

MANAGEMENT SYSTEM AUDIT REPORT

Executive Summary

Company Name: North Staffordshire Residential Homes Limited
Legal Status:
Certification Number: 1585
Head Office Address: Tittensor Road
 Tittensor
 Staffordshire
 ST12 9HQ

Telephone: 01782 373584
Type of Audit: RECERTIFICATION
Visit Number: 6
Date of Audit: Tuesday, 5 March 2019
Audit Team Leader: Mike Pepperell , Paul Grainger
Audit Team Member(s):
Standard(s) Audited: ISO 9001: 2015
EAC Code(S): 38c
Agreed Scope: The provision of nursing, residential, respite, palliative and day care.

Non-applicable clauses:

Main client representative: Mrs B Warren
Telephone: 01782 373584
E-mail: heyfieldshouse@tesco.net
Consultant representative if used:

Staff FT: **Staff PT:**

Start Time: **Finish Time:**

Total Hours:

Justification for early finish time (less than 8 hours):

Surveillance visits set at:	2	per year of	1	days per visit
Date(s) of next visit	28-10-2019			

NB If the next visit is a Recertification Visit additional days over and above the surveillance days may be required.

Alcumus ISOQAR's Rules of Registration Apply See www.alcumusgroup.com/ISOQAR

This report is confidential and its distribution will be limited to the audit team, client representative and Alcumus ISOQAR office

1. Audit Summary (Non-conformance, Opportunities for Improvement, Good Practice etc)

The documented quality system has been maintained and meets the requirements of ISO9001:2015.

2. Findings

NCR N°	Details of Non-conformances Raised	Standard/ Clause N°	Major/ Minor	Completion Date
1.				
2.				
3.				
4.				
5.				

The organisation's representative understands the above Non-conformances and agrees to determine the root cause(s), and implement appropriate corrections/corrective actions.

Agreed by (organisation representative) Date

Method of Close Out

Corrections/Corrective Action Evidence to be sent to ISOQAR YES NO

Check Corrections/Corrective action taken at next visit YES NO

Revisit to check Corrections/Corrective Action required YES NO

Note to Client: Please complete the Corrective Action Report Section of this report for any Non-conformance

Total Number of Non-conformances Major Minor

*** PLEASE NOTE THAT THERE WILL BE AN ADDITIONAL CHARGE FOR ISOQAR TO CLOSE OUT ANY MAJOR NON-CONFORMANCES AS PER THE RULES OF REGISTRATION**

3. Any significant Organisational Changes (also include any changes to surveillance visit patterns e.g. if additional standards have been added) and any additional information or any significant changes to the plan for stage 2 or planned arrangements (produced at stage 1)

No significant changes since the last visit.

4. Audit Conclusion

The audit team concludes that the organisation **HAS** established and maintained its management system in line with the requirements of the standard(s) and demonstrated to the audit team that it has the ability to systematically achieve the requirements for products and or services within the scope of its activities and in accordance with its policy and objectives.

The audit team recommends that based on the evidence obtained during this audit that Certification should be:

Recommended Continued Deferred (until satisfactory corrections/corrective action has been completed)

Corrective Action Report

CLIENT to complete this section following Stage 2 audits, Recertification Audits and Majors Raised on surveillance only if evidence of corrective and preventive action is required to be submitted to ISOQAR see above.

AUDITOR to complete this section if any non-conformances are closed out prior to the end of the audit as evidence of close out.

COMPLETE FOR NON-CONFORMANCES RAISED IN SECTION 2 Following Stage 2 audits, Recertification Audits and Majors raised on surveillance only

Client Name: Certification Number: Audit Date(s):

NCR N°	Corrective Action Taken	Root Cause	Action taken to prevent recurrence	Evidence	Accepted by
1					
2					
3					
4					
5					

This page **must** be completed and sent to ISOQAR (either via e-mail or post) along **with any relevant documentary evidence** if instructed to do so in the Executive Summary

ISOQAR e-mail Address certdept@alcumusgroup.com
Post to FAO Cert Dept, ISOQAR Ltd. Cobra Court, 1 Blackmore Road, Stretford, Manchester M32 0QY

Completed By (Company Representative) Date

Additional Information:

NB. Where evidence of corrective action is required to be submitted, Certificates of Registration can only be issued after the evidence supplied has been received, reviewed and accepted. Any Non-conformances not closed out within 3 months of the audit date may result in a re-audit being conducted and could also result in Certification being suspended.

FOR OFFICE USE ONLY WHEN EVIDENCE IS SUBMITTED TO ISOQAR

Satisfactorily closed out? YES NO Reviewed By Date

If **not** satisfactorily closed out next actions to be taken:

NB Where Non-conformances are raised

- For Initial Audits, Extensions to Scope and Recertification Audits; all Non-conformances must be closed out before a Certificate is authorised for issue and **can only be closed out** either by submission of evidence to ISOQAR or a re-visit to audit the corrections/corrective action (**see Non-conformance section of this report**).
- For Surveillance Audits any Non-conformance **classified as Major can also only be closed out** either by submission of evidence to ISOQAR or a re-visit to audit the corrections/corrective action (**see Non-conformance section of this report**).

NB All Non-conformances **must be actioned** within the agreed timescales.

Please Note: The audit conclusion is provisional and subject to review by ISOQAR's Certification Review Team.

Detailed Audit Report

The objectives of the audit:

- To confirm that the management system conforms with the requirements of the audit standard and also any statutory, regulatory and contractual requirements that are applicable;
- To confirm that the organisation has effectively implemented the planned management system;
- To confirm that the management system is meeting its specified objectives
- The auditing is based upon a sampling process of available information
- As applicable identification of areas for potential improvement of the management system.
- To identify any non-applicable clauses under the scope of certification

Audit scope:

- The audit will evaluate the effectiveness of the processes identified within the visit plan and in line with the 3 year plan. The audit will be conducted at the location(s) specified within the visit plan.

Pre- Audit Activities

1. Opening Meeting Attendees:

Name	Position
Tim Warren	Owner
Sharon Jones	Matron
Debra Finney	Bursar

2. Follow up of previous audit results

Have previously raised Improvement Requests/Non-Conformances been effectively closed out? Yes: No:

Has the root cause been determined and effective actions taken Yes: No:

If **Yes** summarise the evidence seen if **No** what actions have resulted:

N°	Previously raised IRs/NCs	Action	Closed out
1.	N/A		
2.			

Site Walk

The premises consist of a Country house converted into a nursing home consisting of resident rooms, lounges, dining rooms, bathrooms, a laundry, kitchen and food storage areas, and nursing stations.

A purpose build annex was added approximately six years ago which extended the capacity of the nursing home to approximately 46 beds.

The buildings are surrounded by well maintained gardens and farmland.

The resident's rooms are all en-suite.

The home has attained the gold standard framework award which was recently upgraded to "Platinum status".

Main Audit (ISO 9001:2015, ISO 14001:2015)

4. Management System and Its processes (Including Interview with Senior Management to discuss context, interested parties, scope, any non-applicable clauses)

Detail and evidence:

Context of the Organisation (PG)

Quality manual is currently at version 2 Dated - 10/10/17 and includes organisational context which is defined within the scope which remains unchanged from the previous management system and is defined as follows;

Interested Parties / Internal & External Issues (PG)

Internal and external issues include individual client risks, regulatory requirements, funding (local and government) Residents, relatives, local authorities and regulators.

Interested Parties include; Management Team, Workforce, Residents, Families, Suppliers, Local Councils. These are captured in section 3.2 of the Quality Manual and include;

Scope of the Management System (PG)

The scope of the QMS has been determined as *"The provision of nursing, residential, respite, palliative and day care"*. Design and development is not applicable to the scope of certification.

The Quality Manual also includes an interaction of processes Roles and Responsibilities, Policy Statement and Processes and Procedures

Summarise Conformity with Requirements:

Complies with clause 4 of ISO9001:2015

5. Leadership (Including interview with Senior Management to discuss commitment, customer focus, policy, organisational roles, responsibilities and authorities)

Detail and evidence:

Leadership (PG)

The management team were able to explain the context, interested parties and how they have defined their risks and opportunities. Leadership and context are also defined within the quality manual. Top management ensure adequate resources are in place to administer the QMS and also ensure North Staffordshire Residential Homes maintain high standard of service delivery.

Quality Policy (PG)

The Quality policy is reviewed during the quality management review meetings and has been revised to capture the enhanced requirements of the new standard. Policy on display in both buildings and shared externally upon request. The policy is also included in the manual.

Customer Focus (PG)

Customer focus demonstrated through resident meetings, care planning meetings, end of life care plans. Questionnaires are also used with residents and families to ensure they are happy with level of service being provided by the staff. Additional to this there is a robust customer complaints procedure in place which includes full visibility of issues to all within the nursing home.

Roles and Responsibilities (PG)

Roles, responsibilities and authorities are defined in individual job descriptions, these are overseen by the Nursing / Quality officer. Section 5.3 of the Quality Manual also gives brief description of the responsibilities of the Proprietor, Matron (Quality Nursing Officer) and General Nursing Staff.

Summarise Conformity with Requirements:

Complies with clause 5 of ISO9001:2015

6. Planning for the Management System

Detail and evidence:

Risks & Opportunities (PG)

Risks and opportunities are identified through care plans, resident's needs are identified during the care plan reviews, internal / external audits, and definition of requirements from internal and external interested parties including resident and relative's feedback forms and complaints, these are subject to regular review. Section 6.1 of the Quality Manual details the actions to address risks and opportunities. Risk are discussed and reviewed through the management review meetings and are then communicated out to the workforce appropriately.

Key risks identified have been captured in Appendix 1 in the QMS and the following reviewed by the auditor;

Identified Risks	How Risks are Managed
Healthcare changes	Continually update ourselves on any legislation changes i.e. CQC, DOLS, Environmental Health -Maintain effective registration
Care Quality Commission	De registration from nursing to residential or loss of certificate. Make sure we keep ourselves up to date on changes and ensure we ask questions
Local and Government funding	Ensure variation in type of funding i.e. not 100% CHC due to risk. Make sure reports are carried out on time and invoicing. Government or private are done on a regular basis.
Council and government policy changes	Keep up to date with policies
Staff changes and staff turnover	Intensive Selection and Recruitment of staff
Time pressure and constraints on nurses	Ensure good working conditions/hours/rates of pay for RN's to maintain retention. Good support network for all staff.

Objectives and Targets (PG)

Objectives are addressed in section 9.3 of the quality management system manual, Objectives and targets regarding training and linked to the training plans and reviewed at management review by top management to ensure plans are being achieved.

Objectives include;

1. Retain ISO9001:2015 and also a high standard of CQC inspections.
2. Retain the Gold Standard Framework.
3. Retain and recruit high calibre quality staff.
4. Provide ongoing training for all staff
5. Refurbishment of the main house (*Where Required*)

Planning of Changes (PG)

This is managed through management review meetings any changes to the QMS and its associated processes and procedures are authorised by the Senior Management Team. This is detailed with the Quality Manual. Planning for change also encompasses the following other areas of the management system;

- Internal and external issues
- Interested parties
- Risks and opportunities
- Quality objectives
- Roles, responsibilities and authorities
- Resource requirements

Summarise Conformity with Requirements:

Complies with clause 6 of ISO9001:2015

Detail and evidence:

QMS Manual - Section 7.0 - Details Resources, Competence, Awareness, Communication, Documented Information and Calibration & Maintenance of Equipment.

Training & Competence (PG)

The Training matrix defines individual job roles and competencies and there are also training incorporated into the business management plan, reviewed at management review and defined in the individual training records, these are reviewed frequently as a requirement of the CQC. Training records were reviewed for;

JW – (RGN)

Catheterisation update for Nurses -Dated – 25/05/16 – NHS Mids & Lancs
NCFE Level 2 – End of Life Care – 12/10/15 Cert No. 3540654
PEG Training – NHS North Midlands 20/10/16

JM - Cook

Manual Handling Training – 19/12/18
Adult Safe Guarding – 13/02/19 – Chris Doyle Care Training
Fire Marshall Training – 05/09/18
Food Hygiene Safety Training – Level 2 – 27/07/18
Hand Hygiene Training – 24/05/16

DC - Kitchen

Manual Handling Training – 19/12/18
Adult Safe Guarding – 13/02/19 – Chris Doyle Care Training
Food Hygiene Safety Training – Level 2 – 12/09/17
Hand Hygiene Training – 24/05/16

BD - Kitchen

Manual Handling Training – 19/12/18
Adult Safe Guarding – 30/01/19 – Chris Doyle Care Training
Food Hygiene Safety Training – Level 2 – 05/09/18
Fire Marshall Training – 05/09/18

Maintenance, Infrastructure & Calibration

The Infrastructure and Environment is suitable and effective and provides a relaxed and friendly atmosphere for the residents, the residents are fully engaged in a number of activities that are stimulating and entertaining and include trips out to the cinema and theatre as well as one to one trips to coffee and tea shops, newspaper groups and crosswords.

The infrastructure in the home is maintained and serviced and this can be demonstrated e.g. thermometers are calibrated, lifts and hoists are serviced, portable appliances are tested regularly, and electrical and safety equipment is maintained.

The following maintenance records were reviewed by the auditor;

- Romedic 7500 System – Last serviced on 21/11/18 by Lifting Equipment Services Ltd (Rep 6766)
- Birdy Invacare Hoist (150 kgs) - Last serviced on 21/11/18 by Lifting Equipment Services Ltd (Rep 6761)
- Heating Boiler (Annexe) - Last serviced on 05/06/18 by OFTEC CD/11 Report on file
- Stable Wing Boiler - Last serviced on 05/06/18 by OFTEC CD/11 Report on file
- Garden Wing Boiler - Last serviced on 05/06/18 by OFTEC CD/11 Report on file
- PAT testing was carried out by Calbarrie on all appliances in April 2018
- Weigh scales calibrated 07/09/18 by Scaleways – Various
- Thermistor Thermometer & Probe – SN – 1415552 5552 – Calibrated by Hanna Instruments – Cert No. 258694/1
- T34 Syringe Driver – Service and Calibration 29/03/18 by CME
- Lift serviced 23/01/19 by RJ Lift Services - Rep No. 49477
- Extinguishers serviced 12/10/18

- Weekly and Monthly records viewed for the Descaling of shower heads
- Daily records viewed for the temperature checks of the medicines fridge and Fire Panel

Control of Documented Information (PG)

Formally documented control system with document register defining procedures and processes (Detailed in Section 7 of the Quality Manual), All key documents, procedures and forms are version controlled including changes to revision / issue the quality policy and quality manual are currently at version 2. Robust system are in place for records; data protection, freedom of information act, information governance planner, etc. The QMS Manual is dated October 2017 and is at Issue 2 During the audit there appeared to be no conflict with the procedures regarding issue numbers. (No changes since the previous audit)

A sufficient sample of a variety of documents and records demonstrated effective controls were in place. Paper documents are retained in suitable files and folders.

The Environment is suitable and effective and provides a relaxed and friendly atmosphere for the residents, the residents are fully engaged in a number of activities that are stimulating and entertaining and include trips out to the cinema and theatre as well as one to one trips to coffee and tea shops, newspaper groups and crosswords.

Summarise Conformity with Requirements and any non-applicable clauses with justification:

Complies with clause 7 of ISO9001:2015

8. Operation

Detail and evidence:

Drug Administration (MP)

Through the Medical Admin record sheet the scheduled drugs are administrated to the residents, either blistered or from new boxes (in the case of new residents whose drugs aren't delivered blistered yet). Correct drug, dose and expiration date is checked for every drug. Drugs are handled as little as possible manually by staff by popping into pots, and are then placed for the resident to take without forcing, liquid is made available for the resident to help the consumption of the drugs. Staff witness that the resident takes the drug and then sign the record sheet as administrated. Drug administration for residents D.M in room 29, V.D in room 30, J.H in room 31, B.T in room 32, the drug trolley is left closed locked with key or attended at all times, the drug room is locked with the trolley tethered and locked to the wall.

Controlled drugs are booked in and out as and when received or used the actual quantity of drugs and the quantity in the register tallied.

Controlled drugs are locked in a safe in a locked cabinet in a locked room.

Kitchen (MP)

Witnessed the preparation of today's midday meal, this consisted of Roast Ham, Pineapple, Cauliflower Cheese, Roast Potatoes and pancakes for dessert.

The menus are planned in advance in a menu book up to 10 March 2019 and look well balanced and nutritional, there are no celiac or Gluten intolerant residents, some residents are diabetic and these are catered for in that a sugar free option is available where necessary, a number of residents require a soft food option and this is provided for.

The kitchen staff are well trained in food hygiene and were observing all the correct protocols and wearing the correct clothing. Knives and chopping boards are colour coded Red for Raw meat, Blue for Raw fish, Yellow for cooked meat, Green for salads and fruit, Brown for vegetables, White dairy products.

The content of the fridges and freezers were well segregated and labelled with the date they were put in the fridge or freezer, fridge and freezer temperatures are taken daily and recorded e.g. 4-3-2019.

The food is checked on completion of cooking for temperature and then again on serving and this is recorded e.g. 1-3-2019, 2-3-2019, 3-3-2019.

An insectocutor was available and switched on.

The food purchasing book was reviewed and orders for the 1-March-2019 and 2-March-2019 and the goods receiving book for 4-3-2019 and 28-February-2019 were reviewed, on receipt of chilled and frozen food the temperature is taken and recorded.

M.S.D.S sheets were available for the chemicals used within the kitchen e.g. flash all purpose cleaner, food area degreaser, liquid bleach, dishwasher detergent.

Two fire blankets and an extinguisher were available in the kitchen and had been serviced in April 2018.

All portable appliance within the kitchen have been P.A. Tested in April 2018.

Dry food is stored in the cellar and in the outhouse, strict stock rotation is observed to prevent stock going past its best before date and a sample of produce was checked for their best before dates.

All fridges and freezers within the kitchen were examined and a high level of food separation and control was noted.

The kitchen has a daily and weekly cleaning schedule and this was seen for weeks commencing 4/3/2019 and 25/2/2019. A calibrated thermometer serial number 07021070 is available in the kitchen, this was calibrated on 9-3-2018 and a certificate is available.

Admissions (MP)

Admission records where reviewed where applicable as follows:

Residents name and room number	J.R room 6	K.T room 22
Entered in Admission book	✓	✓
Activities of daily livings	✓	✓
Contact details	✓	✓
Care Assessment	✓	✓
Care Plans	✓	✓
Dependency Assessment	✓	✓
Risk Assessments	✓	✓
Medication Administration Record	✓	✓
Medical Disposal form	✓	✓
Mechanical aids consent	✓	✓
Resuscitation Policy	✓	✓
Effects Inventory	✓	✓
GSF Register	✓	✓
Fall Risk Assessment	✓	✓
Personal Evacuation Plan	✓	✓

Resuscitation information is kept in whiteboard within the office for easy access to information. In case of DNAR forms signed, this are kept in the resident's file and the date of expiry in the whiteboard as well.

Housekeeping (MP)

A Housekeeping rota is kept in the Laundry room that includes all non-daily scheduled cleaning. Rooms 2, 4, 7, 17 and 18, dining room and lounge have were visited (Rooms are cleaned daily) as well as common areas including lounge, bathroom and offices.

A colour code is in place for cleaning cloths and mops (Blue, yellow, red) to differentiate cleaning cloths used to clean toilets (Red), general cleaning (blue) and tables and surfaces that might be in contact with food (yellow).

Rooms checked were found clean and tidy.

COSHH sheets are kept for all cleaning and laundry products in a folder in the laundry room e.g. Ariel professional S1, Mr Muscle, Lenor S2.

The home as always was clean, neat and tidy and fragrant.

Laundry (MP)

Laundry Room comprises of 2 (Miele) washing machines and 2 (Miele) dryers. Washing machines have automatic dispense of detergent, de-stainer and conditioner.

One of the machines is used solely for clothes and linen that need disinfectant. Resident's clothes are identified by name and/or room number and a list of residents and their room numbers was available, on completion of the resident's laundry their clothing is placed in a basket with their room number on it.

Portable appliances electrical tests were carried out in April 2018, both washing machines and both dryers were new in April 2018; a CO² extinguisher was available in the laundry and serviced in April 2018.

Residents Activities (MP)

Activities are logged in a daily activities book that includes dates, activities and attendance. Activities reviewed included Zoolab 19/2/2019, shopping afternoon 6-3-2019, singalong 1-3-2019, Bingo 2-3-3019, Trivia quiz 6-3-2019, Film afternoon 22-2-2019, Valentines afternoon 14-2-2019.

The residents always appear to be happy and relaxed.

A newsletter is produced every two months and Jan/Feb and March/April issues were reviewed

Waste (MP)

Checked waste carriers licence Trust Hygiene CBDU143881 expires 19-12-2019 and annual waste transfer notes for drugs and clinical waste valid until 6-2-2020 was reviewed, transfer notes were reviewed for 2-1-2019 and 6-2-2019 and 1-3-2019.

A log is retained of what was collected and when.

Summarise Conformity with Requirements and any non-applicable clauses with justification:

Complies with clause 8 of ISO9001:2015

9. Performance Evaluation

Detail and evidence:

Internal Audits (PG)

There's an internal audit schedule for 2019 which was reviewed by the auditor in conjunction with internal audits 07/2019 – Paycare (No NC's), 06/2019 – Devising & Maintaining Care Plans (2 NC's), 05/2019 Control of Quality Records - (2 NC's), 01/2019 – Management Review (1 NC's) All actions raised are assigned to defined owners with progress checked. Root cause analysis conducted on all corrective and preventive action issues. There is a team of 3 internal auditors who carry out audits to a defined schedule, issues are entered into CAPA log for action and also reviewed at Management review.

Management Review (PG)

Management reviews are held twice per year, and attended by the management team, the meetings are held against a set agenda, this also includes regulatory requirements, context of the organisation, interested parties and risks and opportunities the most recent meeting was 06th of February 2019 and the agenda included a follow up to the previous meeting, client satisfaction, work performance and conformity to standards, status of C+P actions, results of audits, changes affecting the QMS, policy and objectives, training and resources, context, interested parties and risks and opportunities.

Customer Satisfaction (PG)

Resident survey feedback forms from March 2018 for J.H, J.C, A.N, E.C, M.B, A.S were reviewed, and these were mainly positive and complimentary with only a couple of minor points or issues raised. Additional to this there are numerous letters and cards on display in the main corridor from residents and families saying how satisfied they are with the nursing home and staff.

Summarise Conformity with Requirements:

Complies with clause 9 of ISO9001:2015

10. Improvement

Detail and evidence:

Customer Complaints and Non-Conformance (PG)

There is a robust complaint handling procedure in place; customer satisfaction is gauged through face to face residents meetings e.g. 25-10-2018 with 20 residents attending, funding reviews; surveys, CQC inspections also gold/ platinum standard scheme.

The CAPA log – accessible by all, anyone can raise a NC – each department has their own complaint and the Quality Officer is responsible for monitoring / progress chasing and reviewing closeouts a review was carried out of 171, 172, 173, 174 and 178.

Continual Improvement (PG)

Continual improvement from business planning – annually for objectives which focus on training and development, future business goals / aims with a view to improving patient care. Continual improvement is also identified via staff appraisals, team meetings, CQC inspections, national food hygiene rating scheme, and funding reviews

The home is currently having an extension built this will increase capacity.
New washing machines and tumble driers were recently fitted in the laundry.

Summarise Conformity with Requirements:

Complies with clause 10 of ISO9001:2015

Post Audit Activities

1. Closing Meeting Attendees:

Name	Position
Sharon Jones	Matron
Debra Finney	Bursar
Jayne Winstanley	Nurse
Karen Poole	Activities Co-ordinator

2. Activities planned but not covered on this visit and require planning for the next visit.

None

3. Head Office/Locations/Branch Offices visited during this audit

Date	Location	Auditor(s)
5-3-2019	H.Q	M.P

4. Client/Contract Sites/Temporary Sites visited during this audit (if applicable).

Date	Location	Auditor(s)
5-3-2019	N/A	M.P

5. Locations/Branch Offices

All permanent Locations/Branch offices for which certificates are required (**Check on Business Manager**) are current and correctly identified

Yes: No:

If no correct details are

Location (Town/City)	Address	Standards

6. Registration Marks

Use of Registration Marks is in accordance with the Use of Logo Rules (if used)

Yes No May use in the future

Brief details of where the UKAS Accreditation Mark and Alcumus ISOQAR Logo is used.

On letter headed paper.

Use of Registration Marks on website is appropriate to the scope of the certification

Yes No Not Applicable

7. Recertification Visits (complete only at a Recertification Visit)

Has the review of activities (**in particular complaints against the client**) and reports covering the certification cycle revealed any issues?

Yes No

If **yes** please provide details:

--

AUDIT PLAN NEXT VISIT

Please note that changes to Auditors may be unavoidable due to operational requirements

The objectives of the audit:

- To confirm that the management system conforms with the requirements of the audit standard and also any statutory, regulatory and contractual requirements that are applicable;
- To confirm that the organisation has effectively implemented the planned management system;
- To confirm that the management system is meeting its specified objectives

Audit criteria:

- Documents, procedures and policies relevant to the standard being audited will be required.
- The audit will be performed against the scope of activities agreed at the opening meeting or as agreed at stage 1 or as detailed on the Certificate.
- The audit will be conducted at the locations identified on this audit plan.

Lead Auditor	Mike Pepperell	Additional Auditors (Expert)			
Standard(s)	ISO9001:2015	Type of Audit (e.g. Surveillance)		Surveillance 1	
Audit Dates	28-10-2019	Location(s)	Tittensor Staffordshire		
Audit Start Time	09:00	Does Client need to confirm site visit with ISOQAR Head Office prior to next visit YES/NO			No
Audit Language (if not English)		Is Recertification Planning Required YES/NO			No

Management Processes

Date	Time (or AM/PM) or N/A		Auditor
		Maintenance of equipment and calibration	M.P
		Context of the organisation and scope of the business	M.P
		interested parties and their needs and expectations	M.P
		Risks and opportunities	M.P
		Document and record control.	M.P
		Training	M.P
		Customer satisfaction and complaints	M.P
		Quality audits and management review	M.P
		Corrective actions and continual improvement	M.P

Locations/Branch Office Visits

Date	Time (or AM/PM)	Process/Aspects/Activities etc. to be Audited	Auditor

NOTE TO CLIENT: No further confirmation or reminders will be issued. Failure to honour the date arranged may result in extra charges being incurred by your company as stated in ISOQAR Rules of Registration. Cancellation of audit or surveillance dates within 20 working days of the agreed date will result in ISOQAR claiming an extra levy from the company for each staff day cancelled.

Note to Auditor

Refer to 3-year Audit plan and last Audit plan when producing the audit plan for the next visit

Ensure client fully understands the cancellation policy stated above.

All Management System Elements must be audited once per year as a minimum

Ensure that all clients' locations/branches are visited in accordance with the 3 year audit plan

Ensure that site activities are witnessed as appropriate and in accordance with the 3 Year Audit plan

Review the 3-year audit plan and if appropriate and necessary amend the plan

AUDIT PLAN COVERING THE 3 YEAR ASSESSMENT CYCLE

Organisation Name North Staffordshire Residential Homes Limited

This plan commences:

- On the date of the first surveillance visit following the initial audit (stage 2) or;
- On the date of the Surveillance Audit following the Re Certification Audit;
- At the next surveillance visit if the plan requires amending or to take into account extensions to scope.

	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
	Sept 19	Mar 20	Sept 20	Mar 21	Sept 21	Mar 22
	1	1	1	1	1	2
Month and Year						
Number of Days						
Standards	ISO9001	ISO9001	ISO9001	ISO9001	ISO9001	ISO9001

Area/Function/Process/Activity/Site Visits (temporary sites) etc	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
Admissions and care plans		✓		✓		✓
Housekeeping		✓		✓		✓
Laundry		✓		✓		✓
Resident activities, resident and family meetings		✓		✓		✓
Drug administration		✓		✓		✓
Waste control including clinical and drug waste		✓		✓		✓
Kitchen/ catering and food storage	✓		✓		✓	✓
Maintenance of equipment and calibration	✓		✓		✓	✓
Context of the organisation and scope of the business	✓		✓		✓	✓
interested parties and their needs and expectations	✓		✓		✓	✓
Risks and opportunities	✓		✓		✓	✓
Document and record control.	✓		✓		✓	✓
Training	✓		✓		✓	✓
Customer satisfaction and complaints	✓		✓		✓	✓
Quality audits and management review	✓		✓		✓	✓
Corrective actions and continual improvement	✓		✓		✓	✓

Head Office/Locations/Branch Offices Visit Plan

	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
Head Office	✓	✓	✓	✓	✓	✓

Indicate with a when audit of this function planned or when a visit is planned.

When producing this plan ensure that all clauses of the standard(s) can be attributed to Area/Function/Process/Activity/Site Visits (temporary sites) and are audited over the 3-year Recertification Cycle.

The clients Locations/Branch Offices must also be appropriately sampled over the 3 Year Certification Cycle.

Plan Produced By Mike Pepperell

Date 5-3-2019

Plan Amended By

Date

Plan Amended By

Date