

Monitoring Template

Date: _____

<i>Issue(s) identified/rationale for visit:</i>	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 (RQJA, whistleblowing, complaints, SEA, SAI etc)	x			
Quality issues (QMRs, poor communication with families\AHPs, broken equipment, poor use of PPE etc)				



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Monitoring Template

Date: _____

Name:	[REDACTED]		
Signature:	[REDACTED]		
Role:	[REDACTED] CREST		
Care Home:	Oaktree manor		
Unit:	Residential and nursing (dementia)		
Time:	0915- 1200 22/07/2020		
Copy of record provided to care home:	Yes:	No: x	
Action plan communicated with staff:	Yes: x	No:	Staff Member: [REDACTED] home manager and regional manager
Further monitoring required: To be discussed at governance meeting	Yes:	No:	
Planned date of next visit: To be confirmed			
Date: _____			



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<p>Areas of focus:</p>	<ul style="list-style-type: none"> ➤ Care planning ➤ Communication with family ➤ Visiting protocol ➤ Use of PPE/IPC ➤ Diet records
<p>Documentation:</p> <p><i>(Number, type, residents name etc)</i></p>	<ol style="list-style-type: none"> 1. Resident 1 (Dementia Nursing unit) 2. Resident 2 (Dementia Residential unit)
<p>Observations:</p> <p><i>(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)</i></p>	<p>Infection Prevention:</p> <p>Temperature checked and recorded on arrival. Alcohol gel available at all necessary areas (entrance points, nursing stations, donning doffing areas.) All areas of nursing unit were observed. Residents rooms were clean and domestic staff were in process of further cleaning. No obvious malodours present. Staff were observed exiting rooms after completing personal care washing hands and using correct bins. No observations of PPE in non-clinical waste bins. Areas checked included nursing station and unit kitchen area.</p> <p>Upstairs dementia nursing unit:</p> <p>Environment appeared clean and clutter free. Residents were presented in tidy clean, clothes and present in a notably calm atmosphere with staff present. One agency 1:1 carer was interacting appropriately with female resident. Discussed with Staff Nurse rationale for the upstairs lounge (which had better positioning of furniture, larger windows for residents to look out of etc) not being used. S/N advised this was to ensure they could achieve social distancing effectively. Rooms were decorated and residents who were in their rooms appeared comfortable with no indications of distress. Residents on this unit did not engage in conversation at time of visit.</p> <p>Residential dementia unit:</p> <p>Environment observed to be clean and clutter free. Residents were receiving tea from tea trolley. Staff wearing appropriate PPE required for food handling. Residents appeared in settled form and were able to communicate how they were feeling. Residents appeared comfortable and clothes were neat and tidy. Communication with 5 residents who identified no issues or concerns.</p> <p>Visiting protocol:</p>



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Relatives can book 30 minute slot per week Monday to Friday. Where families cannot attend Monday to Friday there are available slots at the weekend. Any cancellations, families are offered these slots.

Diet records:

Diet record sheets are held by the kitchen staff for reference. Nursing care plans are updated as necessary with evidence of same. Laminated copies of residents who have a modified diets are kept in the unit's kitchen for meal times. Staff Nurse advised this was useful for periods when they would use agency staff. These laminated copies are used as table mats. On one side the residents name is recorded and the other side there is further information about the person's diet.

Resident 1– Dementia Nursing unit - Room no: ■■■



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Person-centred

	<p><u>Resident 2:</u> Residential dementia unit - Room no: [REDACTED]</p> <p>[REDACTED]</p>



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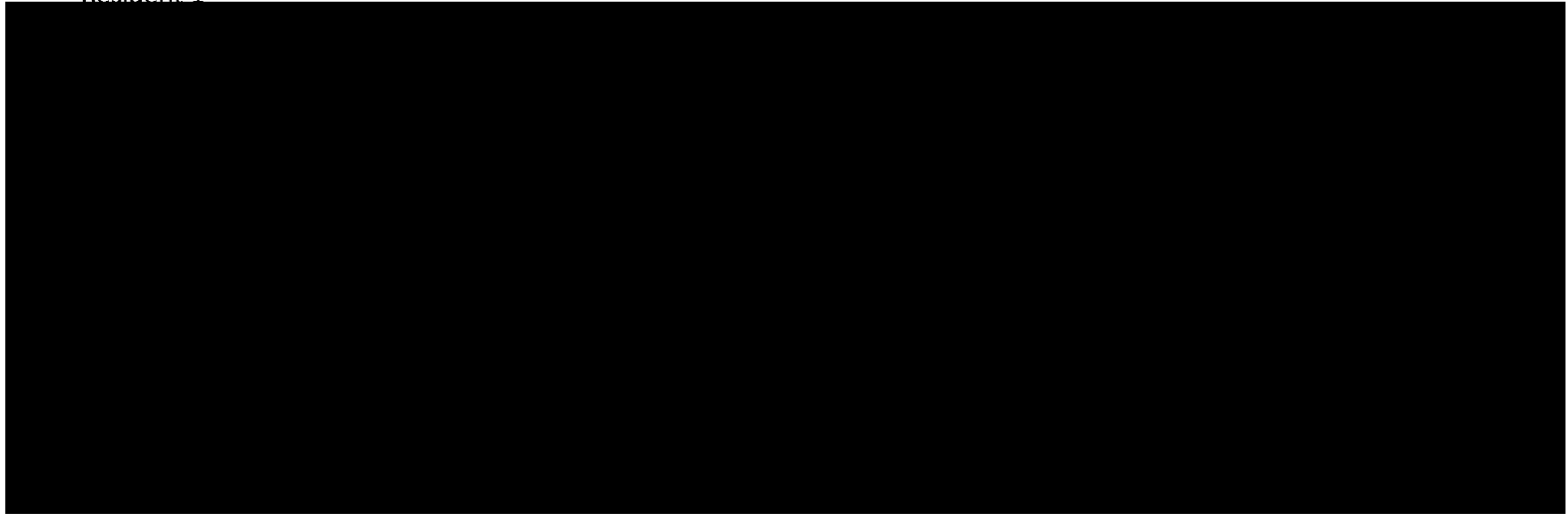


Transparency

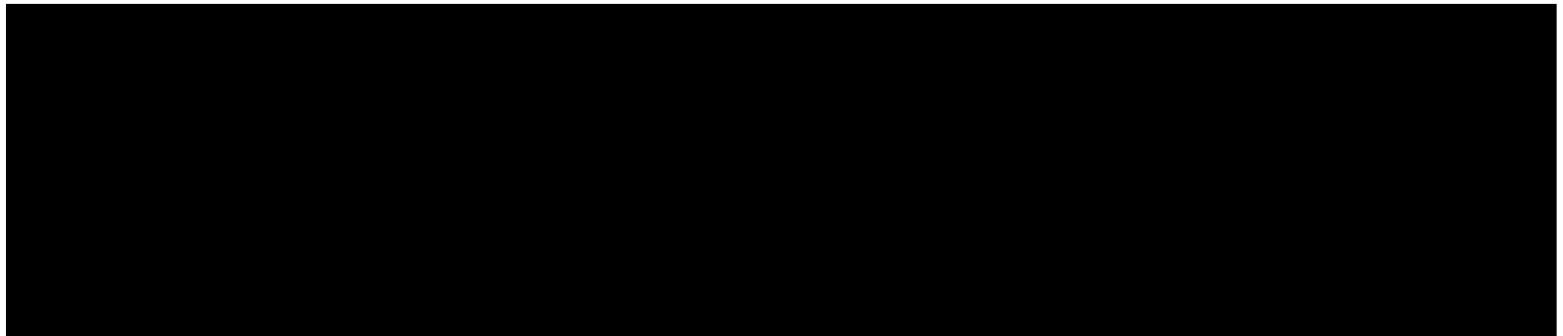
<p>Summary:</p>	<p>Attended care home for a monitoring visit following concerns raised by family and home on escalation due to SEHSCT concerns. 2 resident care planning reviewed. Care plans required updating to reflect current needs and information. ██████ residents reviewed required referrals to professional for weight loss recorded. ██████ care files required updating for close observation planning. Communication with 5 residents on dementia residential unit no identified/expressed concerns. ██████ residents reviewed - presentation required staffs attention ██████</p> <p>Discussed with home manager regarding previous meetings with Resident 1 NOK. Home manager, advised ██████ ██████ process in action with keyworker. No issues identified regarding IPC observed. Care planning viewed was detailed and appropriate however some central care plans required updating. Further evidence of communication with families regarding care planning to be actions.</p> <p>All actions communicated with care home staff nurses and manager at time of visit.</p>

Actions required:

Resident 1



Resident 2



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