Mrs Christine Dodge

Westcliff House

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?	**Inadequate**

Summary of findings

Overall summary

Westcliff House is operated by the registered provider Mrs Christine Dodge, and is registered as a care home without nursing to provide accommodation to 34 people living with learning disabilities and/or mental health needs. The service was divided into two wings. The Sidborough Wing provides a more traditional care home setting substantially for people with learning disabilities, some of whom are older people who have lived there for many years. The Roborough wing is set up as individual flats for people living with learning disabilities or long term mental health needs. At the time of our visit there were 29 people living at the service.

This inspection took place on 28 March and 4 April 2018 and was unannounced. At our last inspection of the service in January 2017 the service had been in breach of three regulations of the Health and Social Care Act 2014. These were in relation to acting in accordance with the Mental Capacity Act, good governance and staff training and support.

On this inspection we found the service had taken action to meet the breach in relation to staff training and support, but remained in breach of regulations relating to the Mental Capacity Act and good governance. The breach for the regulation regarding staff training was however again breached as we found instances of where there had not been sufficient staff on duty to meet people's needs. In addition we identified new breaches of regulations relating to safe care and treatment, treating people with dignity and respect, safe staff recruitment, safeguarding and person centred care.

We found the overall rating for the service is requires improvement for the second time.

The service has 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. The registered manager was not present for the first day of the inspection, but was for the second.
The service was not developed and operated in line with the values that underpin the "Registering the right support" and other best practice guidance as it preceded this guidance being in place. Values identified in the guidance include choice, promotion of independence and inclusion, so that people with learning disabilities using the service can live as ordinary life as any citizen. We have asked the registered manager and provider to consider how their service can be further aligned with these values.

The service was not always well led. We identified a number of new concerns on this inspection that had not been identified in the service's own quality assurance systems. The service was not always following their own policies and procedures in practice and had not regularly taken actions to assess the quality and safety of the services provided, including regular audits.

People were not always being kept safe because the provider had not ensured systems in place were

effectively protecting people from abuse. Policies and procedures were in place to identify and respond to allegations of abuse and staff had received training in how to identify concerns. However, we found that staff and management had acquired a tolerance of behaviour from the people living in the home towards others that was potentially abusive.

Risks to people were not always reduced because staff did not understand people's health and welfare needs and what actions they needed to take to keep individual people safe. Records were not always in place to support people with risks associated with specific health conditions. Risk assessments did not always contain detailed guidance for staff on how to reduce or manage risks related to people's behaviours.

Risks associated with the environment had not always been assessed or mitigated. We found two windows above ground level did not have window restrictors fitted, water temperatures at taps and baths were delivered at temperatures higher than recommended and radiators were not covered. This meant people were not being protected from hot surfaces or from the risk of scalds. Not all areas of the buildings were clean or well maintained.

People's rights were not being protected because the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments completed by staff were general statements and not decision specific. Decisions made for people had not been recorded in line with the best interests decision making process. People were being deprived of their liberty without the necessary legal authorisation to do so.

People's care plans did not always reflect a person centred approach, or follow the principles of positive behavioural support when supporting people living with a learning disability. Plans did not focus on identifying people's goals or strengths or how to meet any aspirations they may have, including increasing independence. Some needs assessments or plans relating to physical conditions were not completed in sufficient detail for staff to understand what actions to take for that person.

People told us they did not know about their care plans or had not seen them. We made a recommendation to the provider about seeking guidance about involving people further in their care planning.

People told us they felt safe and well supported by the home and the staff. We saw staff supported people with patience and a caring attitude. Staff knew people and their wishes well. Staff spoke about people they supported with affection and compassion. They told us "We strive to give our best to everyone." However, not all comments from people living at the service were positive and we saw occasions where people's privacy or dignity was not always respected. One person told us they did not feel they were always treated with respect with regard to managing a continence issue. We saw several people did not appear well groomed.
The service had supported people to raise concerns about treatment they had experienced. However, people told us they were not all sure of what they would do to raise a complaint. Some people told us "I don't know how to make a complaint", "I don't bother" or "I would not know what to do but I would be afraid to complain as I am afraid of what they would do". One person told us they had made a complaint but nothing had improved. We made a recommendation about managing complaints.

Systems were in place to ensure staff were recruited safely but these were not always being operated robustly. One staff file did not contain a full employment history. There were not always enough staff on duty to support people to carry out the activities they wanted to do.
Staff were receiving regular supervision, and received training to help them carry out their work. Staff told us they felt supported by the management.

People received their medicines safely. Protocols were in place for the administration of 'as required' medicines however, there was not a robust system in place for the auditing of medicines. We made a recommendation the provider reviews their medicines administration auditing processes.

We received variable feedback about the food and meals served. Some people told us they really enjoyed the meals and had a good variety. Other people told us there was little choice or variety. We have recommended the service consult with people about their satisfaction of the meals served. People were supported to have access to health care services when needed.

People were supported to follow their own activities and interests. Some of the people living in the Roborough wing were largely independent and 'very active in the local community'. However, some people living in the Sidborough wing were much more dependent on activities arranged by the service. When we asked how they spent their time we received mixed views. One person said, "We haven't got anything to do. I used to like puzzles. I don't do them anymore."

Westcliff House is comprised of two period buildings spread over five floors some of which could be accessed via a stair lift. We found some of the accommodation was looking tired and in need of refurbishment. The registered provider told us they were carrying out improvements on the environment this year.

Some people living at the service were elderly, and some also had sensory impairments. No assessment had been carried out to assess how people with sensory impairments such as sight loss, could have their environment improved to increase their independence or maximise their vision. We made a recommendation about improving the environment to meet the needs of people.

People told us they felt the service was well led and were positive about their support. People were encouraged to give their views about how well the service was working and what could be improved through regular questionnaires. Staff told us they enjoyed working at the service, worked well as a team and understood their roles.

We found breaches 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people from their health care needs or the environment were not being robustly assessed and mitigated wherever possible.

The provider had not always taken action to protect people from abuse and behaviours that could be abusive to others were tolerated and not addressed.

Safe staff recruitment practice was not always being followed.

Records were not always well maintained.

Medicines were ordered, stored and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective

The service was not always acting in line with the principles of the Mental Capacity Act 2005 in protecting people's rights.

People had enough food to maintain their wellbeing and were consulted on menu choices

The premises had not been assessed to take account of the needs of people with sensory impairments. We have made a recommendation about this.

People received support from staff who were well trained, supported and understood people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always being respected.

Staff were kind to people and demonstrated compassion and affection.

People were supported to maintain relationships important to them.

People were encouraged to have their say about the services they received at regular meetings.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not be assured their care needs would be fully met. Care and support plans did not always reflect all areas of need in sufficient detail.

People's support plans did not contain details of hobbies and interests and how people could be supported to follow these.

People told us they were not all confident about how to raise concerns and some were not confident enough to do so. We have made a recommendation about this.

People living at the service were able to receive information in formats they could understand.

No-one living at the service was in need of end of life care.

Is the service well-led?

Inadequate

The service was not well led.

People were not being protected because the service's own quality assurance and management systems were not operating robustly.

The service had failed to make improvements to meet concerns previously identified.

Care was not always delivered in line with best practice.

Staff worked well as a team; they had clear guidance on their role and told us they enjoyed working at the service.

People said they were asked for their views and but not everyone told us they felt listened to.

Westcliff House

Detailed findings

Background to this inspection

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

This inspection took place on 28 March and 4 April 2018 and was unannounced for the first visit.

The inspection was carried out by one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using, supporting or caring for someone who uses this type of care home.

Prior to the inspection we looked at all the information we held about the service, including previous inspection reports and notifications. Statutory notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. The provider had completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

During the inspection we looked at the support plans for five people living at the service, and sampled other records relating to people's care. We spoke with or spent time with ten people living at the service, one relative, four members of care support staff, the registered provider, the registered manager and deputy manager and the service's maintenance person. We looked at records in relation to the operation of the service, such as risk assessments, medicine records, policies and procedures and three staffing files, and we looked around the building.

We also contacted the local authority quality improvement team who had supported the service since their last inspection, and three healthcare professionals who have supported people living there.

Requires Improvement

Is the service safe?

Our findings

On our last inspection of the service in 10 January 2017 we had rated this key area as good. On this inspection we found this had not been sustained and the service was rated as Requires Improvement.

People told us they felt safe at the service. People told us "I feel safe here, but if I didn't I would speak with my keyworker or the owner", "I feel safe here. I love the staff and the other residents. I have my own flat I can spend as much time there or join others in the lounge" and "Yes I am safe here. I have friends here and if there is an issue with another resident, staff will resolve it. They do talk to me about keeping safe and how to manage if I get uptight." A relative told us "I visit (relations name) regularly and feel he is very safe here. If he had concerns he would tell me."

However, we found people were not always being kept safe because the provider had not ensured systems in place were effectively protecting people from abuse. On the first day of the inspection we saw people being subjected to abusive behaviour, in that we witnessed a person living at the service expose themselves in front of other people on two occasions. Other people living at the service asked the person to pull up their clothing as there were no staff present. People and staff told us the person was "always doing it" but we found action had not been taken to prevent this. Following our first visit we had requested the registered provider contact the local safeguarding team to raise an alert. When we returned to the service a week later the provider had not done this. We requested the registered manager do so and confirm to us the actions they had taken. The registered provider told us the person had also exposed themselves the day after the first visit. The provider told us they had ensured the person was wearing different trousers they could not easily pull down. There was nothing in the person's care plan or risk assessment to instruct staff as to how to support the person to reduce this behaviour.

The provider had policies and procedures in place to identify and respond to allegations of abuse. Staff had received training in how to identify concerns about people's welfare or abuse following the last inspection, and told us if they had any concerns they would not hesitate to raise any them appropriately. However, staff and management at the service had acquired a tolerance of behaviour towards others that was potentially abusive. We had concerns about the casual acceptance of this behaviour by staff and other people living at the service. Policies covered whistleblowing, and the registered provider told us they had not received any concerns from staff.
On the first day of the inspection one person told us they had been shouted at by staff and had not received appropriate care overnight to manage their continence needs. Two people told us they were too scared to report concerns to the management team. We shared this information with the registered provider. When we returned to the service for the second visit we found the provider had taken some actions to investigate the concerns.

The failure to act to take actions to protect people from abuse was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not always reduced because staff did not understood people's health and welfare needs and what actions they needed to take to keep individual people safe. Risk assessments were not always in place to support staff to understand and support people with their health. For example, four people living at the service had diabetes. Only one of these four people had a clear and individual protocol for managing their condition.
We saw a care file for a person who needed to take insulin to maintain good health and stable blood sugars. There was no personalised risk assessment in place to detail the risks associated with this condition, such as low or high blood sugars, or their impact on the person. There was no detailed care plan explaining how the person's blood sugar levels were being managed.

This person administered their own insulin injection, observed by staff. The service's policy for the management of diabetes indicated the ideal range for people's blood glucose levels was between 6 and 10mmol. There was no individualised plan for this person as to what was a safe level for them. The records for the person's blood glucose levels for the eight day's preceding our visit showed that on only three out of the 15 occasions the levels had been within the 'ideal range' as indicated in the overall policy. There was no guidance for staff as to what actions they should take when the person's levels remained high. Staff told us they would refer to the service's policy on the management of diabetes for what actions to take or signs to look for that the person may be having low blood sugars. This meant people may be at risk from a lack of a clear individual assessment of the risks associated with high or low blood glucose levels.

Three people were living with epilepsy, and were receiving medicines to manage any risk of seizures. There were no risk assessments or protocols guiding staff how they should support the person if they experienced a seizure. This left people at risk of receiving poor or inconsistent care. The registered provider told us they knew people well and they had not had any significant seizure activity since being at the service.

Some people living at Westcliff House had behaviours that had previously presented risks to themselves or others. There were not always detailed care and support plans to demonstrate how risks were being reduced or how to manage incidents of concern. One person had detailed plans compiled by an external agency but another person's file did not contain detailed guidance for staff on how to manage any incidents of self harm the person had previously exhibited.

The registered manager told us incidents and accidents were collated and reviewed on an annual basis to ensure any learning happened to prevent a re-occurrence, and any needed actions were taken as a result. However this had not yet been carried out for 2017-2018, and the registered manager could not locate records of previous year's collations. They told us they had sat down with the registered provider and discussed these as a part of their annual review and planning. The registered manager told us they had taken actions to protect people when incidents had been identified. For example they told us they had fitted a stair gate to a staircase as they had identified one person was at risk because of a degenerative eye condition. There was no detailed risk assessment to identify any other risks from the person's eyesight or review as to how they could be kept safe.

Risks to people associated with the environment had not always been assessed or mitigated. We found two windows above ground level did not have window restrictors fitted. This meant people may be at risk of exiting the windows. The provider told us this had been an oversight as new windows had recently been fitted to these rooms. We found water temperatures at taps and baths were delivered at temperatures higher than recommended. This put people at risk from scalding.

Radiators were not covered, which meant people were not being protected from hot surfaces. Some people living at the service were subject to regular falls, and some had been diagnosed with epilepsy. This meant

people could potentially be at risk from falling against hot surfaces and suffering injury from prolonged contact with the hot surface. There had been no detailed risk assessment about this.

Not all areas of the buildings were clean or well maintained. For example, a bathroom on the ground floor in the Sidborough wing, had a mouldy ceiling and mould around the walk in shower bath. An internal shower room on the second floor had no ventilation so smelled damp and had mould in the shower cubicle. There was a wet and soiled upholstered dining chair in the bathroom for people to sit on when they got out of the bath. A staff member told us people only sat on this when it was covered by a towel, but this would not have prevented any potential cross contamination. The lock on the bathroom door was not easy to operate and a member of the inspection team cut their hand on a sharp edge trying to use it. On three occasions we saw people using this bathroom with the door not fully closed.

Some stair carpets were torn and could present a trip hazard. Paper towels and soap was missing from some toilet and shower rooms. This meant people were not able to wash their hands adequately to control risks of infection. The service did not have an infection control risk assessment in place.

The failure to properly assess risks to people from their care or the environment is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our second visit a week later the bathroom had been thoroughly cleaned and redecorated. The soiled seat had been removed. The registered provider told us the lock was on the maintenance list to be addressed. Maintenance staff told us they were carrying out a programme of refurbishment on the premises, which would include redecoration and new carpets.

Systems were in place to ensure staff were recruited safely but these were not always being operated robustly. We looked at three staff files and found one where the person had not supplied a full employment history. The registered manager had not identified this as a concern, or investigated this further. We did not find this had impacted on people's safety, but the failure to carry out a robust assessment of the person's employment history could lead to risks.
The failure to ensure effective recruitment procedures were operated is a failure of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and proper persons employed).
One person felt there were not always enough staff available to support them at certain times. For example, they said there were not always enough staff on at weekends. They said "I would like to go out on a weekend but can't because there is not enough staff to go with me." We discussed this with the registered manager who confirmed there was not always a member of staff who was a 'driver' to take people out at a weekend, but if they were aware in advance people wanted to go out rotas would be changed to enable this to happen.
We looked at how the service managed people's medicines. No one at the service was managing their own medicines. However, some people were being supported with elements of this. For example some people managed their own insulin injections under supervision, and one person would be 'encouraged' to take an inhaler with them when they went away from the service. Protocols were in place for the administration of 'as required' medicines. Medicines were stored safely. Some medicines needed to be stored in a refrigerator. We saw charts were in place for staff to record refrigerator temperatures each day to ensure it remained within the safe range for the storage of medicines.

The medicines were being reviewed regularly by a member of staff who checked to see, for example, where administration signatures were missing. A full medicines audit was last completed in July 2017, although the registered manager had requested one be carried out by the supplying pharmacist. The local authority's quality improvement team (QAIT) had recommended the service have the support of the community

pharmacist to advise and review how medicines were managed.

We recommend that the provider reviews their medicines administration auditing processes to ensure safe medicines storage and administration at all times.

People told us "The staff do my medication for me. If I ask them what they are giving me and why they always tell me" and "I take my meds when they give them to me and I know what it is for." We saw people receiving their medicines without delay when they wanted them.

Information was available for staff on what to do in case of emergencies. The registered manager told us they were available for staff support out of hours, and could discuss with us instances where they had responded to support staff. Information was available on notice boards with emergency numbers and information to be supplied, for example when calling for out of hours emergency medical support. Regular checks were made of fire precautions, and there were suitable arrangements for clinical waste disposal. Each person had an individual evacuation plan in their file.

Requires Improvement

Is the service effective?

Our findings

On our last inspection of the service in January 2017 we had rated this key area as requires improvement. Following the inspection the registered provider sent us an action plan telling us actions they were taking to improve the service. On this inspection we found the actions taken had been partially successful.

On the last inspection the service had been in breach of Regulation 11 Health and Social Care Act 2008 Regulated Activities) Regulations 2014. This was because where people lacked mental capacity the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. We found this regulation remained in breach. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Each person's file contained a general statement as to whether the person had 'capacity to consent to their care'. Other decisions made in people's best interests were not always being recorded.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made no applications for DoLS authorisations, and told us they 'did not restrict anyone's liberty'.

One person's care plan said a staff member had 'escorted' the person back to the service when they had left because they wanted to go to a local shop. The record said they had told the person they "mustn't go out on their own". We spoke with the person who told us "They won't let me go out on the roads. I'm so clumsy. I used to go out – not now - I've got to go with the staff if I want something". Sufficient action had not been taken to lawfully manage this person's need. Staff were acting in the person's best interests, but the lawful basis for escorting the person or refusing to allow them to leave was not clear.

We recommend the provider seeks additional guidance on the principles and application of the Mental Capacity Act 2005.

At the last inspection in January 2017 we had identified concerns that had amounted to a breach of legislation in relation to the training and supervision of staff. On this inspection we found improvements had been made. Staff were receiving regular supervision and had received training to help them carry out their work. The registered manager told us they ensured training was embedded in practice by giving staff regular practice scenarios to talk through. Staff told us they had received the support they needed when they had started working at the service through an induction programme and new staff would be expected to complete the Care Certificate.

There was a training matrix that identified when staff needed updates. Staff told us they felt supported by the management and received regular supervision and appraisals. The matrix did not identify staff had

received training in how to support people living with learning disabilities or mental health needs. However the registered manager told us this was underway and had been completed by all bar two staff. Staff told us they had previous experience of supporting people with mental health needs or learning disabilities and were confident in doing so.
We observed staff working with people during our visits. Staff understood people's needs and could tell us about signs or behaviours that indicated people may be becoming distressed.

We received variable feedback about the food and meals served. Some people told us they really enjoyed the meals, had a good variety and choices. One person said "The meals I think are lovely and if you don't like something you can have an alternative. For example I don't like liver, so I have sausages instead. We get beans on toast or sandwiches for tea. Cereal and toast for breakfast." Another person told us "The meals are good and we have a meeting to change the menu, our most recent request was for us to have more pork which we are now getting."

People were involved in making suggestions about meals served at regular meetings. On the first day of the inspection we looked at the four weekly menu with staff. The meal on the menu planner for that evening was fish fingers. However, staff told us they had changed this to spaghetti hoops on toast as the fish fingers were not being delivered until the next day. People had had beans on toast the previous evening, which meant they had not had much variety. On other days we saw that people were offered a variety of meals, such as sausage pie, salmon, pasties, sausages or beef burgers and chips. A senior staff member told us meals were decided according to the menu planner, but people could choose other options if they wished. It was not clear how this would happen if the menu was changed. People told us they bought snacks of their own choice such as fruit teas, as these were not provided.
We asked people if they could be involved in cooking and preparing of meals but were told by staff, people didn't want to do this. We were told the service catered for diabetic diets, but did not see any adaptation on the meals served. One person was a vegan and told us they had eaten vegetables only for their lunch, followed by fruit. We were told the options were in accordance with their wishes.

No-one at the service was receiving regular support from community nursing services, but people attended their own local GP surgeries for any healthcare needs. People living with long term conditions were monitored and people needing specialist care received this. For example we saw people with diabetes had their feet monitored by a specialist podiatrist. One person told us "Staff will take me to see the GP and hospital. I recently went into hospital and the manager and another resident came to see me." The registered manager told us people were supported well by the community mental health teams.

Westcliff House is comprised of two period buildings. We found some of the accommodation, especially on the Sidborough wing, was looking tired and in need of refurbishment. Accommodation for people was spread over five floors. Some people living at the service were in their eighties and had some sensory loss, including two people with poor vision and one person with a hearing loss. No assessment had been carried out to assess how people, who had sensory impairments, could have their environment improved to increase their independence or maximise their vision.

We recommend the service seeks advice from a reputable source on the adaptation of the existing premises to meet the needs of people with sensory loss or ageing.

People had in many cases personalised their rooms with belongings. The registered provider told us people were involved in choosing the décor of their rooms but, with the exception of one person, people told us they had not been involved. Systems were in place to record maintenance needs, and these minor jobs were 'signed off' as they were competed.

The registered provider told us they were carrying out improvements on the environment this year. They were unable to provide us with a schedule or plan of how and when this would be carried out on our first visit. On our second visit the registered manager, who had not been present on the first day was able to show us a schedule for improvements.

Requires Improvement

Is the service caring?

Our findings

On our last inspection of the service in January 2017 we had rated this key area as good. On this inspection we saw many instances of staff being caring towards people and positive relationships in place. However we also saw instances where people's privacy or dignity was compromised.

People told us they felt well supported by the home and the staff. People said "Yes they are very kind, I can't fault them" and "All staff here are kind to you." However, one person told us they did not feel they were always treated with respect with regard to managing a continence issue.
People's privacy was not always respected. People told us staff knocked on their doors before entering their rooms. However during our visits we saw on three occasions people using a central shower/bathroom in the Sidborough wing without the door fully closed. We also saw there had been a long term tolerance from the staff and management of one person removing items of clothing without taking action to protect their dignity. Following our first visit the registered provider had given the person new trousers, which had substantially reduced the person's removal of clothing.
The failure to ensure people were treated with dignity and respect is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and Respect).
Staff supported people to manage their own personal hygiene and increase their independence, but this was not always completely successful. We saw several people did not appear well groomed. Some people had poorly fitting or stained clothing, were unshaven or had unwashed hair. The registered manager told us how they had been working with another agency to support one person with their personal hygiene as there had been concerns expressed external to the service. One person told us "They help wash my hair and they observe me whilst I am doing my personal care. They also encourage me to strip my bed and make it up." For other people their individual style in personal clothing was acknowledged and embraced as part of their personality.

Records were written in ways that demonstrated respect for the person. People had opportunities to make changes at the service. One person told us "We have meetings and we can talk about anything we want changed. We decide what we would like for the next month." The registered manager told us their door was always open for people to come and talk to them. The registered provider told us people lived very much as a family.

We saw staff supporting people with patience and a caring attitude when they were distressed. We saw a staff member speaking with a person who was expressing concerns over some new medicines they were taking. The staff member explained to the person it was 'early days' with regard to the medicines being effective, and reminded the person the reasons the medicines had been changed, namely helping the person to sleep better at night. The person acknowledged this was improving. Staff spoke about people they supported with affection and compassion. They told us "We strive to give our best to everyone."

During the day we saw evidence of a relaxed and comfortable service. People came down for the breakfasts and medicines when they wished and were able. We saw people eating their meals in the Roborough wing. The meals were a social event which people chose to attend, even people who had kitchen facilities in their

own flats and who could prepare their own meals if they wished. People were sharing Easter eggs they had been given prior to the Easter weekend, and there was general good humoured chat and teasing.

A visitor told us they were welcome to visit the service, and we heard about arrangements and support people received to maintain contact with family and friends. This included people being supported to maintain friendships. For example one person had developed a friendship with someone outside of the service and helped walk their dog regularly. Other people liked to sit outside the front of the service and engage with passers-by. We saw people speaking with a passer-by and their dog during the inspection.

No-one at the service was involved in mental health self-help groups or networks, or had formal advocacy arrangements in place at the time of the inspection visits, however some had done so in the past.

Requires Improvement

Is the service responsive?

Our findings

On our last inspection of Westcliff House in January 2017 we had rated this key area as requiring improvement. This was because we had identified a lack of clear care planning and guidance, in particular when people were presenting difficult to support behaviours or high anxiety. Following that inspection the service told us they had implemented a new system for care planning and had been working with the local authority's quality improvement team to make the changes needed.

At this inspection we found the changes made had not been sufficient to ensure the care plans always contained the levels of detail required, and the key area was again rated as requires improvement.

People's care plans did not always reflect a person centred approach, or follow the principles of positive behavioural support when supporting people living with a learning disability. Plans did not focus on identifying people's goals or strengths or how to meet any aspirations they may have, including increasing independence. Some needs assessments or plans relating to physical conditions were not completed in sufficient detail for staff to understand what actions to take for that person, for example with the monitoring of blood glucose levels.

When people displayed behaviours that others might find distressing there was not consistent clear guidance for staff to follow. For example, for the person who removed their clothing there was no guidance for staff about how to best support the person, what actions they needed to take to help reduce this behaviour or how staff might support them to retain their dignity.
The service's management told us people were always involved in the development of their care plans, although they did not all want to have a copy of this themselves.
People's support plans did not contain details of hobbies and interests and how people could be supported to follow these. The registered provider and registered manager told us people living at the service followed their own activities, although some were provided in house.
Some of the people living in the Sidborough wing were much more dependent on activities arranged by the service. Staff and the registered provider told us sometimes people were hard to motivate to do things. The registered provider told us they provided art and craft activities on a Tuesday afternoon and a weekly exercise class. During the inspection we did not see people in this wing engaged in activities. When we asked how they spent their time people told us, "I watch horror movies", "I go out walking and also to charity shops and pick up watches that need repairing…I do watch TV but I love to listen to music" and "I take part in art therapy, but otherwise I please myself what I do such as colouring, word search." One person told us "they had a nap in the afternoon as "we haven't got anything to do. I used to like puzzles. I don't do them anymore." During both afternoons we found people asleep in the lounges in the Sidborough wing or smoking at the front of the home for much of the afternoon without much staff stimulation or contact.

The failure to design a plan of care and treatment for each person to meet their assessed needs is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We also saw some good practice in relation to care planning. Some people living at Westcliff House had

been living there for over 35 years. One person told us "Yes, I have been here donkeys years now, so I'm head boy." A senior staff member told us when they had been compiling the new care plans they had tried to include the information they knew about the person in the most up to date assessments. Most of the files we saw had a clear personal history, including incidents and places they had lived, and the impact of some poor or institutional care people had received. This included for some people information about negative experiences of other services and healthcare provision. This helped ensure staff could have a good understanding of the person and why perhaps they were reluctant to re-connect with some services or might feel fear or anxiety.
Other care plans contained detailed information, for example one person had a long history of self-harming behaviours. The person had an agreement with the service that if they self-harmed they would ask staff for an ambulance or to see a doctor. The person had not self-harmed since being at the service. Another person had a clear structure to their day to help them manage anxiety or repetitive concerns. They had a refocusing plan in their file which showed they were to have regular times each day set aside to discuss any worries they had. The person told us this was followed and it helped them.
Staff knew people and their wishes well. A staff member described one person they had been supporting that day. They told us one person was "not a morning person" so they knew to avoid too many choices or information for them at that time of day. They said "As the day progresses their mood changes. We have to deal with each person differently."

People's communication needs were met. The service was complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We were told only one person at the service had communication difficulties, in that they could not read or write, and that another had a hearing impairment. The registered provider told us they used short sentences of simple construction and had picture cards to support communication. There was no technology in use to assist people with communication or activities of daily living.

Some of the people living in the Roborough wing were largely independent and 'very active in the local community'; they had bus passes and were able to get transport from directly opposite the service into Dawlish or other local towns to go shopping or meet with others. One person attended a local group and charity shops and others went to a local day centre in Teignmouth.

Another person had beautifully maintained the gardens at the front of the home, with each plant tended and labelled. They told us the registered manager had offered to get them an allotment but they said they did not want this. However, they also had worked at a local garden centre and project.

Systems were available within the service to support people to raise any concerns or complaints that they had. Easy read information was on display to support people living in the home to raise any concerns. We saw where concerns had been raised they had been recorded in a book, but there was not a detailed response explaining what actions were taken and how this was in line with the service's complaints process.

The registered manager told us all of the people living at the service would be able to raise a concern, and a relative told us their relation would also be able to tell them if they were unhappy about anything. The service had supported people to raise concerns about treatment they had experienced, which demonstrated good practice. Evidence of this could be seen in the 'complaints book'. However people told us they were not all sure of what they would do to raise a complaint. Some people told us "I have never made a complaint, but I know how to make one. I would go to the manager or owner in the first place". But others said "I don't know how to make a complaint", "I don't bother" or "I would not know what to do but I would be afraid to complain as I am afraid of what they would do". We discussed this with the registered

provider. On the second day they told us they had spoken with the person and begun looking into their concern.

We recommend the registered persons ensure people understand how to raise a complaint within the service without a fear of recriminations.

Nobody at the service was receiving end-of-life care. One person who had experienced the care shown to a relation, who had died at the service, had said how well this had been managed. The person told us "I haven't made a will, but I have asked them to make sure no-one tries resuscitation."

Inadequate

Is the service well-led?

Our findings

At our last inspection of the service in January 2017 we had rated this key area as good. At that inspection the service had been in breach of three regulations of the Health and Social Care Act 2014. These were in relation to acting in accordance with the Mental Capacity Act (Regulation 11), Good Governance (Regulation 17), and Staff training and support (Regulation 18).

On this inspection we found the service had taken action to meet the breach of Regulation 18 regarding staff training, but remained in breach of Regulations 17. In addition we identified breaches of Regulation 9 (person centred care), 10 (dignity and respect), 12 (safe care and treatment), 13 (safeguarding), and 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have also made a number of recommendations.

We found the previous good rating had not been sustained and we have rated this key question as Inadequate.

We found the service was not always well led, and we identified a number of new concerns on this inspection that had not been identified in the service's own quality assurance systems. The service had not taken sufficient action to address all the previous breaches of legislation. The service was not always following their own policies and procedures in practice and had not regularly taken actions to assess the quality and safety of the services provided, including regular audits. Risks to people from their care or the environment were not always being fully assessed or mitigated.

Although we did not identify people had come to harm as a result and swift action was taken to address some of the concerns such as the cleanliness of the bathroom, the failure of the services own quality assurance systems to identify or address the issues did not give us confidence they were operating effectively or were robust.

In their PIR the registered manager told us they ensured the service was well led "By acting on feedback both positive and negative". The Quality team from the local authority had visited the service since the last inspection and had created a service improvement plan. The last report of this plan completed on 29 November 2017 had confirmed some care plans were still lacking in detail and advised the registered provider and manager of the need to ensure this was achieved. We found this still to be the case.

Records were not always clearly completed or accurate. Since the last inspection the service had purchased a new computerised records management system. We saw this was available on both paper copy in the office and on the service's computer. However when we reviewed the policies we saw they had not always been acted upon or were not a reflection of the service provided. For example the accommodation standards policy and procedure stated "A written assessment (audit) of the premises will be undertaken … and an action plan prepared to cover any development needs. The audit will cover accommodation standards, and specialist residents needs such as loop systems and large print signs". This had not been carried out.

On second day of this inspection we found the daily records for the person who had removed their clothing twice on the first day of our visit had not mentioned either incident or one the registered provider told us had occurred the following day. The incidents had not been reflected in an updated plan of care for the person, despite having been raised with the registered provider.

People could not always be assured of safe or high quality care because audits in place to assess the quality and safety of services had not always identified issues. Risk assessments such as those relating to people's care needs, had not been updated. People were not always treated with dignity and respect. There were no effective audits in place to cover areas such as infection control risks and the full medicines audit had not been carried out since July 2017. Incidents and accident analysis was not sufficiently frequent to ensure any trends would be identified in a timely way. Accurate records were not always being maintained of people's care and treatment.

Westcliff House provides a service for people living with learning disabilities or longer term mental health needs. The service was not always operating in ways that reflected best practice and guidance when supporting people with these needs. For example care plans were not written in line with person centred planning principles or using positive behavioural support principles. Plans were not written in ways that reflected people's goals or aspirations. People were not always being encouraged to increase their independence, learn new skills, such as meal preparation or experience greater social inclusion. Where guidance on best practice had been provided to the service it had not always been followed. For example, the local authority QAIT had recommended the service "Implement a structured programme of quality improvement including regular monitoring audits and feedback". This had not been fully implemented, and the service improvement plan had not been completed.

The failure to establish and operate effective systems to assess monitor and improve safety; assess, monitor and mitigate risks and maintain accurate records was a breach of Regulation 17 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to give their views about how well the service was working and what could be improved through regular questionnaires. These were being collated, but we could not see evidence of how these were completed the previous year or what actions had been taken as a result. People told us "They do ask for our views and if I have something to say I feel they listen to me and will help make changes if necessary." and "They do ask for your views and they do listen to you."

People told us they felt the service was well led and were positive about their support. They said "I think the service is well led and managed. We have meetings regularly and can talk about anything we want changing", "They ask for feedback" and "I can talk to the managers when they are not busy. This is the best home I have ever been in."

Westcliff House had been developed and designed prior to Building the Right Support and Registering the Right Support guidance being published. These set values and principles for services supporting people living with learning disabilities, ensuring services are designed to ensure people live as ordinary a life as any citizen. Services achieve this by promoting enablement, independence, choice and inclusion. We have asked Westcliff House to consider how they meet and can continue to meet these values including through person-centred care and ensuring people have easy access and inclusion with the local community.

The registered provider and manager told us they felt the service was operated like a supportive 'family', that they were regularly available on the premises and 'their door was always open.' They said the service clearly worked well for many people because they were living active lives. In previous services some of these

people had lived disordered lives with self-harm or risky behaviours they no longer experienced. People gave us positive feedback about the registered manager. They said, "You can talk to the manager and he is reasonably fair. In fact he is the best manager we have had here." This view was offered by several other people we spoke with.

Staff told us they enjoyed working at the service, worked well as a team and understood their roles. They had regular team meetings and confirmed they had the training and support they needed.

The registered manager told us they took advantage of the internet and CQC website to enhance their knowledge. They had also attended local manager forums but had not done so for some time. The registered manager was not fully aware of changes made to the key lines of enquiry the Care Quality Commission (CQC) used to assess services in November 2017. They had also only recently been aware of changes to CQC standards for example with regard to accessible information but received information and updates from other agencies, such as the Food Standards Agency. The service had been given a five out of five rating at their recent inspection for food hygiene.

The service had notified the CQC of events they were required to do by law, called notifications. This helps ensure there is oversight of any issues or concerns by external agencies.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider has failed to design a plan of care and treatment for each person to meet their assessed needs. People's care plans did not always reflect a person centred approach, or followed the principles of positive behavioural support when supporting people living with a learning disability.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that at all times people were treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to properly assess risks to people from their care or the environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured systems in place were effectively protecting people from abuse.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems to assess monitor and improve safety; assess, monitor and mitigate risks and maintain accurate records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effectively safe systems for the recruitment of staff