Nottinghamshire County Council

Quality Monitoring Audit Form

Westdale

Residential Care Home

Home Name:	Westdale Residential Care Home		
Manager: (Are they registered with the CQC?)	Stuart Malcolm Best (CQC Registered)		
Provider:	Westdale Quaker Housing Association Limited		
Type of Service:	Residential		
Home Address:	129, Melton Road, West Bridgford, Nottingham, NG2 6FG Telephone no: 0115 9233128		
Email Address:	stuart.best@westdalecare.com		
Date of Audit:	11 October 2023		
Band:	5	Previous Band:	5
Score:	53/57	Action Plan Required?	No

Key:	**Excellent**	**Good**
	Improvement Required	**Does Not Meet**

Standard One: People who use the service experience outcome focussed person centred care: People who receive a care service receives outcome focussed person-centred care, which considers their choices and preferences. Care is provided in a positive risk-taking environment, which supports people to make decisions regarding their care.

1.1 Each service user has a personalised support plan which identifies patterns of daily living. Service users and / or families / advocates are involved in the process and are able to contribute their views.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. Care Plans are now electronic. We looked at a sample of care plans [5]. For example, Initial assessment of needs, Likes, dislikes, preferences, physical, social and wellbeing information. We spoke with residents regarding the care they received. They said, “I feel so supported by the manager and care staff” “They make me feel very special”. One resident said, “The kindness I receive from all of them is wonderful” and “I have been unwell recently, they have done lots to make me feel better” and “My own personal needs are catered for here” and “It’s a lovely, clean and homely place to live” and “We are all safe and in good hands with these people” and “We have been choosing paint for the walls in the corridor” and “We are all a happy family together and long may it continue”. Of the care plans we looked at [5] we found that each resident had a personalised plan of care. We found that care plans had been reviewed within appropriate timescales. Records seen show that wherever possible the care staff obtain consent from the residents. For example, medication, continence care and personal care needs. Life histories are compiled and used. This means each resident has a personalised assessment and care plan that identifies, through inclusion, the patterns of daily living in relation to their assessed needs, individual’s wishes, choices, goals and sets out how the support, care and treatment is delivered.

1.2 Care / support plans include identified areas of risk and details how these will be managed and are reviewed, supporting service users to make informed choices.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process for 2023/2024. We spoke with residents regarding choices they were given by staff. They said, “The staff consider our needs everyday”. Of the completed risk assessments, we looked at [5] we found that these were being completed appropriately and are being reviewed within acceptable timeframes. An example of risk assessments having been completed is for the use of equipment. We found these are reviewed monthly and sooner if required. We found on observation that these risk assessments are working as expected. We looked at training records and statistics and found care staff do have access to training and have a good understanding with assessing and identifying risks and the importance of keeping residents safe. This means care plans include identified areas of risk and detail how these will be managed. They are reviewed within appropriate timescales. The staffing team have received training to understand, assess and manage risks.

1.3 Accurate records relating to service users are completed in a timely way and stored in a safe place.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with a resident regarding their involvement in their care and support. One resident said, “I have a care plan and we update this together” and “The staff do talk to me about my care needs, choices and wishes”. We looked at daily records regarding what residents were involved in each day. We found that these records were relatively detailed. One resident told us they do go out of the home to the shops and the staff ensure the resident has everything they need before departure. The resident said, “I have a mobile phone if I need to call them”. We found that if residents did lack the capacity to make certain decisions, the Mental Capacity Act 2005 (MCA) would be implemented. We found that all residents care plans and documentation is stored away safely when not in use. The staff we spoke with had a good understanding and knowledge of confidentially and records seen evidence the staffing team have completed General data protection regulation (GDPR) training. This means residents are telling us they are involved in the care planning process and can contribute their views, opinions and wishes. Confidentiality regarding protecting resident’s personal details are upheld.

1.4. Service users are afforded a choice of suitable nutritious food and in sufficient amounts in accordance with their identified needs and wishes.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with residents regarding the quality and choice of food. They said, “The meals are good, and we get plenty” and “We have a nice choice each day”. We observed the lunchtime meal and found this was a very sociable and friendly experience. Staff were seen assisting residents where needed. We found the staff to be kind and respectful with residents and responded in a timely manner to residents needs and wants. The meals being offered look nice and were presented well. For example, all the vegetables are in serving dishes and residents can help themselves independently and we found staff will support residents as and when needed. We found Nutritional assessments had been completed where required. We looked at the training records and found staff have completed any relevant training. For example, hydration and nutrition. We spoke with staff, and they provided us with records and information to support residents likes, dislikes, preferences, special dietary needs, and any allergies. We spoke with the team leader supporting us at the time of this visit and have agreed to forward details and link access to IDDSI modified diets training. We found the dietician and SALT team are involved as required. New cook is being recruited. Kitchen staff have a good understanding and knowledge of all resident’s nutrition requirements. Fluid intake for residents is monitored and evaluated. This means residents are afforded a choice of suitable nutritious food and in enough amounts for their needs in accordance with their identified needs and wishes. Relevant professionals are involved where required. Fluids (intake) are monitored, and appropriate action taken if required. IDDSI training link to be forwarded to the management at the home.

1.5. Service users are supported with dignity through individual stages of life, by staff respecting their choices and preferences.		
Score	**Recommendations:**	**Observed Evidence**
Good	Continue to ensure care plans contain information and details about resident's end of life care needs (last wishes and preferences).	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at [5] care plans and found some care plans that documented person-centred end of life care specifics. They included consideration of the residents' preferences and wishes regarding care, support, and treatment. We also found care plans that required more detail. We found care plans contained completed RESPECT forms. We looked at the care plan for one resident who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. We found this had been completed appropriately and was in line with the MCA requirements. We looked at the associated care plan and found this had been documented. We saw the resident had been included in the decision regarding the DNACPR. Staff have received end of life care (EOLC) training. This means residents are mostly supported with dignity through individual stages of life, by staff respecting their choices and preferences. Staff have received end of life care and dignity training.

Standard Two: Keeping People Safe: People are protected from abuse or the risk of abuse, including financial abuse and the safe handling of their medication. People are supported and needs are met in line with MCA and DoLs / DoLiC requirements.

2.1 Service users are protected from abuse or risk of abuse. Their human rights are upheld through the effective operation of safeguarding arrangements. These identify and prevent abuse and are responded to appropriately.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at the safeguarding procedures and found this to be detailed and included the contact details for Nottinghamshire County Council's adult safeguarding team (MASH). We spoke with staff regarding their understanding of adult safeguarding and found they knew what abuse is and how to report this, using the local reporting requirements. We looked at the training records and found staff had completed safeguarding training. We looked at the safeguarding folder which contained the safeguarding information for all referrals, investigation outcomes. We found this folder to be well organised, divided into sections (for easy use) and indexed. On discussion with the team leader, they were able to provide a good knowledge and understanding of the safeguarding pathway and referral procedures for safeguarding. We saw evidence to support the providers contact with the Care quality commission (CQC) in the event of a safeguarding referral being submitted. This means residents are protected from abuse or risk of abuse. Staff have completed the training they require regarding safeguarding procedures.

2.2 Where the service user lacks capacity to make decisions, the requirements of the Mental Capacity Act 2005 are met.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at a sample of care plans and found if people lacked the capacity around their care and treatment staff are aware of the assessment process. We found most of the residents who reside at this service have full capacity to make decisions independently. However, we found where MCA/BI assessments are required these are completed and reviewed. We looked at staff training records and found that staff had received Mental capacity act (MCA) training. Refresher training is arranged and completed by the staffing. This means the requirements of the mental capacity act (MCA) are met. Staff have received the appropriate training.

2.3 Service users are protected and supported to live with the least restrictions to their liberties. Where the service user is subject to restrictions and restraint, they must be authorised under the Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty in Community referred to in Nottinghamshire as (DoLiC).		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. Records seen show that any DoLs referrals have been submitted and have been and are being managed appropriately. For example, any conditions are looked at and transferred and used in the respective care plan for the resident. Any actions are addressed. Statutory notifications are completed and forwarded to the Care quality commission (CQC). DoLs file in place and a matrix has been compiled and updated when needed. Training records seen show that the staffing team have received DoLs training. This means the requirements of Deprivation of Liberty Safeguards (DoLs) are met. Staff have received Deprivation of liberty safeguards (DoLS) training.

2.4 Service users are protected from financial or material abuse.

Score	Recommendations:	Observed Evidence
Good	Note: to purchase a duplicate receipt book and to ensure all people depositing money with the provider receives a receipt to support and evidence the transaction having taken place which safeguards all involved in this process.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with the operations co-ordinator about resident finances (weekly personal allowances). They told us they do hold some money for residents. We looked at a sample of these (evidence obtained for reference and all in good order). We asked the operations co-ordinator if they hold any residents credit, debit or bank cards and PIN numbers and they told us they don't hold any. Receipts are provided and obtained for purchases. However, not for deposits of money from relatives to top up money floats. It was agreed that a duplicate receipt book is purchased and used when relatives provide money to top up money floats. The operations co-ordinator and the team leader said they would discuss this with the manager on their return from leave. We found all money is locked away safely in a robust secure metal safe. We looked and found the residents small money floats held at the care home are audited regularly. This means that residents are mostly protected from possible financial abuse. Management to obtain a duplicate receipt book and for people who deposit cash/money are given a receipt which supports the transaction taking place.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We did not speak with residents or relatives about medication. We requested that the provider show us their medication policies and procedures, they complied with our request. This also included policies regarding the administration of covert medication. We looked at the care plans for [5] residents and found that these included considerations of their medication. We saw that where changes in medication had been made, care plans were updated accordingly. We found care plans described how residents preferred to receive their medication, and our observations demonstrated this to be true. We were told none of the residents are receiving their medication covertly. We looked at the storage of medicines and found that this was in line with the provider's policies and procedures. We saw a medication trolley used and are secured to a wall in the treatment room, when not in use. We saw there was a daily record of medication fridge and clinic room temperature measurements, and these were in line with best practice guidelines. All temperature charts seen were in good order. The clinic room has an air-conditioning unit (which was on at the time of this visit). We looked at the system for ordering residents' medicines. We found the system ensured there was enough quantities in stock to meet individual

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residents' needs and in line with their prescriptions. We looked at the homely remedies and found these were being managed appropriately and safely and in line with the provider's procedures.

We looked at the system used for the disposing of medicines, and found the records matched the quantities of medicines held awaiting return. We spoke with staff and their description of the process for returning medicines matched the provider's policies and procedures. We looked at the medication administration records (MAR) for [5] residents. We found that records of medicines being administered matched those identified in in the care plans. No signature gaps evident for the ones we looked at.

We saw where medicines were not administered; the records indicated the reasons for this. Our observations of staff during the medication round found that they were administering medicines safely and in line with prescribing instructions. We found residents were informed by staff of what was happening prior to administration and we saw that staff ensured the medication trolley was locked and safe when not being attended.

We saw where residents have been identified as requiring their medicines 'as and when required' or PRN; we found these to be managed appropriately. Our discussions with staff assured us they understood the provider's policies and procedures in this area. We looked at the residents' care plans and found that reviews of PRN protocols are in place. We saw that records of resident's prescriptions were kept, and a current copy of the British National Formula (BNF) was accessible.

We found some residents are currently on controlled medication (Controlled Drugs CD). We checked a sample and records and counts matched. We found systems in place for the safe disposal of controlled drugs. We spoke with staff regarding their understanding of how to administer and safely dispose of controlled drugs.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.		
		We looked at the provider's records of training and found that staff had received recent training in the safe handling of medicines. We saw that prior to staff undertaking medication administration, their competency is checked (evidence obtained for reference). We saw copies of completed medication audit documentation that had been completed and any actions required are addressed. We looked at a sample of medication cream dispensers and tubes and we found these had a date of opening and discard recorded on them. This means that there are systems in place to manage, store, administer and document resident's medication to ensure residents are protected and kept safe. Medication fridge and medication room temperature documentation is in good order. Staff medication training and competencies are up to date. The clinic room is kept clean and tidy.

Standard Three: People who use services are supported by competent staff: People are supported and cared for by sufficient numbers of staff who are suitably recruited and sufficiently inducted and trained to provide them with the knowledge, skills and experience to be competent and professional.

3.1 Robust recruitment processes are completed with structured probation, supervision and appraisal arrangements in place for staff in line with Policies and Procedures

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at a sample of staffing files [6] and we found that all appropriate checks have been completed. For example, obtaining 4 forms of identification, Disclosure barring service (DBS) checks. We found completed copies of staff induction programmes. Also, references from past employers. There are identification photographs on the staffing files. We spoke with care staff, and they told us they do feel supported by the management. We spoke with the Team leader and the Operations Co-ordinator about supervision and appraisals for the staffing team. Asking how they provide support. They told us they received formal supervision every 2 months. We looked at supervision records [4]. We found that the timescales for completion of supervision sessions is approximately every 2 months. We found that staff do receive an annual appraisal. We also found that staff meetings are held on a regular basis. Care staff told us the management have an open-door policy, so they can speak with a member of the management as and when needed. During our visit to this service, we saw evidence to suggest the open-door policy works well. This means structured supervision and appraisal arrangements are in place for staff. Staff meetings are held. Supervision and appraisal matrix completed. Staff can meet with the management when they wish (the management has an open-door policy).

3.2 Staff have the knowledge, experience, qualifications and skills to support the service users.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure staff receive refresher training updates. For example, Mental Capacity Act (MCA) training. Note: It would be beneficial for all staff to receive the Oliver McGowan training. QCO: DM has forwarded by e-mail the link for this training to the management of this home.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024 We observed staff supporting residents to remain independent and maintained their dignity. Our observations of staff interactions with residents showed us that staff were confident and competent, friendly, and respectful. Training statistics seen show that the staffing team receive training. However, there is training that some staff members require, or need to refresh their knowledge and understanding (evidence obtained for reference). Examples, This means residents can be assured that the staff members delivering their care has all the relevant knowledge and experience they need to provide safe care. A review of staff training is required to ensure all refresher training is received in some areas. Staff to complete the Oliver McGowan training is advisable.

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with staff regarding the staffing levels during day, night and weekend and they told us that they feel there are enough staff on duty and if anyone is off sick or on leave, there are enough staff to cover any shortfalls. We looked at the staff rotas for [4] weeks and found the named staff identified to be on shift at the time of this visit were on duty. Our observations found there were sufficient staff. We didn't observe staff rushing around or residents being left unattended for long periods of time. We looked at how staff were deployed around the care home and found they were well distributed. We found activities were planned and the staff were available to facilitate these activities. We found that activities were an important part of care delivery. Dependencies for the assessed needs of each resident are considered and used to inform the staffing hours needed. This means staffing levels for the service are determined and deployed according to people's assessed needs.

Standard Four: Services are managed effectively: People receive high quality care through an effectively managed service. The provider/manager takes responsibility, is accountable for their actions, and has an effective system for identifying, assessing and monitoring the quality of the service provision.

4.1 People receive high quality care through an effectively managed service.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at the provider's CQC registration and found that care was delivered in line with the registered regulated activities. We found that the home manager was registered with CQC. We looked at the provider's statement of purpose and found that the registered manager has a wealth of experience relating to the Care of Older People and has a passion for good quality care. The staff we spoke with told us that they felt supported by the registered manager. They told us the manager has an open-door policy and is an approachable person. Business continuity plan (BCB) in place. This means the service and the manager is registered with the care quality commission (CQC). A business continuity plan is in place and updated as needed.

4.2 There is an effective system for identifying, assessing, monitoring the quality of service delivery.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure an evaluation of results is completed following the outcome from the questionnaire surveys.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We asked the provider to comment on how residents are consulted about the running of the service. They told us that service users contributed their opinions through the Quality assessment questionnaires which are completed. Records seen show that these surveys are completed. We also saw that a full auditing process is in place. For example, medication audit, Infection prevention and control audit and Health and safety audit. We saw the completed annual quality assurance assessment surveys for 2023 have commenced. However, there is no evaluation completed following the outcomes from the areas measured. We did see some completed documents relating to the questionnaires with favourable comments from people who participated. We also obtained several e-mails and letters commending the management and staff at Westdale care home for the care and service provided (evidence obtained for reference). This means there is a system for identifying, assessing, monitoring the quality of the service delivery and risks to health, welfare, and safety of residents. Quality assurance questionnaire surveys are completed. A written annual evaluation of findings is needed.

4.3 There is an effective system for identifying, receiving, handling and responding to and learning from complaints and concerns raised.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with the senior staff regarding how they used complaints to improve care practices. They told us we speak with staff and put measures in place to rectify the situation. We looked at supervision documentation and found this to be true. We saw the complaints policy and procedure displayed in the home. We looked at the complaints file and found this to be well organised and the records/documentation relating to any complaints. The provider has a whistleblowing policy in place. The staff we spoke with told us they had received a copy of this. Told they haven't had any recent complaints. One resident told us if they were unhappy about any aspects of care and service, they felt they could speak with the management and/or their relative for support. This means there is an effective system for identifying, receiving, handling, and responding to and learning from complaints.

4.4 How is technology used to enhance the delivery of effective care and support?		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with staff [3] and they told us they use an electronic system for the completion of resident's care plans. Computers are available for residents to use for sending emails and accessing the internet. We saw evidence to support this. We asked senior whether they use any technology. They told us residents use Skype/Zoom and FaceTime for contacting relatives, family, and friends if they wish too. We were told that I-pads are used. The home has an electronic call bell system in place. We found some residents have their own mobile phones they can use. This means residents do have access to technology as and when needed.

Standard Five: Environment is safe and homely: People live in an environment which is clean, safe and personalised.

5.1 The accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. There are effective cleaning and maintenance schedules in place which ensure suitable standards of living are maintained.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with [2] residents and they told us they liked the care home. One resident said, “My room is kept clean and tidy by the carers”. We looked around the care home, at communal spaces, residents’ rooms, bathrooms, and toilets. We found the premises to be maintained to a good standard. The premises were appropriately laid out for the care and support being carried out. We found the premises were fit for purpose. We looked at the exterior and grounds of the care home and found these were well maintained. We saw there were sufficient bathrooms, toilets, communal space, and storage space for the residents to use and to store equipment. The care home smelt fresh. The resident’s rooms [6] we saw, we found them to be personalised and to the individual’s preferences. One resident told us they had things in their room from their own home. For example, furniture. The home environment looked safe. We were told a redecoration programme has commenced. We saw evidence of this. This means the accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. Fire risk assessment and Legionella in place and updated.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at systems in place and found Is there a system for managing and monitoring health and safety within the service. We found staff adequately were informed and educated about general health and safety and infection control policies, procedures, and government guidance within the home, and this also includes Coronavirus (Cvd19). We checked the training completed by staff and found staff had completed training in these areas. For example, Infection prevention and control (IPC), COSHH and RIDDOR training and training about Coronavirus (Cvd19). We were told by the management that they keep in close contact with the NHS Infection prevention and control team and Public Health England (PHE). Records seen support this. We saw staff wearing Personal protective equipment (PPE) appropriately. We found the provider has a good stock of PPE. We looked at equipment and found these had been regularly checked and maintained. Staff are aware of how to report any maintenance issues. We found where issues are identified all measures are followed to rectify them with clear actions documented. We saw records regarding the completion of Infection prevention and control (IPC) audits and action plans are generated when required. This means there are systems in place to help prevent and control of health associated infections. The premises are clean, well maintained and smell pleasant. The staffing team have received the appropriate training. Equipment is well maintained, serviced, and checked regularly.