity to reconsider their selection. One person said, "You get a choice of meal. You can have whatever you want at breakfast within reason." Drinks were accessible and offered throughout the day. There was a kitchenette area, where people and relatives could make drinks.

Mealtimes were flexible and there were two sittings, we noted people could eat in their rooms if they preferred. We observed the meals service at lunch time. We observed examples of people being sensitively supported and encouraged by staff with their meals. Various choices and alternatives were offered. The meals served looked plentiful and well presented. Some people indicated the meals were not always at the time they expected. We therefore discussed with the registered manager ways of monitoring and developing the catering service, to further enhance people's mealtime experience.

We looked at how the service made sure that staff had the skills, knowledge and experience to deliver effective care and support. People we talked with said, "Well they seem to work fairly hard," "They seem to know what they are doing," "There's always training" and "Generally speaking they are a mixed bunch, but they are very pleasant." A visitor told us they thought that staff were competent and had relevant skills and experience.

Processes were in place for new staff to complete an initial 'in-house' induction training programme. This included an introduction to the service, familiarisation with policies, procedures and health and safety matters. Processes were in place to monitor their performance and development as part of their probationary reviews. One person told us, "You can always tell new ones…. they don't do any personal care at first…..they just ask what you want and they watch the others. It's very well organised actually." We spoke with one staff member who confirmed they had completed the induction training. The induction training incorporated learning based upon the Care Certificate training modules. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

Staff spoken with told us about the training they had received and had access to. They confirmed that there was an ongoing programme of staff development. This included: infection prevention and control, food hygiene and nutrition, moving and handling, health and safety, fire safety, MCA and DoLS, dementia care and equality and diversity. We looked at a sample of certificates which confirmed training had been completed. There were processes in place to identify and plan for the delivery of suitable refresher training. We found some of the information recorded in the training matrix was unclear. However the registered manager assured us staff training was up to date and further training had been arranged as appropriate. The service supported staff as appropriate, to attain recognised qualifications in health and social care. All carers had a Level 2 or level 3, National Vocational Qualification (NVQ) or were signed up for/working towards a Diploma in Health and Social Care.

Staff spoken with indicated they had supervisions sessions with a member of the management team. We saw records confirming individual and group supervision meetings had been held. The meetings had provided the opportunity for two-way discussions on the staff's role, responsibilities and any concerns. We noted plans were in place for all staff to receive an annual appraisal of their work performance in January 2018.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises. We looked around the premises and noted furnishings, carpets and decoration were of a high standard. We found people had been encouraged and supported to personalise their rooms with their own belongings. They had been enabled to choose their own colour schemes and make shared decisions on furnishings for communal areas. This had helped to create a sense of 'home' and ownership. There were various lounges and seating areas for people to use. There was access to the enclosed outside garden where there were raised flower beds, sensory features and garden furniture. We discussed the provision of suitable adaptations for people living with a dementia, including signs and colour schemes to help with orientation. The registered manager explained the services response to this provision was currently being researched and reviewed.

We reviewed how the service used technology and equipment to enhance the delivery of effective care and support. We noted light sensors had been fitted in the new extension, to provide timely illumination. The service had internet access to enhance communication and provide access to relevant information. This included: accessing specific music to assist with reminiscence, sending and receiving e-mails and supporting people to have on-line contact with families and friends. E-learning formed part of the staff training and development programme.

Good

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. People spoken with made some positive comments about the staff team and the care and support they received. They said, "They seem to be [caring], generally speaking they are," "Oh the staff are lovely ," The girls all respect me, they seem to do," "They are very good at listening to you," "Nothing's a trouble to them. I can't praise them highly enough" and "They are very caring. The night staff are exceptional."

We checked how the service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. Although people spoken with did not express much awareness of their care records, we noted examples where people had signed in agreement with them. Our discussions and observations also indicated people's care needs and preferences had been discussed with them. We discussed with the registered manager ways of promoting the care plan processes, to further encourage people's awareness, understanding and involvement.

Staff spoken with knew people well and understood their role in providing people with person centred care and support. They were aware of people's care plans, their individual needs, routines, backgrounds and personalities. They gave practical examples of how they supported and promoted people's individuality and choices. Staff indicated they had time to listen to people and involve them with decisions. They were provided with equality and diversity training. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences.

Everyone had a care plan which identified their needs and preferences and how they wished to be supported. This included a people's background history and a 'one page profile' with information about the person's preferences, interests, significant relationships and life experiences. There were personalised summaries such as, 'about me,' 'my life now' 'what's important to me' and 'how best to support me.' One staff member commented, "It's all person centred here. I have read through the care plans. I think they have all the information needed."

We reviewed how the service empowered and enabled people to be independent. Residents meetings had been held. This provided the opportunity for people to make suggestions, be consulted and make shared decisions. We noted from the records of meetings that various topics had been raised and discussed, including food, activities and laundry systems. We talked with the registered manager about ways of using the residents meetings to share everyday information and enlighten people on relevant topics. This could help empower people and further promote their rights, knowledge and awareness when making decisions.

We saw people being as independent as possible, in accordance with their individual needs, abilities and preferences. We talked with people who chose to be in their bedrooms; they described their preferences, which clearly indicated they had control over how they spent their time. One person said, "They put no pressure on you to do anything. You can do what you want."

We asked people if they were supported to be independent. Their comments included, "Yes but they keep their eye on me. If I want someone I know where to go," "They'll help me if it's necessary" and "If I need anything I'll tell them." Staff explained how they promoted independence, by offering choices and enabling people to do things for themselves. They said, "We promote independence as much as possible. People can make their own decisions" and "I let them get on with it. I stand back. I explain, 'I am here to help, not take over.'"

We looked at how people's privacy was respected and promoted. All bedrooms were for single occupancy and had en-suite facilities. Some people preferred to spend time alone in the privacy of their rooms and this choice was respected by staff. People's doors were fitted with suitable locks to help promote privacy of personal space and people had been offered keys. We observed staff knocking and waiting for a reply before entering people's rooms. One person told us, "They usually come and knock on the door." Staff were aware of the importance of maintaining people's privacy and confidentiality. They gave us practical examples of how they applied these principles in practice. One staff member told us, "Information and records are kept confidential and shared on a need to know basis."

There were notice boards and displays which provided details of forthcoming events and planned activities. Information was also available on, fire procedures, making a complaint, safeguarding adults and the local advocacy service. Advocates are independent from the service and provide people with support to enable them to make informed decisions. We noted the service's CQC rating was on display and this was proactively added to the provider's internet website during our visit. This was to inform people of the outcome of the last inspection. A copy of the previous CQC inspection report was also available.

Requires Improvement

Is the service responsive?

Our findings

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. People we spoke with expressed an awareness of the service's complaints processes. They indicated they would feel confident if they had concerns or wished to make a complaint. Their comments included, "I'd go to a member of staff," "I think I'd know who to tell. But there's nothing really" and "The only complaint I've had is about my tea and it was addressed straight away." The registered manager and staff spoken with expressed an understanding of their role in supporting people to make complaints and described how they would respond should anyone raise concerns or dissatisfaction with the service.

The service had policies and procedures for dealing with any complaints or concerns. This meant the management of complaints should be consistently dealt with to ensure appropriate action was taken. The policies made reference to managing verbal and written complaints, the investigation process and expected timescales. Included were contact details of the local social services, the government ombudsman and the CQC. However we found the complaints procedure available for people who used the service and their families did not adequately reflect the policy. For example, some of the contact details had not been included and there was conflicting guidance on how complaints should be made.

We reviewed the record of complaints procedures with the registered manager and the nominated individual. We noted concerns, complaints and compliments were recorded together in a bound book. Although this recording method was not used for 'serious and formal' complaints, it did not support the principles of confidentiality and effective data management. There was also a lack of structure and clarity on how some of the concerns had been managed and responded to. This meant the process had not been used proactively to empower people in improving the quality of care. We discussed the progress of an ongoing complaints investigation, which we were told was almost concluded. There was information to demonstrate that action had been taken to investigate and resolve the matters raised. This showed that the matters raised had been taken seriously. However records were lacking to support the timeline management of the complaints and the investigation process. We discussed with the registered manager and nominated individual, the significance of ensuring appropriate complaints process records are effectively maintained, to show how concerns are objectively investigated, managed and responded to.

We recommend that the provider consider current recognised guidance on managing complaints processes and take action to review and update their practice accordingly.

We looked at how people received personalised care that was responsive to their needs. People had individual care and support plans, which had been developed in response to their needs and preferences. We looked at three people's care and support plans and other related records. This information identified people's needs and choices and provided guidance for staff on how to respond to them. Included were people's communication needs, to highlight appropriate methods of engagement and interaction. The care plans reflected people's preferences and included details about how their care and support was to be delivered. They were underpinned by a series of risk assessments, which aimed to respond to people's

rights, needs and choices, whilst keeping them safe.

Staff spoken with indicated the care plans were informative, they said they had access to them during the course of their work. We were made aware of the progress people had made, resulting from the service being responsive and developing ways of working with them. The care plan process included scope for specific goal planning and skill development. We discussed with the registered manager, the value of including learning objectives, to help focus upon the person's progress and recognise their achievements.

Care staff were allocated people to work with on each shift, this was to promote continuity and accountability. Records were kept of people's daily living circumstances, their general well-being, involvement with social activities and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours, accidents and incidents. There were 'hand over' discussion meetings between staff to communicate and share relevant information. These processes enabled staff to monitor and respond to any changes in a person's needs and well-being. There was evidence that the care plans were reviewed and updated regularly with the involvement of people who used the service.

People spoken indicated they were satisfied with the range of activities provided at High Brake House. They said, "The activities person has been to see me. I am okay with things and happy as I am," "They are having a pantomime" "I read a lot and watch TV" and "We went out for lunch, to the garden centre. It was really nice." There was a programme of planned activities, stimulation and interaction on display in the dining area. We observed organised group activities taking place on both days of our visit. There were also photographs available showing people experiencing previous events, including firework displays, barbeques and an 'indoor seaside' encounter. Since our last inspection, the provision of activities and engagement had been reviewed in response to comments in consultation surveys. A member of staff was designated as responsible for planning and coordinating activities in response to people's individual and group needs. The registered manager explained that further attention was being given to suitable stimulation and engaging with people living with a dementia. We noted a folder of potential 'mindful activities' had been collated for reference.

We found positive and meaningful relationships were encouraged. People were actively supported as appropriate, to have contact their family and friends. There were no visiting resections at the service; we saw several family members and friends during the inspection. The service also had a 'keyworker system.' This linked people using the service to a named staff member who they worked more closely with. The main aim of the 'keyworker system' was to develop more trusting and beneficial relationships. The system was kept under review and people offered the opportunity to change their keyworker.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We noted some of the information in care plan records included large type and pictorial references to help explain the content. There was a guide to the service which included the philosophy of care, aims and objectives, the accommodation, facilities and services available, visiting arrangements and complaints procedures. The information was produced in a conventional style. We therefore discussed with the registered manager, ways of producing the service's written material in a more 'user friendly' format which would help with meeting the expectations of the Accessible Information Standard. The registered manager agreed to give this matter their attention.

We evaluated how were people were supported at the end of their life to have a comfortable, dignified and pain-free death. Some staff had received training in end of life care to help ensure they were able to provide the best care possible at this important time. The service worked with other agencies as appropriate, when responding to people's specific needs. The care planning process included an 'advanced decisions' section; this was to record information about the agreed care and support people wished to receive at the end of their life. We did note in some care records the basic details around people's preferences and expectations in the event of death had not been recorded. However, the registered manager explained this information was obtained sensitively in response to individual circumstances. We noted there were letters and cards of appreciation from families expressing their appreciation for the care and attention their relatives received during this sensitive time.

Good

Is the service well-led?

Our findings

We reviewed how the service promoted a clear vision and approach, to deliver high-quality care and support which achieved positive outcomes for people. People spoken with had an awareness of the overall management arrangements at the service. They expressed an appreciation of how the service was run. They told us, "They are very, very busy people they work very hard," "They will do anything for you" and "Actually this is a place I would recommend to anybody."

Since our last inspection there had been an increase in the number of registered places at the service. This had resulted in some changes in how the service was managed, including arrangements for leadership and the deployment of staff. At the time of this inspection some of the changes and developments were still being 'embedded' into the day to day operation of the service. There was a management team in place which included the registered manager, nominated individual, deputy manager, team leader and senior carers. The staff rota had been devised to ensure there was always a senior member of staff on duty to provide leadership and direction. Arrangements had been introduced for staff to be assigned designated responsibilities on each shift. This was to provide a more person centred approach to care delivery and the monitoring of people's wellbeing. Some staff also had been given 'lead roles' on specific work themes, such as 'dignity champion,' 'nutrition and hydration champions' and a 'dementia friend.'

The registered manager described her leadership and management approach and confirmed her professional development was ongoing. The registered manager and nominated individual were very proactive in their response to the inspection process. Both had attained recognised qualifications in health and social care. They expressed commitment to the ongoing developments at High Brake House. Staff spoken with described the managers as very approachable and supportive. One commented, "It's well organised and managed. The day seems to flow really well."

The service's vision and values were reflected within the 'mission statement' and written material including, the statement of purpose, guide to the service and policies and procedures. The 'mission statement' was on display and had been shared with the staff team. Staff expressed a good working knowledge of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions, contracts of employment and codes of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and were made aware of any updates.

We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. Arrangements were in place for ongoing audits and checks on processes and systems including: medicines management, health and safety, falls, infection prevention and control, dignity and care plans. We noted examples where shortfalls had been identified, and addressed. The nominated individual also carried out quality audits to monitor and achieve adherence to the regulations. We discussed with the nominated individual, the significance of introducing a more structured approach to demonstrating they had oversight of the service, including monitoring the governance processes and checking there were robust plans to rectify shortfalls and make improvements.

We looked at how people who used the service, staff and others were consulted on their experiences and shaping future developments. The service encouraged regular feedback from people. Processes were in place for people who used the service, their families and visiting professionals to complete an annual survey on their experience of the service. We reviewed the collated outcomes of the last survey carried out in February 2017. We noted people had expressed a high level of satisfaction with; food, décor, cleanliness, professionalism and the caring attitudes of staff. The registered manager explained that 'lower scoring' responses had been immediately reviewed and action had been taken to make improvements. For example, two people had indicated activities at the service could be better and therefore action had been taken to make improvements. Various staff meetings were held on a regular basis. We looked at the records of the most recent staff meetings and noted various work practice topics had been raised and discussed. Staff spoken with told us the meetings were useful in sharing relevant information and that they were encouraged to make suggestions and voice their opinions. We noted there were numerous cards of appreciation and thanks, for the care and attention people had experienced at High Brake House, these had been shared with the staff team.

We reviewed how the service continuously learned, improved and developed. There was a business plan available which provided an overall analysis of the service and highlighted considerations for future improvements. Furthermore information in the PIR showed us the registered manager had identified some matters for ongoing development over the next 12 months. The registered provider had achieved the Investors In People (IIP) to a Silver Accreditation standard. IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management. The service had also been part of the 'Red Bag Scheme.' This was an information sharing initiative, to improve the transition process when people accessed other services such as hospitals.

We evaluated how the service worked in partnership with other agencies. We found arrangements were in place to liaise appropriately with others including: social services, healthcare professionals, churches, pharmacists and training providers. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding team and public health. Our records showed that the management team had appropriately submitted notifications to CQC.