# Person-Centred Care Plan Audit

*Category: Care Quality*

Ensures care plans are personalised, up-to-date, and compliant with CQC Regulation 9 (Person-centred care). Reviews assessment, consent, and review processes.

## 1. Personal Details & Consent

[ ] Is the resident's preferred name and life history recorded?

[ ] Is there evidence of consent to care and treatment (signed by resident or best interest decision)?

[ ] Are Next of Kin / Power of Attorney details current?

[ ] Is the DNACPR status clearly documented and valid?

## 2. Assessment of Needs

[ ] Are baseline assessments completed (MUST, Waterlow, Falls Risk, Moving & Handling)?

[ ] Are assessments reviewed monthly or when needs change?

[ ] Do assessments clearly identify risks and control measures?

## 3. Care Planning

[ ] Are care plans written in the first person ('I prefer...')?

[ ] Do care plans address all identified needs (e.g., mobility, nutrition, communication)?

[ ] Are goals specific, measurable, and realistic?

[ ] Is there evidence of resident/family involvement in care planning?

## 4. Review & Evaluation

[ ] Are monthly reviews completed and meaningful (not just 'no change')?

[ ] Do daily notes reflect the care plan interventions?

[ ] Has the care plan been updated following any incidents or hospital admissions?

Completed By: _____ Date: _____

Signature: _____