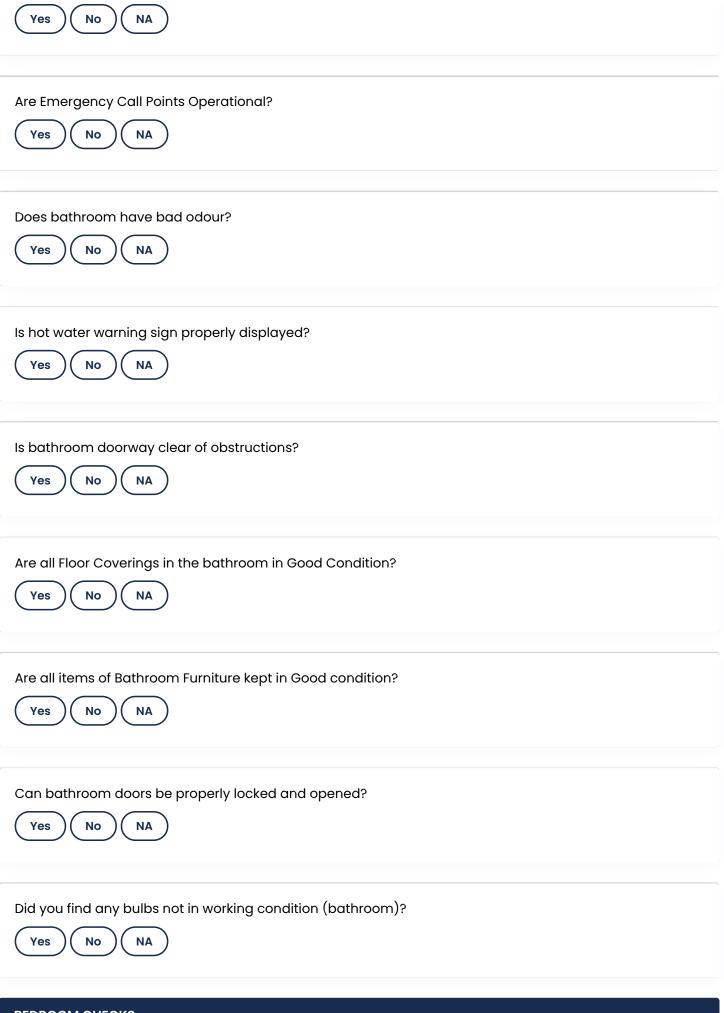
Monthly Inspection Checklist

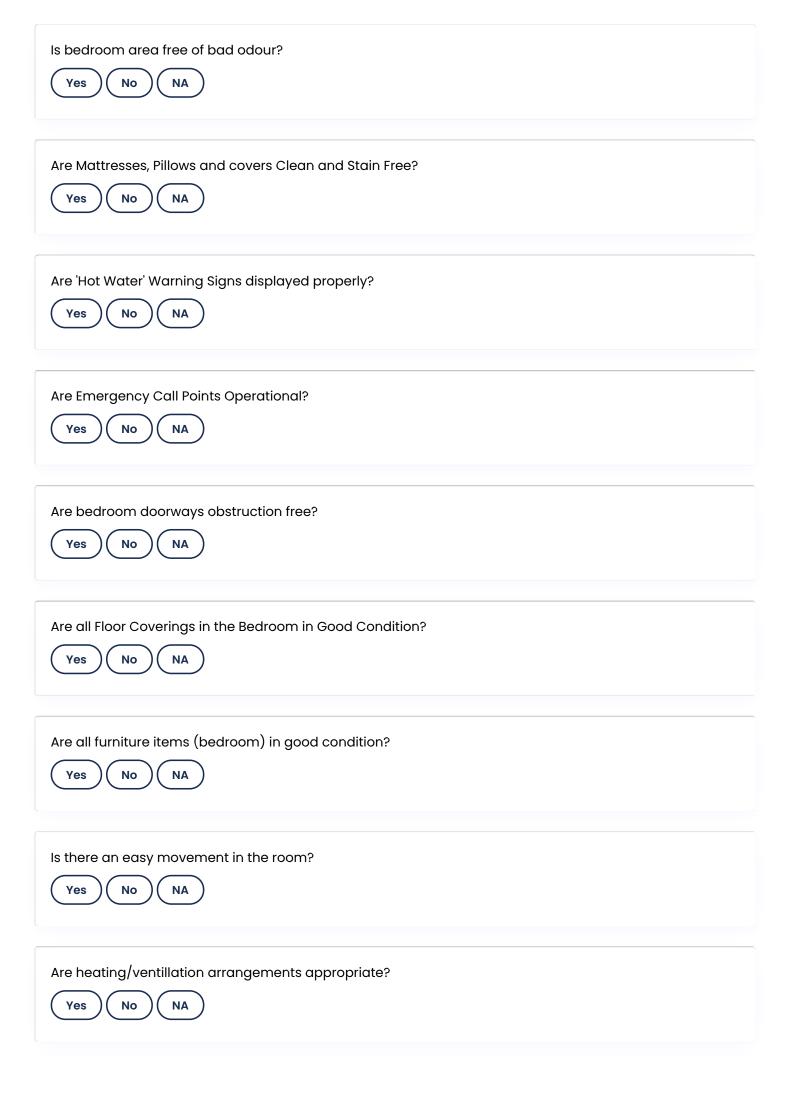
Health Services

ACCIDENT/INCIDENT REPORTINGS

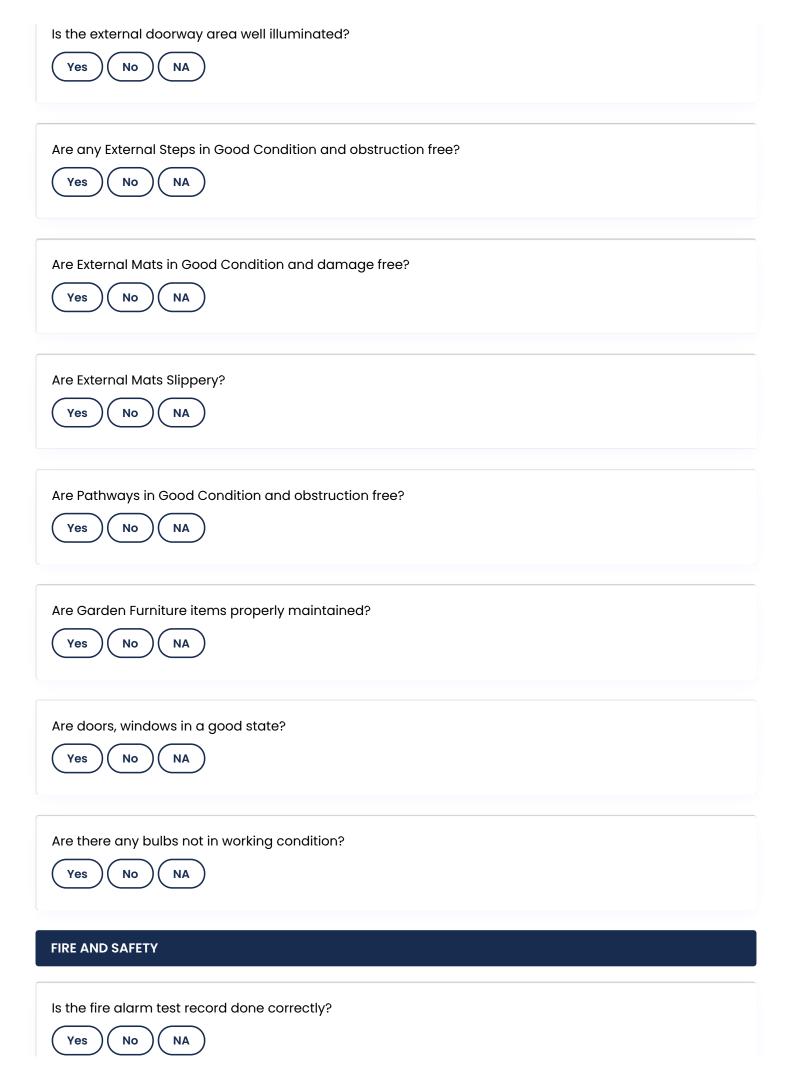
Are Waste Bin 'Foot / Knee' pedals in working condition? Yes No NA
Are All Required PPE Items available for staff? Yes No NA
Are 'Hand Gels / Sanitisers' available throughout the premises? Yes No NA
Have all Accident Forms in the 'Accident File' been logged/recorded? Yes No NA
How many of the following have been reported over the past 30 days (in total)?
Accidents to staff
Accidents to Service users

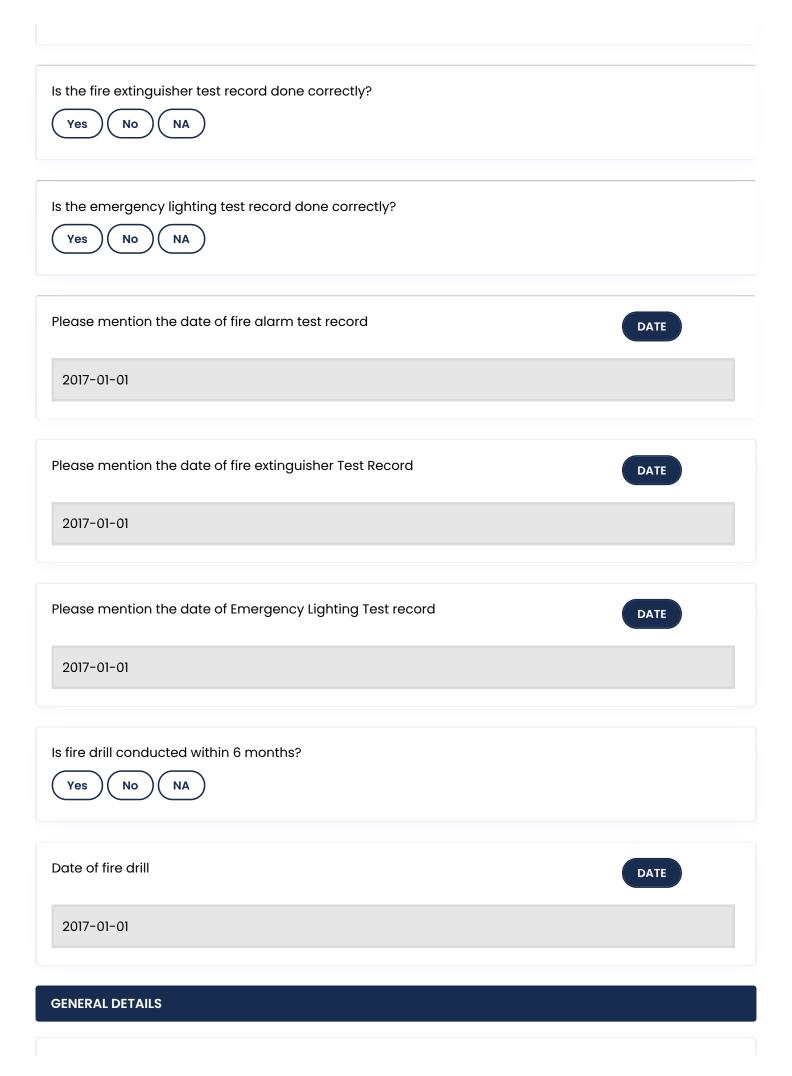
Incidents to staff
Incidents to Service users
Incidents to Others
Is a Hazard Data Sheet available for all substances used? Yes No NA
AUDIT VERIFICATION
Audit Completed By:
Audit Reviewed By:
Audit Reviewed By: Review Date: SIGNATURE SIGNATURE
Review Date:





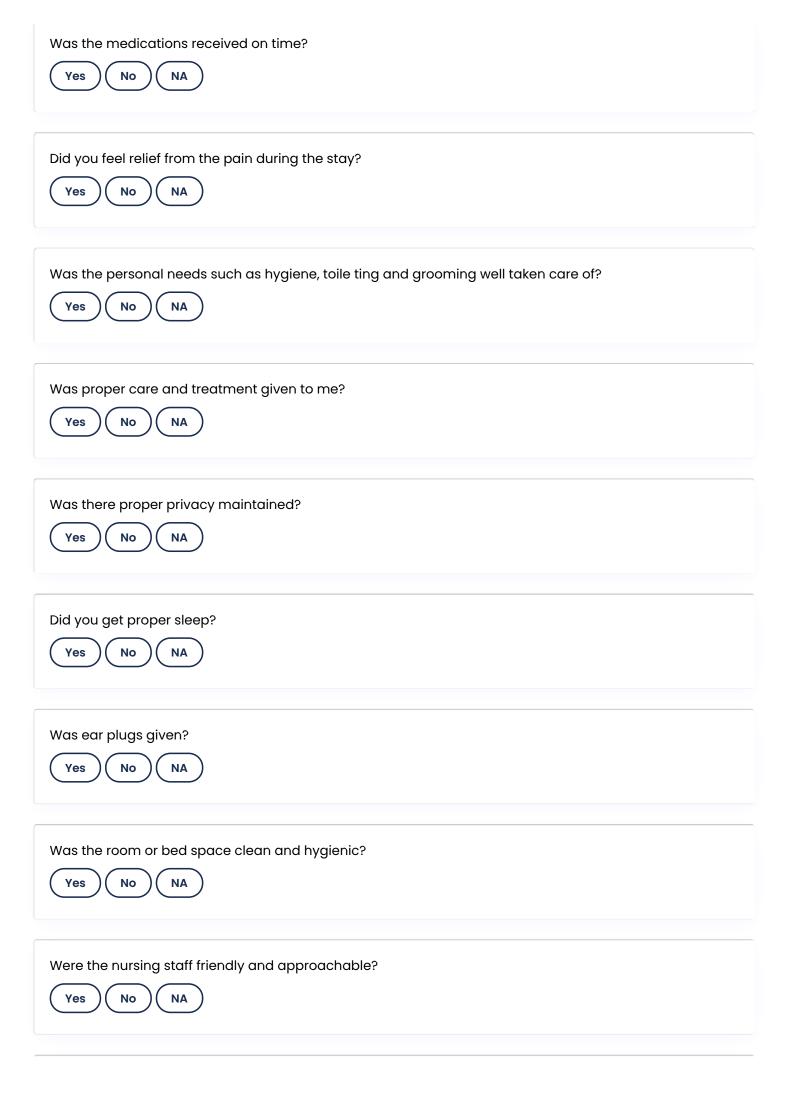
Are all electrical cables stored properly (does not cause any hazard)? Yes No NA
Are there any bulbs not in working condition? Yes No NA
EQUIPMENT CONDITION
Which of the following are in good condition and without defects? Mop Heads Toilet Brushes Cleaning Equipment Hoists & Slings Turning aids
Which of the following are in good condition and without defects? Wheelchairs Frames Stability aids Handling belts Transfer boards
Is a 'Burns Kit' and fire blanket available in the Kitchen? Yes No NA
EXTERNAL CHECKS
Are Doorways Clear of Obstacles (external doors)? Yes No NA
Are external doors easy to open and close? Yes No NA
Do all locks work properly (external doors)? Yes No NA



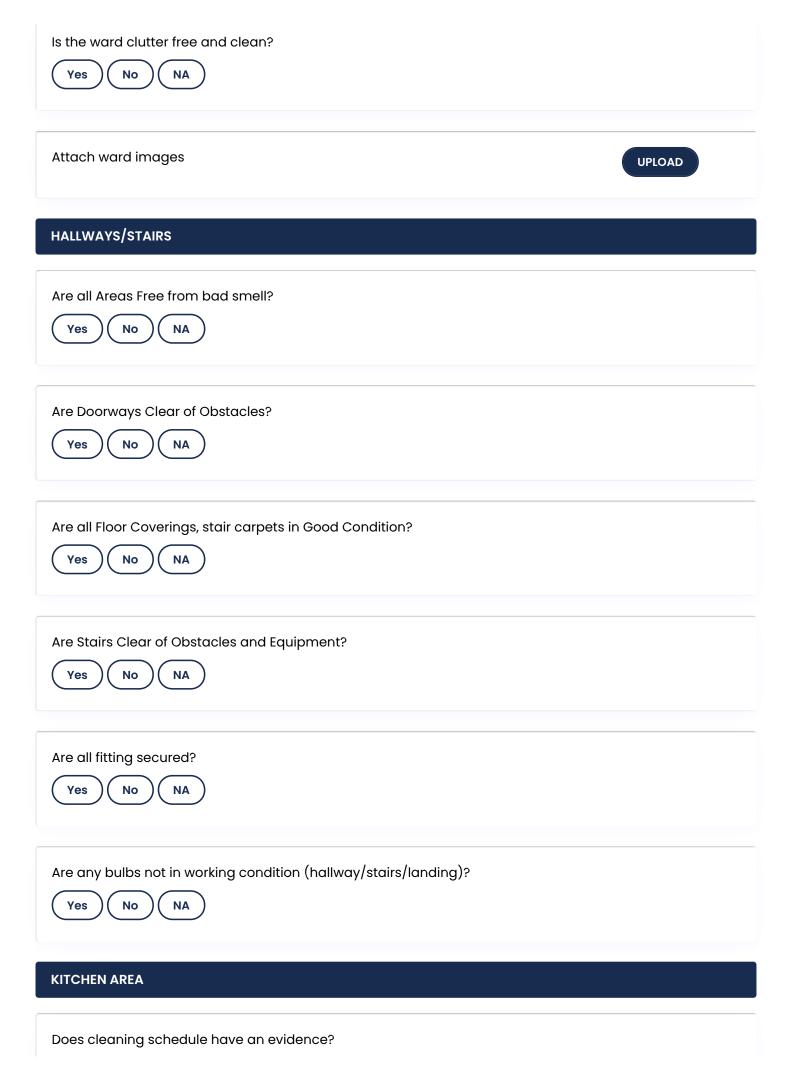


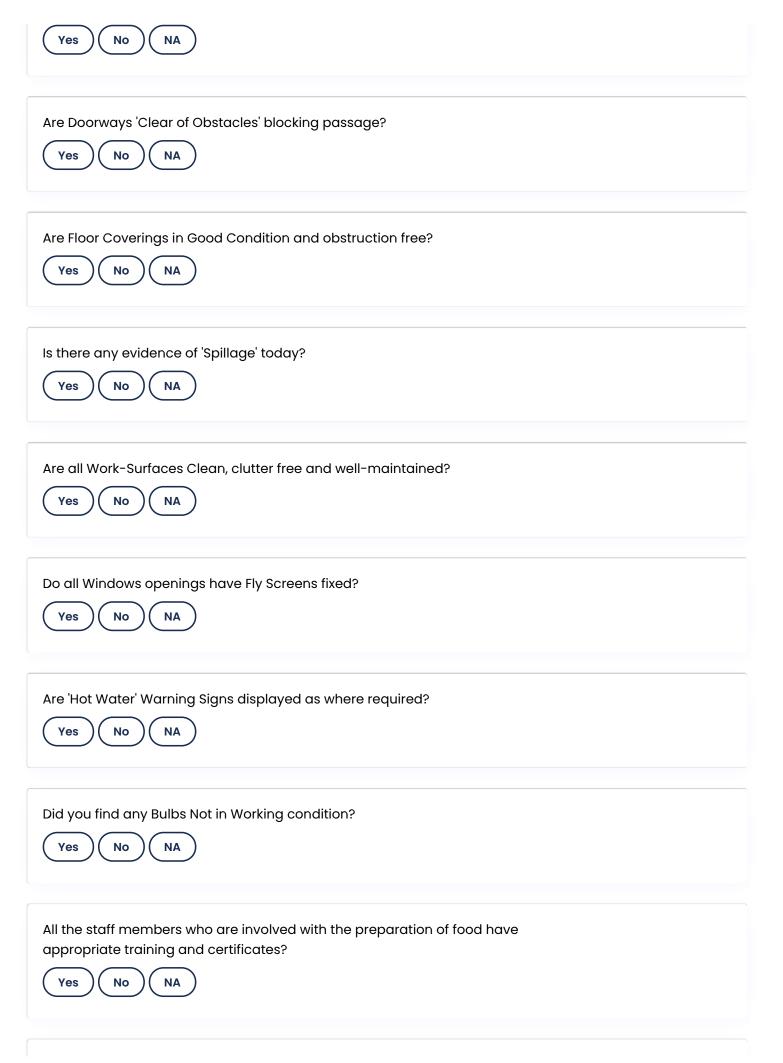
Mention the Total Number of Occupied Beds
Has the audit from the previous month been reviewed and signed off? Yes No NA
How many corrective actions were raised last month? 1 2 3 4 5 6 7 8 9 10
Have all corrective actions raised from last month been completed? Yes No NA
GENERAL DETAILS
Audit Date DATE
Audit Date 2017-01-01
DAIL

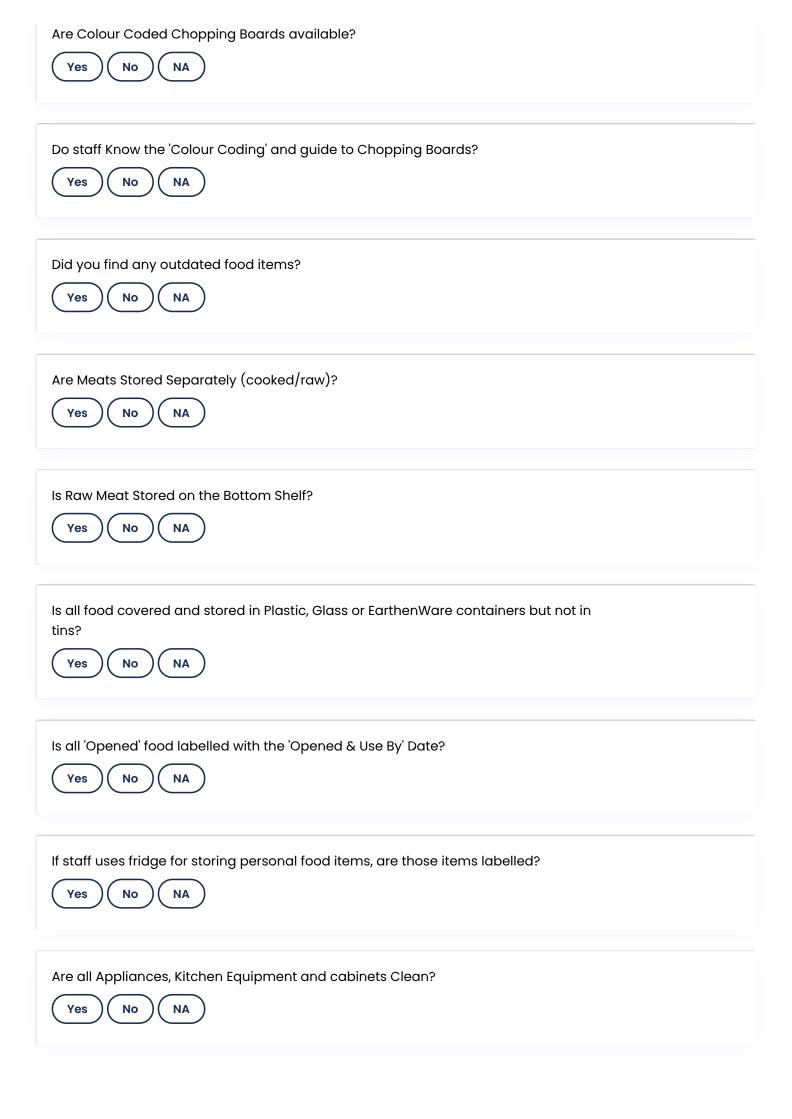
Mention the Total Number of Available Beds

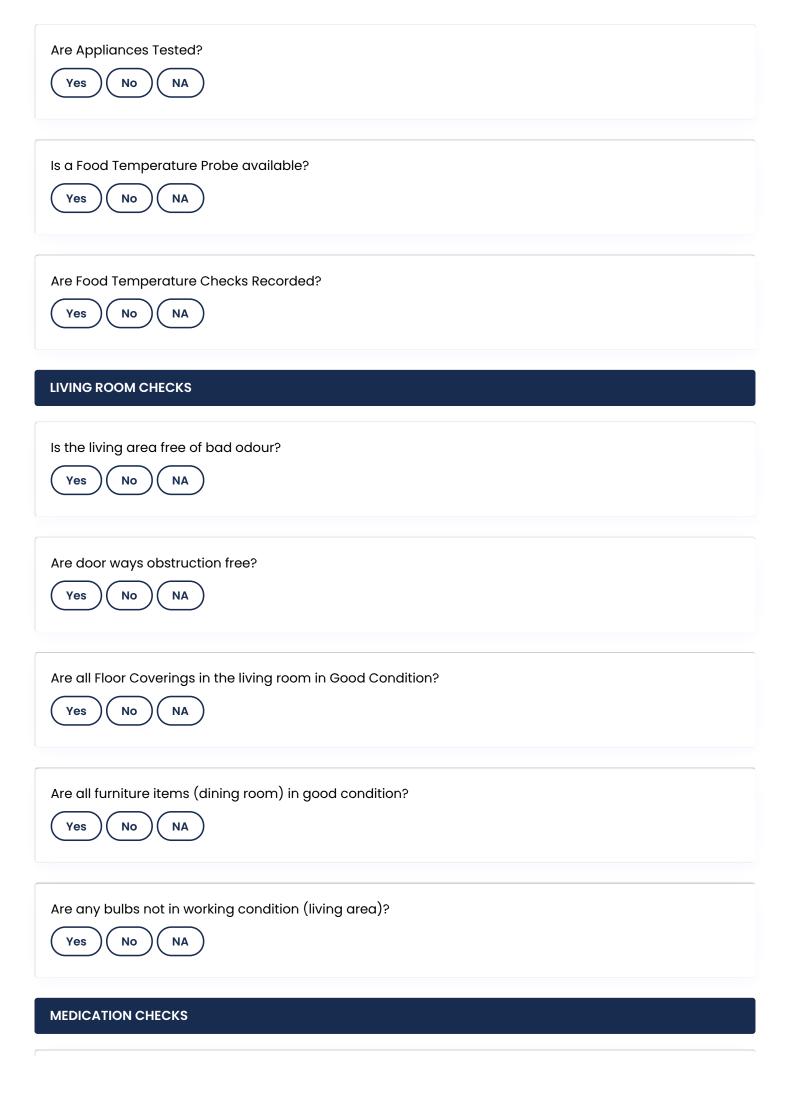


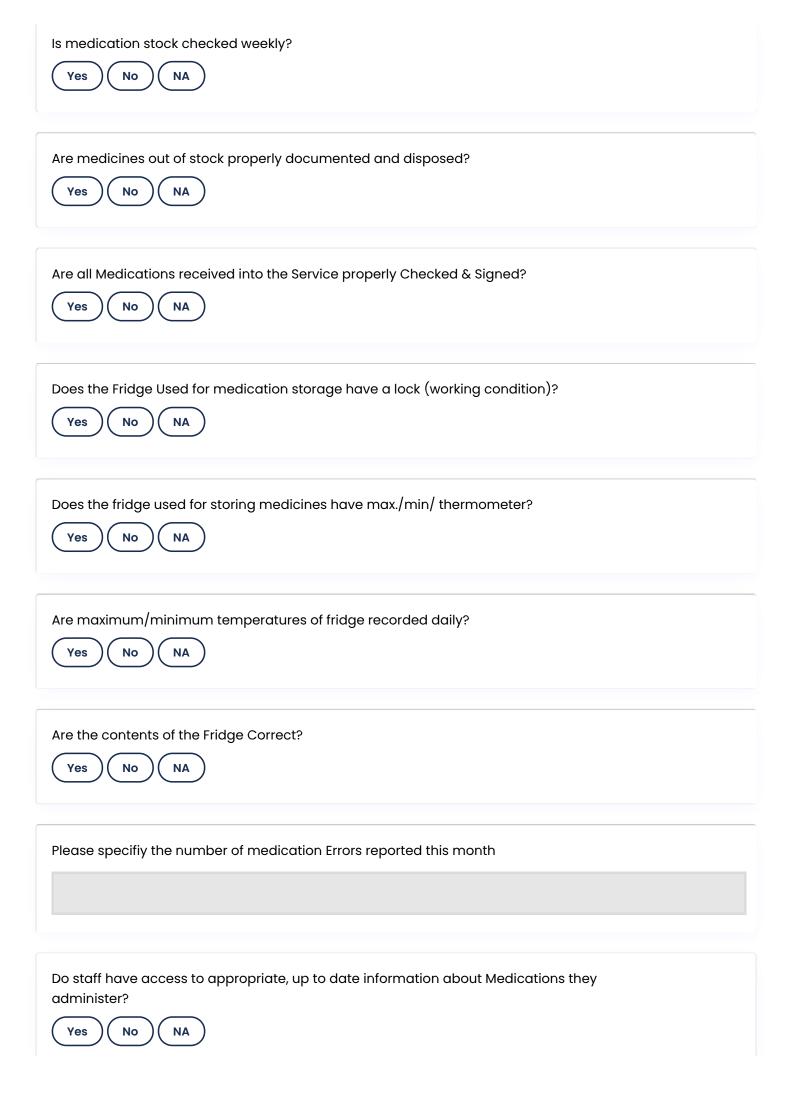
Did you find any staff expectionally professional?
Mark the quality of the food on 1-10 scale 0 1 2 3 4 5 6 7 8 9 10
Mark the overall level of communication on 1-10 scale 0 1 2 3 4 5 6 7 8 9 10
Mark the quality of the food on 1–10 scale 0 1 2 3 4 5 6 7 8 9 10
Did you feel secured at the time of admission? Yes No NA
Any suggestion/feedback which you feel that needs attention in patient safety. textarea
Any conflicting situation you experienced during the stay. Elaborate textarea
Any suggestion/feedback which you feel that needs attention in level of care. textarea

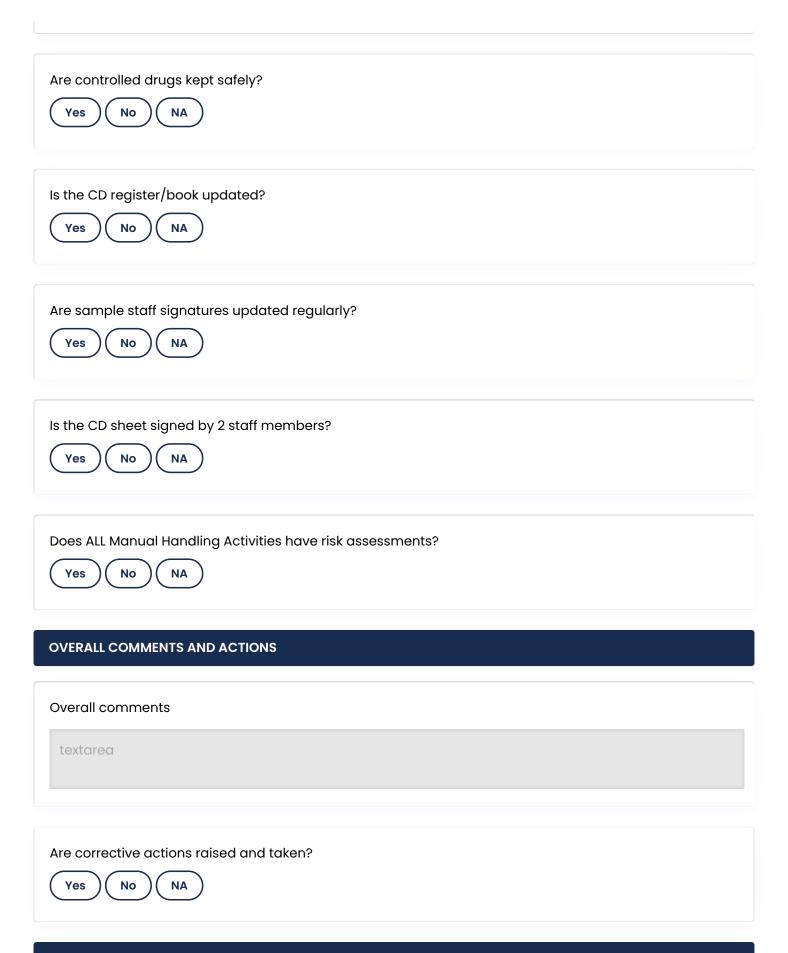












PROTECTIVE GEAR AND HEALTH SAFETY

Is appropriate Clothing and PPE available for the use of the substances?

