Birchwood Retirement Home Limited

Birchwood Retirement Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Birchwood Retirement Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 17 people, including older people and people living with dementia.

We inspected the home on 1 and 6 November 2017. The inspection was unannounced. There were 16 people living in the home on the first day of our inspection.

The home had a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider') 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.

In August 2016 we conducted a first comprehensive inspection of the home. We rated it as Requires Improvement, reflecting shortfalls in a number of areas.

On this inspection we were pleased to find the provider had taken action to address these issues and the rating is now Good.

There were sufficient staff to keep people safe and meet their care and support needs. Staff worked well together in a mutually supportive way and communicated effectively, internally and externally. Training and supervision systems were in place to provide staff with the knowledge and skills they required to meet people's needs effectively. Staff provided end of life care in a sensitive and person-centred way.

There was a friendly, relaxed atmosphere and staff were kind and attentive in their approach. People were provided with food and drink of good quality that met their individual needs and preferences. The physical environment and facilities in the home generally reflected people's requirements. People were provided with physical and mental stimulation appropriate to their needs.

People's medicines were managed safely and staff worked closely with local healthcare services to ensure people had access to any specialist support they required. Systems were in place to ensure effective

infection prevention and control.

The registered manager had worked hard to address the issues for improvement identified at our last inspection. He was well liked and well known to everyone connected to the home. A range of audits was in place to monitor the quality and safety of service provision. People's individual risk assessments were reviewed and updated to take account of changes in their needs. Staff knew how to recognise and report any concerns to keep people safe from harm. There was evidence of organisational learning from significant incidents and events. Any concerns or complaints were handled effectively.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection, no-one living in the home was subject to a DoLS authorisation. Staff understood the principles of the MCA and demonstrated their awareness of the need to obtain consent before providing care or support to people. Decisions that staff had made as being in people's best interests were correctly recorded.

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.

There were sufficient staff to meet people's care and support needs.

New staff were recruited safely.

People's risk assessments were reviewed and updated to take account of changes in their needs.

Effective infection prevention and control systems were in place.

People's medicines were managed safely.

There was evidence of organisational learning from significant incidents.

Is the service effective?

Good

The service was effective.

Staff understood how to support people who lacked the capacity to make some decisions for themselves.

The provider maintained a record of staff training requirements and arranged a variety of courses to meet their needs.

Staff were provided with effective supervision and support.

Staff worked closely with local healthcare services to ensure people had access to any specialist support they needed.

People were provided with food and drink of good quality that met their needs and preferences.

The physical environment and facilities in the home generally reflected people's requirements

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach.

Staff promoted people's privacy and dignity.

Staff encouraged people to maintain their independence and to exercise choice and control over their lives.

Is the service responsive?

Good

The service was responsive.

People were provided with physical and mental stimulation appropriate to their needs.

People's individual care plans were well-organised and kept under regular review by senior staff.

Staff provided compassionate care for people at the end of their life.

People knew how to raise concerns or complaints and were confident that the provider would respond effectively.

Is the service well-led?

Good

The service was well-led.

Sufficient action had been taken to address almost all of the shortfalls identified at our last inspection.

The registered manager was well liked by and well known to everyone connected to the home

A range of auditing and monitoring systems was in place to monitor the quality of service provision.

Staff worked together in a friendly and supportive way.

Internal and external communication systems were effective.

Birchwood Retirement Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited Birchwood Retirement Home on 1 and 6 November 2017. On the first day our team consisted of an 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. On the second day our inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with seven people who lived in the home, two visiting family members, the registered manager, the cook and two members of the care staff team.

We looked at a range of documents and written records including people's care files and staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Good

Our findings

People told us they felt safe living in the home and that staff treated them well. For example, one person said, "I am really safe here. Safer than I was at home. I fell there but here I don't move anywhere without two carers to support me."

Staff were aware of how to report any concerns relating to people's welfare, including how to contact the local authority or the Care Quality Commission (CQC), should this ever be necessary. In response to feedback from our inspector, the registered manager added advice on how to contact these external agencies to the information pack given to people when they first moved into the home.

In the twelve months preceding our inspection there had been two cases concerning people living in the home which had been considered by the local authority under its adult safeguarding procedures. The provider had investigated and resolved both cases to the satisfaction of the local authority. As part of our inspection we discussed these cases with the registered manager who told us that they had been reviewed in a staff meeting, to identify if there were any lessons that could be learned to reduce the risk of something similar happening in the future. Going forward, the registered manager agreed to strengthen and extend this process of organisational learning to all significant incidents and events in the home.

The provider maintained effective systems to ensure potential risks to people's safety and wellbeing had been considered and assessed. Each person's care record detailed the actions taken to address any risks that had been identified. Senior staff reviewed people's risk assessments regularly to take account of any changes in their needs. At the time of our inspection, the provider was participating in the pilot of a 'harm free care' project sponsored by the local authority. The registered manager told us this was a positive initiative which had been helpful in enhancing the assessment and prevention of potential risks in areas including skin care and falls prevention. Using some of the data derived from the project, the registered manager had begun to publicise internally the number of days the home had operated without a fall, a pressure ulcer or a urinary tract infection.

There were five twin bedrooms which comprised almost 60% of the registered beds in the home. The registered manager was aware of the potential risks of people sharing a room with someone they didn't know, particularly if either person was living with dementia. Describing his approach in this area, he told us, "When assessing [a person who was interested in moving into a vacancy in a shared room] I am always mindful of the person they would be sharing with. Have they got dementia, are they aggressive?" Looking ahead, the registered manager agreed to formalise these risk assessments and ensure they were fully

documented in people's care files.

On our last inspection of the home in August 2016 we identified concerns with the laundry arrangements and the cleanliness of some of the communal areas in the home. This created an enhanced risk to people's health and safety and we told the provider that action was required. On this inspection we were pleased to find the necessary improvements had been made and that the provider now had an effective approach to infection prevention and control. Two members of staff had been identified as infection control leads. They attended information sharing events organised by the local authority's infection control team to ensure the provider was up to date with best practice in this area. Commenting positively on the impact of the new lead roles, one member of staff told us, "[They are] very passionate about it. [They] bring back information [which] helps with staff understanding of [for example] hand washing and keeping the building clean." Since our last inspection, the number of housekeeping hours had also been increased and a number of other actions taken to improve the cleanliness of the home and reduce the risk of cross-contamination. For example, additional storage facilities were now available in the laundry to ensure the separation of soiled laundry; the dirty hallway carpet we had noted on our last inspection had been replaced with a vinyl floor covering that was easier to keep clean; new daily, weekly and monthly cleaning schedules had been introduced and supplies of protective gloves, aprons and laundry bags had been placed at various points around the home to make them more accessible to care staff. To help ensure these standards were maintained, the registered manager now conducted a regular infection control audit.

On our last inspection of the home we also identified shortfalls in the management of people's medicines and told the provider that action was required. On this inspection we were pleased to find the necessary improvements had been made and that the arrangements for the storage, administration and disposal of people's medicines were in line with good practice and national guidance. Changes to key-holding arrangements meant people's medicines were now only accessible to staff who had had the necessary training in this area. Additionally, unused medicines were now stored securely, pending collection by the supplying pharmacy. Staff maintained an accurate record of the medicines they administered, including prescription creams. Each person's medicine file had details of any allergies and detailed information was available to staff on all the medicines in use in the home. Daily checks were made to ensure the medicines storage room was at the correct temperature. Staff also conducted daily checks on the temperature of the medicines fridge, whenever this was in use. Arrangements were in place to ensure the safe use of any 'controlled drugs' (medicines which are subject to special storage requirements) although there were none in use at the time of our inspection.

People told us that there were sufficient staff to meet their care needs and keep them safe. For example, one person commented, "If I use the call bell, they don't take long to come." Another person told us, "There are always staff around if you need them." Throughout our inspection we saw call bells were responded to promptly and that staff had time to meet people's care and support needs without rushing. One staff member commented, "I do think there is enough staffing. It's no great rush to get people up." Although generally happy with the staffing levels in the home, one person told us that care staff had limited opportunity for social interaction, other than when providing personal care or other forms of direct support. This person said, "I would like to sit and chat to staff sometimes. But they are so busy. I just chat to my friend [instead]." Reflecting this comment, throughout our inspection we saw that staff engagement with people in the communal areas of the home was always kind and friendly but often fleeting. We discussed this issue with the registered manager who told us he would take another look at staffing levels to ensure they were sufficient to meet people's physical and emotional needs.

We reviewed staff personnel files and saw that references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable

to work with the people who lived in the home. Although we were satisfied that the provider's recruitment practice was safe, the registered manager agreed to document the receipt of references more carefully in future, to evidence that any risks had been considered and mitigated.

Good

Our findings

People told us that staff had the right knowledge and skills to meet their needs effectively. For example, one person told us, "The staff ... really do take care of me." Describing the staff team's specialist knowledge in the care of people living with diabetes, another person's relative said, "[Name] is diabetic and I know she has special food that doesn't contain sugar. And they help me choose things to bring which won't affect her blood sugar."

New members of staff participated in a structured induction programme which included a period of shadowing experienced colleagues before they started to work as a full member of the team. Commenting positively on the provider's flexible approach in this area, one staff member told us, "[New starters] usually have a couple of days of shadowing [but] some people request longer. [Only] when they feel comfortable [do they] move on to the roster." The provider had embraced the national Care Certificate which sets out common induction standards for social care staff and incorporated it into the induction process for newly recruited care staff.

The registered manager maintained a record of each staff member's annual training requirements and organised a range of courses to meet their needs. Speaking positively of the external professional who delivered most of the training courses one member of staff said, "It's all face-to-face. We have discussions, watch DVDs and complete workbooks. I think she is a very good trainer [and] I always learn something [new]." Staff were also encouraged to study for nationally recognised qualifications in care and leadership. For example, one senior member of staff said, "I am planning to start NVQ Level 5 in management. [The registered manager] has got some funding [for it]." Another staff member told us, "I did NVQ2 [in care] a couple of years ago. [The registered manager] encouraged me. I have spoken to him about the possibility of doing Level 3 [and] he is supportive."

Staff also received regular supervision from the registered manager personally. Staff told us that they found this a helpful opportunity to reflect on their practice and to discuss opportunities for further professional development. For example, one member of staff said, "My last [supervision] was in July. It was helpful. I was able to discuss changing to days [from nights] and the possibility of NVQ3."

In addition to their training and supervision, staff had access to a range of publications and other information sources to ensure they were aware of any changes to good practice and legislative requirements. For example, the supplying pharmacy supplied monthly updates on any changes in national medicines guidance that staff needed to be aware of. As described elsewhere in this report, infection control

procedures in the home were also regularly reviewed and updated in line with the local authority's requirements. The provider was a member of the local care provider's association which the registered manager told us was a further source of helpful information and advice.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and understood the importance of obtaining consent before providing care or support. The 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. Describing their approach in this area, one staff member said, "[We make sure] people's rights are not ignored. It's their choice to do what they want to do with their day."

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). At the time of our inspection, no-one living in the home was subject to a DoLS authorisation and the provider had no applications pending.

Senior staff made use of best interests decision-making processes to support people who had lost capacity to make some significant decisions for themselves. At our last inspection we identified shortfalls in the use of these processes and told the provider that improvement was required. On this inspection, we found that our concerns had been addressed and any best interests decisions now reflected the requirements of the MCA. For example, one person's bed was fitted with safety rails and we saw that this decision had been taken as being in the person's best interests following a documented discussion with relevant parties. The registered manager had also reviewed the decision on a regular basis to ensure it was still reflective of the person's needs.

People told us they enjoyed the food provided in the home. For example, one person said, "The food here is good. In fact it is absolutely brilliant!" With a smile on their face, another person told us, "Do I look like I go hungry?" People had the choice of a cooked or continental breakfast. Discussing one person's particular breakfast request, the cook told us, "[Name] has asked for 'pancake eggs' tomorrow. I am not sure what that is but I will find out!" At lunchtime, people had a choice of two main course options, although the cook told us she always happy to make an alternative if requested. Confirming this flexible approach, one person told us, "There is always a choice of food at lunchtime. And if I change my mind they just offer me something else." For the future, the cook told us she was planning to introduce a photographic menu to make it easier for people living with dementia to communicate their food choices.

Kitchen staff understood people's preferences and used this to guide them in their menu planning and meal preparation. For example, the cook told us, "Sometimes [name] likes tinned peas instead of frozen peas. [And] one [short stay respite guest] wanted a different breakfast cereal every day of the week!" The cook said she reviewed the menu on a quarterly basis, taking account of people's dislikes or requests. Describing recent changes to the menu she told us, "At the last residents' meeting they said they wanted yellow fish so we have added smoked haddock. [We have also added] liver and onions." Kitchen staff also had a good understanding of people's nutritional requirements, for example people who needed their food to be pureed to reduce the risk of choking and people who followed particular diets. On the first day of our inspection, the cook had made a Nutella cheesecake as the main lunchtime dessert option but was also planning an alternative for people living with diabetes.

From talking to people and looking at their care records, we could see that their healthcare needs were monitored and supported through the involvement of a broad range of professionals including GPs, district

nurses and therapists. Talking positively of the support they received, one person told us, "I don't really have to go out to see anyone now. The doctor and optician and chiropodist all come to the home." Another person's relative said, "They always let me know if anything is happening with [name]. If she needs a GP visit or has a blood test I get to know about it [which] puts my mind at rest. I [also] get the chance to sit in on any meetings with professionals."

Staff from the various departments within the home also worked well together to ensure the delivery of effective care and support. For example, describing her relationship with the care staff team, the cook told us, "We work together. They are always giving me feedback. For example, [they told me] one person doesn't like broccoli or stuffing." Similarly, a member of the care staff team said, "Everybody works as a team. When we are taking people downstairs [in the morning] we let [the cook] know they are ready for breakfast. And [the housekeeper] and [person living in the home] have a good rapport. She is often in [the person's bedroom] chatting."

Working within the constraints of a relatively old, non-purpose built facility, the provider had given consideration to ensuring the physical environment and equipment in the home reflected people's needs and requirements. For example, a lift had been installed to make it easier for people to move between the ground and first floors. Toilets and other communal facilities were clearly sign-posted to assist people and their visitors. Adapted cutlery was available to assist people to eat as independently as possible. Wi-fi was freely available throughout the home and the provider had recently bought a tablet computer to enable people and their relatives to keep in touch via Skype and other video messaging systems. There were attractive gardens at the front and rear of the home although the registered manager said the latter were rarely used because the access ramps were too steep for people to use safely. Looking ahead, the registered manager said he would explore ways in which the gardens could be made more accessible and further enhance people's quality of life. There was a smoking lounge available to people living in the home. Extraction equipment had been fitted but this was not completely effective which meant there was often a strong smell of smoke in the communal corridor outside the lounge. Although no one raised any concerns about this issue during our inspection, the registered manager agreed to give it further consideration.

Good

Our findings

People told us they were happy living in the home and that staff were caring and kind. For example one person said, "Everyone here is looked after very, very well. And everyone is very cheerful which is nice." Another person told us, "The staff couldn't be kinder to me. They often pop their head round the door to check on me. Everyone is jolly nice here." One person's relative said, "I come here most days [and] they always make me feel welcome. They are such a caring bunch of girls."

There was a calm, relaxed atmosphere in the home and throughout our inspection we saw staff supporting people in kind and caring ways. For example, we observed a member of staff patiently helping someone to settle in their favourite chair, chatting and holding their hand throughout. Before the person sat down, the staff member took time to ensure the cushions were arranged comfortably. Commenting on the helpful, attentive approach of staff, one person said, "Nothing is too much trouble." Another person told us, "If I need anything and my daughter is away, the staff will always get it for me."

Describing his personal philosophy of care, the registered manager told us, "People should feel comfortable living here. It's their home. We have no regimes, it's all [about] client choice." This commitment to supporting people in a person-centred way that met their individual needs and preferences was clearly understood by staff in all departments. For example, one member of the care staff team told us, "It's their home. If they want an extra hour in bed they have an extra hour in bed." Describing her approach to helping people celebrate their birthday, the cook said, "We make a birthday cake. We ask them if they want a fruit or chocolate cake with a plain, buttercream or fondant icing." Confirming the approach of staff in this area, one person told us, "I still have quite a lot of choices really, which helps it feel like my home." With a smile, the registered manager recounted a recent incident when a member of the public had contacted the local social services department because they were alarmed that someone was still up in the home after midnight. When social services got in touch the next day, the registered manager said he told them, "That's right, they were watching a film they wanted to watch."

Staff also understood the importance of promoting people's independence and reflected this in the way they delivered care and support. For example, talking of one person who was recovering following some time in hospital, one staff member said, "We encourage [name] to walk daily with his frame. To keep him independent. The more he walks, the more stable he becomes." Talking positively of the way staff supported her in the shower, one person told us, "When I have a shower they let me get on with it but they make sure I am okay and hold a towel up for me [at the end]." Another person said, "I am pretty independent. I go out with my family and take myself off to bed when I want."

The staff team also supported people in ways that helped maintain their privacy and dignity. Staff knew to knock on the doors to private areas before entering and were discreet when supporting people with their personal care needs. For example, one member of staff said, "We use the privacy curtains in the shared rooms and always shut the door. [And] if someone needs changing we always take them to a private place [to do it]." The provider was aware of the need to maintain confidentiality in relation to people's personal information. People's care plans were stored securely and computers were password protected. The provider had also provided staff with guidance to ensure they did not disclose people's personal, confidential information in their use of social media platforms.

Information on local lay advocacy services was included in the information booklet provided to people when they first moved into the home. Lay advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes. The registered manager told us no one living in the home currently had the support of a lay advocate but that he would not hesitate to help someone secure one, should this be necessary in the future.

Good

Our findings

If someone was interested in moving into the home, the registered manager or another senior member of staff normally visited them personally to carry out a pre-admission assessment to make sure the provider could meet the person's needs. Talking of the importance of managing this process carefully, one member of staff told us, "We assess their mobility, their medical condition, their [mental] capacity. If we feel we can't meet their needs we do, unfortunately, turn them down. We [hope to] care until the end of life [so we need to get the decision right]." People and their relatives were also encouraged to look round the home. Describing the provider's approach to these visits, one staff member said, "We always say, 'Just turn up. That's the best way to view any care home'." Once it was agreed that someone would move in, an admission date was agreed with the person and their family. When the person arrived, senior staff used the pre-admission assessment to provide care staff with initial information on the person's key preferences and requirements, pending the development of a full individual care plan.

We reviewed people's care plans and saw that they were well-organised and provided staff with detailed information on how to respond to each person's individual needs and preferences. For example, one person's plan stated that they washed their hands and face independently but required staff assistance to wash the rest of their body. Staff were also advised to monitor this person's body language and facial expressions as they lacked the ability to communicate verbally. Another person's plan stated that they liked tea with milk and one sugar and that they also enjoyed fresh orange juice and lemonade. Staff told us that they found the care plans helpful, particularly when somebody first moved into the home. For example, one member of staff said, "The background is helpful. For instance, one lady likes cats which is a prompt to conversation. [And] for moving and handling, the equipment and number of carers required is [all] spelled out clearly." A senior member of the care team reviewed each person's plan regularly to make sure it remained up to date. Describing her approach, this staff member said, "I like to keep [the care plans] up to date. I review them monthly and document any changes. [Sometimes] I have to do a whole new care plan." Most of the people living in the home were funded by a local authority and the registered manager told us that these people were invited to participate in an annual review of their care plan, organised by their social worker. For the future, the registered manager agreed to extend this process of annual review to people who were not in receipt of local authority funding.

Staff clearly understood people's individual needs and preferences and reflected this in their practice. For example, talking about their relationship with some of the people living in the home, one member of staff said, "[Name] likes cuddling but [it is] only certain staff that she wants to cuddle. And [name of another person] wouldn't want [a cuddle]. She would make it known." This responsive, person-centred approach

was also reflected in the way staff supported people at the end of their life. Commenting on the provider's approach to end of life care, one staff member told us, "[Name] passed away a few months ago. [Before they died] we arranged for the vicar to come in as the family wanted it. We liaise with the district nurses and the Marie Curie and Macmillan nurses. [And if someone has no family] staff volunteer to sit with them at the end." Following the recent death of their loved one, a relative had written to the registered manager to say, "I can never thank you enough for all your care for Mum. It was the little things you noticed about her that meant so much to me. Her cheeky smile, her love of words. I count those last days I spent with Mum at Birchwood as most special. Not only because I was with my Mum in her final hours but because I learned how much she meant to you."

On our last inspection of the home we found shortfalls in the provision of mental and physical stimulation for people living in the home and told the provider action was required. On this inspection we found improvements had been made. The registered manager had extended the range of professional entertainments and other events booked to take place in the home. This now included visits from a Pets As Therapy dog in addition to the regular organ recitals, armchair sports and singing sessions that had already been in place at the time of our last inspection. People we spoke with told us they continued to enjoy these events. For example, one person said, "We have some good things going on here … like singers and a man that does exercise with us." On the morning of the second day of our inspection we saw a professional entertainer leading an interactive musical quiz in the main lounge which was clearly enjoyed by many of the people present. Commenting positively of the improvements in this area, one relative told us, "I certainly feel [name] gets enough mental stimulation. She is encouraged to join in on the activities, even when she is reluctant. They are gently persuasive." Another relative said, "I see residents reading, knitting and doing puzzles. I think the staff know them well enough to encourage them in whatever they want to do. They certainly know Mum's likes and dislikes."

The registered manager told us that, since our last inspection, he had also encouraged care staff to take a more active role in facilitating activities and other forms of stimulation. One member of the care team said, "There is definitely more going on than a year ago. There's usually something in the morning or afternoon." Reflecting this comment, on the afternoon of the first day of our inspection, we saw a member of the care staff team initiate a game involving balloons and music which was very popular with the participants. Later that day, the same member of staff assisted people to take down the Halloween decorations, a task some of them found to be of considerable interest.

People we spoke with knew how to raise any concerns or complaints and were confident they would be addressed promptly by the provider. For example, one person told us, "If anything was wrong, I would go and speak to [the registered manager]." Another person said, "If I had any problems, which I don't, I certainly wouldn't hesitate to have a word with [the registered manager]." The registered manager told us that formal complaints were relatively rare as he and his team spent time with people and their relatives and were often able to resolve issues informally. In confirmation of this approach, one person's relative said, "I did complain once to a member of staff that the hoist had been left in front of the TV and [people] could no longer watch the screen. They apologised and moved it to another room quite quickly." The registered manager kept a record of any formal complaints that were received and ensured these were managed correctly in accordance with the provider's policy.

Good

Our findings

People we spoke with told us they thought highly of the home. For example, one person said, "I've landed on my feet … here." Another person's relative commented, "I am really happy with Mum's care here." Commenting specifically on the age of the building, another relative commented, "What it lacks in age, it makes up for in love."

The registered manager was well known to, and liked by, everyone connected with the home. For example, one person told us, "Oh he is really nice. I often get a wave from him if he is passing the door." The registered manager told us he worked hard to maintain his visibility and throughout our inspection we saw him circulating in the communal areas of the home, talking to people and their visitors. Describing his leadership style, the registered manager said, "I lead [my staff] in the way that I want [them] to act with residents. I treat people as I would like to be treated myself. [But] I won't tolerate anyone who isn't caring and compassionate." This approach had won him the loyalty and respect of his staff team, one of whom told us, "He's a good manager. He listens to what your concerns are." Another staff member said, "You can always talk to him. If you ask him, usually it happens."

Staff worked together in a well-coordinated and mutually supportive way. For example, one staff member told us, "It's a nice team to work with. It's friendly [and] everyone wants to make sure the residents are happy and safe." To help foster a positive organisational culture, the registered manager told us that he organised regular team outings for himself and the team. Talking of the most recent event, he said, "We went to the greyhounds in Peterborough. I [paid] for that. As a night out it was successful [although] not from a betting point of view!" Team meetings, communication logs and shift handover sessions were used by the provider to facilitate effective internal communication. Reflecting this systematic approach, one member of staff said, "[The home] is well run. We know what we are all doing, what is expected of us." Systems were also in place to ensure effective external communication with people's relatives and professionals involved in their care. For example, we saw a written comment from a local health professional which stated, "[Staff] are extremely helpful and always willing to help. [Our advice is always] followed up." Describing the staff team's proactive approach, a relative told us, "They have always involved me in Mum's care. I certainly have no worries there."

The registered manager and his team were committed to the ongoing improvement and development of the home and, as described elsewhere in this report, had worked hard to address the shortfalls identified at our last inspection. To assist in this process of continuous improvement, the provider conducted regular surveys of people, their relatives and visiting professionals to measure satisfaction with the service provided. We

reviewed recent survey results and saw that satisfaction levels were extremely high. For example, one person had written, "You can't improve on the home. It's all good." Another person had written, "I like it here. There's nothing to improve." Nevertheless, despite the generally very positive feedback, the registered manager told us he reviewed the survey returns carefully to identify any areas for improvement. People's satisfaction with the service provided was also reflected in the many letters and cards received from family members and friends. For example, one family had written to the registered manager to say,"[We] would like to say a sincere thank you to you and all your helpers for the wonderful care [name] received during her three years at Birchwood. She was very happy with you all and often praised her care. Many, many thanks for everything. We were so pleased to see so many of you at her funeral."

The provider maintained effective systems to monitor the quality of the care provided, including regular care plan reviews and equipment and infection control audits. The provider was aware of the need to notify CQC or other agencies of any untoward incidents or events within the home. The report and rating from our previous inspection was on display in the home, as required by the law.