**MONTHLY MANAGER’S AUDIT**

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| CARE HOME |  |
| FOR THE PERIOD |  |
| COMPLETED BY and POSITION |  |
| DATE COMPLETED |  |

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|  | **Continuous Improvement Plan** | | | | | |
| **Date of Action** | **Action Identified** | **Responsible person** | **Completion date** | **Progress Notes** | **Lessons learnt and sustainability plan – diarised checks?** | **Status** |
| SECTION 1 – CARE PRACTICES | | | | | | |
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| SECTION 2 - SAFEGUARDING | | | | | | |
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| SECTION 3 – ADMISSIONS/DISCHARGES | | | | | | |
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| SECTION 4 – HR & TRAINING | | | | | | |
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| SECTION 5 - ENVIRONMENT | | | | | | |
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| SECTION 6 - EQUIPMENT | | | | | | |
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| SECTION 7 – HEALTH & SAFETY | | | | | | |
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| SECTION 8 – COMPLIMENTS & COMPLAINTS | | | | | | |
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| SECTION 9 – ACTIVITIES & MEALTIMES | | | | | | |
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| SECTION 10 – REGULATORY COMPLIANCE | | | | | | |
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Section 1 - Care Practices

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| **PRESSURE SORES – (CQC to be informed for a grade 3 or above)** | | | | | | |
| **Residents Name** | **Grade** | **Where did it start** | **Is there a care plan in place and has the risk assessment been reviewed** | **Are dressings being changed as required** | **Is the Tissue Viability Nurse**  **involved** | **Have CQC been informed** |
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| NUMBER OF **NEW** NOTIFICATIONS TO CQC FOR PRESSURE SORES: | | | | | | |
| NUMBER OF GRADE 3 PRESSURE SORES (Or Above): | | | | | | |
| **Comments** | | | | | | |

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| **WEIGHT MANAGEMENT (Residents with a MUST SCORE of 2 or above)** | | | | | | |
| **Residents Name** | **Must Score** | **Current Weight** | **Are weekly weights being conducted and are all food and fluid charts being completed** | **Is the resident under the care of the dietician/nutrition team** | **Is there a care plan in place and has the risk assessment?**  **been reviewed** | **Has there been a weight loss or a weight gain since the last**  **audit** |
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| **Number** of residents with weight change of 3kg: | | | | | | |
| **Number** of residents at HIGH Nutritional Risk: | | | | | | |
| How Many Residents taking Nutritional Supplements? | | | | | | |
| **Comments** | | | | | | |

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| **END OF LIFE CARE** | | | |
| **Residents Name** | **Is there a DNAR in place** | **Is there a personalised Care Plan for the last days of**  **Life in place (if applicable)** | **Are the family aware that the resident is End of Life** |
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| **Number** of residents currently on the End of Life Pathway: | | | |
| **NOTES** | | | |

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| **DEPRIVATION OF LIBERTY (DOLS) – list all resident who have an authorised Dols in place** | | | | |
| **Residents Name** | **What date was the Dols authorised** | **When is it due to expire** | **Has a further request been made** | **Have CQC been notified of the authorised Dols** |
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| Number of DoLs applications still awaiting authorisation? | | | | |
| Number of Authorised DoLs in place: | | | | |
| Number of DoLs with conditions: | | | | |
| **Comments** | | | | |

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| **MOVING AND HANDLING** | | |
|  | **Yes** | **No** |
| **Have you witnessed staff using the moving and handling equipment as they should**  (if the answer is yes, please explain below in the comments what you did about it) |  |  |
| **Have you received any reports of staff manually moving and lifting residents** (if the answer is yes, please explain below in the comments what you did about it) |  |  |
| **Is the equipment used to lift and move residents fit for purpose** (if the answer is no,  please explain in the comments below why) |  |  |
| **Are there any resident whose needs are not able to be met safely due to lack of**  **equipment in the home** (if the answer is yes, please explain who and the reason why) |  |  |
| **Comments** | | |

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| **ACCIDENTS & INCIDENTS** | | |
| **Have all accident/incident forms been completed and sent to Head Office** | **YES** | **NO** |
| |  |  |  | | --- | --- | --- | | **Incidents/Accidents** | **Number of incidents/accidents** |  | | **Number of accidents (FALLS)** |  |   **Have any trends been identified?** | | |

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| **MEDICATION** | | |
| **How many medication audits have you conducted since the last**  **Managers Audit (please write below any findings from the audits);** |  | |
| |  | | --- | | **Number of Gaps from Monitoring audit** | | **Number of Medication errors** | | **Number of stock errors** | | **Number of Admin Errors (not GAP)** | |  | |
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| **Gap Monitoring/Errors – Have the staff responsible for the gaps had 1-2-1 sessions to discuss and has this discussion been documented** | **YES** | **NO** |
| **Is the MAR signature sheet updated and a most recent copy sent to**  **Head Office** (show the signatures of staff who administer medication) | **YES** | **NO** |
| **Comments** | | |

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| **How Many Admissions in the last month?** |  | **Number of overdue Care Plan Reviews:** | |  |
| **CARE PLANS – please list below the names of residents whose care plans have been spot checked since the**  **last Managers Audit. Is care plan reflective of current level of care and support?** | | | | |
|  | | | **Significant change to care/risk/support?**  **Yes/No** | |
|  | | | **Significant change to care/risk/support?**  **Yes/No** | |
|  | | | **Significant change to care/risk/support?**  **Yes/No** | |
|  | | | **Significant change to care/risk/support?**  **Yes/No** | |
|  | | | **Significant change to care/risk/support?**  **Yes/No** | |

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| **REFERRALS** | | | | |
| **Have you checked to make sure that referrals have been made for residents to the**  **following;** | | | **YES** | **NO** |
| **Falls Team – numbers of referrals** |  |  |  |  |
| **Tissue Viability Team – number of referrals** |  |  |  |  |
| **Continence Team** | | |  |  |
| **Dietetics Team** | | |  |  |
| **Salt Team** | | |  |  |
| **Diabetes Team** | | |  |  |
| **Other** | | |  |  |
| **Comments** | | | | |
| **HEALTH CARE PROFESSIONALS AND EMERGENCY CALLS** | | | | |
|  | | | **YES** | **NO** |
| **Have there been any instances where staff have not called the GP in a timely manner or when required** | | |  |  |
| **Have there been any instances where staff have not requested the intervention of a District Nurse when required** | | |  |  |
| **Have there been any instances where staff telephoned 111 when 999 should have been called** | | |  |  |
| **How many calls have been made to the out of hours GP since the last Manager’s audit** | | |  | |
| **How many calls have been made to 111 since the last Managers audit** | | |  | |
| **How many calls have been made to 999 since the last Managers audit** | | |  | |
| **How many calls to 111 or 999 have resulted in a hospital admission** | | |  | |
| |  | | --- | | **Total number of A&E attendances** |   **Notes:** | | |  | |
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| **NURSING AND SENIOR CARE PRACTICES** | | | | |
| **Have there been any concerns with infections, outbreaks, MRSA etc?**  **Notes:** | | | **YES** | **NO** |
| **Have there been any issues or concerns with dressings** (if the answer is yes, please explain what these are in the comments section below) | | |  |  |
| **Have there been any issues or concerns regarding catheter care** (if the answer is yes,  please explain what these are in the comments section below) | | |  |  |
| **Have there been any issues or concerns regarding SHARPS** (if the answer is yes, please  explain what these are in the comments section below) | | |  |  |
| **Have there been any issues or concerns regarding PEG feeds** (if the answer is yes,  please explain what these are in the comments section below) | | |  |  |
| **Have there been any issues or concerns regarding Syringe Drivers** (if the answer is yes,  please explain what these are in the comments section below) | | |  |  |
| **Comments** | | | | |

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| **STAFF ENGAGEMENT WITH RESIDENTS** | | |
|  | **YES** | **NO** |
| **Have you witnessed staff speaking politely with residents** |  |  |
| **Have you witnessed staff knocking before entering a resident room** |  |  |
| **Have you witnessed staff standing over residents when assisting with food** |  |  |
| **Have you witnessed staff talking across residents to one another when assisting with an activity or personal care** |  |  |
| **Have you witnessed staff engaging with residents keeping them informed about**  **what is happening whilst assisting with an activity e.g. transfers, bathing, meals** |  |  |
| **Have you witnessed instances of staff unnecessarily restricting residents** |  |  |
| **Have you witnessed staff unreasonably making choices for residents** |  |  |
| **How many staff observations have been conducted since the**  **last Manager’s audit (please attach any new observations with this report)**  **Type of observations carried out;** | Number: | |

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| **NEW ADMISSIONS** | | | |
| **How many new admissions this month? :** | | | |
| **Residents name, room number and admission date** | **Has the residents care plan and charts been generated** | **Are risk assessments, care plans and personal charts up to date** | **Have the resident and/or family been involved in the care planning process and is this evidenced?** |
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| **Comments** | | | |

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| **OTHER** | | |
|  | **YES** | **NO** |
| **Have you identified any issues with Diabetes management** |  |  |
| **Have you identified any issues with Infection Control practices** |  |  |
| **Are fluid/food and spot-checked recording charts completed accurately and consistently** |  |  |
| **Have you identified any other issues surrounding medication; administration, receipt, returns, storage, recording and auditing.** |  |  |
| **Have you identified any issues surrounding**  **handovers** |  |  |
| **Have you checked that keyworker inputs are**  **being completed consistently** |  |  |
| **Comments** | | |
|  | **YES** | **NO** |
| **Are there any further issues that need to be**  **discussed surrounding the standards of care practices** |  |  |

**Action Required**

Section 2 – Safeguarding

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| |  |  | | --- | --- | | Number of Adult Protection Alerts or referrals |  | | Number of open safeguarding referrals at month end |  | | |
| **Have there been any**  **safeguarding’s since the last**  **Managers audit (please list**  **names below)** | **Notes** |
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Section 3 – Admissions/Discharges/Deaths

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|  | **ADMISSIONS (from the 1st – 30th/31st of the month)** | | |  | |
| **Residents Name** | | **Admission Date** | **Room Number** | | **Type of bed admitted into (permanent, respite, Interim, Discharge to Assess** |
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|  | **DEATHS (from the 1st – 30th/31st of the month)** | | |  | | | |
|  | |  |  | | --- | --- | | **Number of Expected Deaths** |  | | **Number of Unexpected Deaths** |  | | | |  | | | |
| **Residents Name** | | **Date of death** | **Cause of death** | | **Expected/Unexpected** | **Passed away in Home/Hospital** | **Have**  **CQC been notified** |
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|  | **DISCHARGES (from the 1st – 30th/31st of the month)** | |  | |
| **Residents Name** | | **Date of Discharge** | | **Reason for Discharge** |
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Section 4 – HR and Training

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| **HR** | | | |
|  | **YES** | **NO** | **COMMENTS** |
| Are there any poor attendance, lateness or  staff making regular requests that need to be highlighted |  |  |  |
| Are there any performance/conduct issues that need to be highlighted |  |  |  |
| Have you been made aware of or received any notification of a staff members intent  to leave |  |  |  |
| Are there any staff who have been absent since the last Managers audit |  |  |  |

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| **SUPERVISIONS** | | |
|  | **Yes** | **No** |
| Have all scheduled supervisions been carried out as per the matrix? |  |  |
| Has the matrix been updated accordingly |  |  |
|  |  |  |
| Number of days staff sickness? **:** | | |
| Number of staff left in the month? **:** | | |
| Comments: | | |

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| **APPRAISALS** | | |
|  | **Yes** | **No** |
| Have all schedule appraisals been carried out as per the matrix? |  |  |
| Has the matrix been updated? |  |  |
|  |  |  |
| Comments: | | |

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| **TRAINING** | |
| **Please list below the trainings that have taken place since the last Managers audit (this can include flash training sessions)** | How many staff did not attend as per the training list |
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Section 5 – Environment

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| **Environment** | | | |
| Number of Maintenance Issues outstanding from the maintenance book | | | |
|  | **YES** | **NO** | **COMMENTS** |
| **Are there any defective floor coverings, wall coverings, ceilings etc… that require attention (if you**  **have answer yes, have the relevant people been notified?** |  |  |  |
| **Are there any areas in the home with any lasting offensive odours** |  |  |  |
| **Are there any areas in the home that are unsightly** |  |  |  |
| **Are there any defective windows that are not fit for purpose** |  |  |  |
| **Are there any beds or furniture that are defective or require**  **replacement** |  |  |  |
| **Are there any slip or trip hazards that require attention** |  |  |  |
| **Are environmental maintenance issues being dealt with in a timely manner?** |  |  |  |
| **Are carpets regularly having a thorough clean?** |  |  |  |
| Notes: | | | |

Section 6 – Equipment

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| **Equipment** | | | |
|  | **YES** | **NO** | **COMMENTS** |
| **Is all equipment in the home in**  **effective working order, safe and fit for purpose** |  |  |  |
| **Are there any concerns with lifting equipment, bed rails or window**  **restrictors** |  |  |  |
| **Are staff using equipment safely**  **And in accordance with their training** |  |  |  |
| **Maintenance book updated, reviewed and signed off?** |  |  |  |
| **Are equipment maintenance issues being dealt with in a timely manner?** |  |  |  |

Section 7 – Health and Safety

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| **Health and Safety** | | | |
|  | **YES** | **NO** | **COMMENTS** |
| **Are there any significant health and**  **safety updates to report since the last Managers audit** |  |  |  |
| **Are there any significant accidents or hazardous incidents to report**  **since the last Managers audit** |  |  |  |
| **Have fire alarms been tested weekly since the last Managers audit** |  |  |  |
| **Are fire checks up to date** |  |  |  |
| **Are the PEEPS and grab files up to date and stored securely in line with GDPR?** |  |  |  |
| **Has an emergency lighting test been conducted since the last Managers**  **audit** |  |  |  |
| **Have you conducted a Health and**  **Safety Audit since the last Managers audit** |  |  |  |
| Notes: | | | |

Section 8 – Compliments and Complaints

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| --- | --- | --- | --- |
| **Compliments and Complaints** | | | |
|  | **YES** | **NO** | **COMMENTS** |
| **How many complaints have there been since the last Managers audit** | No: | |  |
| **How many of these complaints have been dealt with within 24 – 48 hours** | No: | |  |
| **How many complaints are still to be resolved/signed off?** | No: | |  |
| **How many complaints have been raised by residents** | No: | |  |
| **How many complaints have been raised by visitors** | No: | |  |
| **Have there been any significant**  **compliments since the last Manager’s audit** |  |  |  |
| **Are visitors and residents being**  **encouraged to complete a comment card for carehome.co.uk** |  |  |  |
| **Notes:** | | | |

Section 9 – Activities and Food

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| **Activities and Food** | | | |
|  | **YES** | **NO** | **COMMENTS** |
| **Are the activities well organised and do the residents enjoy them?** |  |  |  |
| **Have you conducted a review of the**  **activities since the last Managers audit** |  |  |  |
| **Have any changes resulted from the**  **review** |  |  |  |
| **Are there any issues surrounding**  **mealtimes and food** |  |  |  |
| **Notes:** | | | |

Section 10 – Compliance

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| **Compliance** | | | |
|  | **YES** | **NO** | **COMMENTS** |
| **Are the actions from the last CQC**  **visit in place and are these actions continued to be met** |  |  |  |
| **Have CQC or or external body made contact with you**  **since the last Managers audit** |  |  |  |
| **Are the actions from the last Local**  **Authority/NHS visit in place are these actions continued to be met** |  |  |  |
|  |  |  |  |
| **Are the actions from the last independent auditor visit in place and are these actions continued to**  **be met** |  |  |  |
| **Are there any areas of non – compliance with the regulations** |  |  |  |
| **Have CQC been notified of all safeguarding concerns, deaths, major accidents and incidents and**  **grade 3 pressure sores** |  |  |  |
| |  | | --- | | Notifications sent outside of timeframe |   **Notifications to CQC sent on time (number)** |  | Comments | |
|  |
| **Have the Local Authority and the resident’s family/representative been informed of any safeguarding**  **concerns** |  |  |  |
| **Have there been any other external visits to the home?** |  |  |  |

**\*\* UPDATE THE ACTION PLAN EVERY MONTH AND CARRY OVER ANY INCOMPLETE ACTIONS.**