Danaz Healthcare Limited

Pax Hill Residential Home EMF Unit

Inspection report

Pax Hill
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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

Pax Hill Residential Home EMF Unit is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Pax Hill Residential Home EMF Unit accommodates up to 26 people with dementia. At the time of our inspection, 15 people were living there. The building had been extensively renovated and areas had been newly built. The building had been thoughtfully furbished using published research into colours suitable for people with a dementia. There were three floors, which provided a mix of communal areas and individual bedrooms.

At our last inspection we rated the service requires improvement in safe and good in all other areas. This meant the service was rated Good overall. We asked the provider to take action to make improvements to staff recruitment and provide appropriate training where staff did not have a good command of English. We also undertook a focussed inspection on 15 June 2017 and found the provider was meeting legal requirements. At this inspection, we found the requirements around recruitment continued to be met. At this inspection we found the service to be Requires Improvement in Well-Led and Good in all other areas. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated Good.

Recruitment, staffing, medicine management, infection control and upkeep of the premises protected people from unsafe situations and harm.

Staff understood their responsibilities to protect people from abuse and discrimination. They knew to report any concerns and ensure action was taken. The registered manager worked appropriately with the local authority safeguarding adults team to protect people.

Staff were trained and supported to be skilled and efficient in their roles. They were very happy about the level of training and support they received and showed competence when supporting people.

The premises provided people with a variety of spaces for their use with relevant facilities to meet their needs. Bedrooms were very individual and age and gender appropriate.

Staff promoted people's dignity and privacy. Staff provided person-centred support by listening to people and engaging them at every opportunity. Staff were very kind and caring and people using the service were calm.

Support plans were detailed and reviewed with the person when possible, staff who supported the person

and family members. Staff looked to identify best practise and used this to people's benefit. Staff worked with and took advice from health care professionals. People's health care needs were met.

People had a variety of internal activities (such as music therapy) and external activities which they enjoyed on a regular basis.

Relatives' views were sought, and opportunities taken to improve the service. Staff were supervised, supported and clear what was expected of them.

Audits and checks were carried out in-house, but had not identified the shortfalls we found. Staff needed training about restraint. Although staff knew people well, people did not have clearly written Personal Emergency Evacuation Plans and staff had not taken part in emergency evacuations. We also found the registered manager had informed Public Health England about a suspected outbreak of Norovirus but did not notify the Care Quality Commission. The registered manager took immediate action to address these shortfalls.

People's legal rights were understood and upheld. People were supported to have maximum choice and control of their lives; the ethos of the home supported this practice.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service has improved to Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service has deteriorated to Requires Improvement. The registered manager had not identified that people needed full emergency evacuation plans. The registered manager had not identified that staff needed to be trained about restraint.	**Requires Improvement**

Pax Hill Residential Home EMF Unit

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 comprehensive inspection took place on 08 and 09 January 2019 and the first day was unannounced.

The inspection was carried out by one adult social care inspector.

We were unable to speak with some people using the service due to their highly complex needs. We therefore spoke with three people, four relatives, staff and a GP to help form our judgements. We observed the care and support provided and the interaction between staff and people using the Short Observational Framework for Inspection (SOFI). This is a helpful tool to use if we are unable to find out people's experiences through talking to them, for example if they have dementia or other cognitive impairments.

We spoke with the registered manager, the provider and two staff members. We looked at three people's care records and associated documents. We looked at three staff files, previous inspection reports, rotas, audits, staff training and supervision records, health and safety paperwork, accident and incident records, statement of purpose, complaints and compliments, minutes from staff meetings and a selection of the provider's policies. We also looked at records that related to how the home was managed, such as quality audits, fire risk assessments and infection control records.

Before our inspection we reviewed all of the information we held about the home, including the provider's action plan following the last inspection and notifications of incidents that the provider had sent us. We looked at the 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.

After the inspection, we contacted two healthcare professionals for their views of the service.

Good

Is the service safe?

Our findings

Staff did not have easily found guidance from individual fire risk assessments, known as Personal Emergency Evacuation Plans (PEEP's), about the level of support people would need in the event they would need to move people to a place of safety. However, staff knew people's needs very well and knew what to do in the event of an emergency. Staff said, "In the case of a fire there is a fire register, this has a column with the (people's) mobility needs. Most people are independent with either a Zimmer or a stick. People have dementia, so it will be a bit more challenging, because they might not understand what we're asking them to do" and, "Being a new building it's a bit more fire safe, we don't want to evacuate unnecessarily. There's a fire refuge area and all our doors are one hour resistant."

Although staff had received annual fire training, staff we spoke with told us they had not taken part in a fire drill to practice evacuation. The registered manager confirmed staff did not practice evacuating the building but felt because staff assembled at the fire point weekly when the alarms were tested, this was sufficient. The government website states, "You must carry out at least one fire drill per year and record the results. You must keep the results as part of your fire safety and evacuation plan." The registered manager took immediate action to hold fire drills for staff

The registered manager also explained the stairwell areas were certified as fire resistant for up to one hour, and these would be the safe zones for people to be.

After the inspection, the registered manager sent us an example of a new PEEP and information to show a fire drill had taken place, which four staff had attended. The registered manager assured us fire drills would be arranged for all staff and we were informed that these drills had commenced soon after the inspection visit..

At the inspection in April 2016, we found not all of the required information was available in relation to every member of staff employed and not all staff were sufficiently competent in English to be able to communicate with people effectively. We undertook a focussed inspection on 15 June 2017 and found the provider was meeting legal requirements. At this inspection, we found the requirements continued to be met. We looked at the recruitment records for new staff and found staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK and any gaps in employment had been explained. We spoke with one member of staff who felt their English was not good, however they told us they had been signed up for English language lessons and other staff helped them communicate with people if necessary.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. People told us, "It's always calm and relaxed" and, "There's no problems getting staff to help." Relatives told us, "I've never seen any problems with staffing", "There's always enough" and, "I don't have any problems with staffing numbers." Other comments included, "There's always enough staff, and they've

kept the same staff throughout the building works, so people have had consistency." A healthcare professional told us, "They've never looked short of staff." The registered manager used a dependency tool to identify the numbers and skills staff should have for each shift. Rotas showed these staff had been provided.

Staff told us, and records seen confirmed, that all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Staff said, "We have both in house and external training" and, "If I saw anything I'd report it." Senior staff said, "We ask the local authority if we're not sure. They're open and helpful and make homes more aware of what to do." Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

We saw that risk assessments had been carried out in respect of people's support needs, such as their risk of falls, nutrition and mobility. Where someone had been assessed as being at risk, appropriate action had been taken to minimise the risk. Relatives told us, "We were involved in the discussions when [name] first came here" and, "We've been asked for all kinds of information."

People's medicines were administered by staff who had their competency assessed twice yearly to make sure their practice was safe.

One person was receiving covertly administered medicines. The GP and family had been involved in this decision and all necessary paperwork was in place. No one was self-medicating, though the providers medicines policy contained the process for staff to follow should this be necessary.
There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored, and clear records were in place. We checked records against stocks held and found them to be correct.

We observed that the premises were clean and odour free during our inspection. Relatives told us, "The home is always clean when we visit" and, "There's never any concern about hygiene." Staff were observed washing their hands before handling food and wore appropriate gloves and aprons. Disinfectant hand gel was available.

There were arrangements in place to deal with other foreseeable emergencies. The provider had emergency policies and procedures for contingencies such as utility failures.

Staff told us lessons had been learned when things went wrong and gave us an example. As a result of this learning, people were carefully assessed before moving into the home to ensure their personalities and characteristics were compatible with people already living in the home.

Good

Is the service effective?

Our findings

Staff needed training around what constituted restraint. Staff held one persons' hands as a means of gently restraining them while staff provided personal care. This was because there was a risk to the person's health and an infection control risk when the person refused personal care. Staff had recorded in one person's daily records they had held them to provide personal care. Two staff we spoke with confirmed they would hold people's hands and said, "We try to convince people to have care. Sometimes we'll hold their hand while we do this" and, "It's more to stop them falling, but they couldn't walk away if they wanted to." We discussed this with the registered manager, who immediately sourced appropriate training for staff.

With the exception above, staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Staff said, "First we say 'hello', then we ask if we can do something for them" and, "Consent and choice is very important. We gain consent for everything, such as going into someone's room, what they want to eat, wear, where they want to go."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One member of staff said, "I've been trained to do the capacity assessments and DoLS applications. It's about giving people different ways of answering questions, sometimes it's beneficial to ask questions in a different way" and, "DoLS assessments are not just for living here, it's about assisting people with care, nutrition and activities of daily living."

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, six people were subject to DoLS, four people's applications were in progress and four assessments were pending response from the local authority. One person had capacity to consent to living in the home. No-one had any conditions attached to their DoLS. This meant the service was working within the principles of the MCA.

The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. Families where possible, were involved in person centred planning and "best interest" meetings. A "best interest" meeting is a multidisciplinary meeting where a decision about care and treatment is taken for an individual, who has been assessed as lacking capacity to make the decision for themselves. A member of staff said, "If I'm not sure I'll ask a Best Interests Assessor to do an assessment."

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Records showed training staff completed, included: food safety, infection control and

positive behaviour support. One member of staff, who was a trained nurse, told us how they were supported to maintain the training necessary to keep their professional registration.

New staff were supported to complete an induction programme before working on their own. They told us, "We do a three-day induction which is about the home, then staff do the Care Certificate if they're new to care." The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. Relatives told us, "There's always someone offering drinks and biscuits; there aren't any set times" and, "They'll always have sandwiches or something else people can have, especially if they don't want the choices offered." The chef told us, "I get information about people's allergies, likes and dislikes. I chat with people quite often. I'm told daily if people need any special textured diets." No-one living in the home needed their food and fluid intake to be monitored. One person had a low body weight, however they were being seen regularly by the GP, were being weighed regularly and were being provided with additional nutrition. A healthcare professional told us, "People are offered food fortified diets where necessary. Staff understand and take Speech and Language Therapists advice on board."

We observed lunch in the dining room. We observed staff supported people to be as independent as possible. Where staff assisted people to eat, this was done appropriately. Staff explained to people what they were eating, and chatted with them throughout to make the meal-time experience a pleasant one.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. One healthcare professional told us, "Staff have always kept me well informed of any concerns they had in relation to one person. Whenever I contacted the person's family, who visited frequently, they always seemed well informed and aware of any concerns."

The home had been extensively renovated and improved; staff told us the work had taken two years. People had access to appropriate space indoors to create a restful environment, where people could enjoy a variety of activities. People could help with washing up and folding clothes if they wished, as well as having access to a variety of games and craft activities. The provider had created an indoor garden complete with patio and grass effect. They told us, "Various aspects of the home have been adapted for dementia friendly activities." People were also able to access the garden and patio areas outside. One healthcare professional told us, "When I last visited the home was undergoing quite extensive building work, but had measures in place to protect residents from any disruption. Due to the open plan layout it always felt that staff were able to keep a close eye on residents without limiting the space available."

Staff told us they had Equality and Diversity training and had access to the provider's Equality and Diversity policy. Staff confirmed their understanding of this training and said, "We don't discriminate against anyone."

Good

Is the service caring?

Our findings

Staff developed relationships with people that were based on mutual respect and trust. One person had been able to take part in the recruitment and selection process, which enabled the registered manager to match the skills and interests of staff to the interests of people living with dementia. The variety of staff skills had been used with good effect to match staff to people, so they could enjoy shared interests together such as gardening, art and entertainment. One healthcare professional told us, "I'd put my Mum here. It's a nice atmosphere for people at this stage of dementia." Another healthcare professional said, "I often observed how kind staff appeared towards residents" and, "I have always felt very positive about the care and environment they provide."

We saw all staff spoke to people in a polite and respectful manner and staff interacted with people at every opportunity. Relatives told us, "They're terribly respectful" and, "I come at all different times of the day, I've never heard anyone distressed." People were assisted by staff in a patient and friendly way. We saw and heard how people had an excellent rapport with staff. For example, we saw staff singing impromptu songs with people and one person enjoyed dancing with staff. We observed that people were asked what they wanted to do, and staff listened. In addition, we observed staff explaining what they were doing, for example in relation to medicines and supporting people with activities. A healthcare professional told us, "Staff are very respectful and gentle. I think they're very good because they speak like a friend and try to encourage people to do things" and, "People always seem so relaxed, I'm impressed."

When staff carried out tasks for people they bent down as they talked to them, or sat next to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. Each interaction from staff was undertaken in a caring, focussed manner which promoted the person's well-being.

The registered manager led by example to ensure people received kind and compassionate care. It was apparent that the registered manager was very visible in the home because they were warmly greeted by people and staff. This enabled them to continually monitor standards and make sure people were treated with respect and dignity. We observed staff knocking on people's doors before entering, and relatives confirmed this.

Most people who used the service were not able to give us feedback directly about the care that they received, however we made observations and were able to speak with two people and four relatives during our inspection. We viewed three care plans and saw that they gave a comprehensive picture of people's needs and the way in which the person should be supported. Plans showed that people's level of need varied but it was clear where people were able to be independent. In one plan for example, it stated that the person was able to manage their personal care independently with some prompting from staff. Relatives said, "I've never seen anyone not dressed appropriately" and, "They always help people going to the toilet and wait outside so people maintain their privacy and dignity and can keep their skills." People were able to move around the home as they wished; staff asked them if they wanted any help and respected their choices.

Where people were not able to communicate verbally, staff found other ways to help the person communicate. Staff used pictures or objects of reference to help people communicate their wishes.

Good

Is the service responsive?

Our findings

People's needs were assessed before they began to use the service and reviewed regularly thereafter. People's assessments considered all aspects of their individual circumstances, including; their dietary, social, personal care and health needs and considered their life histories, personal interests and preferences. Care plans reminded staff that all outcomes should be met through positive, individualised support. One member of staff told us, "The pre-admission information doesn't give me everything I need to write the care plans, it takes a few days to get the information together. The assessments give the basic information and we will then observe the person to learn about their personal needs. It's about understanding the person."

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. Plans had been completed for dietary needs, skin integrity, mobility and communication needs. One person's care plan, for example, said, "Music can help [name] relax and communicate better. [Name] cannot verbalise their needs appropriately; staff will need to anticipate their needs to reduce anxiousness."

The care records seen had been reviewed on a regular basis. This ensured the care planned was appropriate to meet people's needs as they changed. Relatives told us, "I'm involved in reviews" and "I'm always asked my opinion." We saw other professionals had been involved in a timely way when required, to ensure the health and well-being of people. Staff we spoke with told us they used care plans to inform their practice. Profiles within care records showed a good understanding of individual's care needs and treatment.

Concerns and complaints were used as an opportunity for learning or improvement. The registered manager acknowledged families had found the on-going building works difficult and had offered to move people closer to their friends while work was continuing. Two complaints had been received in the past year, both had been satisfactorily resolved. One person told us, "I'd complain if I was worried about anything." Relatives said, "It was difficult for 18 months while the building work was going on, but it's sorted now" and, "[Name] would probably tell me if they were unhappy and I'd speak with the registered manager."

Staff had received several 'thank you' cards and letters. One letter included the comments, "We could not have wished for a more wonderful place for our lovely Mum to spend her last few years. You kept her independence with the greatest degree of respect and care, and love. Mum lived her life with dignity and surrounded by love, a love which you also extended to us, her family and friends. You will always hold a special place in our hearts, thank you."

At the time of our inspection, no-one was receiving end of life care. Staff told us about the training they received, and the care people would receive. Staff said, "We speak with the family and the GP and create a care plan to prepare. We find out what the person would want such as if the person would like music playing. We also support the family, we ask them what they want. Families can stay the night, have food and we make sure they're comfortable. We have everything in place, prescriptions for medicines, district

nurses, everything."

People were supported to follow their interests and take part in social activities. Relatives told us they received quarterly newsletters and there was a mix of activities people could take part in. Staff said, "The registered manager encourages all staff to do activities with people" and, "We've got our own minibus and can go out a couple of times a month. We'll do a mystery tour and stop for a drink. People love going to a garden centre for a cup of tea and cake." People were supported to say what activities they would like during a residents' meeting. The last meeting was held in December 2018, when a wide range of activities such as various entertainers, gardening, cooking and a garden party were all planned. Healthcare professionals confirmed there were a variety of meaningful activities and said, "People are able to go to the garden centre and they have fetes."

Requires Improvement

Is the service well-led?

Our findings

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.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. For example, the registered manager checked the environment, personal care, complaints and medicines. However, neither the registered manager nor the provider had identified where further training was required. They had not identified that staff had not been trained in how to restrain people using the least restrictive means and there were no risk assessments in place for this. We discussed this with the registered manager who told us, "We don't have any restraint. No special training because we don't use it. Hospitals might use restraint if they have aggressive behaviours, we don't have any aggressive behaviours. If people have a history of physical aggression we will not take them." However, following our discussion the registered manager sourced relevant training for staff. After the inspection, the registered manager sent us an updated risk assessment for managing the person's personal care needs.

The registered manager had not identified that people needed full Personal Emergency Evacuation Plans (PEEP's) in the fire risk assessment. PEEP's should identify those who cannot evacuate unaided, those who cannot do so quickly, those whose behaviour could put them at risk, for example, people who react badly to noise and chaos. PEEP's should consider the person's medical conditions, sensory awareness and mobility and identify the support and equipment people would need to evacuate safely. The fire register showed the only information about the support people would need was either 'Independent, independent with frame, independent with stick or independent with rollator." The information available did not identify any differences between the help people would need if an emergency occurred during the day when more staff were available, or during the night when fewer staff were on duty. The risks to people were low because all of the staff were knowledgeable about the missing information. However, risks would increase if people were supported by staff unaware of these specific details who would rely on a PEEP for this information. The registered manager addressed this immediately.

The provider and registered manager had an action plan in place to improve the service, based on the Care Quality Commission's key lines of enquiry. Our observations of the registered manager showed the way they worked was based on the actions identified, such as holding short daily discussions with staff to reinforce the ethos of the home and ensure staff felt valued and supported. Staff were encouraged to contribute to improve the service. The registered manager said, "Anyone can make suggestions to improve the service, we're happy to try anything new." An audit of the dining room included how the dining room was laid out and the use of scarves rather than aprons for people, to maintain their dignity. A relative told us, "I think they run a tight ship, the standard of care is high."

According to the records we inspected, the service had not notified the Care Quality Commission (CQC) of one significant event which had occurred in line with their legal responsibilities. There had been an

outbreak of sickness and diarrhoea in December 2018, suspected to have been Norovirus. This resulted in the registered manager stopping any visitors from entering the home. Affected people had been isolated and closely monitored, the GP had been informed and a notification had been sent to Public Health England. CQC expects to be informed of events which stop the service; however, this was not done. After the inspection, the registered manager submitted a retrospective notification. The registered manager has met all other legal requirements about notifications.

The provider was passionate and excited about the new build project. They told us about the work they did with the architect, interior designer and how they utilised staff skills for the various features. They said, "I wanted something dementia friendly but homely, something that was practical. It's an environment that's comfortable to live in." One relative told us, "It's beautiful, the environment is lovely, but staff are the most important. They're such a good team, always got a finger on the pulse, always do the right thing."

Everyone we spoke with was enthusiastic and committed to providing an excellent level of dementia care. The provider and registered manager had an action plan to create a more dementia friendly home and had identified how they would measure the success of this. The plan had been developed using a variety of academic studies and well-known projects such as Dementia Care Matters and the Butterfly Model. An acoustic system alerted staff to a variety of sounds, such as people moving about or coughing. This meant people weren't disturbed by call bells ringing and staff could reassure people the moment they heard anything. A project which included using music and different sensory activities such as taste or touching different textiles helped people with their communication. The provider said, "The member of staff doing this has been outstanding. She helps the staff manage challenging behaviours and has got lots of experience." Staff wore 'bum bags' which contained items which enabled staff to interact with people. A relative told us, "Their understanding of the disease is good. They're very good at pairing people who are at similar stages, so they can chat" and, "They're astute."

Relatives had opportunities to feedback their views about the home and quality of the service. Relatives completed a survey in November 2018 and these had been analysed. Relatives had been asked to comment on personal care, choices, activities, the environment, catering and the management of the home. The results had been positive and had not identified any areas for improvement. Relatives told us, "We were asked to complete a survey but chose not too" and, "We were given a survey asking how we would rate the home. We could do this anonymously if we liked. We were asked what we'd do to make the home better." The registered manager told us they met with relatives each time they visited to check if there were any concerns and provide updates; relatives we spoke with confirmed this.

Staff told us they were able to speak with the registered manager at any time and said, "The registered manager and director are great. They'd definitely listen to me if I said anything" and, "They're always willing to try things and be there to listen. We had a 'no uniform' trial." Staff meetings had been disrupted by the building works but were held every two months. Staff had been able to discuss topics such as medicines, training, entertainment, rotas and staff levels. Healthcare professionals told us, "The registered manager is lovely, very sensible and perceptive" and, "The registered manager in particular seemed to have a good relationship with her staff and a good knowledge of my client's needs."

The service had a positive culture that was person-centred, open, inclusive and empowering. It had a well-developed understanding of equality, diversity and human rights and put these into practice. People were asked about their choices for meals and their choices about the gender of staff supporting them. Where people expressed a wish to follow a particular faith, a minister of that faith was able to support their spiritual needs. The registered manager said, "Everyone is free to come and talk."

The registered manager had a clear vision for the home, which was summarised by the phrase "Residents don't live in our workplace, we work in their home." Staff we spoke with were aware of the values and told us, "The residents are the priority, we do everything we can for them." Their vision and values were painted on the wall in the staff area and communicated to staff via formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

The registered manager regularly worked alongside staff which gave them an insight into people's changing needs. Staff told us they felt the service was well-led and said, "The service has come on in leaps and bounds."