

Scope

Birchwood

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

Birchwood is a care home which accommodates up to 15 people with learning and physical disabilities. It does not provide nursing care. It consists of three bungalows and a small car park.

Birchwood had a registered manager in place. 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.

The inspection took place over two days on 21 and 28 May 2015 and was unannounced.

At the time of our inspection fourteen people were living at Birchwood.

People told us they felt safe living at Birchwood and knew who to speak with if they were not happy. Comments included "The staff here are very good", "I am happy with the care I get", "If I was not happy I would go to X [named staff member]". A visitor to the home told us "the staff are very caring, helpful and approachable and the manager deals with any issues they are very supportive."

Summary of findings

At a previous inspection in August 2014 we found people who use the service were not protected from the potential risk of financial abuse. This was because staff were not following the organisations policy and procedure to safeguard people's monies and a compliance action was set.

Improvements to procedures had been made although there were some discrepancies found during our visit. The registered manager took immediate steps to ensure people's finances were safeguarded and informed the local authority and the Care Quality Commission of the actions taken as a result.

Whilst there were improvements in relation to protecting people from the potential risk of financial abuse; we have made a recommendation about the recording of financial transactions.

There was a relaxed atmosphere in the home and we saw that staff did not rush people and gave them time to make their own decisions. It was evident staff had built up good positive relationships with people who lived in the home. Similarly people had built up strong relationships with others who lived in the home and enjoyed taking their holidays together. One person told us they were looking forward to going on holiday with another person who lived in the home and with some staff. People had opportunities to go out into the community together and enjoyed participating in going to the cinema, shopping trips and taking meals together at local restaurants.

People were provided with a range of activities both within the home and local community and were supported to follow their interests.

Staff we spoke with were happy working in the home. They were knowledgeable about the needs of people who lived in the home and of their responsibilities in keeping them safe from harm. They were familiar with the whistle blowing policy and were confident they would be protected if they raised any allegations of poor practice to their line manager.

Staff told us they were provided with a good level of training to assist them in their roles and felt well supported. They received regular supervision and an annual appraisal which enabled them to discuss their work with their line manager, raise any areas of concern and discuss any personal development needs.

Staff demonstrated a good understanding of people's individual nutritional needs and how to support them to have sufficient to eat and drink throughout the day to maintain a healthy well balanced diet. People were involved in making decisions and choices in relation to the meal planning with support from staff.

We found sufficient numbers of staff were available throughout our visit to meet people's needs.

Risks to people using the service were identified and incorporated into their care plans to enable staff to manage any such risks appropriately and keep people safe.

The service maintained good links with health professionals such as Doctors, District Nurses, Speech and Language therapists and Chiropodists and referrals were made when required to ensure people remained healthy and well.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

There were weaknesses in the recording of financial transactions which meant people's monies were not being safeguarded properly.

People were protected from harm because staff understood their duty of care and responsibilities in relation to safeguarding people.

There were sufficient staff to meet people's needs and there were safe recruitment procedures in place to ensure only suitable people were employed to work in the home.

Requires Improvement



Is the service effective?

The service was effective.

Where people lacked the mental capacity to make decisions the service followed the provisions of the Mental Capacity Act 2005 to ensure that any decisions were made in people's best interests and protected their human rights.

Systems were in place to ensure staff were trained, supported and monitored to meet people's individual needs effectively.

Good



Is the service caring?

The service was caring

People were treated with respect and their privacy and dignity were upheld and promoted.

Staff supported people in a caring, compassionate manner. They were familiar with people's needs and supported people according to their wishes and preferences.

Good



Is the service responsive?

The service was responsive

People were provided with activities and entertainment to ensure their social needs were met and to ensure they were not socially isolated.

People and/or their representatives were consulted with about their care and support needs and were fully involved in the development and reviews of their care and support plans.

Good



Is the service well-led?

The service was well led.

Good



Summary of findings

There was an open culture within the home and the provider encouraged people to provide feedback on the care and services people received. This enabled them to make improvements to areas which mattered to people living in the home.

Staff felt well supported by the management team and were confident that any issues raised would be dealt with.

Birchwood

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 21 and 28 May 2015 and was unannounced. The inspection team consisted of one inspector. 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 reviewed the information provided within the PIR and information the Commission holds about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

During the two days we spoke with the registered manager, four people who lived in the home, four care and support workers, a visiting outside trainer and one visitor who was also a volunteer.

We reviewed care and support records for three people, daily records, monitoring forms, rotas, and recruitment records for three staff who had been appointed since our last inspection in August 2014. We also looked at training and supervision records, the systems in place for the safe keeping, administration and recording of people's medicines and an action plan in response to recent quality audits. Over the course of the visit we observed the care and support people received and the interactions between the staff and those they supported to help us understand how people viewed the support they received at this service. This was because some people we met did not communicate verbally and were not easily able to tell us about their experiences.

Is the service safe?

Our findings

People told us they felt safe living at Birchwood and knew who to speak to if they had any concerns. A visitor told us “the staff are very caring, helpful and approachable and the manager deals with any issues and is very supportive.”

At a previous inspection in August 2014 we found people who used the service were not protected from the potential risk of financial abuse. This was because staff were not following the organisations policy and procedure to safeguard people's monies and a compliance action was set.

During this inspection we looked at the actions which had been taken and put into place to protect people's finances. We were informed clear comprehensive financial support needs were now recorded in people's support plans along with a financial risk assessment to detail the level of support people required with their finances. Further actions included the checking and signing of receipts against people's expenditure by two staff. We saw that people's financial support needs were now recorded. We also noted financial risk assessments were in place detailing the level of support they required with their finances.

Whilst checking the records of three people's financial records for the month of May 2015 we found some discrepancies in relation to the recording of people's transactions. We found that when people had been out on a group shopping trip their finances had not been properly accounted for. We found a till receipt in one person's file which accounted for the total bill for the group shopping and for group meals they had together from a restaurant. This had not been copied and added to each individuals records to provide them with a receipt of expenditure and highlight their individual portion of the bill.

We found a further discrepancy in relation to another person in which their change had not been returned to the safe but rather remained with the individual and was therefore not accounted for on their records. Similarly we found a lack of receipts or confirmation for items they had been supported to buy over the internet.

The registered manager acted swiftly on our findings and made a safeguarding referral to the local authority's safeguarding team and notified the Care Quality Commission accordingly including actions they were taking

to ensure people's finances were managed safely. We received correspondence from the local authority to advise that they were satisfied that the registered manager responded comprehensively and appropriately to the weakness in finance procedures identified by this inspection.

There was a system in place in which staff audited people's finance records and cash counts on a weekly basis which the registered manager checked at the end of each month using a specific finance audit tool. The registered manager would have been due to undertake their audit at the end of the month.

Staffing levels were determined according to people's assessed dependency levels. We found sufficient numbers of staff were available throughout our visit to meet people's needs and the worked rotas we viewed confirmed this too.

Accidents and incidents were recorded appropriately. We read a sample of accident/incident reports which showed staff had taken appropriate action in response to them, such as calling for an ambulance, gaining advice from the GP and other healthcare professionals. They also had completed body maps and updated risk assessments and sought new equipment where the need arose. For example we noted a new bed had been sourced in response to one incident and a wheelchair had been fitted with an adaptation to hold an individual's refreshments so they could access their drinks safely whenever they wished.

Staff understood their duty of care and responsibilities in relation to safeguarding people from harm. Through discussions with staff, it was evident they were knowledgeable about what constituted abuse. They knew how to deal with any incidents, suspicions or allegations of abuse and who to report them to. Staff told us they received safeguarding training during their induction and regularly thereafter. We were informed staff had been provided with training in March 2015 and the registered manager had made contact with the local authority's quality in care team to access some further training. We saw correspondence to verify this and that the training would be delivered in July 2015.

Staff had access to policies and procedures to guide them on how to deal with any allegations or suspicions of abuse. Information about referring any allegations or incidences of abuse to the local authority was also accessible to staff. Staff had signed documentation to confirm that they had

Is the service safe?

read and understood the policy and procedures. In addition, our records confirmed that the registered manager had followed the locally agreed procedures for notifying the local authority of any potential incidents or suspicions and notified the Care Quality Commission too. They worked collaboratively with the local authority to safeguard and protect the welfare of people who used the service.

In discussion with staff it was evident they were familiar with the whistle blowing policy and felt confident that they would be protected if they raised any allegations of poor practice.

Staff who handled medicines had completed appropriate training and their competency was assessed to make sure they followed correct procedures in a safe manner. Medicine administration records were kept up to date and showed people received their medicines as had been prescribed by their GP.

Systems were in place to regularly audit medicines within the home. This was to ensure they were managed safely and in line with the homes policies and procedures. Where any concerns were highlighted, actions were taken. These were discussed with staff, the GP and where necessary the pharmacy to prevent a reoccurrence and maintain people's health and welfare.

People and/or their representatives were involved in decisions about any risks to their health and welfare and the management of these. This ensured people's care and support was planned with their safety and welfare in mind, both within the home and in the wider community. For example appropriate referrals were made to access equipment to enable people to maintain independence and mobilise safely in and around the home. We saw documentation to show one person had a broken plate on their wheelchair and the wheelchair service was contacted and visited to assess and repair it. We also saw documentation in another person's file which informed us the specialist disability service had reviewed their wheel

chair seating position and adjustments had been made so they could reach the controller more comfortably. We saw risk assessments within people's care plans were regularly reviewed and updated to reflect any changes. This ensured they remained up to date with guidelines in place for staff to follow. These included any risks in relation to moving and handling, nutrition and hydration, pressure area care, the use of bed rails and accessing the community.

People had been provided with the equipment they needed to meet their care and support needs safely. These included hoists where people could not mobilise independently, pressure relieving equipment such as mattresses and profiling beds to prevent the risk of pressure sores, grab rails to aid people with poor mobility and communication aids to support people with communication difficulties to express themselves effectively.

Arrangements were in place for responding to emergencies. For example we saw we saw personal emergency evacuation plans were completed for each person who lived in the home. These informed staff how people were to be evacuated in the case of an emergency such as fire. These were reviewed regularly to ensure they remained up to date and any changes had been documented. We also saw a copy of the homes business continuity plan dated October 2014 along with a risk assessment, which covered events such as a fire, flooding, and major staff loss. Similarly we noted people's files contained a hospital grab sheet for use if people were suddenly taken to hospital in an emergency. These provided information about each individual's health and personal care needs and the support they required. If a person was taken to hospital in an emergency these went with them along with their medicine administration records to ensure they received consistent care and support.

We recommend the provider finds out more about training of staff based on current best practice in relation to the recording of financial transactions.

Is the service effective?

Our findings

People we spoke with told us they enjoyed the food at Birchwood and were involved in making decisions and choices in relation to the meal planning with support from staff. Staff supported people to make choices from their known preferences and used food pictures as aids with people who were unable to communicate verbally. One person told us they did some of the home's online shopping and another told us that when they wanted specific items of food, which others did not particularly want, "I buy my own food for the month and freeze it." They gave the example of lamb chops which they enjoyed. This showed that there was flexibility to meet people's individual needs. We observed lunch being taken and noted it was taken in a relaxed manner, people were not rushed and we saw lots of positive interactions took place between staff and other people living in the home. We saw people were enjoying their lunch and there were enough staff available to help them where needed. People were encouraged to eat independently, but where needed staff offered support and assistance in a kind, discreet manner.

Staff told us they were provided with a good level of training to assist them in their roles. They said the provider was very proactive in ensuring their training was up to date. New staff were provided with induction training which included introduction to the people living at the service, induction to the premises and to the company's policies and procedures. Induction training followed the Skills for Care Common Induction Standards (CIS). Practical competencies were assessed for topics such as manual handling and the administration of medicines to ensure they were competent to undertake these activities safely and competently. Staff told us their induction was thorough and how they had shadowed established staff members. They had not been allowed to work with individual people unsupervised until they felt comfortable and had been assessed as competent to do so.

The provider had a programme of on going training to ensure the team of staff's skills and knowledge were kept up to date. We saw a copy of the training matrix, which highlighted when people had undertaken the organisations mandatory training and their due dates for refresher training. The training matrix informed us staff training included safeguarding, moving and handling, medication, health and safety, first aid and food hygiene. Further

training was provided for staff to enable them to meet people's specific individual needs. For example, care staff were trained in challenging behaviour, feeding people who were fed by a tube and risk assessment training. The registered manager told us they had been supported by the local authority's quality in care team since our last inspection in August 2014. We spoke with a representative from the quality in care team who informed they had visited the service in September 2014 to provide support around dignity, safeguarding, equipment and assisted technology. The manager informed us as a result a 'dignity charter' had been developed by people living in the home with the aim to demonstrate how the principle of dignity can impact upon the quality of support people receive. The registered manager told us dignity and respect was included in the quarterly direct observations of staff to assess and monitor staff competence in their work.

Staff demonstrated a good understanding of people's individual nutritional needs and how people were supported to have sufficient to eat and drink throughout the day to maintain a healthy well balanced diet. Where a risk had been identified there were nutrition and weight charts in place to enable staff to monitor people and seek appropriate health care professional's advice when required. We noted people who were at risk of dehydration and malnutrition had support from the dietician to ensure their health care needs were met appropriately. Similarly we noted one person had input from the speech and language therapist to ensure they were protected from the risk of choking.

People's rights to make their own decisions, where possible, were protected. Staff received training in the Mental Capacity Act 2005 (MCA). There were procedures in place in relation to the MCA and the Deprivation of Liberty Safeguards (DoLS). The MCA is a law about making decisions and what to do when people cannot make some decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Staff we spoke with demonstrated an understanding of capacity and consent, and acting in people's best interests.

Is the service effective?

They told us they always explained what they were going to do and gained people's consent prior to providing them with any care or support. This was confirmed to us by the people we spoke with and through our observations.

The registered manager demonstrated a knowledge and understanding of the MCA and DoLS and when an application was to be made to the authorising local authority. We were advised of a person for whom an application had been made and were informed further applications were in the process of being sent to the local authority in relation to the use of bed rails and wheelchair straps. This ensured there were proper safeguards in place to ensure decisions were taken in people's best interests and involved appropriate professionals.

The service maintained good links with health professionals such as Doctors, District Nurses, Speech and Language therapists and Chiropodists and referrals were made when required. Each person's file contained a health record summary which detailed any visits or appointments with healthcare professionals and the outcome of those visits. Where these resulted in any changes to the care and support required people's care and support plans were updated accordingly to ensure their health care needs were met and their support plans were up to date.

Is the service caring?

Our findings

People we spoke with were complimentary about the staff who worked in the home. Comments included “the staff here are very good”, “I am happy with the care I get.”

There was a keyworker system in place so people had a named member of staff who reviewed their care with them each month or sooner if their needs changed. People could speak with their key worker if they had any concerns or issues. People we spoke with verified this. A keyworker was an allocated staff member who had particular responsibility for a person using the service. This enabled staff to develop effective, long term and trusting working relationships with people they provided care and support for.

Staff were attentive to people’s needs. We observed them talking to people in a respectful manner, using their preferred names and ensuring they told people what they were doing and gained their permission before they undertook any tasks. We saw staff knocking on people’s doors and waiting to be invited in before entering their rooms. Where personal care was provided, this was undertaken in privacy to ensure people’s privacy and dignity was respected. We saw that staff gave explanations in a way that people understood. This demonstrated that people were treated with dignity and respect.

We saw staff sitting beside people and making sure they were at their level when they engaged in conversation with them. It was evident through observation and discussion that staff knew the people they supported well.

Staff showed patience and encouragement when supporting people, and had a good understanding of their needs. We noted staff took time to sit with people spending quality one to one time with them and engaging in conversation.

Staff supported people through the bereavement process and the further process of grieving and mourning the loss of the deceased person. They facilitated meetings so people could meet with other key people to enable them to make informed decisions and choices.

People were given choices as to how they spent their day, what time they wished to retire to bed and get up in the mornings as well as choices around what they liked to eat. People’s choices were clearly recorded in their care and support plans.

People’s bedrooms were personalised with items of memorabilia and they were encouraged to bring such items with them when they came to live at Birchwood.

People’s right to confidentiality was protected. All personal records were kept in the office and were not left in public areas of the service. Visits from health professionals were carried out in private in people’s own rooms. We observed staff protected people’s rights to privacy and dignity as they supported them during the day and personal care was carried out behind closed doors.

People were supported to be as independent as possible. For example, one person was able to have a drink whenever they wanted because staff had sought an appropriate aid which fitted to their wheelchair. This meant the person was then able to drink independently. People were provided with communication aids to enable them to communicate with people, which gave them a voice. For example some people used a ‘light writer’ which was operated by touch and spelled out words. Others used picture and word boards. Another person used an aid in which they were able to use their knee to spell out words on a screen. This gave people the means to get their voices heard and provide them with a means to communicate with people effectively. They enabled people to participate in personal choices, as well as more general choices relating to their home which aided their independence.

Is the service responsive?

Our findings

People we spoke with told us or indicated that they were consulted with about their care and support needs and were fully involved in the development and reviews of their care and support plans. This was evident in the care plans we viewed. They were personalised according to people's individual needs, preferences and wishes and contained documentation to show they and/or their representatives had been consulted with and agreed to the contents. The agreement and consent form set out how the support plan had been shared with the individual and how their consent was sought. Staff signed to confirm they had read and understood the individual support plans and they would inform the registered manager of any concerns or inaccuracies. People's individual likes and preferences were known to the staff and the personal histories and care plans captured details of people's individuality. These details were based on staff's experience of working with the people over time.

Documentation within people's care files showed their needs had been assessed prior to them moving into the home and receiving a service. This ensured people received care and support that was person centred and individualised to their personal preferences and needs.

People's life histories had been documented and completed. These provided staff with a picture of the person's life history, their hobbies and interests and family connections. People told us they were supported to follow their interests and take part in social activities both within the home and within the local community. For example three people were supported to attend college to study drama and art. Another person told us how they enjoyed watching sports and were supported by volunteers to follow their interest in sport and take part in leagues and regional and national championships. Further social activities included visits to the cinema, theatre, shopping visits and visits to local restaurants and public houses. We noted an individual was supported to seek fund raising opportunities and raise funds for a charity of their choice using their artistic skills. The organisation is supported by a team of volunteers who assist people to access the local community and follow their interests.

We found people's care and support plans had taken into account people's individual wishes and preferences in the way they wished their care and support to be provided. For

example one person's support plan detailed they wished the staff to support them with the management of their diabetes, which we saw they did in conjunction with the district nurses. It also detailed that the person wished the staff to encourage them to eat healthy low calorie food when they planned their own meals to help them keep their weight down. The person told us the staff did this. We saw support plans where people had requested support from staff to use the internet and people confirmed they did this.

People's care and support plans were individualised and person centred. In situations where people did not have the mental capacity to contribute, best interest meetings were held which involved family or representative(s). We saw some signed documentation to show they and/or their representatives had been consulted with and they had signed documentation agreeing to the care and support detailed in their plan of care. Care and support plans were regularly reviewed in consultation with the person, their representatives and their key worker to ensure they were up to date and met their needs accordingly. Where any changing care needs had been identified they had been documented in their care plan and communicated to the staff team.

Staff were pro active in supporting people to move to other care services when their needs changed and Birchwood was no longer suitable to meet those needs. They worked with people and facilitated visits to other services to help them make an informed choice.

We were informed meetings were held every month for people who lived in the home and staff. We saw minutes of these meetings and spoke with people who verified this. We looked at the minutes for January 2015, February 2015, March and April 2015 which covered topics such as activities, health care appointments, discussions around redecorating parts of the home and people's choices.

The organisation routinely sought people's views about the service and any concerns they had both formally and informally. This was done through the use of surveys, during people's reviews of care and on a day to day basis through talking to people and during their monthly meetings. This enabled the registered manager to identify any themes or trends and to make any changes which were needed to improve people's lives. The registered manager informed one such theme had been a lack of quality time due to staffing shortages over the previous 12 months. In

Is the service responsive?

response to this they actively sought and engaged more volunteers to spend time with people and offer companionship. They also developed a key worker system so people had a named member of staff who reviewed

their care with them each month and who they could go to with any concerns or issues. This had enabled people to build effective, long term, trusting relationships with an individually matched support worker.

Is the service well-led?

Our findings

The service had a registered manager in post who met all their legal obligations. They were supported by their area manager, three team leaders and a dedicated team of staff and volunteers.

Staff told us they found the registered manager approachable and they had no concerns in bringing any concerns to their attention. They described them as supportive and we observed positive and friendly interactions between staff and the registered manager throughout our visit. They told us they worked together well as a team and felt the manager listened to any concerns they raised and acted upon them.

People we spoke with told us and they could meet with the registered manager at any time without the need for making an appointment. Through observation it was evident the registered manager had built up good relationships with people living in the home and they felt comfortable in the manager's presence. Through discussions with the registered manager it was evident they were knowledgeable about people's needs and how they liked their needs to be met.

Staff practice was monitored to ensure people received care and support safely and we saw evidence of this had been recorded and was held on staff files.

Information about how to raise a complaint and the timescales in which people and their relatives and visitors could expect their complaints to be dealt with were clearly documented within the home. When any complaints were received these were logged in a complaints book along with the actions taken in response to them. People we spoke with knew who to raise any concerns with if they were not happy. They told us they would raise any concerns with the manager or their key worker.

We looked at the complaints log and noted six complaints had been received since our last visit. We saw these had been responded to and dealt with in line with the organisations policy and procedure and within a timely manner. We noted there was one on going complaint received from a member of the public. This had been inputted onto the organisations database and following investigation a letter of response was being sent to the complainant from the organisation within the documented timescale.

Surveys were sent annually to people using the service and their families, staff and volunteers to gain their feedback on the quality of service provided and to ascertain where any improvements could be made. We were informed the results of the surveys were collated and any actions in response to the feedback were acted upon. An action plan would be drawn up and any actions required added to the home's service improvement plan. The registered manager informed us they had recently sent surveys to people living in the home and staff in February 2015, relatives in March and volunteers in April and were awaiting their return so they could be analysed. We were informed the results of the surveys would be fed back in team and house meetings and in the quarterly newsletter which all families and people using the service receive.

The provider had further systems in place to monitor the quality and safety of the service provided and to ensure they consistently met the needs of people who used the service. These included monthly internal audits of key activities including the care provided, an analysis of any accidents and incidents and any trends, an analysis of any complaints received and an audit of the management of people's medicines and finances. Where any areas of concern were highlighted, action plans were put into place detailing actions to be taken and addressed within a specified time span and added to the home's on going service improvement plan. We looked at a copy of the on going improvement plan and found clear actions were documented detailing who was responsible for the actions and by when. For example we saw an action to address finance audits had been identified in August 2014. The improvement action was to check people's records and cash counts on a weekly basis and the registered manager to check them at the end of every month. We also saw an audit tool had been provided for the registered managers use. We saw that the audits were taking place as defined on the service's improvement plan. Another entry on the improvement plan was to access training on nutrition and hydration by May 2015. We saw this had been acted on within the documented timescale and the training was delivered by Buckinghamshire University during our visit.

The area manager visited the home monthly to undertake a quality assurance visit after which they completed a site visit report and highlighted any actions that needed to be put into place. The visits included observing practice, talking to people living in the home about their experiences and the care and support they received and any concerns

Is the service well-led?

they had. During these visits the area manager also discussed the findings of the manager's monthly audits and the progress on the on going service improvement plan. We saw documentation to show these had been undertaken. We looked at the visits undertaken in March and April 2015 and the actions put into place following these. For example we noted one of the actions was that more fire drills were to be undertaken so the management team had a better understanding of their role. The registered manager informed us these had been undertaken weekly.

The provider was committed to developing the skills and knowledge of the staff working in the home and adding to their personal development. For example staff were supported and encouraged to expand upon their personal development. This involved supporting staff to undertake Diplomas in health and social care through levels 2, 3 and 5

and encouraging support workers to take on additional roles to gain experience and develop into team leader roles. This showed the organisation provided opportunities for people to grow within the organisation and progress in their career path.

The registered manager continued to be proactive in keeping their own knowledge and skills up to date. They told us they had recently enrolled on a 'My Home Life' leadership programme in December 2014 and began the course in March 2015. The course is attended by other managers of care homes. The aim was to share good practice and identify how as a service they could improve. This would enable the manager to help staff deliver an enhanced quality of life for people living in Birchwood and to maintain a positive culture within the home.