Birmingham Multi-Care Support Services Ltd

Silver Birch Road

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 23 February 2017. This was an unannounced inspection.

At the time of our last inspection in February 2015, the provider was rated as 'good' over-all with a rating of 'requires improvement' in one of the areas we looked at; whether the service was safe. This was because risk assessments were not always sufficiently detailed to ensure staff had all of the information they needed to keep people safe. At this inspection, we found that improvements had been made.

Silver Birch Road provides respite accommodation and personal care for people who require specialist support relating to their learning and physical disabilities. 'Respite' is the term used for when people receive care and support at a location for a short period of time. The provider is registered to provide accommodation and personal care for up to four people at any one time. At the time of our inspection, there were two people staying at the service.

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.

People were supported by enough members of staff who had been safely recruited and received adequate training to ensure they had the knowledge and skills they required to do their job effectively.

People received care and support with their consent and people's rights were protected because processes had been fully followed to ensure people were not unlawfully restricted. They were also supported by staff who protected their privacy and dignity.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary. People received support to take their prescribed medicines as required.

People were supported by staff that were kind and caring and that were dedicated and committed to getting to know people well. This meant that people received the care they wanted based on their personal preferences, likes and dislikes.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives. Staff were respectful of people's diverse needs and the importance of promoting equality.

The provider was very responsive because people felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were encouraged to engage in activities that they enjoyed and were supported to maintain positive relationships with their friends and relatives.

The service was not always well led because systems and processes in place to monitor the quality of the service were not always effective and staff felt that the organisation and the communication within the service could be improved. People were encouraged to offer feedback on the quality of the service and knew how to complain.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse and avoidable harm because staff had the knowledge and skills they required to keep people safe and knew what the reporting procedures were.

People were supported by enough members of staff to meet their needs.

People received support with their prescribed medicines as required.

Is the service effective?

Good

The service was effective.

People received care from staff who had received training and had the knowledge and skills they required to do their job effectively.

People received care and support with their consent and people's rights were protected because key processes had been fully followed to ensure people were not unlawfully restricted.

People's nutritional needs were assessed and monitored to identify any risks associated with their diet and fluids and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and caring.

People received the care they wanted based on their personal preferences and dislikes because staff were dedicated and committed to getting to know people.

People were cared for by staff who protected their privacy and dignity

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Good

The service was responsive.

People felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People had engaged in activities that they enjoyed because staff actively encouraged and supported them to follow their hobbies and interests.

People were supported to maintain positive relationships with their friends and relatives.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes in place to monitor the quality of the service were not always used or recorded effectively.

Staff felt that the organisation and the communication systems within the service could be improved.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Silver Birch Road

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.

This unannounced inspection took place on 23 February 2017. The inspection was conducted by one inspector and an 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 care service.

Before an inspection we ask providers to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. The provider had returned the PIR to us in January 2017 and we used this information to inform our inspection.

As part of the inspection we looked at the information that we hold about the service prior to visiting the location. This included the PIR, as well as notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also requested feedback from the local authority with their views about the service provided to people at Silver Birch Road, as well as from Health Watch Birmingham. Health Watch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we were unable to speak with the two people who were currently using the service, because one person was out at a Day Centre and the other person did not want to speak with us. We were also unable to use the Short Observational Framework for Inspection (SOFI) because the person was not happy with us being in the same room for any extended periods of time. A SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where people are not able to tell us verbally. However, we were able to make some general observations and we spoke with six relatives of people who use the service. We also spoke with three members of staff including the registered manager, and two support workers. We reviewed the care records of three out of the twenty five

people who regularly used the service, to see how their care was planned and looked at the medicine administration records. We also looked at two staff files to check recruitment and supervision processes as well as training records for staff. Records relating to the monitoring of the quality and management of the service were also reviewed; these included health and safety records, maintenance checks, compliments and complaints and accidents and incidents.

Good

Is the service safe?

Our findings

At our last inspection, we found that improvements were required to the safety of the service because risk assessments had not always been completed as required and/or they had not been updated to reflect peoples changing needs. We also found that where risk assessments were in place, these were not always sufficiently detailed to ensure staff had the information they needed to keep people safe. During this inspection, we found that improvements had been made.

Records we looked at showed that people had risk assessments in their care files. These included environmental risk assessments (relating to risks within the home) such as water temperatures, stairs and electrical appliances, as well as risks that were specific to the health and care needs of the individual. These included risk assessments relating to their mobility needs, medication and nutritional risks risk assessments as well as risks that were specific to their physical and learning disabilities; for example, for epilepsy, body temperature regulation and choking. We found that risk assessments provided information on the identified risks, including signs and symptoms and ways to reduce the risk from occurring. However, they did not always provide sufficient detail of what actions staff needed to take or how to respond if required. For example, we saw that one person was at risk of falls. The risk assessment provided information on why this person was at risk of falls and how staff could support them to reduce the risk of falling. However, in the event of a person experiencing a fall, the record advised staff to refer to their manual handling training. It did not provide sufficient details of what action staff should take in the event that the person had fallen and what level of support the person required, such as the use of a hoist for example, or the need to seek medical assistance. Nevertheless, staff we spoke with were aware of the identified risks to people and were knowledgeable about what action they needed to take in order to keep people safe; reducing the impact that this lack of information had on the safety of people.

Staff we spoke with knew how to protect people from the risks associated with their health conditions and were aware of what action they [staff] needed to take in an emergency. One member of staff told us, "If a person was having a cluster of seizures, I would assist them and make sure they were safe, monitor them, and notify management; people have specific protocols that tell us what is 'normal' range for them and when we need to call for emergency services".

Relatives we spoke with told us that they were happy with the care their family member received at the home and that they were confident that people were kept safe. One relative said, "I consider it [service] to be safe, my daughter has been going to Silver Birch for many years and there has never been a problem with her safety". Another person told us, "It is safe and if there are any problems the staff let us know immediately".

Everyone we spoke with were confident that staff knew how to support people in the event of an emergency such as in the event of a fire. Records we looked at showed that regular checks of the fire detection equipment and response systems such as fire extinguishers and emergency lighting were completed to ensure they were working in the event of an emergency. Maintenance records also showed that other high risk facilities such as the gas boiler were monitored regularly to promote people's safety; the provider had

the appropriate safety certificates and service checks. We saw that people had personal emergency evacuation plans (PEEP) within their care records which informed staff of the level of support they required to evacuate the building in the event of an emergency. Not all of the staff we spoke with were familiar with these individual fire evacuation plans, but they were able to tell us what action they would take to ensure people were kept safe in the event of a fire. One member of staff said, "I'm not sure about personal evacuation plans but I know the protocol; we assist people to evacuate who are able to do so, for other people, the fire doors will close and offer protection until the fire service arrive".

During the inspection we saw that people looked relaxed and comfortable in the presence of staff. From records we looked at, including the Provider Information Return (PIR) form, we found that staff had received training on what action to take to keep people safe from the risk of abuse and avoidable harm. Staff we spoke with confirmed that the training they received covered the different categories of abuse, the signs and symptoms to look out for that may indicate a person was at risk of being abused as well as what the reporting procedures were. One member of staff told us, "We [staff] have safeguarding training; it covers the different types of abuse like emotional, physical, financial abuse. I know the signs to look out for like if a person is withdrawn or quiet, if there's a change in their mood, physical signs like bruising. I would report it to management straight away and record it; management would then report it to safeguarding". This meant that staff had the knowledge and the skills they required to identify the potential risk of abuse and knew what action to take to keep people safe. The registered manager was also able to tell us of their role and responsibilities with regards to safeguarding people from the risk of abuse and avoidable harm, including what the reporting procedures were. Information we hold about the service showed there had not been any safeguarding concerns raised since our last inspection.

Everyone we spoke with told us that there was always enough staff available to meet people's needs. One relative said, "Staff are always there if you need them". Staff we spoke with told us that there was always at least two members of staff at the location during the day and one member of staff at night. The registered manager told us that the staffing levels varied according to the needs of the people using the service at any given time. They said, "Sometimes we have three members of staff plus myself on during the day and two members of staff at night, depending on who is staying with us". None of the staff we spoke with raised any concerns about the staffing levels at the home. We were told that in the event of staff shortages for example, due to staff sickness, staffing levels were covered by staff that worked for the provider's domiciliary care agency and that it was always regular staff. This ensured that people were supported by staff that knew them well.

We saw the provider had a recruitment policy in place and staff had been appropriately recruited via a formal interview, references, and a Disclosure and Barring check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. Staff we spoke with told us they had completed a range of pre-employment checks before working unsupervised which corroborated the information we had received as part of the PIR.

We were told that people living at the home required support to take their medication. Relatives we spoke with told us that they had not had any concerns with the way peoples medicines were managed within the home. We found that the provider assessed people to check whether they required support with their medicines or whether people were able to administer their medicines independently. We saw medicines were stored appropriately in a locked cupboard and staff we spoke with told us that they had received sufficient training to ensure they had the knowledge and skills they required to support people with their medicines. Staff were aware of the disposal policy for unwanted or refused medication. Processes were in place to identify missed medication or medication errors early and we saw that these had been used effectively.

Good

Is the service effective?

Our findings

Everyone we spoke with, observations we made and records we looked at showed us that staff had the knowledge and skills they required to do their jobs safely and effectively. One relative said, "They [staff] are all very good". The registered manager told us, "All staff attend training updates which are usually face to face teaching sessions because we find that these are the most effective; we have done some on-line learning with interactive simulation activities which have worked well and I am trained to deliver training in-house; so everyone [staff] has access to the training they need; mandatory [essential/compulsory training] and any specialist training such as epilepsy, dementia". One member of staff we spoke with said, "I feel confident that I have the knowledge and skills to do the job; we have training". However, they went on to say, "I think it would be useful to have training more often though, like refresher training just to keep us more up to date and so we are confident that what we are doing is right, because some training can be valid for three years and it's a long time to go without a refresher". We fed this back to the registered manager at the time of our inspection. We saw that the provider kept a record of staff training. This meant that the provider knew when staff were due any refresher or additional training and ensured that this was facilitated.

We were told by staff and records showed us that the provider offered regular 'house' (staff/team) meetings and supervision to staff and they mostly felt supported in their jobs. One member of staff told us, "I feel supported; I can speak to the deputy or line manager if I need to and we have supervision which is supportive". However, they also went on to say that although the provider does facilitate house meetings, these are not always useful because staff rarely receive any feedback on any of the actions taken from matters arising. They said, "I think staff could be involved more; we raise things but never really see or hear of the outcomes". This was fed back to the registered manager as a point of reflection.

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. It was evident from speaking with staff and from the observations we made that the service was working in line with the requirements of the MCA (2005). Staff we spoke with confirmed they had received training on the MCA (2005) and were able to give examples of how they worked within these legal parameters and protected people's rights and the need for consent. One member of staff told us, "We [staff] talk to people and ask them what they want or need us to help them with. If they can't tell us then we offer choices and get their permission in other ways by showing them options and looking for their reaction; we get to know people well". We saw that people were supported to make everyday decisions such as what they wanted to do and what they wanted eat as far as reasonable possible.

Deprivation of Liberty Safeguards (DoLS) requires providers to identify people in their care who may lack the mental capacity to consent to care and treatment. They are also required to submit an application to a 'supervisory body' for the authority to deprivation of a person's of their liberty in order to keep them safe, for example. The registered manager and staff were spoke with were able to articulate their understanding of

DoLS and were aware of their responsibilities. The registered manager told us that they had submitted an application a long time ago for one person who used the service because they required one to one supervision. However, they had not submitted any other applications because of the limited duration of people's stays. We advised that the law requires providers to apply for the authorisation to deprive a person of their liberty for anyone who they identify as lacking the capacity to consent to their care and treatment and who is under constant supervision and/or control in order to keep them safe. We acknowledged the difficulty respite placements have in meeting these requirements due to the application and assessment processes. The registered manager advised that they would liaise with the local authority to follow up their existing application and also to discuss the best way forward, to ensure that they were providing care to people lawfully, in a way that protects people's rights and to ensure they as a provider are meeting the requirements of their registration.

We found that people were supported to have food that they enjoyed. The registered manager told us, "Because we are a small service we are able to cook different meals to cater for people's individual preferences; there are no set menus, people can have whatever they want". We were told that the shopping is done on a Thursday, and staff look to see who will be using the service the following week, check their care files to see what their likes and dislikes are, and then the staff use this information to write a shopping list. Staff we spoke with confirmed this and stated, "We get to know what people like and dislike by talking to them, or showing them options and letting them pick what they want to eat that way; it's also written in their care plans based on what they and their families have told us". Records we looked at including the Provider Information Return (PIR) form and observations we made confirmed this. We found that people, who were staying at the home at the same time, had different meals in accordance with their preferences. For example, during our inspection we saw one person had chosen cereal for breakfast, whilst another person had had toast. During our inspection we saw one person was given a non-slip mat to make it easier for them to eat without the bowl moving. They were also given a cup with a lid on to enable them to drink independently without the risk of spilling their drink.

We found that people were supported to be as independent as possible in the kitchen and at meal times. The registered manager told us, "The kitchen is spacious so that people can come in and get involved, either to prepare their own meals if they are able to, assist staff or some people like to watch".

We saw that nutritional assessments and care plans were in place for people. These detailed people's specific needs, preferences and risks in relation to their diet. We saw that where risks associated with peoples' diets or fluids had been identified; there was guidance for staff to follow from the appropriate medical professionals. For example we saw a report from a Speech and Language Therapist (SALT) in one person's care file that detailed the support they required when eating and drinking because they were at risk of choking and required a soft diet. A Speech and language therapist provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing. Staff we spoke with were aware of peoples individual needs in accordance with special dietary requirements, such as soft diets and were able to explain to us how these were catered for at meal times. One member of staff said, "Some people have to have a special diet like thickened fluids or soft or pureed meals because of their risk of choking".

We found that people had access to doctors and other health and social care professionals. The registered manager said, "Because we are only a short-stay placement, if someone becomes unwell we would get in touch with their main carer and they would take the person to their own GP; if a person's main carer had gone on holiday, then our local GP practice would see them as a temporary patient". The registered manager told us that they would also support people to attend other medical appointments if they were scheduled for a time when the person was due to be staying at the home. Records we looked at confirmed

that people were supported to maintain good health and contact was made with other health and social care professionals involved in the care of people who used the service where necessary. For example, we saw that the registered manager had recently attended a multi-agency meeting regarding the care of someone who used the service and that they had had follow-up contact with a specialist nurse regarding the management of their seizures.

Good

Is the service caring?

Our findings

Everyone we spoke with was complimentary about the quality and standard of care people received at the home. One relative told us that their son liked all of the staff and always seemed happy to stay at Silver Birch. Another relative said, "They [staff] are all brilliant and it is really focused on the individual; they go out of their way for us". When we looked through the compliments that the provider had received, we saw that people were consistently positive about the caring nature of the staff and valued the service. One compliment read, "We are very happy; [person's name] wants to come and live with you because [staff member] sings; I think you have been spoiling him!" another relative had wrote, "It's so nice to have a break and not have to worry about him [person who used the service]; we are truly thankful to you and your staff".

We observed the home to be warm and welcoming with a 'homely feel'. One relative we spoke with told us that they liked Silver Birch because it was like 'home from home' and they would not want their family member to go anywhere else. They said, "Some places are very 'clinical' looking, but Silver Birch is a very homely, caring environment".

During our inspection we observed staff interacting with people in ways that they could understand. We saw that staff adapted their communication and interaction skills in accordance to the needs of individual people. Staff we spoke with told us that they took the time to get to know people and this helped them to know how best to support and communicate with them. One member of staff said, "It's important to get to know people; I spend a lot of time with them, getting to know them, talking to them if they are able to verbally communicate or if not, just observing, looking for their reactions to things". They gave us an example of how they supported someone to make a 'get well' card for their relative because the person became excited when the staff member suggested making a card so they knew it was important to them.

Records we looked at showed that people had access to information about their care in ways that would help them to understand. For example, we saw information about how to complain, or raise concerns was presented in a pictorial format within the home and feedback questionnaires were also provided in an 'easy read' format.

We saw that staff offered choices to people in a way they would understand and in doing so promoted their independence. For example, we saw one member of staff asked a person if they wanted to sit in the lounge or stay in the dining room; they used verbal and non-verbal gestures to help the person to make their decision and also confirmed their choice with the person to make sure they had understood their wishes.

We found people were treated with dignity and respect. People had their own single occupancy bedrooms. This meant that people had their own personal space that provided them with some privacy if they wanted to spend time alone. Staff we spoke with and records we looked at confirmed that people were supported to maintain their independence with their personal care as much as possible, but staff provided assistance where required, whilst promoting dignity and respect at all times. One member of staff said, "We always close doors during personal care and cover people with towels as much as possible to protect their privacy. People who are more independent with personal care, we remind them to shut the doors and their curtains

and cover themselves up when walking from the shower room".

Staff we spoke with had a good understanding of people's needs and we found that people received their care and support from staff that took the time to get to know and understand their history, likes, preferences and needs. We saw that people were supported to express their individuality and staff were aware of how they could promote equality and diversity within the home. For example, staff we spoke with and observations we made showed us that people often brought their personal belongings in to the home when they stayed to make their bedroom more personalised. We were also told that people often had a preference of what room they liked to stay in and this was taken in to account when the respite placements were allocated so that their preference could be accommodated.

Good

Is the service responsive?

Our findings

We found that people received personalised care that met their individual needs because they and their families were involved in the planning and review of their care. This ensured that people received the care they needed in the way they wanted it. One relative said, "My daughter is not shy in telling staff what she wants or if she is unhappy with something; it is very inclusive and focused on the individual". Other relatives we spoke with told us that they were not involved in a formal care review as such, but instead they are given the opportunity to offer feedback and are asked to contact the manager if anything has changed in relation to the person's care needs. They all reported to be happy with this system and were satisfied that the registered manager was regularly reviewing and updating peoples care plans and risk assessments. The registered manager explained, "The purpose of respite is to give people [carers] a break, so they don't want any more appointments to attend or any unnecessary forms to fill in; so this seems to work well here. We have regular contact with all of the relatives and carers and we get to know people well, a lot of them have been coming here for many years, so if we notice any changes or if we are told any changes, we update the care plan and risk assessments". Records we looked at showed that care plans and risk assessments had been reviewed and updated where necessary. We also saw that changes to people's care needs were recorded in the person's communication log and discussed in 'house meetings' (team/staff meetings) to ensure staff were kept informed of any changes.

We saw that staff had spoken to people and their relatives about what they wanted and needed from their care and what they liked and disliked. For example, in one person's care plan we saw that they liked to spend time watching DVD's, staff we spoke with confirmed this and we saw the person enjoyed watching a DVD during out visit. Staff we spoke with told us how important it was to get to know people and the things they liked and disliked to ensure they were providing 'person-centred' care. Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. We found that staff were knowledgeable about people's care needs as well as their life histories, hobbies, interests and preferred daily routines. The registered manager told us, "It's important that we know people well, especially in services for people with learning disabilities because people can become very upset by changes to their specific routines for example, one person we care for has to have their evening meal at 17:00 otherwise, he gets very agitated".

From looking at the information contained in the Provider Information Return form (PIR) and from speaking with the registered manager, we found that a lot of the people who used the service maintained their usual routines whilst they were staying with them. On the day of our inspection we saw that one person had gone to a day centre that they were used to attending. Records we looked at and observations we made showed that people had opportunities to engage in activities that they enjoyed, which included attending day centres, arts and crafts, and going out. We saw pictures on the wall of people and staff enjoying their time at a local 'Fun Run' charity event. The registered manager told us that they try to get involved in charitable events as much as possible. They said, "A lot of people who use our service attend other local community services too, so we get involved as much as we can". They gave an example of how they accessed the services of a local charity for people with learning disabilities to come and maintain the garden, which some

of the people who use the service are involved in and people who are staying at the home at the time also get involved. We also saw that the registered manager produced a monthly newsletter which asked for ideas and suggestions about activities as well as kept people informed with events that were being held at the home. For example, we saw that the home had had a suggestion about sponsoring an animal, and they were considering adopting a donkey from a local sanctuary because this would mean they could plan for people to go and visit the donkey.

Relatives and staff we spoke with and records we looked at showed that the provider often asked for feedback on the quality of the service and everyone was given the opportunity to suggest improvements. One relative said, "They [staff] always keep us informed of things and ask for our suggestions". Another relative told us, "We complete feedback forms and get newsletters". Staff we spoke with told us, "We have house [staff] meetings, which is an opportunity for us to discuss anything we need to". However, some staff felt that these could be improved because they did not always see or hear of the outcomes from matters arising. This was fed back to the registered manager at the time of our inspection.

Everyone we spoke with were aware of what they needed to do if they were unhappy about any aspect of the care being provided to people. One relative said, "My daughter would tell the staff if she was unhappy; she doesn't hold back!". We saw that the provider had a complaints policy and procedure and this was displayed in the home in a pictorial format to ensure it was accessible to people who used the service. We also found that useful contact numbers including those for senior management were readily available on the monthly newsletter that was circulated to people who used the service; to ensure people were aware of who and how to contact the provider if they wished to raise any concerns or complaints. The registered manager told us and records we looked at showed that there were no outstanding complaints within the service. We saw that where complaints had been raised, these had been recorded and investigated appropriately and the outcome was fed back to the complainant. For example, we saw that a relative had raised a concern that their family member had returned home with too much medicine and they were worried that the person had not been supported by staff to have all of the medicines they required. The registered manager told us that they took this very seriously and investigated it immediately. They looked back at the person's medicine records and noticed that the person had left the home a day early due to an appointment, which accounted for the excess medication being returned. This was sensitively communicated back to the relative and they were satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we saw that there was a clear leadership structure within the service. This included a registered manager and a deputy manager. Relatives we spoke with spoke highly of the registered manager and told us they were dedicated and committed to providing a high quality service. One relative said, "The main strength of Silver Birch is [registered manager's name]; she is very nice and very helpful". Another relative told us, "[registered manager's name] is very flexible; if she can, she will book in stays at short notice and change dates at short notice". However, some of the staff members we spoke with told us that the management of the service would benefit from being more organised in terms of updating records in a timelier way and being more efficient in their communication. For example, one member of staff told us that the information written in the care plans was not always an accurate reflection of the person because they had not been updated. Another member of staff said, "We never know if any issues we have raised have been acted upon and it would be useful if decisions or changes made were shared with staff because it can impact on the way we care for people and their safety". We fed this back to the registered manager at the time of our inspection, to enable them to use the information to drive improvements.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing. They told us that they felt comfortable raising concerns with their manager but were not always confident that things would be addressed or that they would be kept informed of the outcome. Nevertheless, none of the staff we spoke with shared any concerns about the safety of people using the service and did not feel the need to whistle-blow at the time of the inspection. They were also aware of who else they could contact including CQC if they needed to.

We saw that there were systems and processes in place for monitoring the quality and the safety of the service including monthly quality checks and audits of medicines, accidents and incidents. We saw that where issues had been identified, action had been taken to promote the safety of the service. For example, one of the weekly fire tests had identified that the automatic fire door to the bathroom was not closing properly. The records showed that this was reported and repaired within 48 hours. However, we also found that some of the quality monitoring records lacked detail and analysis. For example, we saw that the audit of accidents and incidents had identified that one person had experienced two falls in a given month. There were no details of what action had been taken to prevent this from re-occurring in the future or any further analysis to indicate whether this was a recurrent issue for this person over a longer period of time. We explained the benefits of this level of detail and analysis to the provider in terms of supporting them to monitor the safety and quality of the service, but also to monitor the effectiveness of any changes made. The registered manager acknowledged this and plans to implement additional measures to their quality monitoring systems.

There was a registered manager in post at the time of our inspection. This meant that the conditions of registration for the service were being met. A registered manager has a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had a history of meeting legal requirements and had notified us about events that they were required to by law, including the submission of statutory notifications. Statutory notifications are the

forms that providers are legally obliged to send to us, to notify the CQC of certain incidents, events and changes that affect a service or the people using it. They had also reliably completed and returned the Provider Information Return (PIR) as required and we found that this was sufficiently detailed; the information provided was an accurate reflection of our findings.

Despite the concerns raised by some of the staff we spoke with, we found that staff retention was high within the service and many of the staff had worked for the provider for many years. Staff we spoke with reported the provider to be a good employer and they were happy in their work. One member of staff said, "It's a good job; it's very liberating to know you are giving something back and helping people and I am supported to do my job well".

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found that the registered manager had been open and honest in their approach to the inspection, co-operated throughout and acknowledged the identified areas for development.