MANAGEMENT ANSWERS

QUALITY ASSURANCE INFORMATION ANALYSIS

Candidate Name…….....

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Explain what information you used, what information you rejected and why?

The information below is the core information to be analysed when making decisions regarding how the home is succeeding or not succeeding with it's care and management as a business looking after people. I give general guidance on what is looked for to be good and what to look for that is bad

- Staff

We look at the sickness and absence through:

Monitoring the regularity, is it always the same day, every week, month etc, have they had a good sickness record before and is the new sickness to do with personal problems, alcohol or drug abuse, staff moral or bullying. Are there sickness certificates from doctors, self certification or just an odd day off now and then

- Purchaser

Is the supplier a recognised ongoing supplier, are they new to us but we either will or will not use them again, was the product bought of a quality and cost that would be anticipated, have they a returns policy, have others been contacted who have used the purchaser to check if they are a good supplier and whether or not they are part of an industry group (like the Federation of Master Builders), or have a national quality standard (IS00 9002, Investor in People)

- Resident

Are they well, have there been any changes in condition in the last week, has the needs assessment changed, so therefore the care plan will need to change, are their any outstanding issues that need to be considered (annual GP medical). What changes can be made outside the needs assessment to improve client's motivation and life experiences (Involvement in activities)

- Relatives

Their concerns, update information (change address etc). Relatives meetings, have there been any, what were the outcomes, have they been acted upon, can they be acted upon, how can they be helped through the process of care for their loved one

- Complaints

Monitor numbers, resolution issues, reflect on internal policies with national guidelines for resolution outcomes, what happens if issues cannot be resolved, check on investigations to see if procedures have been followed, personal input, letters and visits where appropriate

• Record of Referrals

Referrals consistent with full occupancy, supplier contact and relationship building. Have relation-

ships been retained, if not why not, what more can be done to re-adjust relationships, check standards (care and environment) to ensure the links are established for full occupancy

• Admission / Discharge Records

Numbers of admissions and discharges, any trends. Increase hospital admissions, deaths, causes of these, clients being moved to other units, causes of these. Survey clients opinions, hold meetings to establish satisfaction or not

• Violent Incident Records

Gives a good indicator into client behaviour assessment, numbers and trends, Care Plan adjustments. Check staffing levels, skill mix, training and qualifications, environment (too crowded areas), medication, physical and mental changes taking place (increased confusion, constipation), medical opinion, adjust diets.

• Accident Records

Gives a good indicator into client needs, numbers and trends, Care Plan adjustments. Same or different client's injured, same or different client causing accident, health and safety issues (wet floor etc), staffing level, skill mix, training, lighting, what can go wrong-does

• Occupancy Levels

Trends, marketing, full occupancy or empty beds, reasons,- good or poor quality fixtures and fitments, good or poor cleaning methods and activity, good or poor interaction with clients and relatives and professionals, good or poor training and development, good or poor decoration, good or poor client activities

The details from each record mentioned above is documented in the form of graphs which will be displayed in the Office and reviewed as part of the Management Meetings.