



Care Provider/Team:

Date of Visit:

Carefirst No:

In-House

Brokerage

Home Care Quality Monitoring Form

BACKGROUND INFORMATION

Name of Service User:

Address:

Telephone Number:

Name and relationship of main carer (if other than Home Care):

Telephone Number (including STD code):.....

Are carer's views included on this form? Yes No

If YES, how? Via telephone During Visit

Date service commenced:

Referral Source:

- | | |
|--------------------------------------|---|
| Hospital <input type="checkbox"/> | Community Mental Health Team <input type="checkbox"/> |
| Intake Team <input type="checkbox"/> | Care Management Team <input type="checkbox"/> |
| PDSI Team <input type="checkbox"/> | Learning Disability Team <input type="checkbox"/> |

Care Plan Tasks	Days	Time/ Duration	Total Hrs per wk	Total Visits per wk

USER FOCUSED SERVICES (STANDARDS 1-6)

Care Needs Assessment (Standard 2)

1. Did you feel you were involved in deciding what type of help or support you needed? Yes No
2. Do you have a copy of your care plan? Yes No
- 2a. If NO, is it because you said you do not want a copy of your plan in your home? Yes No
3. Do you feel that your care plan meets your current care needs? Yes No

3a. Comments:

.....

Information (Standard 1)

4. Were you given enough information about the Home Care Service/Provider before your service commenced? Yes No

4a. Comments:

.....

.....

5. Did you receive a service user guide when your service began? Yes No

Responsive Services (Standard 6)

6. Are you happy with the times your Home Care Assistant arrives? Yes No
7. Is the length of the visit appropriate to your needs? Yes No

7a. Comments:

.....

8. Has your Home Care Assistant ever failed to arrive at the allocated time? Yes No

- 8a. If YES, were you informed in advance that they were not coming? Yes No

8b. Comments:

.....

9. How many different Home Care Assistants normally visit you in a week?
- 1-3
- 3-6
- 7 plus

10. How do you feel about the number of Home Care Assistants that come to you?

Comments:.....
.....
.....

11. Is the service you receive what you expected? Yes No

11a. If NO, why not?.....
.....

12. Can you suggest anything else that can help us to improve the service?

Comments:.....
.....
.....

PERSONAL CARE (Standards 7 - 10)

13. Does your Home Care Assistant introduce themselves on their first visit? Yes No

14. Do you think that Home Care Assistants have enough information about your individual care needs? Yes No

14a. Comments:.....
.....
.....

15. Overall, does your Home Care Assistant carry out agreed tasks in accordance with your preferences? Yes No

(E.g. what are the most important tasks you need doing first, what you want to eat, how you like your food cooked, how personal tasks are carried out?)

16. Have any of the above been unsatisfactory? Yes No

16a. If so, please provide comments:
.....
.....

17. Overall, do your Home Care Assistant/s show respect for you, your possessions and personal way of life? Yes No

18. Have any of the above been unsatisfactory? Yes No

18a. If so, please provide comments:

.....

.....

Autonomy and Independence (Standard 9)

19. Do you feel that your Home Care Assistant encourages and assists you to maintain your independence where appropriate? Yes No

19a. Comments (give practical examples, if possible):

.....

.....

20. Is there anything that can be done to improve this? Yes No

20a. Comments:

.....

.....

ORGANISATION AND REVIEWING OF SERVICES (Standards 22-27)

Complaints and Compliments (Standard 26)

21. Have you ever contacted the Home Care office? Yes No

22. Were you happy with the response you received? Yes No

22a. Comments:

.....

23. Do you know how to make a complaint, comment or compliment about the service? Yes No

24. Are you clear who to contact, should any problems arise?

Out of office hours? Yes No

During office hours? Yes No

25. Overall, how satisfied are you with the quality of Home Care Service you receive?

Very satisfied	Quite satisfied	Quite unsatisfied	Very unsatisfied
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25a. Comments:

.....

PROTECTION (Standards 11 - 16)

Safe Working Practices (Standard 11)

26. Overall does your Home Care Assistant/s take enough account of safety and hygiene practices? Yes No

(E.g. Use disposable gloves, plastic aprons, circuit breaker when using electrical appliances, wash her/ his hands before and after preparing food/ carrying out personal care tasks/use of equipment and correct disposal of incontinence products)

27. Have any of the above been unsatisfactory? Yes No

Please provide comments:

.....

Financial Protection (Standard 13)

28. Does your Home Care Assistant handle any of your financial transactions? (E.g. pension collection, shopping) Yes No

29. If YES, does she/ he give you a receipt and count out your change? Yes No

29a. Comments:

.....

Security of the Home (Standard 15)

30. Does your Home Care Assistant wear an identity badge? Yes No

Records Kept In the Home (Standard 16)

EVIDENCE CHECK *(please ✓ in the box)*

Are the following documents kept in the service user's home?

	present in home	up to date	
Service User Plan	<input type="checkbox"/>	<input type="checkbox"/>	
Service User Guide	<input type="checkbox"/>	<input type="checkbox"/>	
	present in home	up to date	signed
Evidence of risk assessment carried out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of manual handling assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Up to date visit record sheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical record sheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EQUALITY MONITORING: Service User Details:

Age: Ethnicity Code: Sex:

VISIT MONITORING: Was this visit?

Initial visit (up to 6 weeks)	Annual follow-up visit	Ad hoc visit
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PAYMENTS MONITORING (Check information on HEPS)

Did you agree to pay the full cost of your service? Yes No

If No:

Have you been financially assessed? Yes No

Do you have to pay for the services? Yes No

If Yes:

How do you pay for the service? Swipe Card/Invoice

How much have you been assessed to pay? £.....

Have you had any difficulties with paying? Yes No

Comments:
.....
.....

Are you satisfied with the payment process? Yes No

Comments:
.....
.....

Name (printed) of DCM/DCC/Brokerage staff:

Signature: **Date:**.....

Name of Service User:

Signature: **Date:**.....

If service user not able to sign (Please give details):.....
.....



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Actions following visit

Name of Service User:

NB Please note question number, issue, action taken and date.

Question	Issue	Action & Date

DCM (print name) Signature: Date:

DCC (print name) Signature: Date:

Name of Service User:

Date of Visit:

Carefirst No:

Question	Issue	Action & Date

DCM (print name) Signature: Date:

DCC (print name) Signature: Date: