Kiwi House Care Home Limited

Kiwi House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 5 and 6 June 2018. The previous comprehensive inspection was undertaken in July 2017. At that inspection the provider had breached two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches related to medicines and good governance. The service was rated as 'Requires Improvement'. At this inspection we checked whether improvements had been made and the service was no longer in breach of the regulations.

Kiwi House 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.

Kiwi House is purpose built and accommodates 78 people across three separate floors each of which have additional separate units and adapted facilities. One of the units specialises in providing care to people living with advanced dementia. At the time of our inspection there were 72 people using 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.

At our previous inspection in July 2017 we found people did not always receive their medicines as prescribed. Improvements had been made and medicines were, in the main, managed safely. Some areas of managing medicines required further development. We found staff did not always follow procedures for ensuring medicines were used within the recommended expiry date and monitoring charts were not consistently in place for transdermal medicines.

At our previous inspection we found the provider did not have effective systems and processes for monitoring and improving the quality of care. Improvements had been made and detailed audits and checks were in place. Action plans had been developed to identify improvements and ensure these were made in a timely manner. People and relatives were supported to share their views of their care and these were used to make improvements and drive the development of the service.

Risks to people's health and wellbeing had been identified and assessed. Some records had not been updated to reflect people's current needs.

Staff understood about safeguarding and the many different types of abuse. They knew how to report any concerns they may have, within the structure of their organisation or externally or other regulators or local authorities.

Staff had good knowledge of how to keep people safe and had been employed following robust recruitment

and selection processes. There were sufficient staff deployed to meet people's individual needs.

There were arrangements in place for the service to make sure that action was taken and lessons learned when accidents or incidents occurred, to improve safety across the service.

Staff received induction, training and supervision to provide them with the necessary skills and knowledge to meet people's needs.

People were supported to have enough to eat and drink. People were assessed for the risk of malnutrition and when required specialist advice and support was sought.

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. Staff supported people in the least restrictive way possible.

People had developed positive relationships with staff, who were kind and caring and treated people with respect and dignity. People were supported to maintain their independence.

People and their relatives were supported to be involved in the development of their care and information was provided to enable people to access and understand information.

Staff provided care that was focussed on each person as an individual. People and, where appropriate, their relatives, were encouraged to make decisions about how their care was provided. Care plans included information about people's history, likes and dislikes and preferences which supported staff to provide personalised care.

People had access to a varied activities programme. This helped to provide people with meaningful stimulation and reduced the risk of people becoming socially isolated.

People were supported to raise concerns and complaints. These were investigated and used to bring about improvements in the service.

The management and leadership within the service had a clear structure and was used to support and develop the care staff provided. Staff felt supported and valued. Diversity was recognised, respected and promoted within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

At our previous inspection, we found people did not always receive their medicines as prescribed. The provider had made improvements which ensured that medicines were, in the main, managed safely. There were areas were required further improvement.

Risks to people's health and well-being had been assessed, although some records required further review and development.

There were sufficient staff deployed to meet people's needs and keep them safe. Staff were safely recruited. Staff understood how to keep people safe and protect them from the risk of abuse.

Is the service effective?

Good

The service was effective.

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people.

People's care plans included their consent to care and the support they needed to make decisions and choices about their care. Staff demonstrated they understood and worked within the principles of the Mental Capacity Act 2005.

People were provided with assistance and care that met their needs. Staff supported people to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff understood the most appropriate methods to communicate and share information with people and were knowledgeable about the people they supported.

People and relatives were involved in the planning of their care.

Staff protected people's privacy, dignity and confidentiality and were respectful to people and their relatives.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs and wishes. Records were being developed to ensure staff had the detailed information they needed to provide personalised care.

People were supported to be engaged in meaningful, stimulating activities if they wished.

A complaints policy was in place and accessible for people, visitors and staff. People knew how to raise concerns if they needed to.

Is the service well-led?

Good

At our previous inspection the provider did not have effective systems and processes for identifying and assessing the quality of the service. Sufficient improvements had been made. Audits and checks were regularly completed at the service and used to identify and bring about improvements to the care provided.

The registered manager encouraged an open line of communication with their team. Staff had developed positive teamwork.

People were encouraged to provide feedback on their experience of the service and this was used to drive development of the service.

Kiwi House

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 June 2018. The inspection visit was unannounced on the 5 June 2018. The registered manager was aware of our return on the 6 June 2018.

The inspection team consisted of two inspectors and an assistant inspector.

Before our inspection we reviewed the information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We asked commissioners from the local authority for their feedback about the service. We used this information to plan the inspection.

At this inspection we spoke with twelve people and nine relatives of people who used the service. We also spoke with the registered manager, the compliance manager, the care home manager, two maintenance staff, one housekeeper, the hospitality manager, a cook and eleven staff members of the care team. We met with three visiting health professionals who shared their views of the care provided.

We looked at four people's care records, including their initial assessments, care plans and risk assessments. We looked at medication administration records (MARs) and arrangements for storing and managing medicines. We also looked at a selection of documentation pertaining to the management and running of the service. This included recruitment information for five staff members, staff training records, policies and procedures, complaints and work rotas and quality assurance information and audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection carried out in July 2017, we found there was a breach of Regulation 12 of the Health and Social Care Act 2006 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure people received their medicines as prescribed. At this inspection we found that sufficient improvements had taken place to evidence the breach of regulation had been met. However, further improvements were needed to ensure staff consistently followed the provider's medicines policy.

We found further improvements were needed to the management of medicines. For example, we looked at a random sample of medicines in liquid form. We found two bottles of medicines that were in use but did not have the date of opening marked on them. We also found two topical medicines in a person's room that were dispensed in April and November 2017. These were in use but did not have a date of opening on them. This is important to ensure medicines are not administered after their recommended expiry date once opened. Staff took immediate action to remove outdated medicines and ensure date of opening was clear on all topical and liquid medicines.

One person was prescribed transdermal patches (applied to the skin) to support them to manage their health conditions. Although guidance was in place regarding the purpose of this medicine, staff were not following best practice guidance by ensuring a rotation chart and protocol was in place. This is important to ensure records show patches are applied to the person's skin in line with manufacturer guidance. The registered manager told us they would introduce these records following our visit.

Medicines were stored safely. Temperatures of storage areas were monitored and records showed these were maintained within recommended temperatures. The provider used an electronic system for ordering, monitoring and administering people's medicines. This system enabled staff to identify which medicines people needed and the correct time to administer them. This included medicines that were administered as and when required, for example, pain relief. The system alerted staff to any missed medicines which supported staff to quickly rectify their actions. Alerts regarding missed or late medicines were also sent to senior managers at the end of the medicines round. This helped to ensure people received their medicines safely because the risk of errors in administering medicines was significantly reduced.

Electronic records included a photograph of the person, together with any allergies and the level of support they needed to take their medicines. The system alerted staff to time critical medicines which helped to ensure people received their medicines at the time they needed them. We observed staff supporting people to take their medicines. Staff wore tabards which advised others not to disturb them whilst they were administering medicines. We observed staff were patient with people, giving them the time they needed to take their medicines. Staff consulted with people regarding their health and well-being and whether they needed pain relief medicines. Protocols were available to guide staff as to when people needed PRN (as and when required) medicines. We saw staff stayed with people to ensure they had taken their medicines before making entries to confirm medicines had been administered.

Staff told us and records confirmed they had received comprehensive training before administering

medicines. This included competency observations to ensure they were confident and competent following their training. Staff told us they could contact the training manager if they required advice or guidance about medicines. One staff member told us that, in the event they made an error administering medicines, they would be removed from the task, complete refresher training and have to pass further competency observations before they were able to resume administering medicines.

People and relatives told us staffing levels were mostly sufficient to meet people's needs. One person told us, "There is nearly always somebody to help when I need it." A second person felt there was not enough staff as they were 'overworked' and they felt they had to wait for support. Most relatives felt there was sufficient staff to meet people's needs. One relative felt there was generally enough staff around but staff struggled to keep people safe in the event of an emergency. They told us they had witnessed communal areas being left unsupervised during these times which put people at potential risk. A second relative told us they had had concerns about insufficient numbers of staff in the past. They explained previously there had been occasions when they had entered the building and been unable to locate any staff and staff often left communal areas unsupervised. However, in recent months the provider had taken action to resolve concerns and they felt staffing levels were now sufficient to keep people safe.

The provider used a dependency tool to calculate the numbers of staff required to meet people's needs and keep them safe. Staff told us they felt there were enough staff available. We saw there were sufficient numbers of staff to provide supervision in communal areas and respond to people's needs in a timely way. Staffing rotas showed the numbers of staff we observed were the usual ones. The registered manager told us they kept staffing levels under constant review to ensure staff were deployed in sufficient numbers.

People were protected from the risks of poor practice and abuse as the provider had systems in place to safeguard people. Staff were able to demonstrate their understanding of the signs and types of abuse and how they would respond if they suspected a person was at risk. Staff had received training in safeguarding and were confident about how they would report any allegations by following the provider's policies. This included awareness of the whistleblowing policy which supported staff to raise concerns about possible malpractice with appropriate external agencies.

The provider had systems in place to raise alerts with local authority safeguarding teams and carry out investigations if required to do so. This included maintaining records pertaining to incidents, investigations and outcomes. Incidents and accidents were alerted to the local authority who took action and provided advice to reduce the risk of further harm. However, we found one incident where the provider had alerted the local authority but had not made a notification to the CQC in line with their legal responsibilities. The registered manager told us this was an oversight and told us they would ensure notifications were made to the CQC appropriately.

Care plans included risk assessments for areas such as falls, mobility, skin integrity and health conditions. In most cases these were detailed and included guidance for staff on how to reduce the risks of harm to people. When staff needed to use equipment to support people to move, the type of equipment was listed. When people needed to change their positions, the required frequency was documented together with any equipment to support skin integrity. Records showed people had their positions changed regularly.

In other cases, risk assessments did not reflect the care people were having. For example, one person's risk assessment referred to them as using a walking a stick. However, we observed the person was using a walking frame to move around the service. Another person's risk assessment identified they were at risk of drinking too much alcohol and identified staff should remove alcohol from their room and provide it appropriately upon request. We found large amounts of alcohol in the person's room on both days of our

inspection. Staff told us the person would be unable to open the alcohol independently. This information was not consistent with their risk assessment.

Staff demonstrated they were knowledgeable about people's needs and understood how to keep them safe. One staff member told us, "The home is not the solution for people to keep them safe. The staff have to create a safe environment for people to live in every day, and for staff to work in. We do this well here." We saw staff supported people to move around the service and to use equipment safely. For example, staff used hoist equipment safely and in line with best practice guidance. Staff gently supported people to sit safely in chairs and reminded people to use mobility equipment safely.

Some of the people using the service demonstrated behaviours that could challenge. This included verbal and physical aggression to other people and staff. Some care plans included guidance for staff on how to identify the behaviour, how to respond to it and actions they needed to take to reduce the person becoming distressed or anxious. For example, one person's anxiety could be reduced through doll therapy and we saw staff provided this when the person became distressed. This reduced the person's anxiety. We observed a second person became distressed and challenging towards staff. Staff supported the person and reduced their distress. However, their care plan did not include any reference to this behaviour or the actions staff needed to take to reduce the person's distress. This meant a potential risk that staff may not be providing a consistent approach in supporting the person during these times.

There were arrangements in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the events leading up the incident, steps taken to avoid the incident, intervention and reflections. For example, where a person had sustained an injury as a result of falling on an item of furniture in their room, staff had re-located the item of furniture in the room to avoid further harm. Following an incident where a person had been scalded after touching a boiled kettle, staff had responded by ensuring all kettles in communal areas were emptied of hot water once drinks had been served.

Accident and incident forms were not always provided to the registered manager in a timely manner to support their review and analysis. We found one accident record for an incident that had occurred on 22 May 2018 which had not been sent to the registered manager, although action had been taken to reduce the risk of further harm. We also found accidents that occurred in December 2017 had not been reviewed or analysed until February 2018. This had the potential risk of action not being taken in a timely manner to mitigate future risk. We discussed incidents and risk assessments with the registered manager who told us they would update records and ensure systems were followed.

Staff recruitment checks had been consistently carried out in accordance with the provider's policy. Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included a check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and if they were suitable to work in care services.

People were cared for in a safe and clean environment. Rooms were well maintained, hygienic and free from malodours. Housekeeping staff undertook domestic duties and demonstrated they were knowledgeable about cleaning schedules and their responsibilities in reducing the risk of infection for people. Staff knew how to protect people from the risk of infection. We saw staff had access to personal protective equipment (PPE) such as aprons and gloves and used these appropriately when providing care and support. The provider had introduced a project initiative for hand washing to improve staff awareness in the importance of this in maintaining infection control standards.

A full time maintenance person was employed by the service. Regular maintenance and equipment audits relating to fire safety, maintenance of equipment and health and safety compliance was undertaken. Contingency plans were in place in case the service needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP). This provided information about the support the person needed in the event of an evacuation. Where maintenance actions were required they were taken forward within a reasonable timescale and recorded for auditing purposes.

Good

Is the service effective?

Our findings

People and relatives had confidence that staff had the skills and knowledge to meet people's needs. Comments included, "Carers know my routine. If I wasn't in the lounge at a certain time, they would come and check I was okay," "People are very well looked after," and "They [staff] always tell me if anything is wrong with [name]. The home worked really closely with [name] doctor and the crisis team before [name] moved in."

Health care professionals told us staff were knowledgeable and "know what they are doing". They told us staff were quick to provide records and information and followed advice and guidance they provided. They told us, "Staff always act on what we say. They never call us unnecessarily or waste our time. Whenever we visit, staff always know where people are." They told us they had no concerns, from their experience, with the care and support provided.

People's needs were assessed before they began to use the service to identify the support they required. Assessments included people's wishes and preferences, cultural and religious needs, support they needed to maintain or develop relationships and their sexuality. People were supported to identify an outcome from their care and the service worked with external agencies to support people to achieve these. For example, mental health teams and district nurses. This joint working helped to provide people with care that was effective and in line with best practice.

There was a robust induction and training programme in place for all staff. The service's induction was aligned with the Care Certificate. This is a nationally recognised set of standards which supports staff who are new to care to develop within a framework of minimum working standards. Staff were positive about their training. One staff member told us, "The training is great. We have the phone number of the training manager so we can ring [name] with questions at any time." Another staff member told us, "There is a good amount of training here. Some of the training is on-line and mandatory training is updated every year. We also have occasional workshops and training sessions around specific issues, like the specific support we need to give one person, so that all staff are supporting in the same way." Records showed staff received on-going training to enable them to fulfil the requirements of their role. This included development training, such as vocational qualifications and specialist training, such as end of life and dementia care. This helped to ensure staff had information that reflected current best practice in providing care.

People's needs were met by staff who were regularly supported and supervised. Supervision is where staff meet one to one with their line manager. Conducting regular supervisions helps to ensure that staff competence levels are maintained to the expected standard and training needs acted upon. Staff told us they felt supported in their roles, were clear on their responsibilities and could approach senior managers at any time for advice and guidance.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity

to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found training was provided for staff on the MCA. Staff we spoke with showed they understood the importance of consent and we saw that capacity issues were explored when planning people's packages of care. One staff member told us, "We have to have DoLS because the doors are locked and people can't leave even if they wanted to." A second staff member said, "We support people to make real choices rather than just nod in agreement with us. For example, holding up outfits for people to choose what matches."

Staff demonstrated they sought consent before providing care and support and respected people's right to decline care. For example, we observed one person became agitated when staff attempted to provide care. Staff respected this decision, gave the person time to calm and tried a different approach a while later, which was successful.

Care plans showed that people's consent to their care had been obtained. Where they lacked the mental capacity, some care plans showed best interests decisions had been taken. We found two care plans which did not included a best interest decision for the use of sensor mats in people's room. These alerted staff when people got out of bed and were at risk of falling or walking unsupervised. The registered manager told us this process had been completed and would ensure records were updated. Some people were subject to DoLS authorisations and we found these were reviewed and conditions complied with.

People were supported to have enough to eat and drink. People were assessed for the risk of malnutrition and when required specialist advice and support was sought. Records showed staff monitored people's food and fluid intake where they were assessed as being at risk. We found monitoring charts were mostly completed accurately, although some records lacked detail with entries such as 'ate a small amount'. Each communal area had a 'snack station' which had jugs of juice, fruit and snacks for people to have throughout the day. We saw where people were unable to use these independently, staff supported them to have snacks and drinks at regular intervals.

Care plans detailed people's preferences and requirements and staff demonstrated they were knowledgeable about these. The cook demonstrated a good understanding of people's specific dietary requirements, such as celiac, textured diets and cultural needs and these were accommodated. We observed the lunchtime meal across five communal lounges. We saw people were relaxed and received the time and support they needed to eat their meals. People were offered choices of meals from menus and these choices were checked before meals were served. Where people requested alternative choices, these were promptly provided. Staff spent time supporting people to recognise foods by showing them what the plated meals looked like and explaining what each food was. For example, several people were confused by the trifle and staff gave a description of the ingredients that made the trifle.

People had access to on-going healthcare. Records showed people were regularly reviewed by the GP, physiotherapist, dentist, dietician, district nurses and mental health team. For example, staff had requested a medical assessment for a person who had lost weight recently which had resulted in a referral to health professionals. Staff had referred another person for an assessment as they were concerned about a deterioration in their needs which may indicate they required nursing care. A relative told us staff monitored their family member's well-being and behave and contacted the GP if they identified they were not responding in a manner that was usual for them. This gave them peace of mind, although they told us staff

did not always feedback on the outcome of GP visits.

The accommodation was purpose built and designed to support people with a range of needs. Communal areas were spacious and homely and easily accessible. Items of interest were placed around the building, such as rummage drawers, hat stands with items of interest, books and games. People were able to personalise their rooms with their belongings. One relative told us, "We were really impressed when the staff fixed [name] guitars to the wall to make the room feel like home."

Although there was some signage in communal areas, corridors lacked meaningful signage. One person told us they got 'lost' in the corridors and walked a lot further than they needed to which was strenuous for them. Corridors did not support people to orientate around the premises independently. The registered manager told us they intended to improve the signage throughout the premises to provide the directional guidance people needed in an appropriate format.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff. Comments included, "The staff are attentive, nothing is too much trouble," "The staff are very caring. If [name] becomes upset and confused, the staff are really good. They will spend time with [name] and provide lots of reassurance," "They are very caring; I can't fault any of them," and "Very helpful;, they don't intrude."

Staff understood the best communication methods for people and were knowledgeable about the people they supported. For example, staff recognised and responded to gestures and sounds where people used non-verbal communication. People's specific communication needs were included in their care plans which guided staff on supporting people to make decisions and choices.

People's care plans reflected people's needs and wishes and had been developed through consultation with the person and their relatives. A relative told us, "We've given some input into the care plan; there is more work to do on that as [name] hasn't been here long." A second relative told us, "We've been involved in the assessment and putting the care plan together in all it's detail. The details of the care plan are available for staff. The plans work well, staff can always look anything up." Information was available to support people to access advocacy services if required. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

Staff demonstrated they respected people as individuals and recognised what was important to them. One staff member told us, "[Name] likes to wear make-up. I have reminded them if they're not wearing it later in the day and when we have a minute we go back to their room so I can help them put some on." The staff member explained that people took pride in their appearance as this was important to them. Staff told us and we saw they had time to spend talking with people, providing reassurance and comfort when people became distressed or anxious.

There were no restrictions on visiting times and people received visitors when they wished. We saw staff were welcoming to visitors and supporting people to meet with their visitors in private if they wished.

Staff knew how to provide care in a dignified way and supported people to protect their right to privacy. This was confirmed by people and relatives. One person told us, "Staff always knock before entering my room. They are very helpful and they don't intrude." A relative told us, "The staff are very good at maintaining [name] dignity. We never come in and find [name] has been incontinent, staff are very good at identifying when [name] needs support and are discreet about it." We observed staff were respectful in addressing people by their preferred name and in how they spoke with people.

Staff understood the need for confidentiality and ensured conversations were in private. Care plans and records were held electronically, accessed by staff through mobile telephones. Each staff member had a unique PIN which meant information could only be accessed by approved people, therefore protecting people's data. Paper records were kept securely in locked offices. Staff had recently been provided with updated information to ensure they were aware of and complied with the changes in data protection

legislation.

Staff supported people to do as much as possible for themselves. Accessible kitchens were available in communal lounges to support people to make their own drinks and light snacks if they wished. Care plans detailed how much people could do for themselves and when they needed assistance. We saw people were able to move around the premises independently if they were able to do so. A relative told us, "There is a fine line between promoting [name] independence and allowing neglect in the name of independence. Staff do well to promote [name] independence." They told us staff were vigilant and encouraged their family member to used aids and adaptations which helped them to be independent whilst remaining safe.

Good

Is the service responsive?

Our findings

People's physical, mental health and social needs were assessed prior to moving to the service. Staff spoke with people about how they liked to be supported, what they would like to eat or events and activities they wanted to participate in. People and their relatives were supported to contribute to their care planning when they were able to do so.

Care plans were personalised and included details of their interests, preferences and likes and dislikes. For example, one person used non-verbal communication to express their wishes and consent. Their care plan included how they communicated when they needed care and support, for instance with personal care, and how they demonstrated they were in pain. The care plan also provided guidance to enable staff to respond and support the person when they became distressed. This included the use of doll therapy as a source of comfort. We observed staff followed these guidelines when they supported they person.

Staff had recently met with people and relatives to complete a document titled 'My life story'. This captured current information about the person, life history, important relationships and places and a personalised calendar about key events in the person's life to remember and celebrate. Staff explained this information would be included in people's care plans to support staff knowledge of people and ensure they provided personalised care.

Staff demonstrated a good understanding of the needs of people living with dementia and the impact this had on their lives. One staff member told us, "We need to adapt as people's condition's progress and help them to live their lives. We understand people may regress in time and avoid confrontation or disagreeing with people as this doesn't help." Another staff member said, "People living with dementia may have a particular time of day when they are more responsive and can make choices and decisions. We look out for this and include it in the person's care plan. We also adapt our approach to respond to how people are feeling at any given time." This understanding supported staff to respond to people's changing needs.

Staff were able to communicate effectively with people and ensured they could access and understand information in their preferred format. This was in line with the requirements of the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given.

Daily records of people's care and support captured how people were feeling. We found records were not always completed accurately to reflect people's needs. For example, staff used pictorial icons to describe people's health and well-being to support daily monitoring of needs. For instance, staff had recorded one person as being 'sick, very ill and content' on the same day. A second person had been described as 'not eaten' but records showed they had eaten meals throughout the day. The registered manager told us these were recording errors as staff were still getting used to the electronic recording system. They would refresh staff training to ensure recordings were correct.

People had access to a varied activity programme, referred to as 'monthly social and wellbeing programme'. Each unit had activity co-ordinators who supported people to join in activities in groups or individually. During our inspection, we observed people taking part in board and card games in addition to sensory activities. This involved people smelling items in jars to guess the contents, which stimulated memories and reminiscence. Clubs were available for people to join, such as knitting, baking gardening and chit chat. The premises provided an in-house cinema and pub which people were able to access at set times. Other activities advertised included a music and movement session, visiting musicians, festivals and celebrations and trips out, which people confirmed they enjoyed. We saw people were free to move around the premises if they were able to and able to access safe outdoor spaces and balconies which provided further stimulation. Newspapers and magazines were delivered daily and available to people in communal areas. People were supported to pursue their cultural beliefs, through accessing local places of worship or in-house religious services.

The provider had a complaints policy which was accessible for people, visitors and staff. People and relatives told us they felt they could raise concerns and these were listened to. Two relatives told us things had improved since the change in registered manager. Prior to this, they felt concerns were not listened or responded to. Complaints were logged together with investigations and outcomes provided to the complainant. These were used to bring about improvements, for example in records and communication.

The provider had a policy to support people who required end of life care. Two relatives who we spoke with praised staff for the care they provided during the family member's end of life. This included an open visiting policy, the offer of overnight stays for relatives and staff going above and beyond to ensure the person's favourite items, food and drinks were always available for them. They told us staff supported them as well as their family member and liaised well with other agencies. This helped to ensure the person's wishes to remain in the service were fulfilled. Staff had received training in end of life care and care plans included plans for end of life care where possible.

Good

Is the service well-led?

Our findings

At our previous inspection the provider did not have effective systems and processes for monitoring and assessing the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2006 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had been made to rectify the breach.

Quality assurance processes were detailed and included actions to be taken. Regular performance and compliance audits were conducted and they reviewed areas such as health and safety, care records, staffing, cleanliness, working practices and complaints and governance. The compliance manager regularly attended the service and undertook planned checks and audits in addition to observations of working practices. They then produced an action plan detailing action required to make any improvements. The registered manager was responsible for ensuring action was taken within identified timescales. Action plans were kept under review. We saw action plans were comprehensive and detailed, identifying areas for improvements in, for instance, care records. Records showed the registered manager had noted action points and signed these off when completed.

The provider had improved their approach to learning from events. For example, medicine errors were recorded and analysed. Action was taken with staff to give them feedback on performance and support. Records were improving to provide the information staff needed to deliver personalised care.

People and relatives told us things had improved in the service following a recent change in management. Comments included, "I suggested something and received a reply the next day, " "There is good, smooth communication," "We have been very pleased with it here It's a very homely approach. The staff are very attentive; nothing is ever too much trouble," "Kiwi house is very much like a home for those that live here. People are very well looked after," and "Managers are always here and now there is a suggestion box."

The service had a registered manager in post who had only recently been appointed. They were supported by care co-ordinators and senior staff. The provider had recruited a care manager to oversee care standards within the service and they were working through their induction into the service. Staff felt that things were improving in the service and spoke positively about the leadership of the registered manager and senior managers. They told us, "It's been the happiest time here since the new manager came. He is approachable and very positive and made a lot of changes for the better. He is very service user focussed," "[Name] the [registered] manager is fantastic, really approachable and always asking how we are doing. We see lots of people from head office too," "I have seen lots of changes - all of which are for the better," and "Senior managers are always around. They listen and take on board what we say. For example, if we say we need equipment or they see we need some, it will always be provided."

The provider recognised and supported equality and diversity amongst the staff team. These values were embedded in working relationships between staff, who spoke of working well as a team, supporting and respecting each other. Comments from staff included, "We [staff] are as diverse as the people living here. We support each other respect each others diversity," and "Everybody has different values and different beliefs.

Diversity is what makes a good care home." Staff celebrated key festivals from all faiths.

The provider's values were to ensure everyone was treated equally and provide personalised care within a hotel environment. Discussions with staff indicated they embraced these values and applied them to their working practices. Comments included, "The company are all about care. You only have to ask and it is provided," "I treat people living here as I would my own family member," and "It's very individualised here. People are not treated like they are in care. We provide opportunities as they would have had with their friends before they came to live here. This is important to people; it keeps people independent."

Staff were supported to share their views through regular staff meetings. We looked at minutes of meetings held between January and April 2018. We saw these were used to hold discussions about where improvements were needed, clarifying roles and responsibilities, best practice guidance, activities and changes in key policies. The registered manager used these forums to share information with staff and gather ideas and suggestions to develop the service.

People and relatives were supported to share their views directly and indirectly through satisfaction surveys, meetings and suggestions boxes. Meetings were held with the hospitality manager who gathered feedback and discussed this with senior managers to identify areas of improvement. They told us the provider was constantly trying to improve the service people received. For example, they were in the process of changing crockery from white to brightly coloured as trials had shown this appeared to improve people's appetite and encouraged them to eat more. The hospitality manager involved people and relatives in changes and improvements. For instance, they had recently run taster sessions to encourage people to try lots of different sample foods. The feedback from the sessions was used to develop new menus. Housekeeping staff had been trained in towel art which were placed on people's beds on special occasions, like birthdays. People had been involved in this development. The registered manager had arranged to hold 'drop-in' clinics which were advertised and available for people and relatives to discuss any concerns or share information directly.

Commissioners who we spoke with told us found the service had made improvements overall and were working to complete action plans to ensure improvements were sustainable. Staff worked with a range of agencies, including commissioners and health and social care professionals to ensure people received good care. For example, staff had developed a positive working relationship with the local GP which had resulted in a nominated nurse allocated to working with the service. The nurse made entries directly into people's care plans regarding the care they had provided. This had improved the accuracy of information sharing and avoided the need for duplication.

We asked for a variety of records and documents during our inspection. We found these were well kept, accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed CQC of most incidents. However, we found one recent incident that had been reported to the local authority, who had responded to ensure the person was safe. However, the registered manager had not submitted a notification to CQC. The registered manager told us this was an oversight and would ensure all future notifications were made in line with legal responsibilities. This would help us to ensure appropriate action had been taken to keep people safe.

The provider had ensured their ratings were displayed on their website and at the registered location. This is important to support people to make informed decisions when looking for care and support services.