**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** |
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| **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);** |  |
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| **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** |  |
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| **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, pleaseexplain 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 |  |

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| **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)** |  |
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| **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 orstaff 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 intentto 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** |  |  |  |
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| 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.**