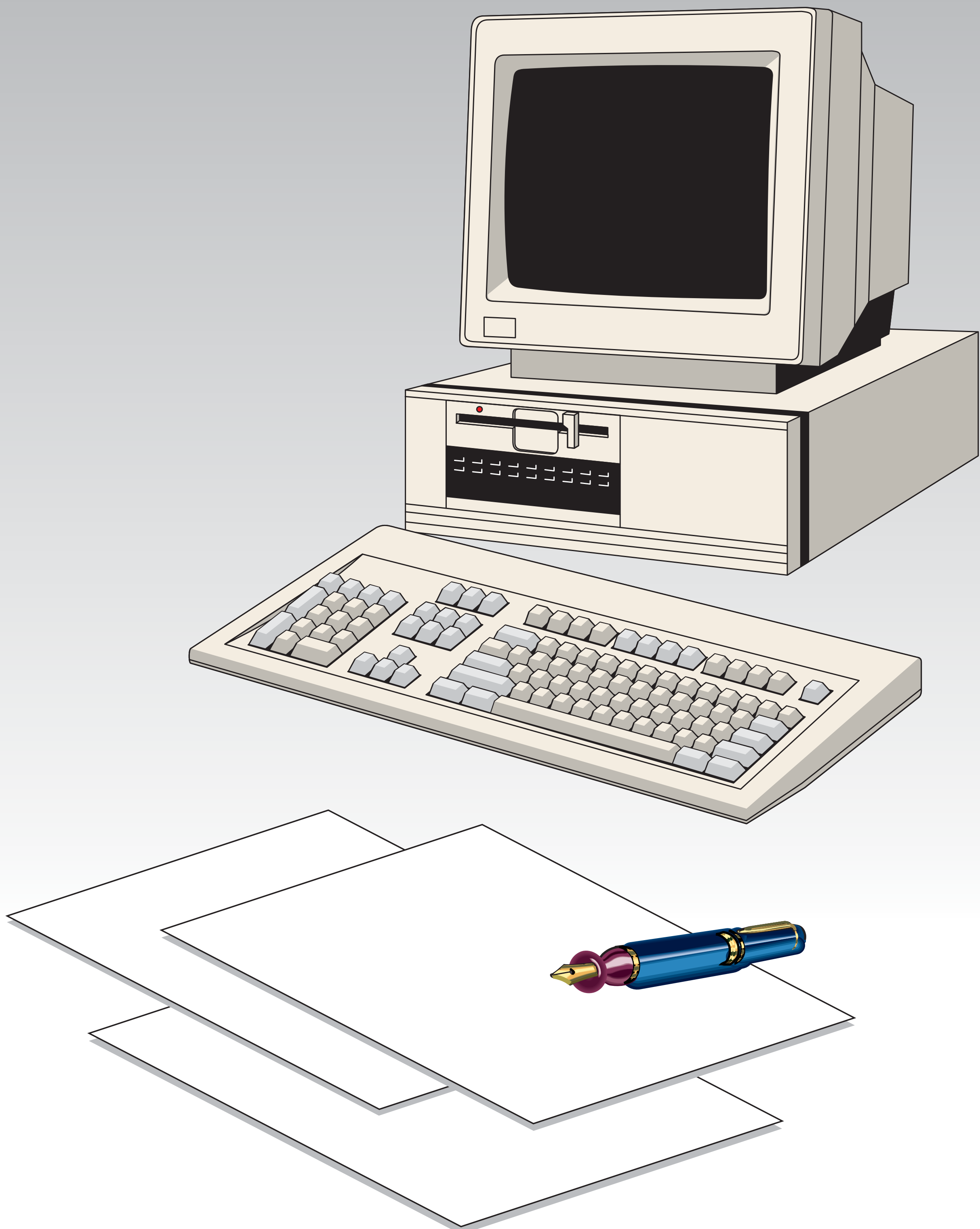
Quality Forms Manual

BS EN / ISO 9002 : 94



QUALITY FORMS MANUAL

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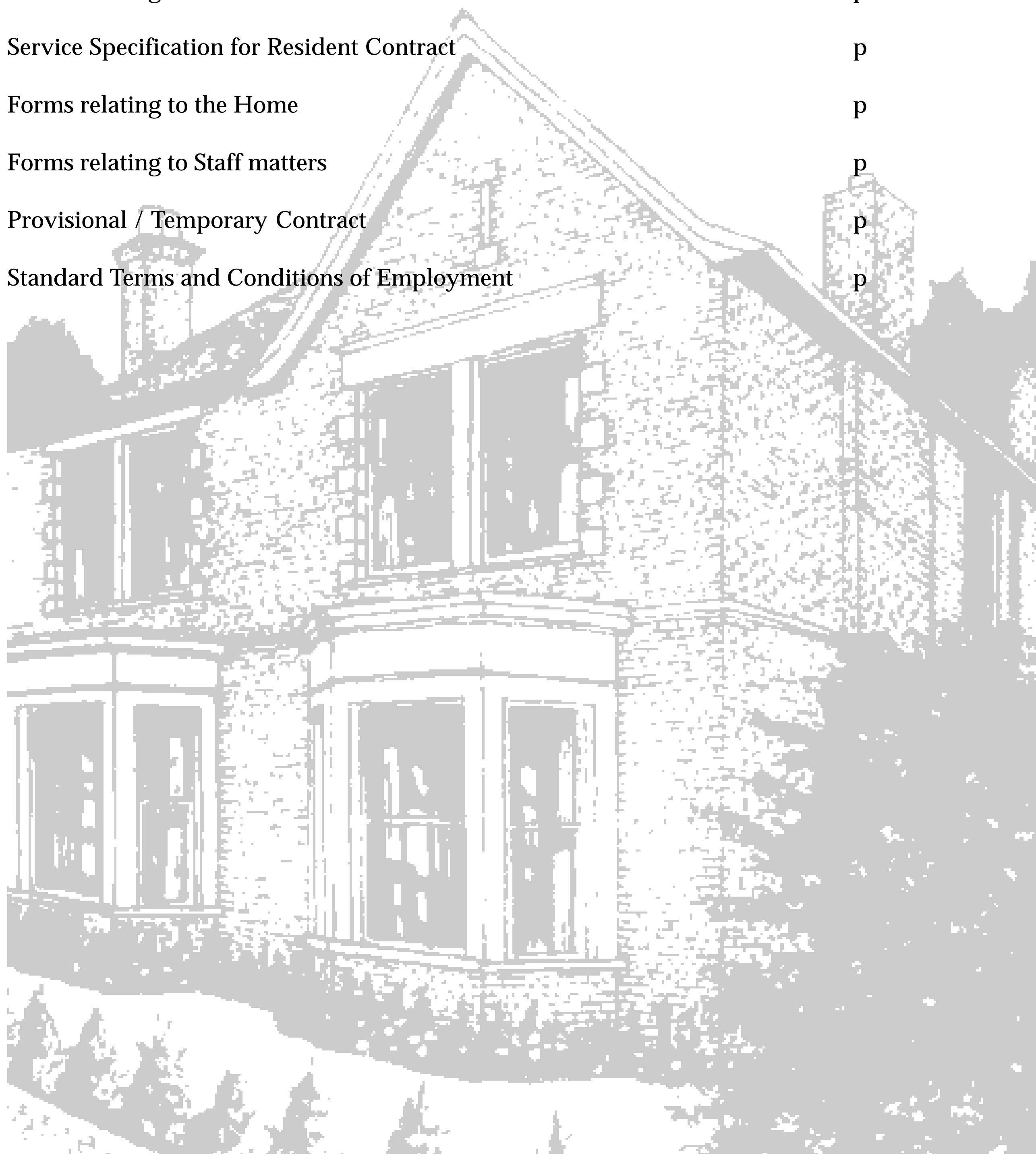


LIST OF QUALITY FORMS

ISSUE No	DATE	DOCUMENT DESCRIPTION	PAGE No	SECTION
2	OCT '96	RECORD OF REFERRALS	1	RESIDENT
2	OCT '96	PRE-ADMISSION ASSESSMENT	2a-2b	RESIDENT
2	NOV '96	INITIAL ASSESSMENT	3a-3e	RESIDENT
2	AUG '96	ADMISSION/DISCHARGE	4	RESIDENT
1	MARCH '95	ADMISSION PROCEDURE CHECKLIST	5	RESIDENT
1	MARCH '95	RESIDENT PERSONAL PROFILE	6	RESIDENT
1	MARCH '95	SERVICE SPECIFICATION/CONTRACT	7a-7b	RESIDENT
1	MARCH '95	RESIDENT EVENT SHEET	8	RESIDENT
1	MARCH '95	RESIDENT CARE PLAN	9	RESIDENT
1	MARCH '95	RESIDENT EVALUATION SHEET	10	RESIDENT
1	MARCH '95	MISSING PERSON	11a-11b	RESIDENT
1	MARCH '95	DEPOT INJECTION CHART	12	RESIDENT
1	MARCH '95	WEIGHT CHART	13	RESIDENT
1	MARCH '95	VITAL SIGNS CHART	14	RESIDENT
1	MARCH '95	WEEKLY CASH AUDIT	15	RESIDENT
1	MARCH '95	SPECIAL PAYMENTS FORM	16	RESIDENT
1	MARCH '95	STANDARD DSS LETTER	17	RESIDENT
1	MARCH '95	RESIDENT SICK NOTICE	18	RESIDENT
1	MARCH '95	STANDARD W.I. REQUEST LETTER	19	RESIDENT
1	MARCH '95	NURSE-IN-CHARGE HAND-OVER REPORT	1a-1b	HOME
1	MARCH '95	DAILY CALENDAR	2	HOME
1	MARCH '95	HEALTH CARE STAFF WORK SHEET	3a-3b	HOME
1	MARCH '95	HEALTH CARE STAFF DAILY REPORT	4	HOME
1	MARCH '95	ACCIDENT REPORT	5a-5b	HOME
1	MARCH '95	COMPLAINTS FORM	6a-6b	HOME
1	MARCH '95	UNTOWARD/VIOLENT INCIDENT FORM	7a-7b	HOME
2	NOV '96	MAINTENANCE FORM	8	HOME
1	MARCH '95	RECREATIONAL PROGRAMME	9	HOME
2	OCT '96	PRE-PRINTED SHOPPING LIST	10	HOME
1	MARCH '95	SUPPLIER QUALITY QUESTIONNAIRE	11	HOME
1	MARCH '95	DOCUMENT CHANGE NOTE	12	HOME
1	MARCH '95	SUPPLIER NON-CONFORMANCE LOG	13	HOME
1	MARCH '95	EQUIPMENT LISTING FORM	14	HOME
1	MARCH '95	PREVENTATIVE CORRECTION REPORT	15	HOME
1	MARCH '95	AUDIT REPORT SHEET	16	HOME
1	MARCH '95	SUMMARY OF AUDIT NON-CONFORMANCE	17	HOME
1	MARCH '95	AUDIT SCHEDULE	18	HOME
1	MARCH '95	AUDIT CHECK-LIST	19	HOME
1	MARCH '95	INSPECTION VISITS RECORD	20	HOME
1	MARCH '95	APPLICATION FOR EMPLOYMENT	1a-1b	STAFF
1	MARCH '95	STANDARD INFORMATION LETTER	2	STAFF
2	NOV '96	INTERVIEW QUESTIONNAIRE	3a-3b	STAFF
1	MARCH '95	REFERENCE FORM	4a-4b	STAFF
1	MARCH '95	INTERVIEW CHECK-LIST	5	STAFF
1	MARCH '95	STANDARD SUCCESSFUL LETTER	6	STAFF
1	MARCH '95	STANDARD UNSUCCESSFUL LETTER	7	STAFF
2	OCT '96	INDUCTION PROGRAMME	8	STAFF
1	MARCH '95	IN-SERVICE TRAINING MANUAL	9	STAFF
1	MARCH '95	PROVISIONAL/TEMPORARY CONTRACT	10	STAFF
2	MARCH '97	PERMANENT CONTRACT	11a-11b	STAFF
2	NOV '96	ANNUAL LEAVE REQUEST FORM	12	STAFF
1	MARCH '95	APPRAISAL FORM	13a-13b	STAFF
1	MARCH '95	IMPROVEMENT ADVICE FORM	14	STAFF
1	MARCH '95	DISCIPLINARY NOTICE	15	STAFF
1	MARCH '95	SICKNESS/LATENESS RECORD	16	STAFF
1	MARCH '95	BANK DETAILS	17	STAFF
1	MARCH '95	RECORD OF TRAINING	18	STAFF
1	MARCH '95	FIRE INDUCTION RECORD	19	STAFF
1	MARCH '95	FIRE EVACUATION CHECKLIST	20	STAFF
1	MARCH '95	DISCIPLINARY REGULATIONS	21	STAFF
1	MARCH '95	INSTANT DISMISSAL RULES	22	STAFF

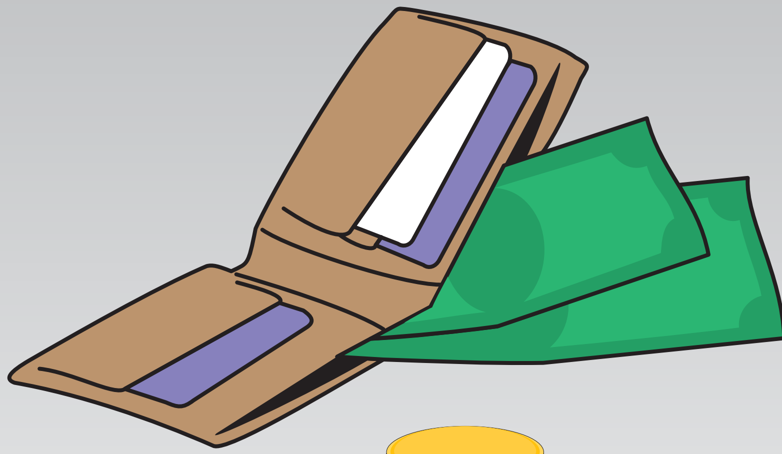
LIST OF QUALITY RECORDS

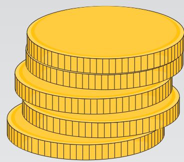
RECORD DESCRIPTION	PERSON RESPONSIBLE	RECORD LOCATION	RETENTION PERIOD
QUALITY MANUAL	Nurse Administrator	Directors office	Ongoing
QUALITY PROCEDURES	Nurse Administrator	Nursing Office	Ongoing
WORK ROUTINES	Nurse Administrator Nurse-in-Charge	Nursing Office	Ongoing
REFERRAL BOOK	Nurse-in-Charge	Nursing Office	3 Years
HOME APPOINTMENT BOOK	Nurse-in-Charge	Nursing Office	3 Years
SOCIAL SERVICE FINANCIAL AGREEMENT	Directors Nurse Administrator	Nursing Office	3 Years
PROPERTY BOOK	Nurse-in-Charge	Nursing Office	3 Years
CASH & VALUABLES BOOK	Nurse-in-Charge	Nursing Office	3 Years
CARE PLAN	Nurse-in-Charge	Nursing office	3 Years
EVALUATION SHEET	Nurse-in-Charge	Nursing Office	3 Years
RESIDENTS CONTRACT	Nurse-in-Charge	Nursing Office	3 Years
DOCUMENT CHANGE NOTE	Nurse Administrator	Nursing Office	Ongoing
LIST OF APPROVED SUPPLIERS	Nurse Administrator	Nursing Office	Ongoing
PURCHASE ORDERS	Directors Nurse Administrator	Nursing Office	3 Years
MENU SHEETS	Chef	Kitchen	3 Years
MINUTES OF MONTHLY REVIEW MEETING	Nurse Administrator	Directors Office	3 Years
MINUTES OF STAFF MEETINGS	Nurse Administrator	Directors Office	3 Years
MINUTES OF POST FIRE REVIEW	Site Manager	Nursing Office	3 Years
MINUTES OF DOCTORS CLINIC	Nurse-in-Charge	Nursing Office	3 Years
RESIDENTS ANNUAL LIST	Nurse-in-Charge	Nursing Office	3 Years
NON-PRESCRIPTION MEDICATION LETTER	Nurse-in-Charge	Nursing Office	3 Years
RECORD OF RESIDENTS MEDICAL NOTES	Nurse-in-Charge	Nursing Office	3 Years
RESIDENTS MEDICAL NOTES CHECK LIST	Nurse-in-Charge	Nursing Office	3Years
BATH BOOK	Nurse-in-Charge	Nursing Office	3 Years
MEDICAL NOTES	N/A	Nursing Office	Ongoing
MEDICAL ADMINISTRATION RECORDS	Nurse-in-Charge	Nursing Office	3 Years
DEPOT INJECTION CHART	Nurse-in-Charge	Nursing Office	3 Years

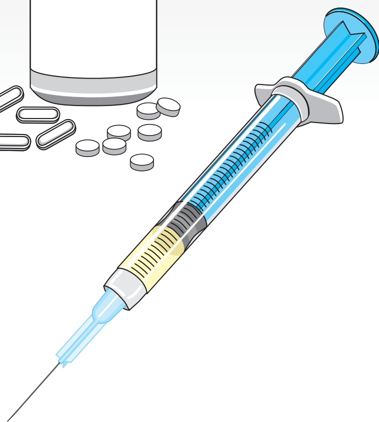
LIST OF QUALITY RECORDS

RECORD DESCRIPTION	PERSON RESPONSIBLE	RECORD LOCATION	RETENTION PERIOD
ACCIDENT BOOK	Nurse-in-Charge	Nursing Office	3 Years
HOME MAINTENANCE RECORD	Site Manager	Nursing Office	3 Years
MISSING PERSONS RECORD	Nurse-in-Charge	Nursing Office	3 Years
FIRE LOG	Nurse-in-Charge	Nursing Office	3 Years
STAFF FIRE INDUCTION RECORD	Site Manager	Nursing Office	3 Years
HEALTH CARE STAFF WORK SHEET	Nurse-in-Charge	Nursing Office	3 Years
HEALTH CARE STAFF DAILY REPORT SHEET	Nurse-in-Charge Senior Care Assistant	Nursing Office	3 Years
TELEPHONE MESSAGE BOOK	Nurse-in-Charge	Nursing Office	3 Years
VIOLENT/UNTOWARD INCIDENT RECORDS	Nurse-in-Charge	Nursing Office	3Years
REFRIGERATOR/FREEZER TEMPERATURE LOG	Chef	Nursing Office	3Years
EQUIPMENT LISTING RECORDS	Site Manager	Nursing Office	3 Years
COMPLAINTS/NON-CONFORMANCE CORRECTIVE PREVENTATIVE ACTION RECORDS	Nurse Administrator Nurse-in-Charge	Nursing Office	3 Years
AUDIT REPORTS	Nurse Administrator	Nursing Office	3 Years
AUDIT SCHEDULE	Nurse Administrator	Nursing Office	3 Years
STAFF FILE	Nurse Administrator	Nursing Office	3 Years
INDUCTION & IN-SERVICE TRAINING MANUAL	Nurse Administrator Nurse-in-Charge	Nursing Office	3 Years
RESIDENT RECREATION ACTIVITIES PROGRAMME	Nurse-in-Charge	Nursing Office	3 Years
SPECIAL PAYMENTS RECORDS	Nurse-in-Charge	Nursing Office	3 Years
PRE-ADMISSION ASSESSMENT FORM	Nurse-in-Charge	Nursing Office	3 Years
INITIAL ASSESSMENT FORM	Nurse-in-Charge	Nursing Office	3 Years
RECORD OF ADMISSION/DISCHARGE	Nurse-in-Charge	Nursing Office	3 Years
WEEKLY CASH AUDIT SHEET	Nurse-in-Charge	Nursing Office	3 Years
HANDOVER REPORT	Nurse-in-Charge	Nursing Office	3 Years
DAILY CALENDAR	Nurse-in-Charge	Nursing Office	3 Years
HOME CARE / DOMICILARY HEALTH SAFETY RECORD	Community Nurse	Nursing Office	3 Years
CLIENT HOME / DOMICILIARY SERVICE RECORD	Community Nurse	Nursing Office	3 Years

Resident







Record of Referrals

Date of Referral: ....

Name .... D.O.B. .... / .... / ....

Present Address: ....

Social Worker: .... G.P.: ....

Consultant: .... CPN: ....

Keyworker: ....

Referred by: ....

Information given by: ....

Preserved rights? YES / NO If NO, funding agreed? YES / NO

Assessed as requiring: Nursing Residential Social Support *(Delete as appropriate)*

Presenting Problem: ....

....

Date arranged for assessment? YES / NO Date: .... / .... / ....

Date arranged to visit Home? YES / NO Date: .... / .... / ....

Transport arrangements: ....

Entered in diary? YES / NO Handed over to next shift? YES / NO

Form completed by: ....

Designation: ....

Outcome of Assessment: Is resident to be admitted to the Home? YES / NO

If YES, date and status: .... / .... / .... Nursing / Residential / Social Support *(delete as appropriate)*

If no, reason: ....

....

....

....

Signed: .... Date: .... / .... / ....

Designation: ....

Pre-Admission Assessment Form

Name .... D.O.B. .... / .... / ....

Referred by: .... Date: .... / .... / ....

Assessed by: .... Date: .... / .... / ....

List others present: ....

Current address: ....

Consultant: .... G.P.: ....

Social Worker: .... CPN: ....

Present care: ....

Preserved rights? YES / NO If no, funding agreed? YES / NO

If YES, assessed as requiring: Nursing Residential Social Support *(Delete as appropriate)*

Diagnosis: ....

Presenting Problem: ....

MOBILITY		
Does poor mobility affect person's independence?	**YES** / **NO**	*Details:* ....
PERSONAL CARE		
Are there any problems with managing personal care?	**YES** / **NO**	*Details:* ....
DAILY LIVING SKILLS		
Is dependency affected by poor skills?	**YES** / **NO**	*Details:* ....
HEALTH PROBLEMS		
If yes, list physical problems?	**YES** / **NO**	*Details:* ....
SENSORY LOSS		
Does impairment of sight or hearing affect independence?	**YES** / **NO**	*Details:* ....

SOCIAL BEHAVIOUR		
Does social behaviour give rise to problems?		
Communication skills	YES NO	*Details:* ....
Orientated to time, place, person	YES NO	*Details:* ....
Tends to wander	YES NO	*Details:* ....
Behaviour likely to upset others	YES NO	*Details:* ....
Social isolation	YES NO	*Details:* ....
Smoker	YES NO	*Details:* ....
Fire risk	YES NO	*Details:* ....
Alcohol	YES NO	*Details:* ....
MENTAL STATE		
Give details of concerns regarding mood, memory, behaviour, etc.		*Details:* ....
CURRENT MEDICATION		
List all medication, including details of depot injections.		*Details:* ....

Date arranged to visit Home? YES / NO Date: .... / .... / ....

Transport arrangements: ....

Information regarding Home and facilities given? YES / NO Home brochure given? YES / NO

Entered in diary? YES / NO Entered in referral book? YES / NO

Handed over to next shift? YES / NO

Signed: .... Date: .... / .... / ....

Designation: ....

Outcome of Assessment: Is resident to be admitted to the Home? YES / NO

If YES, date and status: .... / .... / .... Nursing / Residential / Social Support *(delete as appropriate)*

If no, reason / comments: ....

....

....

Signed: .... Date: .... / .... / ....

Designation: ....

Initial Assessment Form

Risk Management, Manual Handling and Psychiatric Assessment

This form will be completed, by the Nurse-in-Charge, prior to the end of resident's trial period at the Home, usually one month. This initial assessment will be used to formulate a care plan for an individual resident.

NB. All sections must be completed, ticking appropriate scoring boxes.

CONFIDENTIAL

Name: .... D.O.B. .... / .... / ....

Sex: Male / Female Age: .... Date of Admission: .... / .... / ....

Psychiatric Diagnosis: ....

Psychiatrist: .... CPN: ....

G.P.: .... S/W: ....

Preserved rights? YES / NO

If YES, previously assessed for: Nursing Residential Social Support *(Delete as applicable)*

Completed by: ....

Designation: .... Date: .... / .... / ....

Overall Comments

....

....

....

....

....

....

....

....

....

Key	
0 Consistently Normal / Healthy	**3** Unsatisfactory
1 Fairly Normal / Healthy	**4** Hindrance to Normal Activity
2 Below Par	**5** Serious Impediment

A PHYSICAL

SELF CARE AND HYGIENE	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Continence (Urine)							
2 Continence (Faeces)							
3 Washing / Bathing							
4 Hair							
5 Oral							
6 Nails							
7 Shaving or Make Up							
TOTAL							

APPEARANCE	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Dressing							
2 Washing of clothes							
3 Ironing of clothes							
4 Changing of clothes							
5 Storage of clothes							
6 Dress sense							
7 Tidiness of room							
TOTAL							

PHYSICAL HEALTH	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Mobility							
2 General fitness							
3 Sight							
4 Hearing							
5 Speech							
6 Appetite / Diet							
7 Weight _____ st _____llbs	X	X	X	X	X	X	
8 Teeth							
9 Coordination							
10 Side effects from medication							
11 Bowel movements							
12 Physical illness (specify)							
TOTAL							

OVERALL TOTALS						

Specify Current Medication, Dose and Frequency	*Risk / Manual Handling Issues / Assessments*
1	
2	
3	
4	
5	
6	

Key	
0 Consistently Normal / Healthy	**3** Abnormal Behaviour
1 Usually Normal / Healthy	**4** Hindrance to Normal Activities
2 Stable / Normal with Medication	**5** Serious Impediment

B PSYCHOLOGICAL	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Depression							
2 Mania							
3 Obsessional Ideas							
4 Paranoia							
5 Suspicion / Mistrust							
6 Anxiety							
7 Hallucination / Delusion							
8 Personality Disorder							
9 Unpredictable							
10 Hysteria							
11 Threatening Behaviour							
12 Unwarranted Verbal Aggression							
13 Physical Violence							
14 Argumentative							
15 Manipulative Behaviour							
16 Intimidating / Bullying							
17 Self Mutilation							
18 Drug Abuse							
19 Alcohol Abuse							
20 Gambling							
21 Sexual Deviance							
22 Response to Intervention							
23 Insecurity							
24 Insight							
25 Self Esteem							
26 Adaptability / Learning Ability							
27 Motivation							
28 Independence							
29 Trustworthy / Honest							
30 General Mental Health							
31 Medication Administration							
32 Sleep Pattern							
33 Sexuality							
34 Physical Contact / Affection							
35 Emotions							
36 Memory							
37 Thought Process							
TOTAL							

Key	
0 Normal Behaviour	**3** Unsatisfactory
1 Abnormal Behaviour	**4** Hindrance to Normal Activity
2 Eccentric Behaviour	**5** Serious Impediment

C SOCIAL	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Sociability / Personality							
2 Behaviour							
3 Manners							
4 Decision Making							
5 Contact with Family							

C SOCIAL contd	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
6 Conversation with Staff							
7 Conversation with Peers							
8 Speech Content							
9 Understanding							
10 Ability to Deal with Own Affairs							
11 Self Expression							
12 Ability to Follow Instructions							
13 Willingness to Help Others							
14 Willingness to Accept Help							
15 Cooking Skills							
16 Budgeting Skills							
17 Self Sufficiency							
18 Suitability for Independent Living							
19 Social Interaction in Community							
20 Smoking							
21 Alcohol							
22 Gambling							
TOTALS							

Key

0 Normal Behaviour	**3** Encounters Difficulties
1 Less than Normal Behaviour	**4** Needs Help
2 Hesistant	**5** Incapable

D RECREATIONAL	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Involvement in Activities							
2 Reading Ability							
3 Writing Ability							
4 Numeracy Skills							
5 Concentration							
6 Knowledge of Current Affairs							
7 Ability to Go Out Independently							
8 Independent Arrangements							
9 Interest in Hobbies							
TOTALS							

Key

0 Considerable Strength	**3** Weak
1 Some Strength	**4** Hindrance
2 Mediocre Strength	**5** Definite Handicap

E INDIVIDUAL STRENGTHS	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Assertiveness							
2 Self Discipline / Willpower							
3 Ability to Work							
4 Independent Financial Means							
5 Motivation							
6 Special Needs							
7 Sense of Humour							
8 Mobility							
9 Social Skills							
10 Personality							
11 Enjoyment of Life							
12 Supportive Family / Partner							
TOTALS							

							Key
							0 Considerable Strength · **1** Some Strength · **2** Mediocre Strength · **3** Weak · **4** Hindrance · **5** Definite Handicap
F LIFESTYLES	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
1 Enjoys Television							
2 Enjoys Music							
3 Enjoys Radio							
4 Reads Newspapers							
5 Enjoys Painting							
6 Enjoys Writing							
7 Enjoys Reading							
8 Driving Licence							
9 Enjoys D.I.Y.							
10 Enjoys Cycling							
11 Enjoys Swimming							
12 Enjoys Watching Sport							
13 Active Participation in Sport							
14 Practising Member of Religion							
15 Strength of Religious Belief							
16 Enjoys Card Games							
17 Other Hobbies / Interests							
18 Extrovert							
19 Introvert							
TOTALS							

							Key
							0 Considerable Strength · **1** Some Strength · **2** Mediocre Strength · **3** Weak · **4** Hindrance · **5** Definite Handicap
SPECIFIC MANUAL HANDLING	0	1	2	3	4	5	*Risk / Manual Handling Issues / Assessments*
							The higher the number the greater the risk
1 Out of Chair / Out of Bed							
2 On and Off Mechanical Lift							
3 From Bed to Chair							
4 From Chair to Bed							
5 In and Out of Wheelchair							
6 In and Out of Vehicle							
7 On and Off WC / Commode							
8 Walking							
9 Walking Stick / Zimmer Frame							
10 Lifting Light Objects							
11 Lifting Heavy Objects							
12 Lifting Awkward Objects							
13 Strength of Grip							
14 Lifting of Unnecessary Objects							
TOTALS							

Admission / Discharge Register

Nursing / Residential / Social Support *(delete as appropriate)*

Name	Admitted from	D.O.B.	Marital Status	N.O.K.	G.P.	Date of Admission	Admission Authority	Date of Discharge	Discharge Address	Date of Transfer	Address and Reason	Date / Time Cause of Death	Section / Order?

Admission Procedure Checklist

Resident Name .... D.O.A. .... / .... / ....

Make entry in admission / discharge file [ ]

Complete Resident Profile [ ]

Complete Missing Person Form [ ]

Complete Resident Contract [ ]

Complete Cash and Valuables Sheet [ ]

Complete Medication Sheet (if applicable) [ ]

Make entry on Resident Events Sheet [ ]

Complete Property Book [ ]

Complete Cash and Valuables Book [ ]

Order books returned to DSS? [Y] [N]

If YES, date sent ....

If NO, reason ....

....

....

Income Support, A1, form completed and sent with standard letter to DSS? [Y] [N]

If YES, date sent ....

If NO, reason ....

....

Current Sick Note on admission? [Y] [N]

If NO, action taken ....

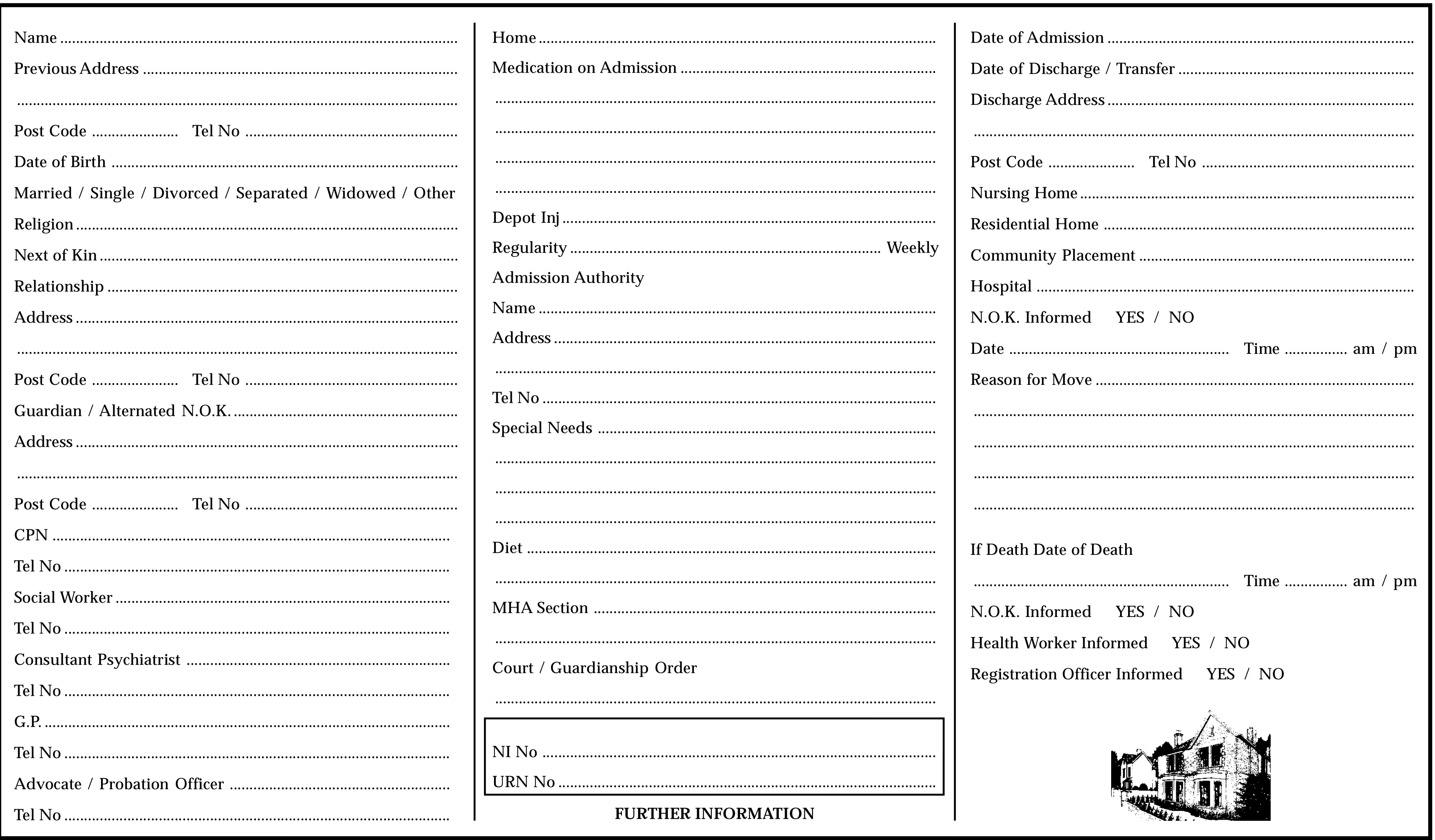
....

Admitted by: .... Date: .... / .... / ....

Signature: ....

Designation: ....

Cornerwood Resident Personal Profile



Name
Previous Address

Post Code ..... Tel No
Date of Birth
Married / Single / Divorced / Separated / Widowed / Other
Religion
Next of Kin
Relationship
Address

Post Code ..... Tel No
Guardian / Alternated N.O.K.
Address

Post Code ..... Tel No
CPN
Tel No
Social Worker
Tel No
Consultant Psychiatrist
Tel No
G.P.
Tel No
Advocate / Probation Officer
Tel No

Home
Medication on Admission

Depot Inj
Regularity ..... Weekly
Admission Authority
Name
Address

Tel No
Special Needs

Diet

MHA Section

Court / Guardianship Order

NI No
URN No

FURTHER INFORMATION

Date of Admission
Date of Discharge / Transfer
Discharge Address

Post Code ..... Tel No
Nursing Home
Residential Home
Community Placement
Hospital
N.O.K. Informed YES / NO
Date ..... Time ..... am / pm
Reason for Move

If Death Date of Death
..... Time ..... am / pm
N.O.K. Informed YES / NO
Health Worker Informed YES / NO
Registration Officer Informed YES / NO

SERVICE SPECIFICATION FOR RESIDENT CONTRACT

Introduction

It is our sincerest intention to provide a comfortable and happy home suited to an individual's special requirements. We undertake to consult the resident and or their family together with any others acting in their interests in all matters to do with their well being.

The decision to become resident needs careful consideration. For this reason, the first FOUR weeks of the stay should be considered as an Assessment period.

Fees

The fees currently payable are as agreed as signed on your Financial Agreement Form with the Social Service Department, of which you have a copy.

The fee is part paid by the Benefits Agency weekly, and the rest from the Social Service Department on a monthly basis.

Fees include the cost of total care with accommodation in either a single or twin room, food and drink, heat and light, laundry cleaned on the premises, Occupational and Music Therapy, Outings and Toiletries. Other Daycare provision as reasonably requested or available.

Fees do not cover the cost of newspapers, hairdresser, chiropodist, dry cleaning, treatment by dentists or opticians or clothing.

Fees are based on residing through a full week, if you leave prior to the week ending, a full weeks fee will be required.

Fees are reviewed periodically, usually in April of each year, except for circumstances unforeseen which are beyond our control.

Four weeks notice in writing will be given of any change in fees, unless circumstances require urgent attention.

Absences

Fees for absences such as holidays or hospitalisation will be 100% for the first 6 weeks and then reduce to a rate of 80% until return.

Personal Possessions

Personal possessions and small items of furniture are encouraged and all possessions will remain the property of the resident. Residents are reminded that items of value kept with them are their responsibility and the Home cannot accept responsibility for any loss or damage.

Whilst every effort will be made to care for items of personal clothing, the proprietors cannot accept responsibility for damage to delicate clothing during laundering, or loss of items not clearly marked with their owner's name.

Insurance

The Home is properly insured by the ....

Policy Number .... **in Nursing Care**

Policy Number .... **in Satellite Care**

Please enquire regarding the insurance cover in relation to your personal property.

Outings

Visitors are encouraged to take residents out although they must advise the person-in-charge that they intend to do so.

The Home cannot accept responsibility for the resident during such outings.

The Home does supply some daycare, outings, and other leisure activities on a regular basis. Some conditions may apply to their use at the discretion of the Manager or Nurse-in-Charge.

Medication

The Boots System of Medication is used at the Home

In Residential and Support Satellite Units prescribed medication is the resident's private property. In cases where the resident is unable to supervise his/her own, authorised staff will make arrangement for its supervision and administration.

In Nursing Care the medication is held and administered by the Nurse-in-Charge, unless agreement between the Registering Authority, the Home and the resident has been reached.

Termination of Agreement

Four weeks notice or payment in lieu will be required should a resident decide to leave the Home except that when the departure results from serious circumstances no such notice will be required. Although it is the aim of the Home to care for residents for life if required, special circumstances, such as a continual need for medical or physical care may make it necessary to ask the resident to leave. In such circumstances we will endeavour to be as helpful as possible to have a smooth transfer of care to suitable alternative accommodation.

Initials .... Resident .... Home ....

Serious Circumstances

In the event of an emergency, the next of kin and/ or legal representative will be informed. The Registration Authority will also be informed.

Registration

The Home is registered as a (Nursing) (Residential) Mental Aftercare Home by the (Health Authority) (Social Services Department) which is responsible for ensuring that standards are maintained. Or you are in Social Support and your Social Worker or C.P.N. is your Monitoring Authority.

Complaints

Please read the full Complaints Procedure which is displayed in the **ENTRANCE HALL**. A copy is supplied with this contract.

Contract with THE HOME and Resident

I HAVE READ THE CONTRACT AND WILL ABIDE BY ITS CONTENTS

Signed .... *for* ....

Date ....

Signed .... *(Resident)*

Date ....

I HAVE RECEIVED A COPY OF THE COMPLAINTS PROCEDURE

Signed .... *(Resident)*

Witness .... *Date* ....

RESIDENT ROOM KEYS

I have received a dual bedroom / front door key from the Home

I understand that if I lose the key, I am responsible for the cost of replacing the key.

I understand that if I move rooms or leave the Home and do not return the key, I am responsible for the cost of a new key.

Resident .... *Date* ....

Witness: .... *Date* ....

Resident Event Sheet

Surname .... Forenames .... Mr / Mrs / Miss / Ms D.O.B.: .... G.P.: ....

Date		

Resident Care Plan

Surname .... Forenames .... Mr / Mrs / Miss / Ms D.O.B.: .... G.P.: ....

Date	Problem	Plan	

Resident Evaluation Sheet

Surname .... Forenames .... Mr / Mrs / Miss / Ms D.O.B.: .... G.P.: ....

Date	Intervention	Evaluation	

Missing Person

Missing Person Book
Item No .... / ....

From: Person-in-Charge ....

Home's Address of Missing Person ....

....

Date of Admission .... / .... / .... Missing From (Date) .... / .... / ....

(For Completion on Admission and Retention with Resident's notes)

Name ....

Place and Date of Birth ....

Occupation (if appropriate) ....

Home Address ....

....

Height .... Build (Stocky / Thin / Fat / Slim / Medium / Heavy)

Hair (Dark / Fair / Auburn / Grey / White) ....

Length of Hair (Short / Long / Bald / Wig) ....

For Males Only (Unshaven / Clean Shaven / Moustache / Beard) ....

Colour of Eyes (Blue / Brown / Hazel / Green / Other) ....

Complexion (Dark / Coloured / Fair / Ruddy / Pale / Sallow) ....

Dentures YES / NO Spectacles YES / NO

Visible Marks / Scars ....

....

Peculiarities or Other Distinguishing Features ....

....

Other ....

....

Missing Person contd.

Missing Person Book
Item No .... / ....

The Police were notified at .... am / pm on .... 19 ......
that the resident was missing and I have searched the immediate area, and made suitable inquiries without finding the resident.

Signed .... *Person-in-Charge*

Description of Clothing Worn ....

....

Known to be in possession of money? YES / NO Estimated £ .... : ....

Warning Signs (Suicidal / Depressive / Confused / Alcohol / Violence)

If necessary this should be reported to one or more of the following services below:

Head of Home informed at ....

Registering Authority Informed at: ....

Social Worker informed at: ....

C.P.N. informed at: ....

G.P. informed at: ....

Relatives informed at: ....

Name: ....

Address: ....

....

Relationship: .... Telephone: ....

Resident found at: ....

Date: .... Time: ....

All of the above who were notified of missing person to be notified when resident is found.

All notified YES [ ] NO [ ]

If NO reason: ....

....

Nursing Notes [ ] Handover Notes [ ] Missing persons File [ ] Personal File [ ] Missing Persons Books [ ] Item No on Forms [ ]

Depot Injection Chart

Resident Name ....

Date	Depot Injection	Dose	Route	Frequency	Sign

Weight Chart

Stones															
20															
19															
18															
17															
16															
15															
14															
13															
12															
11															
10															
9															
8															
7															
6															
5															

Date [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Month .... Year ....

Name ....

Home ....

Vital Signs Chart

Name .... D.O.B. ....

Date .... Time Began .... am / pm to ....

Time [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Temperature																										
104°F																										
103°F																										
102°F																										
101°F																										
100°F																										
099°F																										
098°F																										
097°F																										
096°F																										
095°F																										

Pulse and Respirations																										
160																										
150																										
140																										
130																										
120																										
110																										
100																										
090																										
080																										
070																										
060																										
050																										
040																										
030																										
020																										
010																										
000																										

BP																										
Stools																										
Vomit																										
Input																										
Output																										
Tests																										

Weekly Cash Audit

The person named below has requested the Home to hold cash for safe keeping on their behalf.

Date	Cash Held Held	Amount Returned	Nurse Signature	Resident Signature	Cash Now Held in Res. Box	Nurse to Initial To Confirm Amount	

Under no circumstances must residents' money be used for any other need, even if temporary. Boxes must have a nil balance by 8pm each Thursday night. Night Nurse to inform of any irregularities. Money must not build up. Day Staff to check each transaction, night staff to check each night and distribute cash each Thursday night according to cash printout.

Resident's Name: ....

Special Payments Form

Name: .... Home: ....

	Amount	Signed By	Date
Saturday			
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
TOTAL PAID			

Payments received by: .... this week.

Signed by: ....

For the attention of: ....

Company: ....

Telephone: .... Facsimile: ....

Fax sent to: ....

Sent by: .... Date: ....

Received from: .... the sum of £ ....

Sent by: .... Date: ....

Receipt faxed to: ....

Sent by: .... Date: ....

CORNERWOOD

: . . . . ( ) . . .

STANWAY HOUSE
184 Greenway Road
Taunton TA2 6LH
Tel: 01823 279569
Fax: 01823 330036
Resident Line: 01823 323149
Publications: 01823 354881

EXAMPLE ONLY

_____ / _____ / _____

Dear Benefits Agency

Below is a named person who is having care in the Home

PRESERVED RIGHTS YES [ ] NO [ ]

Re	*Formerly of*
....	....
....	....
....	....
....	....

.... was admitted to the Home today.

He / She is now in our **Nursing [ ]** **Residential [ ]** **Support [ ]** **Aftercare Unit**.

The above named resident suffers from Mental Handicap, Debilities and Disorders.

As from ...., the fee for their residence is .... : .... per week, inclusive of Room, Meals, Heat, Light, Laundry, Medical, Psychological Care and associated services.

A Sickness Certificate is: Enclosed [ ] Forthcoming [ ] in your possession [ ] has a valid Hospital certificate [ ] Other [ ].

Yours sincerely

Manager

INVESTOR IN PEOPLE

CORNERWOOD LTD.

005

Sick Notice

PART A

To: ....

Resident's Full Name: ....

Religion: ....

Next of Kin: ....

Telephone: ....

(Please tick box as appropriate)

TYPE 'A' [ ] **Advised relative to visit as soon as possible**

TYPE 'B' [ ] **Urgent - seriously ill - immediate visit required**

Notified by: ....(Telephone or Police)

Date: .... Time: .... am / pm

Signed: ....

Designation: .... Date: ....

PART B

Sick Notice Type A / B

Resident's Minister: ....

Telephone: ....

Notified: .... Time: .... am / pm

*Note: It is the responsibility of the **Nurse-in-Charge** to inform the residents responsible relative. The **Nurse-in-Charge** should contact the appropriate minister if required.*

CORNERWOOD

STANWAY HOUSE
184 Greenway Road
Taunton TA2 6LH
Tel: 01823 279569
Fax: 01823 330036
Resident Line: 01823 323149
Publications: 01823 354881

EXAMPLE ONLY

_____ / _____ / _____

Dear Woman's Institute

Re: ....

He / she is now in our **Nursing** [ ] **Residential** [ ] **Support** [ ] Aftercare unit.

The above named resident suffers from Mental Handicap, Debilities and Disorders.

His / her clothing needs are unable to be funded by themselves on Income Support / Sickness Benefit.

We would be grateful if you could supply some clothing / footwear described below.

Please supply:..

....

....

....

....

....

Yours sincerely

Manager

INVESTOR IN PEOPLE

CORNERWOOD LTD.

005

Home Care / Domiciliary Health Safety Record

Client .... Date ....

Address ....

....

Equipment / Area Checked ....

Location ....

Condition ....

....

....

Comments / Action Taken ....

....

....

....

....

Client Home / Domiciliary Service Record

Client's Name ....

Address ....

....

Date .... Time ....

Activity ....

....

....

....

Details ....

....

....

....

....

Signed ....