Monitoring Template

Date: _____

Issue(s) identified/rationale for visit:	Level 0	Level 1	Level 2	Level 3
Care planning (AHP advice not adhered to, poor documentation, supplementary records, assessments, wound care etc)	x			
Risk management (smoking/fire/residents absconding/choking)				
Infection prevention & control (incorrect or non-use of PPE, continued outbreak of viruses, Covid19 outbreak etc)	x			
Staffing/ Management arrangements (high turnover of staff, concerns raised by families, unsettled management structure)	x			
Medication management (medication errors, stock/supply issues etc)				
Falls prevention/protocol (management of falls, actions taken post falls etc)				
Adult Safeguarding (increase in referrals, observation of poor practice etc)				
Concerns raised (RQIA, whistleblowing, complaints, SEA, SAI etc)	x			

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Quality issues (QMRs, poor communication with families\AHPs, broken equipment, poor use of PPE etc)				

Name:	[redacted]		
Signature:	[redacted]		
Role:	[redacted] **CREST**		
Care Home:	**Oaktree manor**		
Unit:	**Residential and nursing (dementia)**		
Time:	**0915- 1315 18/08/2020**		
Copy of record provided to care home:	**Yes:**		**No: x**
Action plan communicated with staff:	**Yes: x**	**No:**	**Staff Member:** Via email 19/08/2020
Further monitoring required: To be discussed at governance meeting	**Yes:**		**No:**
Planned date of next visit: To be confirmed			
Date: _____			

Date: _____

Areas of focus:	➢ • **Review a number of residents** ➢ • **Review notes and ensure care plans are reflective of residents needs** ➢ • **Ensure that appropriate PPE is being used** ➢ • **Get a sense of the environment, morale amongst residents/staffing**
Documentation: ***(Number, type, residents name etc)***	**1. Full care plan observed for Resident 1** **2. Residents on 'close observations' rationale records in care plan reviewed** **3. Medications** **4. Communication with residents** **5. Care planning** **9 Residents known to CREST team within all units.**
Observations: ***(details to note: effective record keeping, clear documentation, observations of practice, care plans reflecting needs, individualised, knowledge of staff, staff presence, appearance of residents, environment etc)***	**General:** **Residential unit:** Residential unit had a calm atmosphere and staff were interacting appropriately with residents. Residents appeared neat and tidy, however fingernail care for the majority of residents required attention. Classical music was playing. There is an activity schedule on the window of the Senior carer station for the previous week. There did not appear to be an activity schedule for the present week. **Nursing unit:** Limited activity or mental stimulation observed. **Infection Prevention:** Temperature checked and recorded on arrival. Alcohol gel available at entrance before residential unit. Alcohol gel not available at immediate entrance to residential unit and in dispensers throughout unit. No obvious malodours present. No observations of PPE in non-clinical waste bins - areas checked included nursing station and unit kitchen area for both units. Dishwasher in situ, no tablets observed as kept locked in clinical rooms. Signs placed around care home regarding PPE and COVID precautions. All staff wearing face masks during visit.

1. Blue aprons not worn by staff for tea trolley or lunch time for both units
2. Diet place mats had food residue on these and were not washed for next meal (residential unit)
3. Observations of staff not using alcohol gel/washing hands in between medication administration (residential unit.) If gloves are worn these need to be changed between patients.
4. Picture frames on top of clinical waste bin at entrance of residential unit

Day shift allocation chart for domestic, restocking tasks etc (*Sunday through to following Saturday 15th*): Tuesday to Friday incomplete

Night shift allocation chart for domestic, restocking tasks etc, (*Sunday through to following Saturday 15th):* Completed on Monday night only

Cedar Unit (Dementia Residential)

Resident 1

[redacted]

Monitoring Template

Date: _____

	[redacted]

Date: _____

[redacted]

Resident 2

[redacted]

[redacted]

Resident 3

[redacted]

Residents on 'Close observation' records reviewed:

1. **Resident 4 (BHSCT):**

[redacted]

2. **Resident 5**

[redacted]

3. **Resident 6 (BHSCT):**

[redacted]

4. Resident 7

Date: _____

[redacted]

5. Resident 8

[redacted]

6. Resident 9

[redacted]

7. Resident 2

[redacted]

8. Resident 10

[redacted]

9. Resident 3

[redacted]

Medications:

Resident 11 - [redacted]

Resident 12 – [redacted]

	Laxatives not prescribed for the following residents: 1. XX (behavioural issues) 2. XX (on co-codamol - kardex to indicate frequency of cocodamol 'up to 3 times per day') 3. XX 4. XX (behavioural issues) 5. XX 6. XX **Analgesia not prescribed for the following residents:** 1. XX (behavioural issues) 2. XX 3. XX (behavioural issues) 4. XX **Kardexes:** Double signatures required for: 1. XX 2. XX 3. XX 4. XX 5. XX 6. XX 7. *Suggestions:* Kardexes have blanks under 'Allergies' Previous kardexes remain in the one polly pocket **Care charts for intake and output/continence records:** Blanks observed. Please ensure if nothing has been observed in the 24 hours period that staff are noting 'nothing observed' for review of records. This is necessary for medication reviews and where necessary review of distressed reactions. Care staff had advised that everyone is monitored.

Conversation with residents:

1. XX– 'I'm okay, it's dead on I like it in here.'
2. XX– 'I enjoy it in here, its immaculate'
3. XX and male resident appeared content and smiling at time of visit. Other residents in the lounge were sleeping or did not engage in conversation. 1:1 in place for [redacted] appeared to be interacting appropriately.

Nursing unit:

Resident A:

[redacted]

Resident B:

[redacted]

Resident C:

[redacted]

Resident D:

[redacted]

Resident E:

	[redacted] **Resident F:** [redacted]
Summary:	Issues with IPC, staff not wearing blue aprons during food handling Place mats in kitchen with food residue not cleaned before next meal Empty alcohol dispensers throughout home Medication kardex documentation incomplete Residents not prescribed analgesia/laxatives for PRN basis – to be discussed with GP Weight not taken on admission until 1 month after admission Following recommendations of GP advice re analgesia not adhered to Reporting of incident in timely manner to NOK not completed post fall Rationale for close observations and care planning not documented appropriately Fingernail care of residents needing attention Clarification required whether markings on resident were discussed with ASG champion and reported to BHSCT appropriately General fingernail care to be attended to for majority of residents Ensure care plans reflect current needs of residents (do they wear hearing aids, glasses, behavioural issues, close observations etc) Staff not observed using alcohol gel between patients medication administration Staff must ensure residents are in a safe upright position for meal time Mental stimulation not evident during visit mainly on the upper floor which is split with residential and nursing.

	Residents generally appeared neat and tidy on the residential unit and appeared to be content. Despite there being a calm atmosphere throughout the home there did not appear to be mental stimulation mainly on the upper floor with residents. Please see full report for the full observations of monitoring visit. **Staffing:** Staffing levels completed monthly – staffing levels adjusted accordingly. Staffed higher in Oaktree due to high dependency levels RQIA staffing levels – RQIA 30/06/2020 – no area for improvement on QIP. Goldcrest system for independent needs of residents /reviewed monthly/ or on readmission from hospital / change in condition [redacted] advised the following: Residential is 27 residents on ground floor Day time 8-8 x2 CTLs and x4 Care staff Night Time is x1 CTL and x2 Care staff Residential First floor has 12 residents Day Time x1 CTL and x1 Care staff 8-8 x1 8-2 Night Time is x1 CTL and x1 care staff One to one for [redacted] Nursing has 18 residents Day time x1 nurse 8-8 plus x1 nurse 8-2 and 4 Care staff Night time is x1 Nurse and x2 Care Staff. X2 one to one for x2 residents. *Twilight introduced when 25 residents. (5pm-11pm)*

Actions required:	General: 1. Residents fingernail care on both units require attention 2. Blue aprons not worn for tea trolley or lunch time for both units 3. Diet place mats had food residue on these and were not washed for next meal 4. Observations of staff not using alcohol gel/washing hands in between medication administration 5. Resident JW not weighed until one month post admission. Ensure residents weights are taken as soon as possible and document if issues with same. 6. Ensure language in care planning is appropriate including that in the evaluations. ('aggressive' etc) 7. Place dates on allocation sheets for domestic and restocking tasks (residential unit) Resident 1: 1. [redacted] result date. [redacted] result date recorded as 19/05/2020 2. Name recorded as 'Resident 1' on our system can you please clarify spelling with family Please review records where marks were observed on 27/07/2020 & 20/05/2020. Discussion with ASG Champion and were these reported to BHSCT. (Bloods were obtained between 15th -17th June – may be the cause, was this considered?) 3. Falls evaluation not completed for April 2020 4. Care plan for alarm mat to be created 5. Ensure NOK are update post falls in a timely manner 6. Communication care plan update: Resident 1 is prescribed distance and reading glasses but can often decline to wear same. Care plan should state assessment of current need, i.e. Resident 1 has a hearing aid prescribed but can often decline to wear same.' Please ensure NOK are aware of current needs 7. Please ensure appropriate attention provided for [redacted] at meal times as per care plan Resident: 1. [redacted] Resident 3: 1. [redacted]

	Please review care planning for residents on 'Close Observations' – see section above 1. Care plans require prescription of observations (15 minute, 30minute etc) and rationale for same. Include directions for review as infringing human rights if remains continuous without this. 2. Ensure families and care managers are aware of same. Ensure appropriate input from relevant MDT has been made for each especially those on longer term. (psychiatry, community mental health etc) **Medications:** Resident - frequency of diazepam not on kardex Resident – care plan for aspirin has been discontinued but remains on same. Please ensure this is correct. The below was identified. Please discuss with GP if required on PRN basis especially those who experience behavioural issues or those on codeine based drugs. Regarding the pain relief – please discuss with GP for prescriptions if appropriate for PRN basis. Laxatives not prescribed for the following residents: 6 residents Analgesia not prescribed for the following residents: 4 residents Kardexes: Double signatures required for: 6 residents Suggestions: Kardexes have blanks under 'Allergies' Previous kardexes remain in the one polly pocket '9, 2, 6 etc' used for documenting time of administration. Please use 24 hour clock to avoid errors

Date: _____

	Nursing unit: 1. Ensure residents in safe upright position prior to assisting with meals 2. Update XXX central wound care plan re dry wound 3. Ensure hearing aid batteries for XXX available