Rehabilitation Education And Community Homes Limited

Reach Sistine Manor

Inspection report

Sistine Manor, Stoke green, Stoke Poges, Bucks, SL2 4HN
Tel: 01753 531869
Website: www.reach-disabilitycare.co.uk

Date of inspection visit: 26 & 28 October 2015
Date of publication: 29/03/2016

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Requires improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Reach Sistine Manor is registered to provide residential care for up to 19 adults. The home is split into two, with a coach house to the side which accommodates three service users. The home provides care to people with severe learning disabilities and complex needs. At the time of our inspection, 18 people were living at the service.

Reach Sistine Manor did not have a registered manager. 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. A manager was in post and had sent an application to the Commission which was being processed.

This inspection was undertaken over two days and was unannounced.

We undertook an inspection at Reach Sistine Manor in June 2014 which was unannounced and completed over two days. At our last inspection, we found a number of breaches under requirements and regulations associated with the Health and Social Care Act 2008 (Regulated

Summary of findings

Activities) Regulations 2010. The service was in breach of Regulation 9: Care and welfare of people who use services, Regulation 23: Supporting workers, Regulation 10: Assessing and monitoring the quality of service provision and Regulation 20: Records. After the inspection, we were provided with a comprehensive action plan submitted by the provider on how they intended to address the concerns raised.

We undertook a comprehensive inspection in April 2015 to follow up on non-compliance at our June 2014 inspection. We continued to find concerns with the service and minimal improvement had been made. The service was rated inadequate in four domains (Safe, Effective, Responsive and Well Led) and was placed into special measures and was required to be inspected after six months. After our April inspection, we took enforcement action against the provider in the form of a notice of decision to impose 'positive conditions' on the service, predominantly around their training requirements. The notice was due to come into effect on the 12 November 2015.

At this inspection in October 2015 we found some minor improvements had been made, but not enough to ensure the service was placed out of special measures. Due to the lack of required improvement, the service continues to be rated as 'inadequate'.

Risk assessments were not always reflective of people's needs and did not provide staff with the guidance they needed to ensure people were kept safe. We raised concerns with the local authority around the process of recording and reporting incidents and the lack of improvement to the service. We continued to raise concerns about fire safety and the layout of the building.

Staff were still not receiving adequate training to undertake their roles effectively. Particularly around required training and skills to work with people with severe learning disabilities. Staff were still not receiving training in line with the provider's training plan. Staff input was not always sought into how the service could improve until the second day of our inspection.

The service did not respond to concerns raised by the Commission and local authority commissioners in respect of the Mental Capacity Act 2005. The provider did not ensure staff were working in line with Deprivation of Liberty Safeguards (DoLS).

The service had improved through re-decoration however; this had not improved the quality of care that people received. People were not always treated with dignity, and respect of their privacy protected. Staff appeared unaware how to de-escalate unwanted behaviours. Most staff appeared unaware of how to treat people in a person- centred way. Engagement between people and the majority of staff members did not appear to be meaningful or purposeful.

There were poor quality assurances in place considering the ongoing breaches since June 2014. Although the manager and operations manager had tried to improve the service, there was poor leadership and management within the service. This meant the service had not improved and remained in breach of the required regulations under registration of the Health and Social Care Act 2008. We found the manager and operations manager were not appropriately supported by the provider to ensure the service was safe, effective, caring, responsive and well-led.

We found the home was still not tailored to meet the needs of people with complex needs and learning disabilities.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

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.

Risk assessments did not always reflect people's needs. Clear guidance was not always in place to ensure staff knew how to protect people from harm.

Accident and incident records were not monitored appropriately to ensure people were kept safe.

Requires improvement

Is the service effective?
The service was not effective.

Staff did still not receive the appropriate and required training to undertake their roles effectively.

The provider did not make sure they were working in line with the Mental Capacity Act 2005.

Concerns were still raised about the layout and size of the building.

Inadequate

Is the service caring?
The service was not always caring.

People were not always treated with dignity and respect.

Staff did not always speak with people in a dignified or empathetic manner.

People were not always involved about changes in their care in a way they could understand.

Inadequate

Is the service responsive?
The service was not always responsive.

Care planning had improved, however actions which needed to be addressed had not always been completed.

People regularly accessed the outside community, however activities within the service did not feel meaningful or person led.

People received regular reviews of their care.

Requires improvement

Is the service well-led?
The service was not well-led.

There was poor leadership and management in place.

Quality assurance and governance within the service and at a provider level were poor.

Actions from our last inspection had not been addressed.

Inadequate

Reach Sistine Manor

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 the 26 & 28 October 2015 and was unannounced.

The inspection team consisted of one inspector, an inspection manager and an Expert by Experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked to see what notifications had been received from the provider since their last inspection. We received appropriate notifications from the home since their last inspection in April 2015.

Over both days of our inspection we spoke with the manager, operations manager, external support advisor, eight support workers, three people who used the service and three relatives of people and domestic staff including the chef. We also spoke with two visiting professionals. We undertook observations of staff practice over the two days. We reviewed four care plans, medicines records, daily records, three recruitment files and copies of quality monitoring undertaken by the provider. We also looked at staff supervisions, training records, induction records and rotas.

We also spoke with health professionals and were provided with a copy of the service's last contract monitoring report from the local authority.

Requires improvement

Is the service safe?

Our findings

At the service's last inspection in April 2015, we found concerns around staffing levels, risk assessments, fire evacuation processes, staff identity checks, controlled medicines and recruitment checks. Due to the severity of these concerns, Reach Sistine Manor was rated 'inadequate' for this domain. We found breaches in the following regulations: Regulation 18 and Regulation 12 (Staffing and Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found staffing numbers reflected the required number determined by the provider. A number of staff being used were agency staff and not permanent, however the provider tried to use the same agency staff where possible. At the time of our inspection, 10 staff vacancies were being advertised. We found staff were visible during our inspection and responded to requests and provided assistance where required. Since our last inspection, staff were now receiving breaks; however there was no allocated space for them to have breaks away from the service. Rotas now reflected the current staffing numbers for each shift.

We found some risk assessments had been improved within the service; however these were not always followed through with adequate information on how the risk was to be managed. For example, we saw one person's epilepsy guidance stated 'Staff should respond to this [seizure] by following the training and record an accurate account of what happened.' We were advised staff only received e-learning training by the provider on epilepsy. One staff member told us they weren't sure what they would do if the person had a seizure. We saw no records were provided on the monitoring of any potential seizures. We were also advised that there were associated risks for a person in regards to outside contact from relatives. We did not find any reference to this in their care plan.

Another person had a clear risk assessment around management of their nutrition and hydration needs with clear guidance on how the risk of malnutrition was to be reduced however; staff were not adequately recording food intake in line with the risk assessment. This meant it was not always clear if the person was receiving adequate nutrition.

This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the safety of service users by assessing risks and having adequate management plans in place.

We were provided with a copy of accident and incident records which showed incidents which had occurred since January 2015. We raised concerns about the number of 'unexplained bruising' recorded since January 2015. In total, 20 reports of unexplained bruising for eight separate people using the service were recorded. Three accident forms were missing. We found although body maps had been filled in, there was minimal analysis into unexplained bruising to determine how or why the bruising had occurred and what action needed to be taken. We raised a safeguarding alert to the local authority due to these concerns.

This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the safety of service users by adequately assessing and monitoring accidents and incidents for trends and patterns.

We found fire checks, risk assessments and six monthly fire drills took place.

Where people required medicines, two staff who had been trained administered them. Medicine administration records were kept up to date and showed people received their medicines as prescribed by their GP. Where people were prescribed medicines to be given when required (PRN) there were protocols in place. These explained to the staff in what circumstance these medicines should be given. The protocols were clear and easy to understand and were reviewed at regular intervals. A photograph of each person was located against their medication administration chart, this enabled staff to check the right person received the right medication. We saw evidence that regular checks of medication were made to ensure that the stock levels of medication were correct.

On viewing the medicines records we saw that one person was prescribed a variable amount of a medicine by the GP. The directions for this medicine said that 5 to 10mls should be administered. Staff had signed to say the medication had been given but did not say how much of the medicine had been administered to the person. We asked the staff

Requires improvement

Is the service safe?

administering the medicine and they told us that they always gave 10mls. The amount given should have been recorded on the medicine administration record. This is not in line with best practice. The staff informed us that they would record the amount given in future.

We were told by staff that one person took their prescribed medicines in bread. Staff informed us that they put the medicine in the bread in full view of the person and explained to them what their tablets were for. However, there were no instructions for staff on how to administer this person's medicine to ensure that they were given in the same way by staff and not hidden in the bread without being shown to the person. Giving medication to people hidden in food is known as giving medicines covertly and requires certain protocols to be in place to protect people. By not having clear instruction for staff there was a risk that this person's medicine may be given covertly. It is also best practice to consult a pharmacist if medication is going to be given in food. There was no evidence that the home had done this, which meant there was a risk that the effects of the medicine might have been compromised.

Another person was prescribed a medicated shampoo to used twice a week, we saw that this was being signed for and administered every day. Staff confirmed that this was given every day which was not in line with how the medicated shampoo was prescribed by the GP. During our inspection we saw an incident form date 13 October 2015 in which a person swallowed medicated shampoo that they found in another person's room. Staff we spoke with informed us that medicated shampoos would be stored in people's rooms but should have been locked away securely in their rooms. On this occasion the medicated shampoo had not been stored correctly. This put people at risk of harm. At the time of our inspection, the medicated shampoo was locked away, however the individuals risk assessment had not been updated following the incident.

Staff we spoke with had received training in safeguarding. They were able to explain how they would raise any concerns they had. One staff member told us "If I had any suspicions about another member of staff I would inform the manager. If they didn't listen to me I would speak to X [the operations manager] or contact safeguarding at the council". Details on how to raise a safeguarding alert were available and visible for staff.

We looked at three recruitment files for staff members who had recently commenced employment with the service or had done so within the last two years. All three files contained proof of identity; including their eligibility to work within the UK. Photographs were contained in files. Medical histories and previous employment histories were in place. Copies of staff disclosure and barring checks (DBS) were kept on file including the date they had been received. All files contained evidence of satisfactory conduct in previous employment.

Inadequate

Is the service effective?

Our findings

At the services last inspection in April 2015, we found the service to be in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to concerns around the provision of training, inductions, the safety of the premises, the application of the Mental Capacity Act 2005 and meeting people's nutrition and hydration needs.

The provider had begun to use the new 'care certificate' induction for all new staff members commencing employment at Reach Sistine Manor. The care certificate outlines set standards which new staff were required to meet and to be signed off as competent. At the time of our inspection, new staff members were being supported to complete the care certificate in line with their probation period. We found staff were receiving supervision in line with the provider's policy and supervisions demonstrated a two way discussion. Staff told us they were feeling much more supported since the last inspection, however it appeared that staff input was not always obtained into how the service could improve. A group staff meeting was held by an external support advisor (which had been previously arranged prior to the inspection) on the second day of our inspection to ask for their feedback on what improvements they could make, and what they felt constituted best practice. We did see some staff members trying hard to provide good care and work in line with best practice throughout our inspection.

We raised concerns about some staff members' understanding of the English language. Conversations with some agency staff were difficult as they could not understand our questions. In one case, another staff member had to interpret our questions in the staff member's first language.

Many of the people living at Sistine Manor had communication difficulties and found it difficult to understand verbal communications or express themselves verbally. The service had introduced communication key rings to assist staff and people to communicate. These key rings had a range of pictures and symbols to enable staff to back up verbal communication with pictures they could show people. People could also point to pictures to communicate their needs or wants to staff. However, during the course of our inspection we saw that these key rings were rarely used by staff. Some people used 'Makaton', which is a communication system where verbal communication is backed up with gestures and signs to reinforce the message. Again, we saw little evidence of staff using Makaton with people during our inspection. However, people reacted positively when member of the inspection team used basic Makaton signs when communicating with people in the home. This meant that people were at risk of not being able to communicate their needs to staff or not understanding what staff were trying to say to them.

We raised concerns at our last inspection about the lack of learning disability specific training for staff working at Reach Sistine Manor. We also raised concerns that staff members had been in post for a considerable amount of time and had not received training in line with the providers training plan. The providers training plan for 2015 stated "During the first four weeks after employment commences, all new starters will be offered five online training courses in Safeguarding Vulnerable Adults, Infection Control, Fire Safety, Moving of Objects, Manual Handling of People and Health and Safety."

We found staff were still not receiving training in line with the providers training plan. One staff member who commenced employment in June 2015 had only received 'wellbeing' training. Another staff member employed since August 2015 had received no training at all. Learning disability training such as 'intensive interaction' and autism training had only been provided to a selection of staff. We could see no evidence that training was assessed as being effective, and that staff were deemed competent after undertaking training. There was a reliance on e-learning training, some of which staff told us was difficult to take actual learning from. We were advised a new accredited training programme was coming into effect in November 2015, however concerns around training for staff has been ongoing since June 2014 when training concerns were first identified by the Commission.

This was a breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not receive effective training to undertake their roles.

The homes training programme included training that teaches staff management and intervention techniques to cope with people's escalating behaviour in a professional and safe manner. This included the safe use of techniques and skills to appropriately physically intervene when necessary to keep people safe. We saw in people's care

Inadequate

Is the service effective?

plans that some people had the potential to become physically aggressive towards themselves, other people or staff. The behavioural plans were detailed in how to support people in a way that would reduce people's anxiety and the likelihood that their behaviour would become challenging towards others. However, these did not provide clear guidance for staff on which techniques they would need to use if physical intervention was needed. We spoke with staff about what they would do if they needed to intervene to protect people. Staff told us that they would make the area safe by removing either the person or other people from the immediate area. However, they were unable to tell us how this would be done.

The behavioural plans did not contain guidance for staff on discussing and recording an incident after it happened. This is important as it allows the service to think about what staff did that went well during the incident and what didn't go well. This allows the service to learn from incidents to reduce the possibility of them occurring again and to improve the management of future incidents and the safety of people and staff.

We found the service was still not following the principles of the Mental Capacity Act 2005. We found examples where people's capacity had not been assessed and best interest meetings and decisions were not undertaken. For example, no formal capacity assessment and best interests meeting was held in regards to the use of homely remedies for one person. Another person refused all medical assistance and intervention. No capacity assessment or best interest's decisions were made to ensure the person stayed healthy and well. Previous visits in September 2015 by commissioners identified issues with the lack of mental capacity assessments undertaken. We found these concerns were still not addressed at this inspection. We found people were not always asked for consent before staff undertook tasks. We also found people who were being moved from the service were not offered advocates when they had no relatives. We also raised concerns that a person was being given their medicines in bread. We were advised the person was shown the medicine being put in the bread and they did not have the capacity to understand why. We found no mental capacity assessment or evidence of best interest meetings in place.

This was a breach Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the principles of the Mental Capacity Act 2005 were not followed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people were subject to Deprivation of Liberty Safeguards (DoLS) paperwork was in place, however there were some delays between applications running out and the new applications being submitted.

We found the layout of the house meant that it could be difficult for staff to observe people to ensure their safety. We did see improvements had been made to the premises following concerns raised at our last inspection.

We found communal areas to be bare and not personalised. It was difficult to differentiate between people's rooms, cupboards and bathrooms as no signs were on doors. We were told this was because people ripped them off and destroyed them. No ideas had been implemented to provide signage in a way which signs could not be destroyed or ripped from the walls. We raised issues around the lack of personalisation in communal areas, for example, the display of photographs and pictures. On the second day of our inspection, staff were sitting with people and placing their photos into glass frames and putting them in people's bedrooms. This was positive in the sense that the service was personalising people's rooms. However, this didn't address the issues of signage within the home.

Food and drinks were regularly offered to people and since our last inspection; people were able to access the kitchen with staff support to obtain food and drinks. We found where one person required their food intake to be recorded this had not always been done. We also found inconsistencies around choices of food and drink offered to people. We spoke with the chef who told us they had begun to change menus as there were concerns that people were gaining unnecessary weight. Menus were now on display for people using the service to show them what was for lunch and dinner. People were also provided with afternoon tea and snacks. We saw people's weights were recorded and monitored and people's cultural needs were met when preparing and supplying meals.

Inadequate

Is the service effective?

During our inspection, we spoke with two visiting health professionals. Comments from them included “They refer people at the right time”, “The staff seem to work with people well”, “I think the staff have a good rapport with X” and “They [staff] provide what we need and liaise with us appropriately.” We saw people were supported to access healthcare when required and evidence of appointments were recorded and followed up appropriately.

Since our first inspection in June 2014, we had regular contact with local authority commissioners to discuss concerns about the service. Up until this inspection and beyond, we continued to receive concerns from commissioners in regards to the standards of care provided to people living at Sistine Manor.

Inadequate

Is the service caring?

Our findings

At the services last inspection in April 2015, we found the service to be in breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found no improvements had been made around treating people with dignity and respect. Some people were treated with dignity and respect by some staff members but not others.

We spoke with relatives of people who used the service. Comments included "The staff are warm and welcoming, they have worked well with X to develop X's language" and 'There have been lots of changes of staff again and a lot of staff do not speak good English, I think the staff do care but I am concerned that they don't really know what they are doing, they did not even know X is partially deaf, It seems they lack real understanding of people with Autism." Other comments included "Every time I see X, X is laying on the bed. X is refusing to eat and I don't think they are helping him in anyway with that. None of the staff can understand X at all and I am worried about the place X is in, it just doesn't feel right."

People were not always treated with dignity and respect. During the inspection one inspector was reviewing the notes for one person living in the home. They approached a member of staff and asked them to point out this person, the staff member replied "[person's name] is the fat lady."

We saw one person who asked staff "Can we go to Tesco's later." We observed the staff member to reply "No" with no explanation as to why the person could not go to Tesco's. We found some staff spoke to people in a non person centred way, for example "Take your food, sit down and eat." During our first day of observing lunch, we found it to be hectic and chaotic. Staff were still reaching over people and not always offering choices. One person wanted to stand to eat their lunch which they appeared happy with. Staff intervened and tried to get them to sit down when they appeared happy standing. The operations manager had to point out to staff that the person was fine to stand and eat their lunch if that's what they wanted to do. We noted one person sat asleep on the couch and was woken by a staff member to join the table to colour a picture. This indicated the person was not offered choice in what they wanted.

Some people were supported to have their lunch in the outside 'games' room. When we entered the room, music was playing loudly from the stereo. Staff did not respond to turn it down until the activities co-ordinator realised it was too loud. One person's care plan stated that the staff member who supported them on a one to one basis was required to wear a bum bag which contained wipes. This was for staff to use when the person salivated in order to protect their dignity. We saw this did not happen however other staff did respond to protect peoples dignity. On the second day of our inspection, we observed lunch again and found the operations manager had to prompt a long standing staff member to offer to wipe a person's mouth after they had eaten. We again, observed someone to take something off of the floor and eat it.

One person continued to touch and pull a staff member. The staff member did not know how to de-escalate this behaviour and continued to say to the person "Stop it, eat your food." We observed a senior staff member to intervene and provide guidance to the staff member on how to de-escalate the behaviour. After lunch we observed one person to become upset and they began to cry. The person was unable to verbalise why they were upset. One staff member responded to them by saying "Don't cry." After the person was told 'Don't cry' they were supported to use the toilet. The door was left open whilst they used the toilet in full view of the inspector. This did not promote the person's dignity or privacy. On the second day of our inspection, one person was walking around the service with their flies undone. Staff did not respond to protect the person's privacy and dignity.

Before lunch on our second day we observed one staff member who continued to request assistance from a person to lay the dining table. The person ignored the staff's request. The staff member then went up to persons face and in a strong tone stated "Mr X, can you please set this table." During the afternoon on the second day of our inspection, staff said to one person "Come with me, we need to change your pad" in front of the inspector and other people. There was no consideration for the person's privacy and dignity.

This was a breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect.

Inadequate

Is the service caring?

We did praise one staff member on observations we saw of their caring practice. This staff member appeared to know people's needs well and offered advice and support to other staff members, however it appeared the majority of staff did not actively involve themselves in ensuring people's rights, dignity and privacy were promoted despite the fact they had been employed in the service for a substantial amount of time.

We found people were still not being helped to take ownership of their life and to promote their well-being, dignity and life skills apart from regular outings into the community. The service implemented new flashcards which had pictures to show people so they could understand, for example a picture of a cup of tea, which were provided to all staff on their set of keys, however we only observed them to be used once during our inspection. The service still did not support and utilise relevant and appropriate communication tools for people and showed little evidence best practice when providing care for people with learning disabilities.

Two people were due to be moving from the service and were in the process of transitioning [spending time visiting their new placement]. We found there was no evidence of how the people were involved in the transitioning process, for example, the use of social stories or communicating how and why the transition was taking place in a way which they could understand. One person who had no family was not offered any advocacy services in respect of Sistine Manors decision to move them.

Requires improvement

Is the service responsive?

Our findings

At the services last inspection in April 2015, we found the service to be in breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some improvement had been made around peoples care plans and activities.

We found some care plans we reviewed had improved since our last inspection. Care plans were now regularly reviewed and mostly reflected people's needs. Care plans were reviewed regularly and amended where required however, we found outstanding actions written on a piece of paper at the front of some care plans had not been actioned. Guidelines on how people were to be supported had improved however clear guidance on how to de-escalate behaviours were not always present.

People's care was reviewed every six months and was recorded in a comprehensive format which involved the person, relatives and other professionals including keyworkers. Reviews contained information on what had happened in the person's life in the previous six months included any health changes, what activities had been undertaken and what plans were in place for the next six months, We found all people had had their care reviewed and were invited to participate if they wished.

Four people in the service received one to one care due to their complex needs. Although guidance on the provision of one to one care had improved, we still observed little evidence of meaningful activity or stimulation which was delivered in a person led manner. We found again that staff were not aware of distraction techniques or how to de-escalate potentially risky behaviours. For example, one person at lunch kept grabbing a staff member and the staff member told them over again "Please, no, stop it, please." We did note that senior members of staff shared their knowledge on how to de-escalate behaviours, however staff working regularly with people who needed one to one care should be aware of how to deescalate behaviours.

We found people were regularly supported to access the local community however; concerns were still raised about the provision of activities provided within the service. We saw staff were undertaking activities with people such as painting, building blocks and drawing throughout both days of our inspection which appeared to be positive, however on reflection, this was the only activity provided to people. This meant people were painting and drawing all day with no provision of other stimulation or activities except when people went out. Some staff appeared disinterested in participating with these activities and other staff appeared to undertake the activities well. There was a lack of meaningful and person led activity provision for people living at Sistine Manor.

We saw in one person's care plan that if they stood by the door, this meant they wanted to go out for a walk and staff should support them. We saw this did not happen. We still found occasions where people were walking around the service with minimal engagement. One relative commented on the lack of activities recorded in their relatives daily diary. Comments included "The diaries could be improved because it gives us a picture of what has been happening in X's life." We cross referenced people's activity plans with their diaries and found they did not correspond. In some cases, diary entries read that people had got up, had breakfast, had lunch, had dinner and went to sleep. We also found monthly keyworker sessions had not been undertaken, in some cases for months.

We looked at copies of complaints for the service. We saw complaints were responded to appropriately, however we could not see any learning had occurred from complaints. We could still not see evidence that the provider's complaints policy and procedure was provided in an appropriate format for people who used the service. One relative commented "It would be nice not to raise issues when X comes home, for example the clothing X is wearing."

We looked at copies of residents and staff meetings. At previous inspections, we were concerned that staff were not aware of the role of the Care Quality Commission, and what our inspections meant when rating a service. We saw staff were now familiar with the CQC and with our new way of inspecting services. Staff meetings demonstrated discussions from management on what requirements were needed to improve the service, however it appeared staff input was minimal. On the second day of our inspection, the external support advisor undertook a staff meeting [which had been previously arranged] which allowed staff to discuss what improvements they felt they could make, and how they could do it. This appeared to be a positive meeting and staff presented good ideas.

Inadequate

Is the service well-led?

Our findings

At the services last inspection in April 2015, we found the service to be in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection, we found minimal improvement had been made to the provision of good governance and quality monitoring of the service.

We spoke with relatives of people who used the service and commissioners about the management and oversight of the service. Some relatives we spoke with were positive about the manager however other comments were not so positive. Comments included “She knows every bit of them [people who used the service] I trust her completely. If she says that X is well, I believe her.” We raised concerns that the operations manager was not supported wholly by the provider to make the required improvements to the service.

We contacted the manager after the inspection to discuss how they felt the service was progressing. They told us "I feel disappointed [after receiving feedback from our inspection]. I do believe we have still not reached the point we need to. The operations manager and external support advisor have really supported me. I feel we have been working really hard to bring up the staff morale. We have had a high staff turnover and it’s been hard for me trying to find my management style alongside trying to make improvements.”

We found there to be no clear leadership within the service. Since our last inspection, some staff had been appointed as team leaders. We did see some good practice and knowledge shared by some senior staff, yet disappointing practice observed by others. At the time of our inspection, the manager was awaiting their interview to be registered with the Commission. The manager attended the first day of our inspection despite being on annual leave. We were supported to access information and documentation by other senior management who worked for the provider including the operations manager, team leaders and an external support advisor.

We raised concerns about the lack of structured quality assurance checks within the service. This was because the concerns raised by The Commission in regards to Sistine Manor had been ongoing for 18 months since the service was first found to have issues in June 2014. We were provided with a copy of the provider’s quality assurance document. The last quality assurance document was dated July 2015. Since this time, we were informed further quality assurance checks were in place, however we were not provided with evidence that they were being undertaken/ had been undertaken. Since the last inspection in April 2015, The commission had meetings with the provider in regards to the concerns raised and were provided with assurances that improvements were being made. At this inspection, we found although minimal improvements had occurred, these were not sufficient to ensure the service provided was safe, effective, caring, responsive and well-led.

After the last inspection, the provider sent us an action plan outlining the improvements they intended to make in order to satisfy the Commission that the service was no longer inadequate. We found some actions had been addressed; for example, the risks of staff working long shifts with no breaks and improvements made to the environment of the service, however some actions were still outstanding and had not been addressed. Examples of these included guidelines and risk assessments which reflected people’s needs, the provision of training, the effective use of communication aids, evidencing intensive interactions, safety glass issues and staff being supported and trained on how to treat people with dignity, privacy, involvement and respect.

On discussions with the operations manager and external support advisor, it appeared that they were trying hard to make improvements, but we were unsure whether they were being supported at a higher level to make the required changes. We also raised concerns that the service knew they would be re-inspected after six months of their last inspection [April 2015] and had not made the required improvements to be taken out of special measures.

This was a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was ineffective governance in place to ensure the quality of the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:
This will be reported on at a later stage when our action is completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not working in line with the principles of the Mental Capacity Act 2005

The enforcement action we took:
This will be reported on at a later stage when our action is completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected from potential risk and harm.

The enforcement action we took:
This will be reported on at a later stage when our action is completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of good governance in place to ensure the quality of the service.

The enforcement action we took:
This will be reported on at a later stage when our action is completed.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not appropriately supported to undertake their roles through effective training.

The enforcement action we took:
This will be reported on at a later stage when our action is completed.