

MNP Complete Care Limited

Sandgate Manor

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. "Right support, right care, right culture" is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

Sandgate Manor is a care home providing accommodation and personal care to 18 people at the time of the inspection. The service can support up to 22 people. Support was provided to people who lived in one adapted building and there were 3 single person lodges in the grounds. Some people had learning disabilities and or autism, other people received support for physical disabilities.

People's experience of using this service and what we found

Right Support:

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. There were no plans in place to support people to maintain or increase their independence. However, the service was in the process of making improvements to increase accessibility for people and some improvements had already been made.

Staff did not always support people to achieve their aspirations and goals. Processes to do this effectively required review, as goals and aspirations had not been formally assessed. People's sensory needs had not been assessed.

People received their medicines as prescribed. Staff enabled people to access specialist health and social care support in the community. Staff supported people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.

People were supported to engage in activities. Improvement was still needed; however, staff were working towards this.

Right Care:

People's support plans did not always reflect their range of needs as care plans were not up to date and did not include some important information.

Equality and diversity needs had not been assessed to provide people the opportunity to share their views and enable staff to provide support. However, improvements had been made to protect one person's human rights.

There had been improvements in how staff spoke to people and there were positive interactions between staff and people. Staff understood how to protect people from poor care and abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.

Staff understood how people communicated. Where complaints had been received these had been investigated and acted upon. Staff had undertaken training in end of life care. However, end of life care planning needed to be reviewed.

Right Culture:

The management of incidents and accidents needed to be improved. Some incidents were acted upon. Further review was needed to ensure people were receiving the right support.

The new management team was putting improvements in place to address concerns. The office had moved into the main building which improved communication between managers and staff and gave the manager better oversight of the service.

Staff training had improved, and the new management team was making further improvements arranging for staff to attend further learning.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was rated inadequate (published 24 August 2022)

Following the last inspection, we issued Warning Notices for regulation 10, 12, 16 and 17. The provider also completed an action plan to show what they would do and by when to improve. At this inspection we found improvements had been made. However, the provider remained in breach of regulations.

This service has been in Special Measures since 04 August 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of the report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the "all reports" link for Sandgate manor on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to safe care and treatment, promoting independence and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Sandgate Manor

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was undertaken by 2 inspectors, 1 medicines 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.

Service and service type

Sandgate Manor is a "care home". People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Sandgate Manor is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager was in post and was preparing to apply to register.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought and received feedback from health and social care professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 12 people who used the service and 2 relatives about their experience of the care provided. We observed how staff interacted with people in areas such as the lounges and dining areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not or chose not to talk with us.

We spoke with 12 members of staff including the managing director, the manager, the house manager, the cook, senior care staff and care staff.

We reviewed a range of records. This included all or parts of 12 people's care records and medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

- At the last inspection risks to people were not well managed. At this inspection there continued to be concerns. For example, one person was at risk through self-harming behaviours. Guidance for staff in the person's care plan was not clear. We raised this with the manager who took action to address the concern. A new system was also put in place to monitor support provided to the person.
- Care plans and risk assessments needed to be reviewed to include a greater level of detail. For example, where people were supported to be hoisted or assisted to move with manual handling belts. Staff supported people safely during the inspection. However, there had been an incident where agency staff had not used manual handling equipment appropriately. Whilst there was no evidence the person was harmed and staff had received the required training, more detailed information was needed in care plans to set out how the equipment was to be used to reduce the risk.
- At the last inspection some people with Asthma did not have information about this in their care plan. At this inspection there was some information. However, important information about how people used their inhalers was missing. We raised this with the manager who updated the care plan during the inspection. However, care plans had not been sufficiently updated following the last inspection.

The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection staff had not considered how they would ensure people with choking risks were safe during times when there were no staff present to support people. For example, when the fire alarm sounded. At this inspection plans had not been put in place to address this risk. We raised this with the manager who amended the guidance for staff.
- Other environmental risks were appropriately managed. For example, there were window restrictors in place to reduce the risk of accidental falls from a window. There were checks to ensure the gas and electric

were safe.

Learning lessons when things go wrong

At the last inspection the provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

- Some incidents were recorded as 'behaviours'. These incidents were not always followed up or investigated to ensure they were correctly recorded, and action was taken to provide effective support to people. For example, one person was recorded as shouting and swearing. They were upset as one of their medicines was out of stock. There were no records of what action had been taken to investigate how the medicine was out of stock and ensure it did not happen again. We raised this with the manager who agreed improvement was needed regarding how some concerns were recorded and followed up. Management were putting a new system in place to address this; however, this was not in place at the time of the inspection.
- At the last inspection there were concerns some people had not been referred to relevant health and social care professionals following incidents. At this inspection this had improved. For example, one person had been referred for mental health support as incidents showed their needs had changed. However, their care plan had not been updated to include information about the persons current mental health needs to provide guidance to staff on how best to support the person with this need.

The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

At the last inspection the provider had failed to ensure there were sufficient numbers staff deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 for staffing.

- At our last inspection there were insufficient staff to safely provide support to people. People did not always receive allocated one to one support and were observed left for long periods of time with little stimulation, activities or interaction from staff. At this inspection, improvements had been made. Staffing was based upon people's assessed support hours. Care staff deployment centred around people's allocated personal hours of 1 to 1 and shared hours. Where people were allocated personal 1 to 1 hours, named staff provided support to named people. Shared support was met by additional staff.
- People, relatives and staff felt staffing levels had improved. One relative said, "There always seems to be enough staff." We carried out a short observational framework during the inspection. This is an observation of the service delivered and the reactions and interactions with people and staff. We saw frequent interactions between people, managers and staff; people were engaged and occupied. Discussion with the acting manager showed a focus on researching new activities and outings from the home. This was taking place in consultation with people and staff.

- There were two different shift patterns in place. Some care staff worked a combination of early and late shifts from 07:00 to 14:30 and 14:30 to 22:00. Staff were undergoing a consultation period for a change in contracted hours. This was to offer greater consistency throughout the day to support people and to enable people to participate in longer activities outside of the service.

At the last inspection the provider had failed to follow required recruitment processes. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- At this inspection, improvements had been made, staff were recruited safely. We looked at three staff files. Employment history had been recorded and any gaps in employment were reviewed with written explanation provided. Associated reference and ID verifications had taken place.
- The provider had devised a check and control process which now ensured staff could not start work until all required checks were completed. These included Disclosure and Barring Service (DBS) criminal record checks, which help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 for safeguarding.

- At the last inspection potential safeguarding incidents were not always recognised by staff and investigated. At this inspection improvements had been made. Where safeguarding incidents had occurred, they had been investigated and reported to the local authority as required. Action had been taken to reduce the risk of re-occurring.
- Staff had undertaken safeguarding training and knew how to identify concerns. Staff were confident the manager would act when concerns were raised. One staff said, "[manager] would definitely deal with this. I feel comfortable and confident since [manager] is here. If actions were not taken staff told us they would whistleblow and they knew how to do so. A whistleblower is a member of staff who raises concerns in the public interest. For example, a member of staff who shares concerns about poor care with CQC.
- People told us they felt safely supported by staff. One person said, "Yes, I feel safe. The staff are approachable."

Using medicines safely

- People received their medicines as prescribed. Staff were trained to administer medicines safely and checks were carried out to ensure they were competent.
- We observed medicines being administered in a way that maintained people's privacy and dignity. Staff reported medicines incidents and managers took appropriate action and shared the learnings. Staff followed systems and processes to order and store medicines.
- Staff completed risk assessments for people with specific conditions. However, people's medicines recorded in their care plans did not always match medicines administration records (MARs). This is an area

for improvement.

- Medicines audits were not carried out regularly. The last audit, prior to the inspection, was completed in August 2022. Actions were identified for example; people had not yet received self-administration assessments. This meant that people who could safely take their own medicines were not empowered to. However, staff were addressing this following our inspection.
- GPs and health care specialists, for example epilepsy nurses reviewed people's medicines. Staff were aware of STOMP (stopping over-medication of people with a learning disability, autism or both) and its principles.

Preventing and controlling infection

- We were somewhat assured that the provider's infection prevention and control policy was up to date as there had been no recent audit of infection prevention and control.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

The service was facilitating visiting in line with government guidance at the time of the inspection.

Is the service effective?

Our findings

Effective – this means we looked for evidence that People's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of People's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet People's needs

At the last inspection the provider had failed to have due regard to people's protected characteristics (as defined in section 149(7) of the Equality Act 2010). This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10.

- At the last inspection people's needs had not always been fully assessed. For example, People's needs and wishes relating to protected characteristics under the Equality Act 2010 had not been assessed. These needs include disability, gender, culture and religion. At this inspection these assessments had still not been completed and people had not been afforded the opportunity to express if they had unidentified equality-based support needs.
- Some people living at the service had autism. At the last inspection we found people's sensory stimulation needs had not been assessed. At this inspection we identified the same concern.
- Some food and drink making facilities remained inaccessible for some people who used wheelchairs, as the worktops were too high. One person said, "I can't reach the hot water urn in there, so if I want a hot drink, I have to ask the staff to make me one. They make it how I like it, not too strong." The provider was planning to convert one of the outbuildings into a space with an accessible kitchen. However, this had not been completed at the time of the inspection.

The provider had failed to have due regard to people's protected characteristics (as defined in section 149(7) of the Equality Act 2010). This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some improvements had been made to areas of the service to make them more accessible for people who used wheelchairs. For example, there was a ramp to enable people to access the laundry room so they could undertake their own laundry if they chose to. There was also an ironing board which was accessible for people who used wheelchairs. There was a breakfast bar to enable people to help themselves to cereals.
- Some areas of the service needed redecoration. For example, walls were scuffed and there were areas where the carpet was becoming worn. One person said, "It needs to be upgraded." This is an area for

improvement.

Staff support: induction, training, skills and experience

At the last inspection the provider had failed to ensure there were sufficient numbers of suitably qualified and skilled staff deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer breach of regulation 18.

- At the last inspection, not all staff had undertaken training in supporting people with epilepsy. At this inspection there had been improvement, however, further improvement was needed. There were still staff who needed to undertake training in epilepsy. However, staff knew how to support people if they had a seizure. This was an area for improvement.
- At the last inspection there were limited numbers of staff who had undertaken training to administer emergency medicines used in case of a seizure. This limited when people, who needed staff support with this medicine, could go out. At this inspection this had improved, and people were not restricted by a lack of trained staff.
- At the last inspection there were no records of staff having completed training in gastroscopy tube support. At this inspection we had the same concern. However, immediately after the inspection the manager was able to evidence staff had been trained and arranged for the community nurse to undertake further competency checks.
- At the last inspection the provider had not ensured staff had undertaken the training they needed to support people with a learning disability and autism effectively. At this inspection there had been improvements and the manager was arranging for staff to undertake further training in best practice for supporting people with this need.
- At the last inspection staff supervision was not up to date to ensure staff had the support they needed and to monitor their practice. At this inspection the manager was working through a plan to update staff supervision. Staff were also invited to request a supervision if they wanted this support to be prioritised for them. The manager was based in the service main building and were more available to staff if they needed ad hoc support. This also meant the manager had greater oversight of staff practice.
- New staff undertook the care certificate. The Care Certificate is a set of standards which social care workers must adhere to in their daily working life and covers areas such as mental capacity and equality and diversity.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At the last inspection the provider had failed to assess the risks to the health of people and ensure they were doing all that is reasonably practicable mitigate risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer breach of regulation 12.

- At the last inspection staff did not effectively encourage people to eat a healthy and varied diet. At this

inspection improvements were in progress. The manager had offered some people who were at risk from being overweight the opportunity to put a plan in place for healthier eating.

- Feedback from people about healthy choices was mixed. Comments included, "I think we are offered healthy food here" and, "I think the meals are healthy. I want to eat more healthily. I would like support with that." And, "I am not sure whether we are offered healthy choices. I wouldn't mind some smoothies, but we haven't been offered them and I haven't asked." People had choices about what they ate and were provided alternatives when they asked. The provider was changing food supplier to vary the food choices for people. The cook told us this would enable them to provide a greater variety of food such as fruits and healthier snack options which were somewhat limited from their current supplier. This was being arranged at the time of the inspection.
- At the last inspection people's weights had not been monitored when needed. At this inspection we found there continued to be concerns about monitoring people's weights. For example, one person was to be weighted monthly as they did not always eat well. There was no recorded weight for this person since October 2022. They had been gaining weight prior to October, however staff had not monitored this to ensure this was sustained. We raised this with the manager who put a monitoring form in place to ensure weights were monitored going forward.
- At the last inspection people were not always referred to health care professionals to support their wellbeing and to manage risks. At this inspection improvements had been made. For example, people were referred to physiotherapists and occupational therapists when their needs had changed. At the last inspection one person told us they would like to see a health professional to review their mobility following an operation. At this inspection we found this referral had been made.
- At the last inspection people were not well supported to manage risks to their teeth and oral care. At this inspection there had been some improvement. People had been supported to see the dentist or had appointments booked. People's oral care needs had been assessed, however, care plans would benefit from more information, such as what to do if people declined support with their oral care. This is an area for improvement. Staff had completed training in oral care.

Ensuring consent to care and treatment in line with law 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. 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.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

- Some people were able to make decisions for themselves. Where people needed support from staff to make decisions, such as being offered a limited number of choices at once, staff were aware of this. One relative said, "They give [my relative] the choice of two clothes. If you gave [them] 3 choices [they] would be confused."
- Where people needed support to make decisions best interest meetings were held and recorded. However, who attended these meetings to make decisions for people was not always clearly recorded for some decisions. This is an area for improvement.
- At the last inspection people were subject to unnecessary restrictions as they were not allowed to access

some areas of the service. At this inspection this had improved, and people were able to enter the kitchen and laundry room.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting People's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

At the last inspection provider had failed to ensure people were treated with dignity and respect and their privacy maintained. The provider had failed to ensure people were supported with their independence and have due regard to their protected characteristics (as defined in section 149(7) of the Equality Act 2010). This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10.

- At the last inspection people had no plans in place to support them to maintain or develop new skills. At this inspection the concern remained. Some people had discussions with staff about moving to supported living and were considering this. However, there were no plans in place to support people to prepare to live more independently.
- At the last inspection people were not supported to do things for themselves. At this inspection some improvements had been made. For example, there was a breakfast bar so people could choose their own cereal. However, more work was needed to enable and encourage people to do things for themselves. The provider was planning to convert one of the outbuildings into a space with an accessible kitchen.
- Comments from people included, "I have started to do my own ironing. The staff collect my laundry, but I would be happy to do it. I help cook in the kitchen, I like to help., and, "Having the trolley in the lounge area with breakfast things on is an improvement. I can help myself. I would like to be able to make a hot drink on my own.", "I sometimes take my clothes down to the laundry if the staff forget." And, "I would like to do more cooking."
- At the last inspection people told us their laundry was not well managed and their clothes were mixed up. At this inspection people felt improvement was still needed. Comments included, "Sometimes I get the wrong clothes. I don't have labels in my clothes." And "I still sometimes get other people's clothes. I recognise they are not mine. It possibly is improving."

The provider had failed to ensure people were supported with their independence. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection, there were a number of times staff had not spoken to people in a respectful way. At this inspection this had improved. We carried out a short observational framework during the inspection. We saw many positive interactions between people, managers and staff. Staff spoke to people in a polite and respectful way. For example, one member of staff offered to assist a person to move their wheelchair. They explained what they were planning to do and sought permission from the person before they provided any assistance. Another member of staff was supporting a person to eat. They interacted with the person in a meaningful way while they provided support.
- People had completed a feedback survey in November 2022. They were asked how they would rate the kindness and respectfulness of the staff. 90% of people rated this as good. Feedback from people about staff had improved but remained somewhat mixed. Comments included "The staff are nice and listen to me." "The staff are caring and kind. I do think they support me in a good way now, since the changes in management." and, "Some of the staff listen to me, but not all. Half and half as to whether they talk to me in a polite and respectful way." However, the manager had acted when concerns were raised.
- At the last inspection one person told us how their human rights were not being respected. At this inspection the concern had been resolved and the person was being provided the support they needed in this area.
- At the last inspection some people told us their privacy was not always respected and staff did not always knock before entering their room. Most people told us this had improved. However, some people felt more improvement was needed. One person said, "Some staff knock on my door, but others don't."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met People's needs.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant People's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At the last inspection the provider had failed to ensure people were supported in line with their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- At the last inspection there were no plans in place to identify and set out people's goals or aspirations to enable staff to support people to achieve these. At this inspection, there was a lack of evidence people had been supported to identify the goals they wanted to work towards. However, some people had been supported to access opportunities for volunteering and paid work and other people were being supported to consider more independent living arrangements. The manager recognised work was required around formalising goal planning processes and gave their undertaking to do so. This is an area for improvement.
- At the last inspection people told us they were not involved in developing their own care plans. Survey results had shown 40% of people felt they had no involvement in their care plan. Staff were in the process of undertaking reviews with people and feedback from people was positive following these reviews. One person said, "My care plan is good. Things have changed recently, and it has been put in more appropriate language for me. I am treated more like an adult now. I can make changes to the care plan if needed."
- At the last inspection people told us they were bored and there was very little for people to do. At this inspection there were more things for people to do and staff were making improvements. One person said, "Today I went out with 1:1 support. I went into Folkestone, did some shopping and had lunch. I would like to go to concerts and the cinema sometimes. The staff are trying to get it up and running again." The manager was also reviewing staff working patterns to make it easier for people to go out on longer activities during the day when they needed support from staff.

Improving care quality in response to complaints or concerns

At the last inspection the provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

- At the last inspection people told us they did not know how to complain. At this inspection this had improved. People told us they were comfortable speaking to the manager. One person said, "I would go to the management if I had a problem. [manager] is nice." Another person said, "I would complain to [manager] if I had a problem. I wouldn't mind doing that."
- At the last inspection we also identified complaints which had not been recorded or appropriately addressed. At this inspection improvement had been made. Complaints had been recorded and actions had been taken. For example, one person had become distressed which had led to a complaint being made by their family to the service. The manager had addressed why this had occurred and updated the person's care plan to reduce the risk of this re-occurring.

Meeting People's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People had communication plans and there was some information on how some people communicated. Some communication plans needed to be updated where staff had tried tools which had not proven to be successful. However, staff had good awareness and understanding of individuals' communication needs and staff communicated effectively with people using signs. One person used a device to communicate and staff were undertaking training to enable them to add more words and symbols to the person's device to enable them to express themselves more effectively.
- Some easy read information was available to people. However, some people's care plans had not been made accessible to them. The manager had a plan in place to address this.

End of life care and support

- At the time of the inspection the service was not supporting any people at the end of their life.
- Some staff had now completed end of life training to enable them to understand the support people may need at this time.
- Some people had end of life care plans in place. However, these needed to be reviewed to include more information on how people wanted to be supported when they needed end of life care. Some people had no plans in place. This is an area for improvement.
- Staff recognised when people needed more support due to personal events such as bereavement and had put this support in place.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership had been inconsistent. Leaders and the culture they created had not always supported the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

The last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to act on feedback from people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

- Governance processes continued to need improvement. Auditing had not led to all improvements being made before the inspection. For example, audits had not identified that people's weights were not well managed. Auditing had not identified that continence support were not well recorded to provide assurance people was being well supported. The new management team recognised that the current system of audits was not effective and were putting in place a new system. However, these were not in place at the time of the inspection and there were no up to date audits in some areas such as medicines.
- Quality monitoring of care plans had not led to care plans including important information prior to the inspection. For example, a health professional had recommended one person was monitored for signs of overhydration. There was no risk assessment in place. Improvements were being made at the time of the inspection, However, a number of concerns we raised at the last inspection had not been addressed prior to this inspection. For example, we had identified risk assessments were not in place for supporting people with epilepsy if they wanted to have a bath. This had not been completed prior to this inspection.
- Care plans were not up to date, and risk assessments had not been reviewed regularly. For example, one person was at risk of skin breakdown. Although, They had been referred to the district nurse when concerns arose, their assessment for the risk of skin breakdown had not been updated to ensure new staff and agency staff had the information they needed.

The provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain securely accurate, complete and contemporaneous records. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer breach of regulation 17 for this area.

- At the last inspection where people were deprived of their liberty, the legal authority to do so had expired. This had been addressed and was no longer a concern.
- At the last inspection people's care records were not always kept securely. At this inspection this had been addressed and was no longer a concern.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

The last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to act on feedback from people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer breach of regulation 17 for this area.

- At the last inspection there was a poor culture at the service. At this inspection improvements had been made and were being built upon by the manager and the new management team. There had been improvements in how staff interacted with people. People were able to access areas in their home such as the kitchen and laundry room and there were more opportunities for people to engage in activities. However, further improvement was needed. For example, to ensure people were being supported to develop and achieve daily living skills and work towards their goals. Feedback from people was still mixed.
- Action plans in place following the last inspection did not reflect our findings. Actions were recorded as complete when improvement was still needed. However, the manager was in the process on updating this and had identified areas where more improvement was still needed. For example, that care plans and risk assessments needed to be updated.
- Following the last inspection there had been a change in management and a period of temporary management cover. This had resulted in improvements being slower than required and the service remained in breach of some regulations. At the time of the inspection a new manager was in place. They had been recruited as a regional manager but was managing the service at the time of the inspection and planned to do so until improvements were made. There was also a new managing director and another manager providing temporary support. People were positive about the management. One person said, "The new managers are doing a great job now." And, "It is good right now living here because of the new management." And, "I went with [the temporary manager] to a job fair in Folkestone, to try and recruit more staff. He is very approachable."
- The new management team were visible in the service and approachable. The office had been moved into the main building which had given the manager better oversight of staff practice. Staff and people were positive about this. One person said, "The big difference is that [management] can see what is going on, now the office is in the main house." The change had also improved communication between the management team. One staff said, "[manager] is amazing. We are seeing them more, they are more welcoming, communication is much better."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to act on feedback from people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17 for this area.

- At the last inspection people, their relatives and staff had completed surveys to provide feedback. However, the feedback was not always positive, and the results had not been analysed and there was no action plan in place to address concerns.
- Following recent surveys, an action plan was put in place to address the concerns raised by people. For example, a review of staff working patterns was in progress to increase flexibility in staffing to provide more flexibility for people with their support.
- Feedback from staff was also mixed. Some staff were not happy with the on-call system in place when they needed support out of hours. At the time of the inspection the manager was putting a new process in place to address this.
- There were now meetings for people to enable them to express their views and discuss concerns with a senior manager for the provider. This was held jointly with another service. People had expressed that they wanted their own meeting just for the service. The manager told us they would be making this arrangement. One person said, "I think it has improved since [manager] worked here. [They] listen to you."

Working in partnership with others

- At the last inspection people had not been referred to the speech and language team for an assessment where there were concerns they may be at risk from choking. At this inspection this had been addressed. There was a care plan in place, which staff were aware of and were following.
- There had been an improvement in partnership working. The manager had made referrals when people's risks changed or when there were concerns about their health. For example, where people's mobility had changed, they had been referred for an assessment to determine if they needed new equipment to support them to move safely.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- A duty of candour incident is where an unintended or unexpected incident occurs that results in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
- The manager was aware of their responsibilities under duty of candour and had shared information with staff to increase staff awareness. We did not identify any duty of candour events.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 10 HSCA RA Regulations 2014 Dignity and respect</p> <p>The provider had failed to have due regard to people's protected characteristics (as defined in section 149(7) of the Equality Act 2010). The provider had failed to ensure people were supported with their independence.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain securely accurate, complete and contemporaneous records.</p>