Honeysuckle
CARE MANAGEMENT

User Manual

How every tab and window works, for Admins, care providers, support workers and family members

October 2026

The screenshots show a sample care provider, Brookfield Care, with three residences. Every person, address and number in them is invented.

Contents

1. About this manual 6

Who can do what 6

2. Getting started 8

2.1 Signing in 8

2.2 Two-factor login 9

2.3 Finding your way around 10

2.4 How records are kept 14

2.5 Notifications 15

2.6 Alerts on your phone or computer 16

3. Dashboard 19

4. Handovers & Tasks 23

4.1 Tasks 23

4.2 Shift handovers 24

5. Rota 26

5.1 The week at a residence 27

5.2 Planning shifts 27

5.3 Confirming the shifts you've worked 29

5.4 Hours report 30

6. Leave 32

6.1 Your leave 32

6.2 Sickness 33

6.3 Deciding leave (managers) 33

6.4 One person, and allowances 34

6.5 On the rota 35

7. Clients 37

7.1 Adding a resident 37

7.2 The client record 39

7.3 Sections of the record 42

7.4 Care plan 47

7.5 Risk assessments 50

7.6 Care plan and assessment files 51

7.7 Subject Access Requests 52

7.8 Health and Care Passport 52

8. Family 55

8.1 What each family member may see 56

8.2 Messages 57

8.3 Updates and photos 58

8.4 Visits and visiting hours 58

9. Residences 60

9.1 A residence's record and safety certificates 61

9.2 Residence details 3
9.3 Property risk assessments 3

10. Incidents 3

10.1 Reporting an incident 3
10.2 Following up and signing off 3
10.3 The Word report 3

11. Complaints & Compliments 3

11.1 Recording one 3
11.2 Handling a complaint 3
11.3 When things are due 3
11.4 From families 3

12. Daily Records 3

13. Monitoring Charts 3

13.1 The round 3
13.2 Recording 3
13.3 Charts and corrections 3
13.4 Setting up a resident's charts 3
13.5 Alerts 93

14. Capacity, DoLS & Resuscitation 3

14.1 Resuscitation decisions 3
14.2 DoLS 95
14.3 Mental capacity assessments 3
14.4 Legal authority 3
14.5 The register and what is due 3

15. Hospital Transfers 3

15.1 Sending someone to hospital 3
15.2 What the pack says 3
15.3 Back from hospital 3

16. Medication (eMAR) 3

16.1 Adding a resident's medicines 3
16.2 The medication round 3
16.3 Recording a dose 3
16.4 The MAR chart 3
16.5 Controlled drugs 3
16.6 On a phone or tablet 3

17. Events 111

17.1 Creating an event 3
17.2 Inviting people 3
17.3 Replying 3
17.4 Who is going and what it costs 3
17.5 Invoices 3
17.6 Cancelling 3

18. Residents' Money 3

18.1 A resident's account 4
18.2 Cash counts 4
18.3 Mistakes: striking an entry through 4
18.4 Statements, the Dashboard and the record 4

19. Enquiries and Admissions 4

19.1 Recording an enquiry 4
19.2 Working on an enquiry 4
19.3 The pre-admission assessment 4
19.4 Offering a place and admitting 4
19.5 Closing, the Dashboard and the record 4

20. Audits and Maintenance 4

20.1 What is due 4
20.2 Doing an audit 4
20.3 The action plan 4
20.4 Changing the checklists 4
20.5 Maintenance and repairs 4

21. Policies 143

21.1 The Policies page 4
21.2 Reading and confirming a policy 4
21.3 Who has read it 4
21.4 Adding a policy and issuing a version (Admins) 4

22. Invoices & Billing 4

22.1 Making invoices 4
22.2 The invoice list and aged debt 4
22.3 What an invoice shows 4

23. Analytics 4

23.1 CQC inspection evidence pack 4

24. Carers: accounts, training and checks 4

24.1 User accounts 4
24.2 Staff training and checks 4
24.3 Car insurance 4

25. Import and export 4

25.1 Importing from a spreadsheet 4
25.2 The commissioner return 4
25.3 Downloading all records 4

26. Audit Log 4

27. Settings 172

27.1 General & Branding 4
27.2 Compliance & Retention 4
27.3 Email & Alerts 4
27.4 Financial Options 4
27.5 Layout & Permissions 4
27.6 Accounts 4

27.7 Two-Factor Login 5
27.8 Records Due for Deletion 5
27.9 Staff Training & Checks 5
27.10 Rota & Shifts 5
27.11 Services 5

28. A guide for family members 5

29. Glossary 187

1. About this manual

Honeysuckle Care Management keeps a care provider's records in one place: residents' care records, care plans and risk assessments, daily notes, medicines and the record of each dose given (eMAR), incidents, complaints and compliments, handovers and tasks, the staff rota, staff training and checks, residences and their safety certificates, invoicing, and a portal for residents' families. It runs in a web browser on a computer, tablet or phone; nothing needs installing.

The manual follows the pages in the menu (section 2.3), broadly in the order they appear. Each chapter starts with who can use it, then shows the screen and explains each part. Chapter 28 is a short guide written for family members, which you can share with them.

Who can do what

Everyone signs in with their own account. What they see depends on their role and, for staff below Admin, on the residences they are assigned to.

Role	What they are for	What they see
Admin	Managers and owners of the care provider.	Everything in their care provider, at every residence. Only Admins change Settings, manage accounts, write care plans and risk assessments, and see the audit log.
Care provider	Senior care staff and team leaders.	The residences they are assigned to: residents, records, rota, events, invoices and analytics for those residences. They can plan the rota there if an Admin allows it, and organise events.
Support worker	Care and support staff.	The residences they are assigned to. They write daily records, report incidents, log handovers and tasks, confirm their own shifts, and reply to event invitations for residents. They don't see invoices, analytics or staff records other than their own.
Family member	A resident's relative or representative.	Only the resident(s) their account is linked to, and only what staff have recorded they may see, and the events they are invited to. Chapter 28 is their guide.

Tab	Admin	Care provider	Support worker	Family member
Dashboard	✓	✓	✓	✓ (contacts, appointments and events)
Handovers & Tasks	✓	✓	✓	
Rota	✓ (plans)	✓ (plans if allowed)	✓ (own shifts)	
Leave	✓ (decides, sets allowances)	✓ (decides for support workers)	✓ (own leave)	
Clients	✓	✓	✓	✓ (their relative)
Family	✓	✓	✓ (read only)	✓
Residences	✓	✓	✓	

Tab	Admin	Care provider	Support worker	Family member
Incidents	✓	✓	✓	
Daily Records	✓	✓	✓	
Monitoring	✓ (sets up charts)	✓ (sets up charts)	✓ (records)	
Capacity & DoLS	✓ (records)	✓ (records)	✓ (reads)	
Medication (eMAR)	✓	✓ (manages medicines)	✓ (records doses if trained)	
Events	✓ (organises)	✓ (organises at their residences)	✓ (replies for residents)	✓ (their invitations)
Money (residents' cash)	✓ (corrects)	✓ (corrects)	✓ (records)	
Audits	✓ (checklists, actions)	✓ (actions)	✓ (does audits)	
Maintenance	✓ (updates)	✓ (updates)	✓ (reports)	
Policies	✓ (adds and issues; sees who has read them)	✓ (reads; sees who at their residences has read them)	✓ (reads and confirms)	
Enquiries	✓	✓ (their residences)		
Invoices	✓	✓		
Analytics	✓ (with the CQC pack)	✓		
Carers (users, training and checks)	✓	✓ (their residences)		
Import & export	✓ (imports, downloads everything)	✓ (commissioner return, their residences)		
Audit	✓			
Settings	✓			

Admins can hide tabs, dashboard cards and sections of the client record from particular roles in **Settings > Layout & Permissions** (section 27.5), so your screens may show fewer items than this manual. The Rota, Medication, Monitoring, Events, Family and Invoices tabs, care plans and the CQC evidence pack are optional services; if your care provider doesn't have one, or has switched it off at your residence, it doesn't appear (section 27.11).

2. Getting started

2.1 Signing in

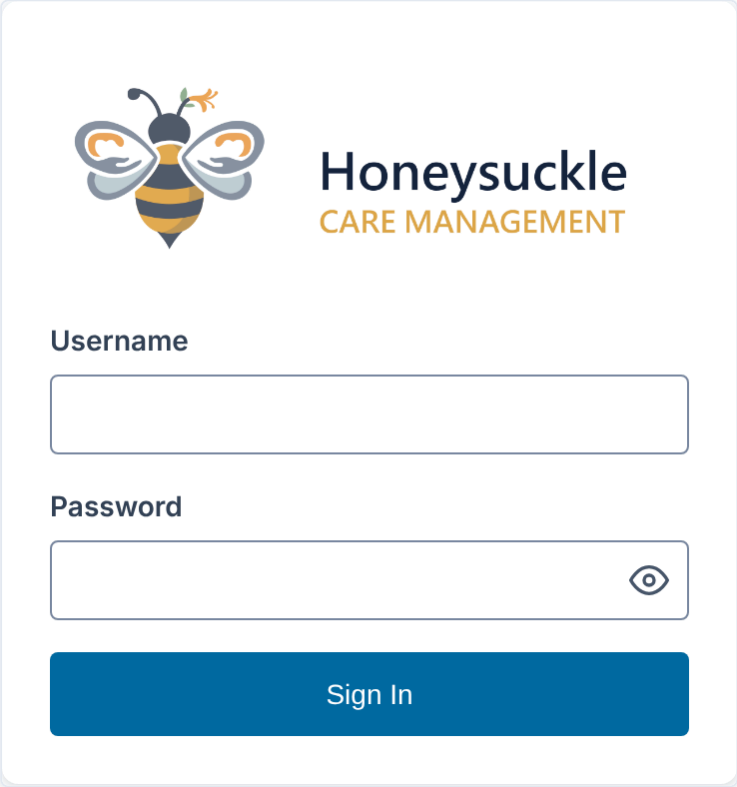


Figure 1. The sign-in screen.

Enter your username and password and press **Sign In**. The eye icon shows the password as you type it. After several wrong passwords, the account is locked for a while; an Admin can unlock it from the Carers tab.

Choosing a password. When an Admin sets up your account, or if your password no longer meets the rules, you are asked to choose a new one before you can carry on. It must be at least 12 characters, must not be a password that has appeared in a data breach, and must not contain your name or username. Three or four unrelated words work well.

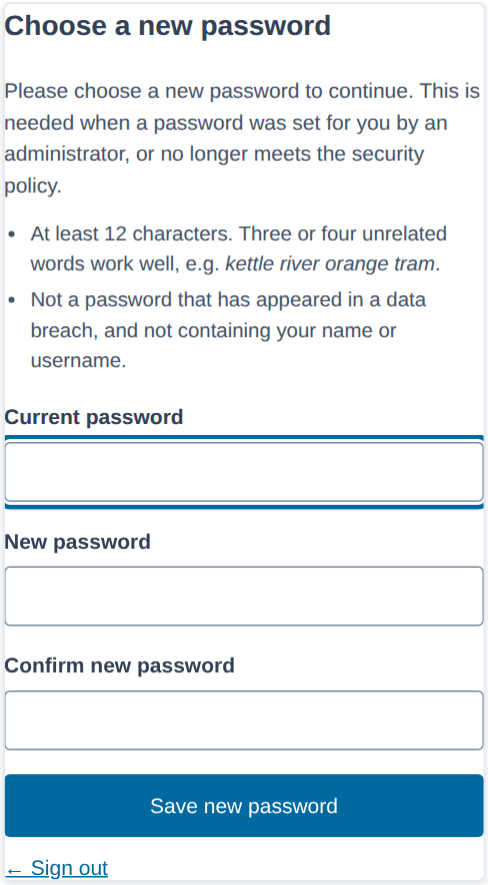


Figure 2. Choosing a new password.

2.2 Two-factor login

If your care provider requires it (section 27.7), you also enter a 6-digit code from an authenticator app (such as Microsoft Authenticator or Google Authenticator) each time you sign in.

Setting it up the first time. Ask an Admin for a *set-up code* (Carers tab, section 24.2). Sign in as usual, type the set-up code, then scan the QR code with your authenticator app and enter the 6-digit code it shows. You are then given **recovery codes**: save them somewhere safe away from your phone. Each one lets you sign in once if you lose your phone.

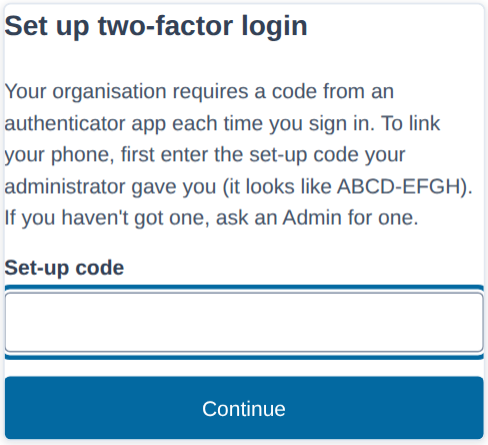


Figure 3. First sign-in when two-factor login is required: enter the set-up code from your Admin.

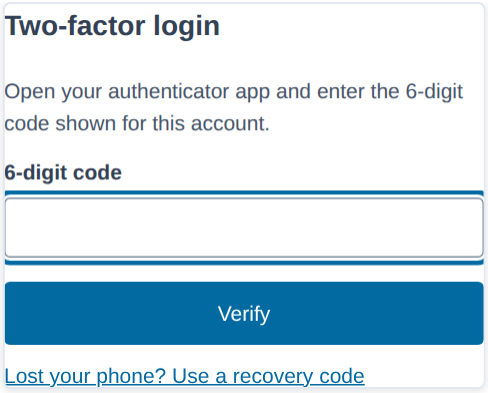


Figure 4. Signing in with two-factor login: the code from your authenticator app.

2.3 Finding your way around

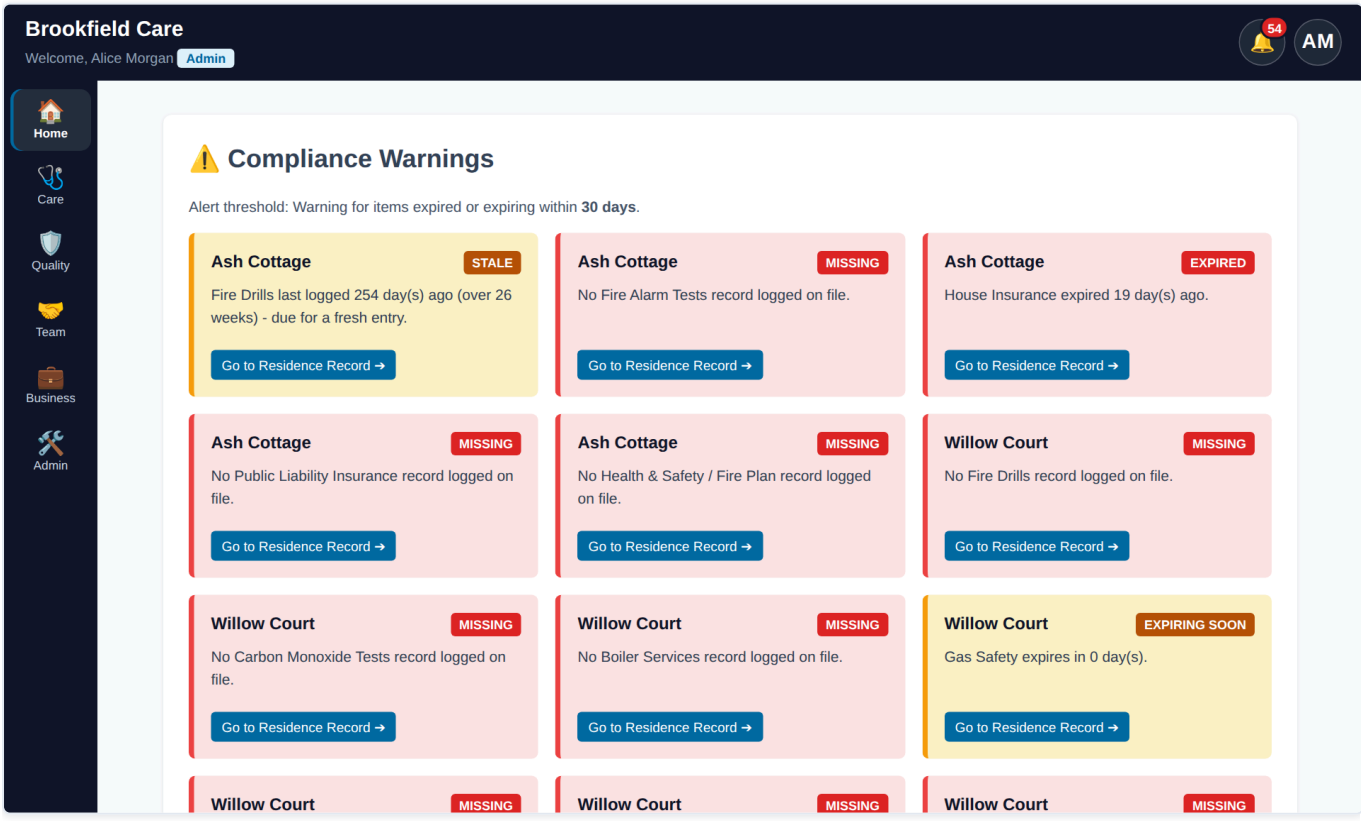


Figure 5. The screen for an Admin on a computer: the provider's name, who is signed in and their role at the top left; the notification bell and the account button (your initials) at the top right; the menu's categories down the left.

- **The menu.** Down the left of the screen is a short column of categories: **Home** (the Dashboard), **Care** (Clients, Daily Records, Medication, Monitoring, Handovers, Family, Events, Money), **Quality** (Incidents, Complaints, Capacity & DoLS, Audits), **Team** (Rota, Leave, Policies, Carers), **Business** (Enquiries, Residences, Maintenance, Invoices, Analytics) and **Admin** (Import & export, Audit, Settings). Press a category and its menu slides out beside it, listing its pages with a line about each; press a page to go there. Press the category again, ✕, the Escape key or anywhere on the page to close the menu without choosing. The category you're in is highlighted, and so is your page in its menu.
- You only see the pages your role uses, and a category with none of them is left out. A category with only one page for you goes straight to it, and shows that page's name; **Home** goes straight to the Dashboard.
- **Find a page.** At the top of every menu, type what you're looking for, for example "holiday", "DoLS" or "staff training": the pages that match are listed from every category. Press Enter to open the first one.

- **On a phone** the categories are a bar along the bottom of the screen. Tap one and its pages slide up above the bar, two to a row; tap a page to go there, or tap the page behind to close it. The bar steps aside while a window is open.
- **With a keyboard**, the arrow keys move up and down the categories and through a menu's pages, Enter opens one, and Escape closes the menu.
- **The bell** shows how many notifications you have not read (section 2.5).
- **The account button** (your initials, top right) opens a small menu with your name and role, and: **Dark mode**: dark backgrounds with light text, easier on the eyes at night. Press it again to switch back. Your choice is saved to your account, so it follows you to any computer, tablet or phone you sign in on, and on a shared tablet everyone keeps their own setting.
- **User manual**: this manual, opened in a new browser tab.
- **Security statement**: how the app keeps information safe, also opened in a new tab (useful if a commissioner or inspector asks).
- **Settings** (Admins only): the same as the Settings tab.
- **Log out**. You are also signed out automatically after **30 minutes** without using the app; anything not saved by then is lost, so save as you go.
- Forms open in a window over the page. Close it with **✕ Close** or the Escape key. You can't go to another page while a window is open.
- Messages confirming a save, or explaining why something couldn't be saved, appear briefly at the bottom of the screen.

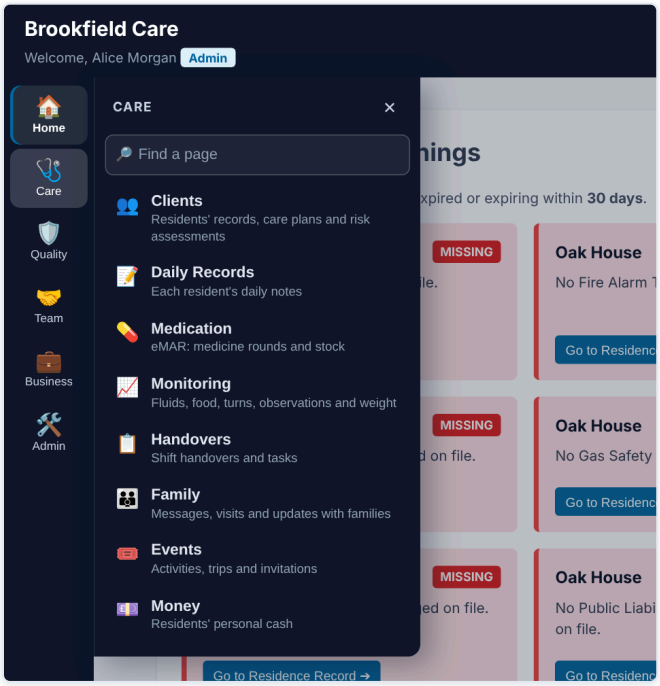


Figure 6. Care's menu, slid out from the column of categories.

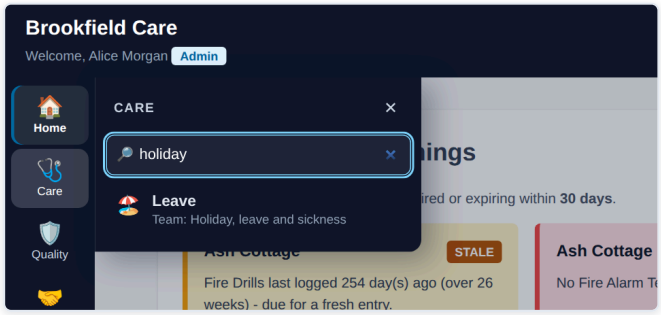


Figure 7. Find a page: "holiday" finds Leave, in Team.

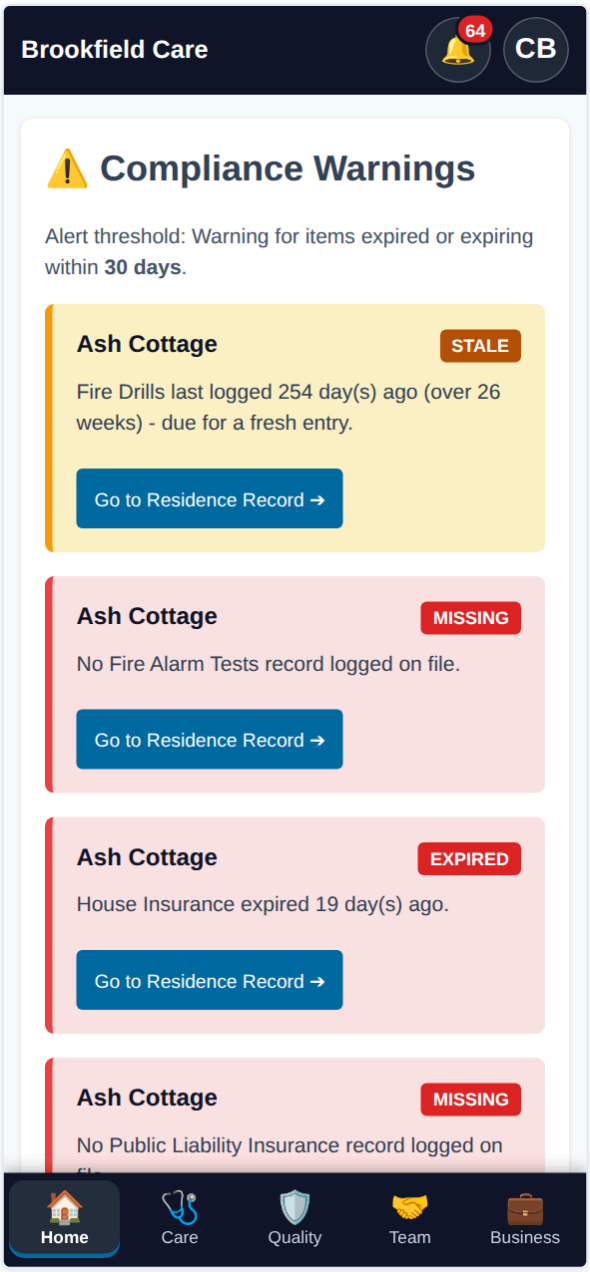


Figure 8. On a phone: the categories along the bottom.

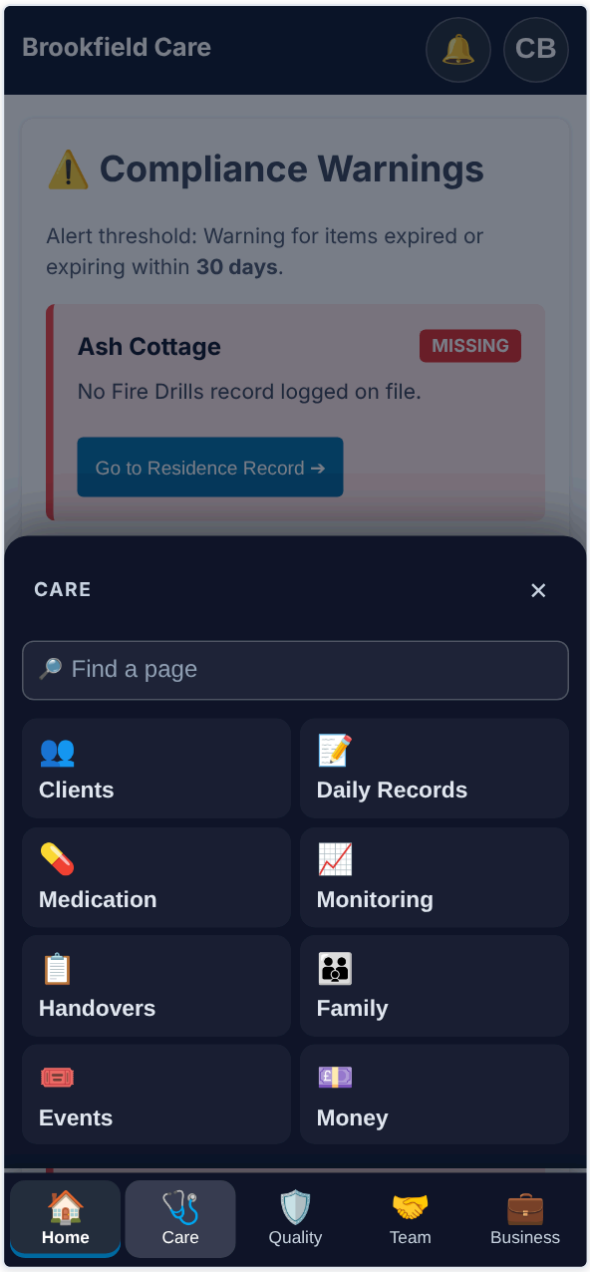


Figure 9. Care's pages, slid up above the bar.

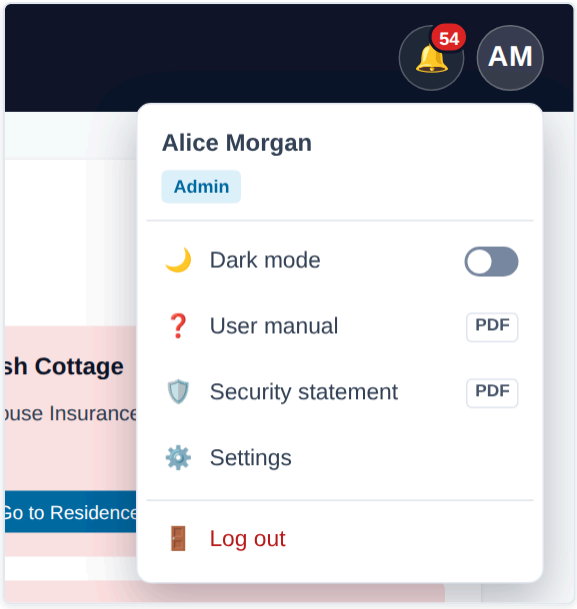


Figure 10. The account menu.

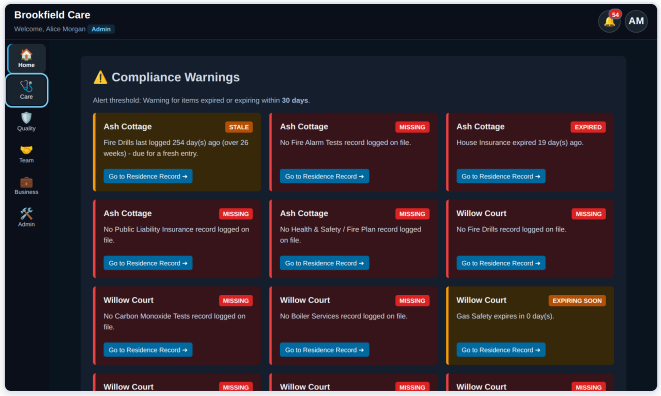


Figure 11. Dark mode: the Dashboard on a computer.

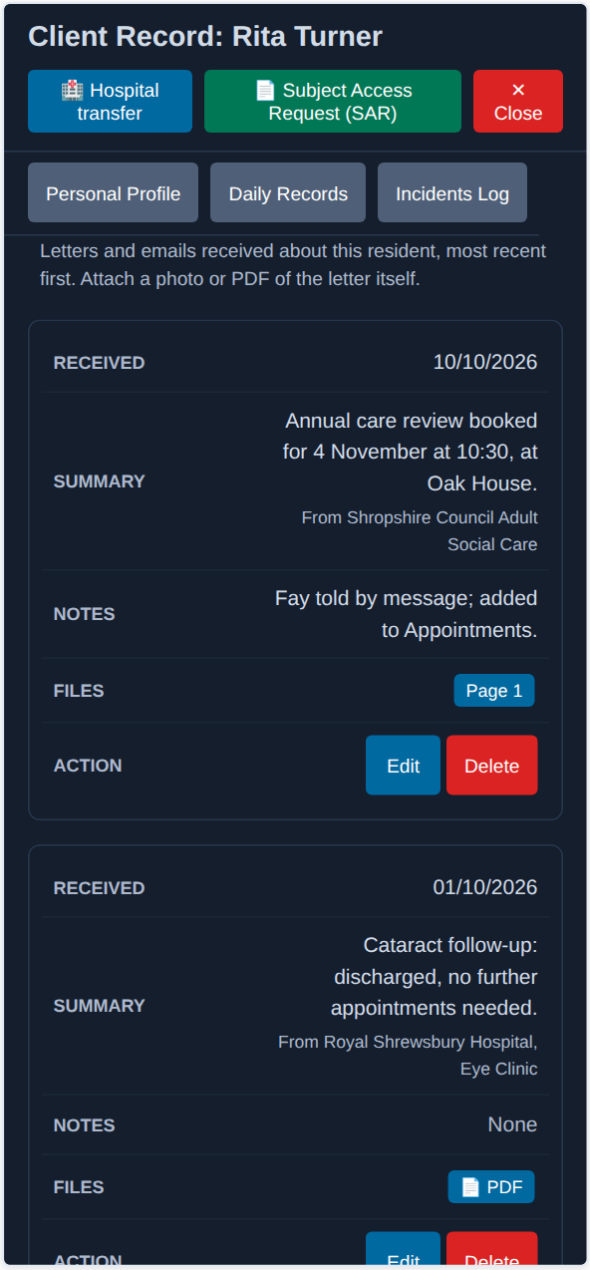


Figure 12. Dark mode: a client record on a phone.

2.4 How records are kept

- **Who can change a record.** Admins can change or delete any record. Other staff can change or delete records they wrote themselves, within the *edit window* (7 days unless an Admin changes it in Settings > Compliance & Retention). After that, ask an Admin. The same goes for deleting a resident's emergency contacts and care plan or assessment file versions: staff can delete only those they added, within the edit window.
- **Amendment history.** Every change keeps the earlier version. Records that have been changed show an **Amended** button that opens the history of changes, with who made each one and when.
- **One person editing at a time.** If someone else is already editing a record, you are told who; try again shortly. An Admin can take over editing if it's urgent.
- **Files and photos.** Photos and PDFs you attach (to daily records, incidents, consent forms, correspondence, certificates and so on) are stored encrypted, and opening one is recorded. Files up to 10 MB each (less if your hosting's limit is lower).

- **A file that can't be attached is never lost quietly.** If you choose a file that is too large, you're warned straight away. If a file still can't be stored (too large, not a photo or PDF, or not really the kind of file its name says), a message names the file and the reason, and everything else is saved: attach a smaller copy, or save the scan again as a PDF or photo. If everything you attached at once is too large for the server to receive, nothing is saved and the message says so.
- **The audit log.** Signing in, opening a resident's record, changes, downloads and exports are all recorded in the audit log (chapter 26).
- **Deleted files** are kept in quarantine for the retention period rather than destroyed straight away, so they can be recovered if a deletion was a mistake.

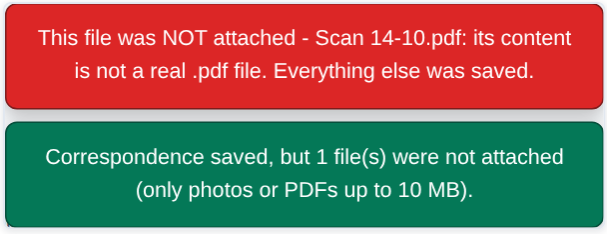


Figure 13. A file that wasn't attached: the message names it and gives the reason.

2.5 Notifications

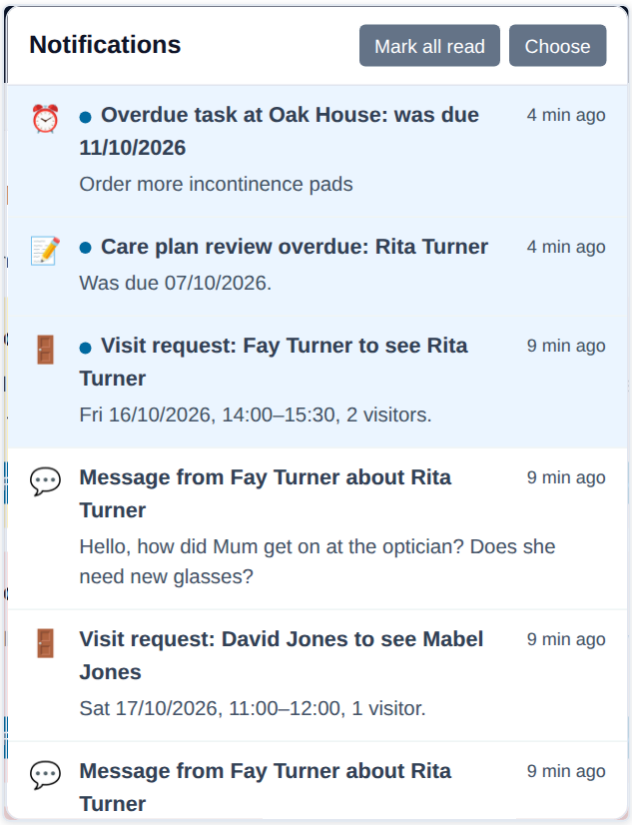


Figure 14. The notification panel.

The bell at the top tells you about things that need your attention. Click it to see the newest first; click a notification to go straight to what it is about (it is then marked read). **Mark all read** clears them all.

You are told about new handovers, incidents and tasks at your residences, overdue tasks, your own training and checks falling due, your shifts (new, changed or cancelled, and ones you have worked but not yet confirmed), messages and visit requests from families, event invitations (yours, and residents' at your residences, to reply for them), replies to events you organised, and events changed or cancelled. Admins are also told about overdue care plan and risk

assessment reviews, and Admins and care providers about incident follow-up that is overdue (section 10.2) and about new and overdue complaints (chapter 11). Everyone at a residence hears about compliments, about monitoring charts that are overdue or show a worrying NEWS2 score (chapter 13), and when a resuscitation decision is recorded or withdrawn (chapter 14). Admins and care providers are also told about property risk assessments that are missing, or whose review or actions are overdue (section 9.3; support workers about overdue actions given to them), when a DoLS or capacity item falls due, when a resident goes to hospital (chapter 15), and about leave requests and sickness in their team; everyone is told when their own leave is decided (chapter 6). Family members are told about messages from the care team, news and photos, answers to their visit requests, event invitations and changes, and progress on complaints they have sent.

Notifications clear themselves once the thing is dealt with, for example when a handover is acknowledged or a review is recorded. They are deleted after 90 days.

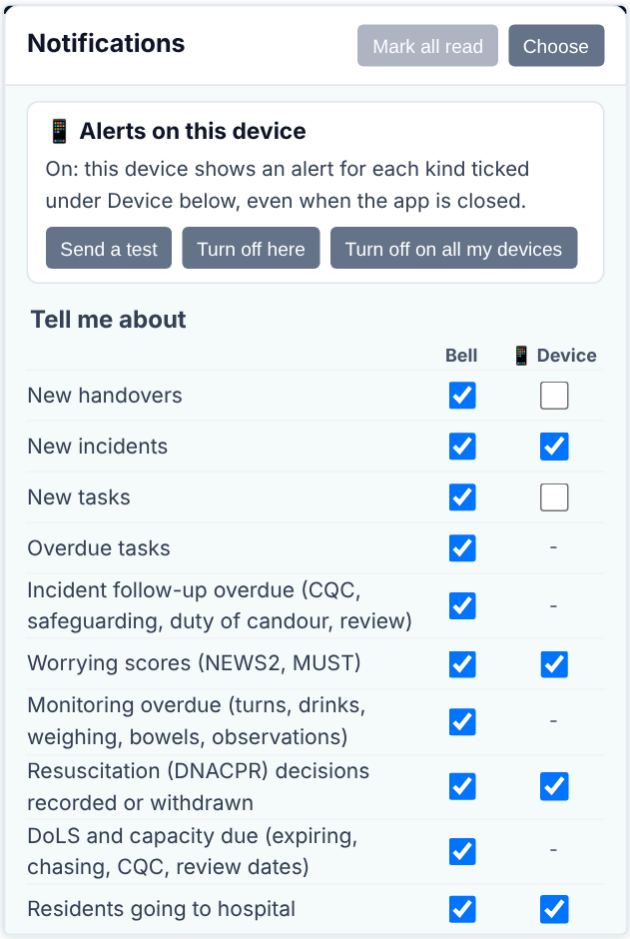


Figure 15. Choose: what you're told about in the bell, and on your devices.

Choose lists every kind of notification you can get. Untick a kind under **Bell** to stop being told about it, then **Save**. The **Device** column is for alerts on your phone or computer (section 2.6).

2.6 Alerts on your phone or computer

> **Who can use it:** Admins, care providers, support workers and family members, each for their own devices.

Alerts let urgent notifications reach you even when Honeysuckle isn't open: they appear on your phone's lock screen, or in the corner of your computer screen, like a message from any other app. Tap or click one to open Honeysuckle at that notification (sign in first if you have been signed out).

To turn alerts on, on the phone or computer you want them on: click the bell, then **Choose**, then **Turn on here** in the **Alerts on this device** box. When the browser asks whether Honeysuckle may show notifications, choose **Allow**. Then press **Send a test**: a test alert should appear within a few seconds. Do this on each device you want alerts on (up to 10).

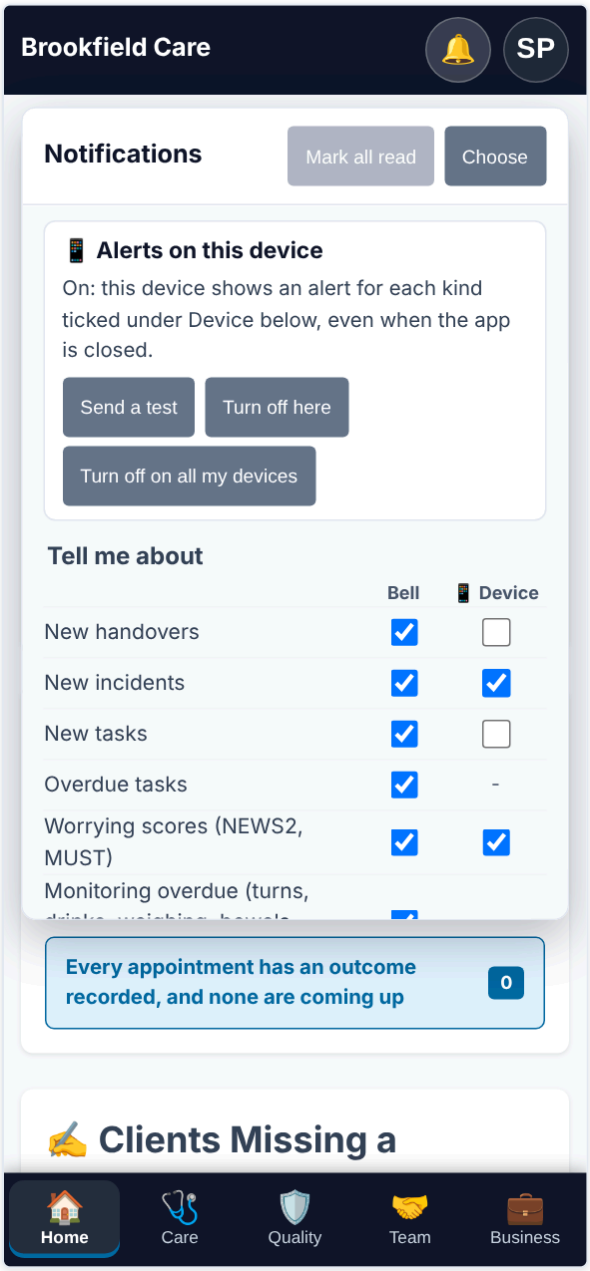


Figure 16. Alerts on this device, on a phone.

Which alerts. Tick a kind in the **Device** column to get an alert for it, then **Save**. To begin with, the urgent ones are ticked: new incidents, worrying monitoring scores, resuscitation decisions, residents going to hospital and changes to your shifts (for family members: messages from the care team and answers to visit requests). Kinds marked "-" are only shown in the bell: they are things that become overdue, and they are checked while you have Honeysuckle open. A kind unticked under **Bell** isn't sent as an alert either.

What an alert says. Only what kind of thing it is, such as "New incident reported" or "A resident has gone to hospital", never a resident's name or any details, because anyone near your phone can see its lock screen. The details are in Honeysuckle, behind your sign-in. Each alert is encrypted so that only your device can read it.

- **iPhone and iPad:** alerts only work once Honeysuckle is on your Home Screen. In Safari, press Share, then **Add to Home Screen**, open Honeysuckle from the new icon, sign in and turn alerts on there. This needs iOS 16.4 or later.
- **Android, Windows, Mac and Chromebook:** alerts work in Chrome, Edge, Firefox and Samsung Internet. On a computer, alerts only arrive while the browser is running (it can be minimised, without Honeysuckle open).
- **"Notifications are blocked":** you, or your browser, said no when it asked. Allow notifications for this site in the browser's settings (on a phone, also in the phone's settings for the browser or the Honeysuckle app), then come back and press **Turn on here**.
- **A shared tablet:** alerts go to whoever last turned them on there. If someone else turned them on, the box says "Off for you", and **Turn on here** moves them to you. On a shared device, it is usually better to leave alerts off.
- **Turning alerts off: Turn off here** stops them on the device you're using. If you lose your phone, use **Turn off on all my devices** from any other device.

Alerts don't replace checking Honeysuckle: a phone that is switched off, out of signal or on Do Not Disturb may get an alert late, or not at all. A phone that is off gets its alerts when it comes back on, if that is within a day. Accounts that are deleted, or moved to another care provider, stop getting alerts straight away.

3. Dashboard

> **Who can use it:** Everyone. The cards shown depend on your role.

The Dashboard is the first thing you see after signing in. It brings together what needs attention across your residences.

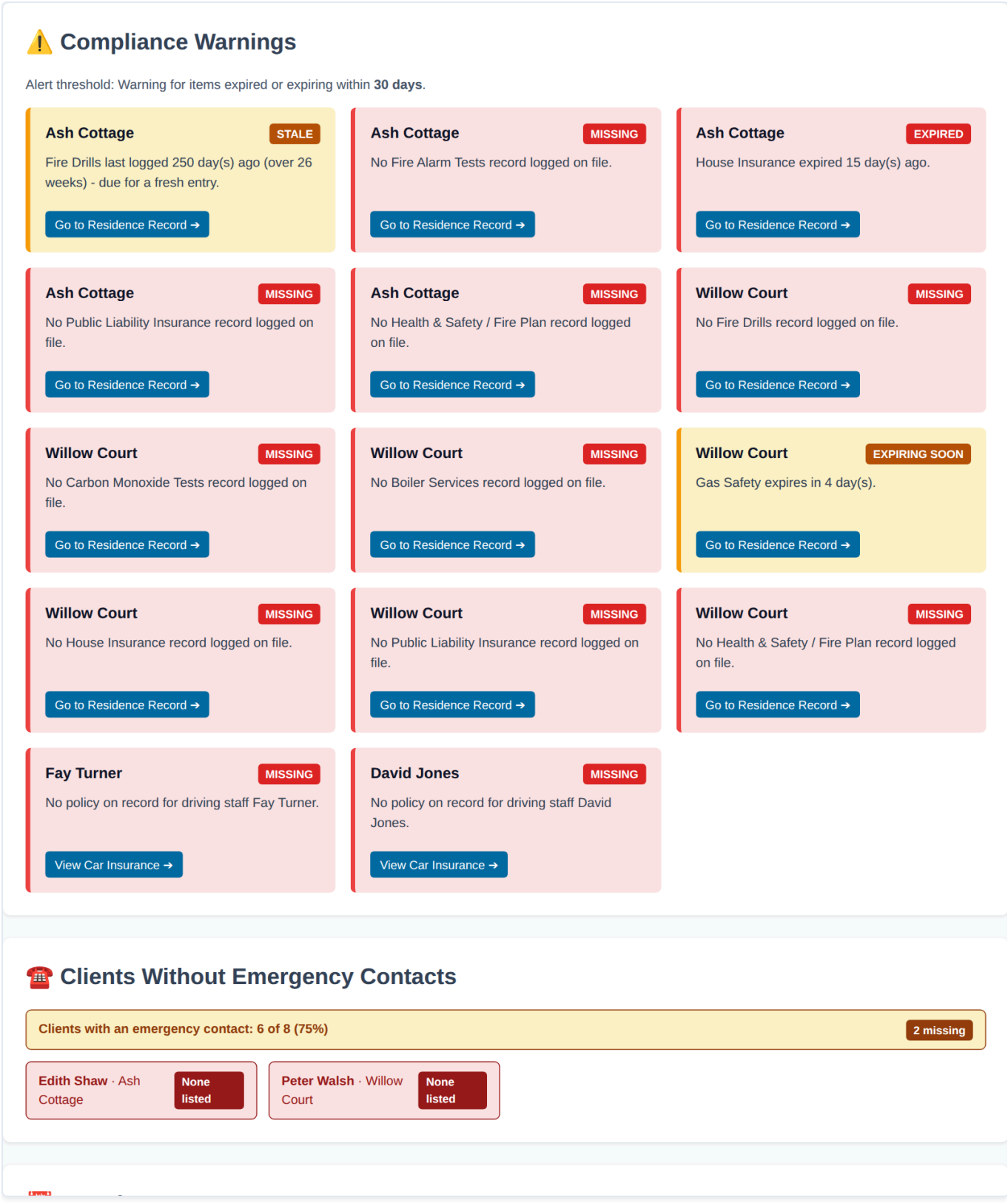


Figure 17. The Dashboard for an Admin (top part).

⚠ Compliance Warnings

Safety certificates and records at each residence that have expired, are due within the Compliance Alert Threshold (30 days unless changed), are missing, or (for things with no expiry date, like fire drills) haven't been logged for longer than the Stale Activity threshold. Also each residence's risk assessments that are missing, overdue or due for review within the threshold, and their overdue actions (section 9.3). Each card's button opens that residence's record so you can log the new certificate.

🎓 **Staff Training & Checks**

Training, DBS checks, right to work, supervision and appraisals that are overdue, due soon or missing. **Open** goes to the training grid in the Carers tab.

💊 **Medication rounds**

Doses more than an hour past their time today that haven't been recorded, at your residences, and how many are due now. **Open** goes to the Medication tab (chapter 16).

🎟 **Upcoming events**

The next events, three to a page (◀ **Previous** and **Next** ▶ for more): when and where, the meeting point, and who is going, as *Residents*, *Family* (with any extra tickets) and *Staff*, with how many haven't replied. Click an event's name to open it (chapter 17). Family members see the events they are invited to, with their own party.

🚨 **Incident follow-up**

Open incidents with something still to do (telling CQC, the local authority, police or family, the duty of candour, the manager's review), overdue ones first, four to a page. **Follow up** opens one; **Open** shows the open incidents in the Incidents tab (section 10.2). Admins and care providers.

📣 **Complaints**

Open complaints with what is still to do (acknowledgement, the final response, closing), overdue ones first, four to a page. **Open** on one opens it; **Open** at the top shows the open complaints (chapter 11). Admins and care providers.

📈 **Monitoring**

Residents on monitoring charts with something overdue or worrying (a high NEWS2, a turn or drink overdue, a MUST score of 2 or more). **Open** goes to them in the Monitoring tab (chapter 13).

⚖ **DoLS & capacity**

DoLS authorisations expired or ending, applications to chase, DoLS outcomes not yet notified to CQC, best-interests decisions to record and reviews due. **Open** goes to the resident's record (chapter 14). Admins and care providers.

🏖 **Leave**

Leave requests waiting for you to decide, and who in your team is off today (chapter 6). Admins and care providers.

👛 **Residents' money**

Residents whose cash count is due or didn't match (chapter 18). Admins and care providers.

📥 **Enquiries**

Places free, and enquiries with a next step due, not answered or a place held too long (chapter 19). Admins and care providers.

✅ **Audits & maintenance**

Audits overdue, actions overdue, and urgent or overdue repairs (chapter 20). Admins and care providers.

📋 **Care Plan & Risk Reviews**

Care plans and risk assessments whose review date has passed or is coming up, and residents with no care plan.

☎ **Clients Without Emergency Contacts**

Residents with no emergency contact recorded.

📅 **Appointments**

Appointments with no outcome recorded: those whose date has passed first (oldest first), then a line marked *Today*, then upcoming ones. Five are shown at a time; use ◀ **Previous** and **Next** ▶ for the rest. Click one to record the outcome. Family members see their relative's upcoming appointments here.

✍ **Clients Missing a Consent Form**

Residents with no consent form given in the last 12 months that is still in date.

🚨 Emergency Contacts

Your provider's important numbers (the on-call manager, the safeguarding team, and so on). **View / Manage Contacts** lists them with a **Call** button; Admins add and remove them.

Financial Summary

Benefits received and contributions paid across residents (Admins and care providers).

📄 Policies & Procedures

The policies you still have to read and confirm, overdue ones in red; for Admins and care providers, the policies not yet read by everyone, and for Admins, those past their review date (chapter 21).

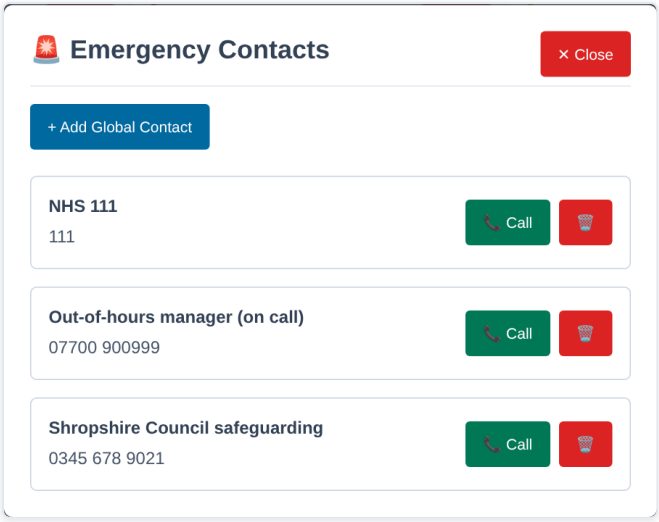


Figure 18. Emergency contacts.

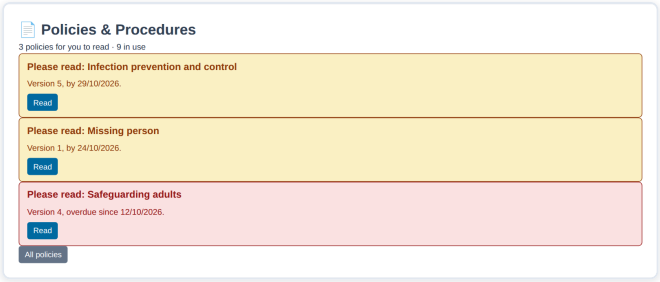


Figure 19. Policies to read.

4. Handovers & Tasks

> **Who can use it:** Admins, care providers and support workers.

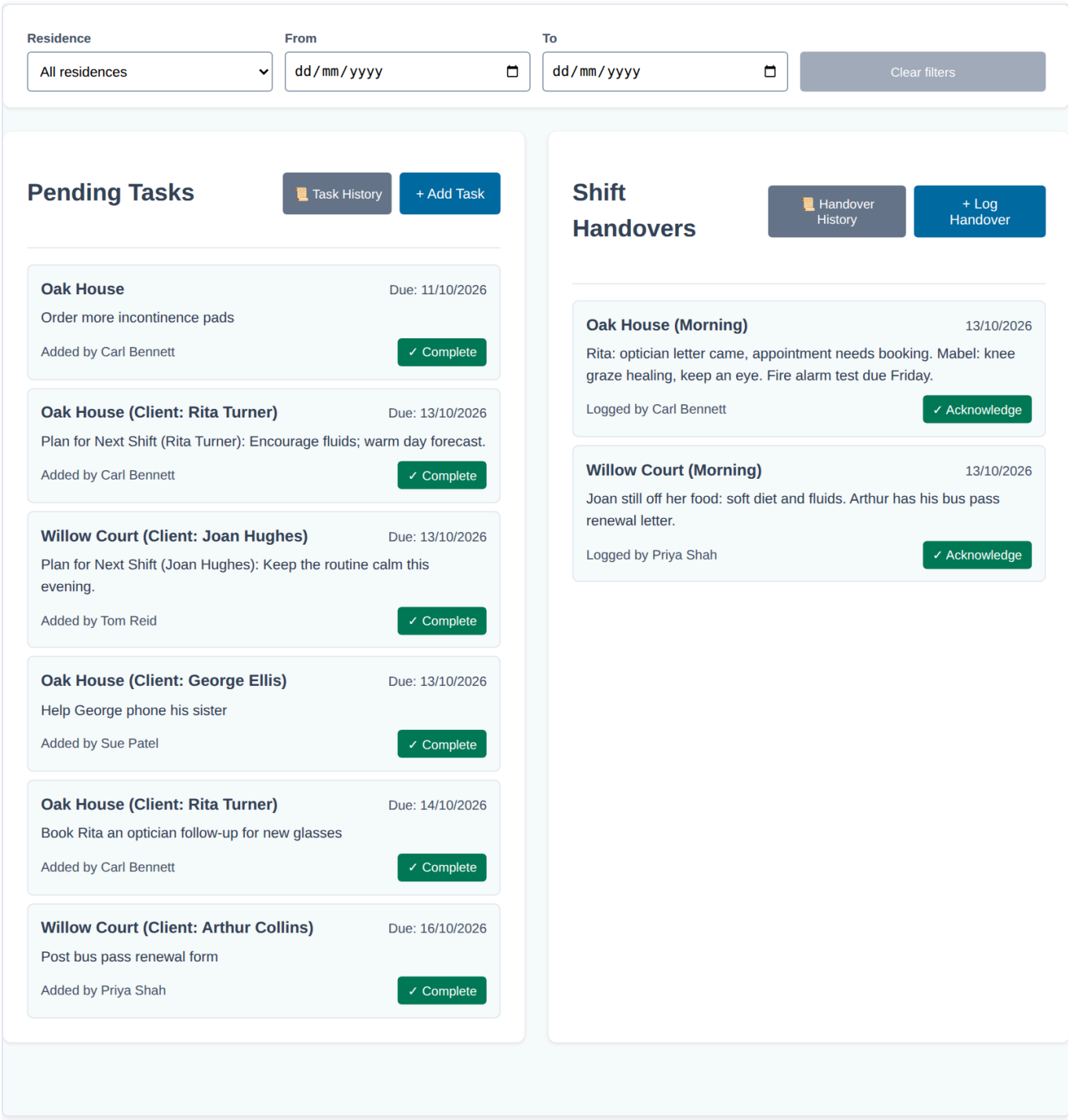


Figure 20. Handovers & Tasks: pending tasks on the left, shift handovers on the right.

Use the filters at the top to show one residence or a range of dates.

4.1 Tasks

Pending Tasks lists jobs still to do, with the residence, the resident (if the task is about one), the due date and who added it. Overdue tasks are highlighted, and staff at that residence are notified. Press ✓ **Complete** when it is done; it

moves to 📜 **Task History**, which records who completed it and when.

Press **+ Add Task** to add one: choose the residence, optionally a resident, the due date and what needs doing.

> Writing something in **Plan for Next Shift** on a daily record (chapter 12) also creates a task for the next day automatically, so the plan isn't missed.

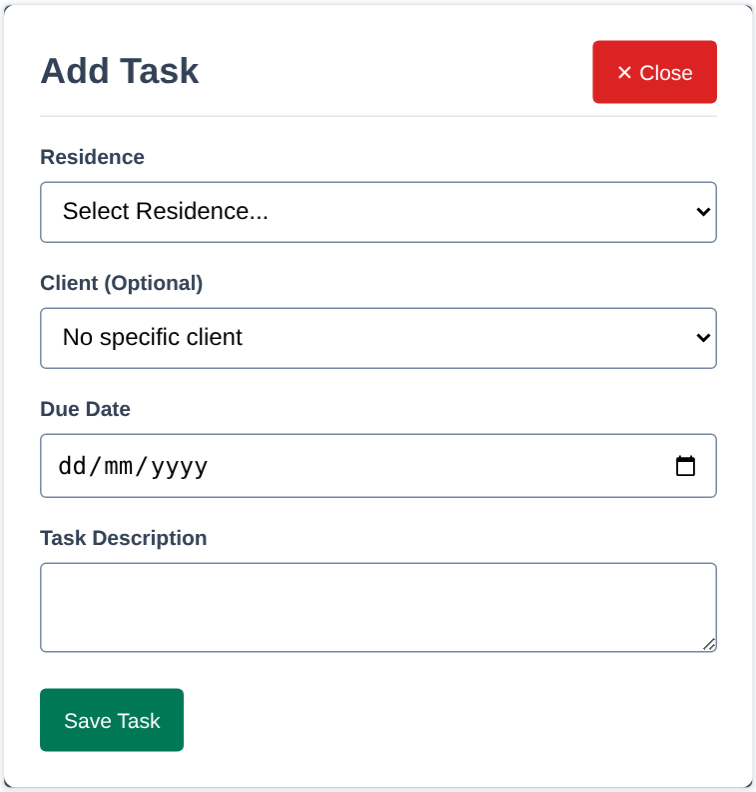


Figure 21. Adding a task.

4.2 Shift handovers

At the end of a shift, press **+ Log Handover**, choose the residence, date and shift, and write anything the next shift needs to know. Staff at that residence are notified. The incoming shift presses **Acknowledge** to show they have read it; earlier handovers are in 📜 **Handover History**.

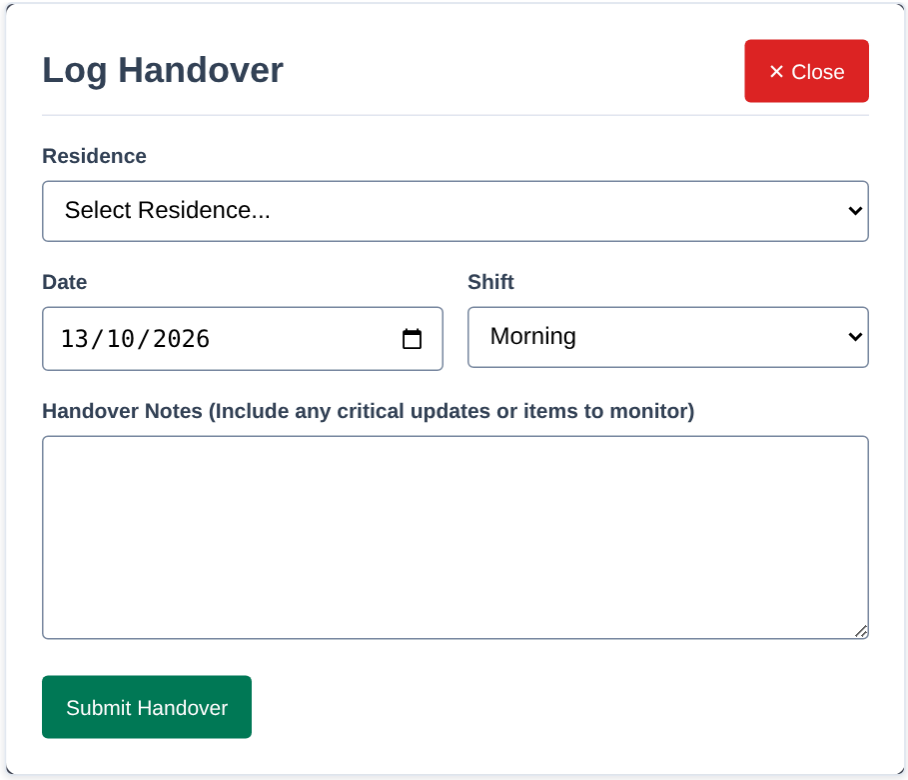


Figure 22. Logging a handover.

5. Rota

Who can use it: Admins plan shifts everywhere. Care providers plan at their own residences if an Admin allows it (Settings > Rota & Shifts). Everyone else sees the rota of their residences and confirms their own shifts.

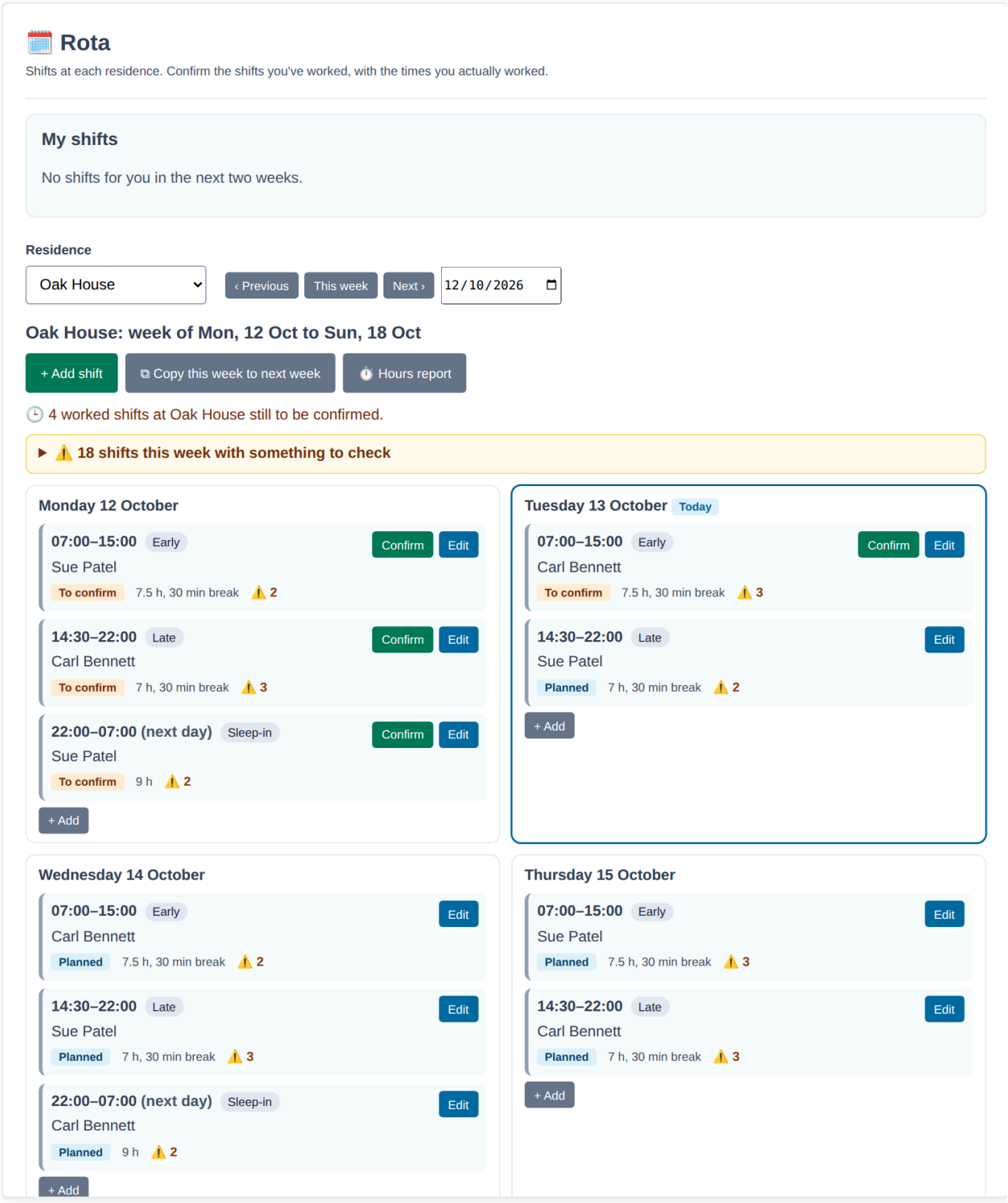


Figure 23. The week at Oak House, with planning tools (Admin).

5.1 The week at a residence

Choose the residence, then move a week at a time with ‹ **Previous**, **This week** and **Next** ›, or pick a date. Each day lists its shifts: the times (a night shift shows "next day"), the shift type, who is on it and its status:

- **Open shift**: nobody is on it yet.
- **Planned**: someone is on it and it hasn't happened yet.
- **To confirm**: it has started, and the person on it hasn't confirmed the times they worked.
- **Confirmed**: confirmed with the actual times (flagged if they differ from the plan).

A ⚠ next to a shift means something is worth checking; the box above the week lists them. Planners also see who is on leave or off sick each day (section 6.5).

5.2 Planning shifts

Press **+ Add shift**, or **+ Add** under a day. Choose the shift type: its usual times and break are filled in, and you can change them for that one shift. Choose who works it, or leave it as an open shift. As you fill it in, the app warns you (it never stops you saving) if the person is:

- already on another shift at the same time, at any residence
- getting less than 11 hours' rest between shifts (sleep-ins aren't counted)
- planned for more than 48 hours that week
- overdue on training or checks that apply at that residence
- not assigned to that residence
- on approved leave or off sick that day (chapter 6)

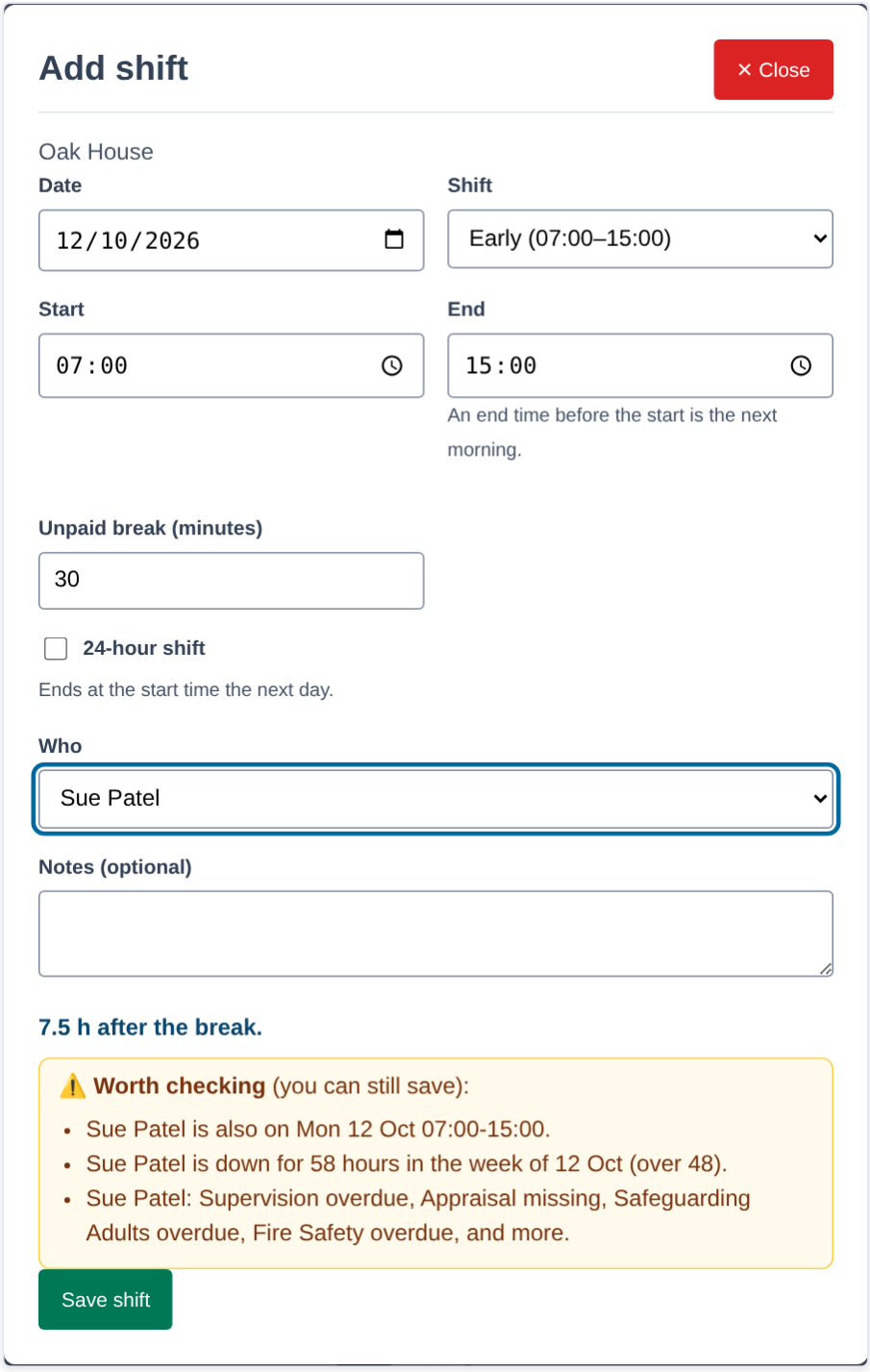


Figure 24. Adding a shift, with warnings about the person chosen.

24-hour shifts. For a shift that ends at the same time the next day (for example 08:00 to 08:00), tick **24-hour shift**. A shift with the same start and finish time is only accepted with this ticked, so typing the same time twice by mistake is caught. Over a clock change a 24-hour shift is 23 or 25 hours, and the length shown says so. The same box is on the confirmation form and on shift types (section 27.10).

To change or delete a shift, press **Edit** on it. The person on the shift is notified when it is added, changed or cancelled. Once a shift is confirmed as worked, only an Admin can change or delete it.

⧉ **Copy this week to next week** copies every shift with the same people and times. Anything already there for the same person and times is left alone, and each person gets one notification about their new shifts.

5.3 Confirming the shifts you've worked

At the top of the Rota tab, **My shifts** lists your shifts for the next two weeks, at any residence, and any you have worked but not yet confirmed. You are also reminded by a notification an hour after a shift ends.

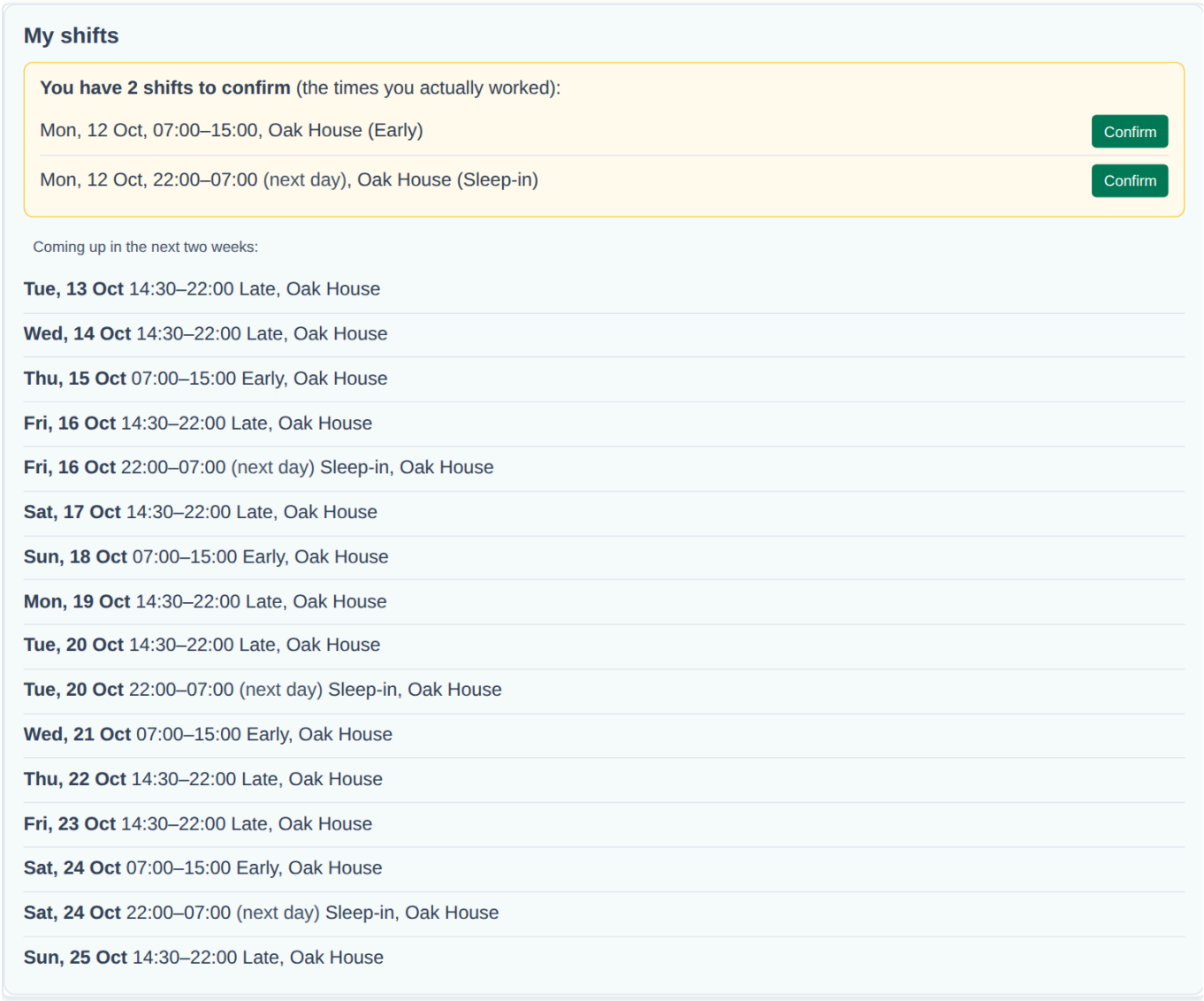


Figure 25. My shifts, with one waiting to be confirmed.

Press **Confirm**, then change the start and finish times if you started or finished at a different time, adjust the unpaid break, and add a note if needed. The hours worked are worked out as you type. You can correct your own confirmation within the edit window; after that, whoever plans the rota can.

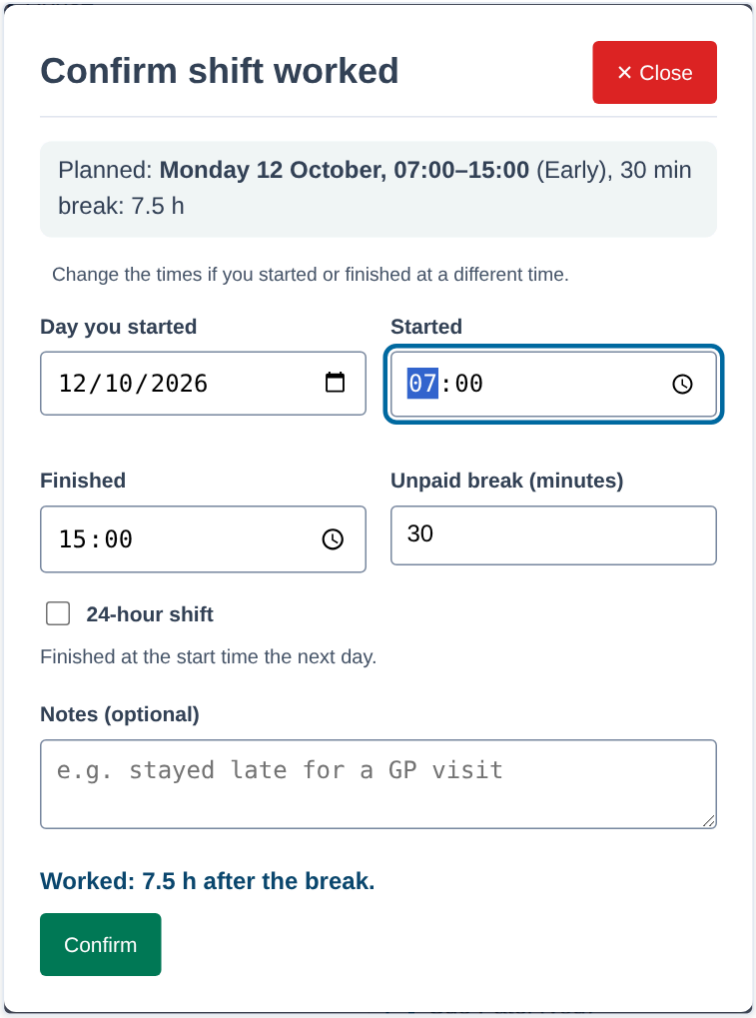


Figure 26. Confirming a shift with the times actually worked.

5.4 Hours report

⏱ **Hours report** shows, for any dates and residence, each person's planned hours, worked (confirmed) hours, shifts still to confirm and sleep-ins. Download the totals, or every shift, as a CSV file for payroll.

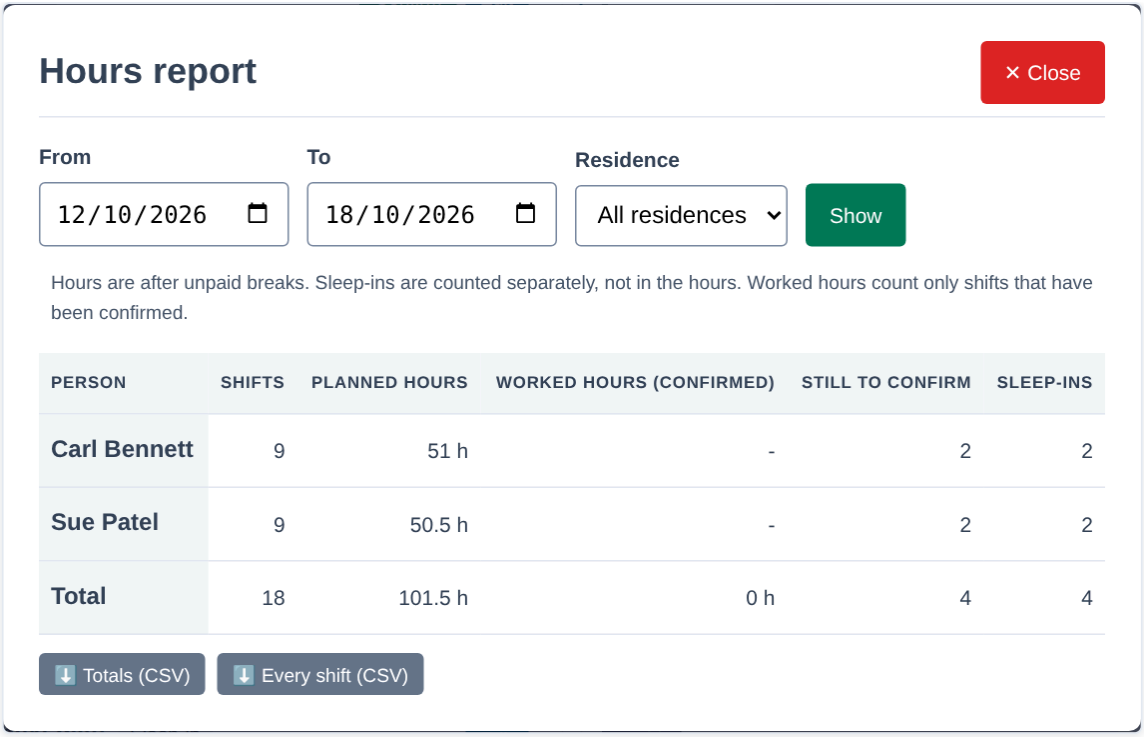


Figure 27. The hours report.

6. Leave

> **Who can use it:** Everyone on the staff requests their own leave and reports their own sickness. Admins decide everyone's leave; care providers decide it for the support workers at their residences. Admins set allowances.

The **Leave** tab (under Team) is for holiday and other leave, and sickness. Holiday is counted in **hours**, so it works the same for someone on 12-hour shifts as for someone on part-time days.

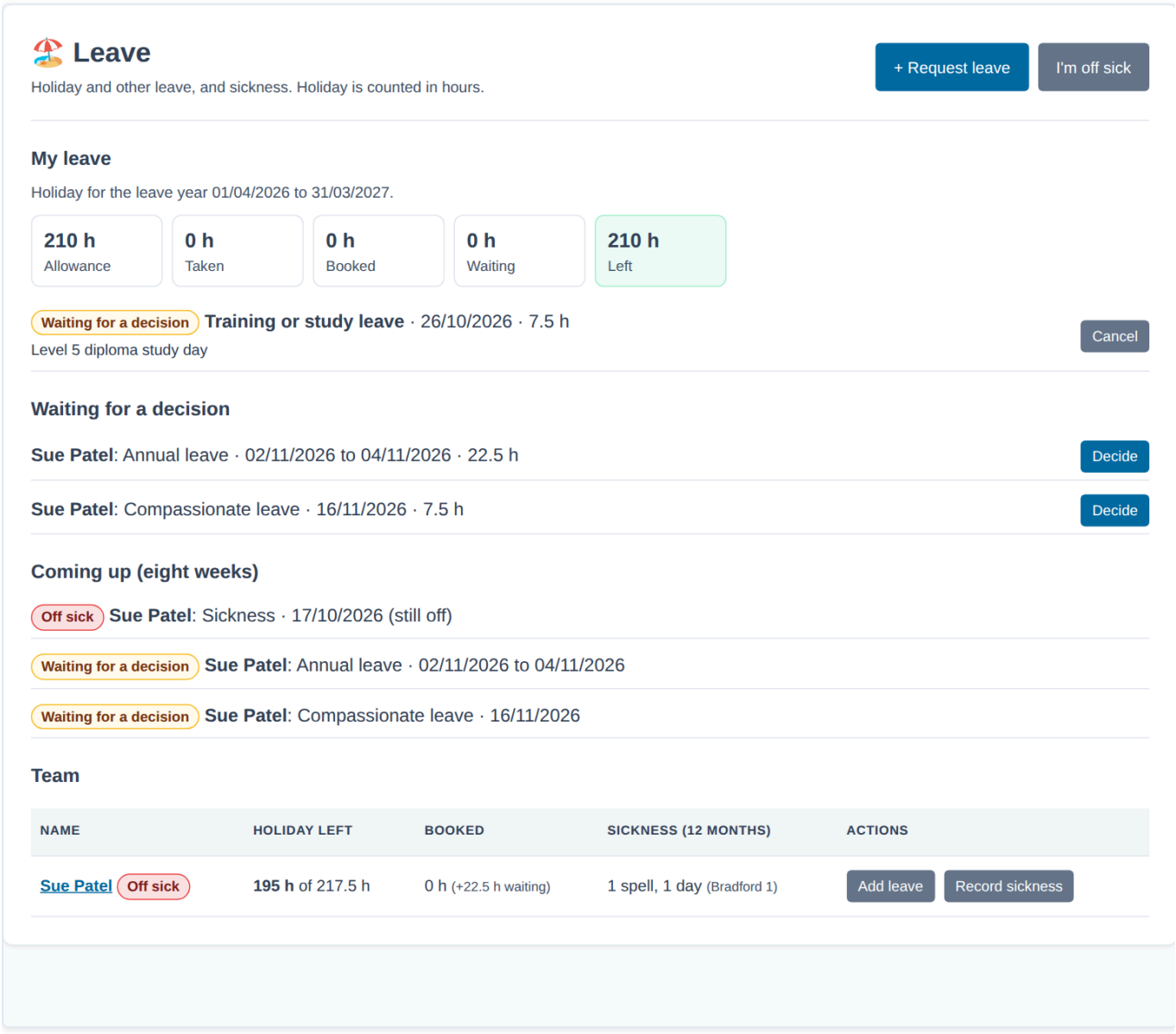


Figure 28. The Leave tab for a care provider: their own leave, requests waiting, what is coming up and the team.

6.1 Your leave

At the top you see your holiday for the leave year: your **allowance** (including any hours carried over), what you have **taken**, what is **booked** (approved, still to come), what is **waiting** for a decision, and what is **left**. Below is your leave, newest first.

Press **+ Request leave**, choose the kind (annual leave, unpaid, compassionate, maternity, paternity or parental, training or study, or other), the first and last day, and add a note if you like. The hours are worked out for you as the number of weekdays times your usual working day (7.5 hours unless your Admin has set yours); change them if you work

weekends or longer shifts. The form shows how much holiday you would have left. If you are on shifts during that time, you are told so your manager can arrange cover. Your manager is notified, and you are told when they decide. You can **Cancel** a request, or booked leave, until it starts.

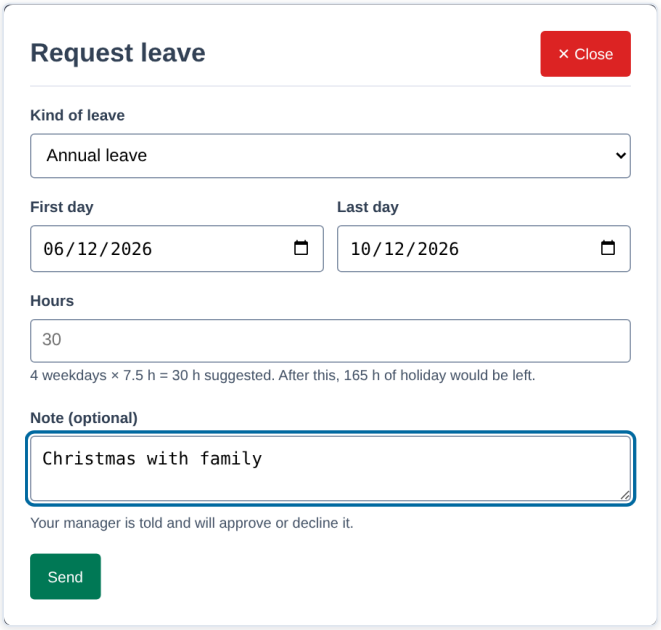


Figure 29. Requesting leave.



Figure 30. The Leave card on the Dashboard.

6.2 Sickness

If you are ill, press **I'm off sick**: the first day is today, and you can add a reason (only you and your managers see it). Leave the last day empty while you are still off. Your managers are notified, and told about any shifts you are on in the next few days. When you are better, press **I'm back** and give your last day off. Managers can also record sickness for their staff with **Record sickness**, and when updating it record whether a fit note was received and the date of the return-to-work interview.

6.3 Deciding leave (managers)

Requests waiting are listed under **Waiting for a decision**, and on the 🏖 **Leave** card on the Dashboard. **Decide** shows the request, the person's holiday left before and after it, and any shifts they are on in that period. Tick **Make their shifts in this period open shifts** to free those shifts for someone else, then **Approve**, or **Decline** with a note saying why. The person is told either way.

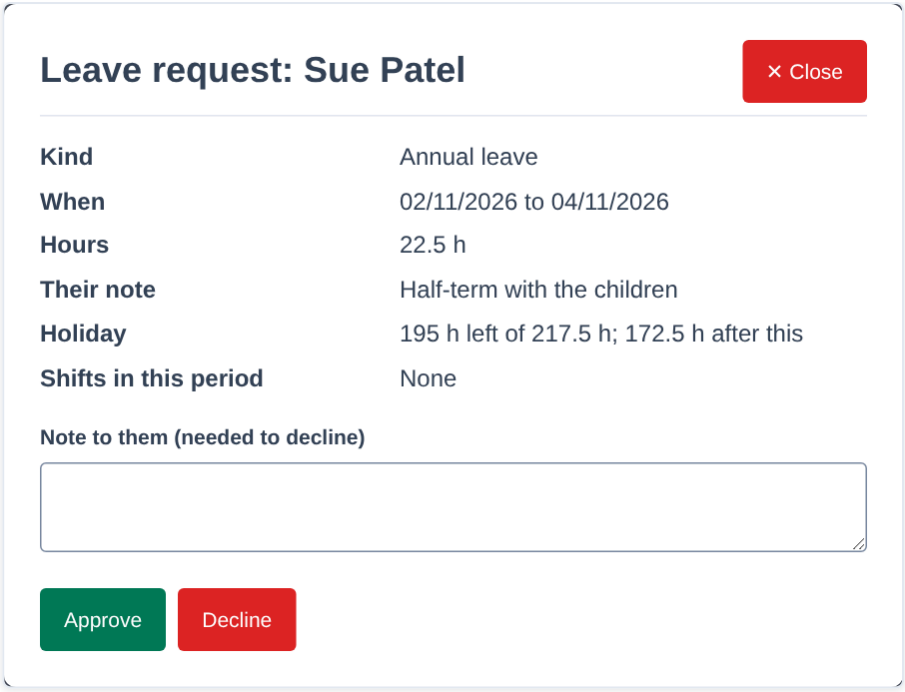


Figure 31. Deciding a request.

Coming up lists everyone's leave and sickness in the next eight weeks, including requests still waiting. **Team** lists the people you manage: their holiday left and booked, and their sickness in the last 12 months (spells, days and the Bradford factor, a common measure where frequent short absences count more than one long one). **Add leave** books leave for someone (for example from a paper request): it is approved straight away and they are told. A care provider's own requests go to the Admins; an Admin's to another Admin (if there is no other Admin, it is booked straight away).

6.4 One person, and allowances

Click a name in the Team list to see all their leave and sickness, with the reasons, and to update or cancel it. Admins also see the **Allowance** for the current leave year: the holiday allowance in hours (empty uses your care provider's default), hours carried over from last year, and their usual working day. Admins can delete a record made by mistake; a copy is kept.

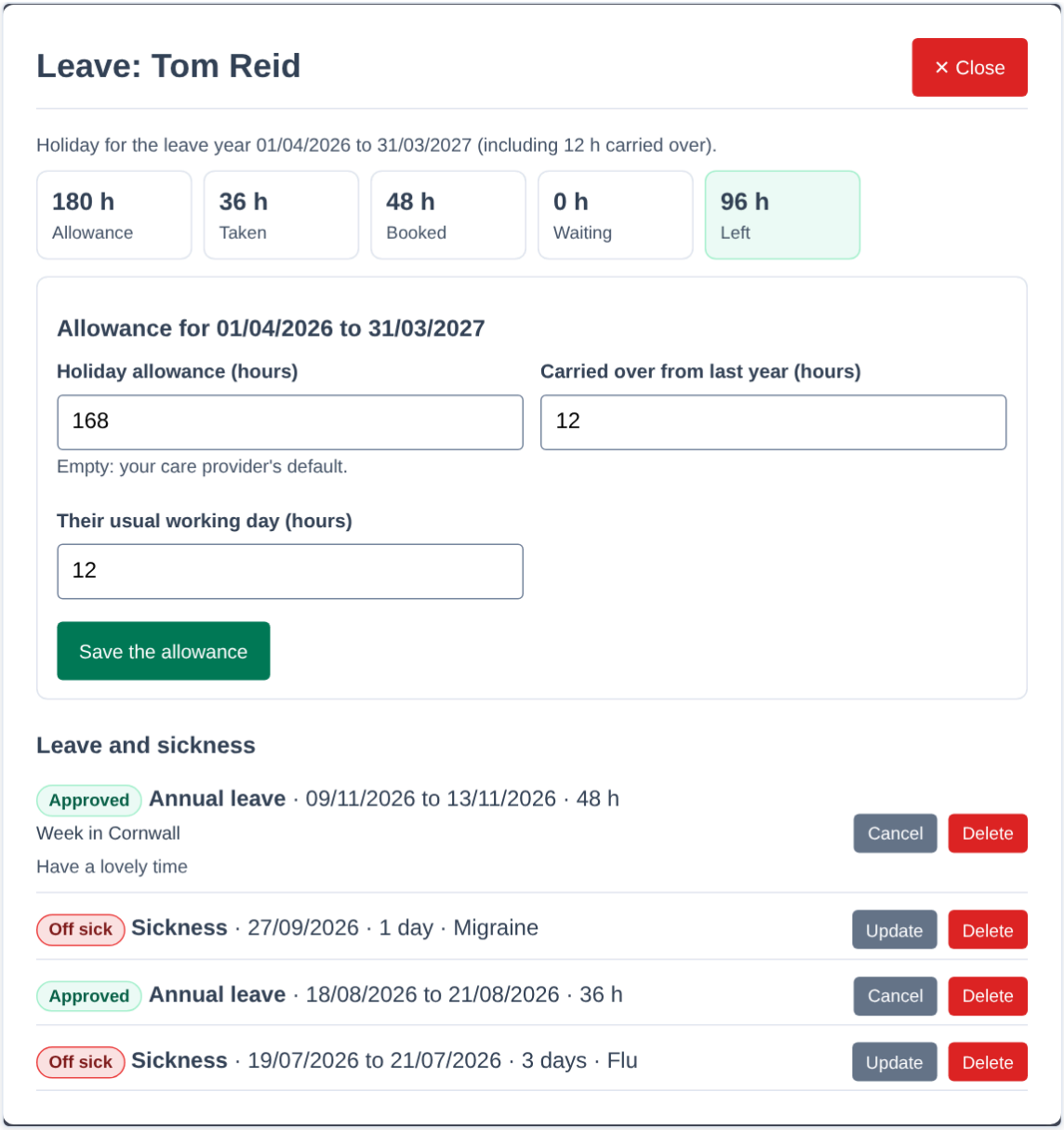


Figure 32. One person's leave, with their allowance (Admin).

6.5 On the rota

On the Rota (chapter 5), planners see who is on leave or off sick each day, above that day's shifts (requests still waiting have a dashed outline), and a shift given to someone on approved leave or off sick is flagged with a ⚠. Support workers see only their own leave there.

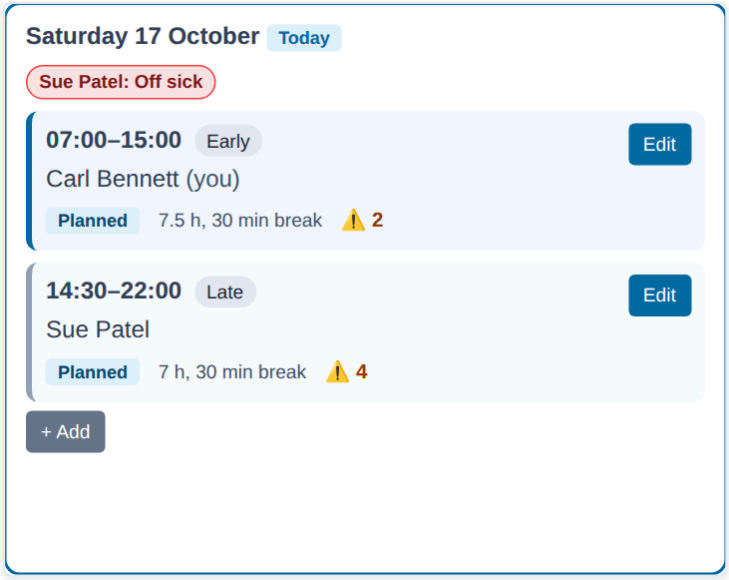


Figure 33. The rota on a day when someone is off sick.

The leave year, the default allowance and a usual working day are set by an Admin in Settings > Compliance & Retention (section 27.2).

7. Clients

> **Who can use it:** Everyone. Staff below Admin see residents at their residences; family members see only their relative.

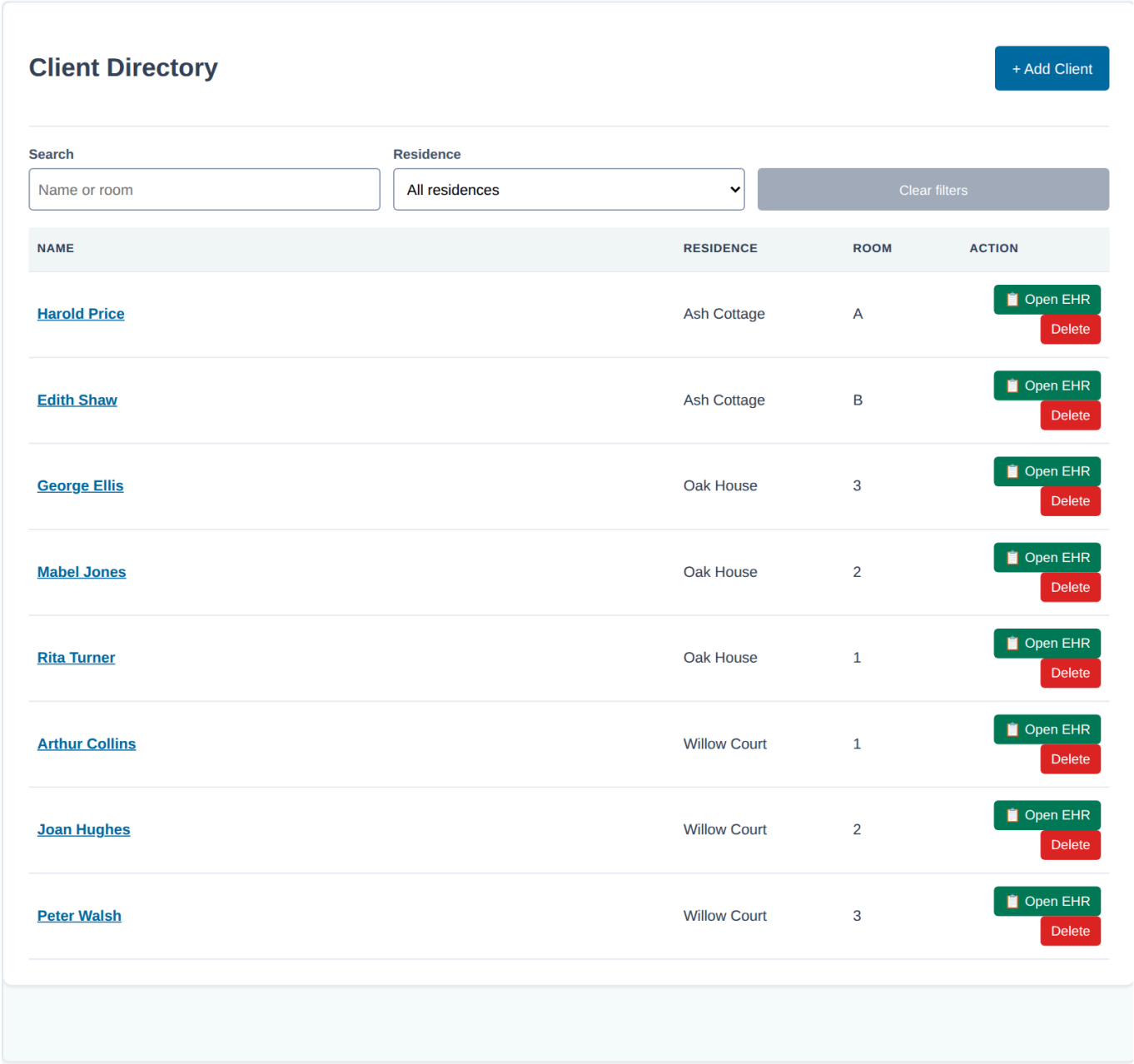


Figure 34. The client directory.

The directory lists current residents with their residence and room. Search by name or room, or filter by residence. **Open EHR** opens a resident's record. Admins can **Delete** a resident (this is rarely right: when someone leaves, record their move-out date instead, so their records are kept for the retention period).

7.1 Adding a resident

Press **+ Add Client** and enter their name, residence, room, weekly rate and the number of days billed in each 4-week cycle (28 for full time). Everything else is added in their record afterwards.

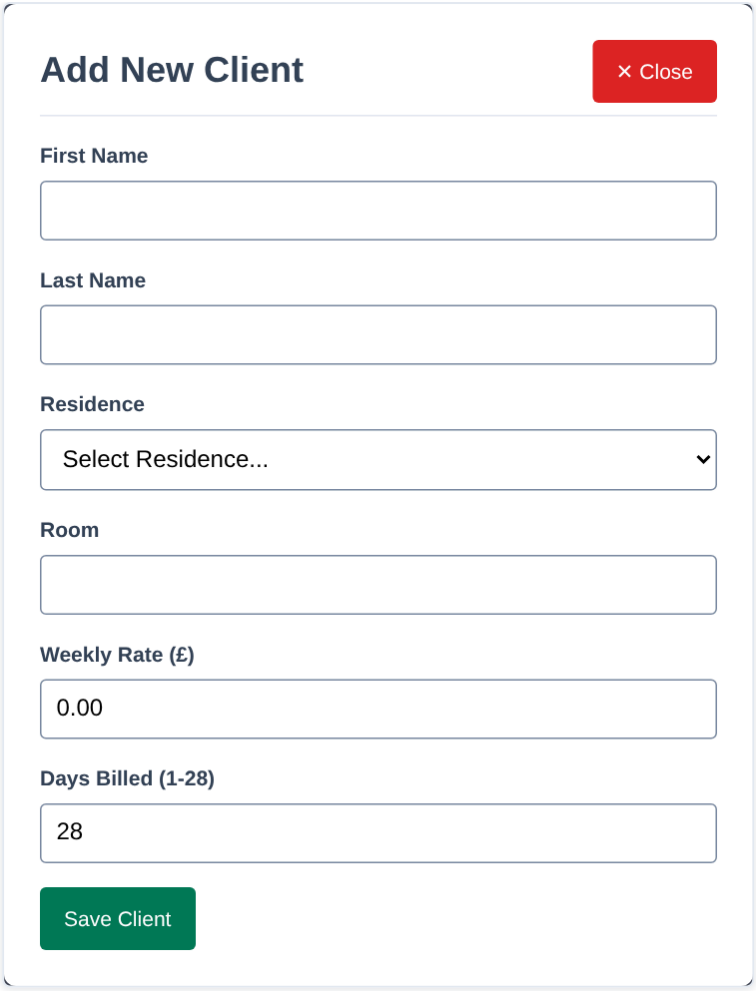


Figure 35. Adding a resident.

7.2 The client record

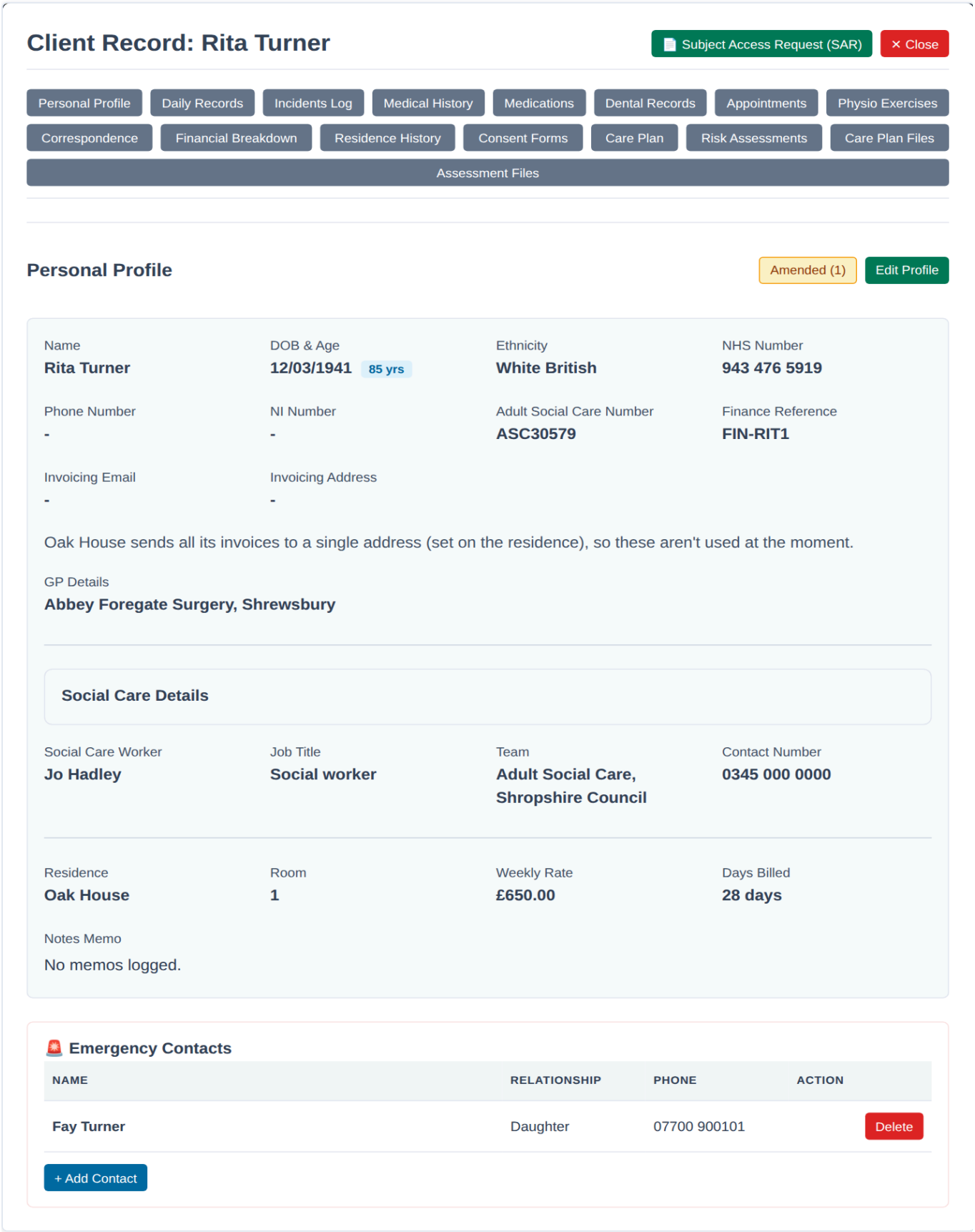


Figure 36. The top of a client record: the jump-to buttons, the profile, emergency contacts and allergies.

The client record (sometimes called the EHR) holds everything about one resident. The buttons along the top jump to each section. Most sections show the latest five entries; 📜 **View Full History** shows the rest, year by year, and can be

exported as a PDF.

Personal Profile. Name, the name they like to be called, how they want to be referred to (he/his, she/her, they/them, or in their own words), date of birth and age, ethnicity, NHS number, phone, National Insurance number, Adult Social Care number, finance reference, GP, their social worker, residence, room, weekly rate and notes. Press **Edit Profile** to change them.

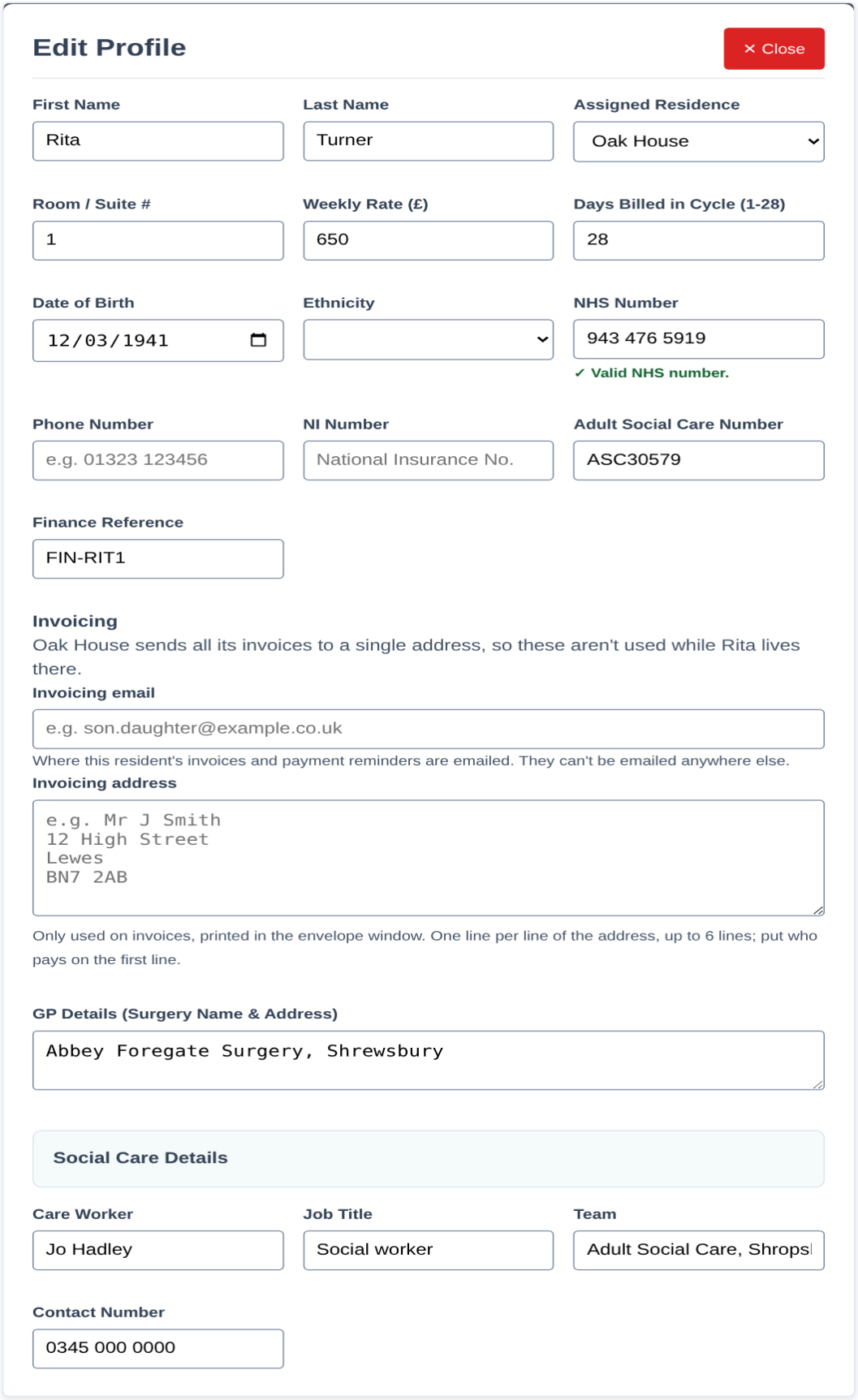


Figure 37. Editing the profile.

NHS numbers are checked as you type. An NHS number has 10 digits, and the last one is a check digit, so most typing mistakes and swapped digits are caught straight away. A valid number is saved in the standard format (943 476 5919). A number saved before this check existed, and which doesn't pass it, is kept until someone changes it, with a warning on the record.

Invoicing (Admins and care providers): the email and postal address this resident's invoices go to. They are used when the resident's residence bills each resident separately and doesn't send everything to one address (section 9.2); otherwise a note says where the invoices go instead. Invoices and reminders can only be emailed to the saved address.

🚨 **Emergency Contacts** and ⚠ **Allergies & Intolerances** are near the top so they are always seen. Severe allergies are highlighted.

7.3 Sections of the record

Daily Records

The resident's daily notes (chapter 12 explains what goes in them), with who last updated each one under its shift. **+ Log Daily** adds one for this resident.

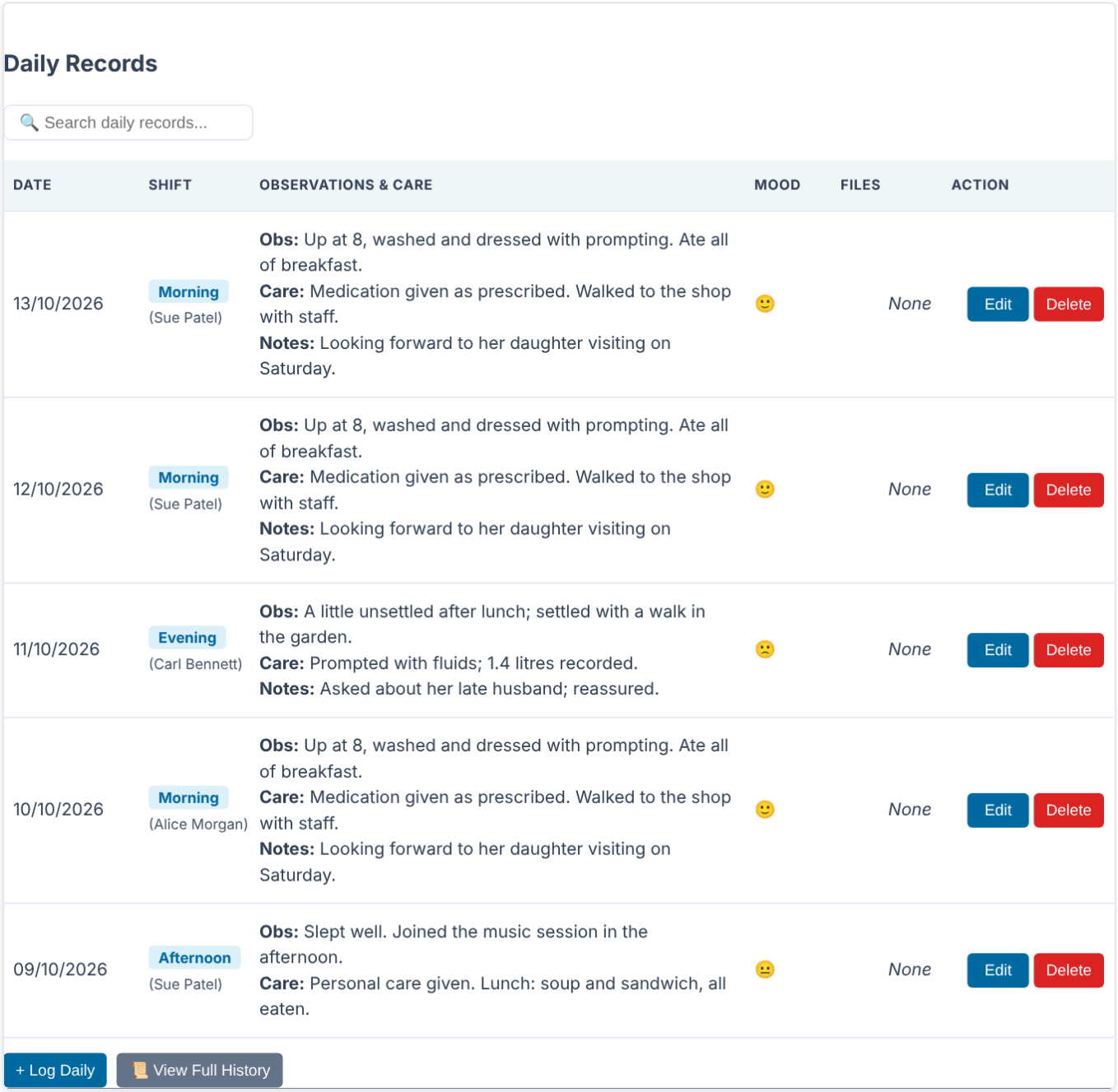


Figure 38. Daily records in the client record.

Incidents Log

Incidents involving this resident (chapter 10). **+ Log Incident** reports one.

Medical History

Conditions, when they were diagnosed, and notes.

Medications

Each medicine, its dose and when it is given (set times, or when required), with any instructions. Admins and care providers add, change and stop them here; doses are recorded in the Medication tab. Chapter 16 explains both.

Dental Records

Visits, the dentist and treatment.

Appointments

Health appointments: the type, who with, when, the reason and the outcome. Record the outcome after the appointment; until then it shows as "Pending" and appears on the Dashboard.



Figure 39. Medical history.

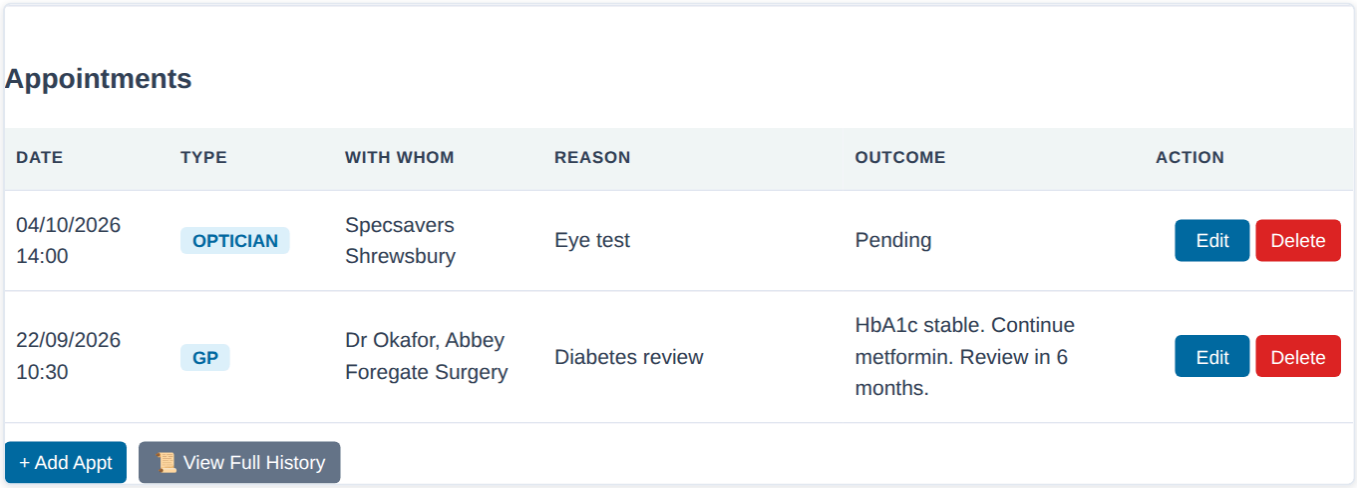


Figure 40. Appointments, one with its outcome recorded and one pending.

Physio Exercises

Exercises set by a physiotherapist: the date issued, an optional end date, the physiotherapist, the exercises, and photos or PDFs of the exercise sheets. Each shows as *Current*, *Ongoing* (no end date), *Starts …* or *Ended*.

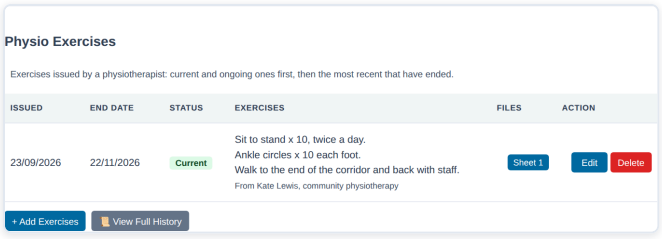


Figure 41. Physio exercises.

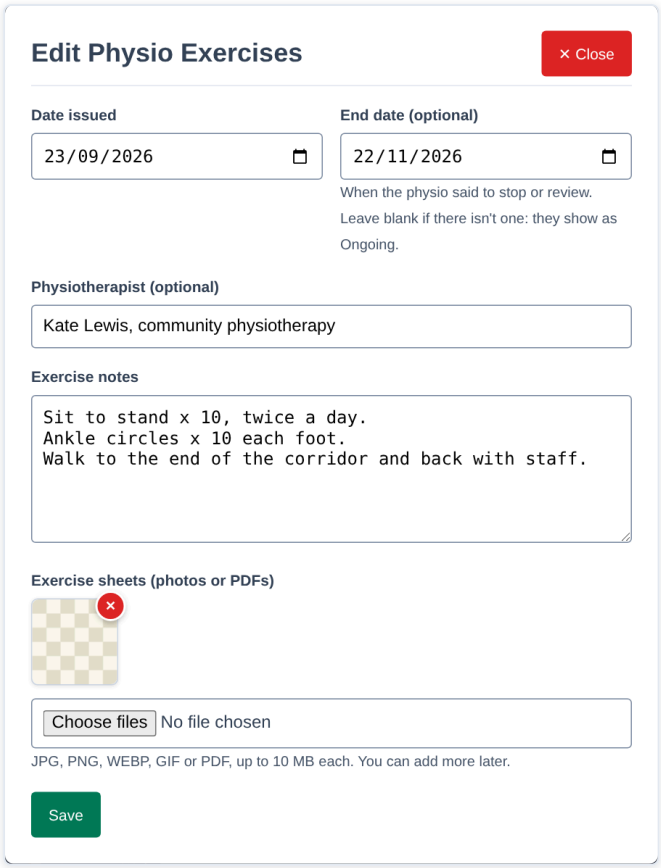


Figure 42. Adding or changing physio exercises.

Correspondence

Letters and emails received about the resident: the date received (today is filled in; it can't be in the future), who it was from, a summary, notes (for example who it was passed to, or the reply sent) and photos or PDFs of the letter. The latest five are shown, most recent first; 📜 **View Full History** lists them all and has a search box, so you can find a letter by who sent it or what it said. Correspondence is for staff only: family members never see it.

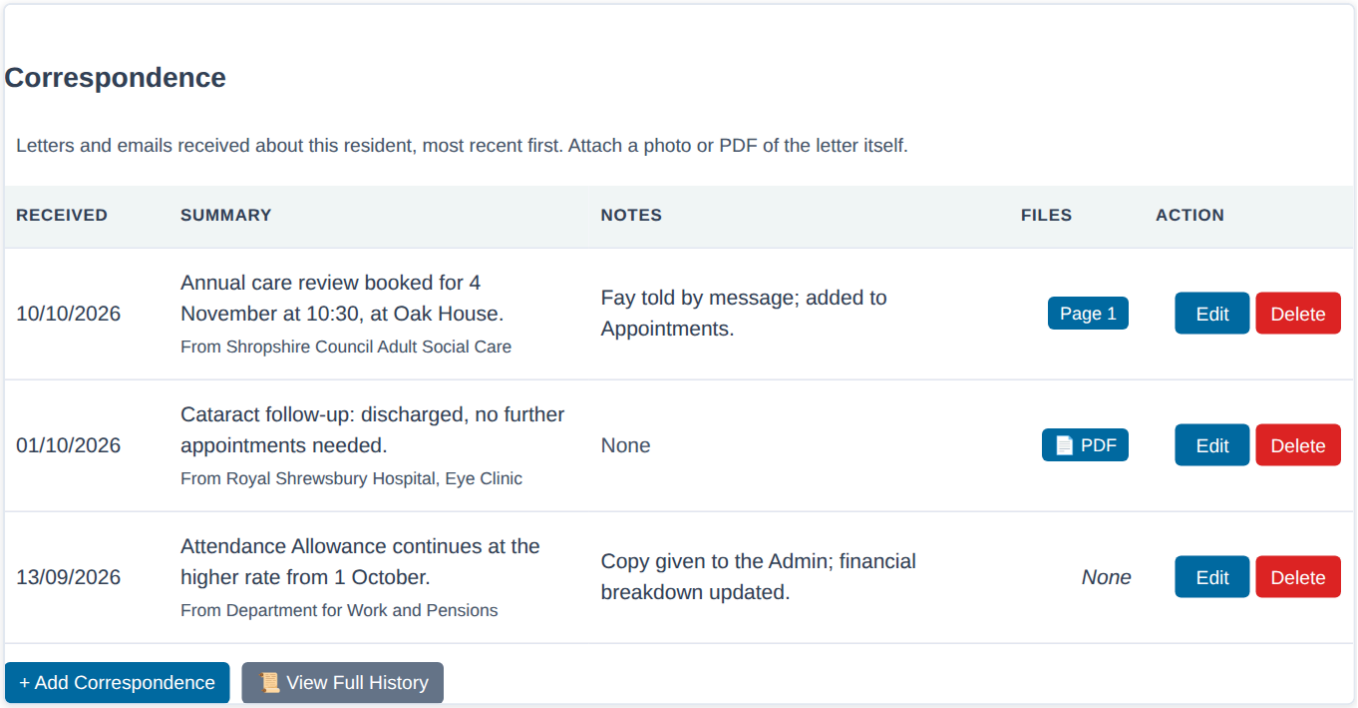


Figure 43. Correspondence in the client record.

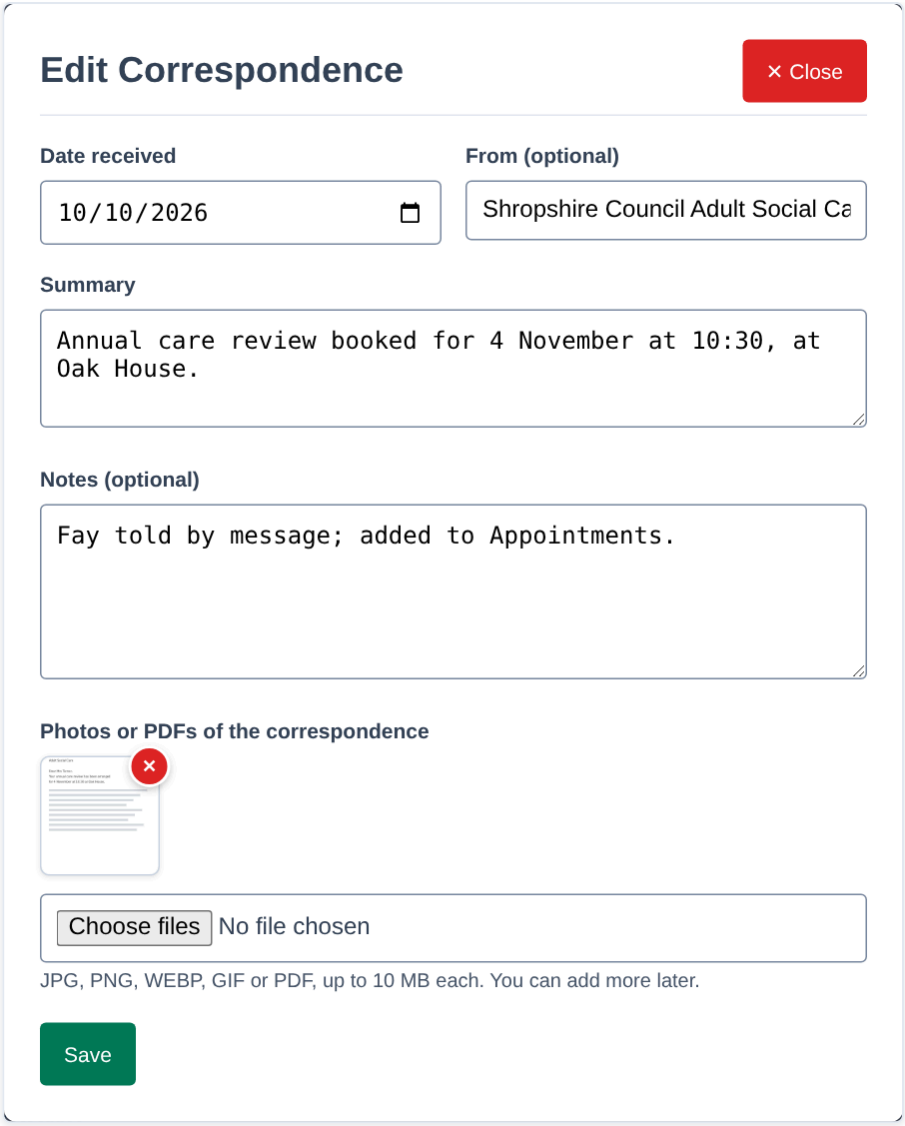


Figure 44. Recording correspondence, with a photo of the letter.

Financial Breakdown

Benefits the resident receives and contributions they pay, from the list of options an Admin sets up (Settings > Financial Options), with the current totals.

Residence History

Where they have lived and when they moved in and out. **+ Log Move** records a move. When someone leaves, record their move-out date here: once care has ended at every residence, the retention period starts (section 27.8).

Capacity, DoLS & Resuscitation

The resuscitation decision, DoLS authorisations, mental capacity assessments and legal authority (chapter 14). The resuscitation decision is also shown at the top of the record.

Consent Forms

What they consented to, when, and when it expires, with a scan of the signed form. Expired forms are marked.

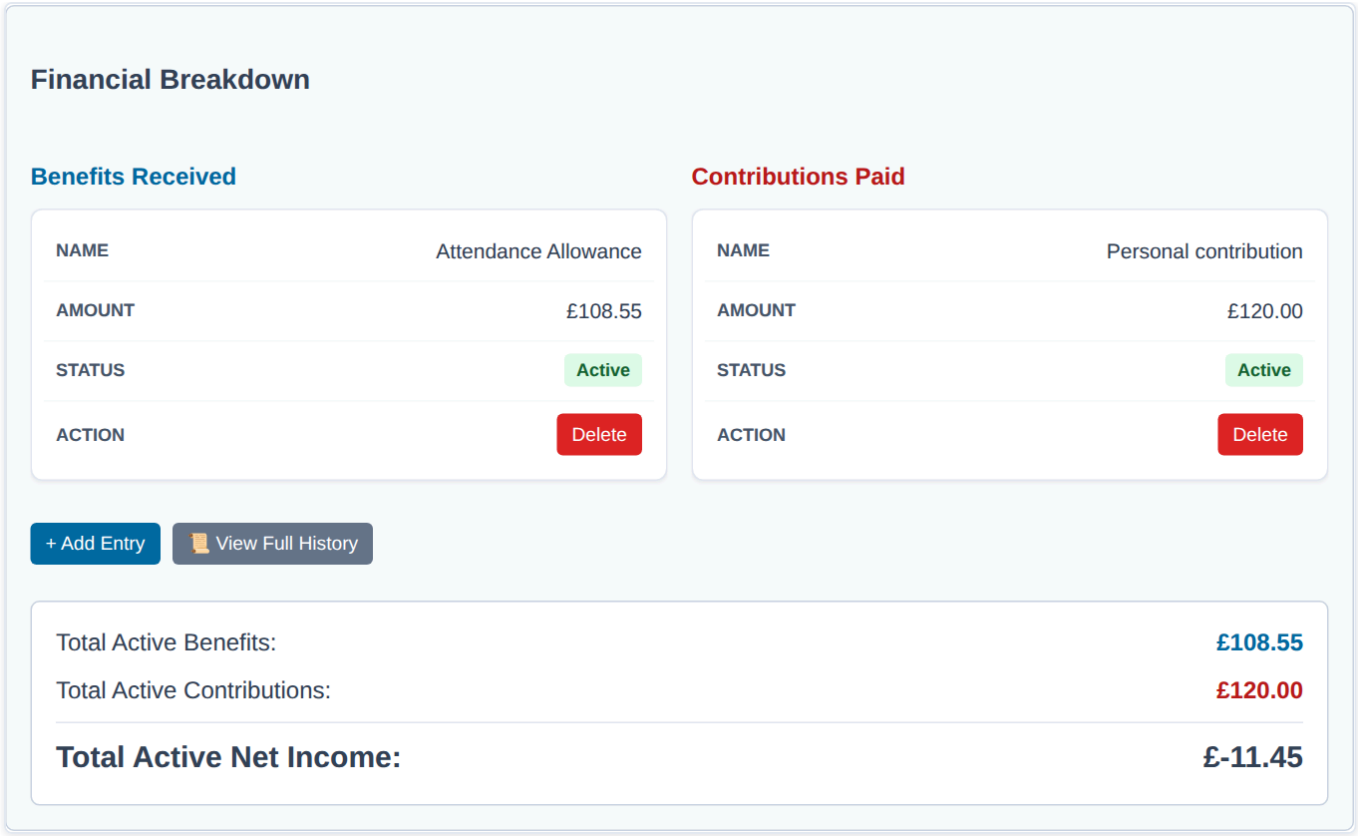


Figure 45. The financial breakdown.

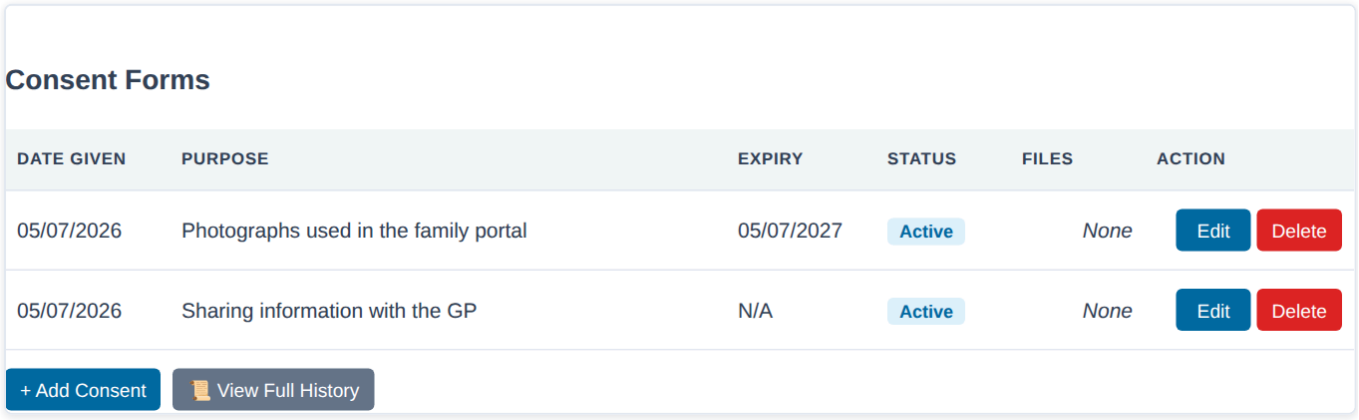


Figure 46. Consent forms.

7.4 Care plan

> **Who can use it:** Admins write and review care plans. Everyone else can read them; family members see the care plan of their relative.

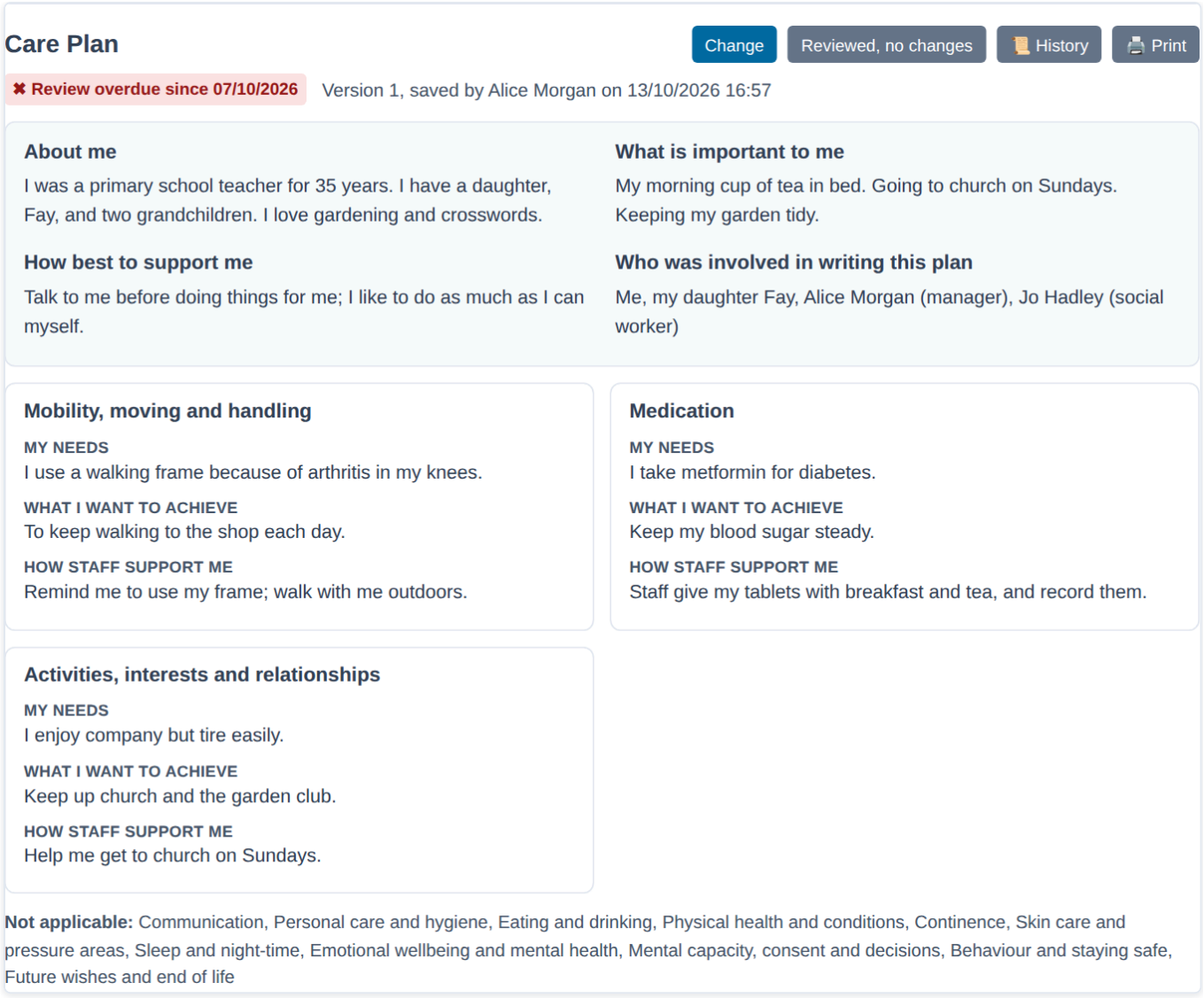


Figure 47. A care plan in the client record, with an overdue review.

The care plan is written with the person, in their own words where possible ("I like…", "please help me to…"). It starts with *About me*, *What is important to me*, *How best to support me* and *Who was involved*, followed by sections from Communication to Future wishes and end of life. For each section that applies, it records the person's needs, what they want to achieve, and how staff support them.

- **Change** opens the editor. Saving creates a new version; earlier versions are kept and can be opened from **History**. Say what changed and why.
- **Reviewed, no changes** records a review where nothing needed changing, who was involved, and when the next review is due.
- **Print** makes a PDF of the current plan.
- When a review is overdue, the plan says so in red, the Dashboard lists it, and Admins are notified.

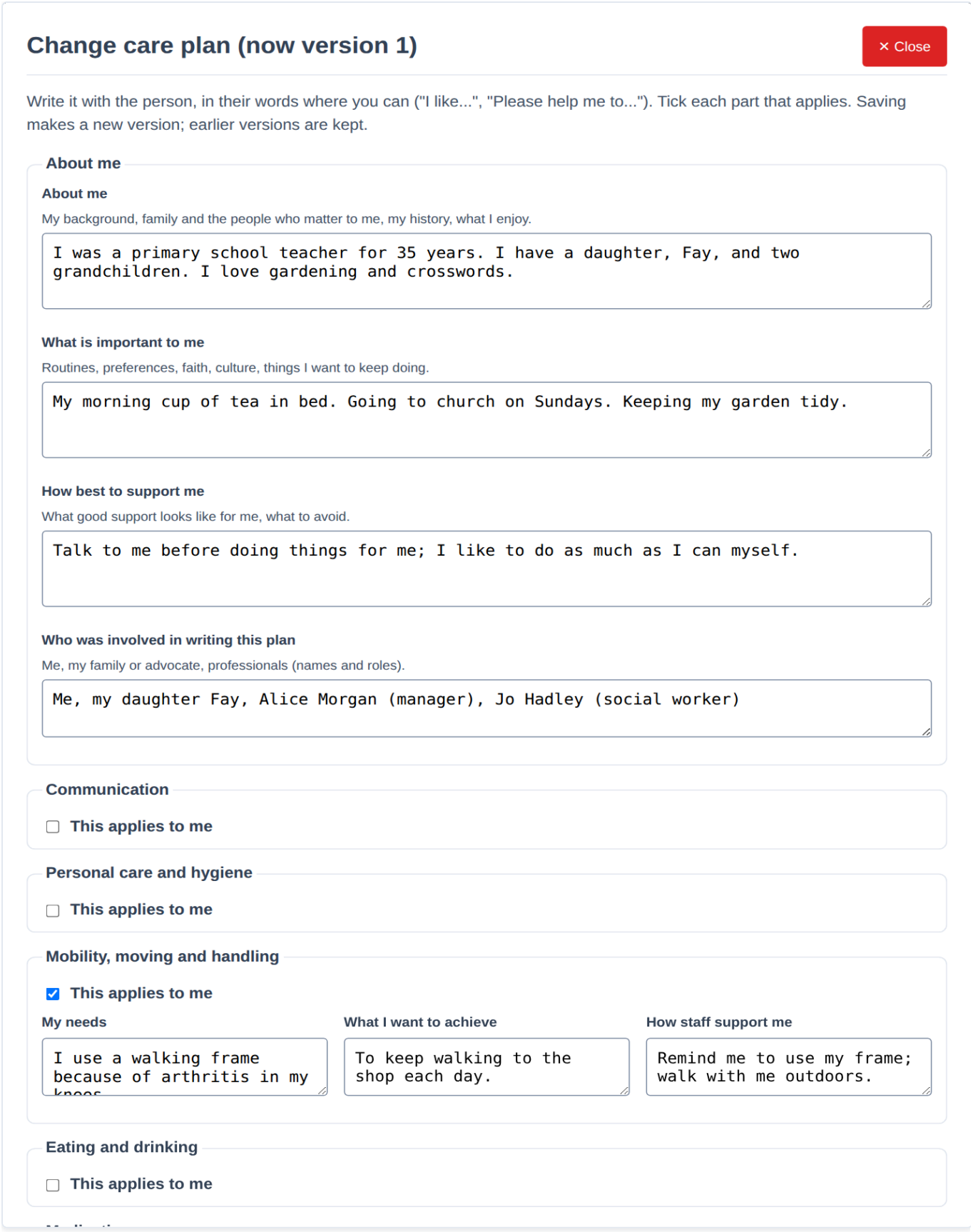


Figure 48. The care plan editor.

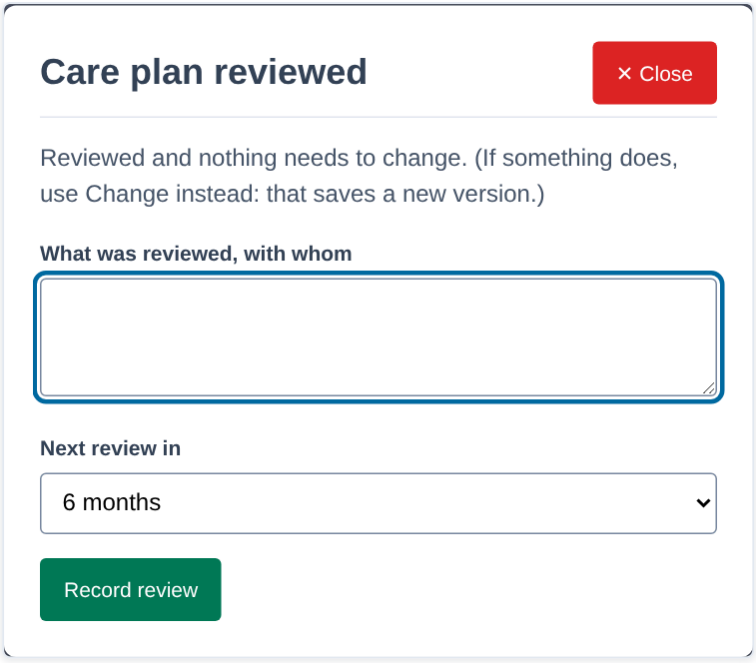


Figure 49. Recording a review with no changes.

7.5 Risk assessments

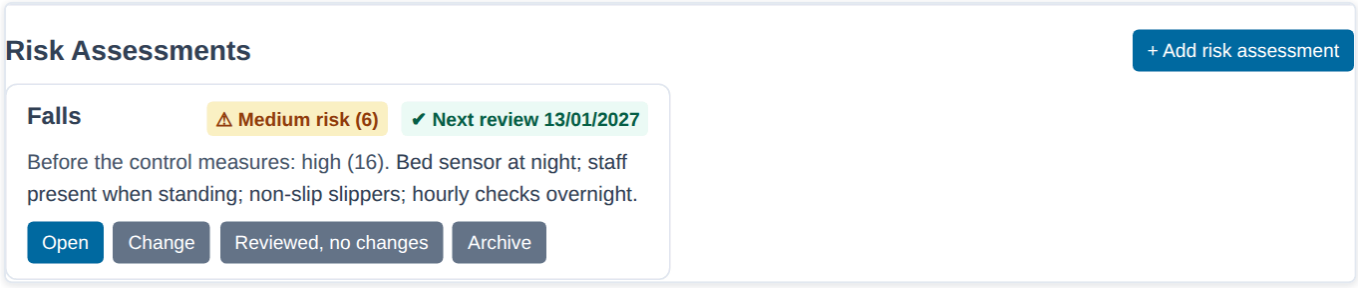


Figure 50. A risk assessment in the client record.

Each risk (falls, choking, moving and handling, going out, and so on) has its own assessment: what the risk is, who could be harmed, what is already in place, the control measures and any further actions. Likelihood and severity are scored from 1 to 5, before and after the control measures. The score with the measures in place gives the rating (low, medium or high) and suggests how often to review it: monthly for high risks, every 3 months for medium and every 6 for low.

Open shows it in full; **Change** saves a new version; **Reviewed, no changes** records a review; **Archive** retires an assessment that no longer applies (it can be restored).

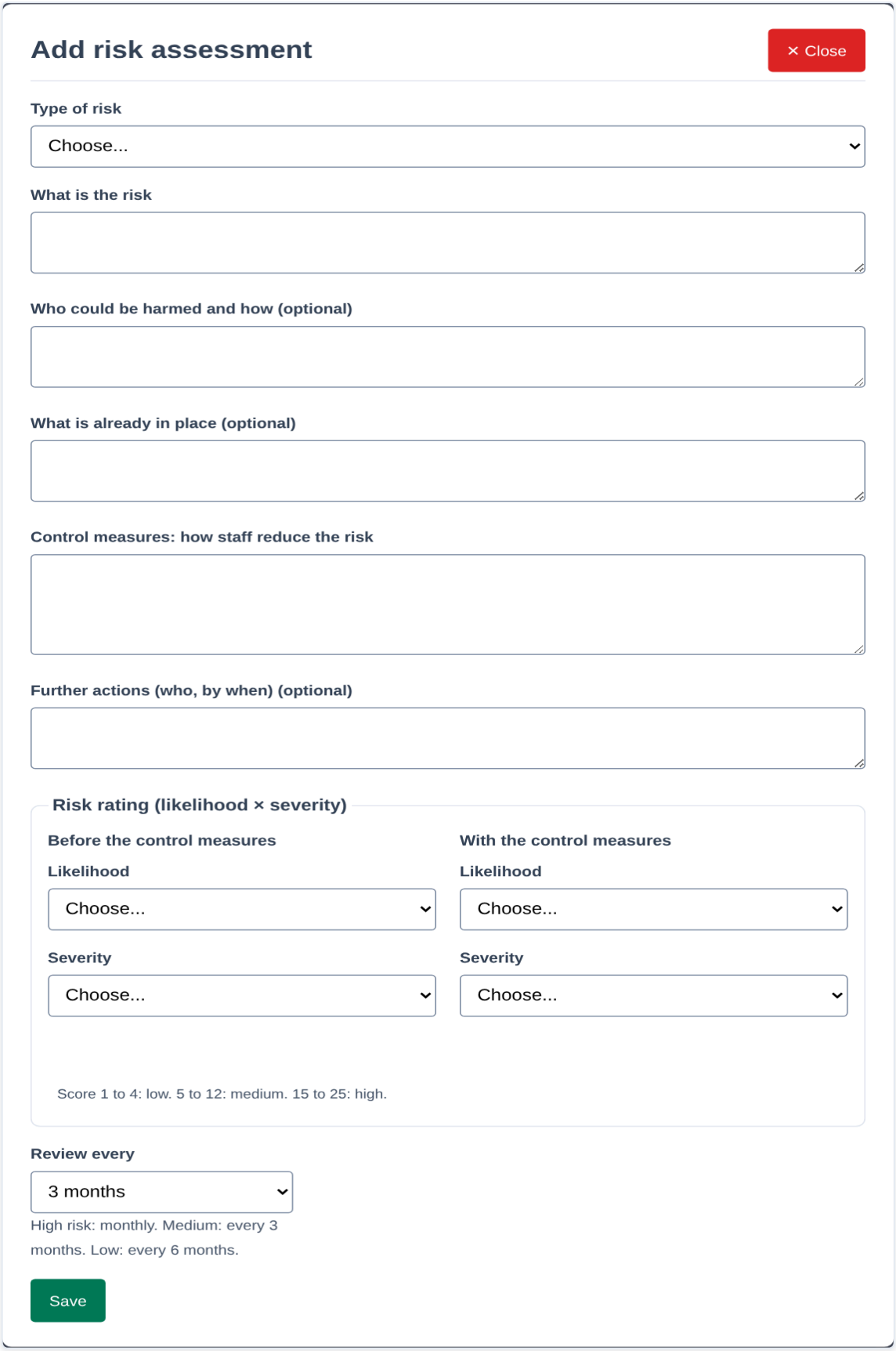


Figure 51. Adding a risk assessment.

7.6 Care plan and assessment files

Care Plan Files and **Assessment Files** hold PDFs, for example plans written before Honeysuckle Care Management was used, or assessments from the local authority. **+ Add New Version** uploads one; every version is kept. Staff can delete a

version they uploaded, within the edit window; Admins can delete any. Family members can see care plan files if staff have shared them (section 8.1), but never assessments.

7.7 Subject Access Requests

When a resident (or someone acting for them) asks for a copy of everything held about them, press 📄 **Subject Access Request (SAR)** at the top of the record (Admins and care providers). It produces a PDF of every section in full, including every version of the care plan and risk assessments and the family portal, and then a ZIP file of every photo and document held about them (you'll be asked for your password again before the ZIP is made). Both downloads are recorded in the audit log.

7.8 Health and Care Passport

> **Who can use it:** Staff who may see the resident read it. Admins and care providers write it. Family members don't see it in the record.

The **Health and Care Passport** section of the record is the NHS "My Health and Care passport", kept up to date: what hospital staff, paramedics and anyone new need to know about the person, in their own words. It isn't for clinical information (that is in their medical records). It goes with them to hospital in the transfer pack (chapter 15), and **Download PDF** prints it on its own, laid out like the NHS form, to take to appointments.

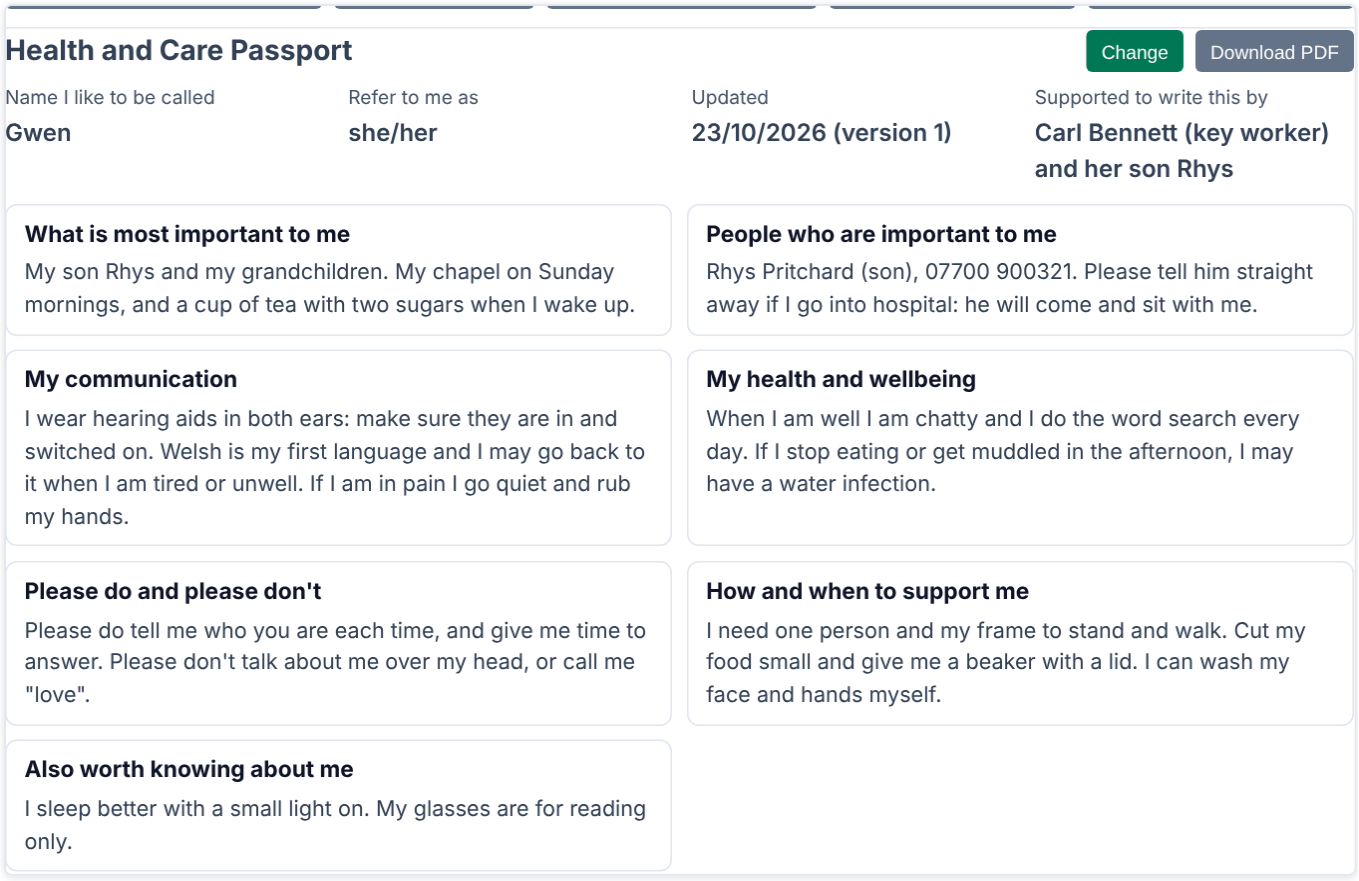


Figure 52. The Health and Care Passport in the record.

It has everything on the NHS form:

- From the Personal Profile: their full name, date of birth and NHS number, and the **name they like to be called** and how they want to be referred to (male, he/his; female, she/her; non-binary, they/them; or in another way, written in). These two can be changed in the passport form or in Edit Profile.

- **What is most important to me**, **People who are important to me**, **My communication**, **My health and wellbeing**, **Please do and please don't**, **How and when to support me** and **Also worth knowing about me**. Each box has a hint about what to write.
- **Supported to write this by**, and the date it was updated (the date it was saved).

Press **Write the passport** (or **Change**) and write it with the person, in their words where you can. If they have a care plan, **Fill the empty parts from the care plan** copies in what the care plan says about what matters to them, the people in their life, communication, health and how to support them, to put into their own words. It only fills empty boxes; nothing you have typed is replaced.

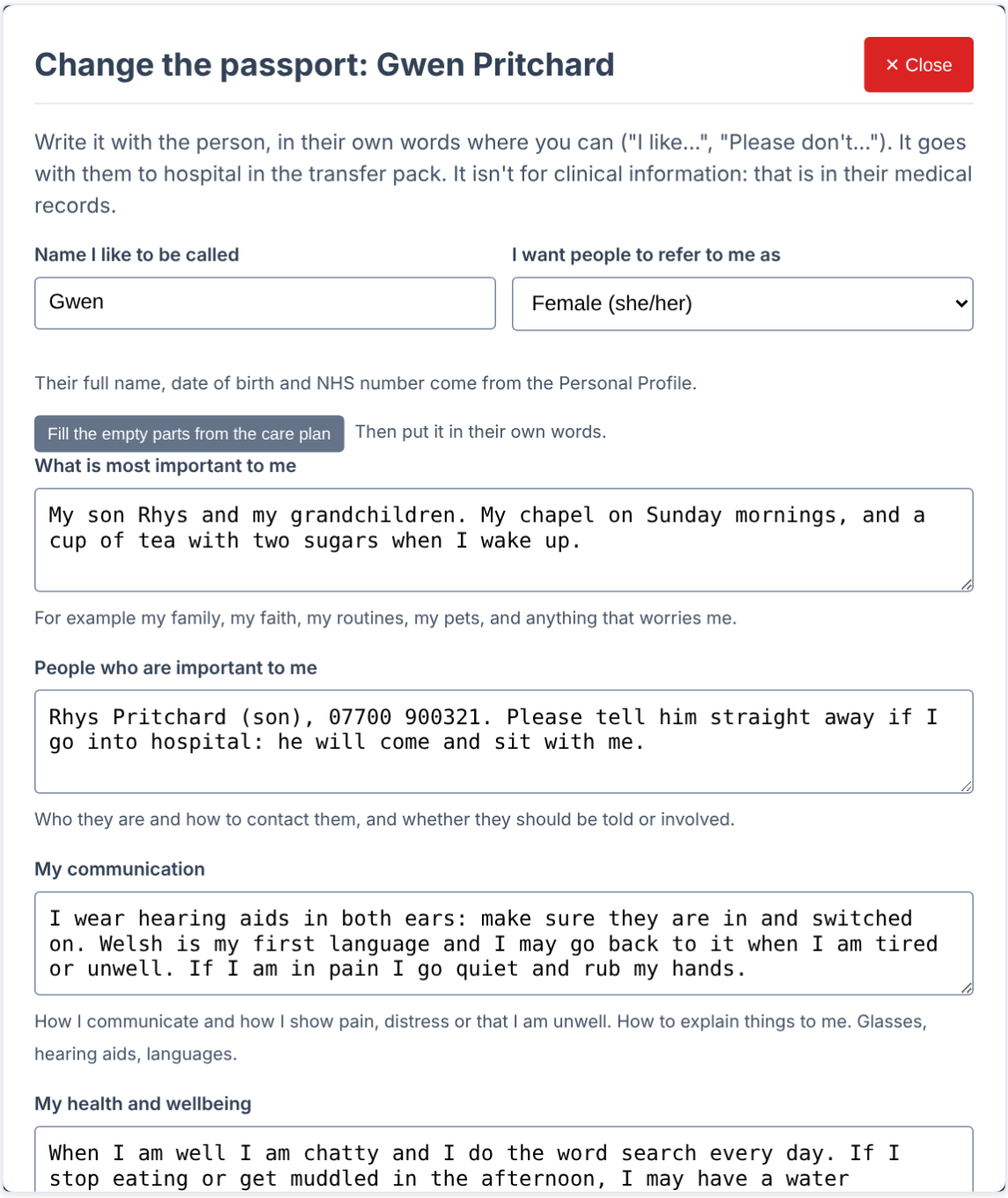
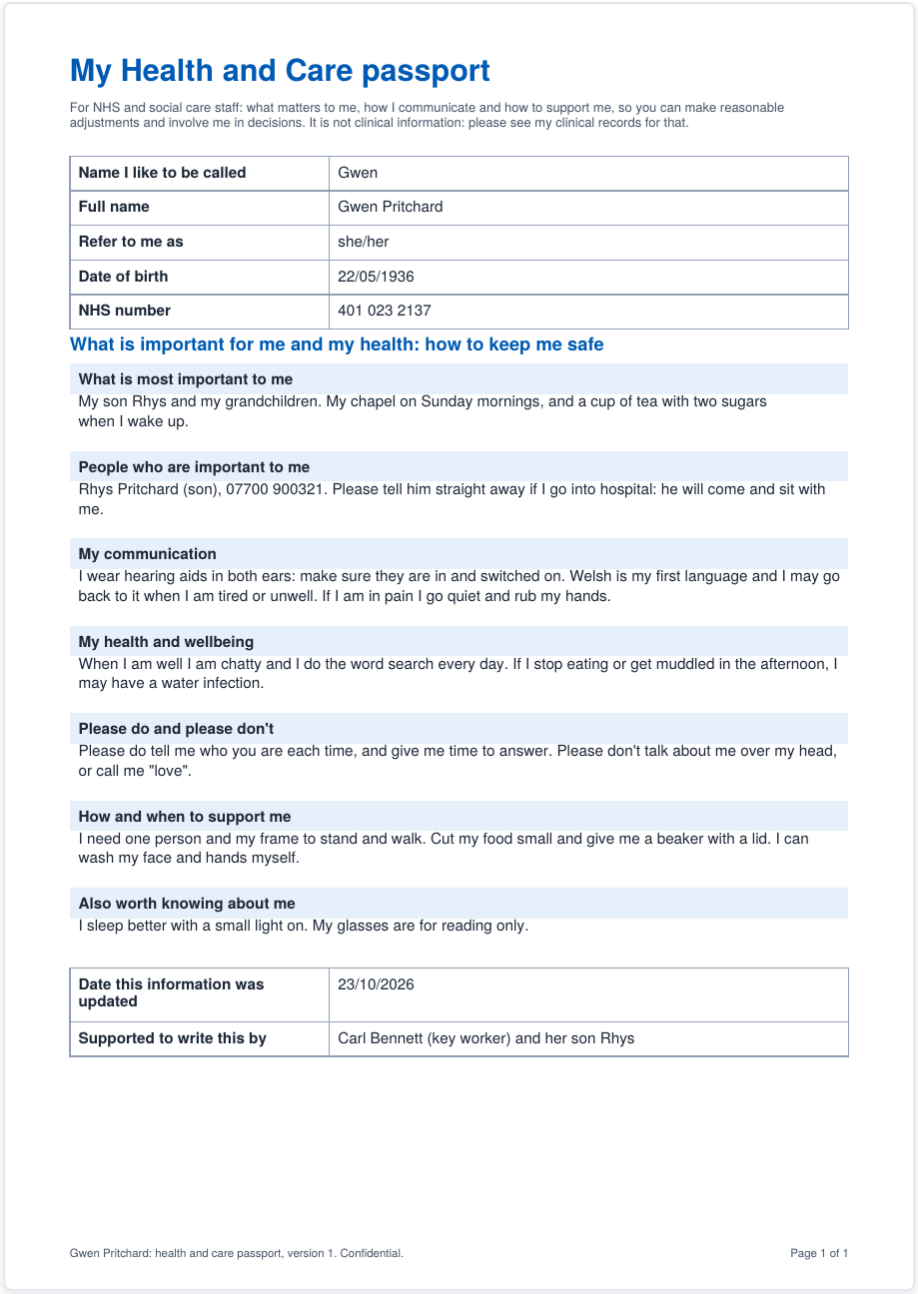


Figure 53. Writing the passport.

Each save is a new version, dated that day. Earlier versions are kept under **Earlier versions** and can be shown, and every version is in the Subject Access Request and the download of all records. Saving is recorded in the audit log.



My Health and Care passport

For NHS and social care staff: what matters to me, how I communicate and how to support me, so you can make reasonable adjustments and involve me in decisions. It is not clinical information: please see my clinical records for that.

Name I like to be called	Gwen
Full name	Gwen Pritchard
Refer to me as	she/her
Date of birth	22/05/1936
NHS number	401 023 2137

What is important for me and my health: how to keep me safe

What is most important to me

My son Rhys and my grandchildren. My chapel on Sunday mornings, and a cup of tea with two sugars when I wake up.

People who are important to me

Rhys Pritchard (son), 07700 900321. Please tell him straight away if I go into hospital: he will come and sit with me.

My communication

I wear hearing aids in both ears: make sure they are in and switched on. Welsh is my first language and I may go back to it when I am tired or unwell. If I am in pain I go quiet and rub my hands.

My health and wellbeing

When I am well I am chatty and I do the word search every day. If I stop eating or get muddled in the afternoon, I may have a water infection.

Please do and please don't

Please do tell me who you are each time, and give me time to answer. Please don't talk about me over my head, or call me "love".

How and when to support me

I need one person and my frame to stand and walk. Cut my food small and give me a beaker with a lid. I can wash my face and hands myself.

Also worth knowing about me

I sleep better with a small light on. My glasses are for reading only.

Date this information was updated	23/10/2026
Supported to write this by	Carl Bennett (key worker) and her son Rhys

Figure 54. The passport on its own (Download PDF).

8. Family

Who can use it: Admins and care providers record what families may see, reply to messages, post updates and answer visit requests. Support workers can read. Family members see their own relative (chapter 28).

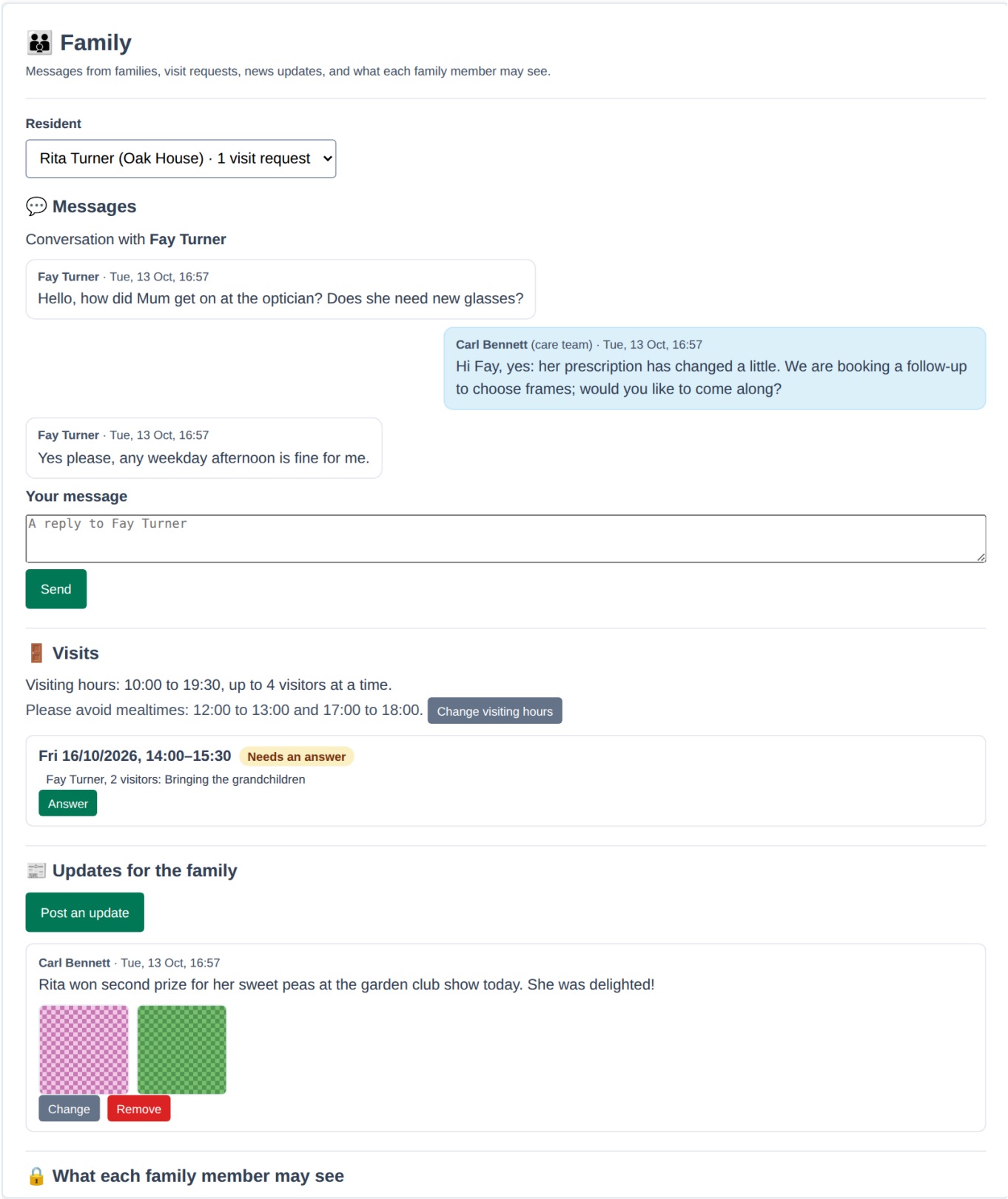


Figure 55. The Family tab for staff, for one resident.

Choose the resident at the top. The list shows how many new messages and visit requests each one has, and residents with something waiting are listed under *Also waiting*.

8.1 What each family member may see

Family members get their own accounts, linked to their relative in the Carers tab (section 24.1). Nothing is shared with them until staff record what the resident has agreed to. At the bottom of the Family tab, press **Change** next to the family member and tick what they may have:

- **Messages** with the care team
- **News updates**, and **photos** with the updates (photos only if updates are shared)
- **Booking visits**

Under **Parts of the record they may see**, tick the parts of the resident's record this family member may see in the Clients tab: daily care records, medical history, medications, dental records, appointments, the care plan, and care plan files. Their personal details, allergies and emergency contacts are always shown. Risk assessments, assessments, consent forms, physio, correspondence, incidents, finances and residence history are never shown to family members, whatever is ticked. Each family member has their own choices, so two relatives of the same resident can see different parts, and someone linked to two residents can see different parts for each.

> Family members whose sharing was recorded before this choice existed keep the standard family view (every part ticked) until you change it; the window says so.

Say on what basis: the resident agreed, a best-interests decision (if they lack capacity), a lasting power of attorney for health and welfare, or other (with a note). Who recorded it and when is shown, and every change is in the audit log.

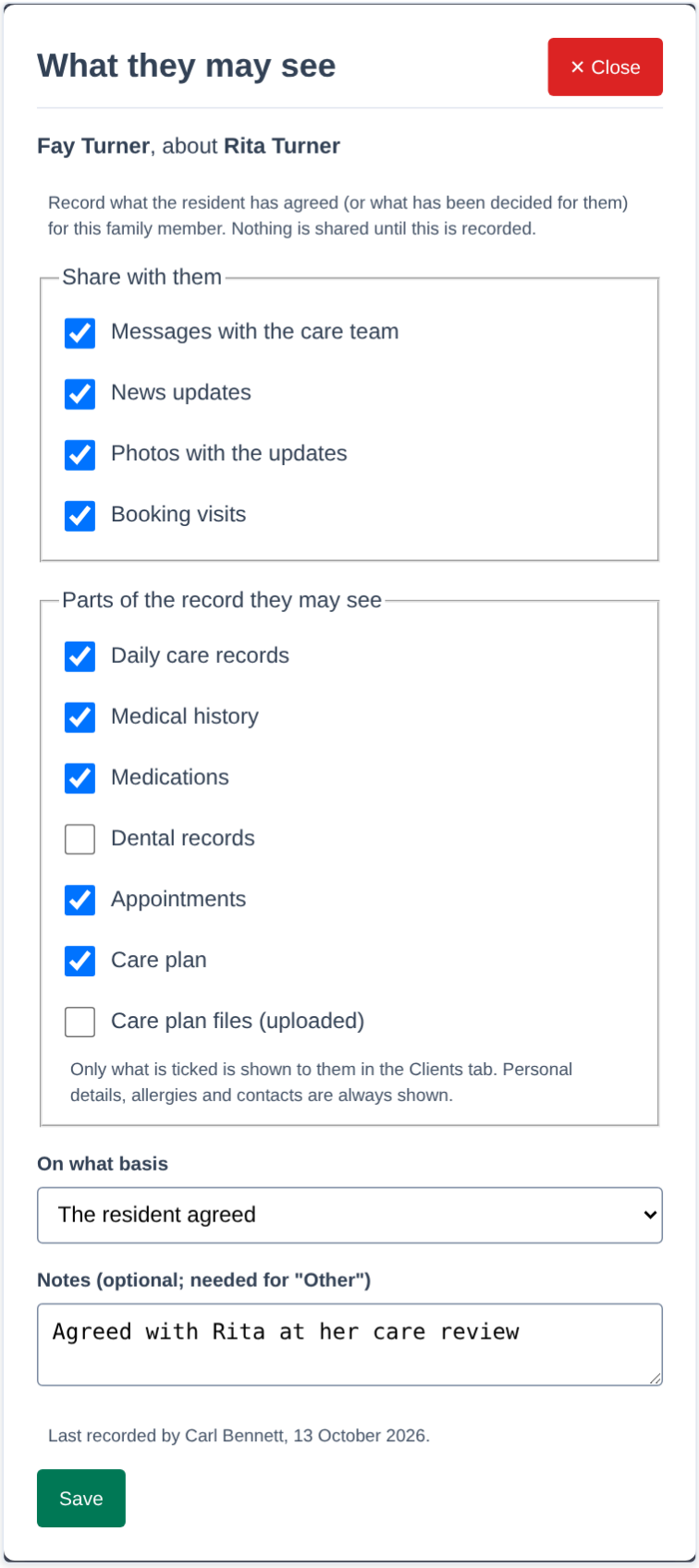


Figure 56. Recording what a family member may see.

8.2 Messages

There is one conversation for each resident and family member. New messages from the family are marked *New*, and Admins and care providers at the residence are notified. Type a reply under the conversation and press **Send**; replying (or opening the conversation) marks their messages as read. Support workers can read the conversation but not reply.

8.3 Updates and photos

Post an update to share news with the family, with photos if you like. Family members who may have updates are notified; only those who may see photos will see them. Whoever posted an update, or an Admin, can change it, remove photos from it or remove it.

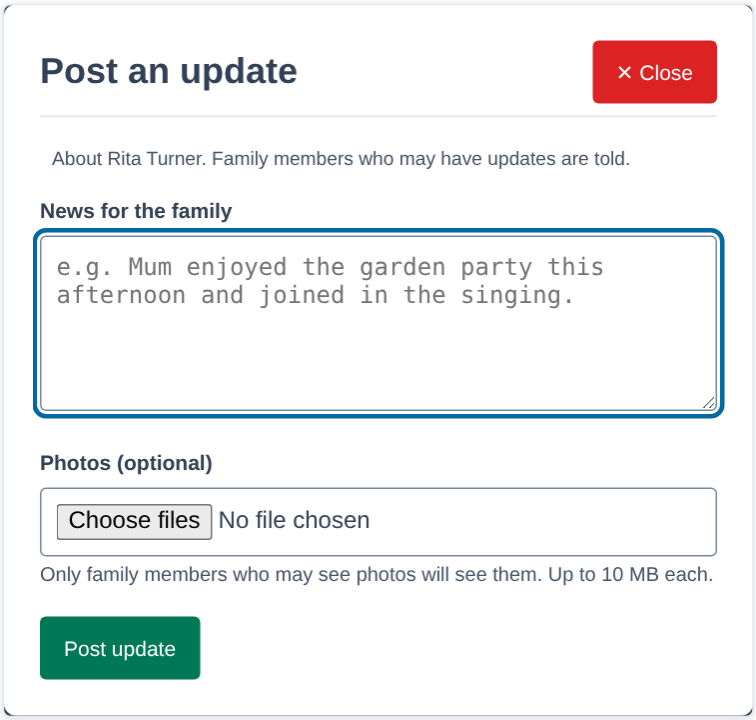


Figure 57. Posting an update.

8.4 Visits and visiting hours

Family members ask for a visit: the day, the times and the number of visitors. Staff are notified, and the request shows as *Needs an answer*. Press **Answer**, then:

- **Confirm this time**,
- **Suggest another time** (the family member can accept it or cancel), or
- **Decline**, giving a short reason.

The family member is told your answer. They can cancel a visit at any time.

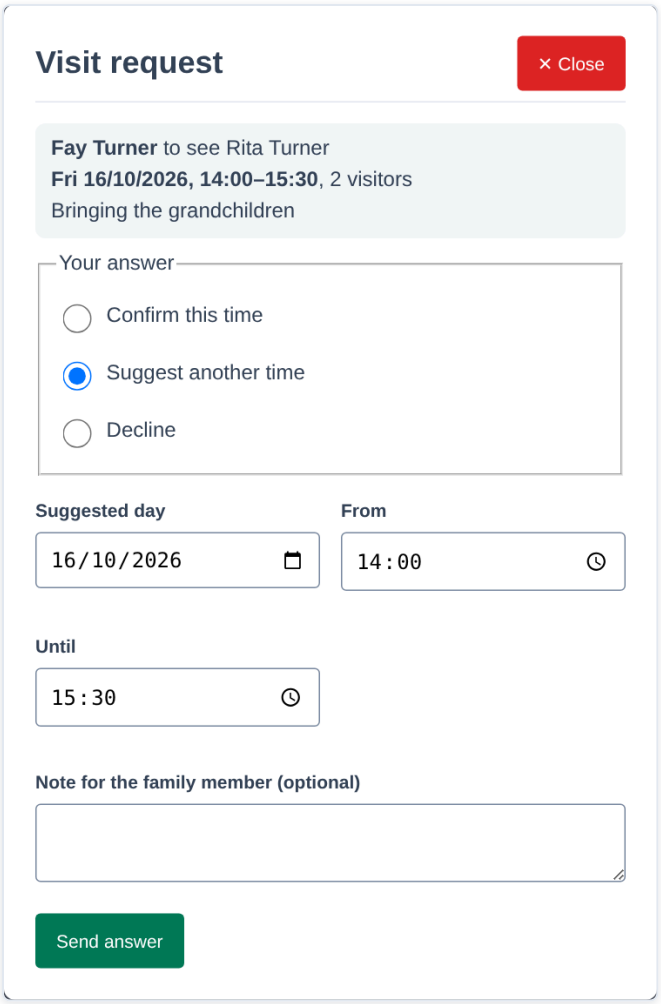


Figure 58. Answering a visit request.

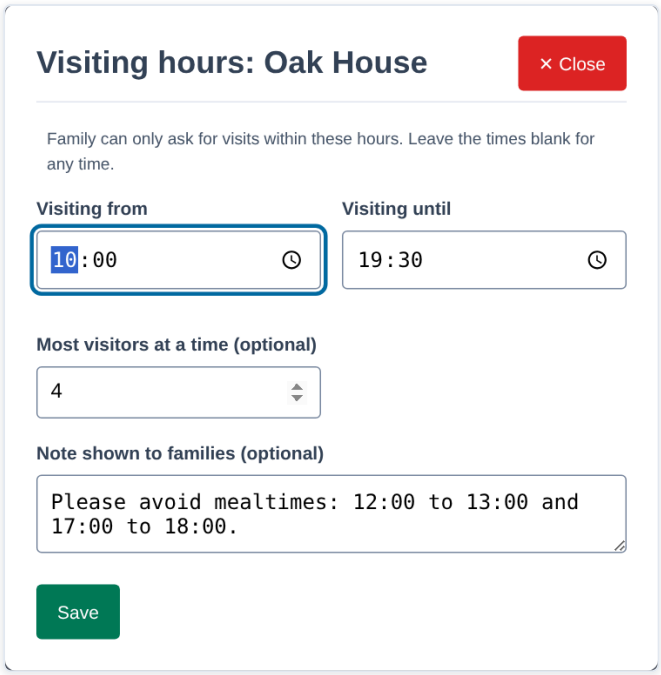


Figure 59. Setting a residence's visiting hours.

Change visiting hours sets when families can ask to visit a residence, the most visitors at a time, and a note shown to families (for example, mealtimes to avoid). Requests outside these hours are refused with an explanation.

9. Residences

> **Who can use it:** Everyone except family members. Admins add residences and change their details.

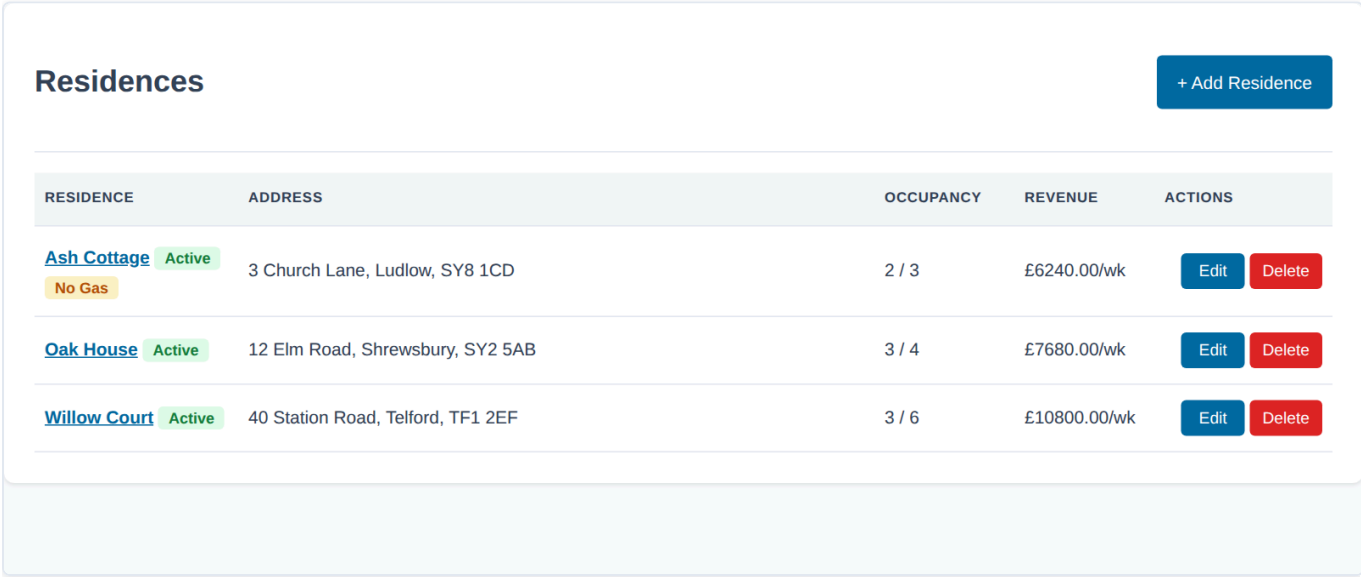


Figure 60. The residences list.

The list shows each residence with its address, occupancy (residents and capacity), and weekly revenue from residents' weekly rates. **+ Add Residence** adds one; click a residence's name to open its record.

9.1 A residence's record and safety certificates

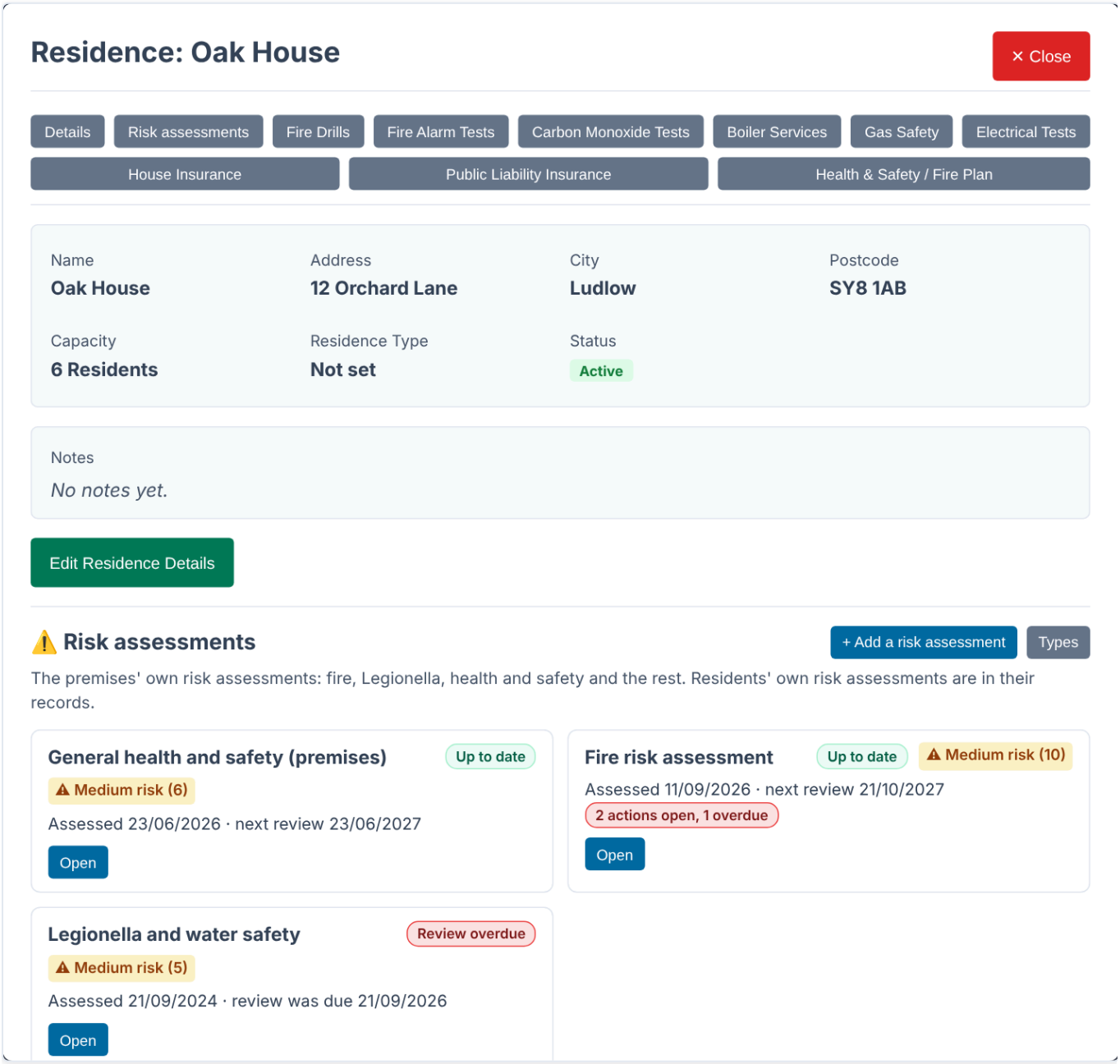


Figure 61. A residence's record: its details, its risk assessments, then each safety record.

The record shows the residence's details and, for each compliance category (fire drills, fire alarm tests, carbon monoxide tests, boiler service, gas safety, electrical tests, insurance and the fire plan), the entries logged with their dates and expiry. Each category shows whether it is in date, expiring soon, expired or missing. Press **+ Log New Record** to add the latest certificate or check, with its date, expiry date (if it has one), notes and a photo or PDF of the certificate. **View Full History** shows every entry ever logged for that category.

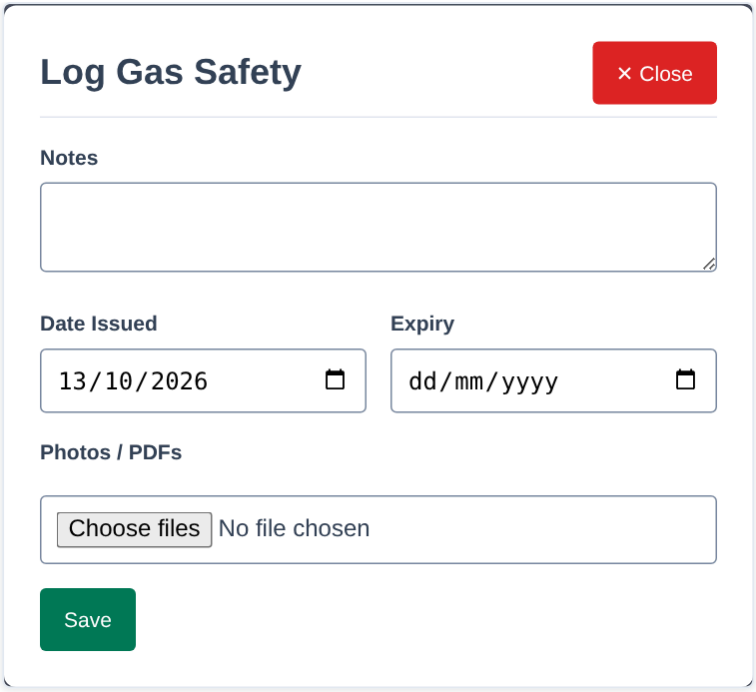


Figure 62. Logging a gas safety certificate.

9.2 Residence details

Edit Residence Details changes the name, address, capacity and type. You can also mark the residence as inactive (it then drops out of lists and compliance checks), and mark it as having no gas services (no boiler or gas safety checks expected).

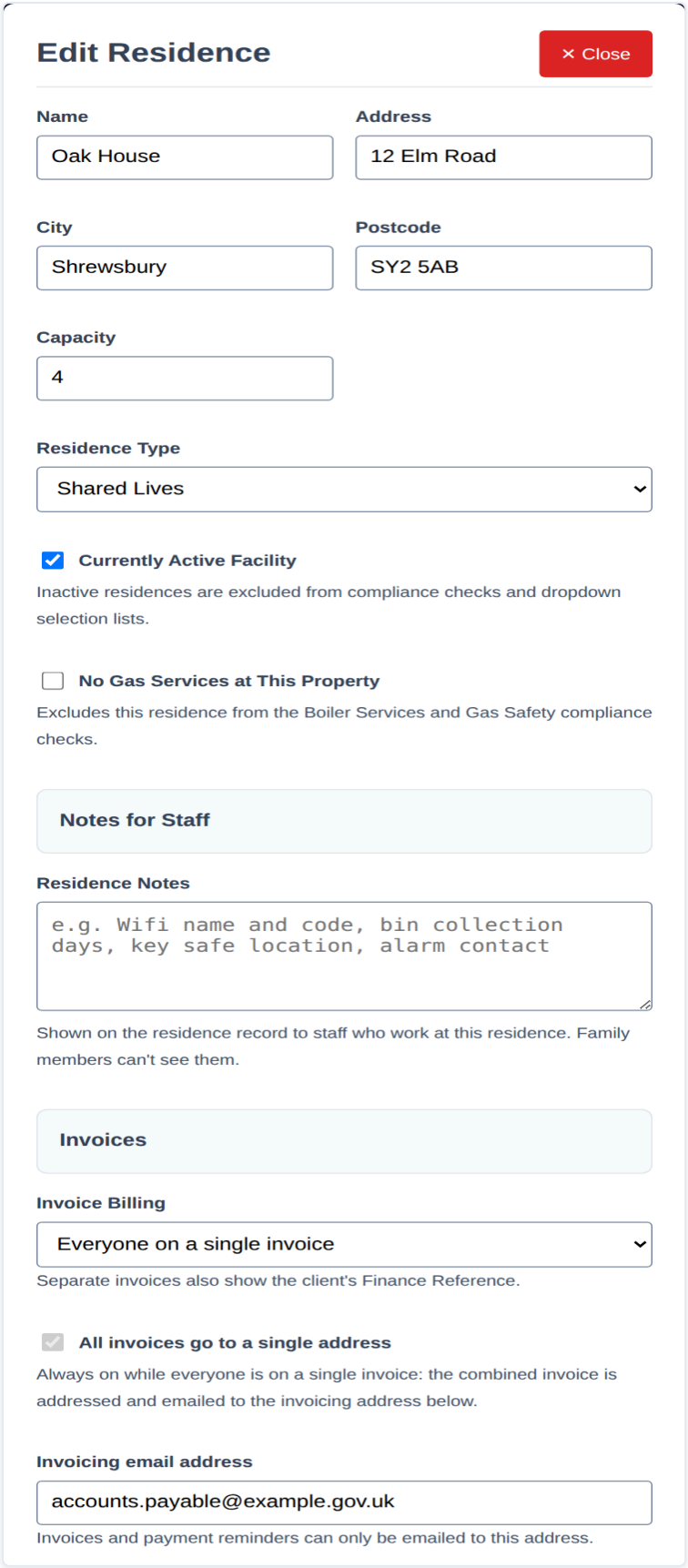


Figure 63. Editing a residence's details.

The **Invoices** part sets how this residence's invoices are made and where they go:

- **Invoice Billing**: everyone on a single invoice, or each client billed separately (separate invoices also show the client's finance reference).

- **All invoices go to a single address**: every invoice from this residence is addressed and emailed to the **invoicing email address** and **invoicing postal address** given here, for example the council's accounts team. It is always on for a single combined invoice. Unticked, each resident's invoice goes to the invoicing details in their own profile (section 7.2). Invoices can only be emailed to the saved address. The postal address is printed in the envelope window: put who pays on the first line.
- **Show Phone Number and Email Address** adds the accounts contact's details, and **Show Invoice Text** prints your own text under the payment details.
- **Default Care Provider for invoices** and **Carer's name**: who signs this residence's invoices, used when the signatory section is switched on (Settings > Accounts, section 27.6). If only one person with the Care Provider role works at the residence, they are chosen automatically; with several, choose one here. The carer's name is printed under the signature, for example the Shared Lives carer.

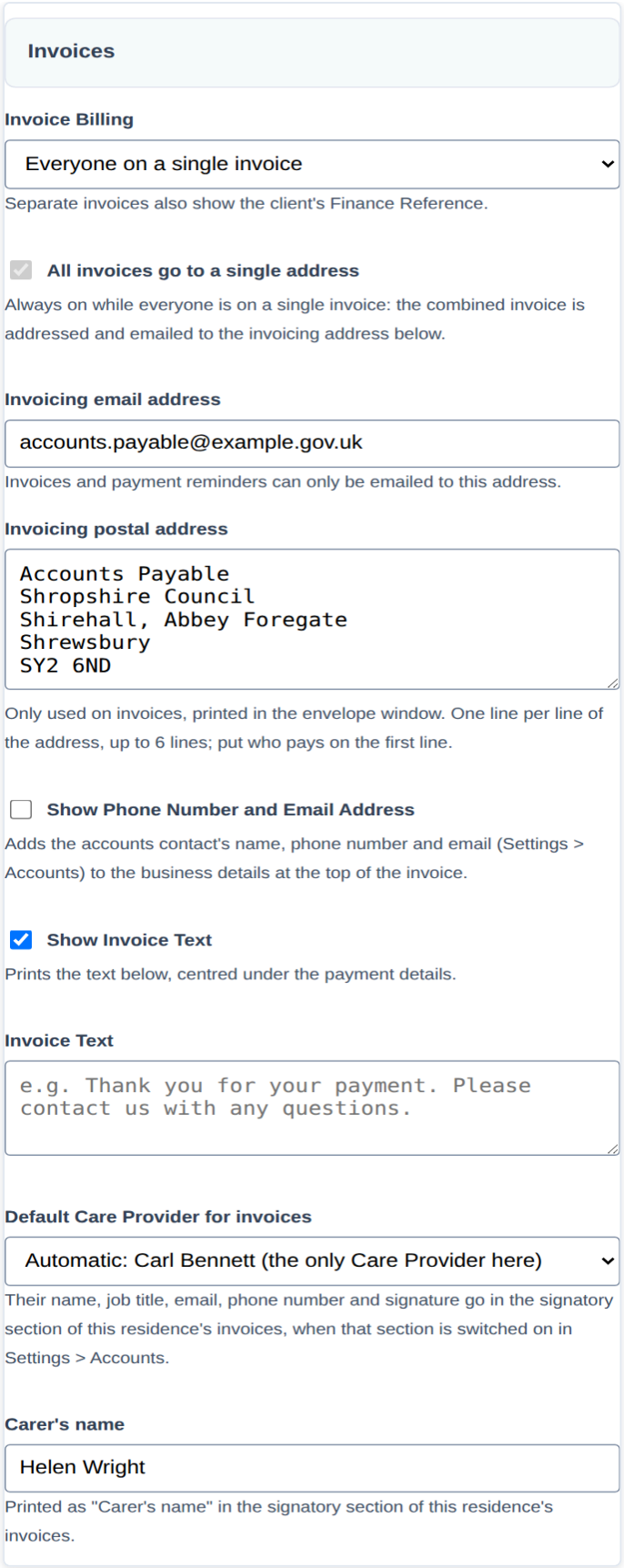


Figure 64. The Invoices part of a residence's details.

Notes for Staff holds everyday information about the residence: the wifi name and code, bin collection days, where the key safe is, the alarm company's number. Notes keep their line breaks and show on the residence record, under its details, to Admins and to staff who work at that residence. Family members never see them. Only Admins can change them, in Edit Residence Details.

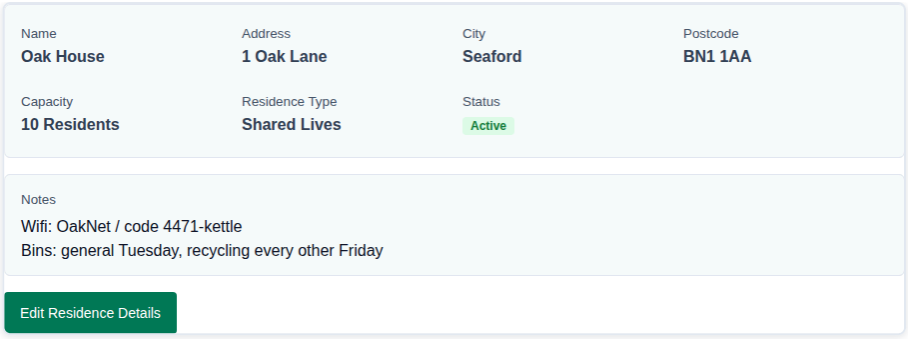


Figure 65. A residence's notes for staff, under its details.

9.3 Property risk assessments

> **Who can use it:** Everyone who works at the residence can read them. Admins and care providers add, change, review and archive them and manage their actions. Whoever an action is given to can mark it done. Admins choose the kinds and delete one added by mistake.

Each residence's own risk assessments are kept in its record, under ⚠️ **Risk assessments** (the **Risk assessments** button at the top jumps there). They are for the premises: fire, Legionella and water, general health and safety, hazardous substances (COSHH), lone working and so on. Residents' own risk assessments are in their records (section 7.5).

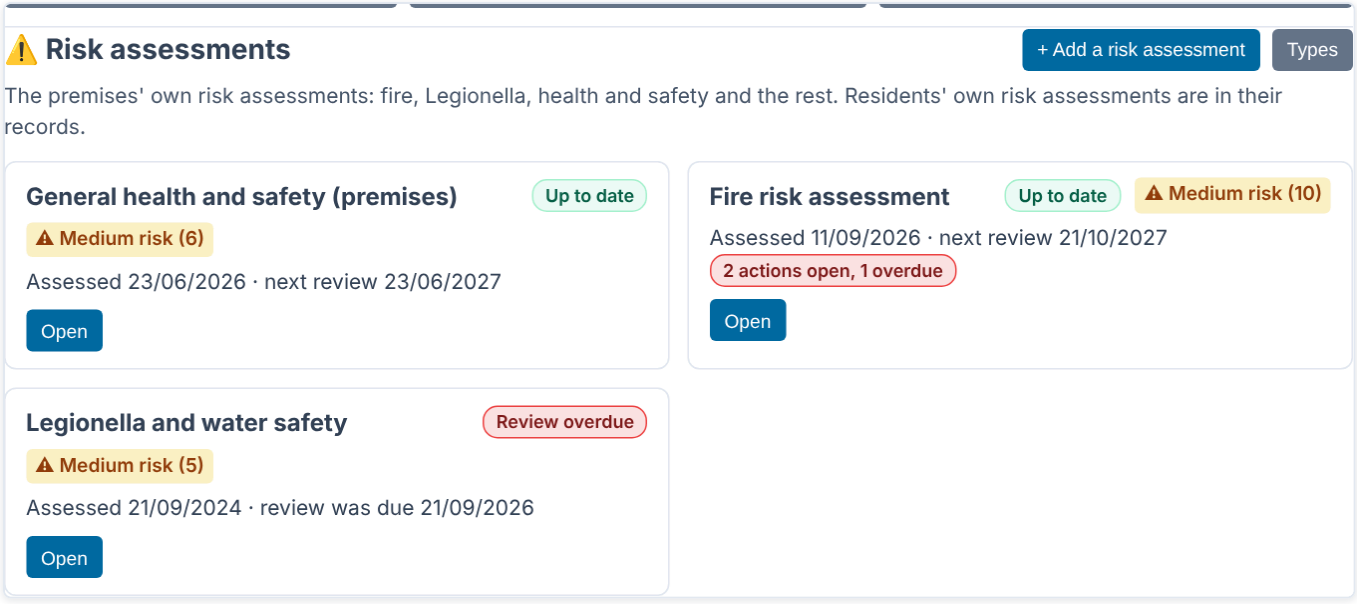


Figure 66. A residence's risk assessments: in date, review overdue, and actions to do.

Each card shows the assessment's name, whether it is **Up to date**, **Review due soon** (within 30 days) or **Review overdue**, its highest risk after the control measures, when it was assessed and is next due, and any actions still open. The kinds every residence must have (to begin with: general health and safety, fire, and Legionella and water safety) show as **Not done yet** until there is one; press **Start it** to write it. **Open** shows the whole assessment.

Writing one

Press **+ Add a risk assessment** (or **Start it** on a card) and fill in:

- **Kind**: one of your kinds, or **Other** with a name of your own (for example "Garden pond"). **Name** starts as the kind's name; change it if a residence has two of a kind (for example "Fire risk assessment: annexe").

- **Date assessed** and **Assessed by**: a person, or the company for a contractor's assessment. Attach their report afterwards (below).
- **What it covers**: the areas and activities, and anything left out.
- **Hazards**: for each, what the hazard is, who could be harmed and how, and what is already in place, then how likely harm is and how bad it would be (1 to 5 each) as things are. Then the further control measures, and the likelihood and severity with them. The score (likelihood × severity) shows as you choose: 1 to 4 low, 5 to 12 medium, 15 to 25 high, the same scale as residents' risk assessments. **+ Add a hazard** adds another.
- **Further actions**: anything that needs doing to put the measures in place, who will do it (Admins, or staff who work at the residence) and by when. If you leave the date empty it is 4 weeks.
- **Review every** 3, 6, 12 or 24 months, from the date assessed. It starts at the kind's usual period; if a hazard is still high after the measures, 3 months is suggested.

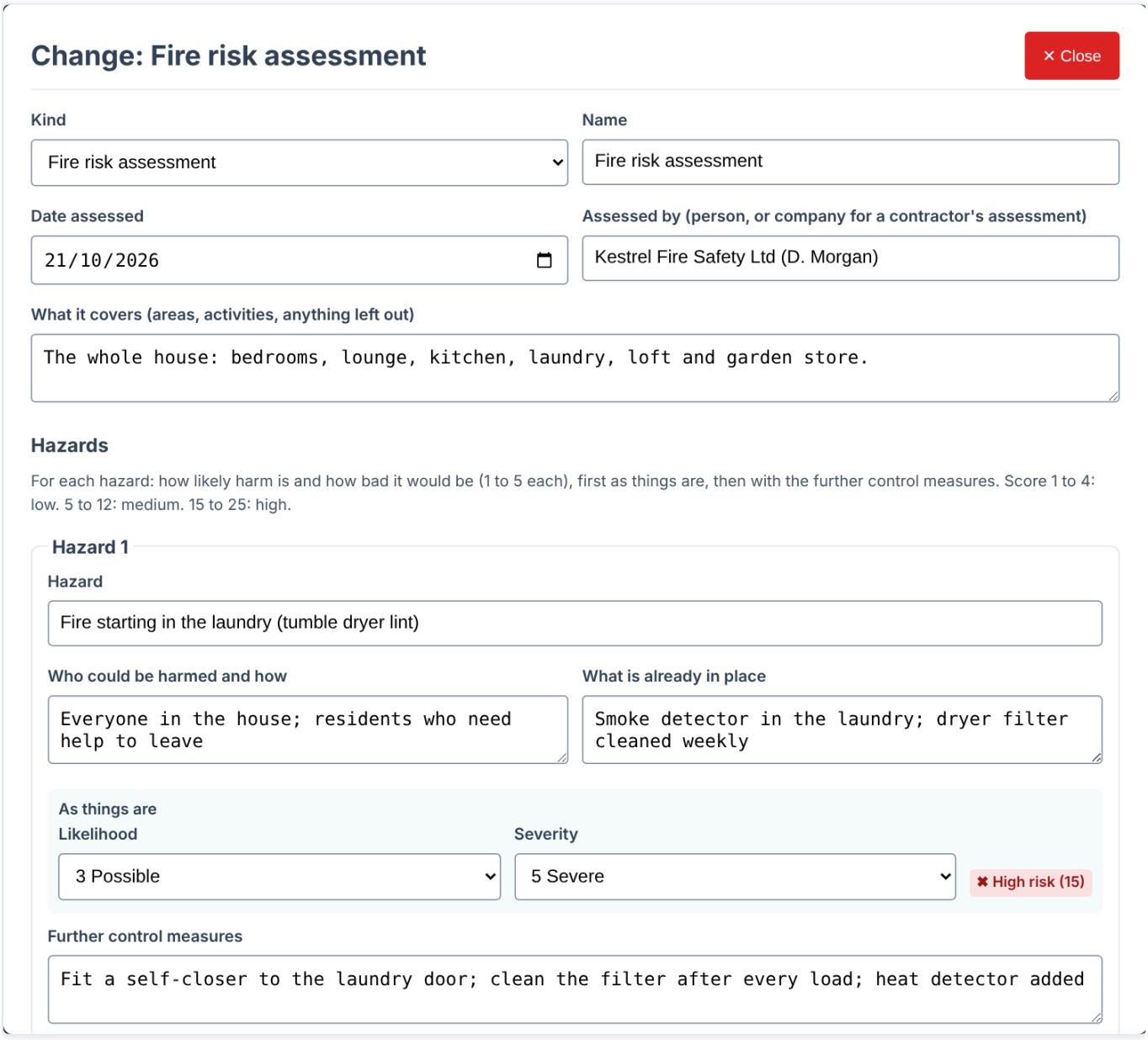


Figure 67. Writing a risk assessment: each hazard rated before and after the control measures.

The overall rating on the card is the highest score after the control measures.

One assessment

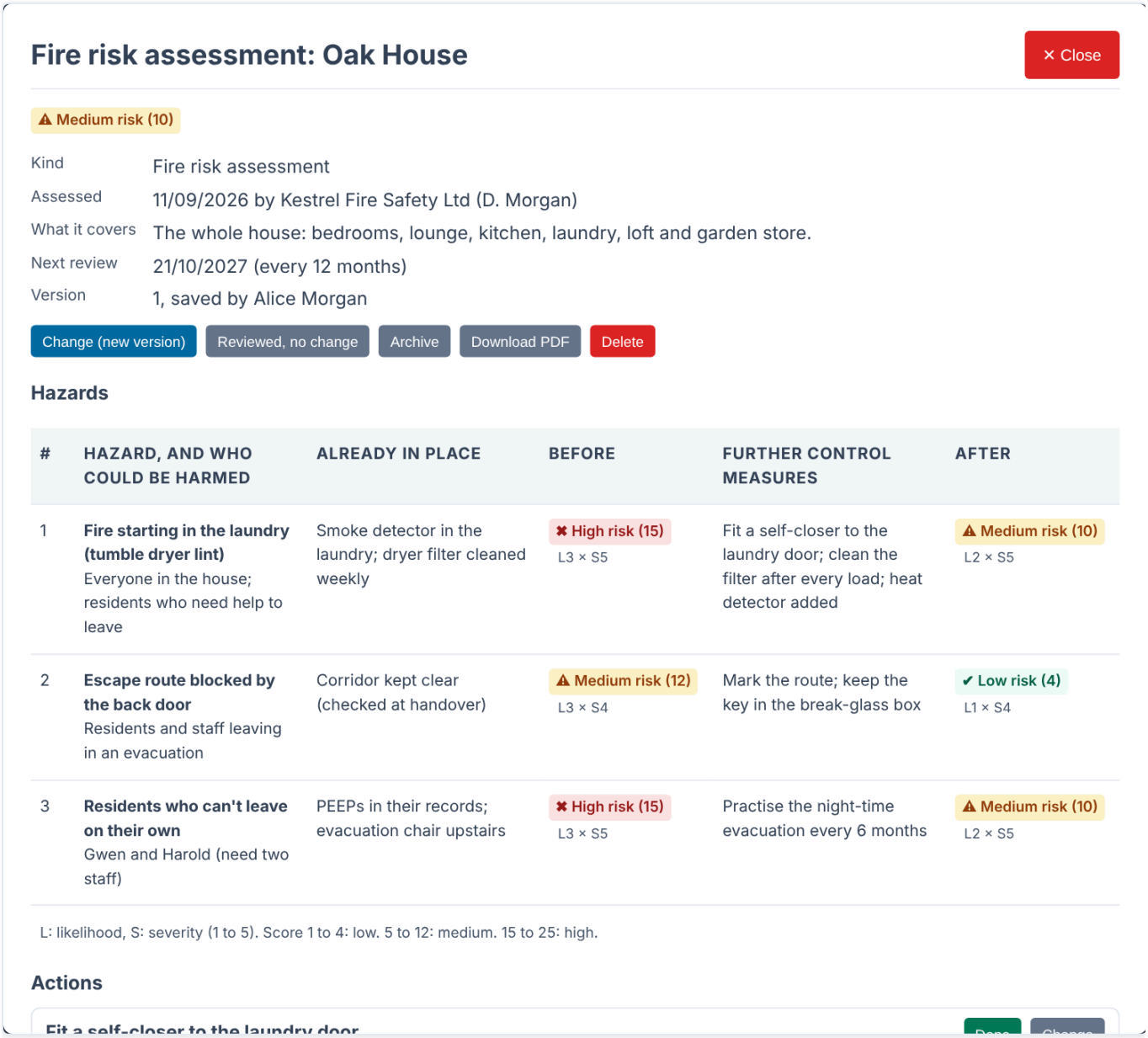


Figure 68. An assessment: who did it, when it is due, and each hazard with its ratings.

The window shows everything in the assessment, its actions, documents, reviews and earlier versions.

- **Change (new version)** opens the form filled in. Say what has changed and why; saving makes a new version and keeps the earlier ones, which you can open from **Versions**. Open actions carry on to the new version.
- **Reviewed, no change** records a review when nothing needs to change: say what you checked and with whom. The next review moves on by the review period from today.
- **Archive** is for an assessment no longer needed (the pond was filled in): give the reason. It stops being chased but is kept, and **Bring back into use** reverses it. Admins can **Delete** one added by mistake, with every version, its actions and documents (documents are kept in quarantine for the retention period).
- **Actions**: **+ Add an action**, **Change** (what, who, by when) and **Done**, with a note of what was done. The person an action is given to sees **Done** on it too.
- **Attach a document** adds a PDF or photo, such as the contractor's report or a plan.
- **Download PDF** prints the assessment, with its hazards, actions and reviews, to file or to show an inspector.

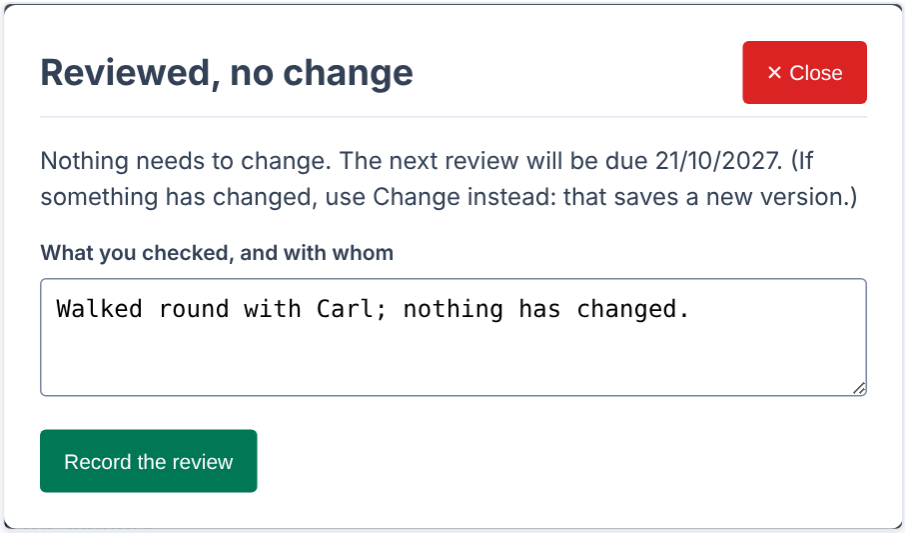


Figure 69. Reviewed, no change.

Kinds (Admins)

Types lists the kinds of risk assessment: the five built in (general health and safety, fire, Legionella and water safety, COSHH and lone working) and any you add. For each, choose how often it is usually reviewed, whether **every residence** must have one, and whether it is **in use**. The last row adds a new kind. Kinds apply to all your residences.

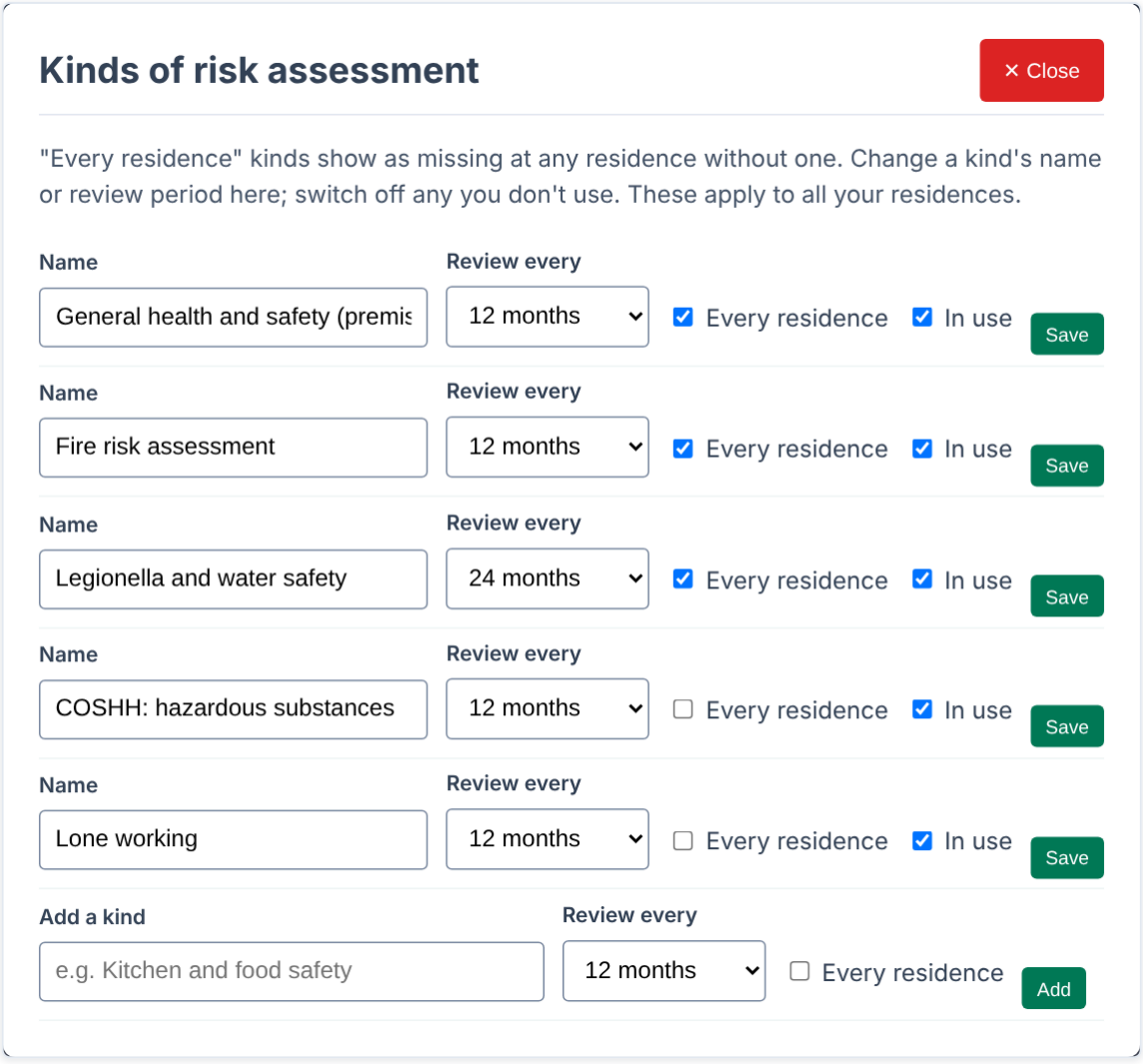


Figure 70. The kinds of risk assessment.

Reminders

A required assessment that is missing, a review that is overdue and an action that is overdue show in the Dashboard's Compliance Warnings, with a button that goes straight to the residence's risk assessments. They are also in the notification bell for Admins and care providers (support workers are told about overdue actions given to them) and in the daily email.

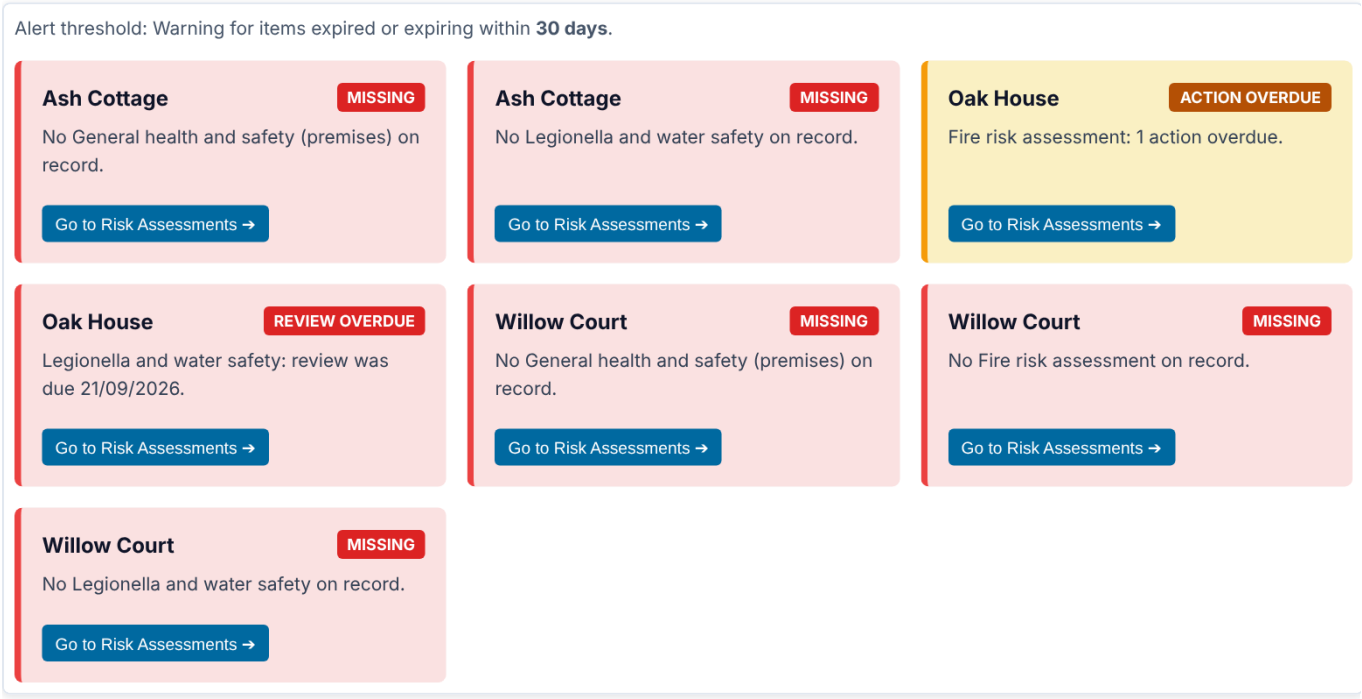


Figure 71. Risk assessment warnings on the Dashboard.

In the CQC evidence pack, property risk assessments are under Safe (Safe environments): each one in place with its date, rating and review date, and anything missing or overdue as a gap to fix. Every assessment, change, review, action and kind is in the audit log, and they are all included when you download all records (section 25.3).

10. Incidents

Who can use it: Everyone except family members. Following incidents up and closing them: Admins and care providers.

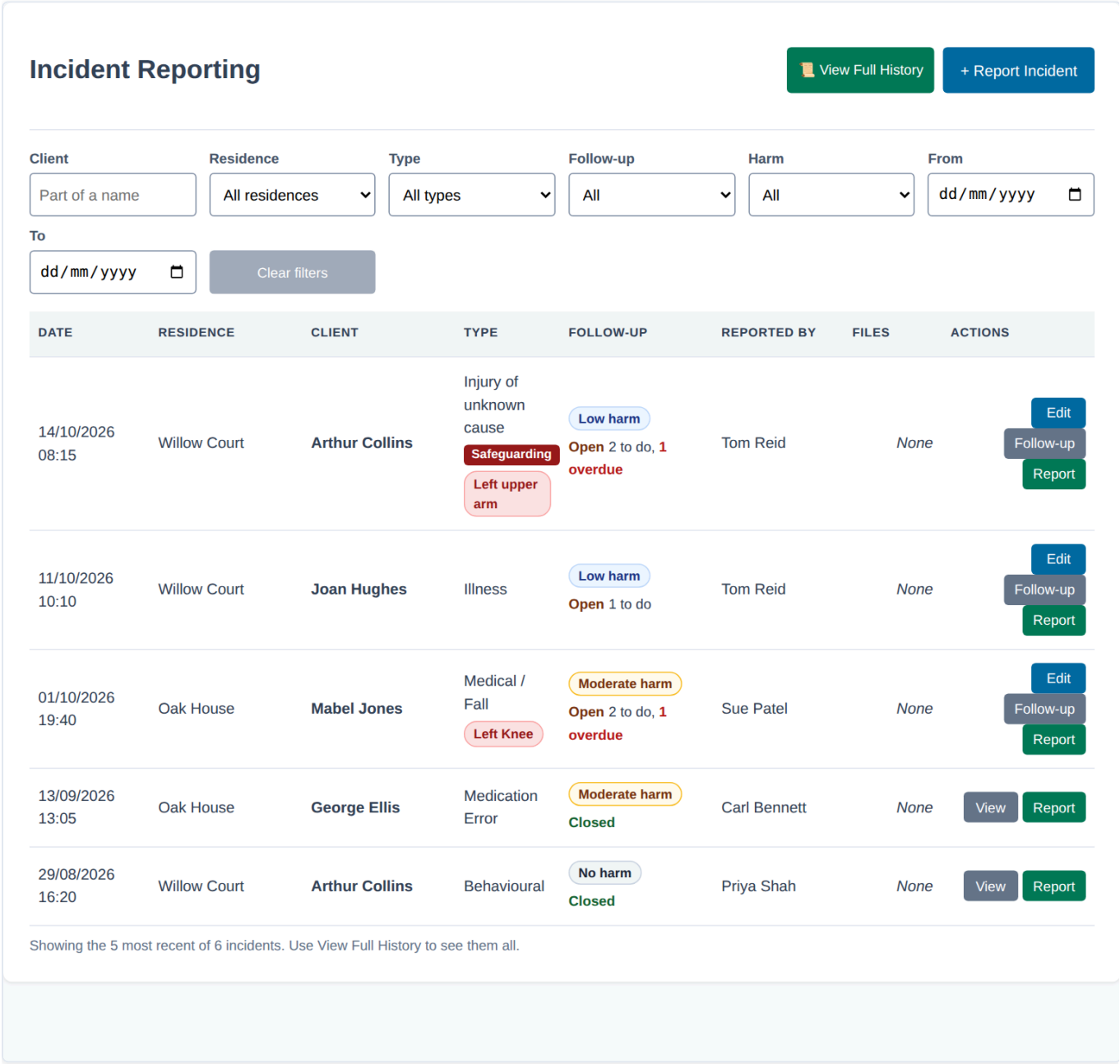


Figure 72. Incident reporting.

The list shows incidents newest first, with the residence, resident, type and body locations, the harm caused, how far the follow-up has got, and who reported it. Filter by resident, residence, type, **Follow-up** (open or closed), **Harm** or dates; *Moderate or worse*, *or safeguarding* under Harm shows the serious ones. 📜 **View Full History** shows every incident.

10.1 Reporting an incident

Press **+ Report Incident** (or **+ Log Incident** in a client record) and record:

- the residence, resident, date and time, and type (for example a fall, illness, behaviour, a safeguarding concern, an injury of unknown cause, pressure damage, choking, a missing person, or a medication error) **How serious**: the harm caused, from *No harm* through *Low*, *Moderate* and *Severe harm* to *Death*. This must be chosen.
- **This may be abuse or neglect**: tick it for any safeguarding concern, whoever may be responsible where on the body any injury is: click the body map (front and back) to mark each place
- who was involved, what happened, and the action taken
- whether it has been reported to the people who need to know (manager, family, GP)
- any photos or PDFs

Staff at the residence are notified. A safeguarding concern, or moderate harm or worse, is marked as such in the notification, and the app suggests what will need to happen next: moderate harm or worse means the duty of candour applies; severe harm, a death or a safeguarding concern means CQC must be told; a safeguarding concern means the local authority must be told. These are suggestions a manager can change. Make sure the person is safe and tell your manager straight away: recording it here doesn't replace your safeguarding policy.

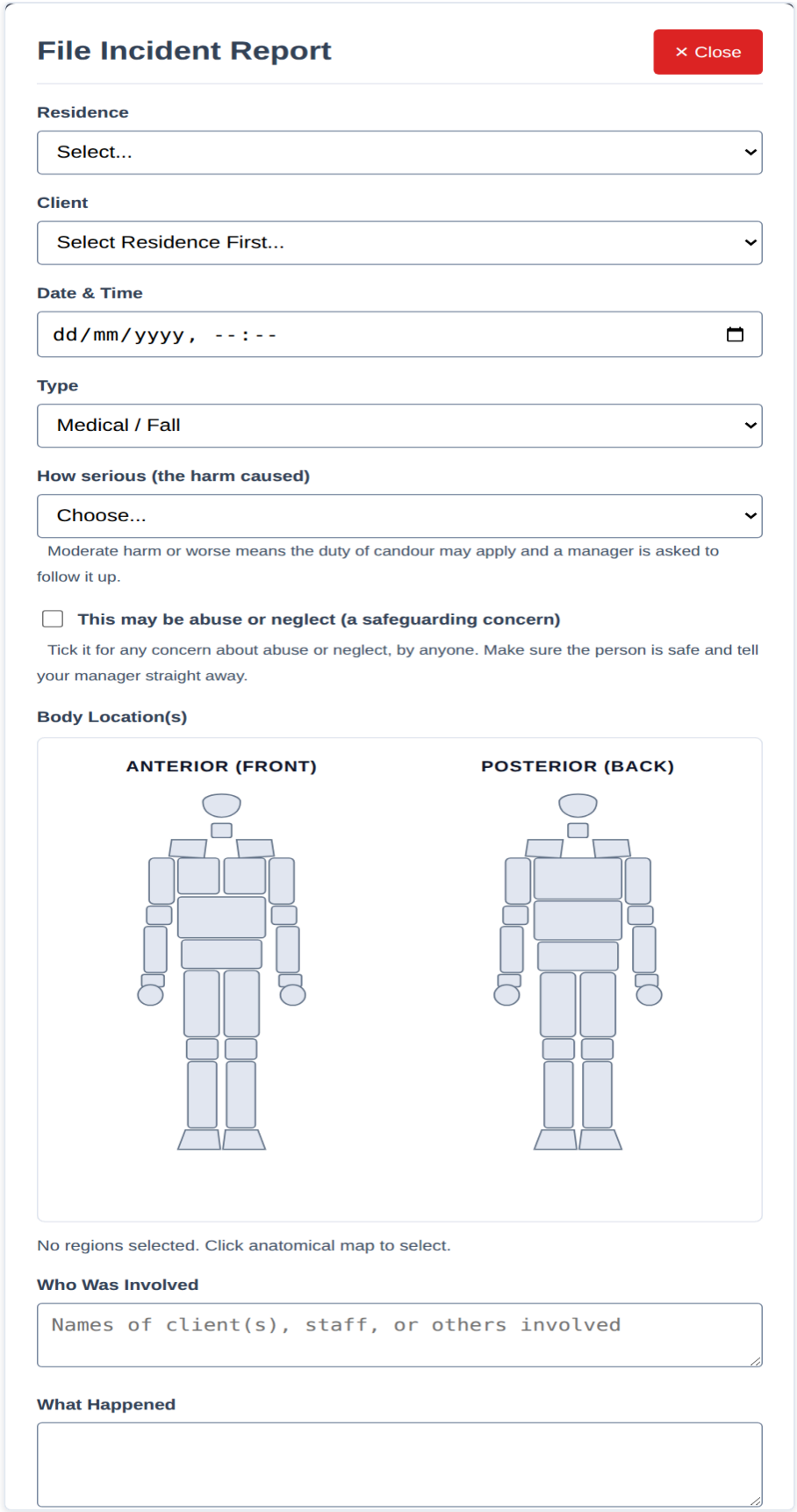


Figure 73. Reporting an incident, with the harm grade and the body map.

Incidents reported before harm grades existed show *Not graded* and can stay so when edited. They aren't followed up unless a manager opens their follow-up and saves it.

10.2 Following up and signing off

Follow-up next to an incident (Admins and care providers; everyone else sees **View**, read-only) opens the incident's follow-up window. At the top is what happened and a **Still to do** list, each item with the date it is due; overdue items are in red. Then:

- **How serious**: the harm grade and the safeguarding tick, which can be corrected here.
- **Who has been told**: for **CQC**, the **Local authority safeguarding** team, the **Police**, and the **Family or representative**, choose whether they must be told (*Yes* or *No*), then the date they were told and their reference (for the family, who was told). The date and reference open once *Yes* is chosen.
- **Duty of candour**: whether it applies, the date the person or their representative was told and given an apology, the date the written follow-up was sent, and notes.
- **Manager's review**: what the review found, the lessons learned, and the changes made so it doesn't happen again.

Save keeps the window open and updates the Still to do list. **Sign off and close** closes the incident with your name and the time. Admins can always sign off; care providers can unless an Admin has unticked **Can care providers sign off incidents?** in Settings > Compliance & Retention, in which case the window says an Admin signs it off. It can only be closed once the harm is graded, each of the four has a *Yes* (with a date) or *No*, the duty of candour is decided (with both dates if it applies), and the findings and lessons learned are written. If something is missing, the message lists it. A closed incident can't be edited or deleted. An Admin can **Reopen** it, giving a reason, which is kept in the audit log.

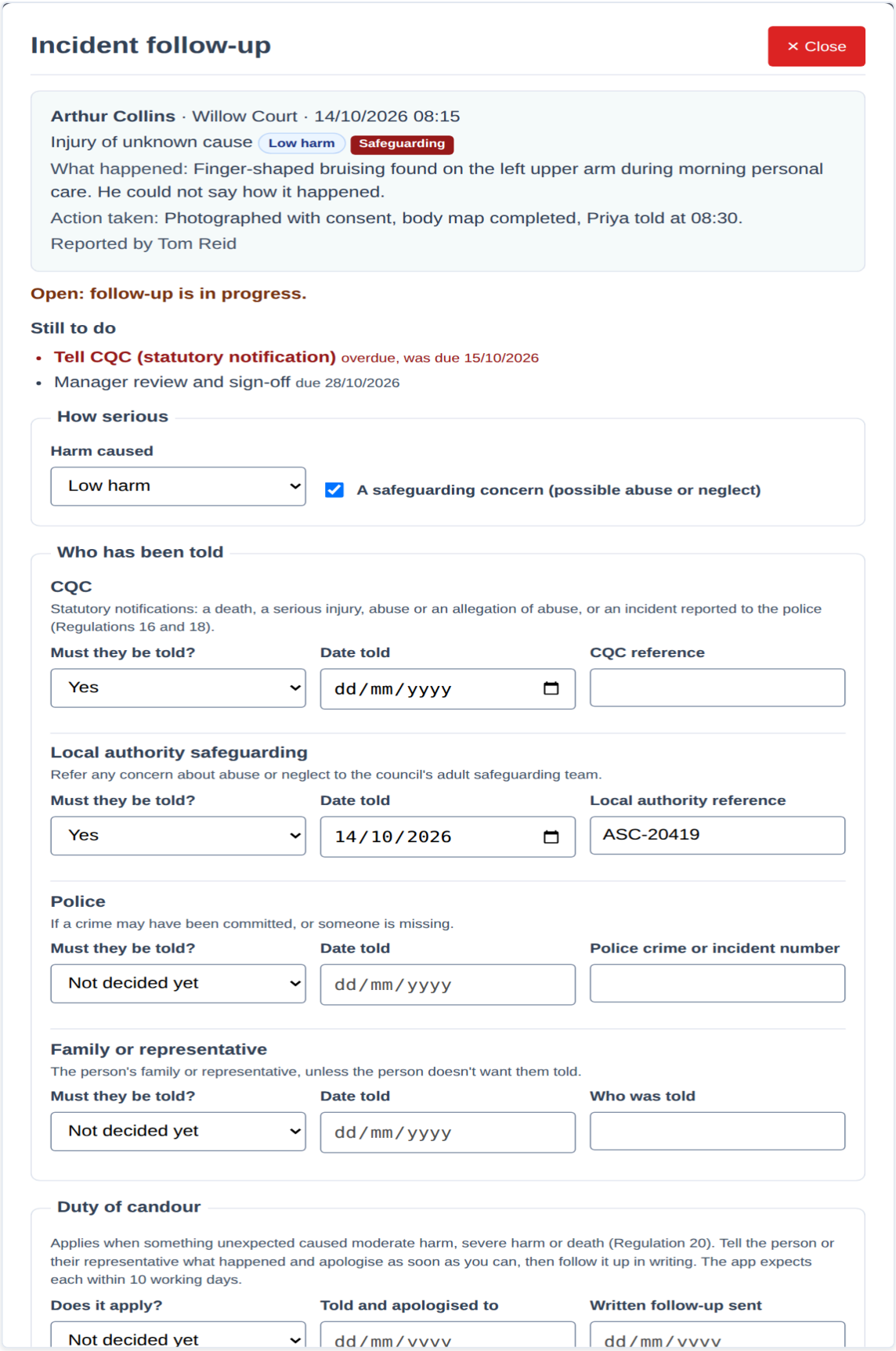


Figure 74. An incident's follow-up window.

When each item falls due, unless your Admin has changed it in Settings > Compliance & Retention (section 27.2):

Item	Due, to start with
Telling CQC, the local authority, the police or the family	The day after the incident
Duty of candour: telling the person and apologising	10 working days after the incident
Duty of candour: the written follow-up	10 working days after they were told
The manager's review and sign-off	14 days after the incident

The 🚨 **Incident follow-up** card on the Dashboard lists open incidents with something still to do, overdue ones first, with **Follow up** to open each. Admins and care providers are notified when an item becomes overdue (at their own residences; Admins at all), and overdue items are in the daily email.

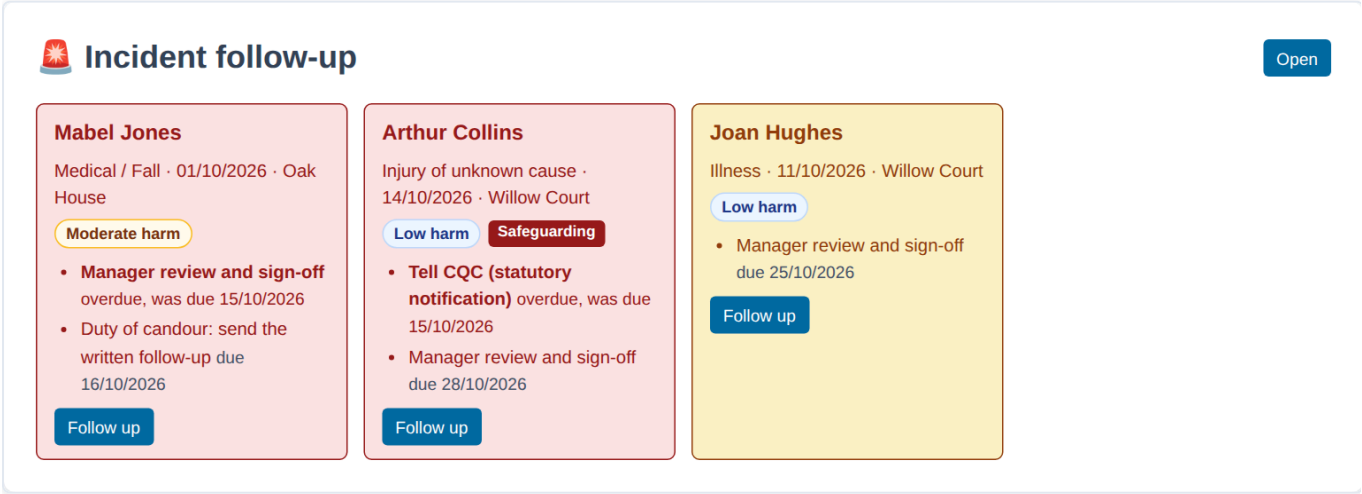


Figure 75. The Incident follow-up card on the Dashboard.

Working days count Monday to Friday; bank holidays are not taken out. The duty of candour applies to registered providers when something unexpected or unintended causes moderate harm, severe harm or death (Regulation 20); statutory notifications to CQC are Regulations 16 and 18. Check your own policies for anything stricter.

10.3 The Word report

Report next to an incident fills in your provider's incident report template (a Word document set up per residence type in Settings > Compliance & Retention) and downloads it. Under the templates, **Words the template can use** lists every placeholder. As well as the incident's details, a template can show <Severity>, <Safeguarding>, <CQCNotified>, <LocalAuthorityNotified>, <PoliceNotified>, <FamilyInformed>, <DutyOfCandour>, <ReviewFindings>, <LessonsLearned>, <PreventionActions>, <IncidentStatus>, <ClosedBy> and <ClosedDate>.

11. Complaints & Compliments

> **Who can use it:** Admins, care providers and support workers record them; Admins and care providers handle complaints. Family members can send them from the Family tab (section 11.4).

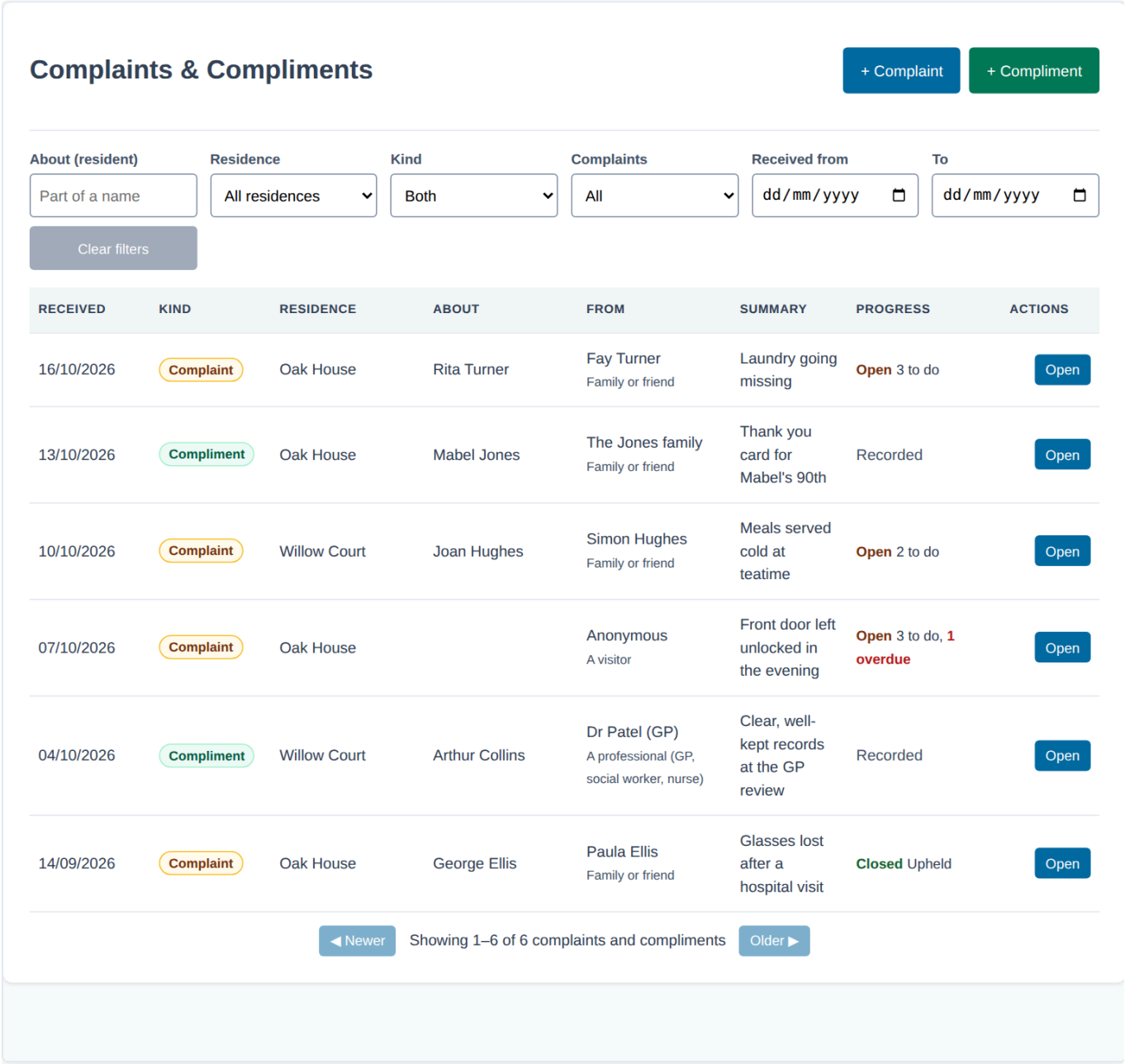


Figure 76. Complaints & Compliments.

The list shows complaints and compliments newest first: when each was received, the residence, the resident it is about (if any), who it is from, a summary and its progress. Filter by resident, residence, kind (complaints or compliments), open or closed, or dates. What you see depends on your role:

- **Admins** see everything.
- **Care providers** see everything at their residences, and anything they recorded themselves.
- **Support workers** see compliments at their residences, and the complaints they recorded themselves (complaints can be about colleagues, so they don't see other people's).

11.1 Recording one

Press **+ Complaint** or **+ Compliment** and record when and how it was received, who it is from (or "Anonymous") and who they are, how to reply to them, the residence and, if it is about one resident, who, a short summary, what it is about (for a complaint, in their words where you can), and any staff it names (for a compliment, who it is about). Under **Letters, emails or photos** you can attach the complaint itself if it came in writing: scan a letter, or print an email as a PDF, and attach it (PDFs or photos, up to 10 MB each; stored encrypted, like every attachment). Support workers and care providers choose one of their own residences; Admins can also choose the whole care provider.

A new complaint tells the Admins and care providers at that residence; a compliment tells everyone who works there. The person who recorded it can change the details, and add or remove files, within the staff edit window; Admins and care providers can while a complaint is open. Attached files are listed under the summary when you open it; click one to view it. A removed file is kept in quarantine for the retention period, and attached files are included in the resident's Subject Access Request download.

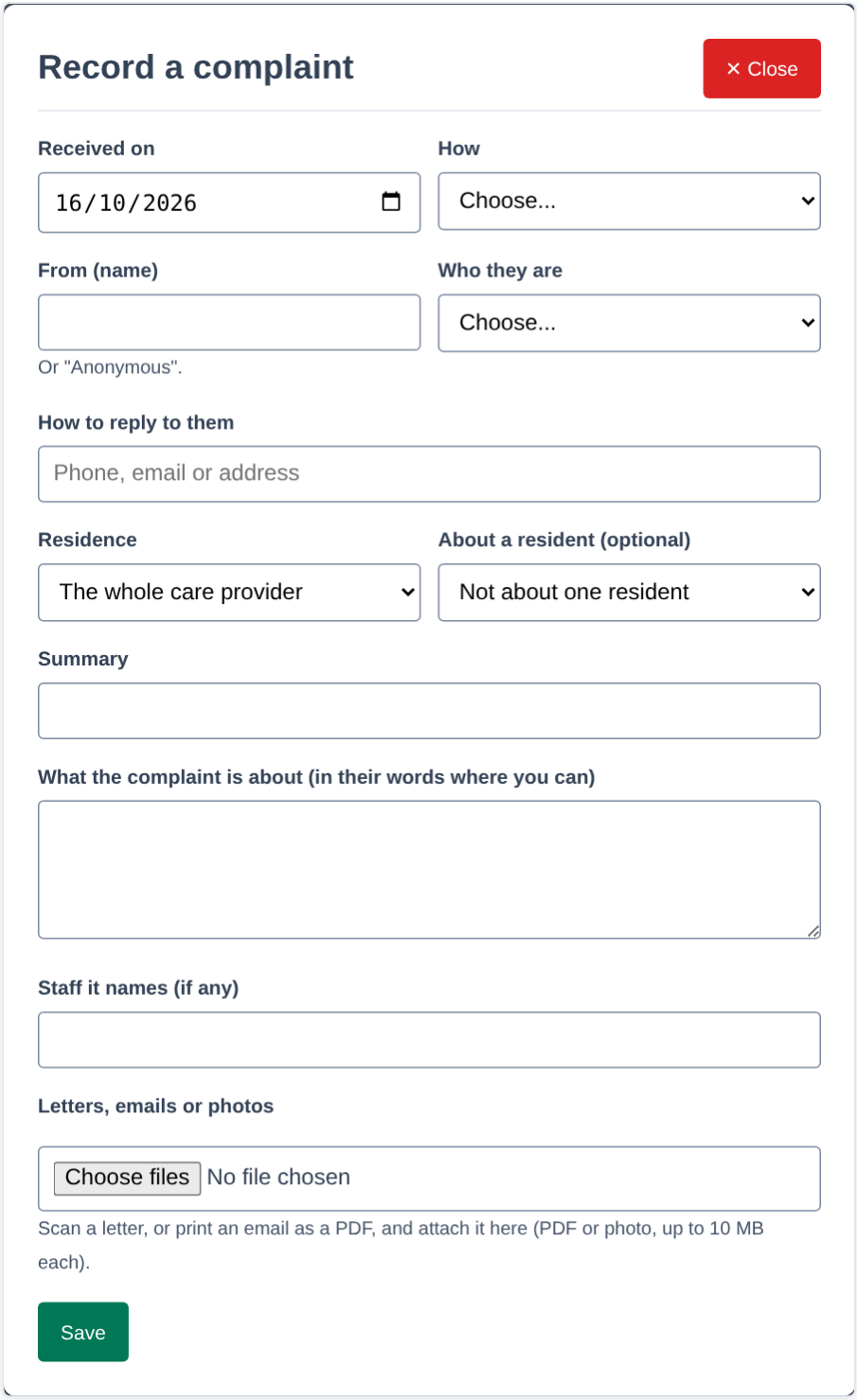


Figure 77. Recording a complaint.

11.2 Handling a complaint

Open shows the complaint, with a **Still to do** list and when each item is due (overdue items in red). Admins and care providers record:

- **Acknowledgement**: the date you told them it had been received, who is looking into it and when to expect an answer.
- **Looking into it**: what you found.
- **Outcome and response**: the outcome (upheld, partly upheld, not upheld or withdrawn), the date the final response was sent, and what it said. The response should tell them how to take it further if they are not satisfied:

the Local Government and Social Care Ombudsman.

- **Learning**: the lessons learned and the changes made.
- **Taken further**: if they went to the Ombudsman, CQC or the council or ICB that pays for the care, who and when.

Save keeps the window open. **Close the complaint** closes it with your name and the time, once it has an acknowledgement date, findings, an outcome, a response date and lessons learned (a withdrawn complaint needs only the outcome and lessons). If something is missing, the message lists it. Admins can always close complaints; care providers can unless an Admin has unticked **Can care providers close complaints?** in Settings > Compliance & Retention. A closed complaint can't be changed or deleted; an Admin can **Reopen** it, giving a reason, which is kept in the audit log. Only Admins can delete a complaint or compliment, for one recorded by mistake; a copy is kept.

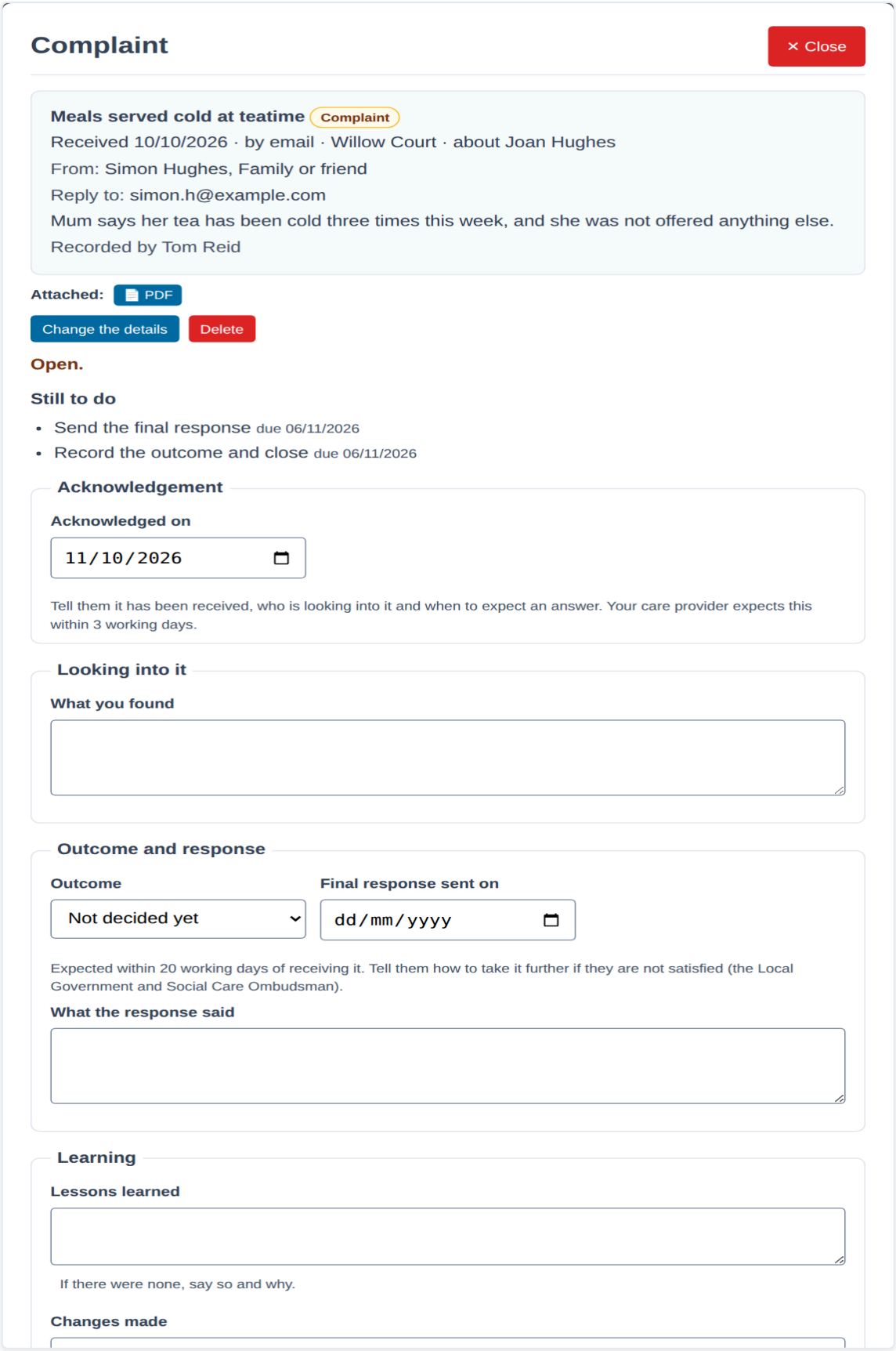


Figure 78. Handling a complaint.

11.3 When things are due

Counted in working days (Monday to Friday; bank holidays are not taken out) from the day it was received, unless your Admin has changed them in Settings > Compliance & Retention (section 27.2):

Item	Due, to start with
Acknowledge the complaint	3 working days
Send the final response, record the outcome and close	20 working days

The 📣 **Complaints** card on the Dashboard lists open complaints with what is still to do, overdue ones first. Admins and care providers are notified when something becomes overdue, and overdue complaints are in the daily email. In the CQC evidence pack, complaints and compliments are under Responsive, and lessons from complaints under Well-led (section 23.1).

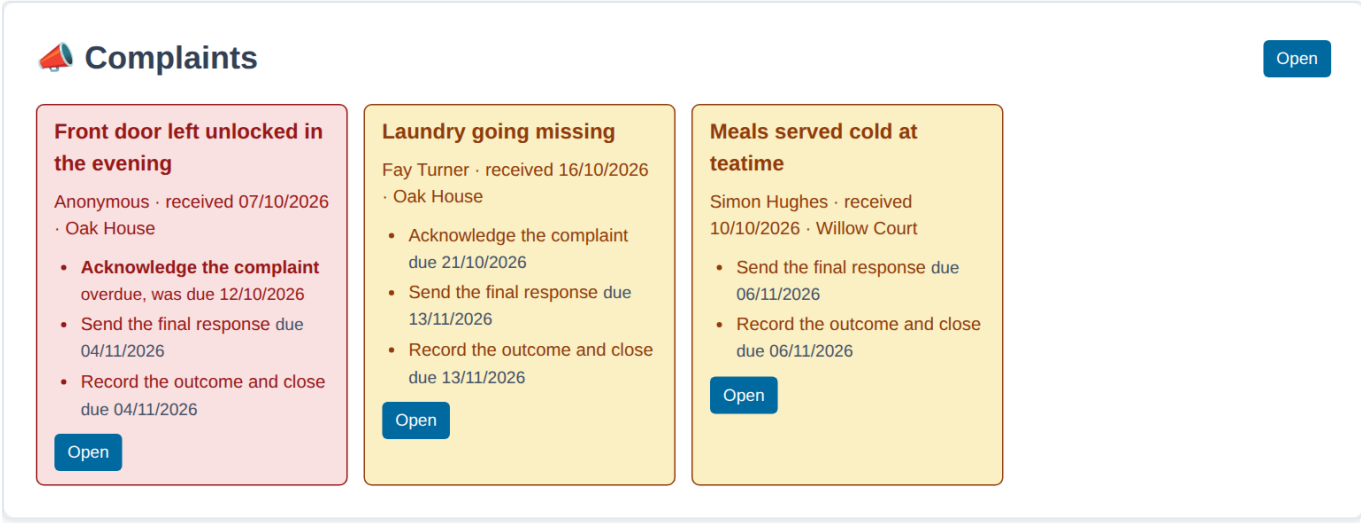


Figure 79. The Complaints card on the Dashboard.

11.4 From families

Family members with a family account can send a complaint or a compliment from the Family tab, under *Complaints and compliments*, whatever else is shared with them. It is recorded as received that day through the family portal, from them, about their relative, and the Admins and care providers at the residence are told. The family member sees what they have sent and how it is going (received, being looked into, closed), and is notified when it is acknowledged and when it is closed. They never see your findings or notes. This needs the Family portal service.

12. Daily Records

> **Who can use it:** Everyone except family members, who see their relative's daily records in the client record.

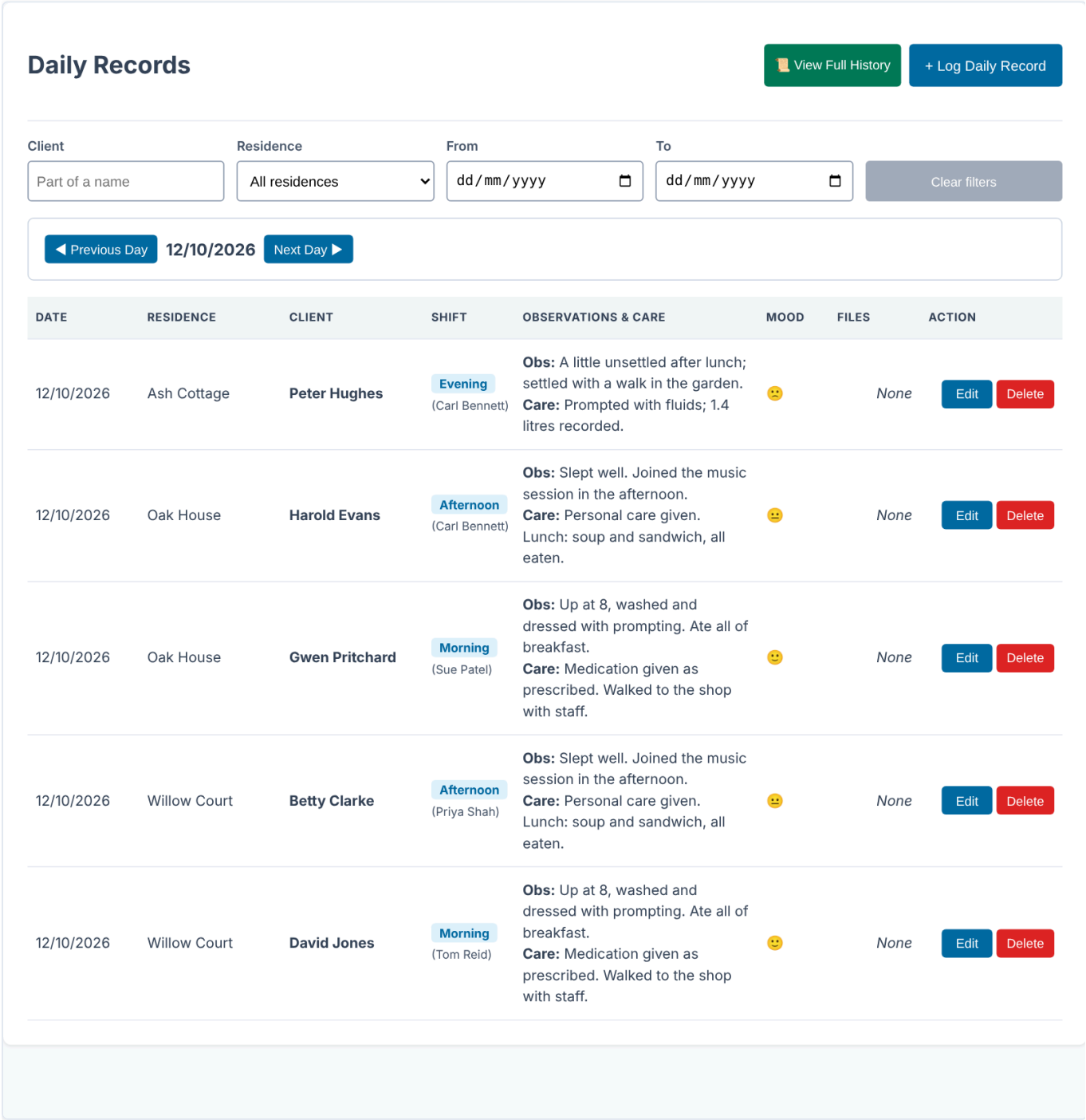


Figure 80. Daily records for one day.

The tab shows one day's records across your residences: move with ◀ **Previous Day** and **Next Day** ▶, or filter by resident, residence or dates. Each record shows the shift, with the name of the person who last saved the record under it (for example "General (Sue Patel)"; "Automated" for a placeholder the system added because nobody wrote one), the observations and care given, the resident's mood, and any files.

Press **+ Log Daily Record**, choose the residence and resident, the date and shift, and record:

- **Factual observations**: what you saw, heard or measured, not opinions.
- **Care & interventions**: meals eaten, medication given, support with mobility and personal care.
- **Mood**: tap the face that fits best.
- **Notes**: anything that needs more explanation.
- **Plan for next shift**: anything the next shift must do. This creates a task automatically (section 4.1).
- Photos or PDFs if useful.

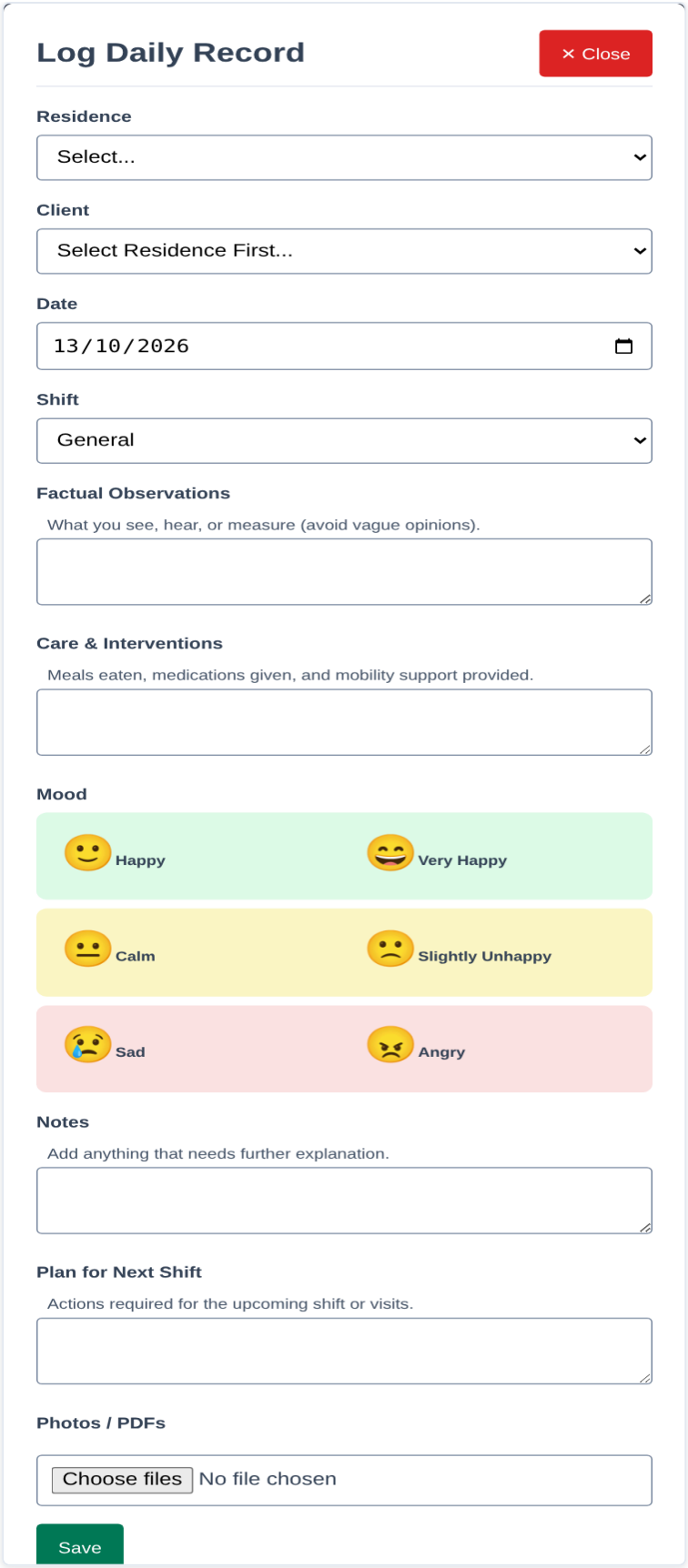


Figure 81. Logging a daily record.

One record per resident per day. Each resident has a single daily record for each day, so the whole day reads in one place. If someone has already written one for that day, saving yours shows who wrote it and asks whether to **add this to the existing record**. If you do, the form shows the combined record: what was there, then a line such as — *Added by Sue Patel, 21:10* —, then what you wrote. Check it and press **Save**; nothing is saved before then, and **Cancel** keeps your

typing in the form. You can add to a colleague's record but not change what they wrote. Your photos are added to the record's photos.

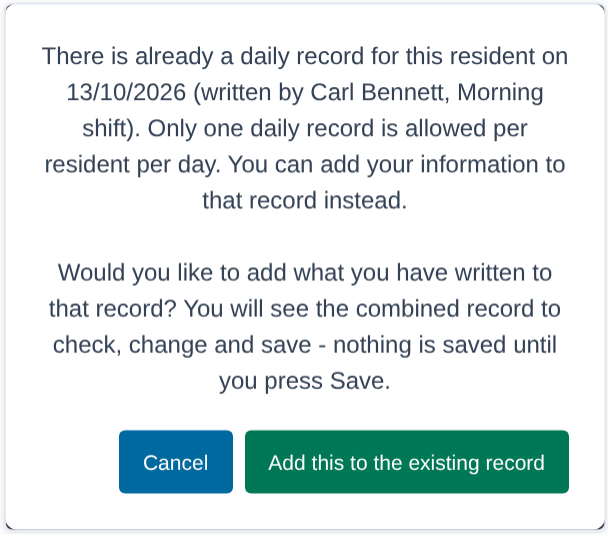


Figure 82. A record for that day already exists.

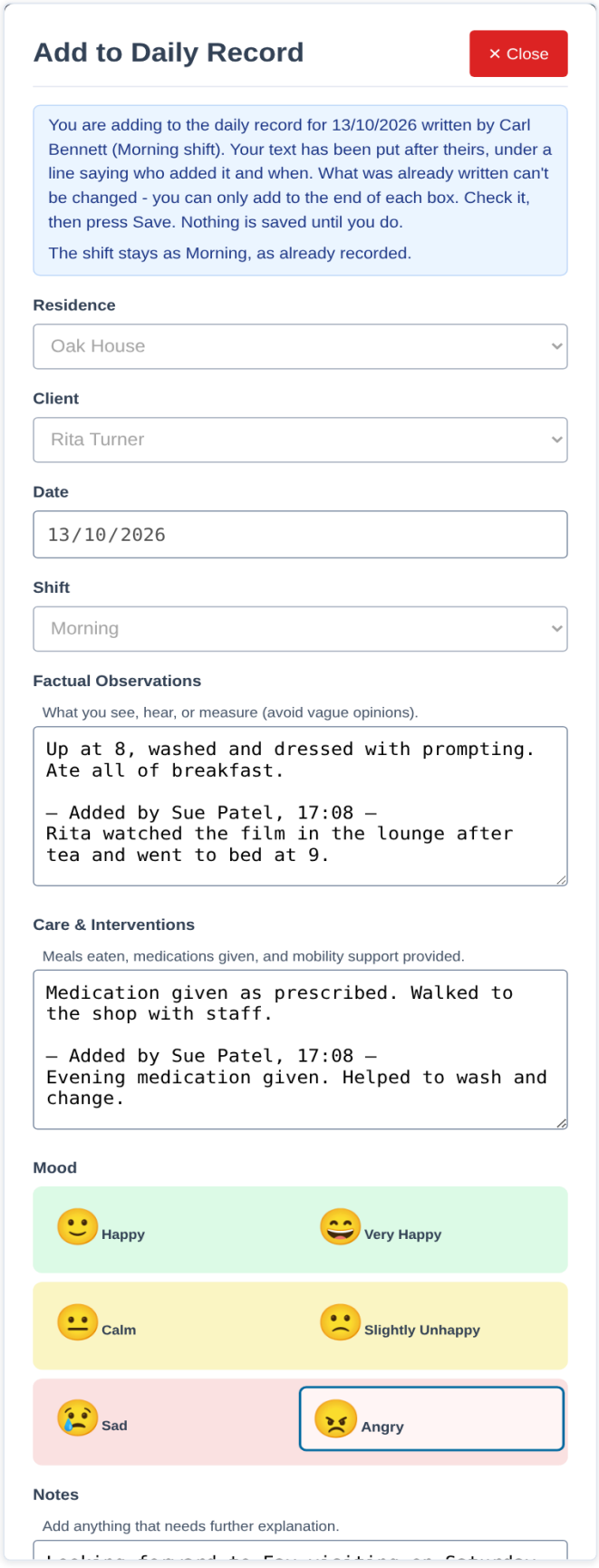


Figure 83. The combined record, ready to check and save.

After saving, the list moves to the day of the record you saved, so you can see it and its files straight away.

13. Monitoring Charts

> **Who can use it:** Admins, care providers and support workers at the resident's residence. Admins and care providers set up each resident's charts. Family members don't see them. Part of the Monitoring charts service.

Monitoring charts are for residents who need a closer eye on one thing: how much they drink and eat, their weight, being turned to protect their skin, their bowels, or their vital signs. Each resident has only the charts in their own plan. Entries are recorded as you go, so the totals, times and scores are always up to date.

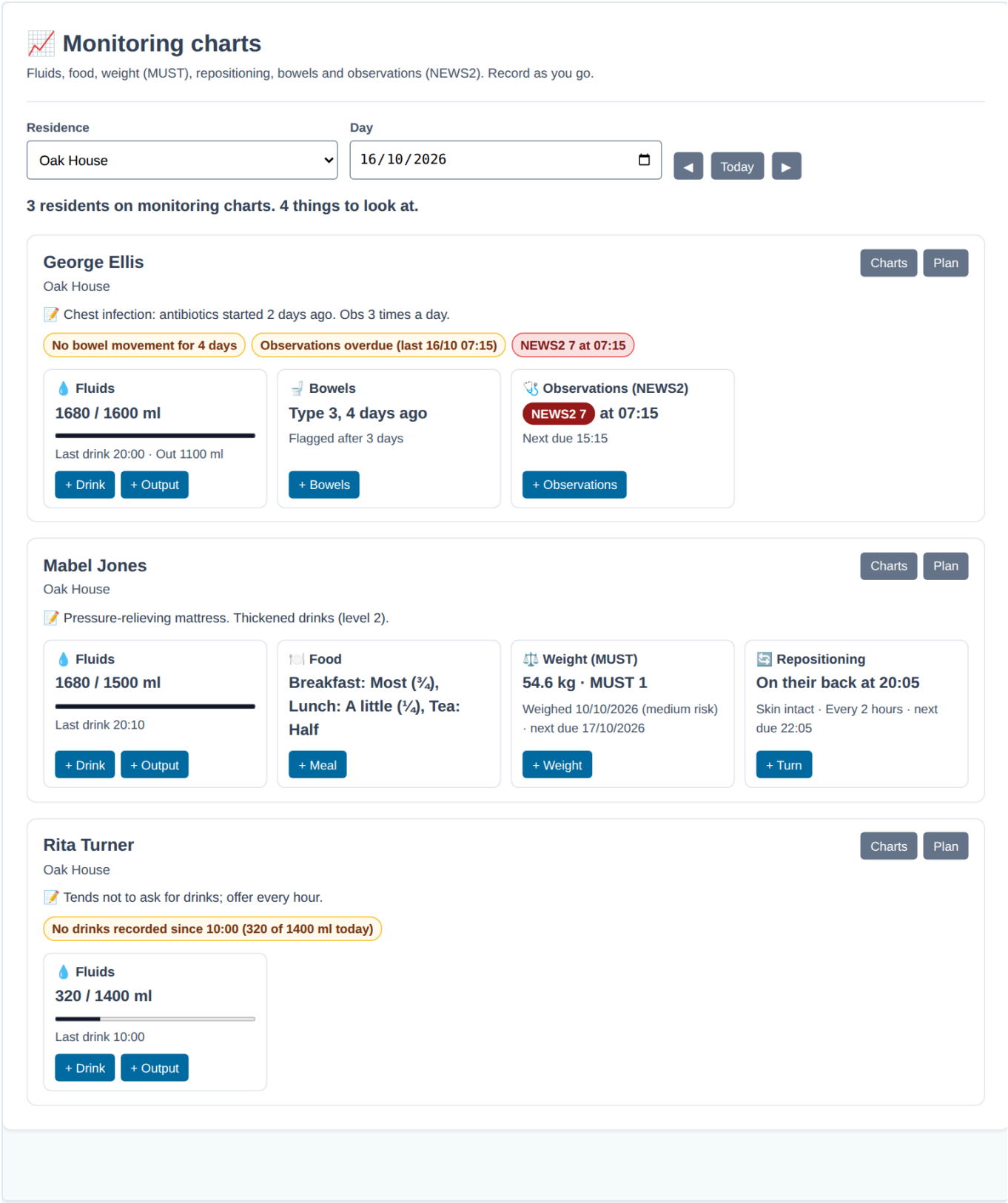


Figure 84. The Monitoring tab: each resident's charts, with what is overdue.

13.1 The round

The **Monitoring** tab (under Care) shows the residents on monitoring charts at your residences, one card each, for today. Choose a residence to see only that one, or use ◀ **Previous Day**, **Today** and **Next Day** ▶ to look back (entries can only be added for today). Each card shows the resident's plan note (for example "Thickened drinks (level 2)") and a tile for each chart:

- 💧 **Fluids**: how much they have drunk today against their daily target, with a bar, when they last had a drink, and any output measured.
- 🍽 **Food**: each meal today and how much was eaten.
- ⚖ **Weight (MUST)**: the last weight and its MUST score, and when they are next due to be weighed.
- 🔄 **Repositioning**: the last position and skin check, how often they are to be turned, and when the next turn is due.
- 🚽 **Bowels**: the last bowel movement and its Bristol type, and after how many days without one it is flagged.
- 🩺 **Observations (NEWS2)**: the last NEWS2 score, coloured by how worrying it is, and when the next observations are due.

Anything that needs attention is shown in a coloured line above the tiles: in red, a NEWS2 of 5 or more, or a 3 in one measurement, in the last 24 hours; in amber, something overdue (a turn, a weigh, observations, no drink for 4 hours during the day, no bowel movement for too long); in grey, a MUST score of 2 or more. Admins and care providers also see the residents without charts, under the cards, each with a **Set up charts** button.

13.2 Recording

Press the button on the tile: **+ Drink** or **+ Output**, **+ Meal**, **+ Weight**, **+ Turn**, **+ Bowels** or **+ Observations**. The time is filled in as now; change it if you are writing up something from earlier today (up to 7 days back, never in the future). Then record:

Chart	What you record
Drink	How much they drank (ml) and what it was.
Output	How much (ml), and what was measured: urine, vomit, a drain or catheter, or other.
Meal	Which meal (breakfast, lunch, tea, supper, a snack or a supplement drink), how much was eaten (all, most, half, a little, none or refused), and what it was.
Weight	The weight (kg), how they were weighed (standing, chair or hoist scales), and whether they are acutely ill and have had, or are likely to have, no food for more than 5 days.
Turn	The position they were moved to, and the skin check: intact, red but fading when pressed, red and not fading when pressed, or broken.
Bowels	The Bristol stool type (1 to 7, each described), the amount, and whether they were continent.
Observations	Breathing rate, oxygen saturation, whether they are on oxygen, blood pressure, pulse, temperature, how alert they are (ACVPU: alert, new confusion, responds to voice, responds to pain, unresponsive), and any soft signs (more sleepy than usual, not eating, new confusion).

Every entry can have a note. Press **Save**.

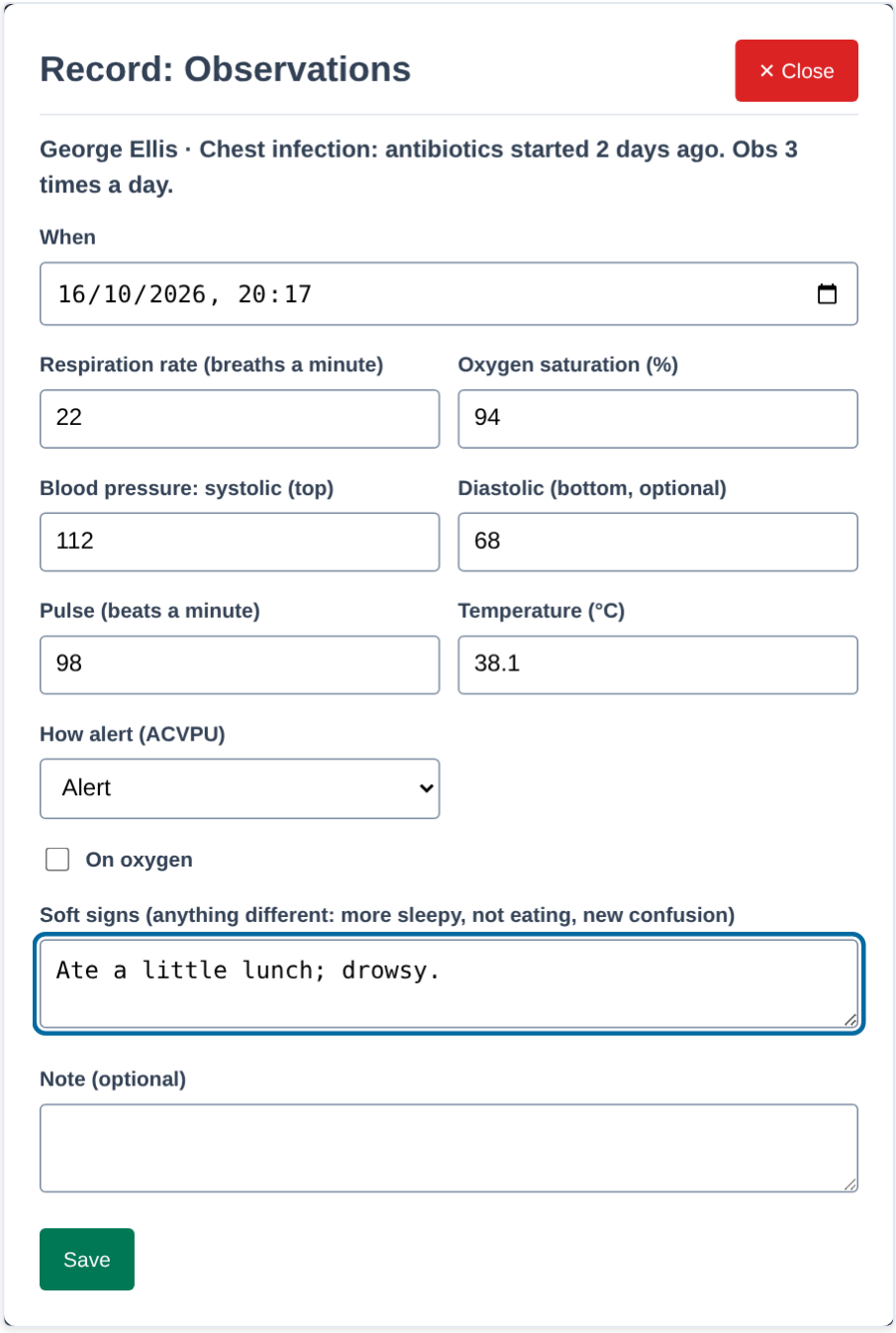


Figure 85. Recording observations.

NEWS2. When you save observations, the app works out the NEWS2 score (the National Early Warning Score, as used by the NHS) and tells you straight away what to do:

NEWS2	What to do
0	Carry on as planned.
1 to 4	Tell the senior on duty and watch more closely.
3 in any one measurement	Get advice from the GP, 111 or the community team.
5 or 6	Get an urgent clinical review (GP, 111 or the community team).
7 or more	An emergency: call 999.

In each case, follow your own escalation policy. A score of 5 or more, or a 3 in one measurement, also notifies everyone working at the residence at once. If a resident has a lung condition and their GP or nurse has set a lower oxygen target (88 to 92%), choose **Scale 2** in their plan so the score is worked out correctly. NEWS2 is an aid to your judgement, not a replacement for it: if you are worried, act, whatever the score.

MUST. When you save a weight, the app works out the MUST score (the Malnutrition Universal Screening Tool) from the resident's BMI (using the height in their plan), weight lost since they were weighed 3 to 6 months earlier, and whether they are acutely ill. A score of 2 or more is high risk: you are told when you save, and Admins and care providers are notified.

13.3 Charts and corrections

Charts on a resident's card opens their charts. Choose a chart at the top and the period (today, 7, 30 or 90 days, or a year). Drinks are drawn as a bar for each day against the target line, with the output; weight and NEWS2 as lines over time; repositioning shows how many times the resident was turned and how many gaps were longer than their plan. Under the chart, every entry is listed, newest first, with who recorded it.

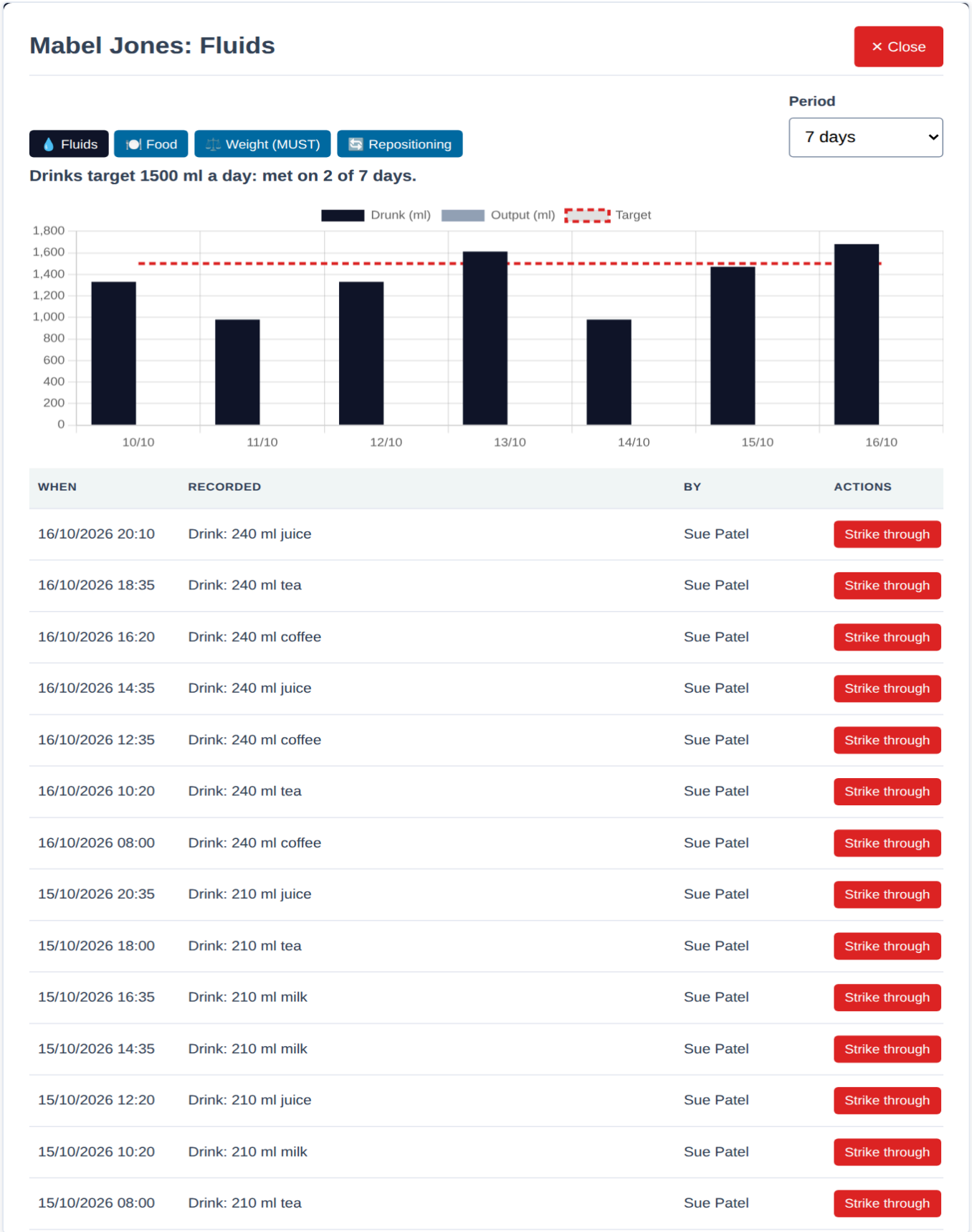


Figure 86. A fluid chart for 7 days.

Entries can't be changed. If one is wrong, press **Strike through** and give the reason: it stays on the chart, crossed out with your name and the reason, and is no longer counted, and you can record it again correctly. The person who recorded it can do this within the staff edit window; Admins and care providers at any time. Every entry, strike-through and plan change is in the audit log, and the charts are included in the resident's Subject Access Request (section 7.7).

13.4 Setting up a resident's charts

Admins and care providers press **Plan** on a resident's card (or **Set up charts** for a resident without one). Tick the charts the resident needs; the targets for each appear:

- **Fluids**: the daily drinks target (1,500 ml to start with).
- **Repositioning**: how often they are to be turned (every 2 hours to start with).
- **Weight**: how often they are to be weighed (every 30 days to start with) and their height, needed for MUST.
- **Bowels**: after how many days without a bowel movement to flag it (3 to start with).
- **Observations**: how often (in hours; leave it empty for "when needed") and the oxygen scale (Scale 1, or Scale 2 for a lower target set by a clinician).

Add a note for the staff (for example about thickened drinks or a pressure mattress) and press **Save**. Untick everything to stop monitoring; what has been recorded is kept.

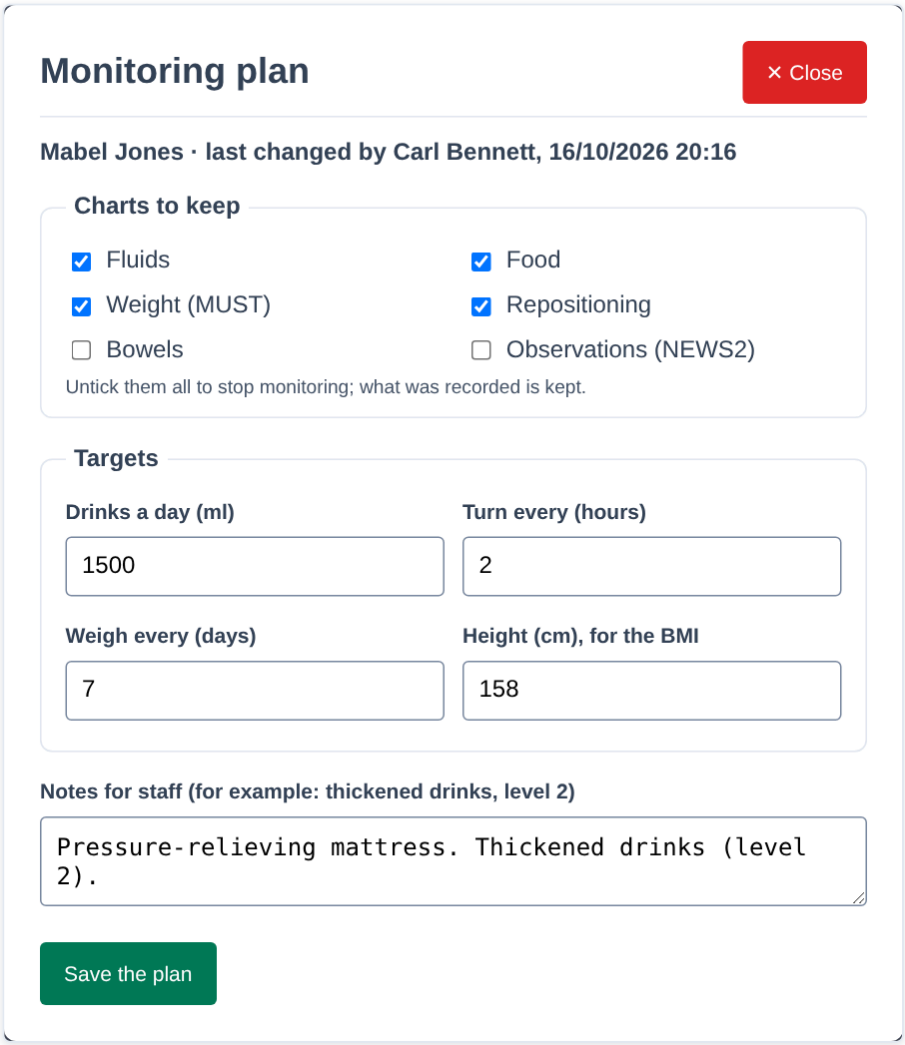


Figure 87. A resident's monitoring plan.

13.5 Alerts

The 📈 **Monitoring** card on the Dashboard lists residents with something overdue or worrying, with an **Open** button. Everyone at the residence is notified once when a turn, a drink, observations, a weigh or a bowel check becomes overdue (and the notification clears when it is recorded). The daily email lists residents who drank less than their target the day before, and anything else outstanding. The drinks alert (4 hours without a drink, between 08:00 and

21:00) can be changed by an Admin in Settings > Compliance & Retention (section 27.2). In the CQC evidence pack, the charts are summarised under Effective (section 23.1).

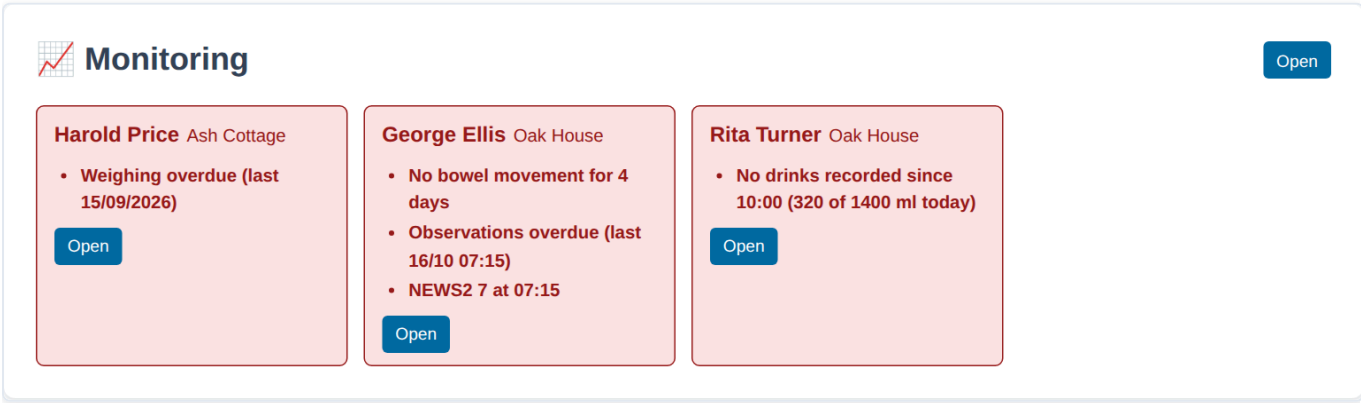


Figure 88. The Monitoring card on the Dashboard.

14. Capacity, DoLS & Resuscitation

> **Who can use it:** Everyone on the staff at the resident's residence sees it. Admins and care providers record it; only Admins can delete a record made by mistake. Family members don't see it.

Each resident's record has a section, **Capacity, DoLS & Resuscitation**, for four kinds of record: their resuscitation decision (DNACPR or ReSPECT), Deprivation of Liberty Safeguards (DoLS) authorisations, mental capacity assessments with best-interests decisions, and who can make decisions for them (lasting powers of attorney, deputies and advance decisions). The **Capacity & DoLS** tab shows the same for every resident at once.

14.1 Resuscitation decisions

The resident's resuscitation decision is shown at the very top of their record, under the section buttons, so nobody has to look for it: ⛔ **DNACPR in place** (red), ✅ **For CPR** (green), or, if nothing is recorded, *No resuscitation decision recorded: CPR would be attempted*. A DNACPR badge also appears by the resident's name in the Clients list.

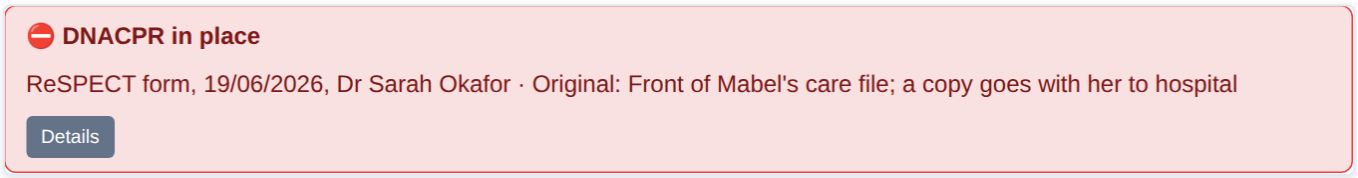


Figure 89. The resuscitation decision at the top of the record.

The decision is made by a doctor or other clinician, on a DNACPR form or a ReSPECT form; the app records that it exists and where it is. Press **+ Resuscitation decision** and record the decision, the kind of form, its date and the clinician who made it, the review date if the form has one, who it was discussed with, where the original is kept (it should go with the resident to hospital), and, for ReSPECT, what matters to the resident and the recommendations. Attach a scan or photo of the form.

Everyone working at the resident's residence is notified when a decision is recorded, replaced or withdrawn. The decision itself can't be edited: if it changes, press **+ Record a new decision**, and the old one is kept, marked *Replaced*. If a clinician cancels the form, **View** it and press **Withdraw**, giving the reason. The review date, where the original is kept, who it was discussed with and notes can be changed with **Change**. When a review date passes, it appears as due (section 14.5).

14.2 DoLS

Press **+ DoLS application or authorisation**. Choose **Standard** (granted by the council, the supervisory body, for up to a year) or **Urgent** (given by the care home itself while a standard application is decided, for up to 7 days, or 14 if the council extends it), and where it stands:

- **Applied for**: the date the application was sent, the council and their reference.
- **Granted**: the date it was granted and the date it ends, any conditions (which everyone working with the resident can see), the relevant person's representative (RPR), and the date CQC was told the outcome.
- **Not granted**: the date of the decision, and when CQC was told.
- **Ended**: when and why (for example, the resident moved, or it was replaced by a new authorisation).

Use **Change** on the same record as it moves from applied to granted. Attach the council's letter. When it is time to renew, record the new application as a new record: it then covers the one running out.

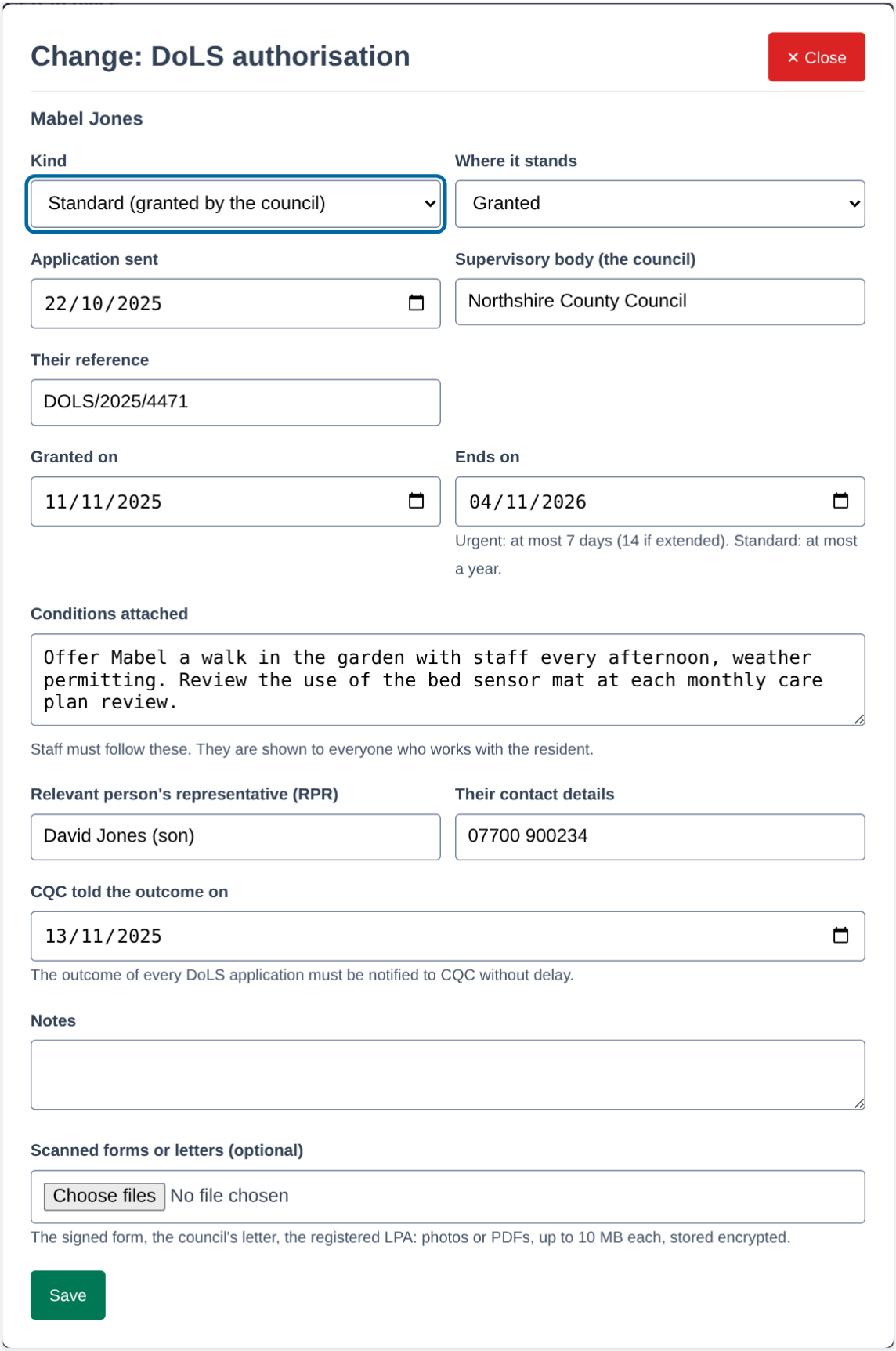


Figure 90. A standard DoLS authorisation, granted with conditions.

14.3 Mental capacity assessments

Under the Mental Capacity Act, everyone is assumed to have capacity unless it is shown that they lack it, and capacity is assessed for one decision at a time. Press **+ Capacity assessment** and record:

- The **decision** (for example "Where to live", "Having the flu vaccine", "Use of a bed sensor mat"), the date, who assessed and their role, and the support given to help the resident decide.
- **Stage 1**: is there an impairment of, or disturbance in, the functioning of their mind or brain, and what it is.
- **Stage 2**: because of it, can they understand the information, retain it long enough, use or weigh it, and communicate their decision? Answer *Yes* or *No* to each, with how you know.
- The **outcome**. The app says what the answers show; it won't accept "lacks capacity" without an impairment and at least one "No".
- If they lack capacity, the **best-interests decision**: their past and present wishes, feelings and values, who was consulted (family, an attorney, the GP, an advocate; tick if an IMCA was involved), the options considered, the decision, why it is the less restrictive option, and who decided and when. If this isn't recorded yet, it appears as due.
- A **review date**, if needed.

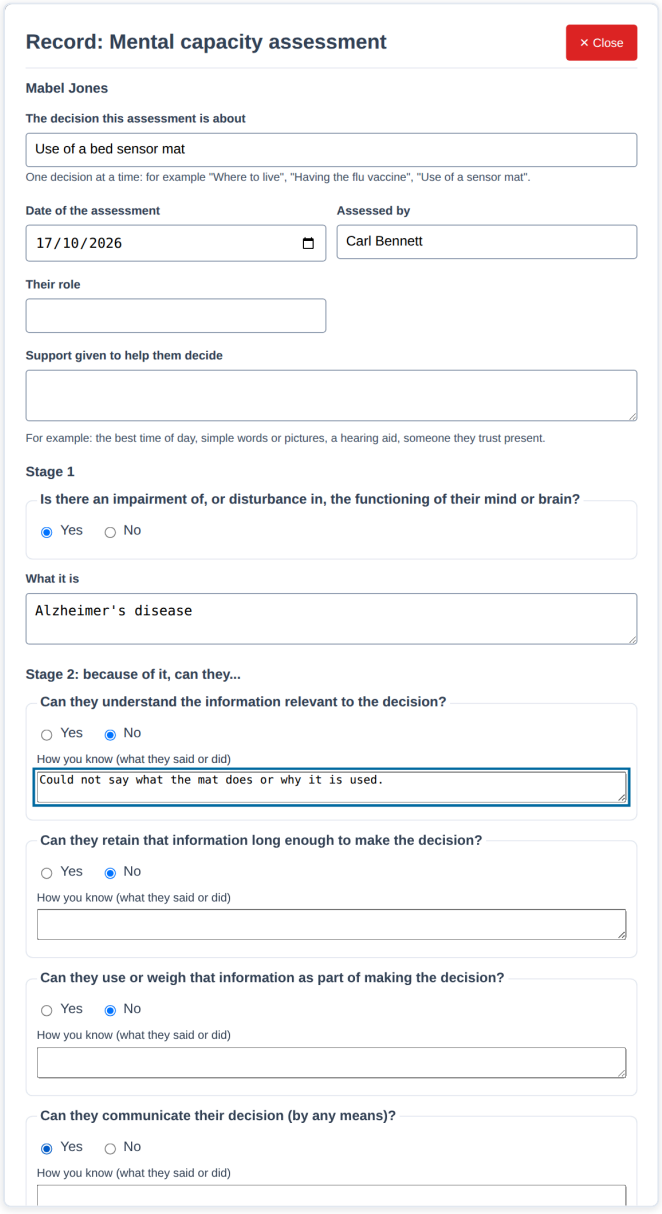


Figure 91. Stage 1 and 2 of an assessment.



Figure 92. A saved assessment with the best-interests decision.

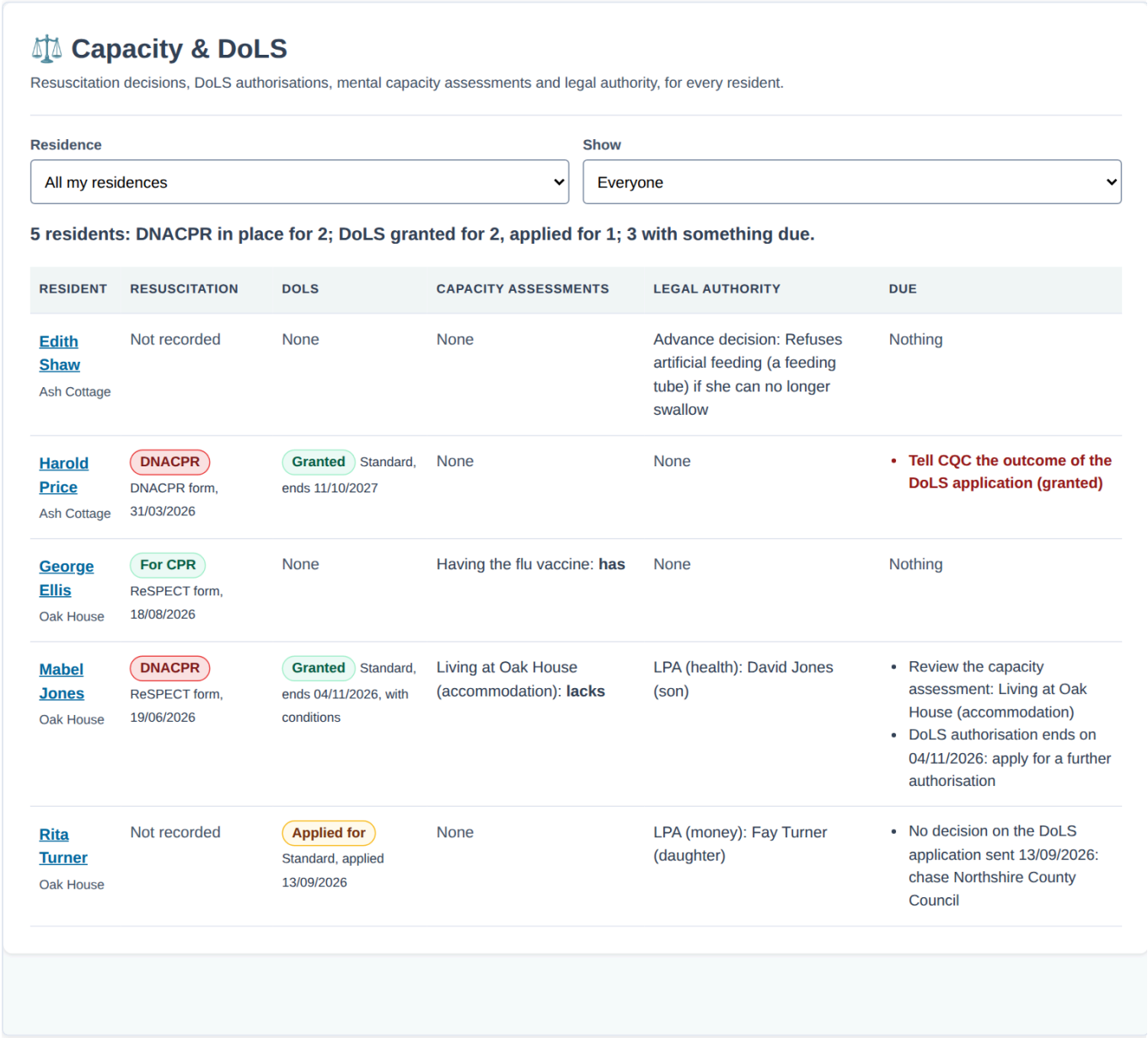
To reassess the same decision, **View** the assessment and press **Reassess (replace)**: the new assessment starts with the same decision, and the old one is kept under *Replaced assessments*.

14.4 Legal authority

Press **+ Legal authority** to record a lasting power of attorney (health and welfare, or property and financial affairs), a court-appointed deputy, or an advance decision to refuse treatment: the attorneys' or deputy's names and contact details, how they act (jointly, or jointly and severally), the registration date and reference, and the date you saw the registered document (always ask to see it before relying on it). For an advance decision, record what treatment it refuses and when. Mark it *Ended* if it no longer applies.

14.5 The register and what is due

The **Capacity & DoLS** tab (under Quality) lists every current resident at your residences: their resuscitation decision, DoLS, current capacity assessments, legal authority and anything due. Choose a residence, or show only residents with something due, a DNACPR in place, or a DoLS. Click a name to open their record at this section.



⚖ Capacity & DoLS

Resuscitation decisions, DoLS authorisations, mental capacity assessments and legal authority, for every resident.

Residence: All my residences

Show: Everyone

5 residents: DNACPR in place for 2; DoLS granted for 2, applied for 1; 3 with something due.

RESIDENT	RESUSCITATION	DOLS	CAPACITY ASSESSMENTS	LEGAL AUTHORITY	DUE
Edith Shaw Ash Cottage	Not recorded	None	None	Advance decision: Refuses artificial feeding (a feeding tube) if she can no longer swallow	Nothing
Harold Price Ash Cottage	DNACPR DNACPR form, 31/03/2026	Granted Standard, ends 11/10/2027	None	None	• Tell CQC the outcome of the DoLS application (granted)
George Ellis Oak House	For CPR ReSPECT form, 18/08/2026	None	Having the flu vaccine: **has**	None	Nothing
Mabel Jones Oak House	DNACPR ReSPECT form, 19/06/2026	Granted Standard, ends 04/11/2026, with conditions	Living at Oak House (accommodation): **lacks**	LPA (health): David Jones (son)	• Review the capacity assessment: Living at Oak House (accommodation) • DoLS authorisation ends on 04/11/2026: apply for a further authorisation
Rita Turner Oak House	Not recorded	Applied for Standard, applied 13/09/2026	None	LPA (money): Fay Turner (daughter)	• No decision on the DoLS application sent 13/09/2026: chase Northshire County Council

Figure 93. The Capacity & DoLS register.

What becomes due:

Item	When
Tell CQC the outcome of a DoLS application	As soon as it is granted or refused, until the date CQC was told is recorded (overdue)
DoLS ended: apply again, or record that it has ended	After its end date (overdue)
DoLS ending: apply for a further authorisation	28 days before it ends, unless a new application is recorded
Chase the council for a decision	21 days after the application, while there is no decision
Record the best-interests decision	When an assessment finds they lack capacity and none is recorded
Review a capacity assessment or resuscitation decision	After its review date

The 28 and 21 days can be changed by an Admin in Settings > Compliance & Retention (section 27.2). Admins and care providers see these on the ⚖ **DoLS & capacity** card on the Dashboard, are notified when they fall due, and they are in the daily email. In the CQC evidence pack they are under Effective (section 23.1). Every record, change and file is in the audit log, and all of it is in the resident's Subject Access Request.

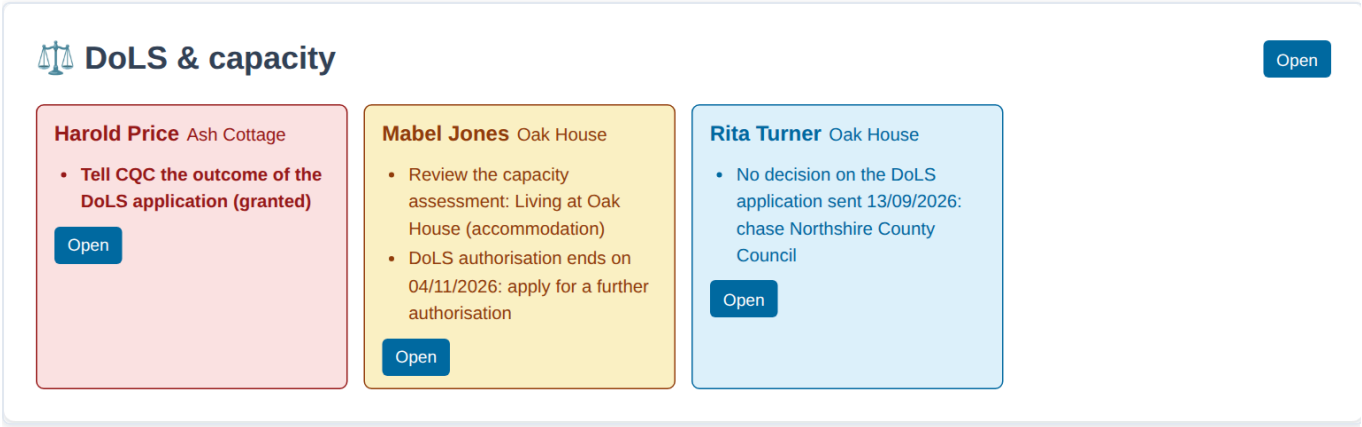


Figure 94. The DoLS & capacity card on the Dashboard.

15. Hospital Transfers

> **Who can use it:** Admins, care providers and support workers at the resident's residence. Family members don't see it.

When a resident goes to hospital, send a transfer pack with them: a printed page with what the ambulance crew and hospital need to know straight away, taken from the resident's record. Recording the transfer also shows the resident as in hospital until they come back.

15.1 Sending someone to hospital

Open the resident's record and press 🏥 **Hospital transfer** at the top. The window shows what the pack will contain (their resuscitation decision, allergies, medicines, their Health and Care Passport, contacts and more) and anything missing that you should check, such as no allergies or no next of kin recorded. Fill in:

- When they left, and the hospital.
- The **reason** (for example "Fall with suspected hip fracture") and what happened and how they are now.
- Who went with them, and the phone number for the hospital to call (your care provider's number to start with, from Settings).
- The **belongings** sent: tick glasses, hearing aids, dentures, walking aid, medicines, the original DNACPR or ReSPECT form, phone, clothes, money or valuables, and list anything else. Recording this means nothing is lost on the way back.

Press **Record the transfer and print the pack**. The pack downloads as a PDF: print it and send it with them. The Admins and care providers at the residence are notified, and the record and the Clients list show the resident as *In hospital*.

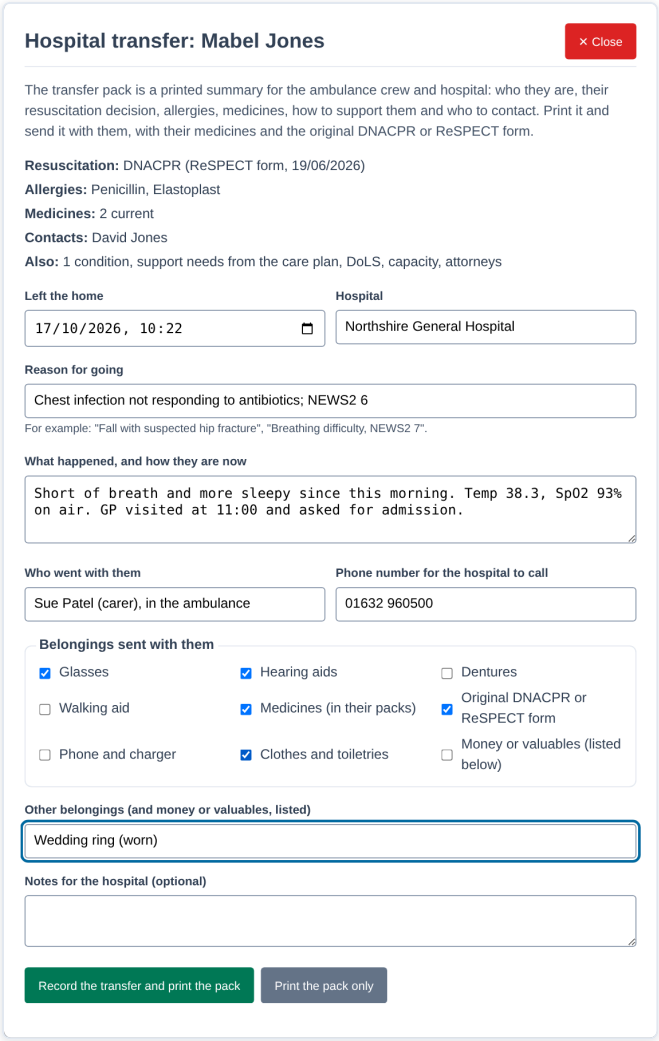


Figure 95. Recording a transfer.

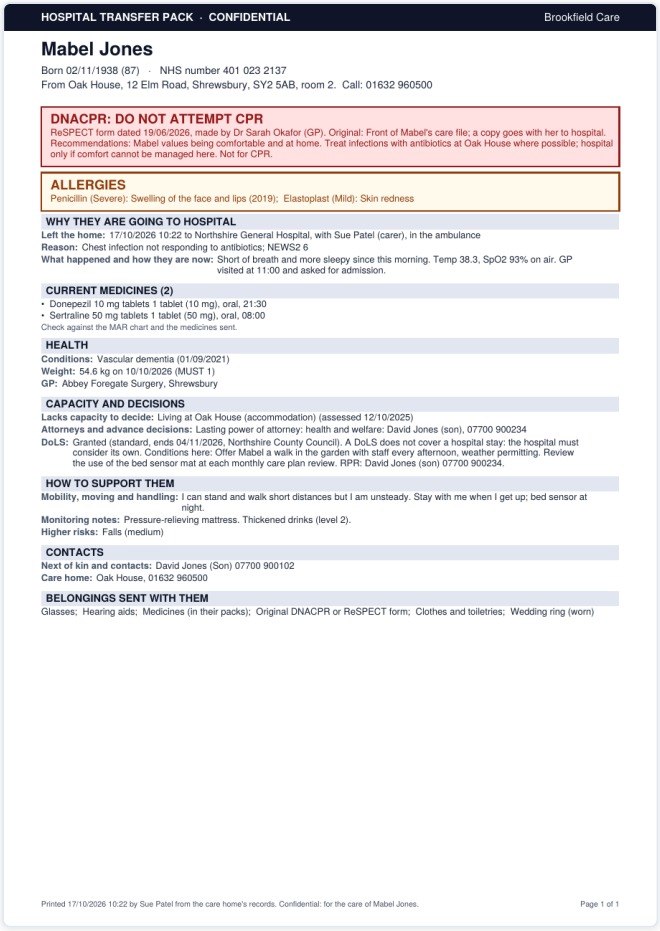


Figure 96. The transfer pack.

15.2 What the pack says

The pack fits on one page for most residents. It starts with the resident's name, date of birth, NHS number and room, and the care home's address and phone number. Then come the most important things, in coloured boxes:

- **Resuscitation**: DNACPR (red) or For CPR (green), the form, date and clinician, where the original is, and the ReSPECT recommendations. If nothing is recorded it says so, and that CPR would be attempted (chapter 14).
- **Allergies**, with severity and reaction, or "none recorded".

After those: why they are going and what happened; current medicines (stopped ones are left out), with their times and, from the eMAR, when each was last given in the last two days; conditions; the latest observations with the NEWS2 score and the latest weight (chapter 13); decisions they lack capacity for, attorneys and advance decisions, and any DoLS, with a reminder that a DoLS does not cover a hospital stay; how to support them (communication, mobility, eating and drinking, continence, personal care, skin and safety, from the care plan), monitoring notes and higher risks; next of kin; and the belongings sent. Every page has a footer saying who printed it and when.

The name they like to be called and how to refer to them are printed under their name at the top. Their **Health and Care Passport** (section 7.8) is printed in full, every part they have written, with the date it was updated and who helped write it. If they have no passport, or no name they like to be called, the window's check list says so before the pack goes.

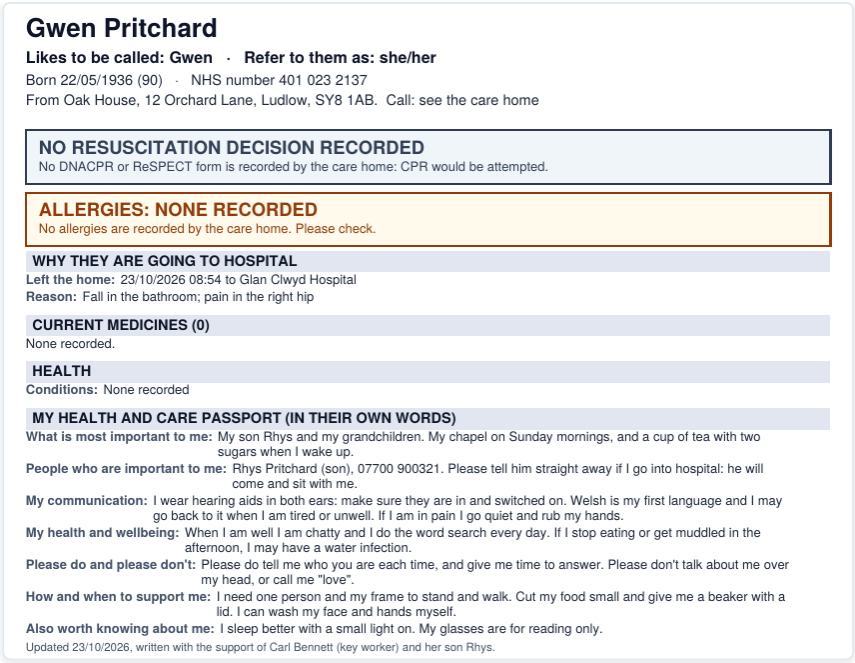


Figure 97. The transfer pack with the Health and Care Passport.

Print the pack only makes the pack without recording a transfer, for example for a planned outpatient appointment. Printing is recorded in the audit log either way.

15.3 Back from hospital

While they are in hospital, the top of their record says *In hospital since…*. When they come back, press **Back from hospital** there (or in the Hospital transfer window), give the date and add notes: the discharge letter, changes to medicines, and whether their belongings came back. The window lists every earlier transfer, with **Print again** to reprint that transfer's pack. Transfers are included in the resident's Subject Access Request, and in the CQC evidence pack under Safe (section 23.1).

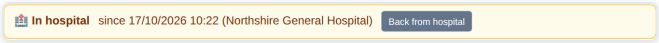


Figure 98. In hospital, at the top of the record.

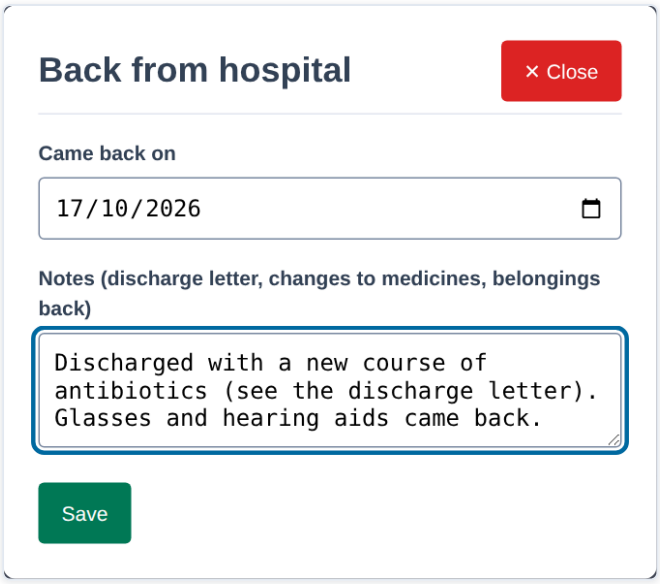


Figure 99. Back from hospital.

16. Medication (eMAR)

> **Who can use it:** Admins, care providers and support workers. Recording a dose needs medication training that is in date. Family members never see this tab.

The Medication tab is the electronic medication administration record, the eMAR. It replaces the paper MAR chart: each dose is recorded as it is given, by the person giving it, and the app keeps the chart.

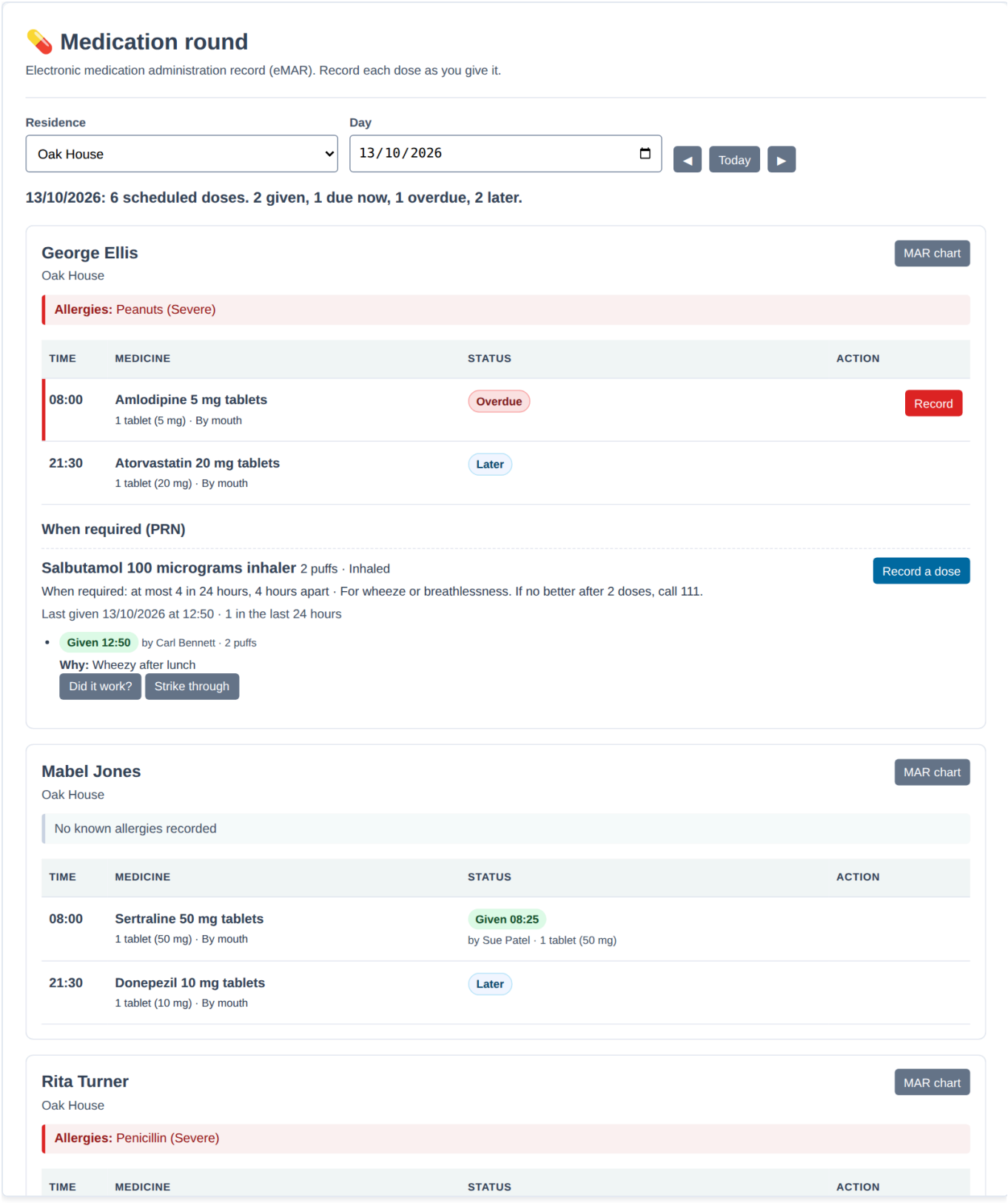


Figure 100. The medication round at Oak House: a dose overdue, one due now, and the when-required medicines.

16.1 Adding a resident's medicines

Medicines are added in the resident's record, in the **Medications** section (section 7.3). Only Admins and care providers can add, change, stop or delete them; support workers can see them.

Press **+ Add Medication** and copy the details exactly from the prescription label or the pharmacy's MAR:

- **Medicine** and **Dose**, for example "Metformin 500 mg tablets" and "1 tablet (500 mg)", and **How it is taken** (by mouth, inhaled, patch and so on).
- **When it is given**: *At set times* (add each time, up to eight a day, and tick the days if it isn't every day, such as a weekly tablet) or *When required (PRN)*.
- For a when-required medicine: **When to give it**, the **most doses in 24 hours** and how many **hours apart** doses must be. The app refuses a dose that would break either limit.
- **Starts** and, if it is a short course, **Ends**; and any **Instructions** (with food, don't crush).
- **Controlled drug**: tick it for medicines such as morphine or buprenorphine patches. Say what the stock is counted in (ml, tablets, patches) and how much one dose uses. Every dose then needs a witness, and the stock is kept in a register (section 16.5).

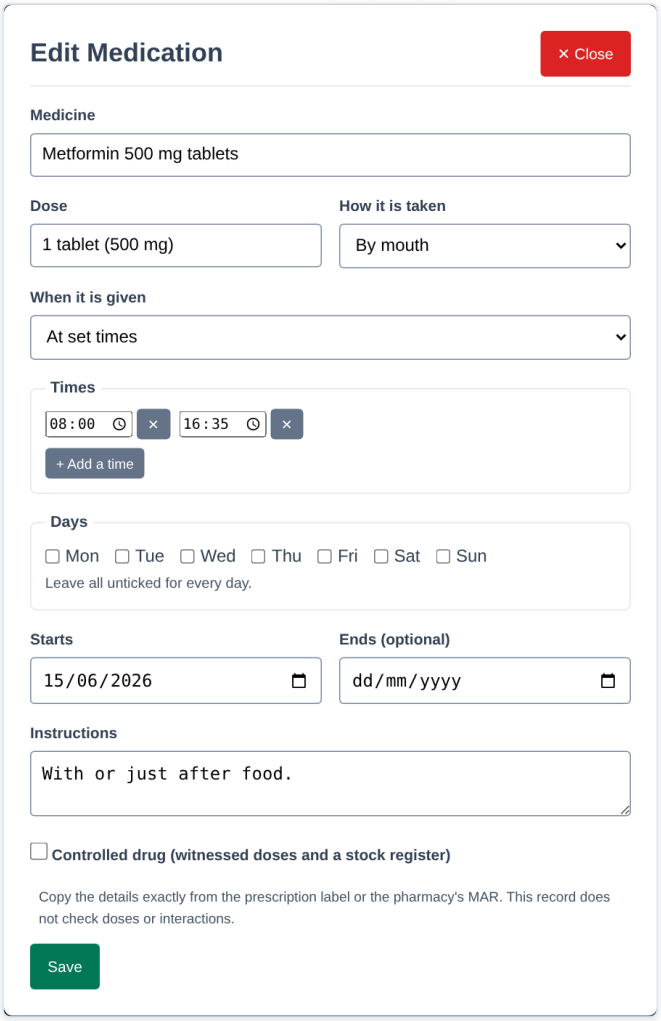


Figure 101. A medicine given at set times.

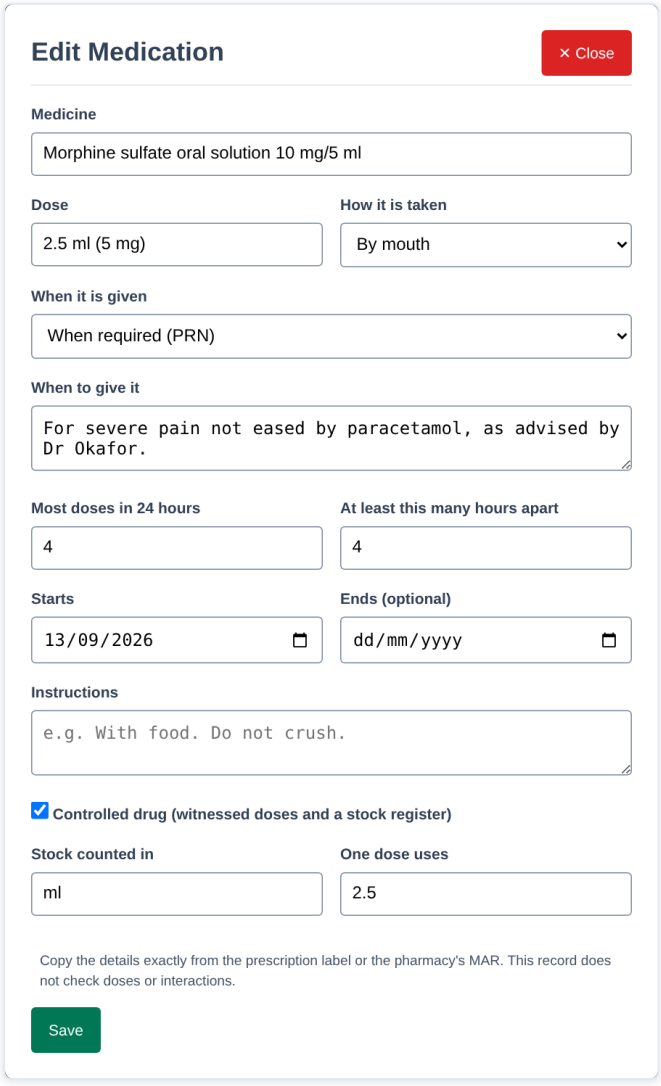


Figure 102. A when-required controlled drug.

The section lists each medicine with its schedule. **Edit** changes it (the earlier version is kept, and the medicine is marked Amended). **Stop** asks for the last day it is given and who stopped it and why; it stays on the record and the chart, and no more doses are due. **Delete** is only for a medicine added by mistake: once any dose has been recorded, it can only be stopped. **Register** opens a controlled drug's stock register, and 💊 **MAR chart** opens this month's chart.

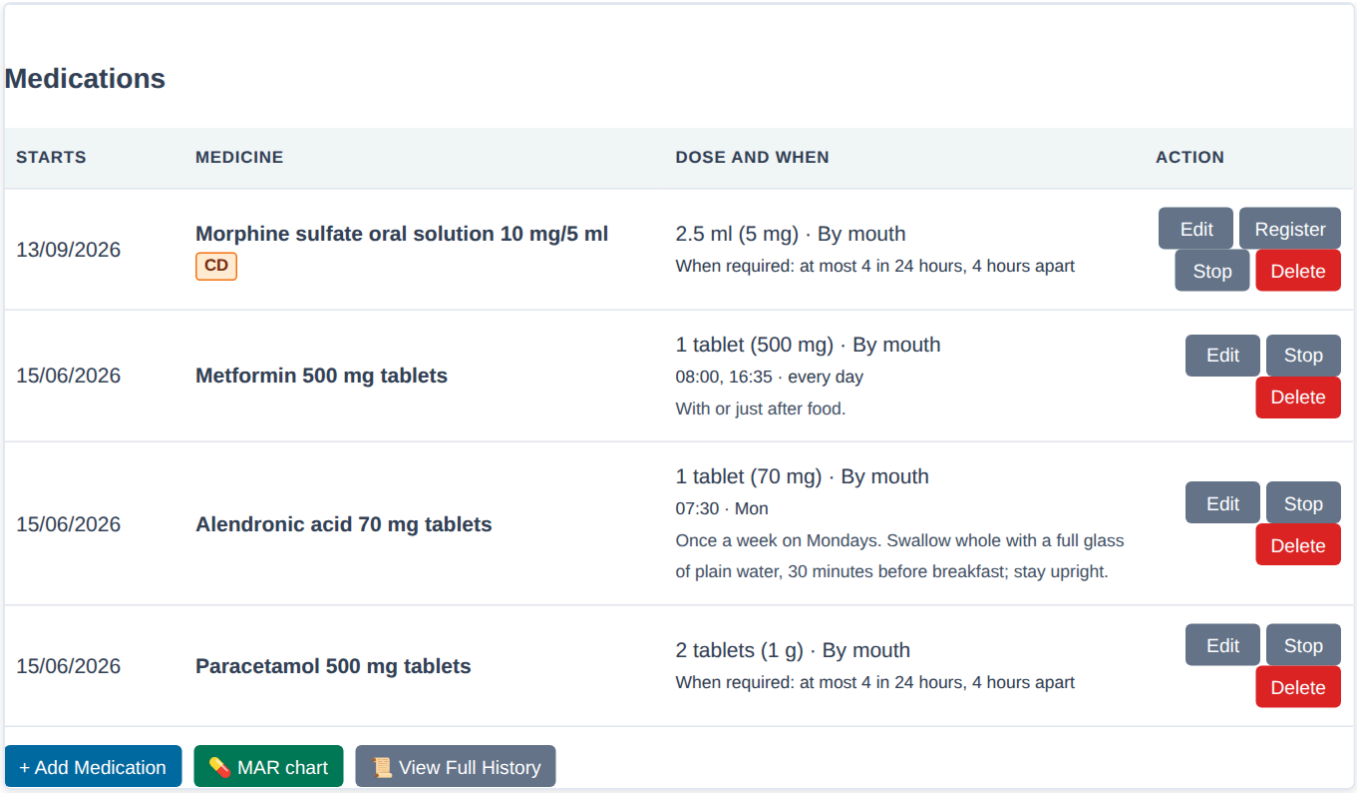


Figure 103. The Medications section of Rita's record.

The app records what was prescribed and what was given. It does not check doses, interactions or allergies against medicines, so the details must be copied carefully, and changes made only on the prescriber's instructions.

16.2 The medication round

Open the **Medication** tab. It shows today for all your residences; choose a residence, or use ◀, **Today** and ▶ to look at another day. The line at the top counts the day's doses. For each resident you see their allergies (or "No known allergies recorded"), then each dose in time order with its state:

Later
: More than an hour before its time.

Due now
: From an hour before to an hour after its time. Press **Record**.

Overdue
: More than an hour after its time today and not recorded. It also shows on the Dashboard's Medication rounds card.

Not recorded
: An earlier day with nothing recorded. You can still record it for up to three days, as a late entry.

Given 08:20
: Recorded as given, with the time, who gave it, and the witness for a controlled drug.

Refused, Asleep…
: Recorded as not given, with the reason.

16.3 Recording a dose

Press **Record** beside the dose. The window shows the resident, the medicine, the dose and instructions, and their allergies in red: check them before giving anything.

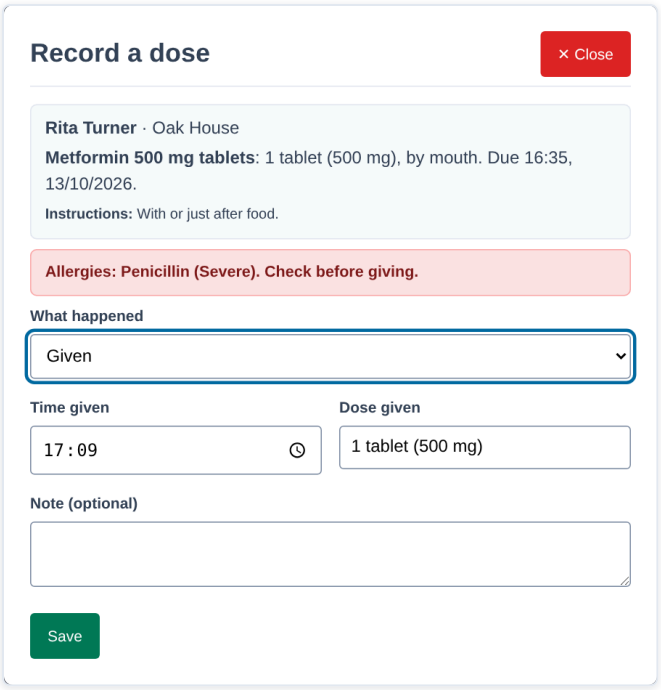


Figure 104. Recording a dose: allergies shown first.

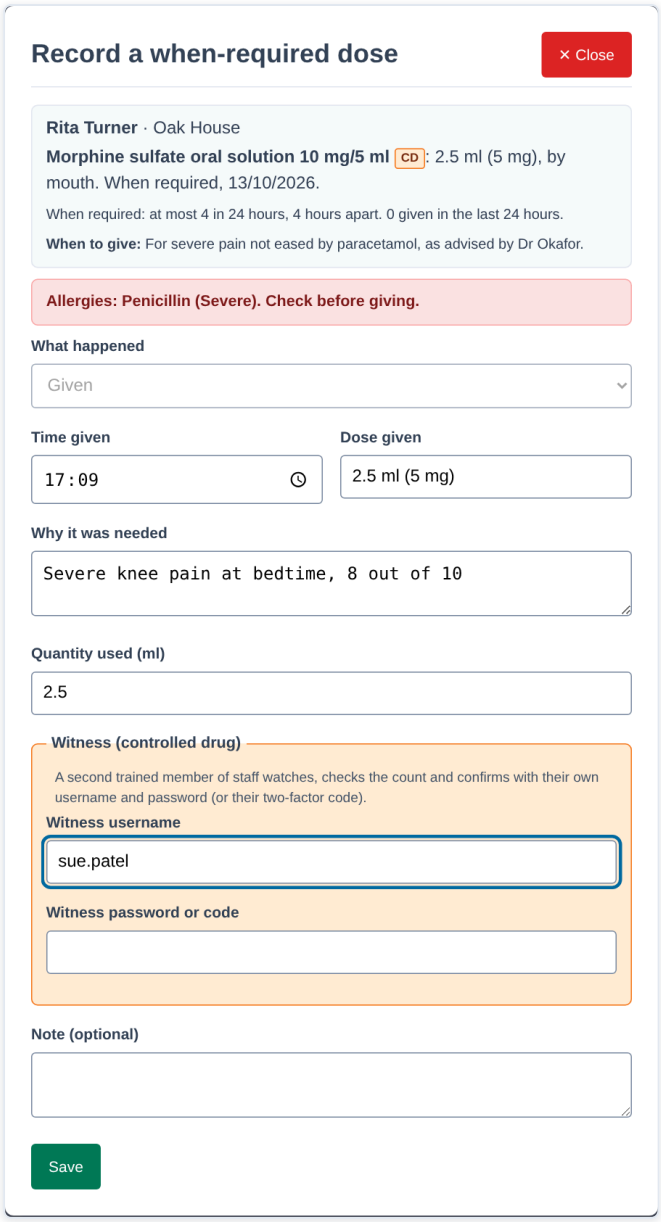


Figure 105. A controlled drug: the witness enters their own username and password.

- **What happened**: *Given*, or why not: refused, nausea or vomiting, asleep, in hospital, away from home, medicine not available, withheld on medical advice, or other. "Other" needs a note saying why; "withheld" needs a note of who advised it.
- **Time given** (now, unless you change it) and **Dose given** (the prescribed dose; change it if something different was given).
- **Note**: anything else, for example "offered again at 09:00".

Each dose can be recorded once. If a colleague has just recorded it, you are told who did, and the round refreshes. A dose can be recorded from an hour before its time; anything recorded more than an hour after the dose time is marked as a *late entry*, showing when it was written.

When-required (PRN) doses. Press **Record a dose** beside the medicine. The window shows the limits and when it was last given. Say **why it was needed**. If the dose would be more than the most allowed in 24 hours, or too soon after the last, it is refused and you are told not to give it. Later, press **Did it work?** to record the effect, for example "Pain eased within half an hour".

Who can record. Only staff whose medication training is in date: a training course with "Medication" in its name (the standard list has *Medication Administration*) recorded for them in the Carers tab (section 24.2), not past its due date. Anyone else sees why at the top of the tab, and no Record buttons.

Mistakes. A record is never changed or deleted. If it is wrong, the person who recorded it (within the edit window) or an Admin presses **Strike through** and says why. It stays on the chart, crossed through with the reason, and the dose can then be recorded correctly.

16.4 The MAR chart

Press **MAR chart** beside a resident (or in their record) to see a month: each medicine and time down the side, the days across, and what happened in each box. A grey box was not due; a dash means nothing was recorded. Today is outlined. Below the chart are notes for every dose with something to say: not given, a note, a PRN reason and effect, a late entry, or a record struck through.

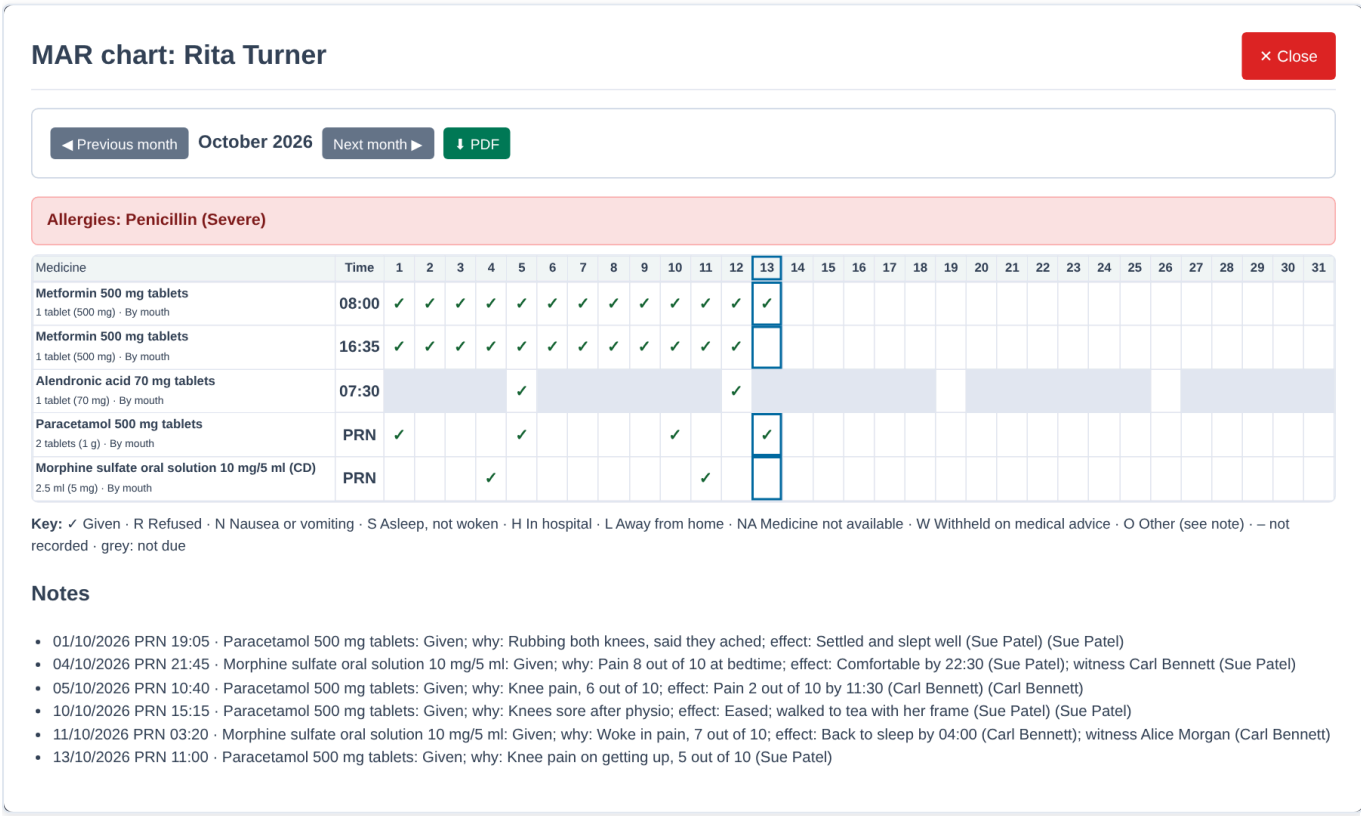


Figure 106. Rita's MAR chart for the month.

⬇ **PDF** downloads the month as a printable chart (landscape A4) for the GP, pharmacist or an inspector. Opening a chart and downloading it are both recorded in the audit log.

16.5 Controlled drugs

Every controlled drug has a register: a running balance of the stock and every movement in or out.

- **Stock received**, **returned to the pharmacy**, **disposed of** or a **correction** (the count was wrong) is recorded by an Admin or care provider in the register window (**Register** in the record).
- **Giving a dose** takes the quantity off the balance automatically.
- Every entry needs a **witness**: a second member of staff, with medication training in date, who works at the resident's residence (or is an Admin). They watch, check the count, and type their own username and password (or

their two-factor code) into the window. You can't witness your own dose. A wrong witness password counts towards locking that account, just as at sign-in.

- The balance can never go below zero: if the register shows too little stock, record what was received first. Striking through a controlled drug dose puts its quantity back, with a witnessed correction.

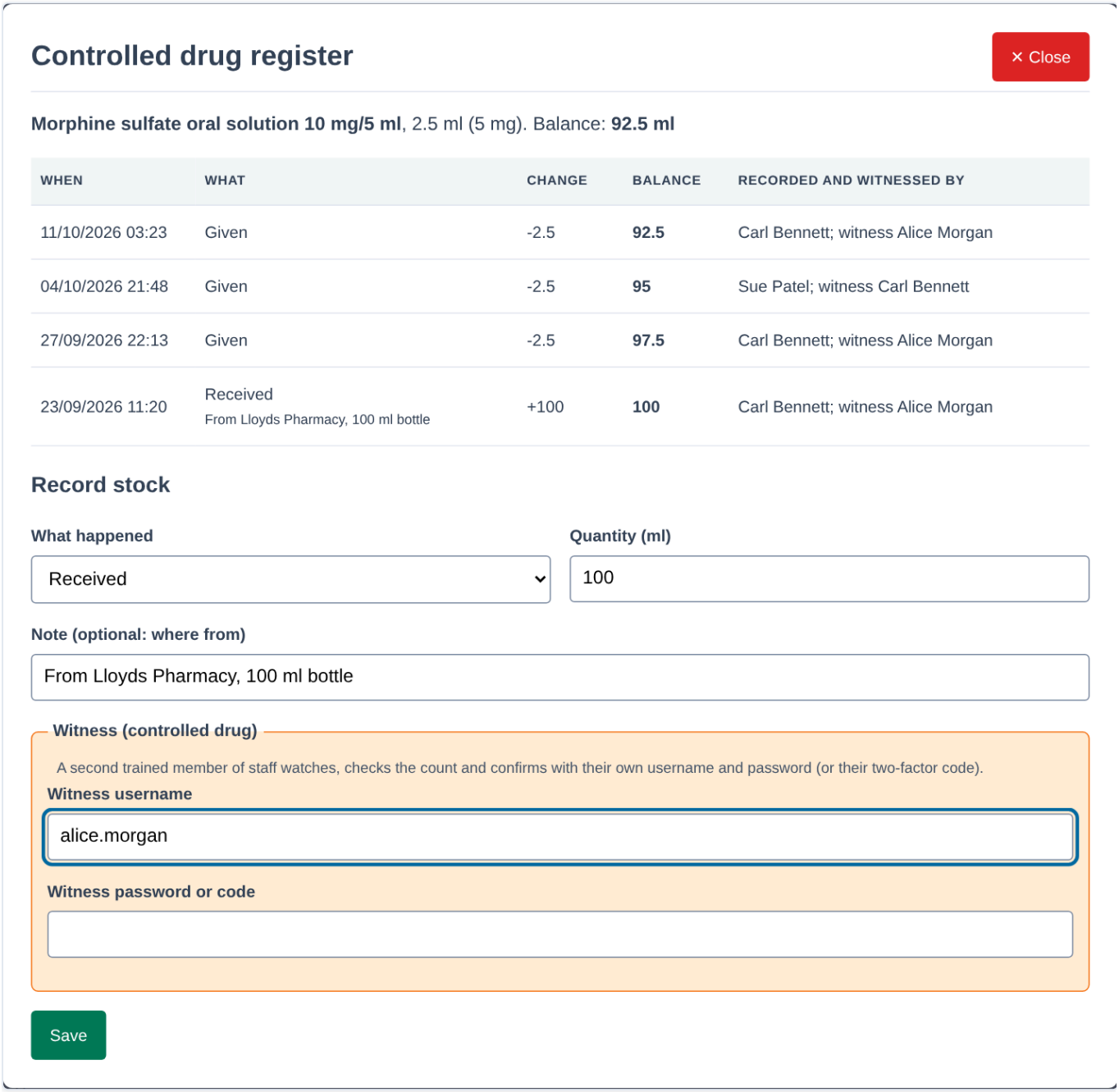


Figure 107. The register for Rita's morphine: every entry with who recorded and who witnessed it.

16.6 On a phone or tablet

The round works on a phone, so staff can record each dose at the resident's side. Each dose becomes a card with its Record button, and the MAR chart scrolls sideways.

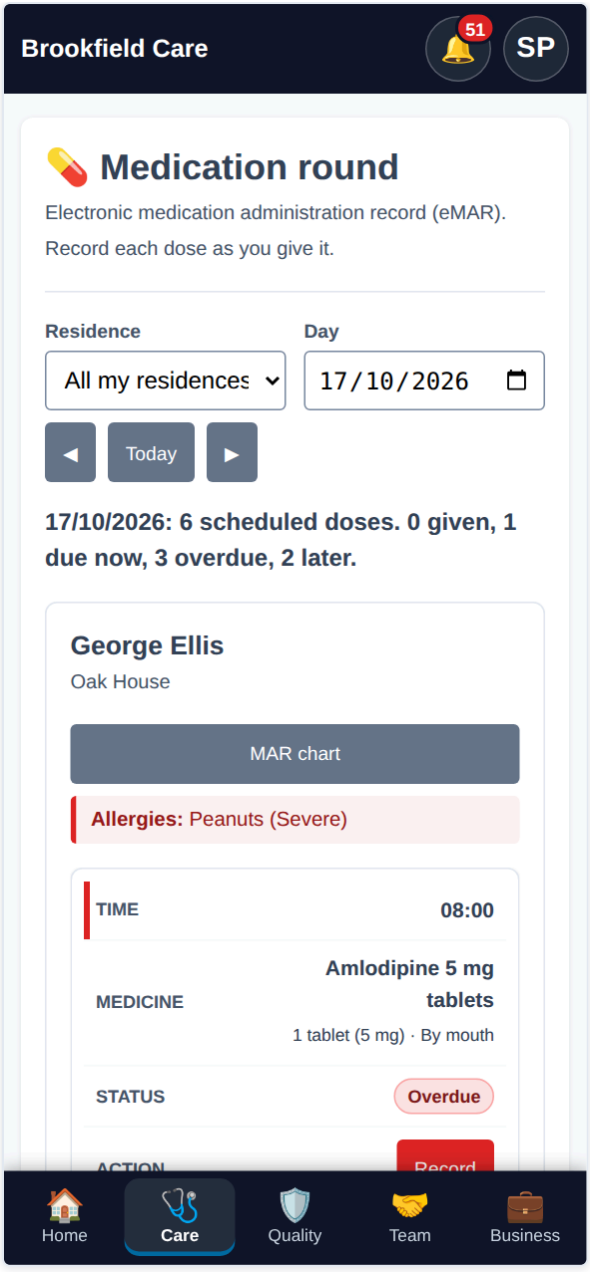


Figure 108. The round on a phone.

17. Events

> **Who can use it:** Admins and care providers create and manage events. Support workers see the events at their residences and reply for residents. Family members see the events they are invited to and reply for themselves.

Events are outings and activities: a trip to the seaside, a Christmas lunch, a garden party. Each event records when and where it is, what it costs, how people get there, who is invited and who is going.

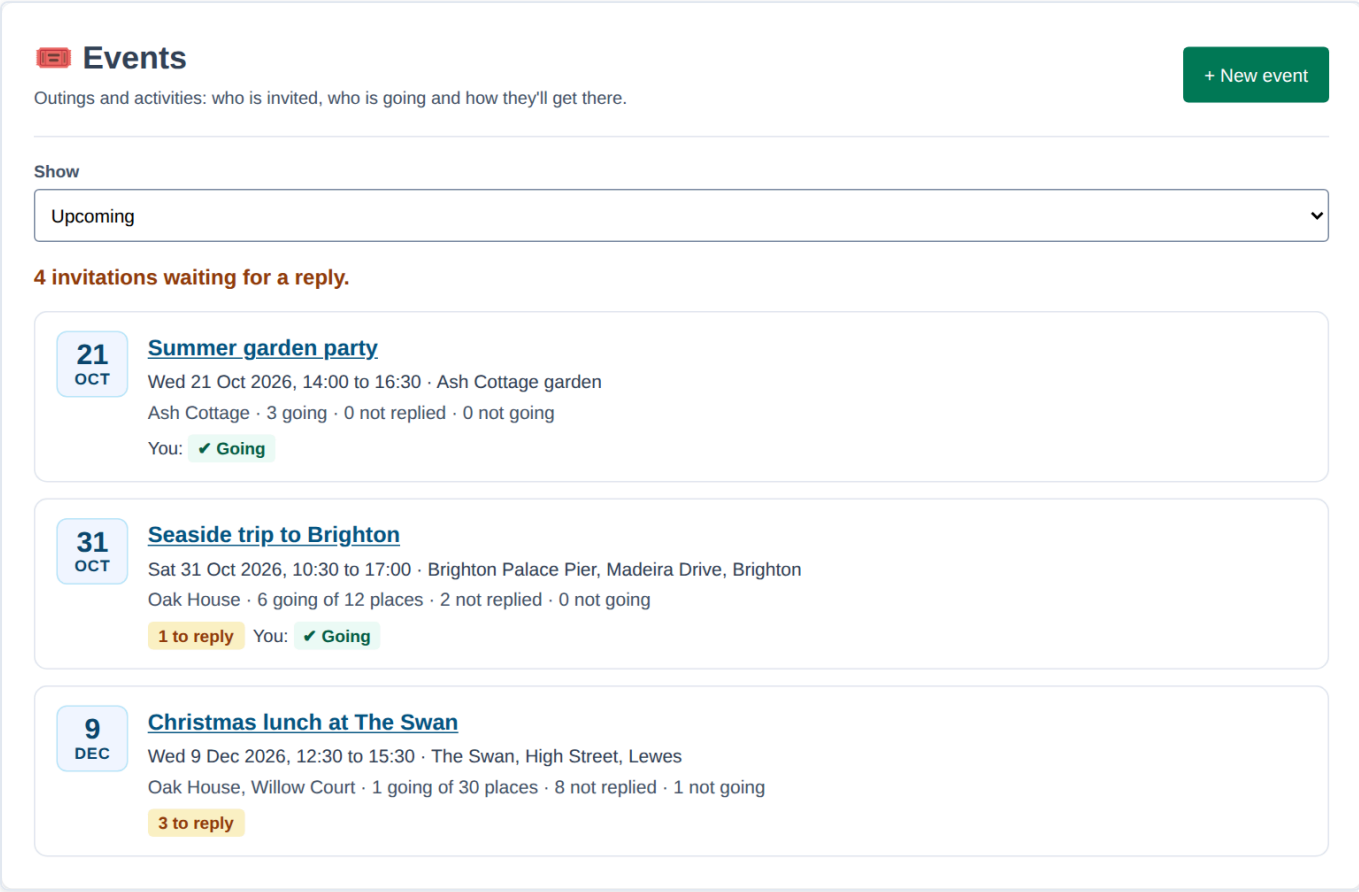


Figure 109. The Events tab: each upcoming event with who is going, and replies waiting.

The tab lists upcoming events, soonest first; choose **Past** under *Show* for earlier ones. Each event shows its date, place, residences and how many are going, not replied and not going. *To reply* means invitations you can answer are waiting; *You* shows your own reply. Click an event's name to open it.

17.1 Creating an event

Press **+ New event** and fill in:

- **Name**, **Description** and **Where**.
- **Starts** and, if you like, **Finishes**.
- **Reply by** (optional): after this date only those managing the event can record replies.
- **Most people who can go** (optional): residents, staff and every family ticket count. Once it is full, nobody else can accept.
- **Residences**: any of your own residences. Residents, staff and family from these residences can be invited.

- **Cost**: *Free*; *a total cost, shared evenly between those going* (for example a minibus and lunch for £240); or *priced per person* (for example theatre tickets at £24). Staff are never charged.
- **Travel**: tick *Travel is needed* to add the meeting point, the times to meet, leave and get back, travel notes, and how people can travel. The four standard options are ticked to start with (going with a carer, going with family, sharing a taxi with other residents, making their own way); untick any that don't apply and press **+ Add another option** for your own, such as *On the minibus*. Everyone invited (except staff) chooses one when they accept.

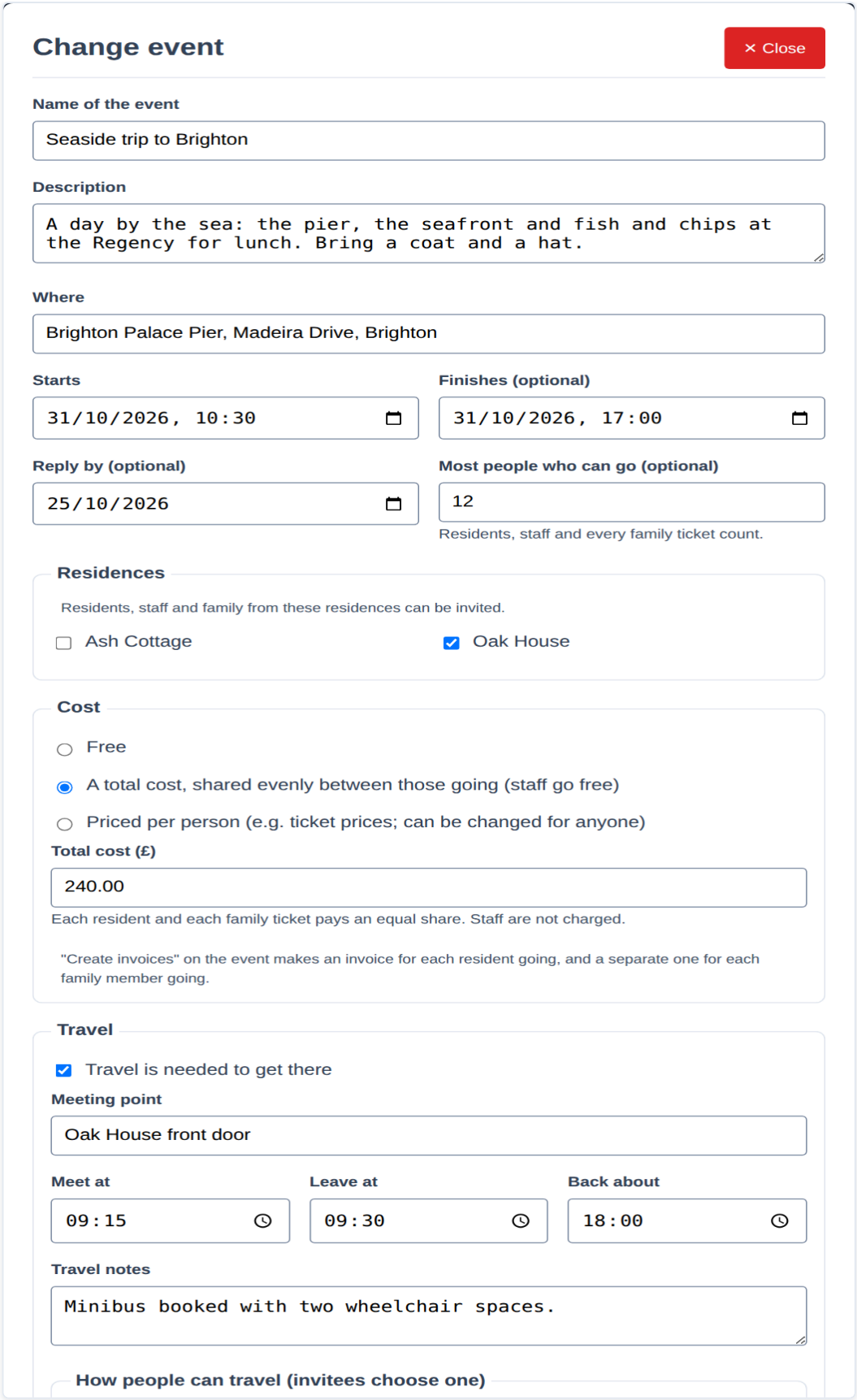


Figure 110. Creating an event: cost and travel.

Saving opens the event. To change it later press ✏ **Edit**. If you change the time, place or travel, everyone invited who hasn't declined is told, in the app and by email. Once invoices have been made, the cost can no longer change.

17.2 Inviting people

Open the event and press ✉ **Invite people**. The window lists the residents of the event's residences, each with their family members, and the staff there. Tick who to invite (**Tick all residents here** ticks every resident of a residence) and press **Send invitations**. Family members are invited with their resident: ticking a family member ticks the resident too. People already invited are shown as *(invited)*.

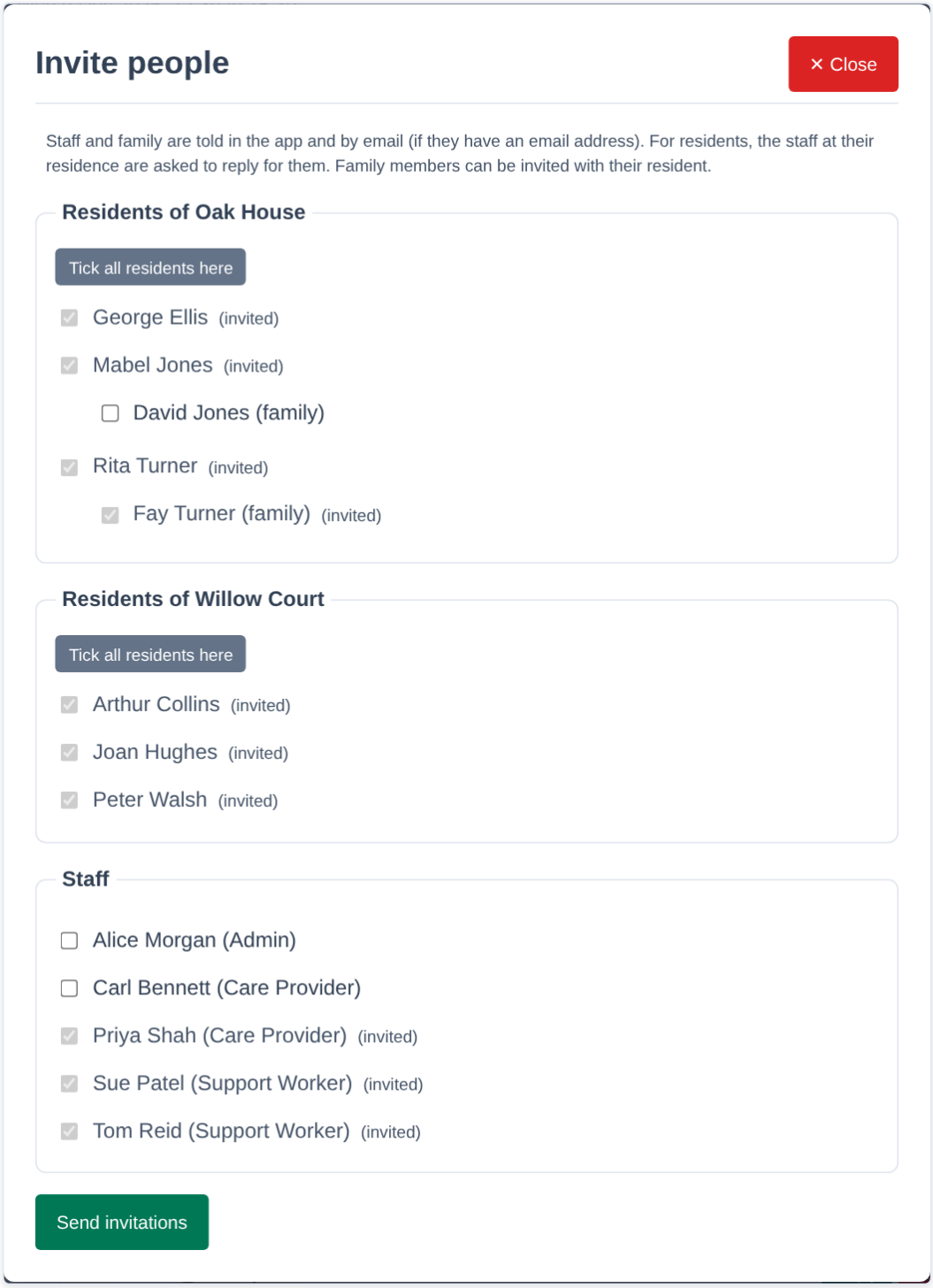


Figure 111. Inviting residents, their family and staff.

Who is told:

- **Staff and family** get a notification (the bell) and, if they have an email address and your email is set up (section 27.3), an email with the details. They reply themselves.
- **Residents** don't have accounts, so the staff at their residence are notified and reply on the resident's behalf.

To take an invitation back, press **Remove** on that row (not once the person has been invoiced; take back a family member's invitation before their resident's).

17.3 Replying

Open the event and press **Reply** on the invitation: your own, or a resident's at your residence. Choose **Accept** or **Decline**. When accepting, choose how they will travel (if the event has travel). Add a note for the organiser if needed, such as a wheelchair space or a dietary need. You can change a reply with **Change reply**.

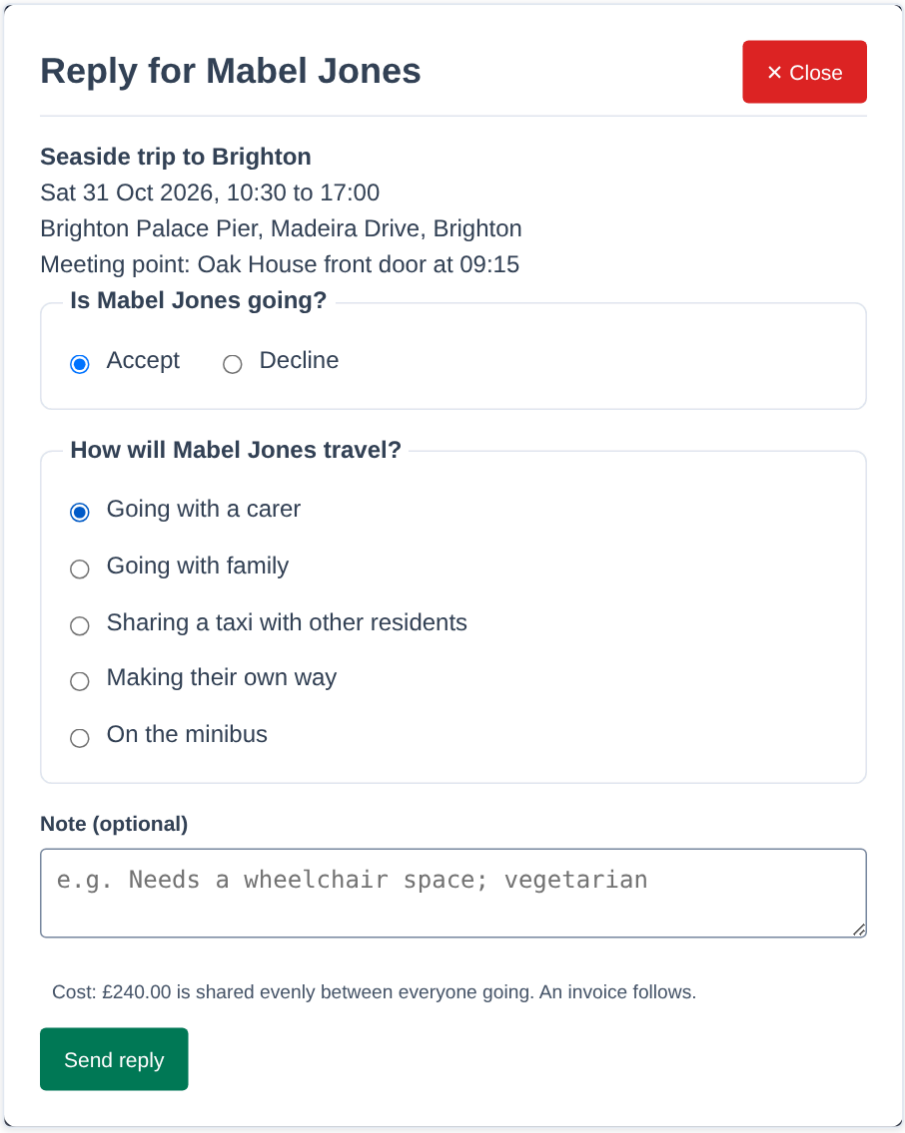


Figure 112. A support worker accepting for a resident.

Family members also say how many tickets they want, themselves included (up to 10), and the names of the others coming with them. Each ticket is one place, and pays for one place.

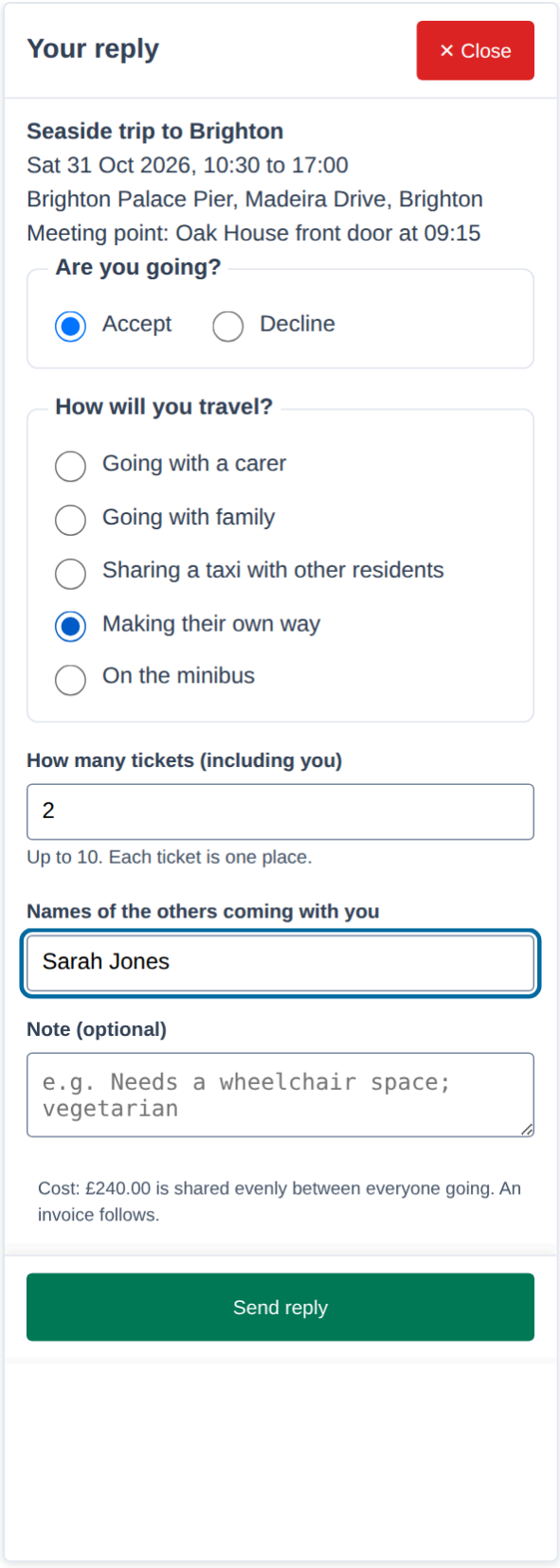


Figure 113. A family member accepting on their phone, with a second ticket.

The organiser is notified of each reply. Replies close when the event starts, or after the *Reply by* date (the organiser can still record one).

17.4 Who is going and what it costs

The event window shows every detail, and a table of everyone invited: their type (*Resident*, *Family* or *Staff*), their reply, how they are travelling, any note, and for staff the amount each pays and their invoice. Family members see only their own invitation and their relative's, and how many are going in total.

How the amount is worked out:

- **Shared total**: the total divided by the paying places (each resident going, and each family ticket). For £240 with six paying places, each place is £40, so a family member with two tickets pays £80. The share is fixed when invoices are first made; anyone who joins later pays the same.
- **Per person**: the price per person for each place. To give one person a different price (a concession, or a carer's ticket paid for by the home), press **Price** on their row; leave it empty to go back to the standard price.

Seaside trip to Brighton

× Close

✏️ Edit | ✉️ Invite people | 💳 Create invoices | Cancel event

When	Sat 31 Oct 2026, 10:30 to 17:00
Where	Brighton Palace Pier, Madeira Drive, Brighton
Residences	Oak House
About	A day by the sea: the pier, the seafront and fish and chips at the Regency for lunch. Bring a coat and a hat.
Places	8 going (2 residents, 4 family, 2 staff) of 12 places
Reply by	25/10/2026
Cost	£240.00 in total, shared evenly between those going (£40.00 each, fixed when invoiced); staff go free
Meeting point	Oak House front door
Travel times	Meet at 09:15, leave at 09:30, back about 18:00
Travel notes	Minibus booked with two wheelchair spaces.
Travel options	Going with a carer Going with family Sharing a taxi with other residents Making their own way On the minibus
Organised by	Carl Bennett

Who is invited

NAME	TYPE	REPLY	TRAVEL	PAYS	INVOICE	ACTIONS
Sue Patel	Staff	✔ Going		Free		Change reply Remove
George Ellis	Resident	✔ Going by Sue Patel	On the minibus	£40.00	EVT-SEASID-20261031-02	Change reply
Rita Turner Note: Needs a wheelchair space	Resident	✔ Going by Sue Patel	On the minibus	£40.00	EVT-SEASID-20261031-01	Change reply
Carl Bennett	Staff	✔ Going		Free		Change reply Remove
David Jones with Mabel Jones 2 tickets: Sarah Jones	Family	✔ Going	Making their own way	£80.00	EVT-SEASID-20261031-04	Change reply
Fay Turner with Rita Turner 2 tickets: Tom Turner (grandson)	Family	✔ Going	Going with family	£80.00	EVT-SEASID-20261031-03	Change reply
Mabel Jones	Resident	⏳ Not replied				Reply Remove

Total to be paid by those going: **£240.00** (6 paying places at £40.00).

Figure 114. An event with its replies, amounts and invoices.

17.5 Invoices

Press 💳 **Create invoices**. You are shown who will be invoiced and how much; press **Create invoices** to make them:

- one invoice for **each resident** going, to the resident's invoicing details, like their other invoices;
- a separate invoice for **each family member** going, addressed to them and emailed to the email address on their account, for all their tickets.

Staff, and anyone not going, are not invoiced. Pressing it again later invoices only those not yet invoiced (for example someone who accepted afterwards). Event invoices are numbered *EVT-*, show the event's date instead of a billing period, and appear in Invoices & Billing (chapter 22) with the event's name, where they are emailed, paid and cancelled like any other. Deleting or cancelling an event invoice lets that place be invoiced again.

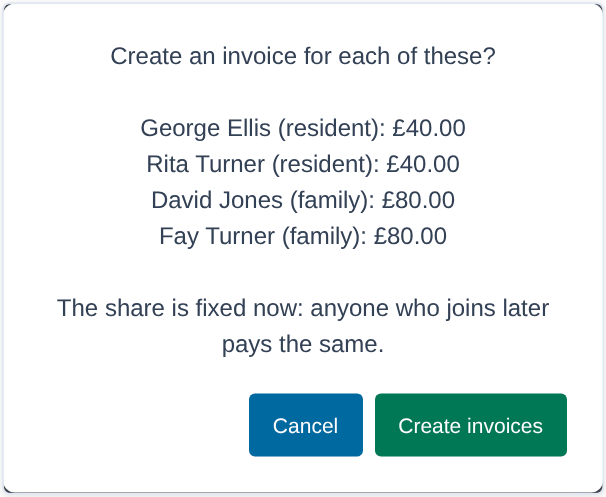


Figure 115. Checking who will be invoiced.

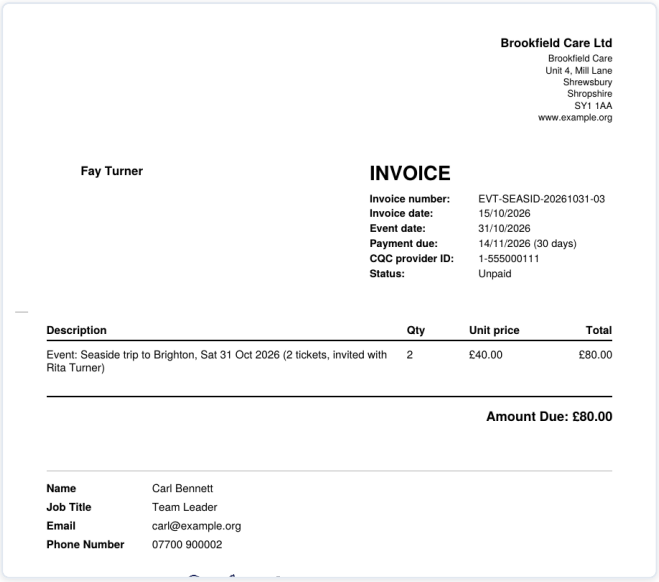


Figure 116. A family member's event invoice.

Event invoices need the Resident invoicing service at the resident's residence (section 27.11). Where it is off, the amounts are shown on the event but no invoice is made.

17.6 Cancelling

Press **Cancel event** and give the reason. Everyone invited who hasn't declined is told, with your reason, in the app and by email. The event stays in the list marked *Cancelled*. Invoices already made are not cancelled automatically: cancel them in Invoices & Billing if they are not owed. An event nobody has been invited to can be deleted instead.

18. Residents' Money

> **Who can use it:** Admins, care providers and support workers at the resident's residence. Admins and care providers can also correct a balance and strike entries through. Family members don't see it.

Many residents keep a little cash with the home for the hairdresser, toiletries, newspapers and outings. The **Money** tab (under Care) keeps an account of that cash for each resident: every amount in and out, a running balance, receipts, and regular cash counts. Every entry is signed off by two members of staff, so no one handles a resident's money alone.

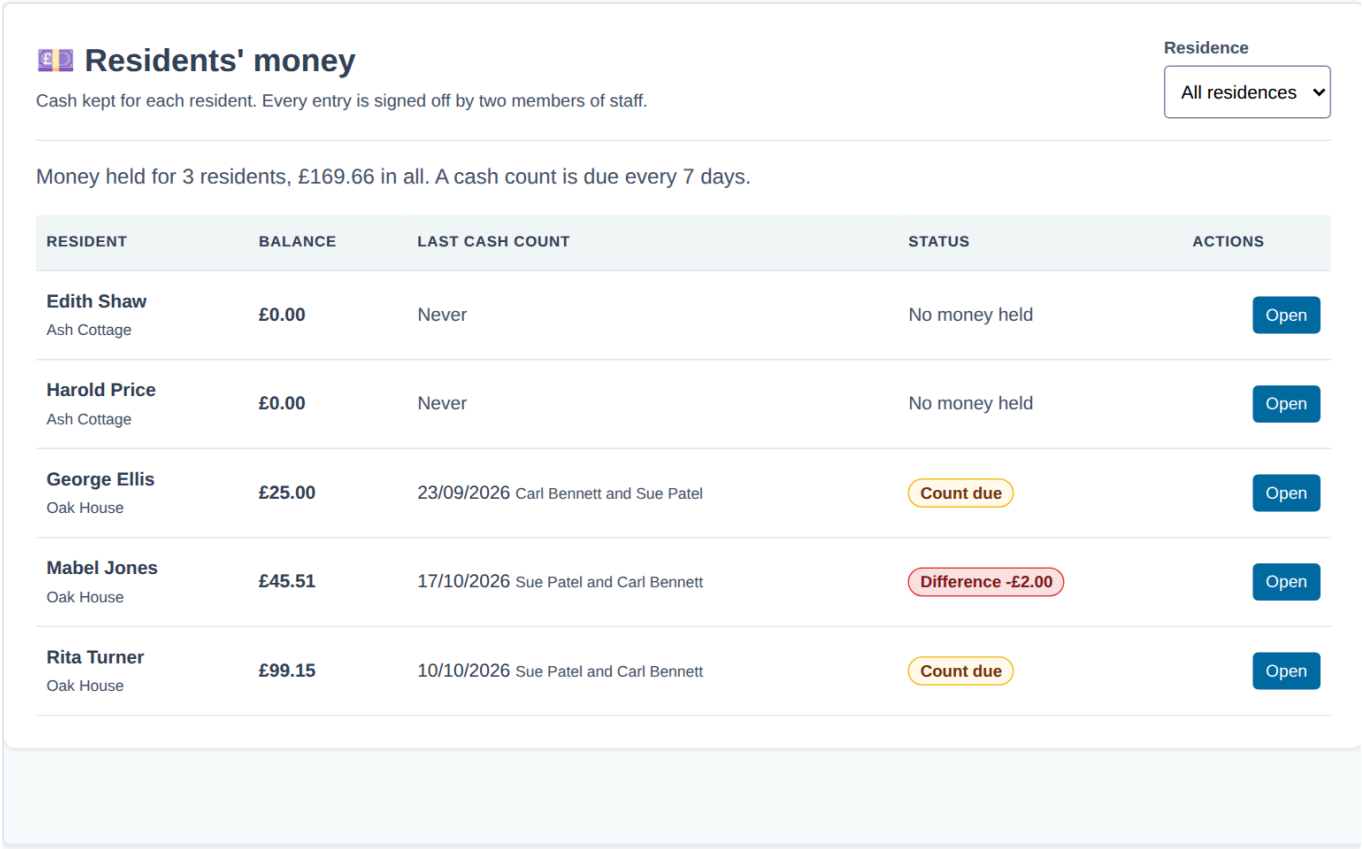


Figure 117. The Money tab: each resident's balance, last count and status.

The tab lists the current residents at your residences (choose one residence at the top to narrow it), with their balance, when the cash was last counted and by whom, and a status: *In order*, *Count due*, *Difference* (the last count didn't match) or *No money held*. Press **Open** to see a resident's account. The same account opens from the **Personal money** section of the resident's record.

18.1 A resident's account

The account shows the balance, the status and every entry, newest first, numbered in order. Each entry has its date, what it was, the amount in or out, the balance after it, who recorded it and who signed it off, and the receipt. Press a receipt to see it.

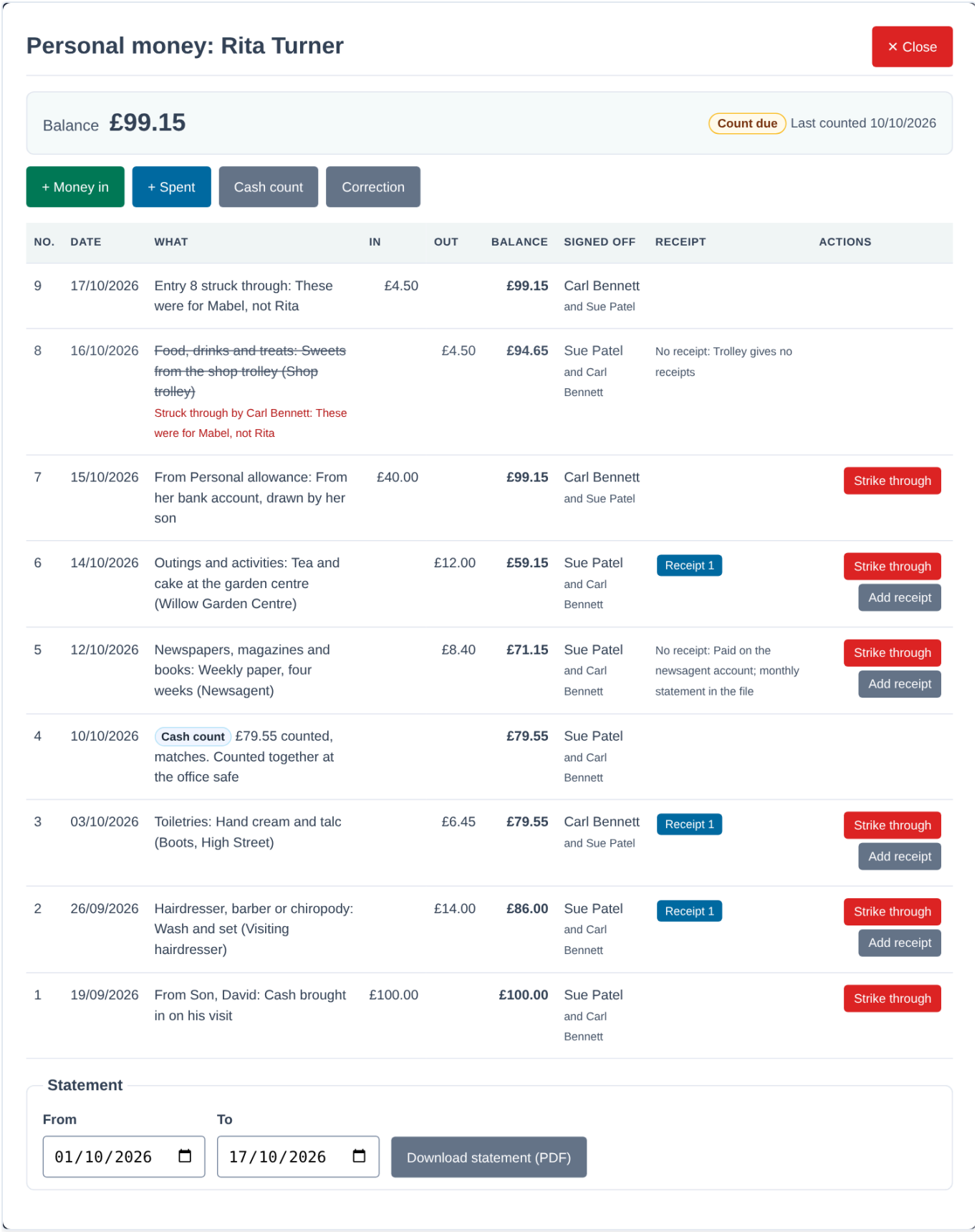


Figure 118. Rita's account: money in, spending with receipts, a cash count and an entry struck through.

Use the buttons at the top to record:

- **+ Money in**: cash brought in by family, drawn from the resident's personal allowance, or from an appointee or deputy. Say who it came from.

- **+ Spent**: what it was spent on (hairdresser, toiletries, clothes, outings, food and treats, newspapers, gifts, transport, money given back to the resident or family, or other), what was bought and where. Add a photo of the receipt, or a PDF. If there isn't one (a shop trolley, say), give the reason: one or the other is needed. A receipt that turns up later can be added with **Add receipt** on the entry.
- **Cash count**: see 18.2.
- **Correction** (Admins and care providers): changes the balance by an amount, up or down, with the reason. Use it after a cash count difference has been looked into.

The date can be up to 31 days back (for something recorded late), but not in the future. Spending can't take the balance below £0.00. To start an account for cash the home already holds, count it with a colleague and record it as **+ Money in** from "Opening balance".

The second signature. Every entry needs a second member of staff, who checks the money with you and types their own username and password at the bottom of the window. They can't be you, and must work at the resident's residence (or be an Admin). A wrong password is refused and recorded in the audit log, and nothing is saved.

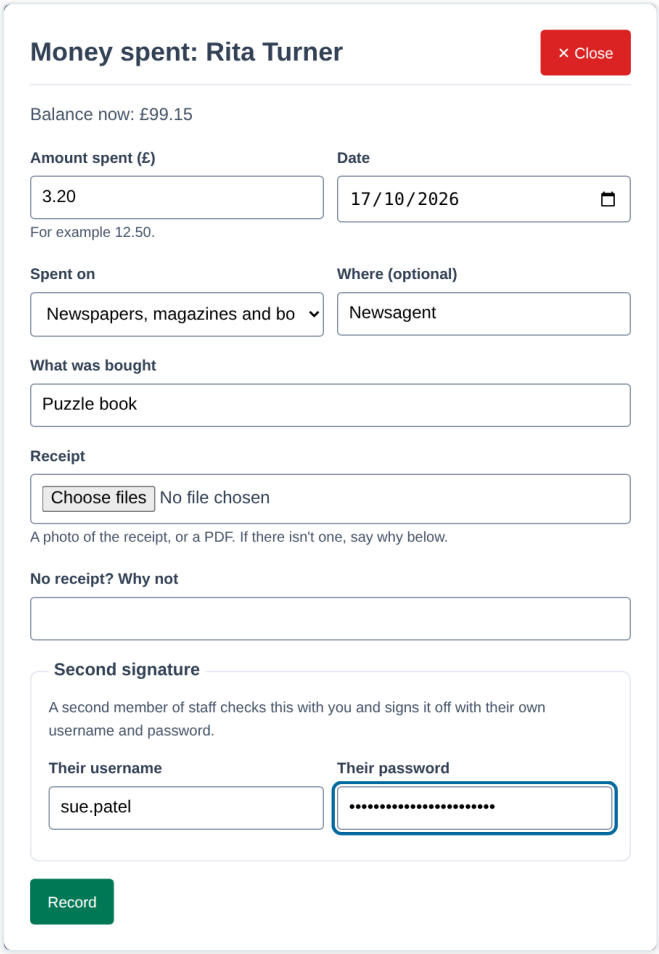


Figure 119. Recording spending, with the second signature.

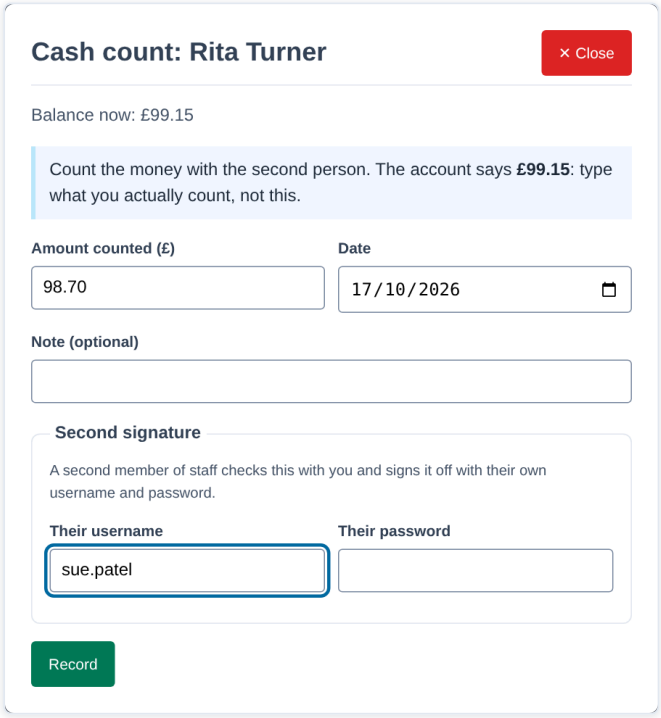


Figure 120. A cash count.

18.2 Cash counts

Count each resident's cash regularly with a second member of staff: every 7 days unless an Admin has changed it in Settings > Compliance & Retention (section 27.2). Press **Cash count** and type what you actually count. The window shows what the account says, but count the cash first and type the real amount, not this.

If the count matches, it is recorded and the status is *In order*. If it doesn't, the difference is shown straight away, the count is highlighted in the account, and the Admins and care providers at the residence are notified. Count again. If it is still different, an Admin or care provider looks into it and records a **Correction** with the reason (and an incident, if money may have been lost or taken). Once the balance matches what was counted, or a later count matches, the status goes back to *In order*. The count itself does not change the balance.

When a count is due, the status says *Count due*.

18.3 Mistakes: striking an entry through

Entries can't be edited or deleted. If one is wrong (recorded against the wrong resident, or twice), an Admin or care provider presses **Strike through** on it, gives the reason, and a second member of staff signs it off. The entry stays in the account, crossed out with who struck it through and why, and a new entry puts the balance back. Then record it correctly.

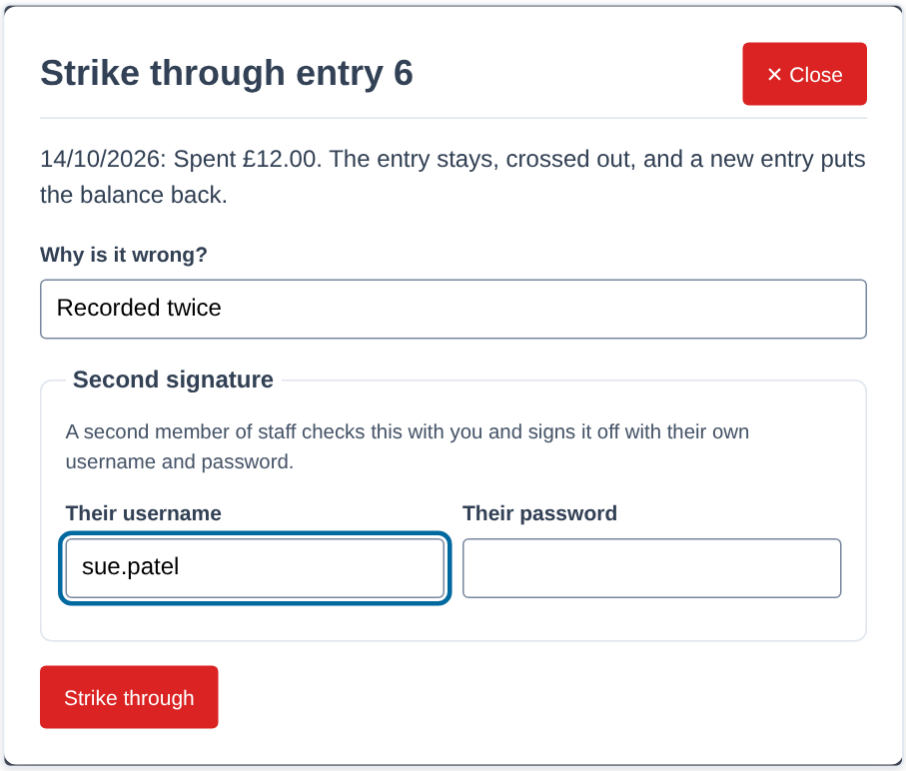


Figure 121. Striking an entry through.

18.4 Statements, the Dashboard and the record

At the bottom of the account, choose a period and press **Download statement (PDF)**. The statement shows the balance brought forward, every entry in the period with who signed it off and whether there was a receipt, the totals in and out, and the balance carried forward. It is useful for the resident, their family or appointee, and for audits.



Personal money statement

Rita Turner — Brookfield Care, Oak House

17/09/2026 to 17/10/2026

Date	Details	In	Out	Balance
17/09/2026	**Brought forward**			**£0.00**
19/09/2026	From Son, David: Cash brought in on his visit - Sue Patel and Carl Bennett	£100.00		£100.00
26/09/2026	Hairdresser, barber or chiropody: Wash and set (receipt) - Sue Patel and Carl Bennett		£14.00	£86.00
03/10/2026	Toiletries: Hand cream and talc (receipt) - Carl Bennett and Sue Patel		£6.45	£79.55
10/10/2026	Cash count: £79.55 counted (matches) - Sue Patel and Carl Bennett			£79.55
12/10/2026	Newspapers, magazines and books: Weekly paper, four weeks (no receipt: Paid on the newsagent account; monthly statement in the file) - Sue Patel and Carl Bennett		£8.40	£71.15
14/10/2026	Outings and activities: Tea and cake at the garden centre (receipt) - Sue Patel and Carl Bennett		£12.00	£59.15
15/10/2026	From Personal allowance: From her bank account, drawn by her son - Carl Bennett and Sue Patel	£40.00		£99.15
16/10/2026	[Struck through] Food, drinks and treats: Sweets from the shop trolley (no receipt: Trolley gives no receipts) - Sue Patel and Carl Bennett		£4.50	£94.65
17/10/2026	Entry 8 struck through: These were for Mabel, not Rita - Carl Bennett and Sue Patel	£4.50		£99.15
	Totals and carried forward	**£144.50**	**£45.35**	**£99.15**

Every entry was signed off by two members of staff (the second with their own password). Receipts are kept on the account. Struck-through entries were reversed by a later entry.

Printed 17/10/2026 by Carl Bennett. Confidential. — Page 1 of 1

Figure 122. A statement for a month.

The **Residents' money** card on the Dashboard (Admins and care providers) lists residents whose cash count is due or didn't match. Due counts and differences are also in the daily email. The **Personal money** section of the resident's record shows the balance and the latest entries, with **Open the account**.

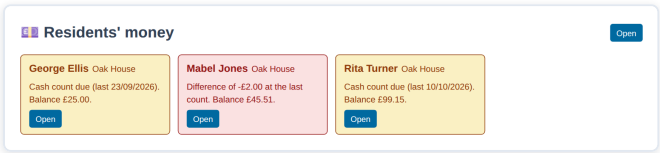


Figure 123. The Dashboard card.

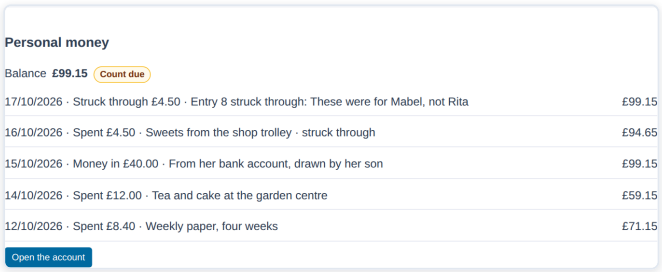


Figure 124. In the resident's record.

Every entry, count, correction, strike-through and failed second signature is in the audit log. The account and its receipts are part of the resident's Subject Access Request, and the CQC evidence pack shows residents' money under Safe (section 23.1). When a resident's record is deleted at the end of the retention period, their money account and receipts go with it. Check your own policy on how much cash may be held and who may handle it.

19. Enquiries and Admissions

> **Who can use it:** Admins, and care providers for their residences (and for enquiries with no residence chosen yet). Support workers see a resident's pre-admission assessment in their record. Family members don't see any of it.

The 📥 **Enquiries** tab (in the Business menu) follows each possible new resident from the first phone call to the day they move in: a visit, the pre-admission assessment, offering a place and admitting them. It also shows how many places are free at each residence.

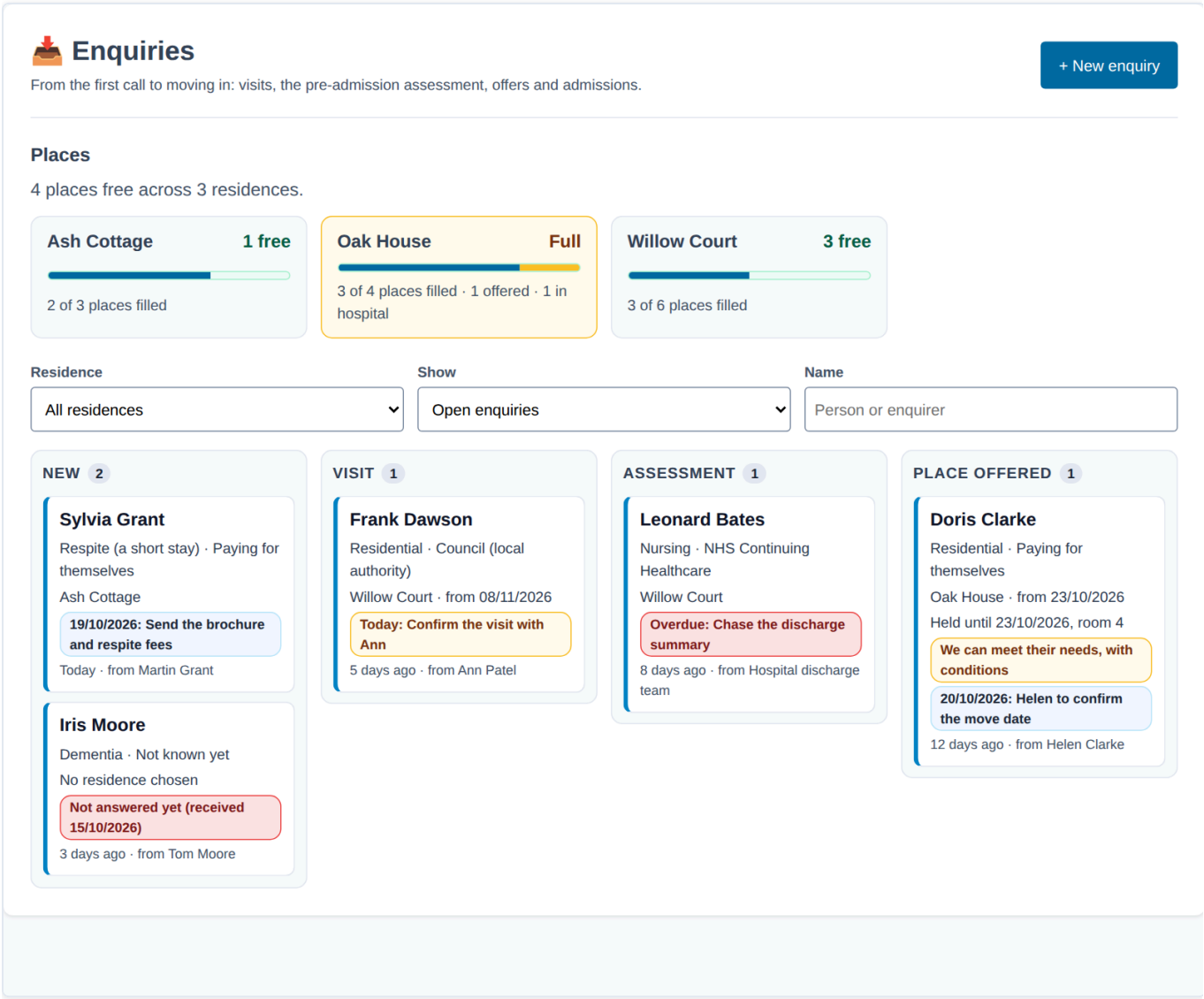


Figure 125. The Enquiries tab: places free at each residence, then the open enquiries by stage.

At the top, **Places** shows each residence's places, how many are filled, any offered and held for someone, and how many are free (and anyone in hospital, whose place is kept). Below, the open enquiries are in a column for each stage: *New*, *Visit*, *Assessment* and *Place offered*. Each card shows the care and funding, the residence, when they would like to move, the assessment's decision and the next step, in amber when it is due today and red when it is overdue or the enquiry hasn't been answered. Choose *Admitted or closed* under **Show** for earlier ones. On a phone the columns are one under the other.

19.1 Recording an enquiry

Press **+ New enquiry**. Give who it is about (a first name is enough to start with), where they are now (at home, in hospital, in another care home), the care wanted, the funding, the residence if they have one in mind, when they would like to move, and their needs in brief: what you were told. Then who got in touch: their name, who they are (a son or daughter, a social worker, the hospital) and a phone number or email address, how they got in touch, and the next step and when (for example *Send the brochure* tomorrow).

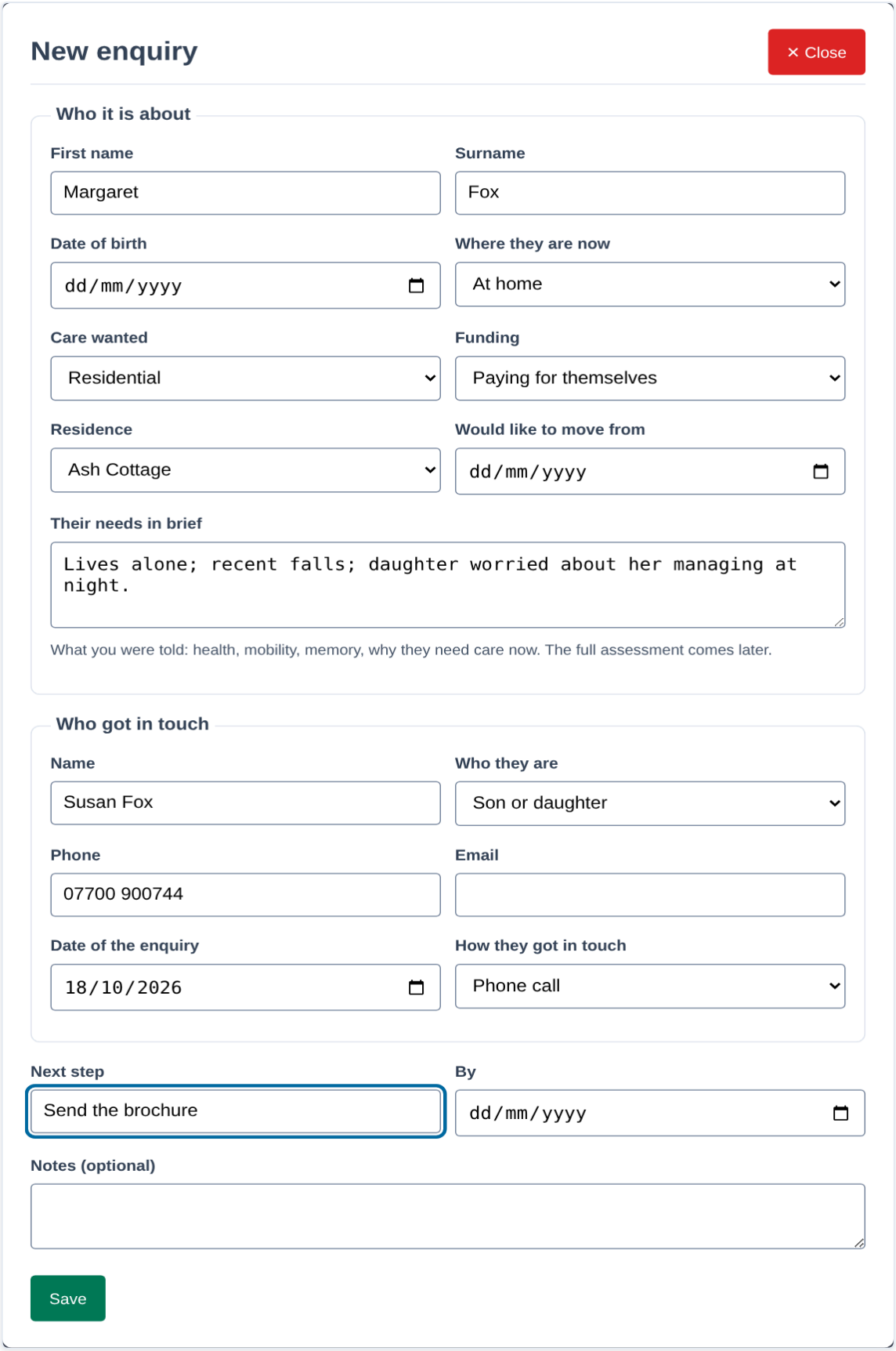


Figure 126. A new enquiry.

The other Admins and care providers at that residence (or all of them, if none was chosen) are told in the bell. A new enquiry with no call, email or visit recorded after 2 days is flagged as not answered (the days can be changed in Settings > Compliance & Retention, section 27.2).

19.2 Working on an enquiry

Press an enquiry's card to open it. Across the top are the stages, with the current one in green. Below are the details (with **Edit details**), the **Next step** and when, and the **History**: add each phone call, email, visit or note as it happens. Changes of stage, the assessment and the offer are added to the history for you, with who and when.

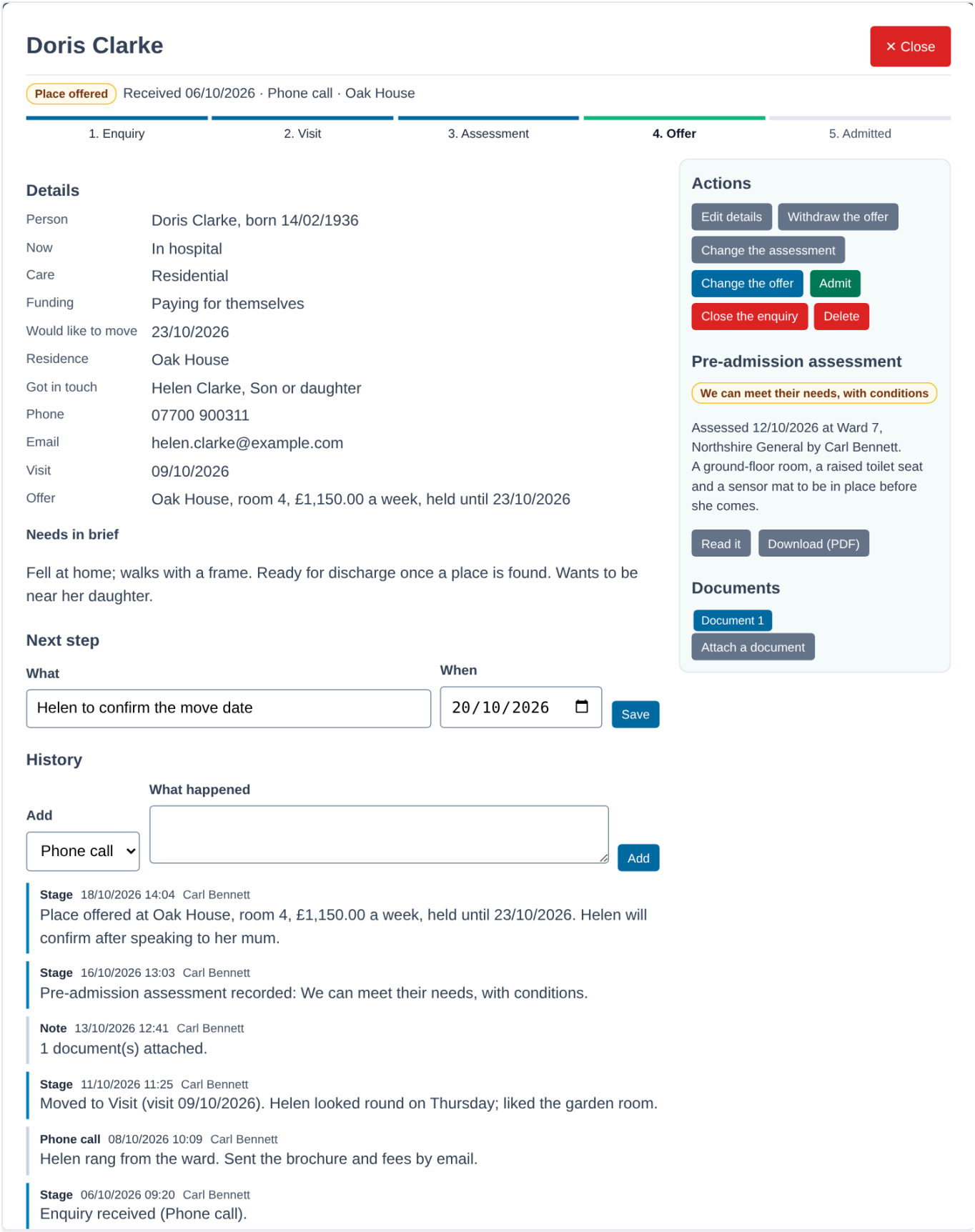


Figure 127. An enquiry: the stages, details, next step, actions, assessment, documents and history.

On the right are the actions: **Move to Visit** (with the date of the visit; recording a visit on a new enquiry does this too), **Move to Assessment**, the pre-admission assessment, **Offer a place**, **Admit** and **Close the enquiry**. **Attach a document** adds a photo or PDF, such as a hospital discharge summary or the council's assessment.

19.3 The pre-admission assessment

Before offering a place, assess the person: in person where possible, with them and the people who know them, and read any assessment from the council or the hospital. Press **Pre-admission assessment** and record the date, where, who assessed and who took part. Then each area of need, each with a prompt: what matters to them, health conditions, medicines, allergies, mobility and falls, personal care, continence, eating and drinking, skin, memory, communication and senses, capacity and decisions, mental health, sleep and night-time, social, cultural and spiritual needs, end of life wishes, risks, and equipment. Leave out areas that don't apply.

Finally, the decision: *We can meet their needs*, *with conditions* (say what: a pressure mattress, training, extra staff) or *We can't meet their needs* (say why). The enquiry moves to Assessment. **Read it** shows the whole assessment and **Download (PDF)** prints it.



Figure 128. Recording the assessment.



Figure 129. The assessment as a PDF.

19.4 Offering a place and admitting

Offer a place: choose the residence (each shows its places free), and optionally the room and weekly fee, and how long the place is held. A place can only be offered where one is free, counting places already offered to others, and not

if the assessment says you can't meet their needs. While it is held, the place counts as taken on the Places tiles. Once the date has passed it is flagged: admit them, change the offer or close the enquiry. **Withdraw the offer** moves it back to Assessment.

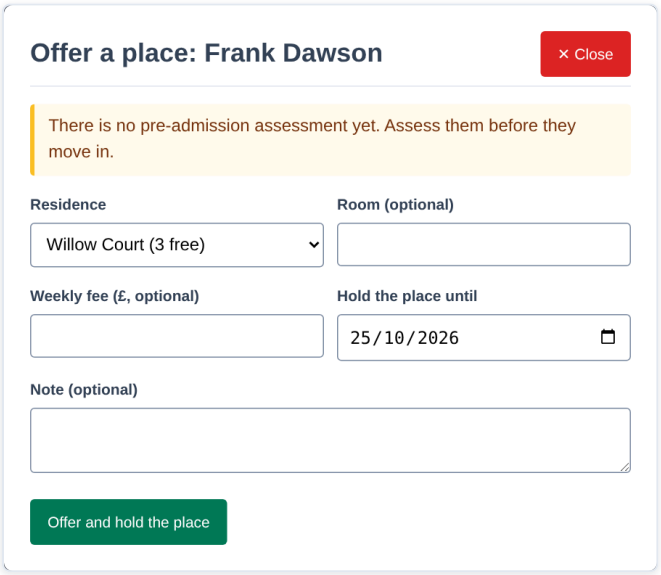


Figure 130. Offering a place.

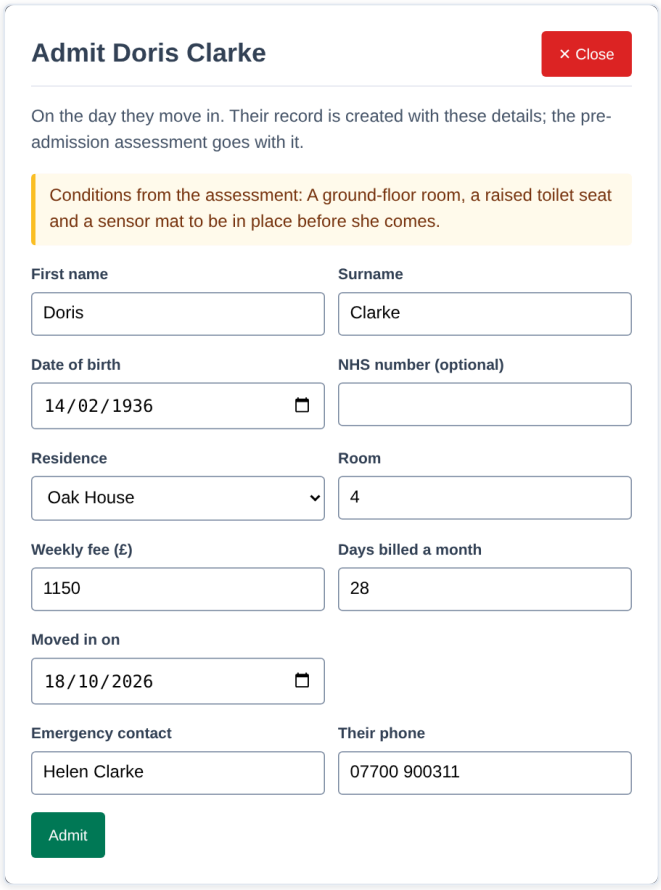


Figure 131. Admitting.

Admit on the day they move in (or up to a month later). The form is filled in from the enquiry and the offer: their name and date of birth, the residence, room, weekly fee and days billed, and the person who got in touch as their emergency contact (not a social worker or the hospital). Add their NHS number if you have it. Any conditions from the assessment are shown as a reminder. Admitting creates their record and placement, as **Add Client** does on the Clients tab, with the pre-admission assessment in it. Then add their care plan, medicines and contacts.

Without a pre-admission assessment, you are asked why: only for an emergency admission. Assess them as soon as you can.

19.5 Closing, the Dashboard and the record

Close the enquiry when they won't be coming, with the reason: chose somewhere else, we can't meet their needs, no suitable place, funding, staying at home, died, couldn't get in touch, or other. A closed enquiry can be reopened. Closed enquiries are kept for 12 months after they closed, then deleted with their assessment and documents by the daily job; the months can be changed in Settings > Compliance & Retention. An Admin can delete an enquiry entered by mistake.

The 📥 **Enquiries** card on the Dashboard (Admins and care providers) shows the places free and enquiries with something to do: a next step due, not answered yet, or a place held past its date. These are also in the bell and the daily email.

In a resident's record, **Pre-admission Assessment** shows how they came to be admitted and the assessment, with its documents, a PDF and (for Admins and care providers) **Open the enquiry**. Support workers see the assessment but not the enquirer's details or the history.



Figure 132. The Dashboard card.

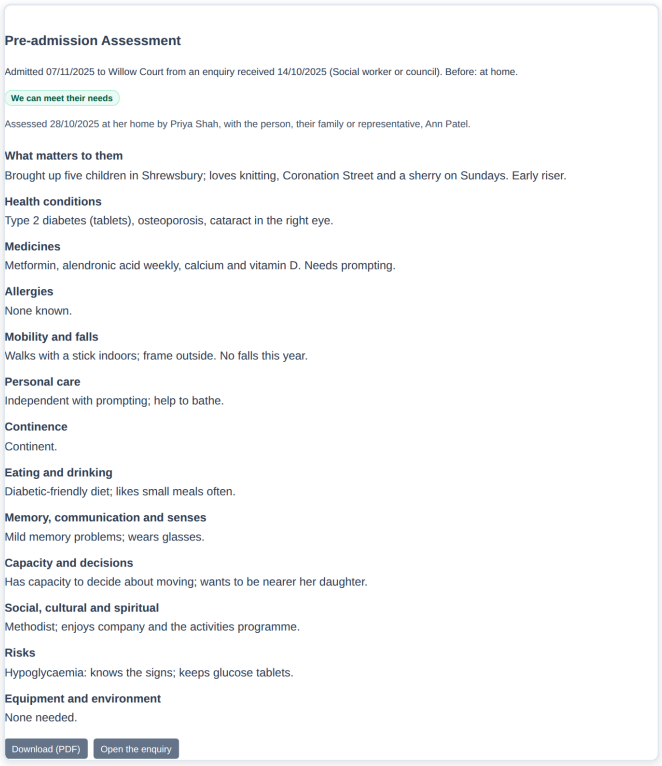


Figure 133. In the resident's record.

Everything about an enquiry is in the audit log. Personal details are stored encrypted. The pre-admission assessment and the enquiry are part of the resident's Subject Access Request, and the CQC evidence pack lists admissions in the period and whether each had a pre-admission assessment before they moved in (Effective, section 23.1). When a resident's record is deleted at the end of the retention period, the enquiry goes with it.

20. Audits and Maintenance

> **Who can use it:** Staff at the residence do audits and report repairs. Admins and care providers manage the actions and repairs; Admins change the checklists. Family members don't see any of it.

The ✅ **Audits** page (in the Quality menu) keeps each residence's quality checks on a schedule, scores them and turns every problem found into an action. The 🔧 **Maintenance** page (in the Business menu) is the log of repairs. Both feed the CQC evidence pack (section 23.1).

20.1 What is due

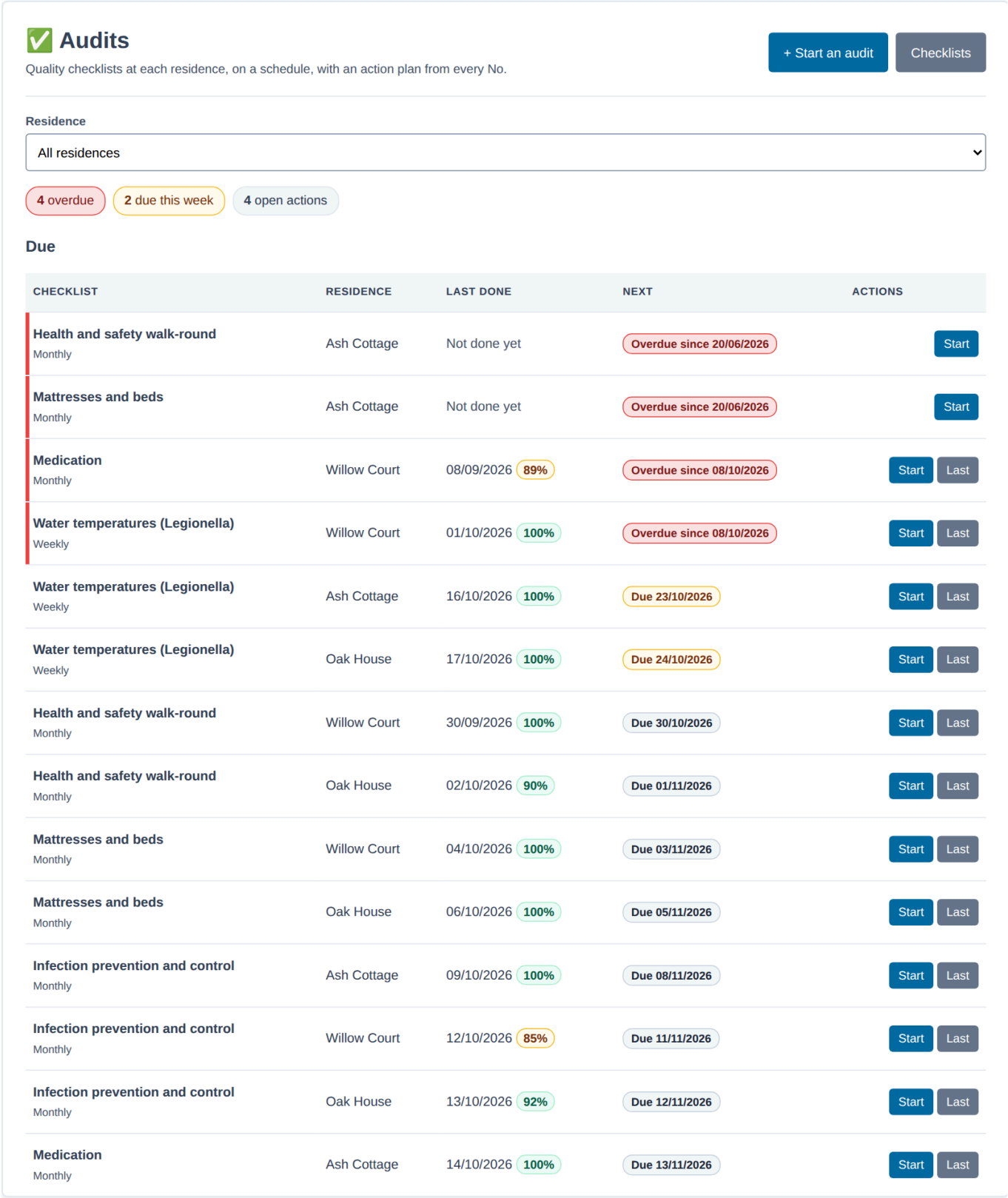


Figure 134. The Audits page: what is due, open actions and recent audits.

At the top are the counts: audits overdue, due this week, and open actions. **Due** lists every checklist at every residence (or the one chosen at the top) with when it was last done and its score, and when it is next due: red when overdue, amber when due within a week. **Start** begins that audit; **Last** shows the last one.

Five checklists come built in, each with its questions:

- **Infection prevention and control** (monthly): hand hygiene, PPE, cleaning schedules, slings, laundry, sharps, waste, fridges and outbreaks.
- **Mattresses and beds** (monthly): covers, foam strike-through, the hand test, pressure mattress settings, beds and bed rails.
- **Medication** (monthly): storage and temperatures, MAR gaps, controlled drug balances, PRN protocols, dating and expiry, covert medicines, disposal, training and allergies.
- **Water temperatures (Legionella)** (weekly): the temperature at each outlet, flushing little-used outlets, shower heads, the hot water store and mixing valves.
- **Health and safety walk-round** (monthly): fire exits and doors, window restrictors, radiators, call bells, trip hazards, lighting, COSHH, wheelchairs and walking aids, hoist inspections and first aid.

A checklist never done yet is first due its number of days after it was added (for example a week for water temperatures).

20.2 Doing an audit

Press **Start** (or **+ Start an audit** and choose the checklist and residence). Answer each question **Yes**, **No** or **N/A**. For a No, say what is wrong: it becomes an action. Every question needs an answer. Add any notes and press **Save the audit**.

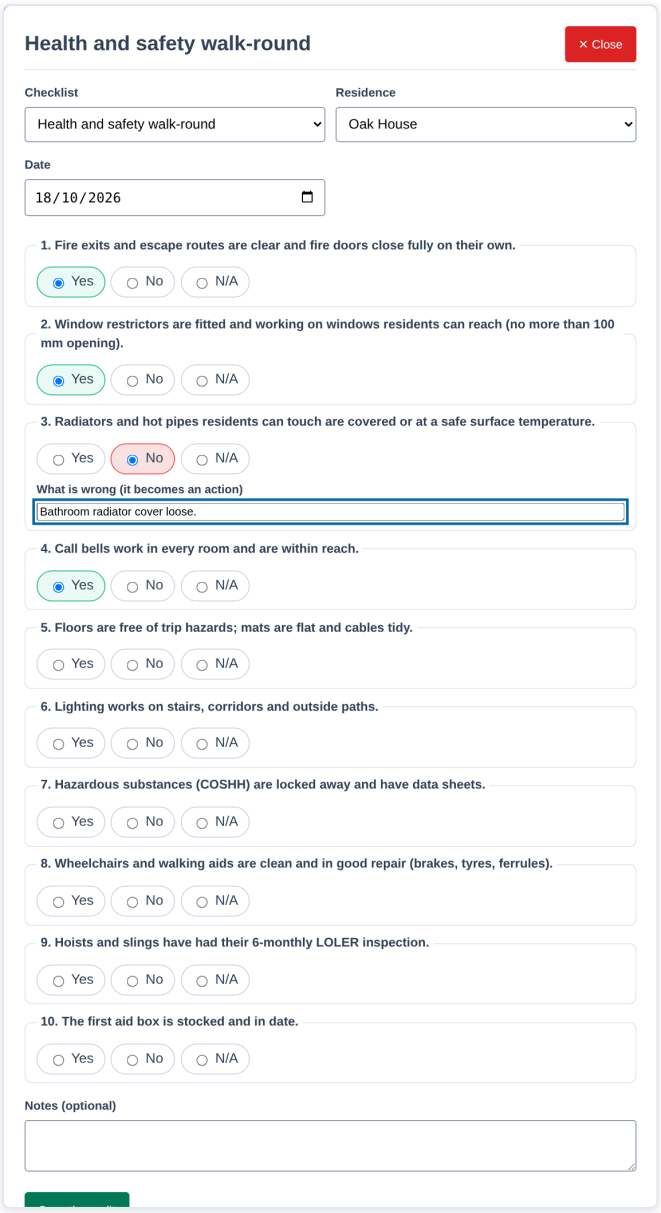


Figure 135. A checklist: a No asks what is wrong.

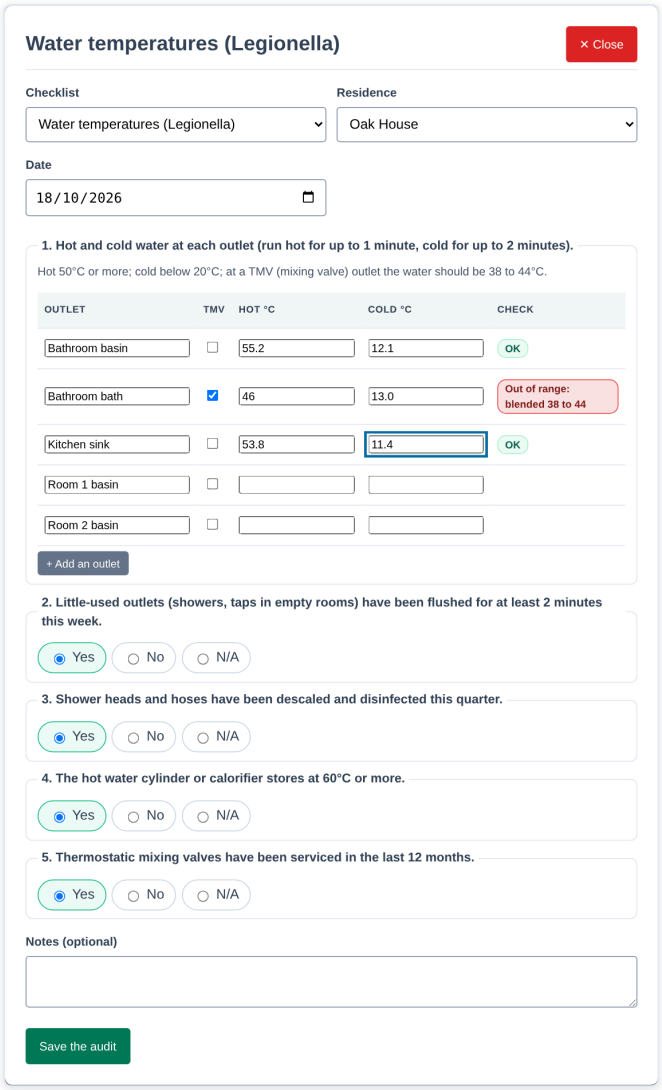


Figure 136. Water temperatures: each reading is checked as you type.

Water temperatures. The table lists each outlet (the ones read last time at that residence, so you only type the temperatures). Run the hot tap for up to a minute and the cold for up to two, and type each temperature. Tick **TMV** where the outlet has a thermostatic mixing valve. Each reading is checked as you type: hot water should reach 50°C or more, cold should be below 20°C, and at a TMV outlet the water should be 38 to 44°C. **+ Add an outlet** adds a row; leave a row empty to skip it. Each reading out of range becomes an action.

The score is the share of questions and readings that passed, leaving out N/A. The result opens straight away, with its actions; **Download (PDF)** prints it. An Admin can delete an audit recorded by mistake (its open actions go too).

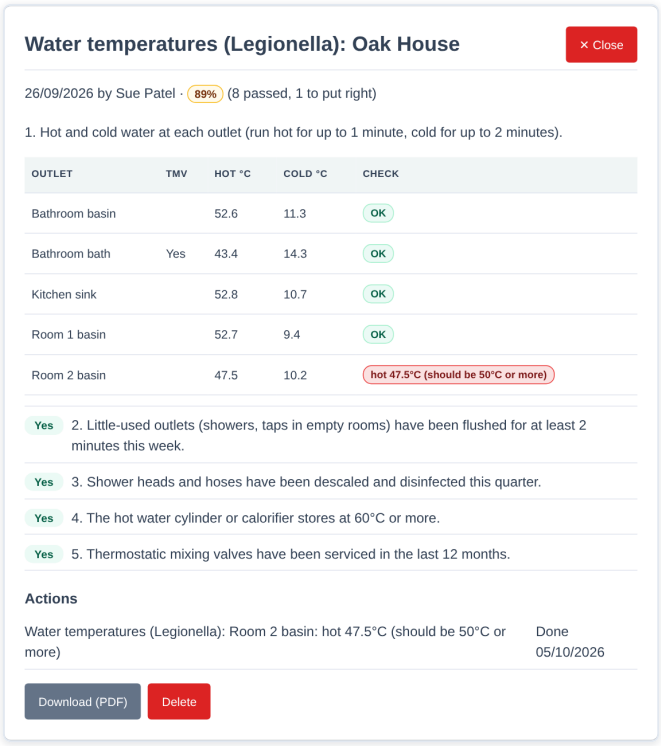


Figure 137. An audit with a reading out of range.

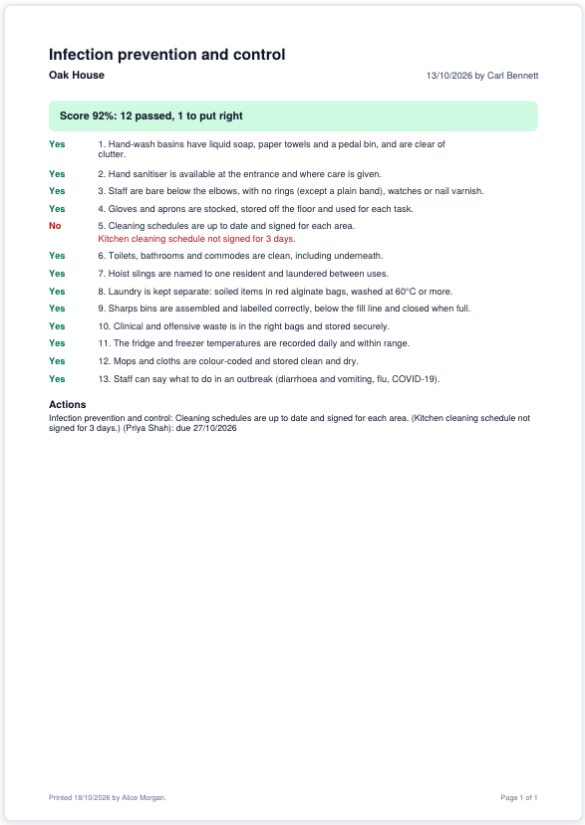


Figure 138. The audit as a PDF.

On a phone, the water table shows each outlet as a card.

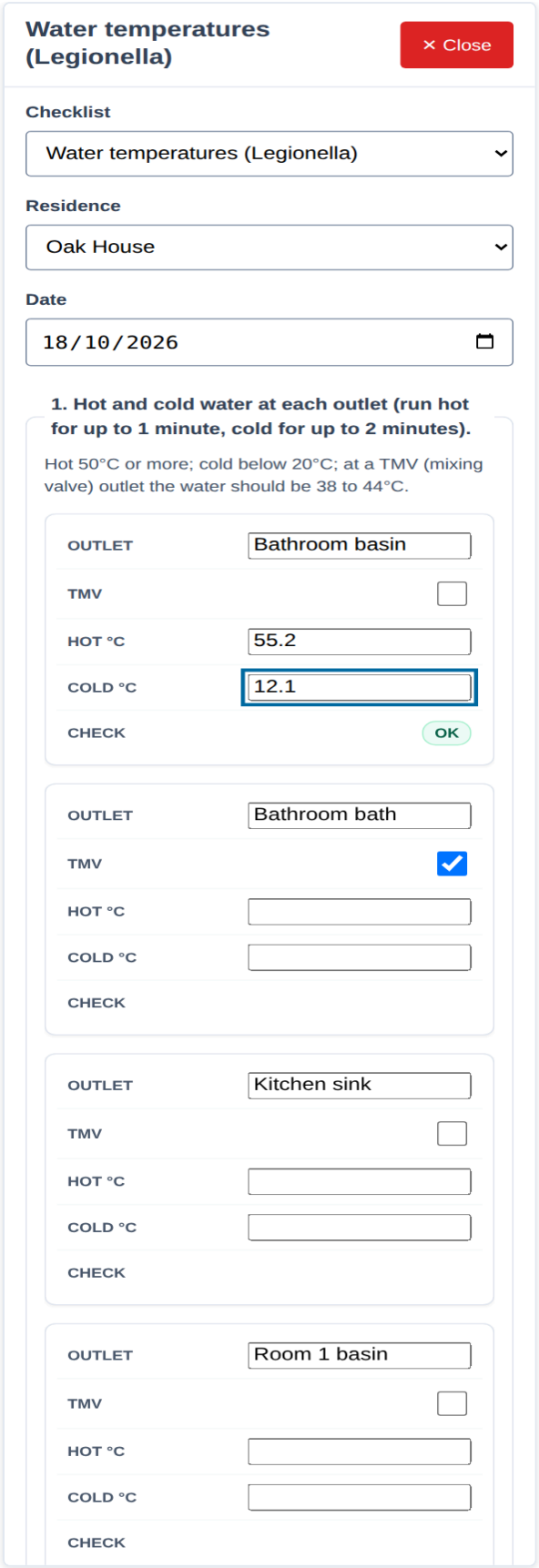


Figure 139. The water table on a phone.

20.3 The action plan

Actions lists what still needs doing, with the residence, who will do it and by when (14 days after the audit to start with), and a link back to the audit. Admins and care providers press **Change** to give it an owner and date, and **Done** to

record what was done. **+ Add an action** adds one that didn't come from an audit (for example from a visit by the fire officer).

Overdue audits and actions are on the ✅ **Audits & maintenance** card on the Dashboard (Admins and care providers), in the bell and in the daily email.

20.4 Changing the checklists

Admins press **Checklists**. Each checklist can be renamed, done more or less often (weekly to yearly), have its questions changed (one per line, each written as something that should be true), or be taken out of use. **+ New checklist** adds your own, for example a dining experience or dignity audit. A line starting *readings:* makes a water temperature table. Changes apply to audits from then on; earlier audits keep their questions.

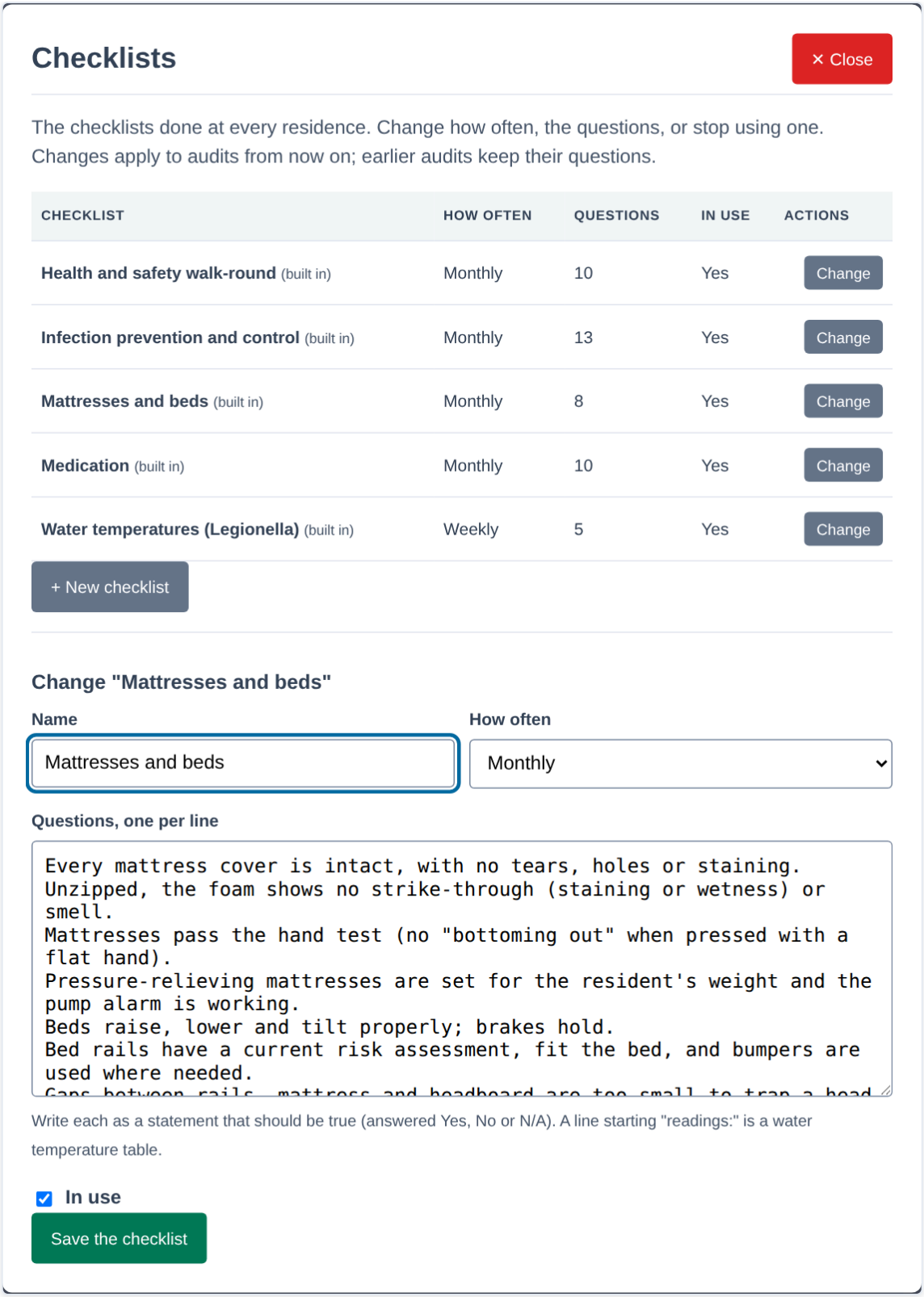


Figure 140. The checklists, with one being changed.

20.5 Maintenance and repairs

Anyone at the residence can press **+ Report a repair** on the Maintenance page: the residence, where (a room or area), the kind of job, how urgent, what is wrong, and photos. *Urgent* is for a risk to someone's safety, or no heating, water or call bell, and is due the next day; *High* within a week; *Routine* within four weeks. The Admins and care providers at the residence are told in the bell.

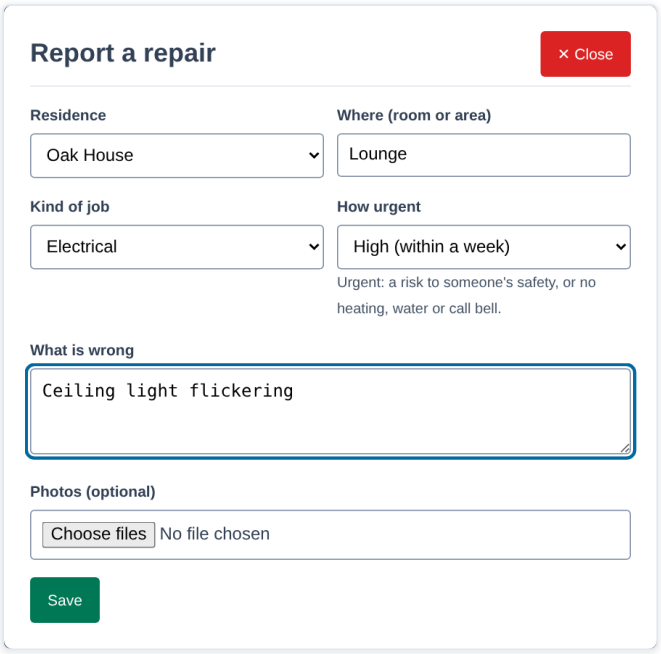


Figure 141. Reporting a repair.

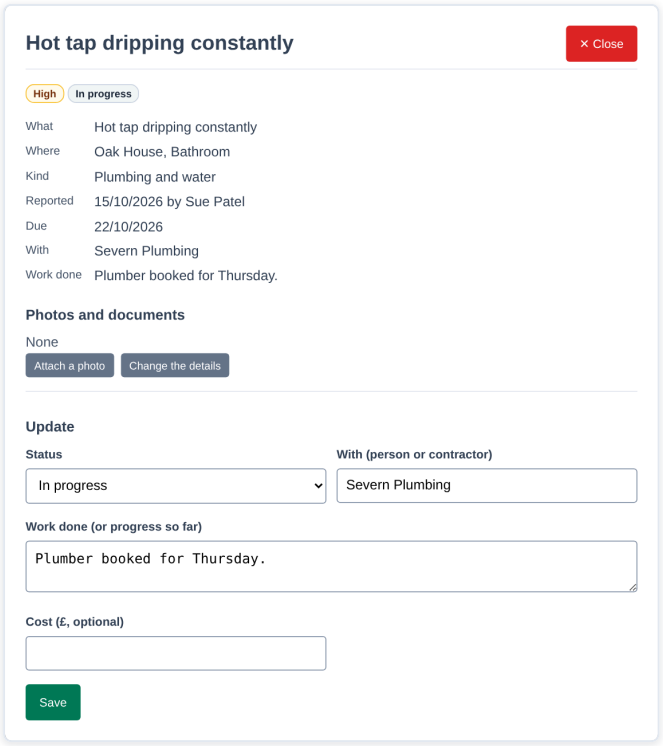


Figure 142. A repair being dealt with.

The page lists open jobs, most urgent first, with overdue ones in red; choose *Done or cancelled* under **Show** for earlier ones. Open a job to see its details and photos (anyone can add a photo). Admins and care providers update it: the status (*Reported*, *In progress*, *Done* or *Cancelled*), who it is with (a person or contractor), the work done and the cost; done and cancelled need the date and what was done or why. The person who reported a job can change its details while it is open.

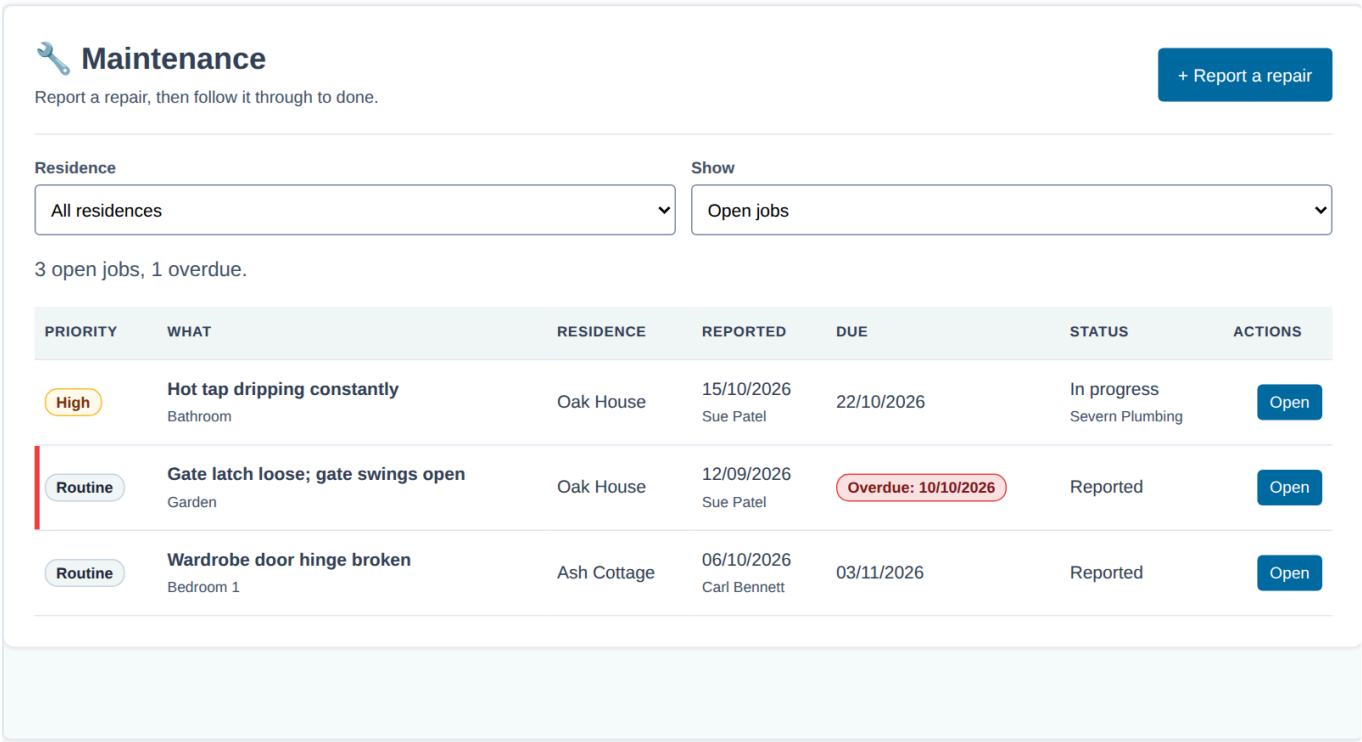


Figure 143. The Maintenance page.

Overdue repairs and open urgent ones are on the Dashboard card, in the bell and in the daily email.



Figure 144. The Dashboard card.

In the CQC evidence pack, audits and their actions are under Well-led (an overdue audit or action is a gap to fix), and repairs and water temperatures under Safe. Every audit, action, checklist change and repair is in the audit log. These checks support, but don't replace, your legally required inspections (gas, electrics, LOLER, the Legionella risk assessment), which stay in each residence's compliance records (chapter 9).

21. Policies

> **Who can use it:** Every member of staff reads and confirms the policies for their role. Admins add policies and issue each version; Admins and care providers see who has and hasn't read them. Family members don't see this page.

The 📄 **Policies** page (in the Team menu) is your care provider's register of policies and procedures. Each policy has its current document; when a new version is issued, the staff it is for are asked to read it and confirm they have understood it, and you can see at a glance who hasn't. CQC inspectors often ask for this.

21.1 The Policies page

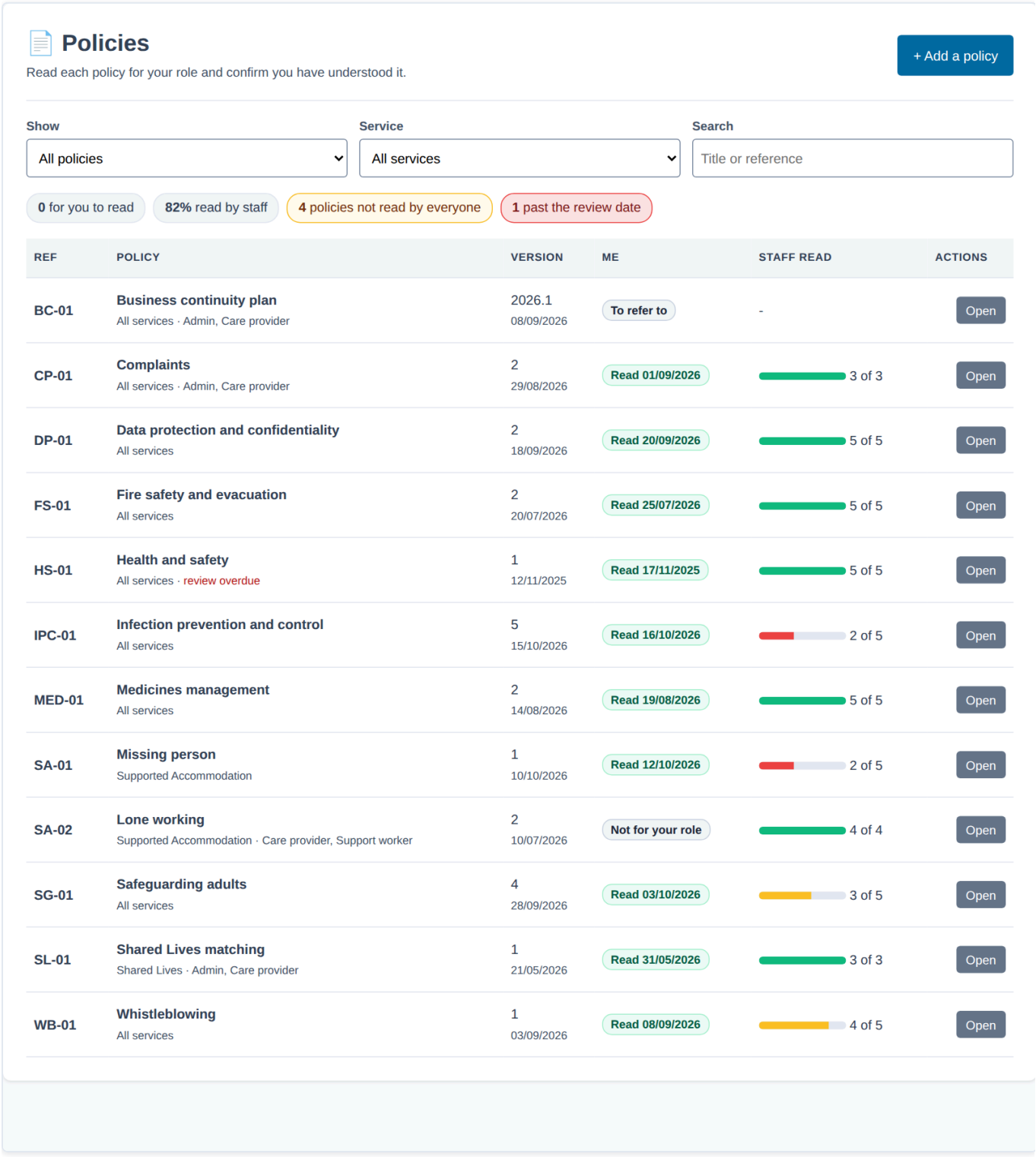


Figure 145. The Policies page for an Admin, with how many staff have read each policy.

At the top are the counts: how many policies you have to read (and how many are overdue); for Admins and care providers, the share of confirmations done, how many policies haven't been read by everyone, and how many are past their review date. Under **Show**, choose *Policies for my role*, *For me to read* or *All policies* (Admins can also show archived ones); **Service** narrows the list to *All services*, *Shared Lives* or *Supported Accommodation*, and **Search** finds a title or reference.

Each row shows the reference, the policy and who it is for, the current version and when it was issued, and under **Me** where you are with it: *To read by* a date (amber), *overdue* (red), *Read* with the date (green), *To refer to* for a policy that

needs no confirmation, or *Not for your role*. Admins and care providers also see **Staff read**: a bar and, for example, *3 of 5*.

21.2 Reading and confirming a policy

When a new version is issued you are told in the bell (🔔) and on the Dashboard. Press **Read** (or open the notification). The window shows what the policy covers, the version, the date to read it by and what has changed. Press **PDF** (or the page buttons) under **The document** and read it all. Then tick **I have read and understood...** and press **Confirm I have read it**. The button only works once the box is ticked.

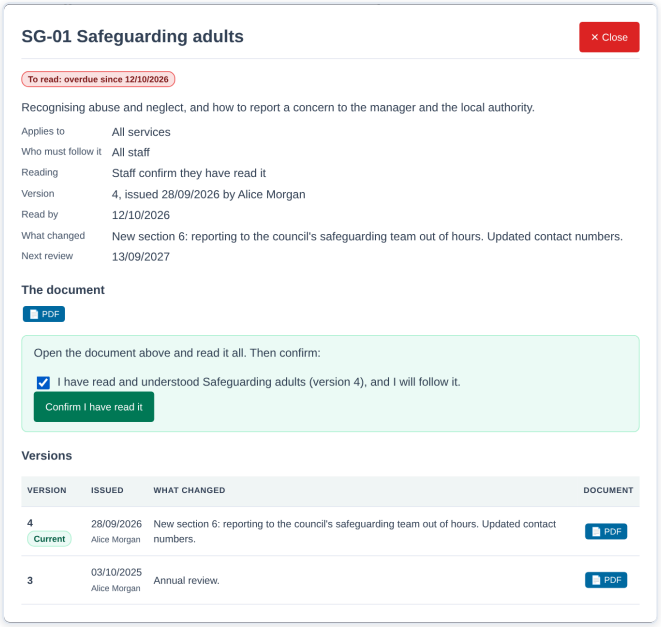


Figure 146. A support worker confirming a policy.

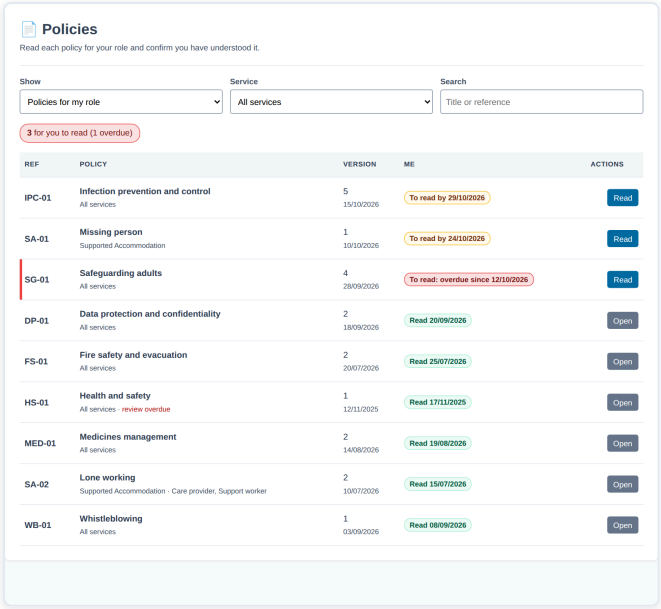


Figure 147. The page for a support worker.

Your confirmation is recorded with the date and time, and the notification clears. If you haven't confirmed by the read-by date, it shows as overdue and you are reminded. When a newer version is issued you are asked to read that one too; your earlier confirmations are kept.

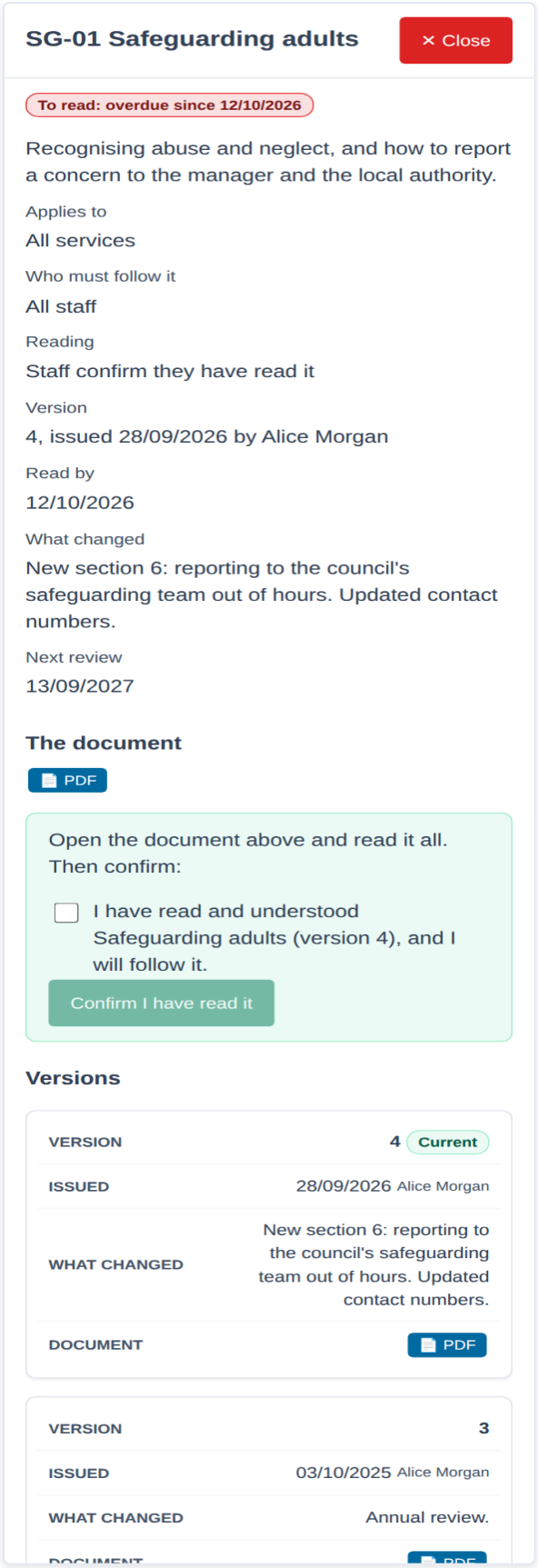


Figure 148. Reading a policy on a phone.

21.3 Who has read it

Admins and care providers see **Who has read it** in the policy window: *Not read yet* (marked overdue once the read-by date has passed) and *Read*, with when. Admins see every member of staff the policy is for; care providers see the staff

at their residences. **Remind those who haven't** sends each of them a reminder in the bell.

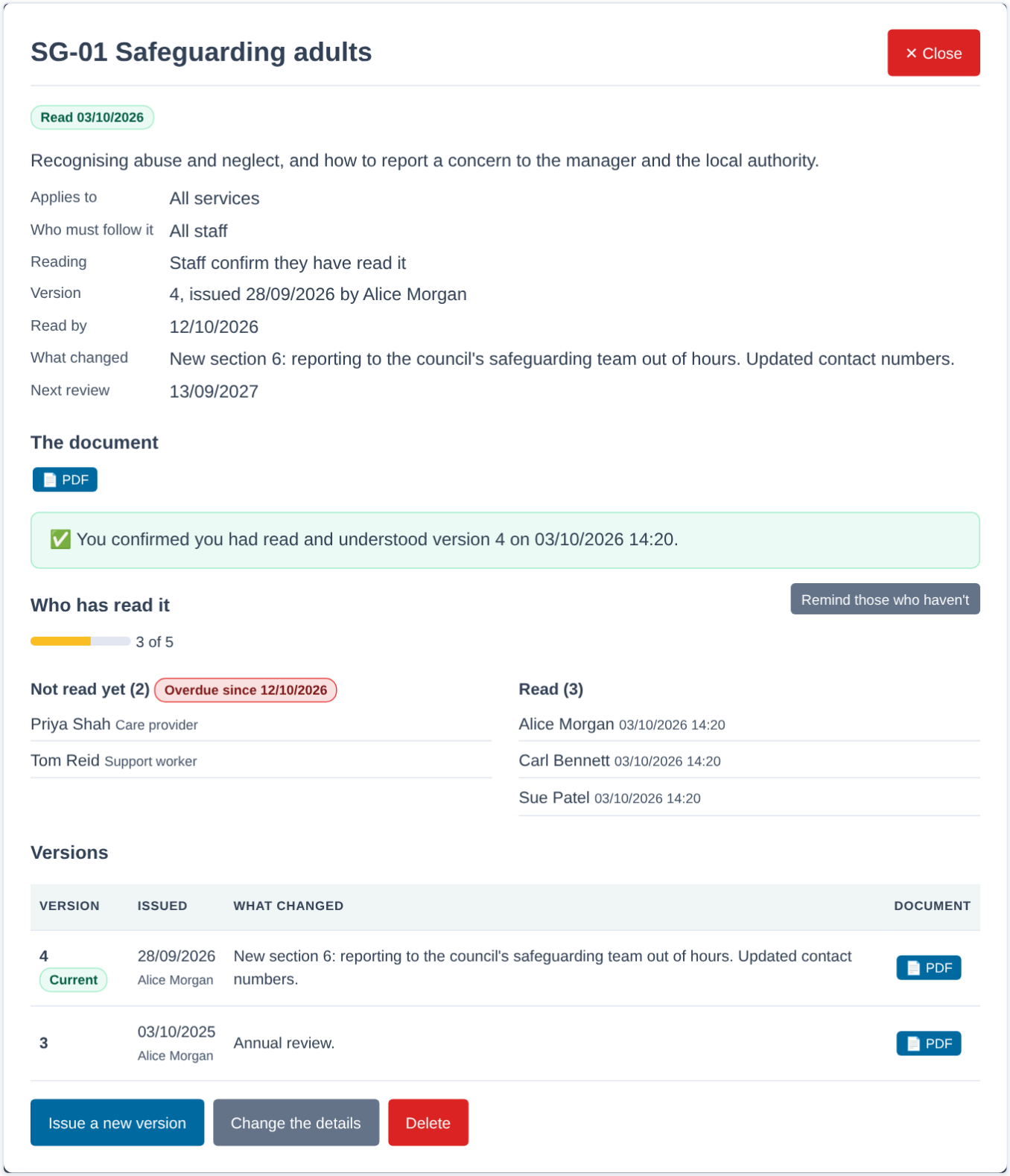


Figure 149. A policy with who has and hasn't read it, and its versions.

Policies not read by the date, and policies past their review date, are also in the daily email.

21.4 Adding a policy and issuing a version (Admins)

Press **+ Add a policy**: the reference (for example HS-01), the title, the service it applies to, **Who must follow it** (Admins, care providers, support workers, or any mix), whether staff must confirm they have read it (untick for a document kept

for reference, such as a business continuity plan), the next review date and what it covers.

You can attach the policy document in the same form, under **The document**: a PDF, or photos of the pages (JPG, PNG, WEBP or GIF, up to 10 MB each), with its version (1 to begin with). Press **Save** and the document is issued as the first version straight away, and the staff it is for are asked to read it. Like every file in Honeysuckle, it is stored encrypted, and only opens through the app for the people the policy is for. If you leave the document empty, you are asked to issue it as soon as the policy is saved, or you can do it later from the policy window.

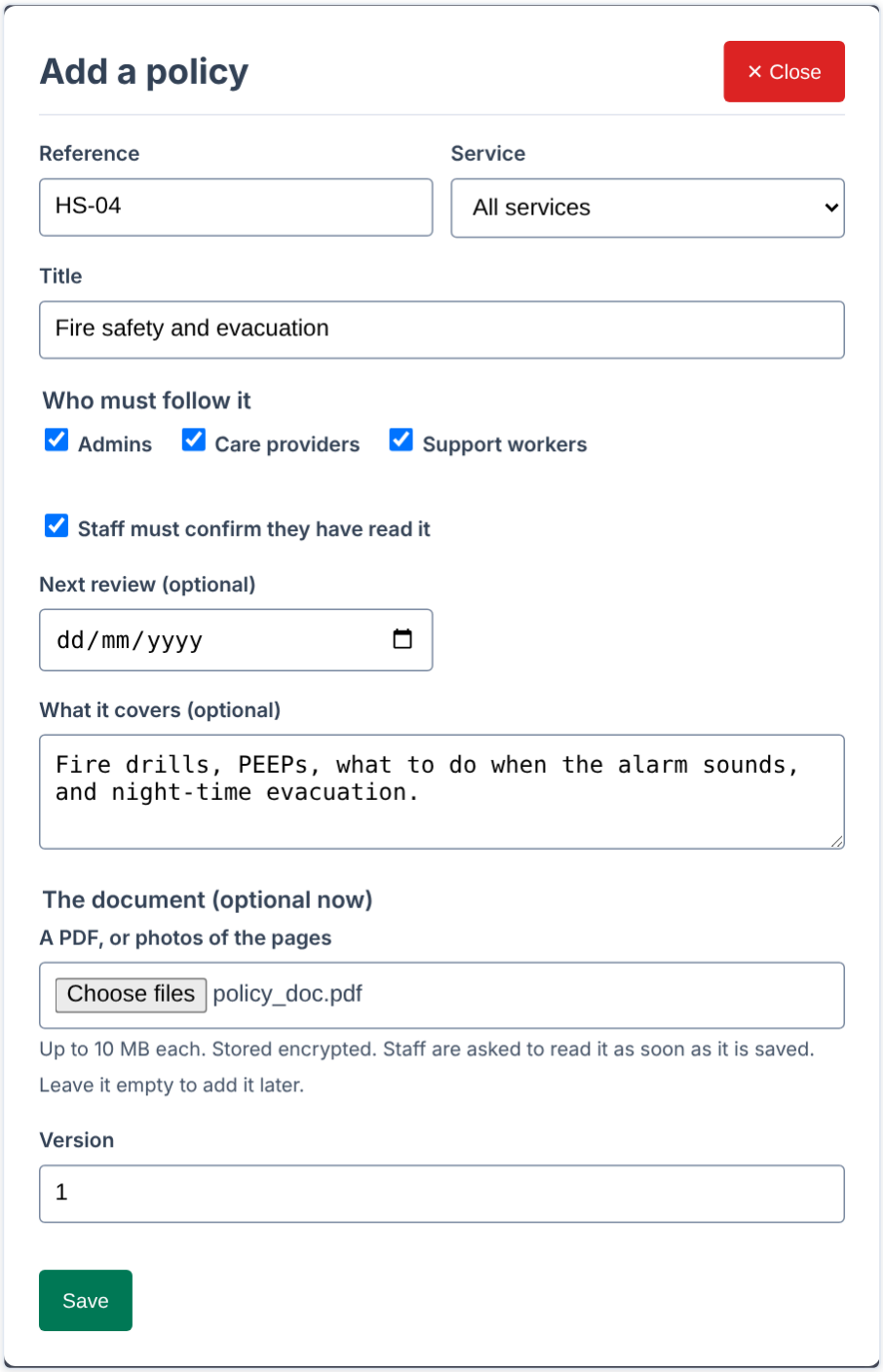


Figure 150. Adding a policy with its document attached.

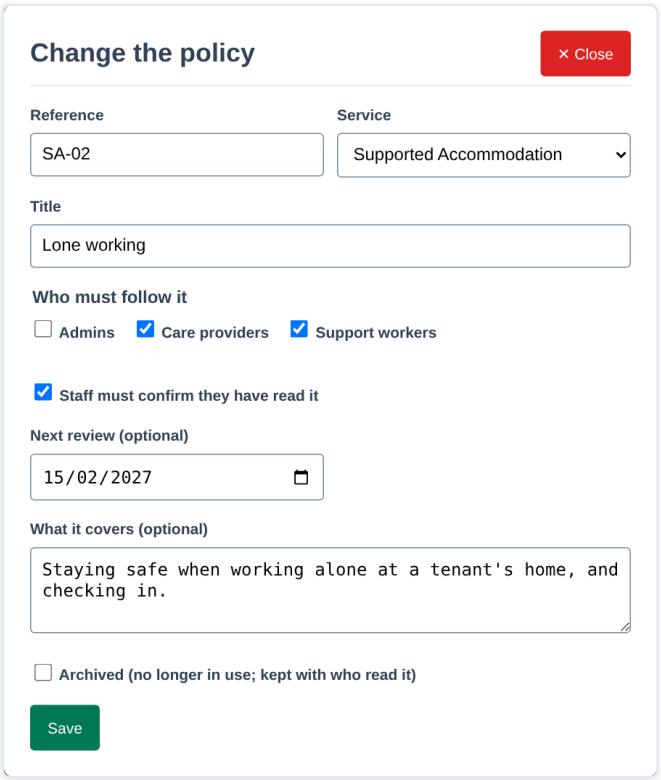


Figure 151. Changing a policy's details.

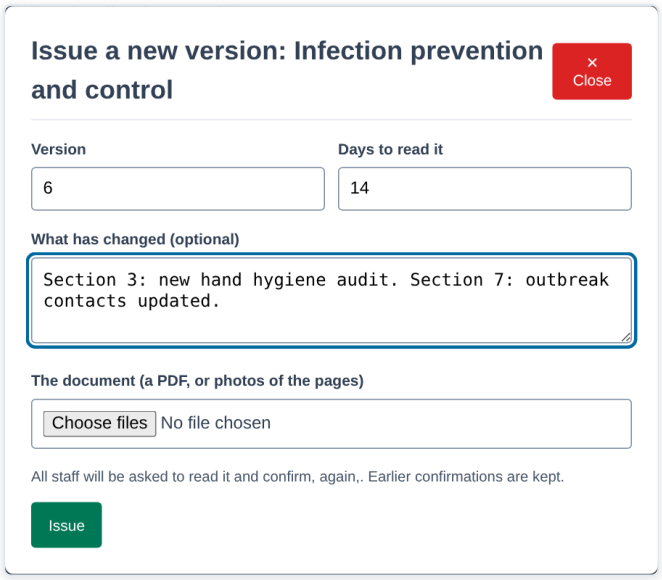


Figure 152. Issuing a new version.

Issue a new version (in the policy window) asks for the version (the next number is suggested), what has changed, how many days staff have to read it (14 unless an Admin has changed it in Settings > Compliance & Retention, section 27.2), and the document: a PDF, or photos of the pages. The staff it is for are told straight away. Earlier versions, with their documents, stay listed under **Versions**.

Change the details changes the reference, title, service, who it is for, the review date or the description without asking anyone to read it again. Tick **Archived** when a policy is no longer in use: it leaves everyone's list but is kept, with who read each version (Admins can still see it with *Archived too*). **Delete** removes the policy with every version, document and confirmation; it asks for your password again. Archive rather than delete if you may need to show who read it.

Every policy added, changed, issued, read, reminded and deleted is in the audit log. In the CQC evidence pack, *Policies read by staff* is under Well-led: how many policies are in use, the share of staff confirmations, and any not read by the date or past their review date (a gap to fix). When a member of staff's records are deleted at the end of the retention period, their confirmations go too.

22. Invoices & Billing

Who can use it: Admins and care providers.

💳 Invoice & Payment Management

Generate 4-week invoices, email them, record payments (including part payments) and see what is owed.

⚡ Generate Invoices

These residences send all their invoices to a single address, but their invoicing details aren't complete: Ash Cottage (no email and postal address). Until they are, those invoices can't be emailed, and are addressed to the residence itself. Add them in Residences: Edit, under "All invoices go to a single address".

Aged debt

⬇️ Download (CSV)

What is still owed on 13/10/2026, by how long past its due date. Due dates are 30 days after the invoice date (your payment terms). Click a residence to see its invoices.

RESIDENCE	NOT YET DUE	1-30 DAYS OVERDUE	31-60 DAYS	61-90 DAYS	OVER 90 DAYS	TOTAL OWED
Willow Court 1 invoice	£10800.00	-	-	-	-	£10800.00
Oak House 2 invoices	£5200.00	-	-	-	-	£5200.00
Ash Cottage 1 invoice	£3120.00	-	-	-	-	£3120.00
All residences	**£19120.00**	**-**	**-**	**-**	**-**	**£19120.00**

Invoices

Invoice number: e.g. INV-OAK | Residence: All residences | Show: Everything | Clear filters

INVOICE #	RESIDENCE	PERIOD	AMOUNT	BALANCE	STATUS	EMAILED	ACTIONS
INV-ASHCOT-20260908	Ash Cottage	08/09/2026 - 05/10/2026	£6240.00	**£3120.00** £3120.00 paid	Part paid Due 12/11/2026	*Not yet* No invoicing email saved	📄 PDF ✉️ Email 💳 Payments
INV-OAKHOU-20260908-01	Oak House	08/09/2026 - 05/10/2026	£2480.00	**£0.00** £2480.00 paid	Paid	*Not yet*	📄 PDF ✉️ Email 💳 Payments
INV-OAKHOU-20260908-02	Oak House	08/09/2026 - 05/10/2026	£2600.00	**£2600.00**	Not yet paid Due 12/11/2026	*Not yet*	📄 PDF ✉️ Email 💳 Payments 🗑️ Delete
INV-OAKHOU-20260908-03	Oak House	08/09/2026 - 05/10/2026	£2600.00	**£2600.00**	Not yet paid Due 12/11/2026	*Not yet*	📄 PDF ✉️ Email 💳 Payments 🗑️ Delete

Figure 153. Invoices, with the aged debt summary.

22.1 Making invoices

Invoices for events are made from the event itself (section 17.5). Other invoices cover a 4-week cycle. Press ⚡ **Generate Invoices** and choose the start date: an invoice is made for each residence (or for each resident, if the residence bills residents separately), charging each resident's weekly rate for the days billed. Check them before sending.

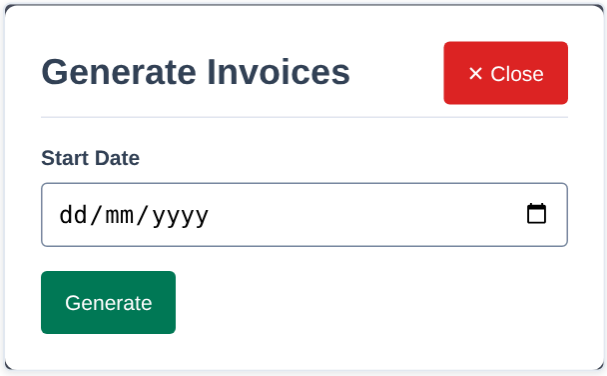


Figure 154. Generating invoices.

22.2 The invoice list and aged debt

Aged debt shows what is owed, by residence, split by how overdue it is. Download it as a CSV file. Below it, the invoice list can be filtered by number, residence and status: everything, outstanding (anything left to pay), overdue, paid or cancelled. Each invoice shows its amount, the balance still to pay, its status and when it was last emailed.

- **PDF** downloads the invoice.
- **Email** sends it as a PDF attachment (for an overdue invoice the button says **Remind** and sends a payment reminder). It always goes to the saved invoicing email: the residence's single address, or the resident's own (section 9.2). The address can't be typed in this window; to change it, change the residence or the resident's profile. Emails need the mail server set up in Settings > Email & Alerts.
- **Payments** records money received: the amount, date, method and reference. Part payments are fine; the balance goes down and the status becomes Part paid, then Paid. The same window has **Cancel invoice**, for an invoice raised in error or not owed: it is kept, marked cancelled.
- **Delete** (Admins) removes an invoice that has no payments recorded against it.

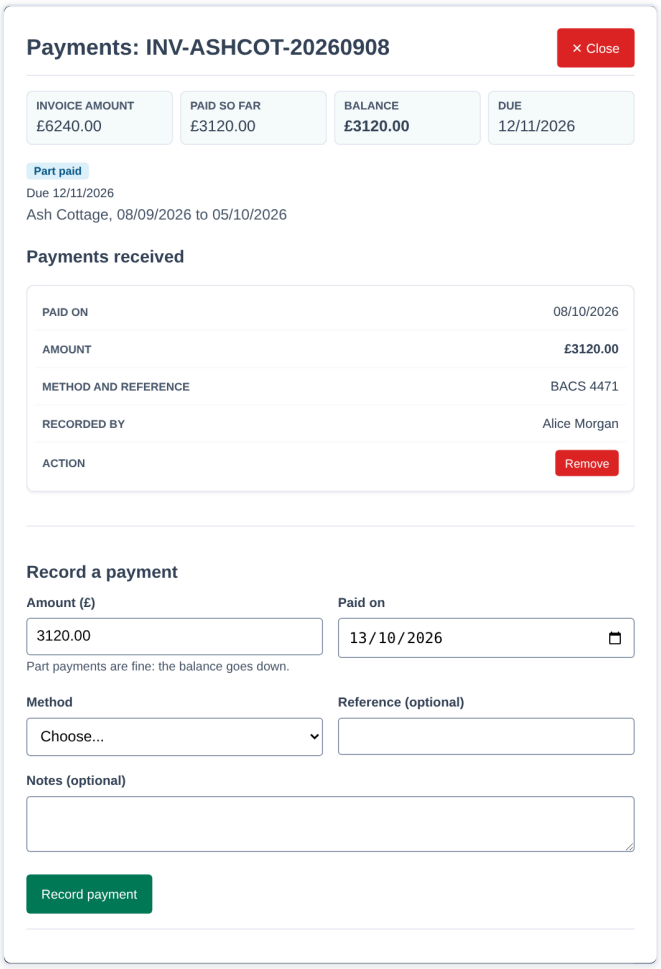


Figure 155. Recording a payment.

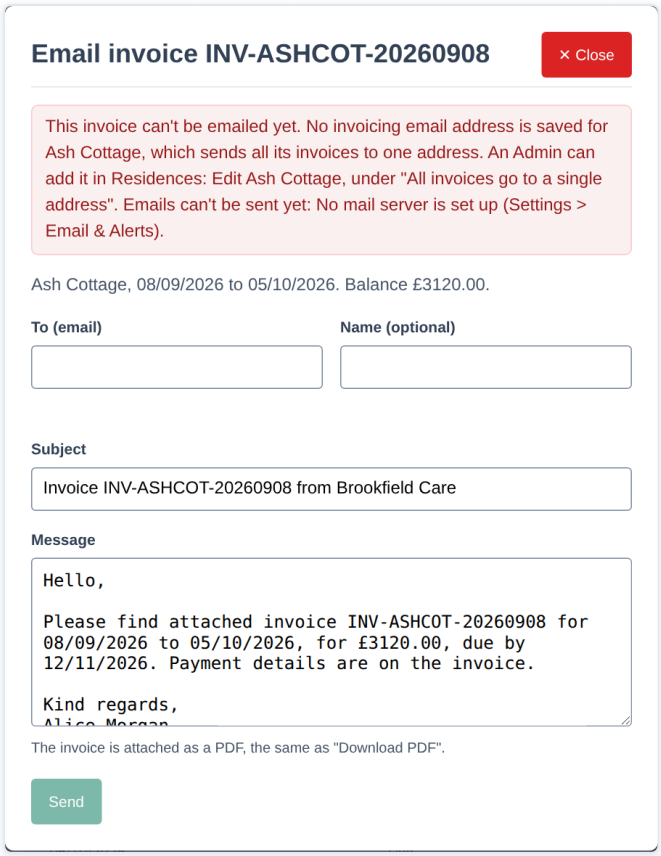
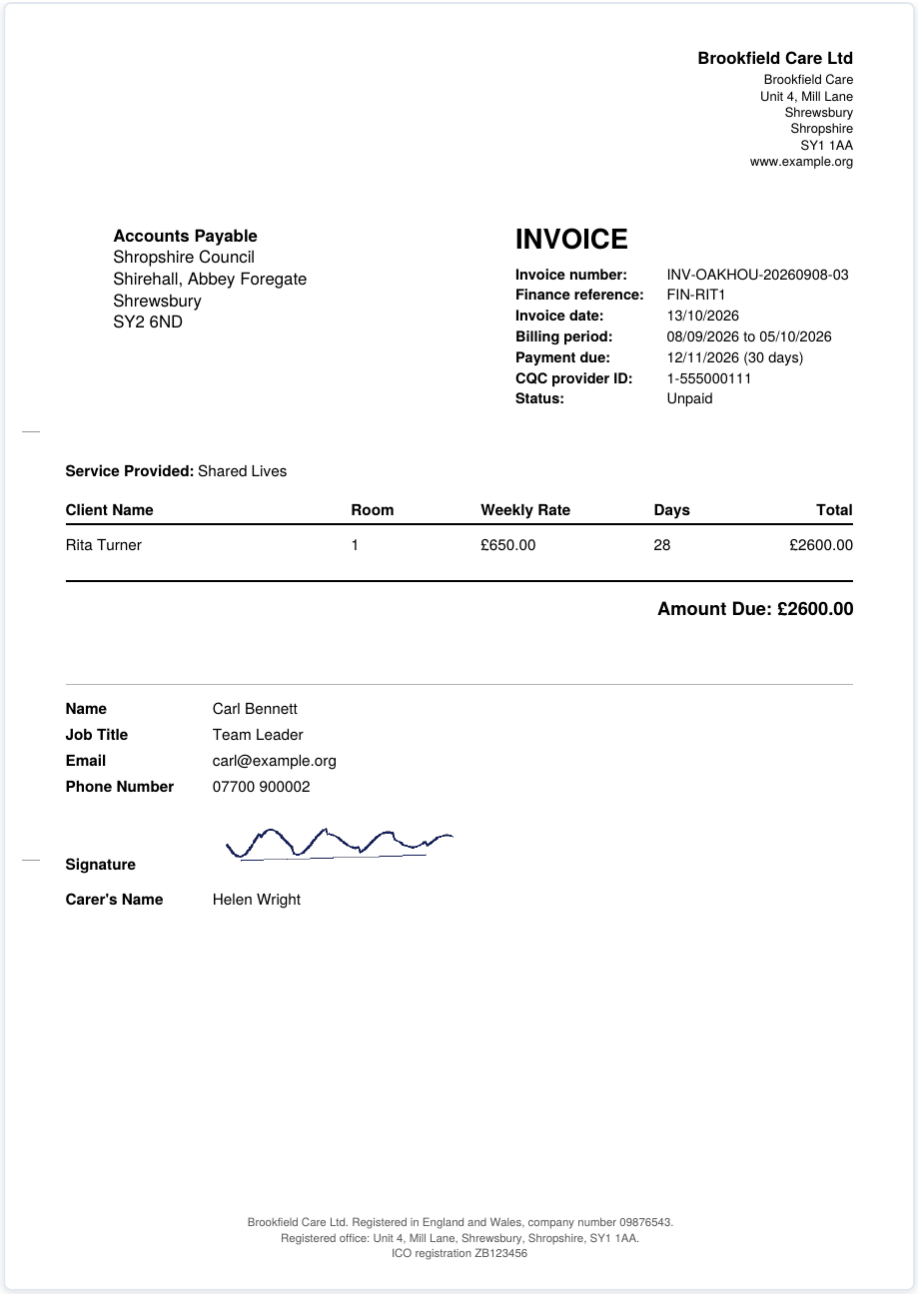


Figure 156. Emailing an invoice.

22.3 What an invoice shows

Two optional parts can be switched on for all your invoices in Settings > Accounts (section 27.6):

- **Service Provided**: the residence's type, for example *Service Provided: Supported Accommodation*, under the invoice details.
- **The signatory section**: under the invoice, the name, job title, email, phone number and signature of the residence's default Care Provider (section 9.2), and the carer's name. Job titles and signatures are added on each person's account (section 24.1). If a residence has no default Care Provider yet, the invoice is made without the section and a message says what to do; if some of their details are missing (a job title or signature, say), those are left blank and the message lists them.



Brookfield Care Ltd
Brookfield Care
Unit 4, Mill Lane
Shrewsbury
Shropshire
SY1 1AA
www.example.org

Accounts Payable
Shropshire Council
Shirehall, Abbey Foregate
Shrewsbury
SY2 6ND

INVOICE

Invoice number: INV-OAKHOU-20260908-03
Finance reference: FIN-RIT1
Invoice date: 13/10/2026
Billing period: 08/09/2026 to 05/10/2026
Payment due: 12/11/2026 (30 days)
CQC provider ID: 1-555000111
Status: Unpaid

Service Provided: Shared Lives

Client Name	Room	Weekly Rate	Days	Total
Rita Turner	1	£650.00	28	£2600.00

Amount Due: £2600.00

Name Carl Bennett
Job Title Team Leader
Email carl@example.org
Phone Number 07700 900002

Signature

Carer's Name Helen Wright

Brookfield Care Ltd. Registered in England and Wales, company number 09876543.
Registered office: Unit 4, Mill Lane, Shrewsbury, Shropshire, SY1 1AA.
ICO registration ZB123456

Figure 157. An invoice with Service Provided and the signatory section.

23. Analytics

> **Who can use it:** Admins and care providers. The CQC evidence pack is for Admins.

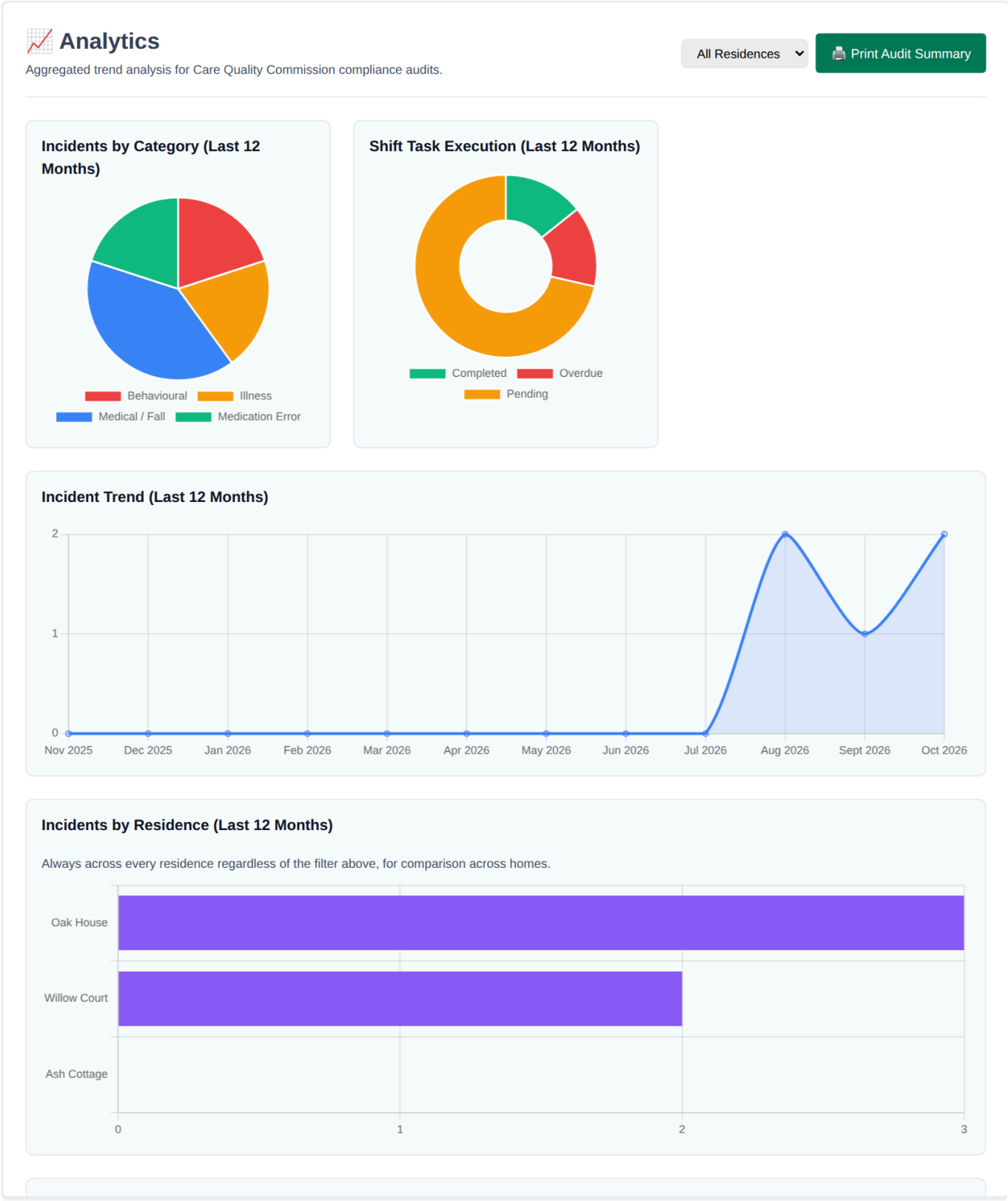


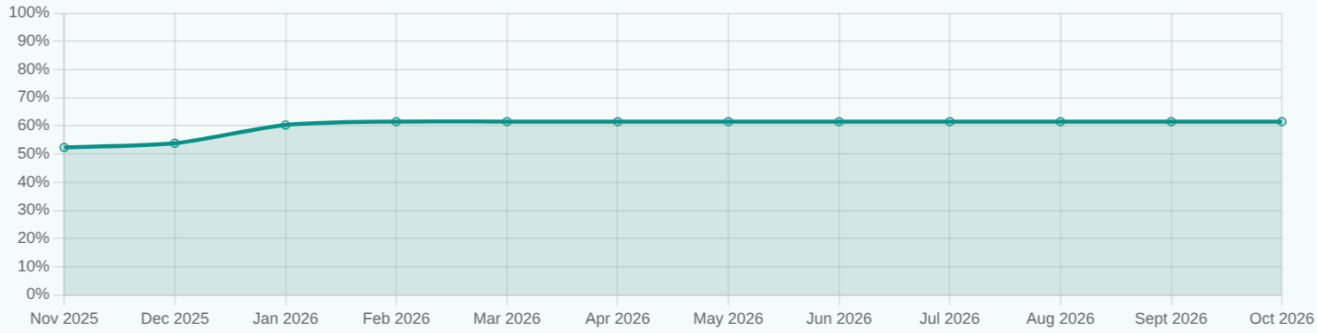
Figure 158. Analytics for the last 12 months.

Charts of the last 12 months for all residences, or one chosen at the top: incidents by type, task completion, the monthly incident trend, incidents by residence (to spot an outlier), the state of each residence's safety records, residents with repeat incidents, and where on the body injuries happen. 🖨 **Print Audit Summary** prints the page.

At the top, **Occupancy** shows the share of places filled each month (each resident's days at the residence against its number of places now) and, for each residence, its places, residents now, places offered and free, and occupancy this month and over the year. Beside it, **Enquiries** shows how many enquiries reached each stage, how many became admissions, the average time from enquiry to moving in, where enquiries came from and why they closed (chapter 19).

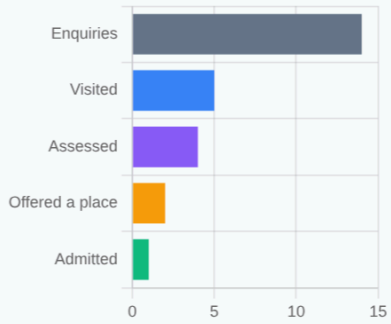
Occupancy (Last 12 Months)

The share of places filled each month: each resident's days at the residence against its number of places now. Uses the residence filter above.



RESIDENCE	PLACES	RESIDENTS NOW	OFFERED	FREE	THIS MONTH	LAST 12 MONTHS
Ash Cottage	3	2	0	**1**	66.7%	66.7%
Oak House	4	3	1	**0**	75%	75%
Willow Court	6	3	0	**3**	50%	46.6%

Enquiries (Last 12 Months)



How Enquiries Turned Out

- **14** enquiries, **1** admitted, **8** closed, **5** still open.
- Of those decided, **11%** became admissions.
- From enquiry to moving in: **24 days on average**.

Where enquiries came from

SOURCE	ENQUIRIES	ADMITTED
Phone call	4	0
Website	3	0
Word of mouth	2	1
Hospital discharge team	2	0
Social worker or council	2	0
Other	1	0

Why enquiries closed

REASON	ENQUIRIES

Figure 159. Occupancy and enquiries.

23.1 CQC inspection evidence pack

At the bottom of the Analytics tab, Admins can prepare for an inspection. Choose a residence and a period (the last 12 months to start with) and press **Check the evidence**.

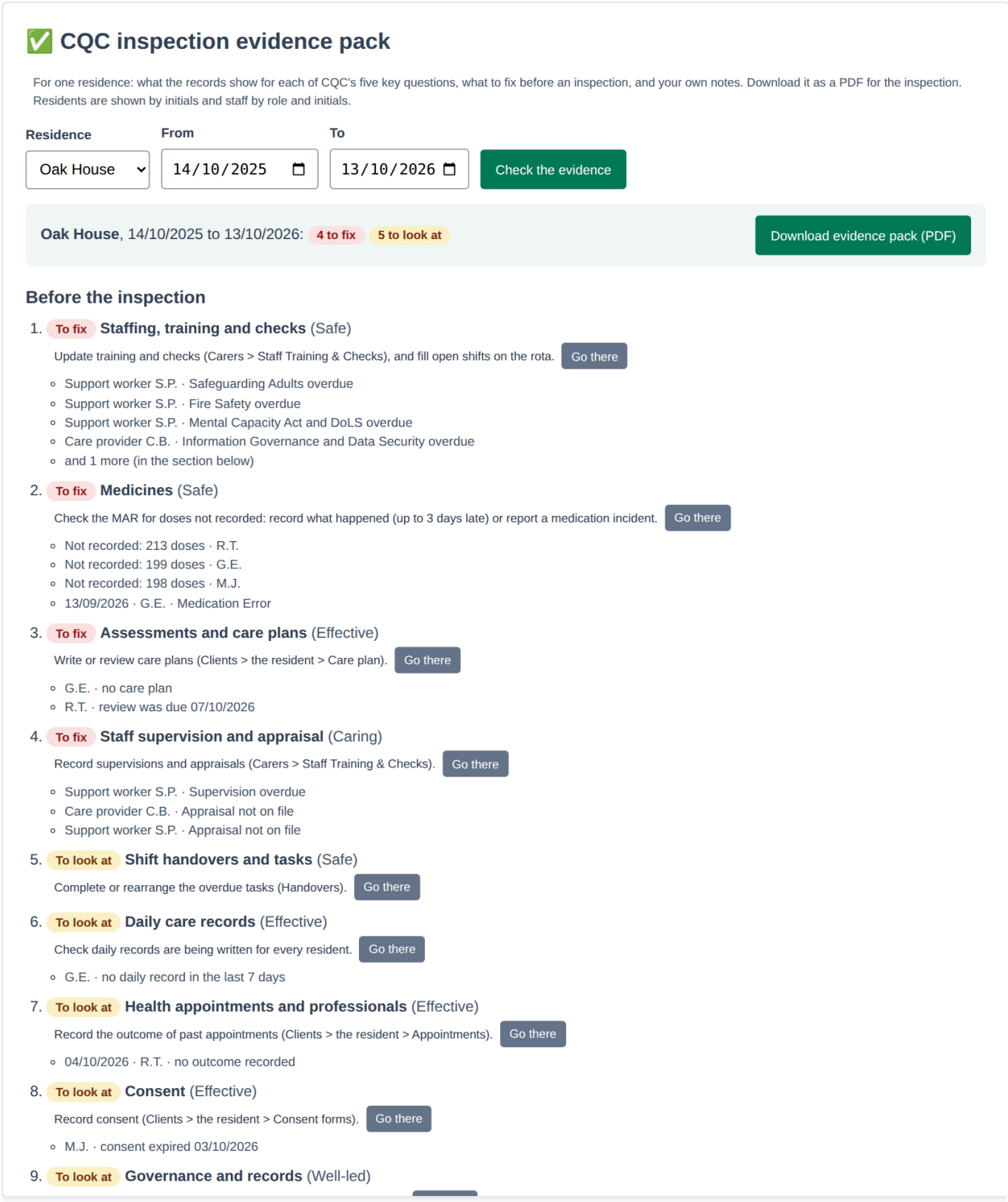


Figure 160. The evidence pack: what to fix, then the evidence for each key question.

- **Before the inspection** lists what to fix (*To fix*: missing or overdue) and what to look at (*To look at*), worst first. Each one says what to do, with a **Go there** button.
- **The five key questions** (Safe, Effective, Caring, Responsive, Well-led) each list what the records show, the CQC quality statements each piece supports, and a status: To fix, To look at, In order, or Figures.
- **Your notes**: for each key question, write what you do well and what you are improving. Add the CQC location ID and registered manager for the cover, and press **Save notes**.

- **Incidents and accidents** (under Safe) shows the harm caused, safeguarding concerns and how many were referred to the local authority, CQC notifications sent (and any sent more than a day late), the duty of candour, and how many incidents were reviewed and closed by a manager. Anyone still to be told, or follow-up overdue, makes it *To fix*. **Learning and improvement** (under Well-led) lists the lessons learned recorded when incidents were closed.
- **Hospital transfers** (under Safe) shows how many residents went to hospital in the period with a transfer pack, whether belongings were recorded, and how many came back.
- **Mental capacity, DoLS and resuscitation decisions** (under Effective) shows DoLS authorisations in force and awaiting a decision, capacity assessments in the period and best-interests decisions, and resuscitation decisions recorded. A DoLS outcome not notified to CQC, or one expired, makes it *To fix*.
- **Monitoring charts** (under Effective) shows, for residents on charts in the period, how often drinks targets were met, gaps in repositioning, MUST and NEWS2 scores, and entries struck through.
- **Medicines** (under Safe) now includes the eMAR: how many scheduled doses there were, the percentage recorded, how many were not recorded and for whom (by initials), doses not given and why, late entries, records struck through, and controlled drug register entries. **Go there** opens the Medication tab.
- **Quality statements** lists all 34 statements of CQC's Single Assessment Framework, and which ones the records provide evidence for. The rest rely on your notes and other evidence you hold.
- **Download evidence pack (PDF)** produces the pack for the inspector: a cover, a summary, the areas to address, a section per key question with your notes and the evidence, and the quality statements list. Residents appear by initials and staff by role and initials.

24. Carers: accounts, training and checks

> **Who can use it:** Admins, and care providers for staff at their residences.

24.1 User accounts

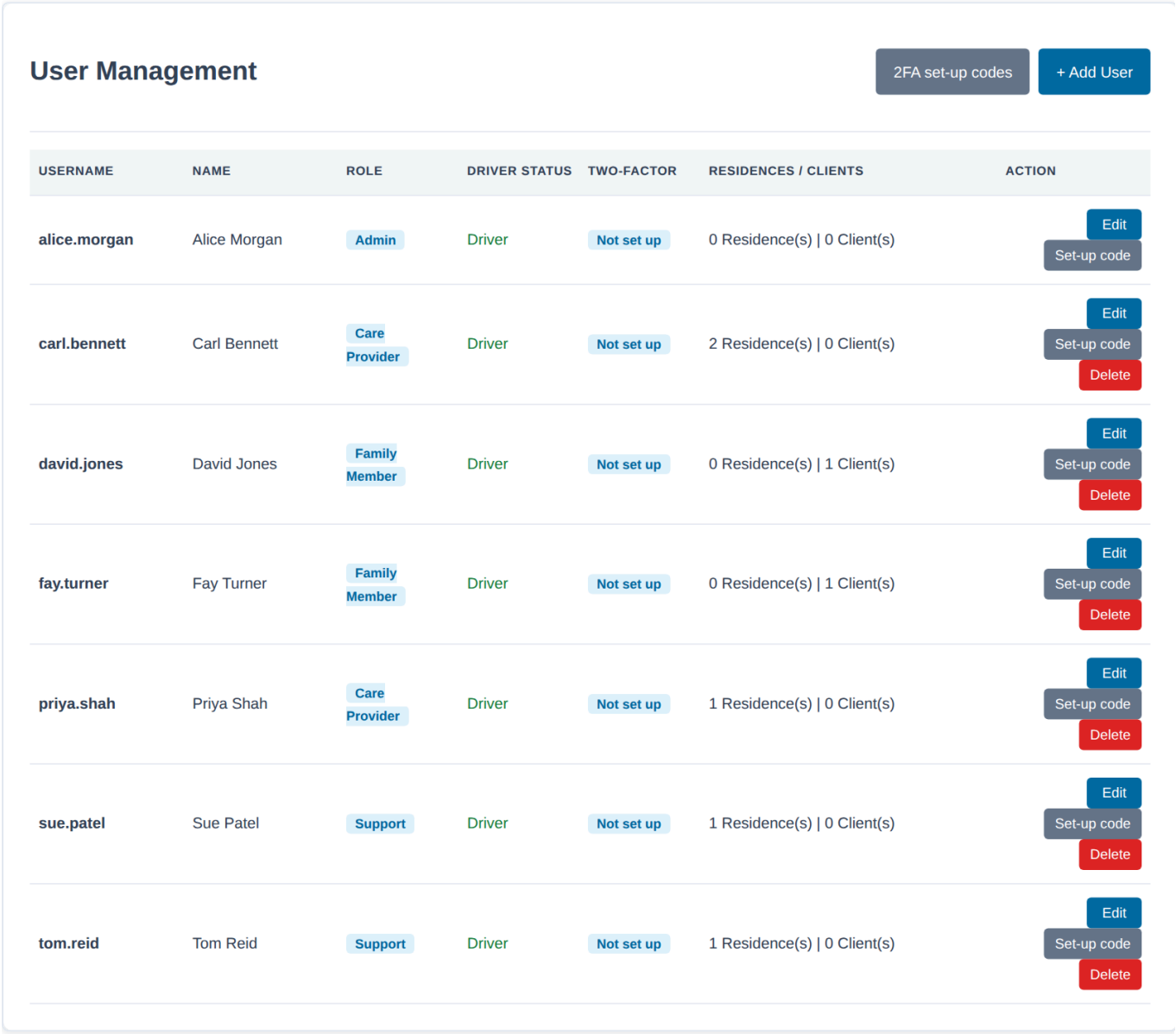


Figure 161. User management.

Every member of staff and every family member has their own account. The list shows each account's username, name, role, whether they drive, whether two-factor login is set up, and the residences (staff) or residents (family) they are linked to.

+ Add User: enter a username, a starting password (they choose their own when they first sign in), their name, contact details and role. Tick the residences a member of staff works at, or the residents a family member is linked to. **Edit** changes an account, **Delete** removes it.

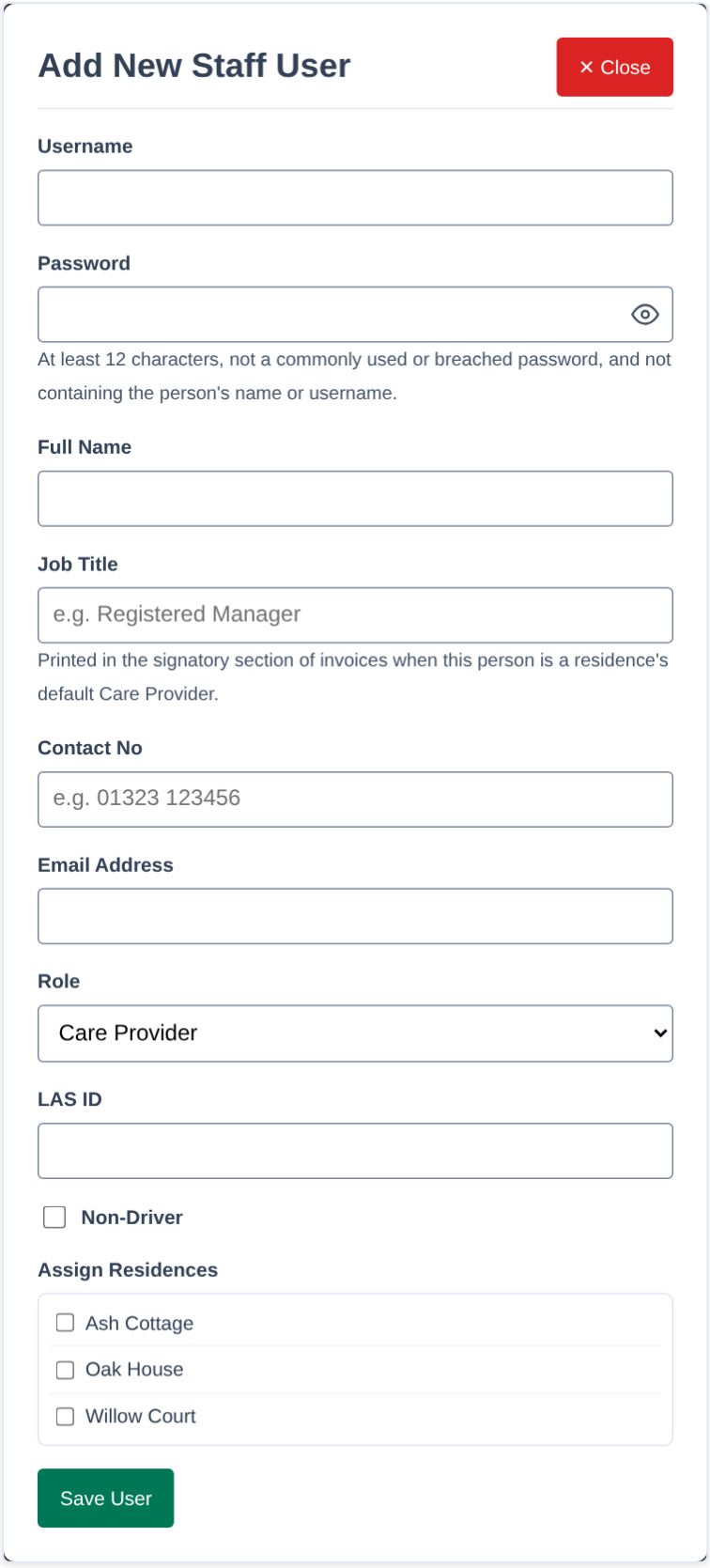


Figure 162. Adding an account.

- **When a member of staff leaves**, delete their account. Their training and check records are kept, read-only, as a *leaver* for the period set in Settings (6 years to start with), then listed under 🗂 **Leavers** for an Admin to approve deleting them.
- **Set-up code** gives someone a one-time code to set up two-factor login (section 2.2). **2FA set-up codes** at the top issues codes for everyone who still needs one.

- **Reset 2FA** is for someone who has lost or replaced their phone: they set it up again at their next sign-in.
- **Unlock** appears when an account is locked after too many wrong passwords.
- **Job title and signature**, for invoices: when editing a member of staff, enter their job title and upload a photo or scan of their signature (PNG, JPG or WebP, up to 1 MB; a transparent PNG in dark ink, cropped close, prints best). It goes on invoices when they are a residence's default Care Provider (section 22.3). Only Admins, and each person for their own, can see, change or remove a signature; a care provider can also upload their own from their training record (section 24.2).

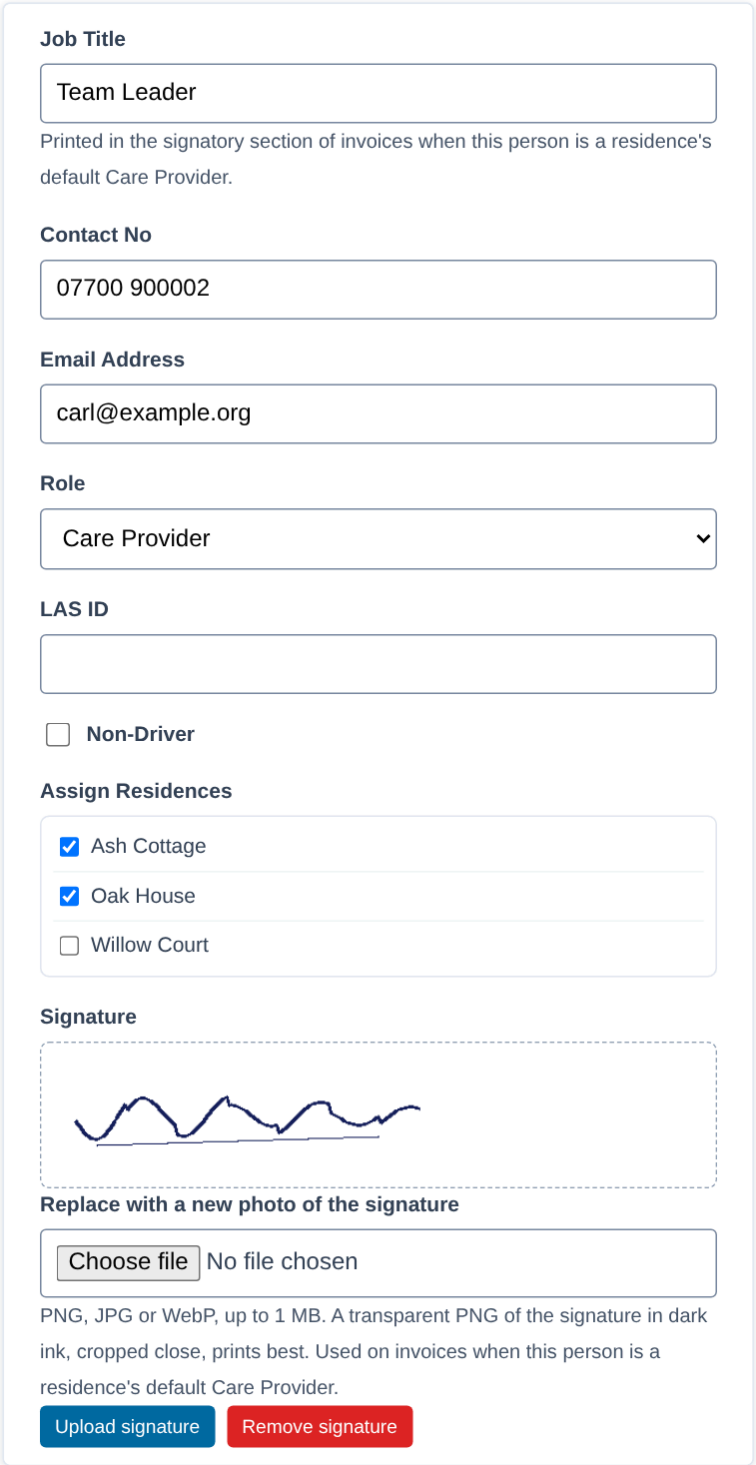


Figure 163. A member of staff's job title and signature.

24.2 Staff training and checks

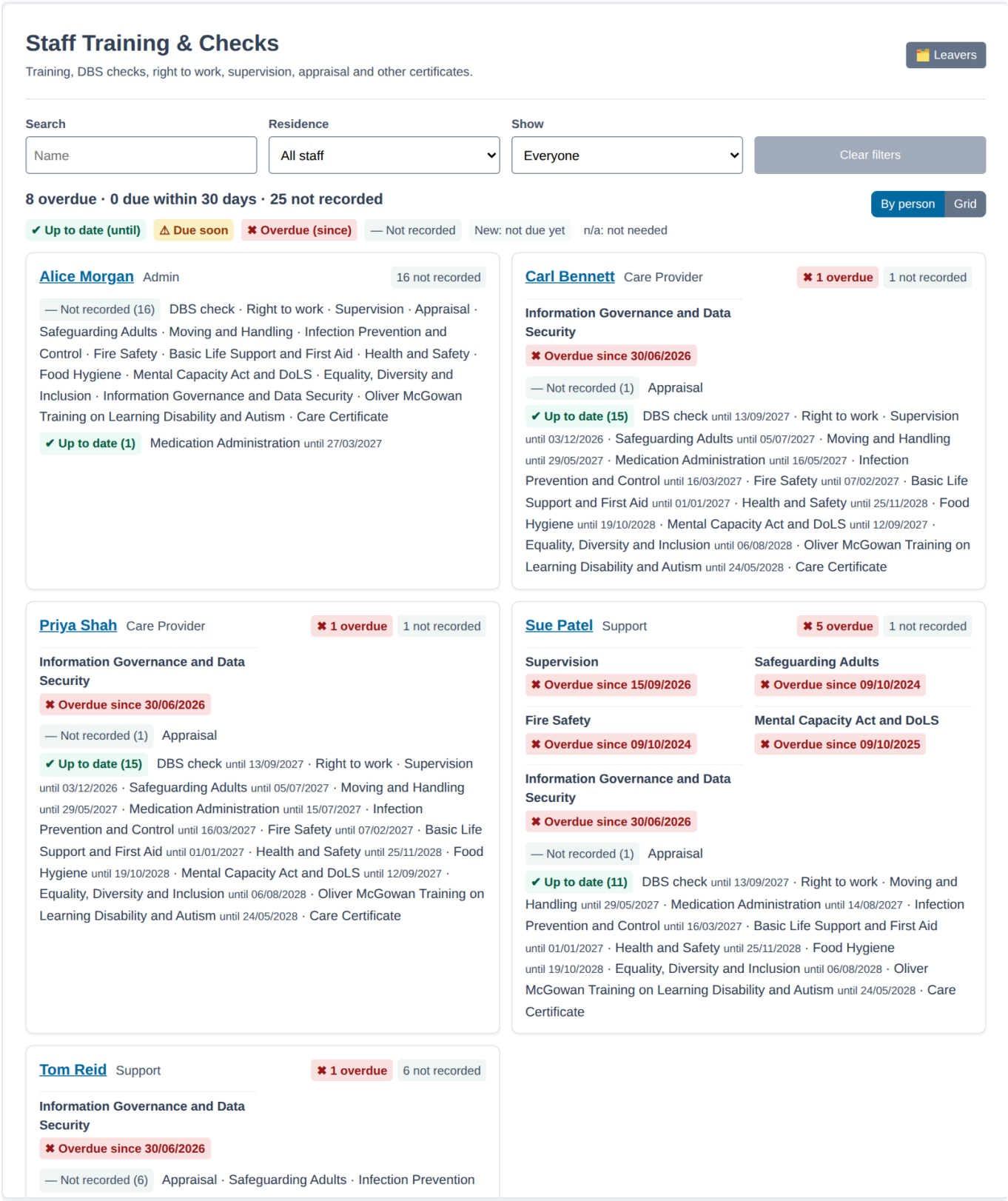


Figure 164. Staff training and checks, by person.

For each member of staff: their training courses, certificates, DBS check, right to work check, supervisions and appraisals, each marked up to date, due soon, overdue or not recorded. Switch between **By person** and **Grid** (everyone against every check), and filter by residence or by what is overdue. Click a name to open their record.

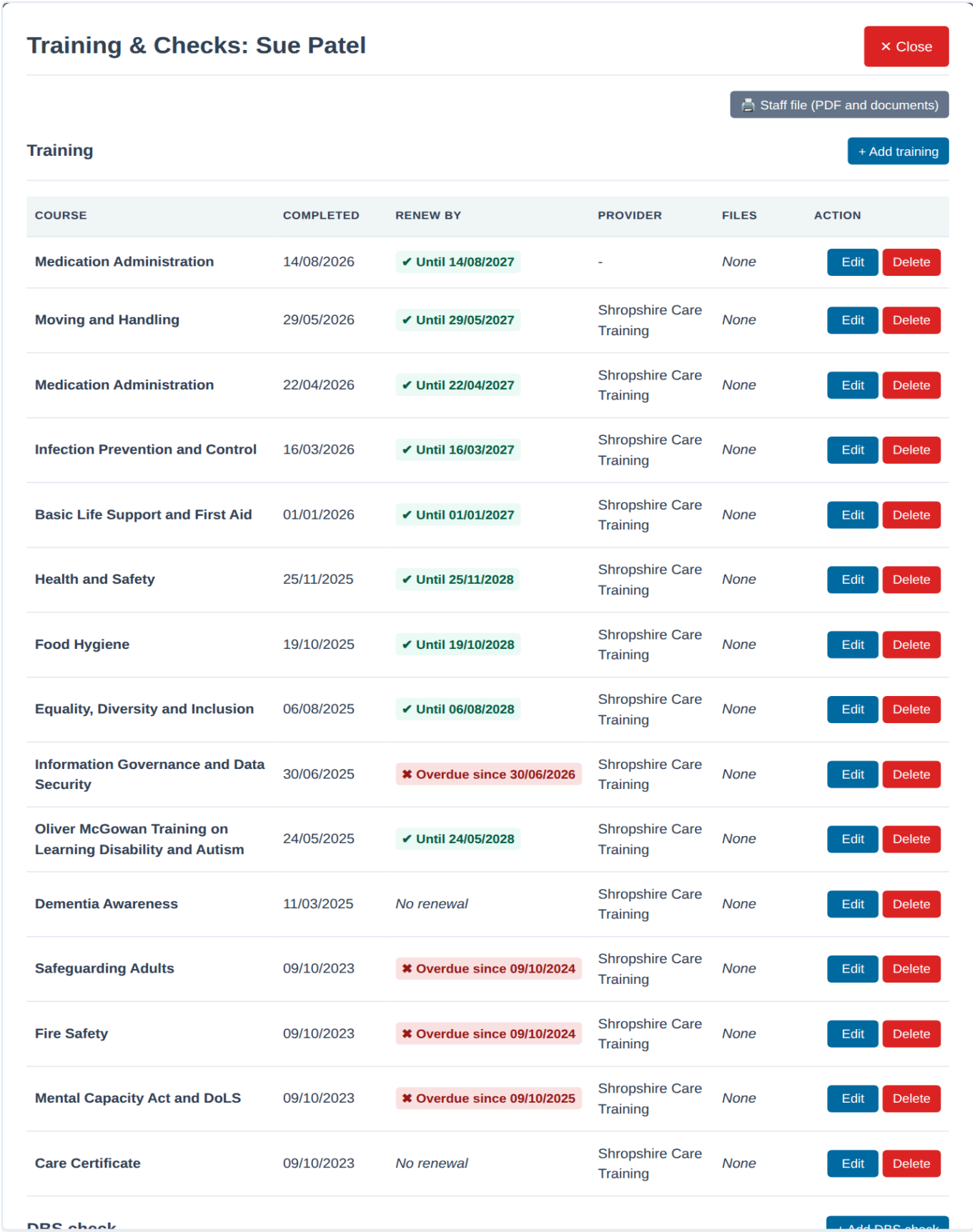


Figure 165. One person's training and checks.

In a person's record, add an entry with the button for each kind. You record the date, when it is due again (filled in from the course's renewal period), a reference, details such as the training provider or the DBS level and Update Service status, and photos or PDFs of certificates. 🖨 **Staff file** produces a PDF of their whole file, with the documents, for an inspection or audit.

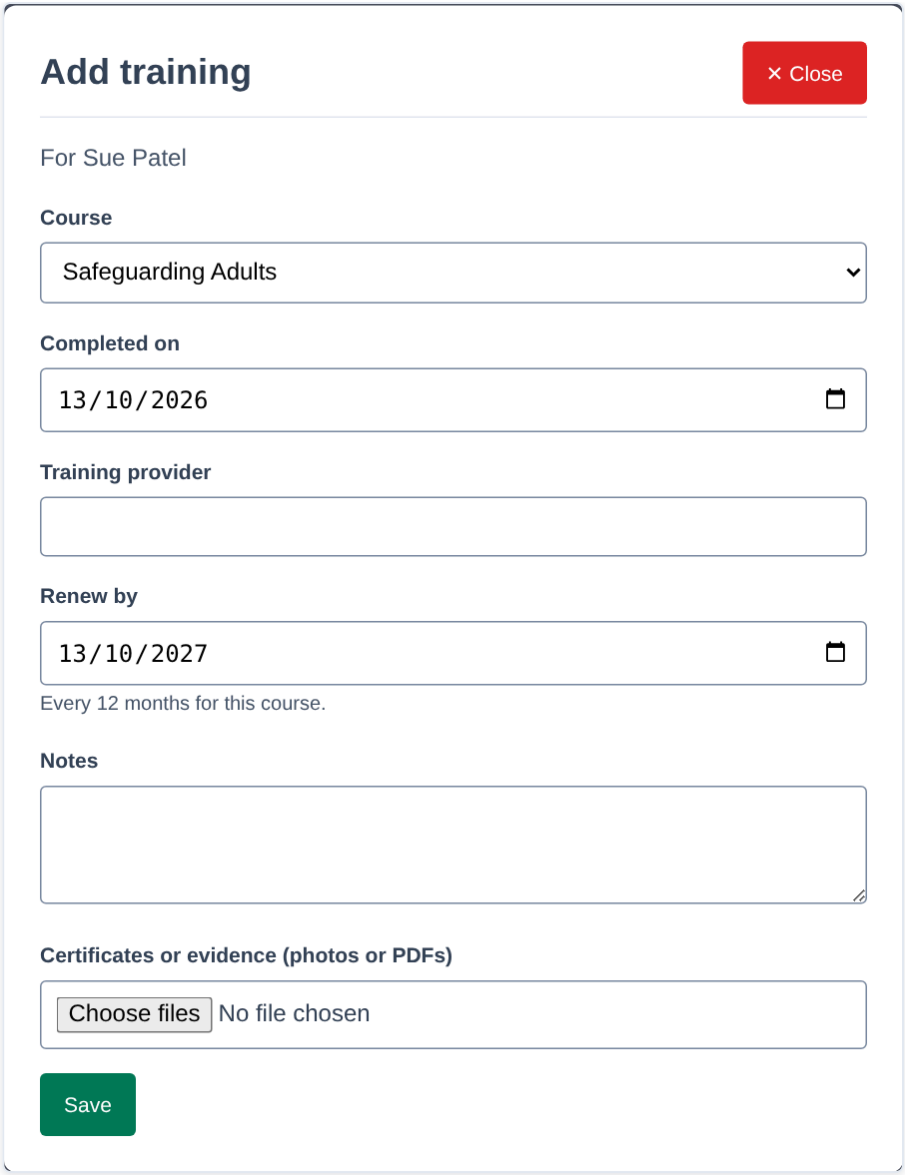


Figure 166. Recording training.

Medication training matters for the eMAR: only staff with a course with "Medication" in its name recorded and in date can record doses or witness controlled drugs (section 16.3). Keep the due date filled in, so the training runs out when it should.

For DBS checks, only the fact of the check is stored (level, date, certificate number and Update Service status), not the content of the certificate.

24.3 Car insurance

For staff who drive for work, record their car insurance with **+ Add Policy**: the insurer, policy number, vehicle, dates and whether it covers business use, with a copy of the certificate. Policies expiring soon or expired are highlighted. Care providers see the policies of staff at their residences; support workers, if they are given this tab, see and add only their own.

25. Import and export

> **Who can use it:** Admins import residents and staff, and download all records. Admins and care providers download the commissioner return (care providers for their residences). Support workers and family members don't see this page.

The 🔄 **Import & export** page is in the Admin menu (for care providers, in the Business menu). It brings residents and staff in from a spreadsheet when you start using Honeysuckle Care Management, gives you the return that local authorities and ICBs ask for, and lets you take a copy of everything you hold.

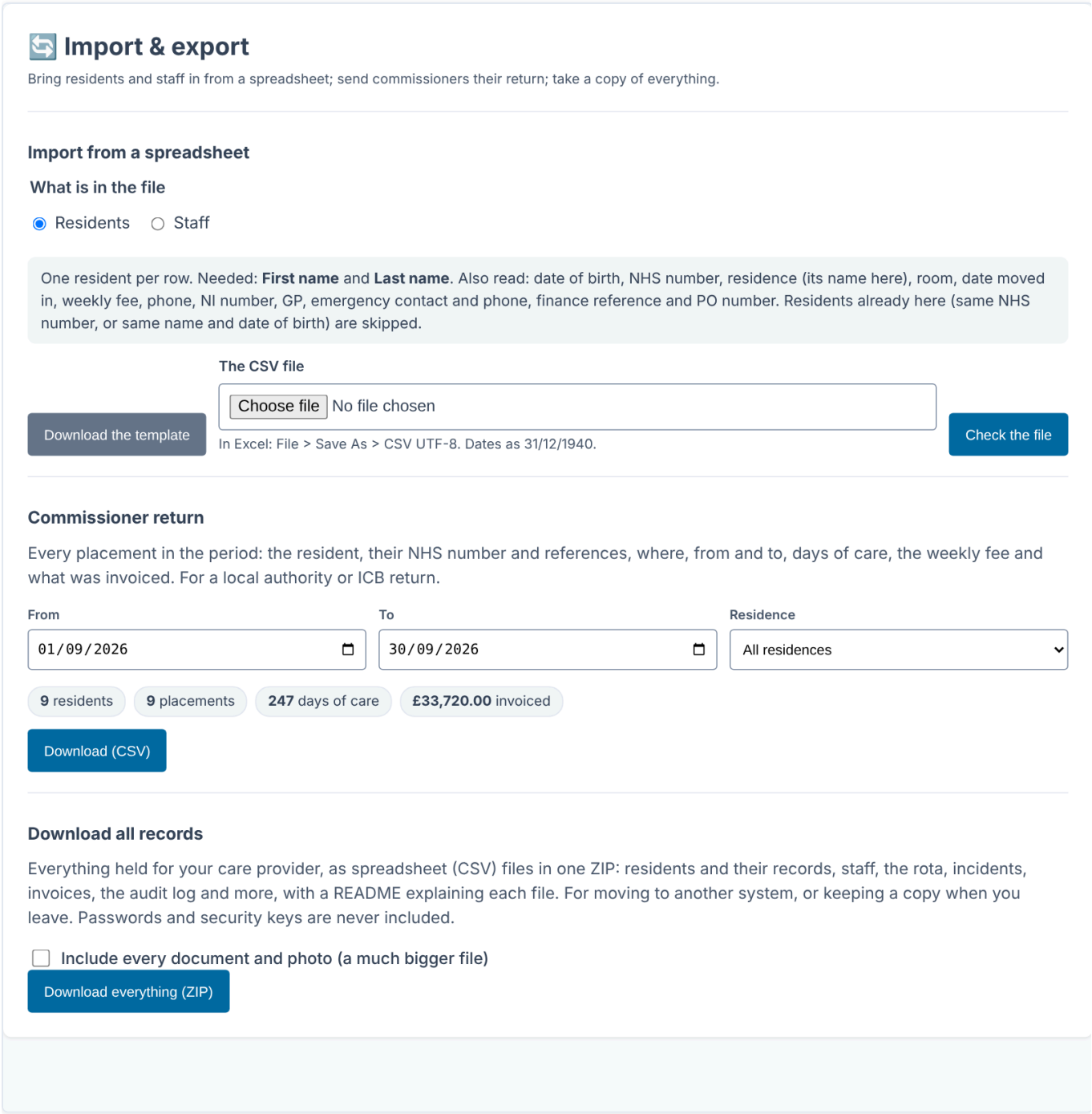


Figure 167. The Import & export page for an Admin.

25.1 Importing from a spreadsheet

Choose what is in the file, **Residents** or **Staff**, and press **Download the template** for a spreadsheet with the right headings and an example row. Fill it in (or use your own spreadsheet: the headings don't have to match exactly, so *Surname*, *Forename*, *DOB* or *NHS No* are understood too, and columns that aren't needed are ignored). Save it as CSV (in Excel: **File > Save As > CSV UTF-8**). Dates are written as 31/12/1940.

- **Residents**: first name and last name are needed; also read are date of birth, NHS number, residence (its name exactly as in Honeysuckle Care Management), room, date moved in, weekly fee, phone, NI number, GP, emergency contact and their phone, finance reference and PO number.
- **Staff**: name and role are needed (*Admin*, *Care provider* or *Support worker*; everyday words such as *senior carer* or *care assistant* are understood); also read are username, email, phone, job title and residences (separate several with a semicolon).

Choose the file and press **Check the file**. Nothing is saved yet: each row is shown as *Ready*, *Already here* (a resident with the same NHS number, or the same name and date of birth; a member of staff with the same name or email) or *Problem*, with the reason, for example a date that doesn't exist, an NHS number whose check digit is wrong, a residence that isn't set up yet, or a residence that would be over its number of places.

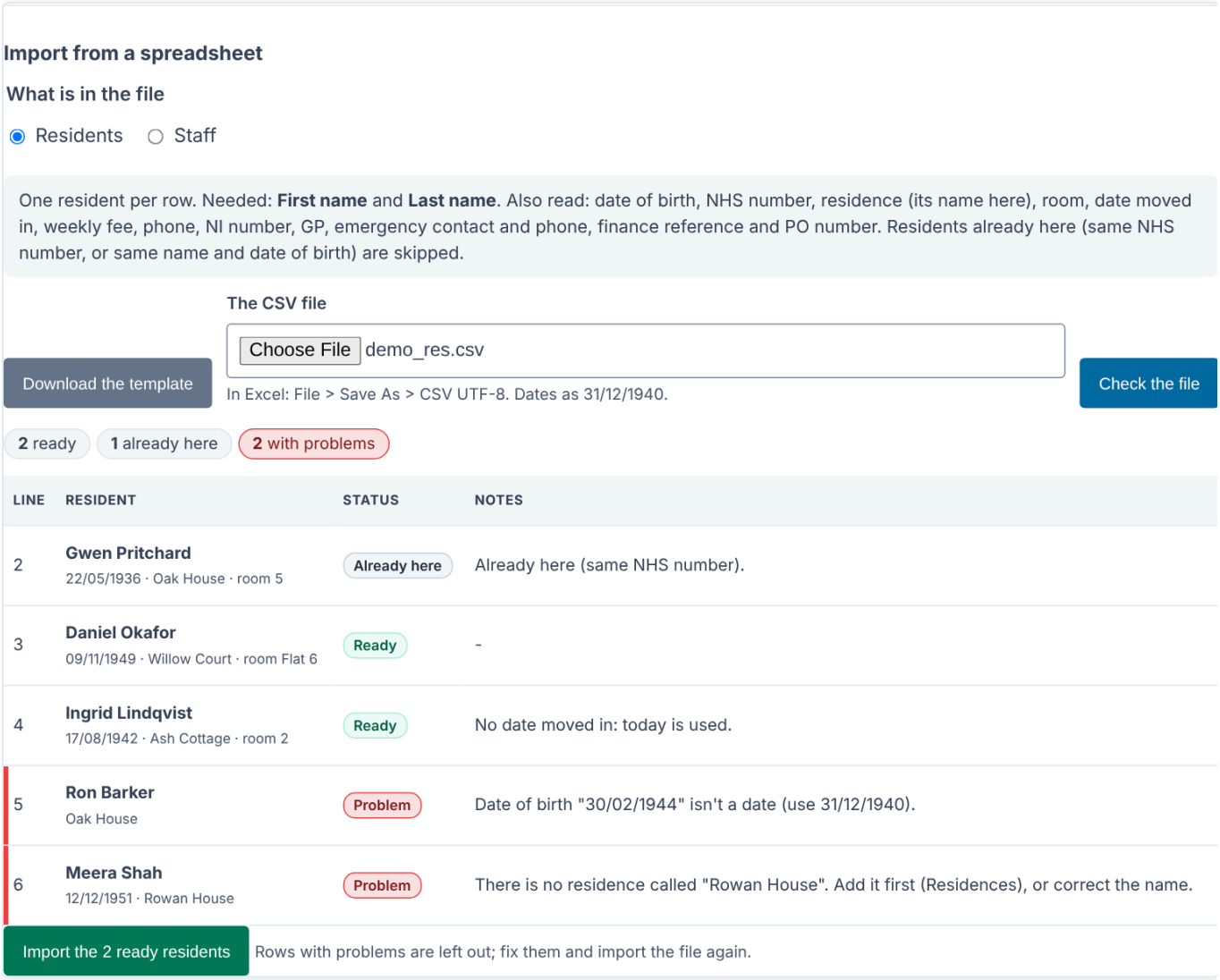


Figure 168. A residents file checked: two ready, one already here, two with problems.

On a phone, each row is shown as a card.

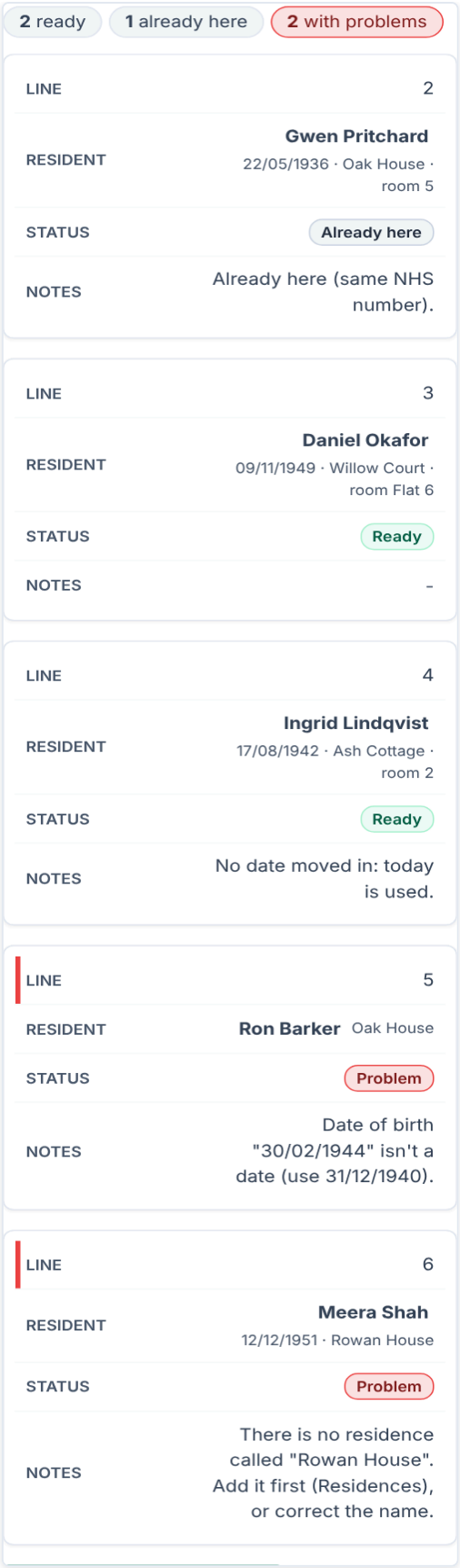


Figure 169. A checked file on a phone.

Press **Import the ready residents** (or accounts). You are asked to confirm it's you. Rows with problems are left out: fix them in your spreadsheet and import the same file again, and the rows already added are shown as already here. Residents get their placement at the residence, from the date moved in (today if blank), with the weekly fee; each one added is in the audit log.

Staff sign-in details. Each new account gets a username (made from the name if the file has none) and a temporary password of four words. They are shown **once**, straight after the import, with **Download these (CSV)**. Give each person their own details privately; they choose their own password the first time they sign in. Where two-factor login is required, each also gets a set-up code (section 2.2). Care providers and support workers see residents only at the residences listed for them; add residences later in the Carers tab if needed.

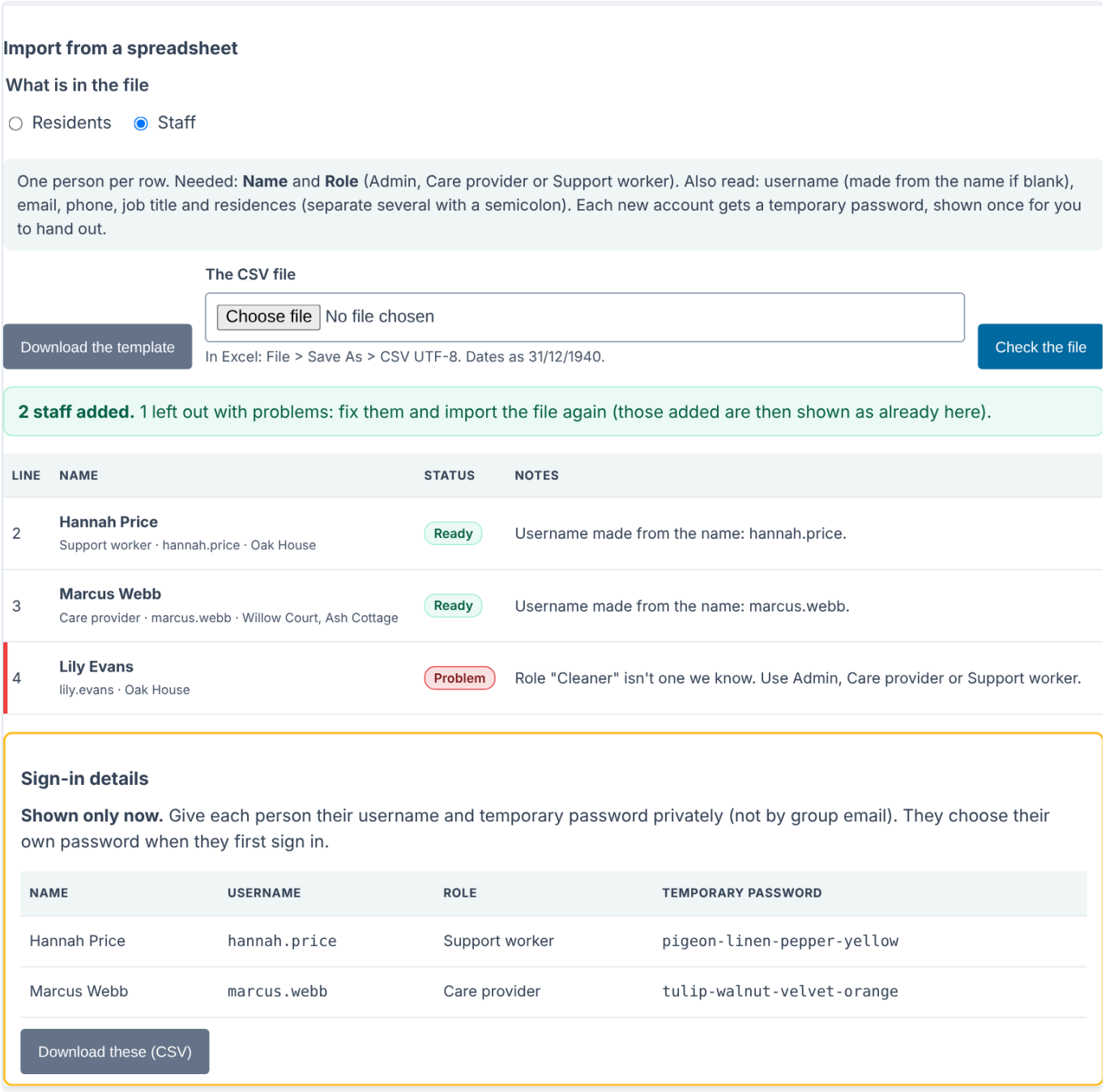


Figure 170. Staff imported, with their sign-in details shown once.

25.2 The commissioner return

Choose the period (last month to start with) and, if you like, one residence. The totals show straight away: residents, placements, days of care and what was invoiced. **Download (CSV)** gives one row per placement in the period: the residence, the resident's name, date of birth and NHS number, their finance reference, PO number and social work team, the placement's start and end, the days of care in the period, the weekly fee, and what was invoiced for them for invoice periods starting in it (cancelled invoices are left out), with a total. Care providers see only their residences.

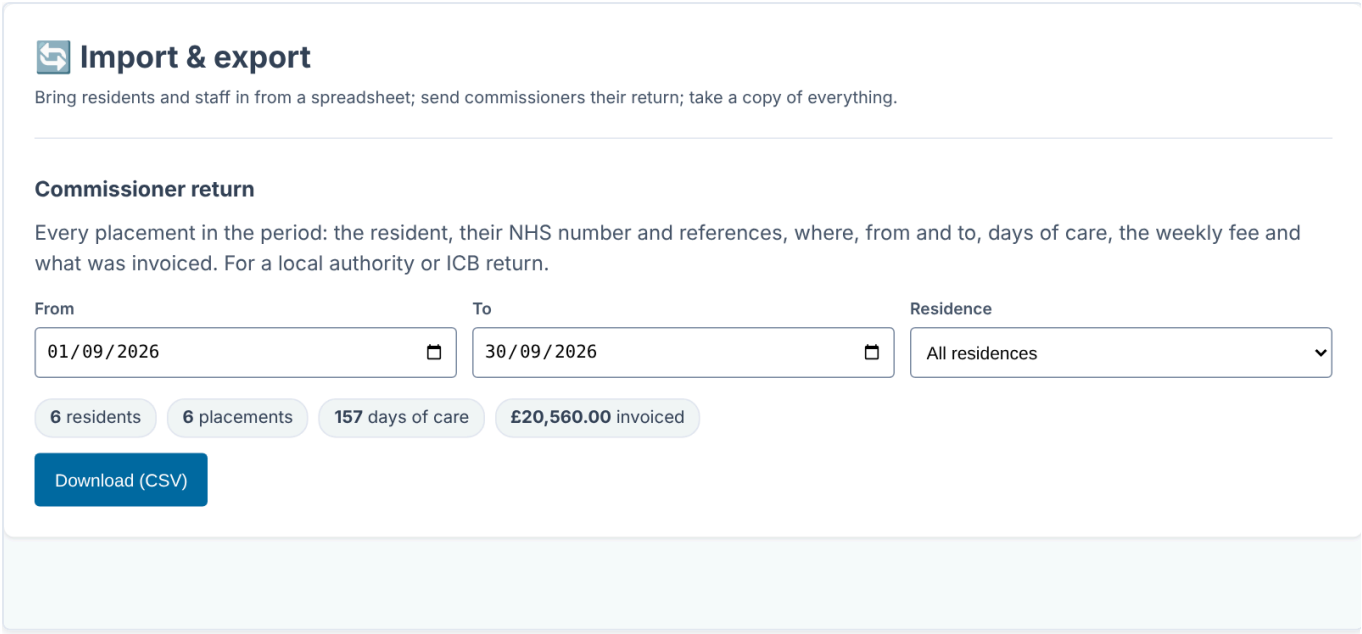


Figure 171. The commissioner return for a care provider.

25.3 Downloading all records

Download everything (ZIP) gives every record your care provider holds as spreadsheet (CSV) files in one ZIP file, decrypted: residents and every part of their record, placements, staff and their training, the rota, leave, incidents, complaints, monitoring, medicines, money, enquiries, audits, maintenance, policies, invoices and payments, and the audit log, with a README that explains each file. Records refer to each other by their id columns. Tick **Include every document and photo** to add the files themselves (a much bigger download). Passwords, two-factor secrets and other keys are never included.

Use it when moving to another system, or to keep a copy if you stop using Honeysuckle Care Management. You are asked to confirm it's you, and the download is in the audit log.

> The ZIP holds personal data about everyone you support and employ. Keep it somewhere secure (not a shared or personal drive), share it only with the people who need it, and delete it when it is no longer needed. Imports, returns and downloads are all in the audit log.

26. Audit Log

Who can use it: Admins.

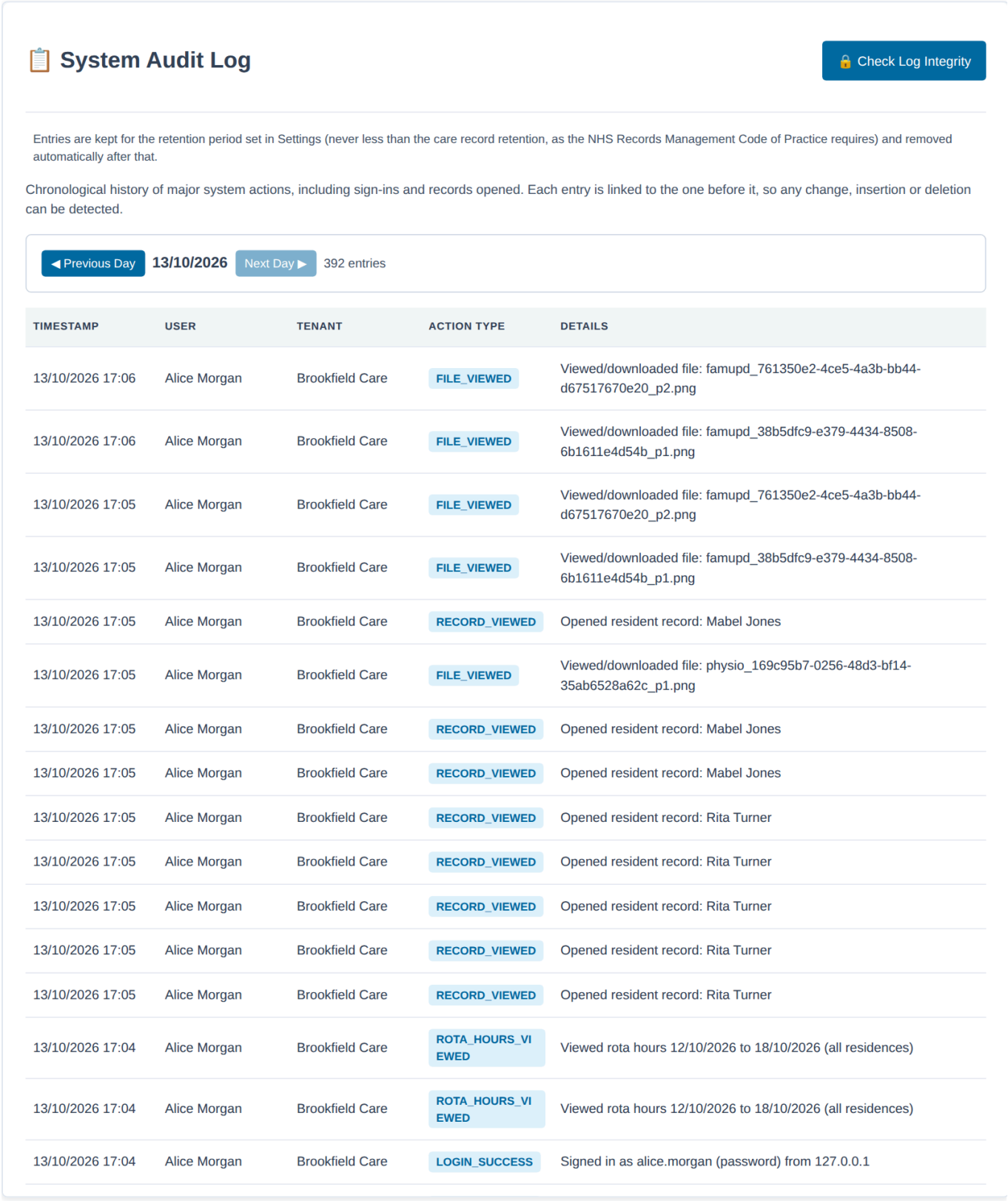


Figure 172. The audit log for one day.

The audit log records who did what and when: signing in and out, opening residents' records, adding, changing and deleting records, opening files, exports and downloads, and settings changes. It shows one day at a time; move with ◀ **Previous Day** and **Next Day** ▶.

Entries are chained together so that any change to the log can be detected: 🔒 **Check Log Integrity** checks the chain. Entries older than the audit retention period (never less than the care record retention) are removed automatically each day.

27. Settings

> **Who can use it:** Admins.

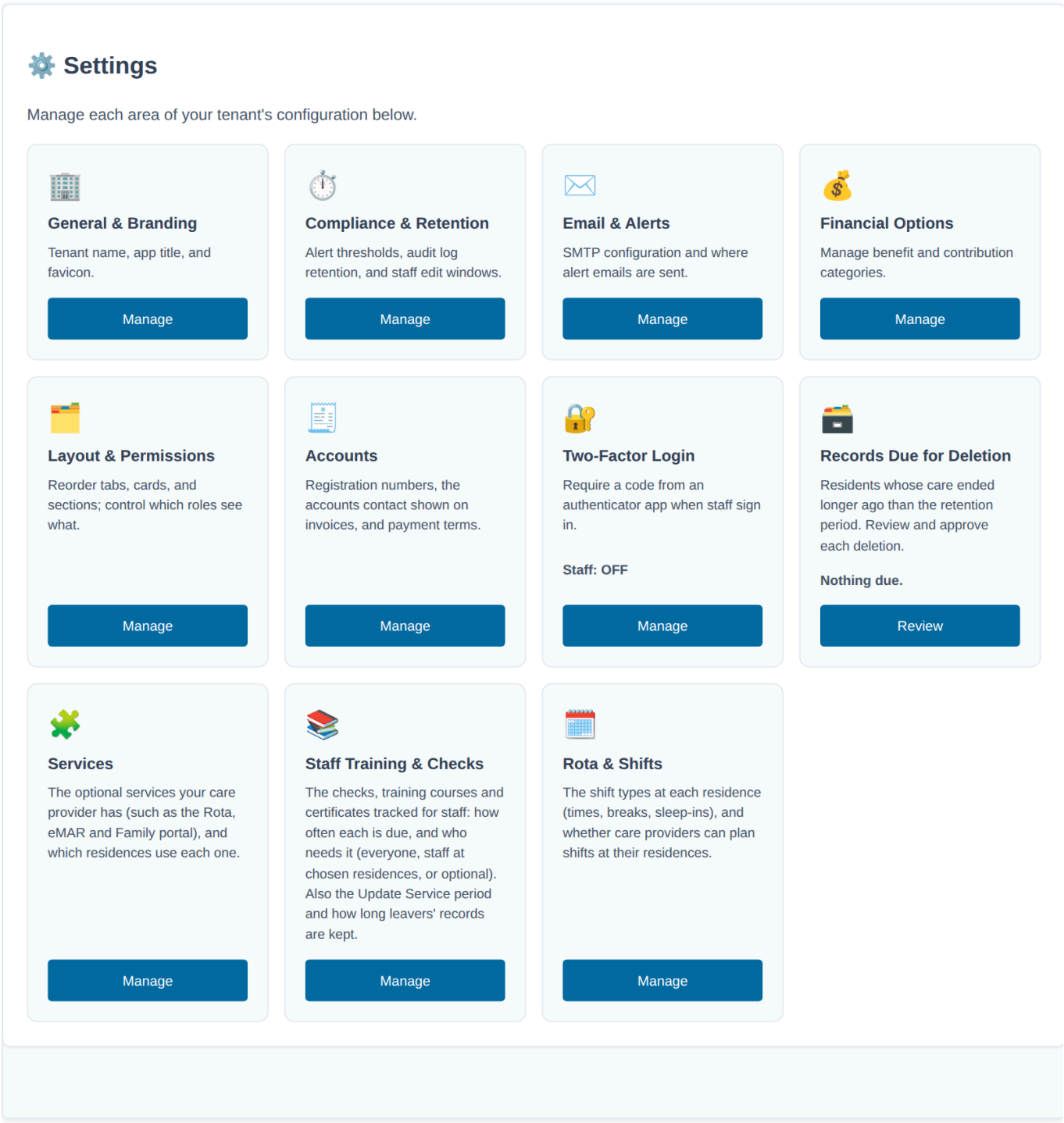


Figure 173. Settings.

27.1 General & Branding

Your provider's name as shown in the app, your logo (printed on PDFs, invoices and emails), and how much of long incident text is shown in tables before it is shortened.

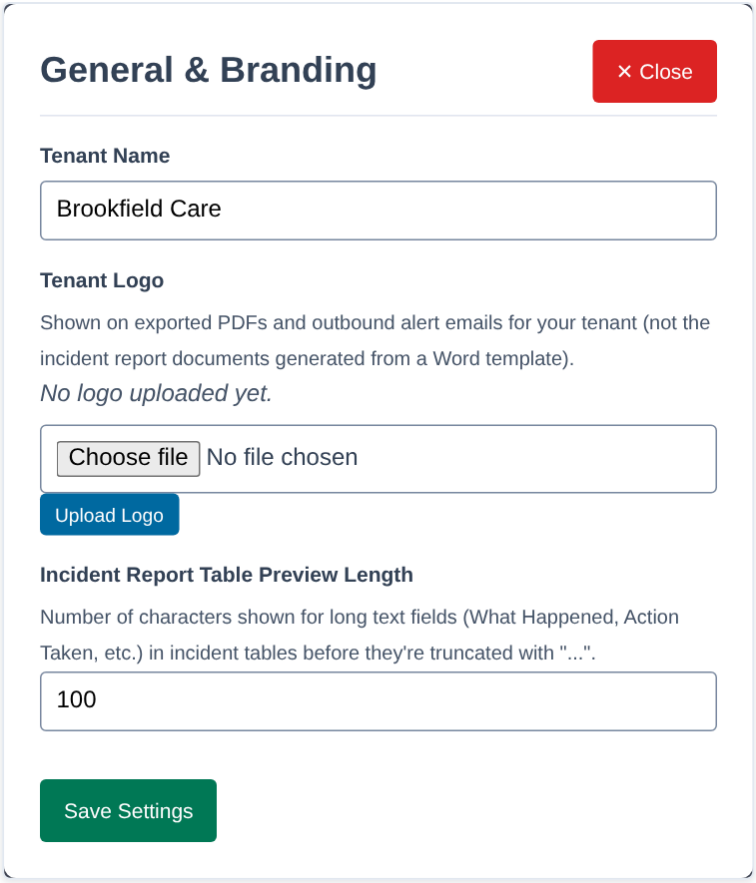


Figure 174. General & Branding.

27.2 Compliance & Retention

- **Audit log retention**: how long audit log entries are kept, in days. Never less than the care record retention (8 years).
- **Compliance alert threshold**: how many days before an expiry date a warning appears.
- **Stale activity alert threshold**: for checks with no expiry date (fire drills, alarm tests), how many weeks before a warning that none has been logged.
- **Appointment reminder window**: how far ahead the daily alert email, and family members' Appointments card, list upcoming appointments (14 days to start with).
- **Staff edit window**: how many days staff can change their own records.
- **Complaints**: how many working days you allow to acknowledge a complaint (3 to start with) and to send the final response (20 to start with), and **Can care providers close complaints?** (ticked to start with). See chapter 11.
- **Staff leave**: the day the leave year starts (1 January to start with), the holiday allowance everyone starts with, in hours (for example 5.6 weeks of 37.5 hours is 210), and a usual working day in hours (7.5 to start with). Each person's own allowance is set on the Leave tab (section 6.4).
- **Residents' money**: how often each resident's cash should be counted, in days (7 to start with). A count is shown as due after this (section 18.2).
- **Enquiries**: how soon a new enquiry should be answered, in days (2 to start with), and how long a closed enquiry is kept before it is deleted, in months (12 to start with). Admitted ones stay with the resident's record (chapter 19).
- **Policies**: how many days staff have to read a new policy version (14 to start with). Suggested when a version is issued; anyone who hasn't confirmed by then shows as overdue (chapter 21).
- **DoLS**: how many days before a DoLS authorisation ends to flag it (28 to start with), and after how many days without a decision to chase the council (21 to start with). See section 14.5.

- **Incident follow-up**: when each part of an incident's follow-up becomes overdue: telling CQC, the local authority, police or family (days after the incident, 1 to start with; 0 means the same day), each duty of candour step (working days, 10 to start with) and the manager's review and sign-off (days after the incident, 14 to start with). A box left empty goes back to its starting value. **Can care providers sign off incidents?** is ticked to start with; untick it so that only Admins can sign off and close incidents (care providers can still record the follow-up). See section 10.2.
- **Monitoring charts**: after how many hours without a drink, between 08:00 and 21:00, a resident on a fluid chart is flagged (4 to start with; 0 turns this off). Each resident's other targets are in their plan. See chapter 13.
- **Incident report templates**: a Word template for each residence type, used by **Report** on an incident.

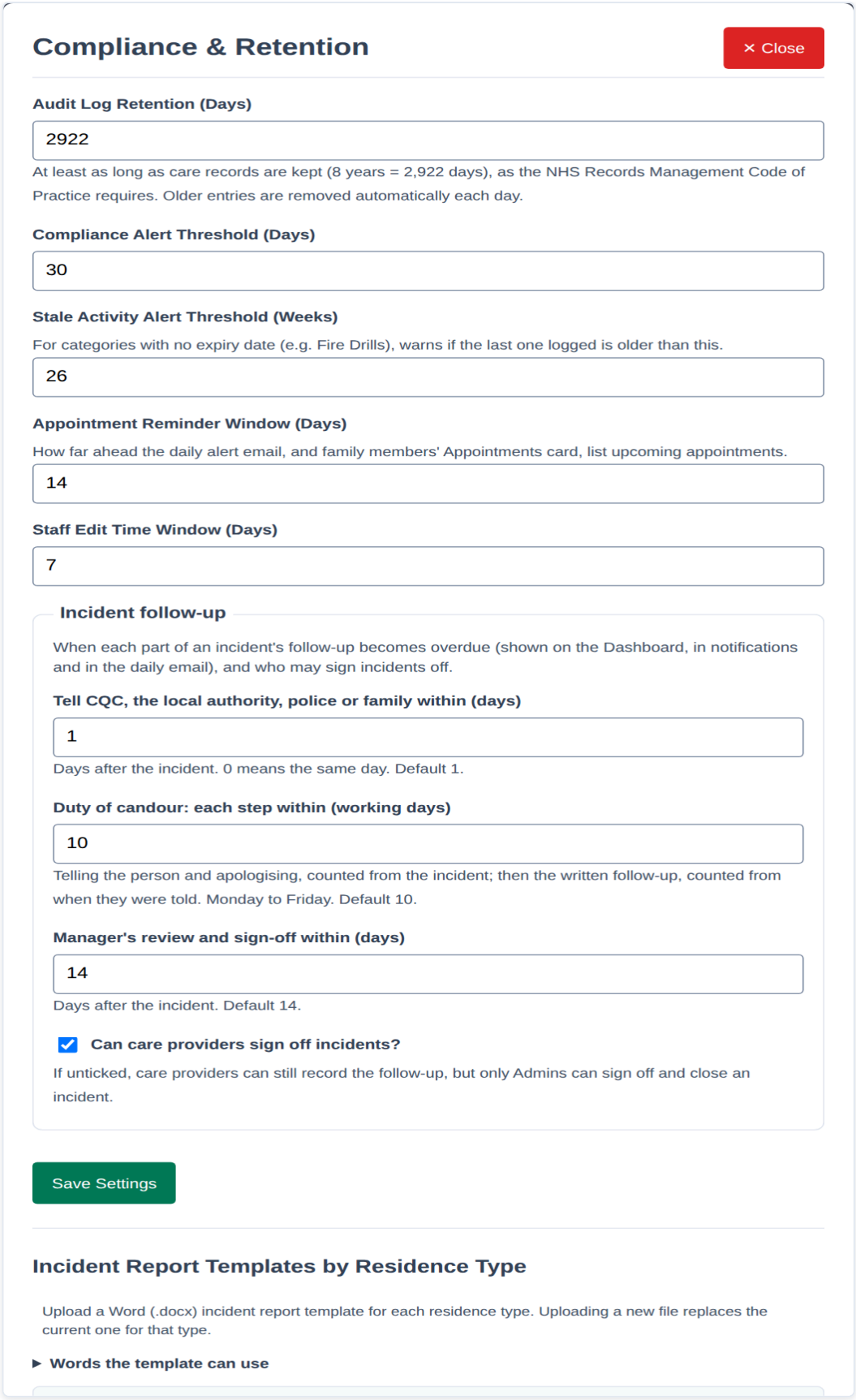


Figure 175. Compliance & Retention.

27.3 Email & Alerts

The mail server used to send invoices and the daily alert emails, and the address alerts go to. For Gmail or Google Workspace use smtp.gmail.com, port 587 (STARTTLS) and an *app password*, not your normal password; for Microsoft

365 use smtp.office365.com, port 587. **Send a test email** saves the settings and tries them, showing exactly what the mail server said if it fails. *Common settings and troubleshooting* lists the usual causes.

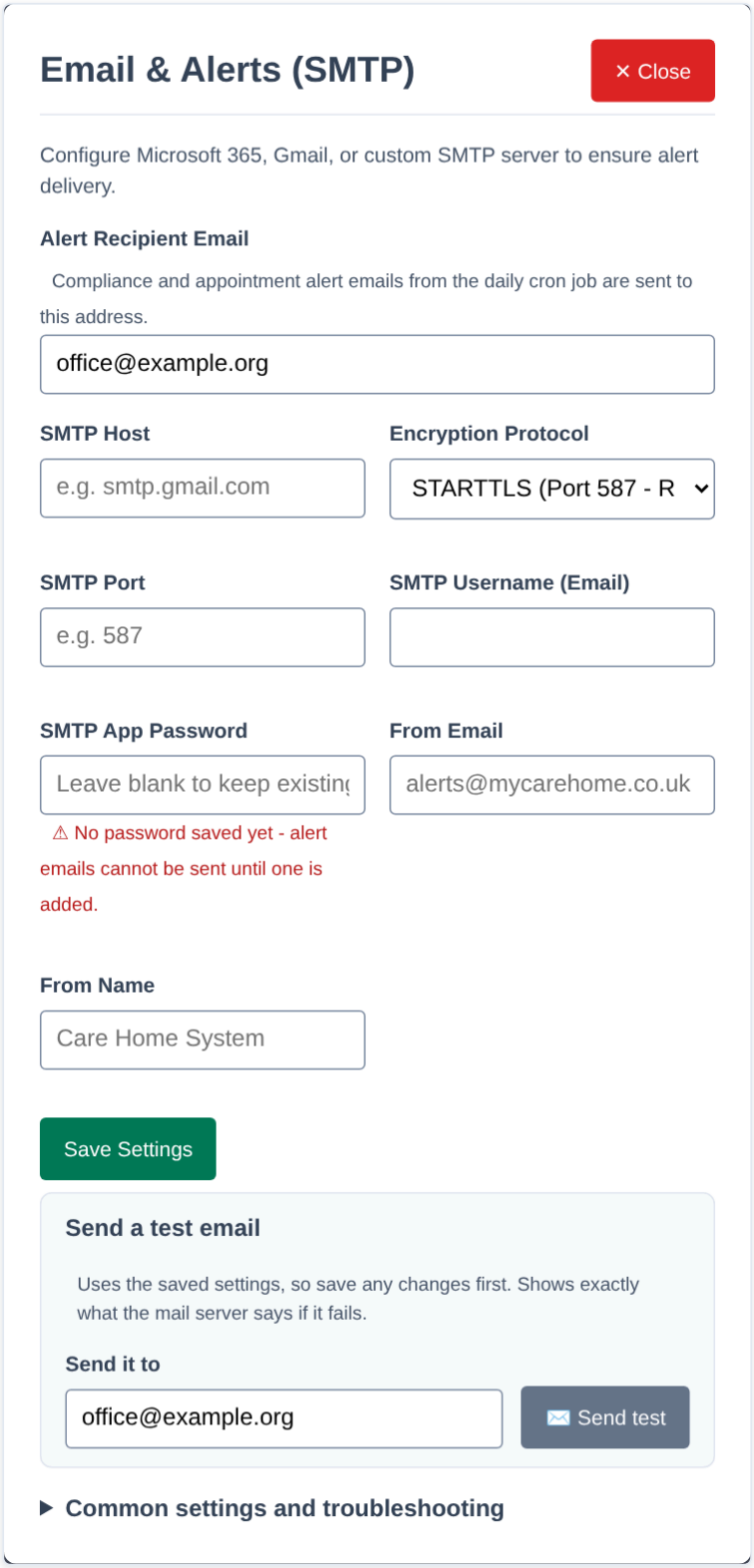


Figure 176. Email & Alerts.

27.4 Financial Options

The benefits and contributions offered in residents' financial breakdowns (for example Attendance Allowance, Pension Credit, a personal contribution).

27.5 Layout & Permissions

For each role, tick which tabs, Dashboard cards and client record sections they see, and use the arrows to change the order. Each tab shows the menu category it is in; the arrows set the order of the pages within each category's menu. You can also order the residence compliance categories. Some things are never shown to family members, whatever is ticked: risk assessments, assessments, consent forms, physio and correspondence. Which other parts of the record each family member sees is chosen in the Family tab (section 8.1).

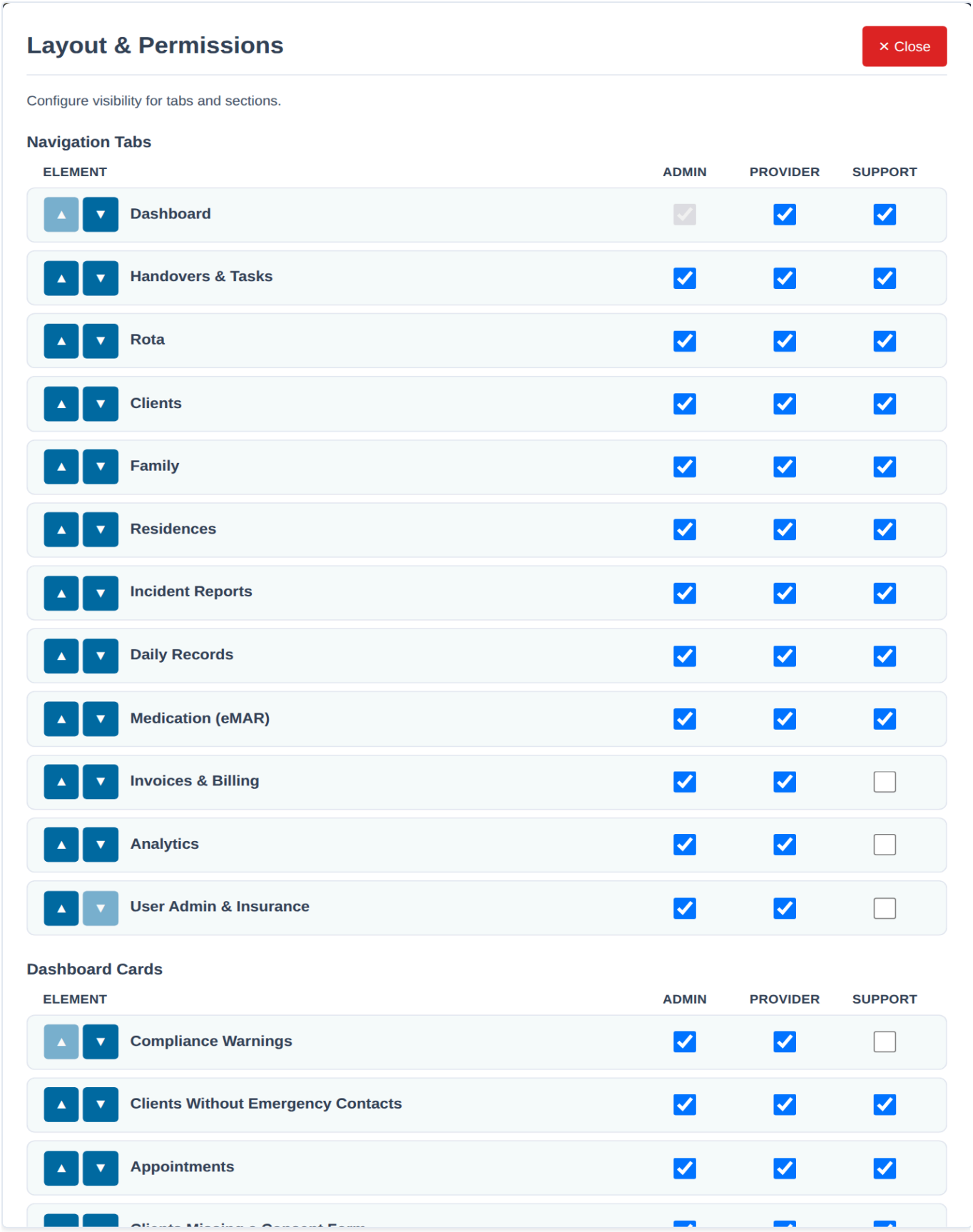


Figure 177. Layout & Permissions.

27.6 Accounts

Your CQC provider ID (or Care Inspectorate, CIW or RQIA number), ICO registration number and ODS/DSPT code, which appear on invoices and in the CQC evidence pack; the accounts contact shown on invoices; and the payment terms

(days until an invoice is due). Two switches add optional parts to every invoice: **Show "Service Provided" on invoices** and **Show the signatory section on invoices** (section 22.3). Both start switched off. Before switching on the signatory section, tell the staff concerned that their name, job title, email, phone number and signature will appear on invoices.

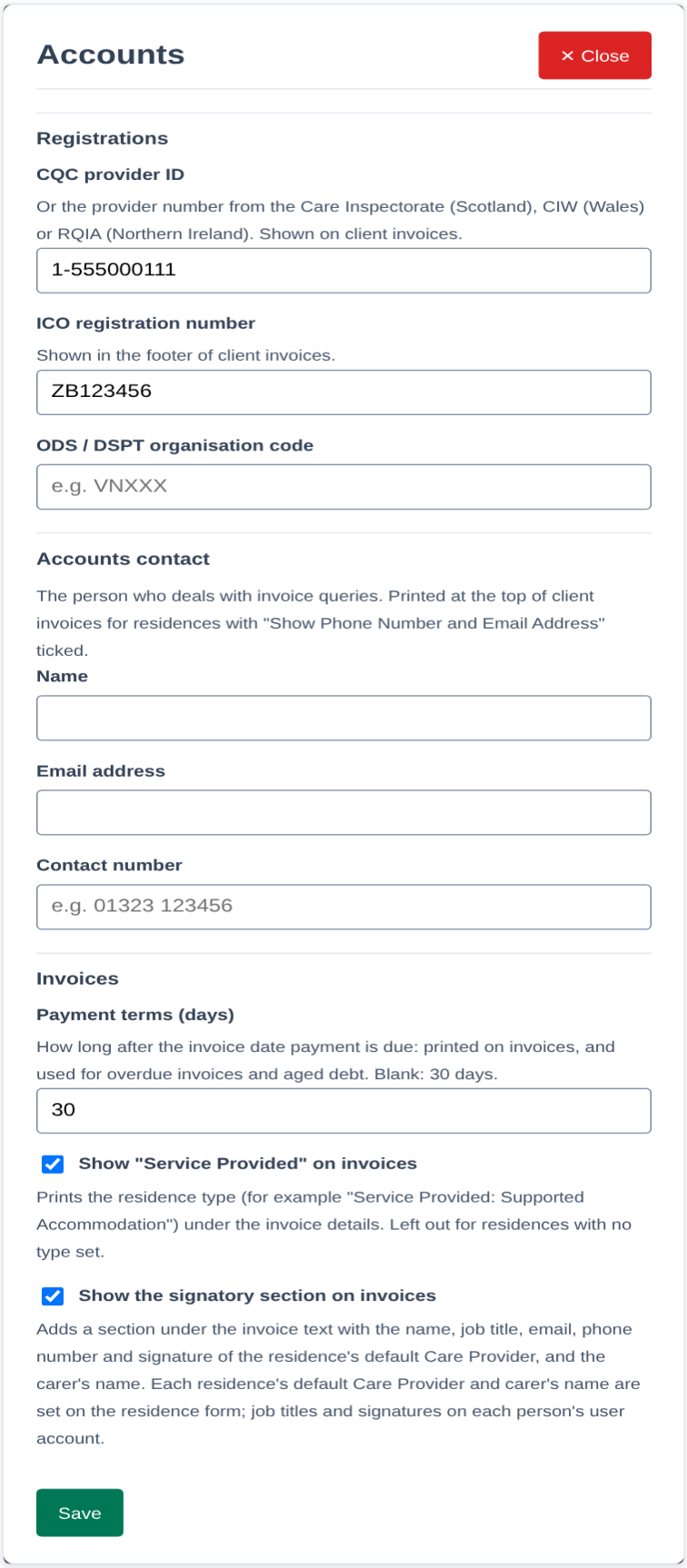


Figure 178. Accounts.

27.7 Two-Factor Login

Require two-factor login for all staff. Strongly recommended: it is needed for Cyber Essentials and supports your NHS Data Security and Protection Toolkit. If you have to switch it off for a while, choose when it switches back on automatically.

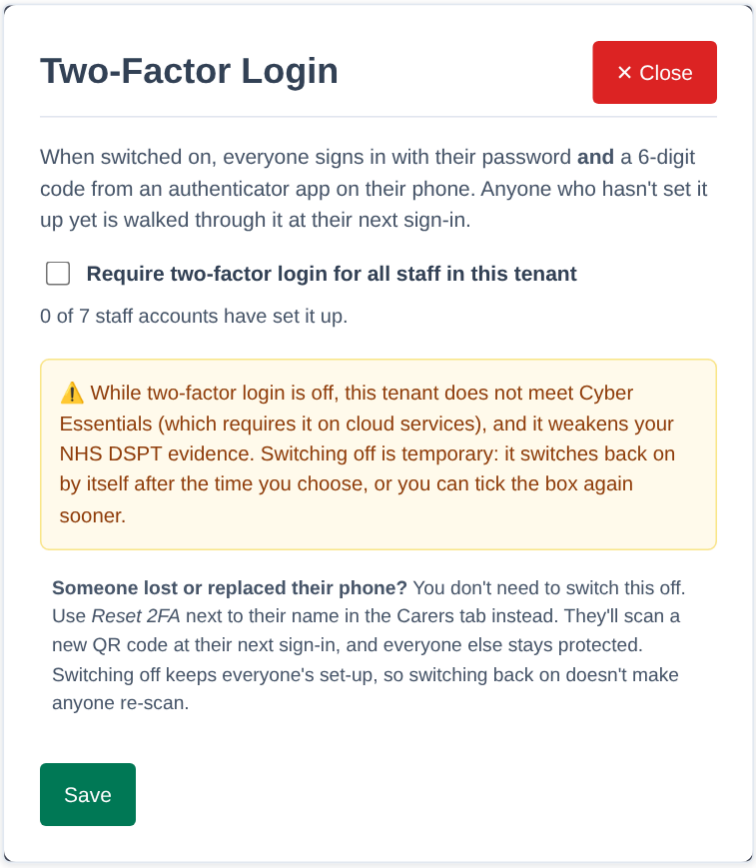


Figure 179. Two-Factor Login.

27.8 Records Due for Deletion

Care records are kept for 8 years after care ends (the minimum in the NHS Records Management Code of Practice). When that time has passed for a resident, they are listed here. Before approving, check there is no reason to keep the record longer, such as an open complaint, safeguarding enquiry, inquest or legal claim. Approving permanently deletes the whole record, including files. Invoices are kept under their own rules.

27.9 Staff Training & Checks

The checks, courses and certificates you track: how often each must be renewed, and who it is required for (everyone, staff at particular residences, or no one). You can also set how often to check the DBS Update Service, and how long to keep a leaver's records.

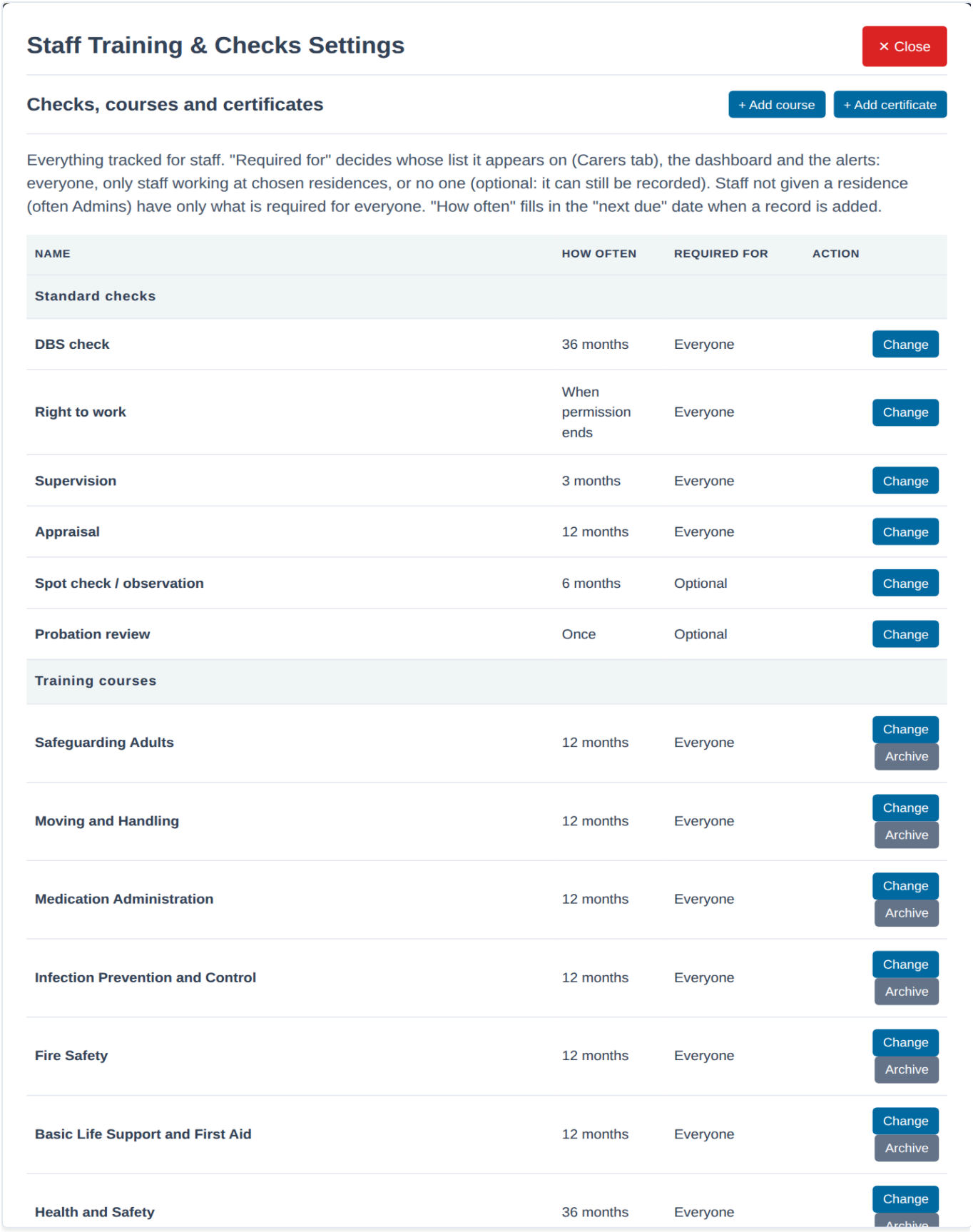


Figure 180. Staff Training & Checks settings.

27.10 Rota & Shifts

Whether care providers can plan shifts at their residences, and each residence's shift types (name, start, end, unpaid break, sleep-in, in use). Each residence starts with Early, Late, Long day, Night and Sleep-in, which you can change or

switch off. Tick **24-hour shift** on a type that ends at its start time the next day.

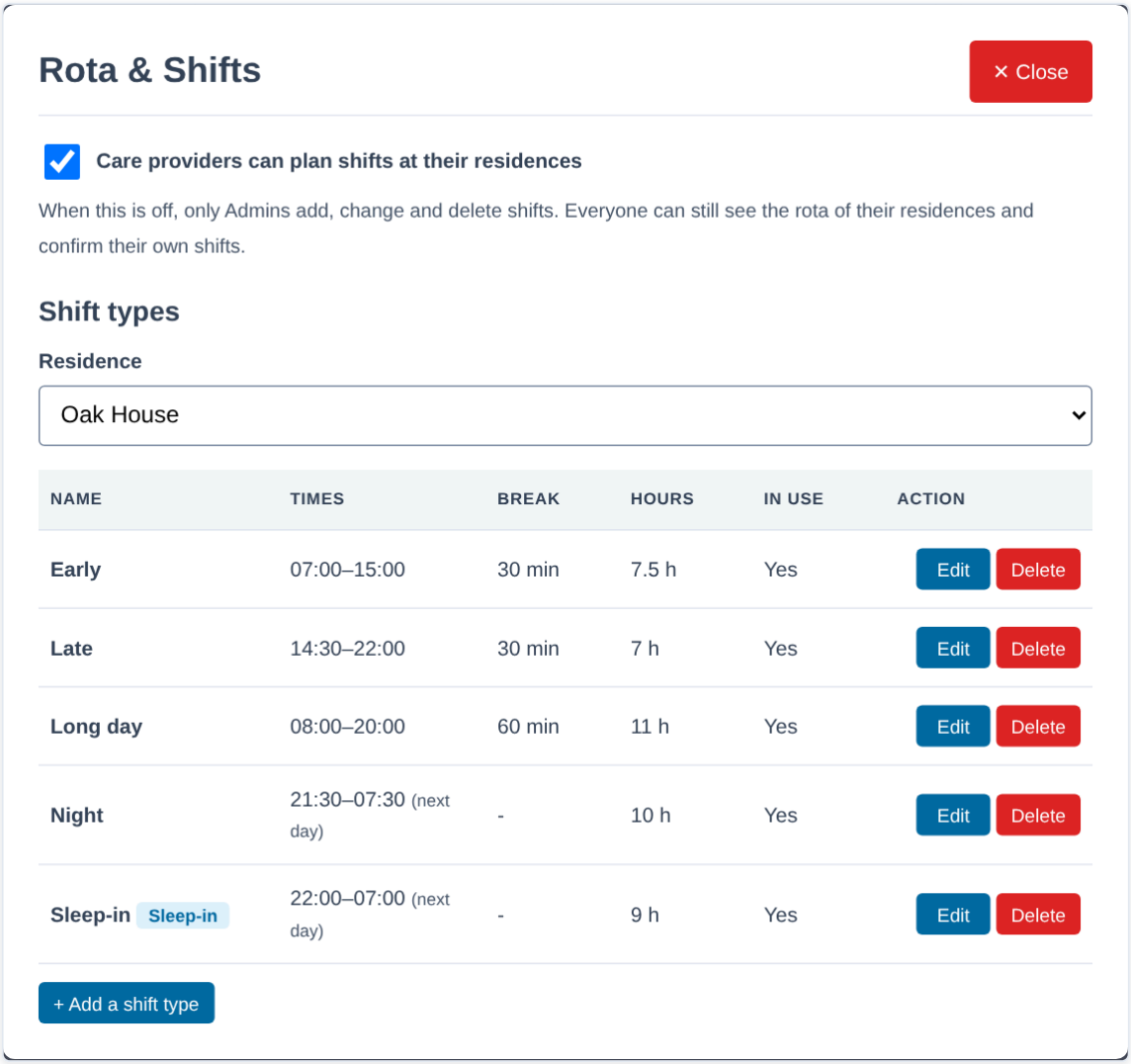


Figure 181. Rota & Shifts.

27.11 Services

Some parts of the app are optional services, which your care provider has as part of its subscription: the **Rota**, **Medication (eMAR)**, the **Family portal**, **Resident invoicing**, **Care plans & risk assessments**, the **CQC evidence pack**, **Events** and **Monitoring charts**. Everything else (residents' records, daily records, incidents, handovers and tasks, staff training and residences) is always included.

Settings > Services shows each service, whether it is *Included*, and a tick box for each residence. Untick a residence that doesn't need a service: it is hidden for staff there, its residents aren't counted for it, and the app refuses its actions for that residence. For example, if only one of your homes uses the Rota, untick it at the other. You are asked to confirm before a service is switched off. Anything already recorded (shifts, doses, care plans, messages, invoices) is kept and comes back when you switch it on again, and is still included in a Subject Access Request. Every change is in the audit log.

A service marked *Not included* isn't part of your subscription: its tab and cards don't appear for anyone. To add it, contact your platform provider. Services are charged per resident each month, counting the residents at the residences where the service is switched on.

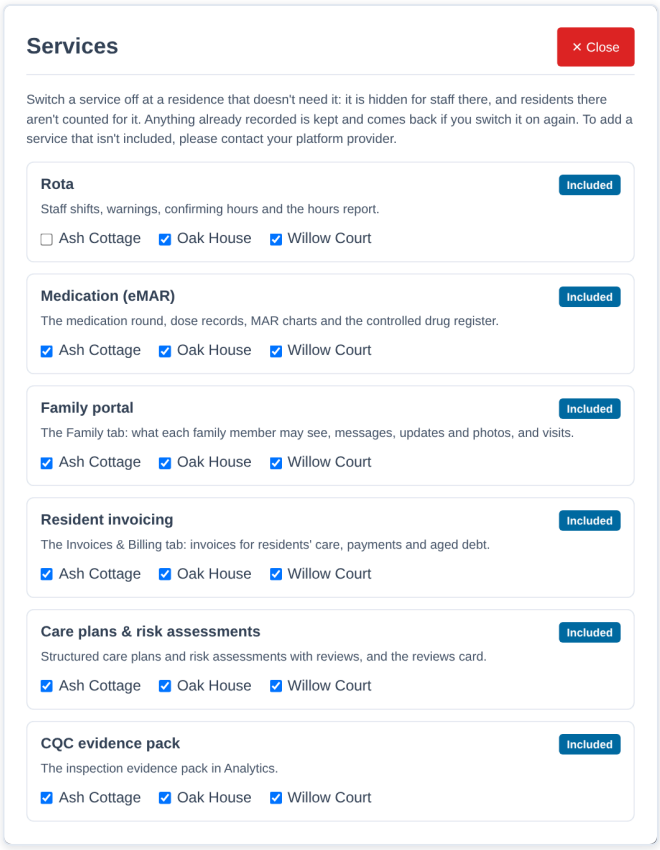


Figure 182. Settings > Services: the Rota is used at Oak House and Willow Court only.

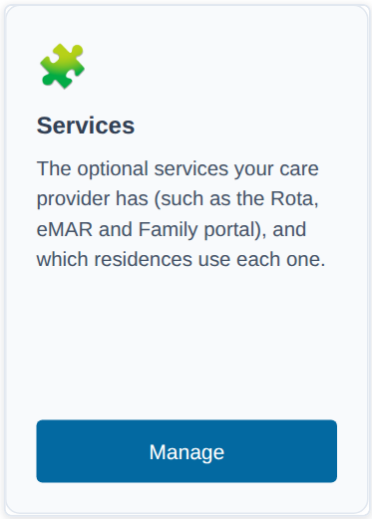


Figure 183. The Services card in Settings.

Without the Medication (eMAR) service at a residence, the Medications section of a resident's record there is a simple list of what they take (name, dose and dates), with no schedule, round or MAR chart.

28. A guide for family members

This chapter is written for residents' relatives and representatives who have a family account.

Signing in. The care team sets up your account and gives you a username and a starting password. When you first sign in you'll be asked to choose your own password (at least 12 characters; three or four unrelated words work well). You can use a phone, tablet or computer.

What you can see. Your account is linked to your relative. The care team records what your relative has agreed to share with you; if something is missing, ask them. You can see:

- **Dashboard**: the home's emergency contacts, your relative's upcoming appointments, and the events you are invited to.
- **Clients**: your relative's record: their details, allergies and contacts, and the parts the care team has shared with you, such as daily notes, health appointments, the medicines they take and their care plan. The record of each dose given is kept by the care team and isn't shown in the family account; ask them if you have a question about it.
- **Family**: messages with the care team, news and photos, and visits.
- **Events**: outings and activities you are invited to.

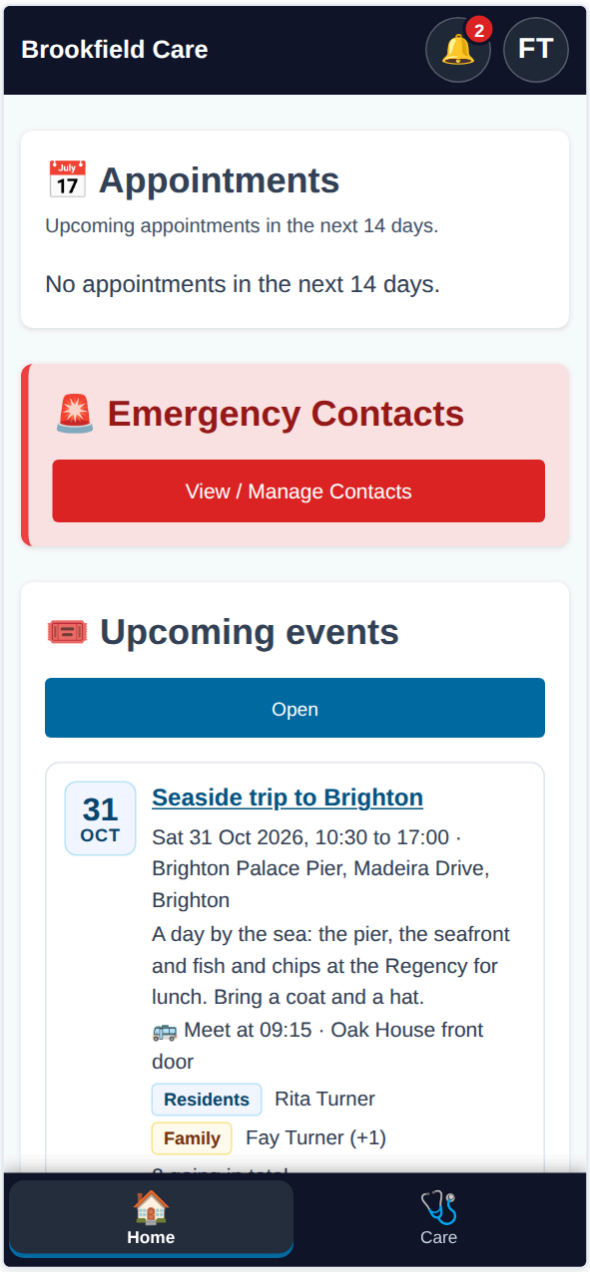


Figure 184. The Dashboard on a phone.

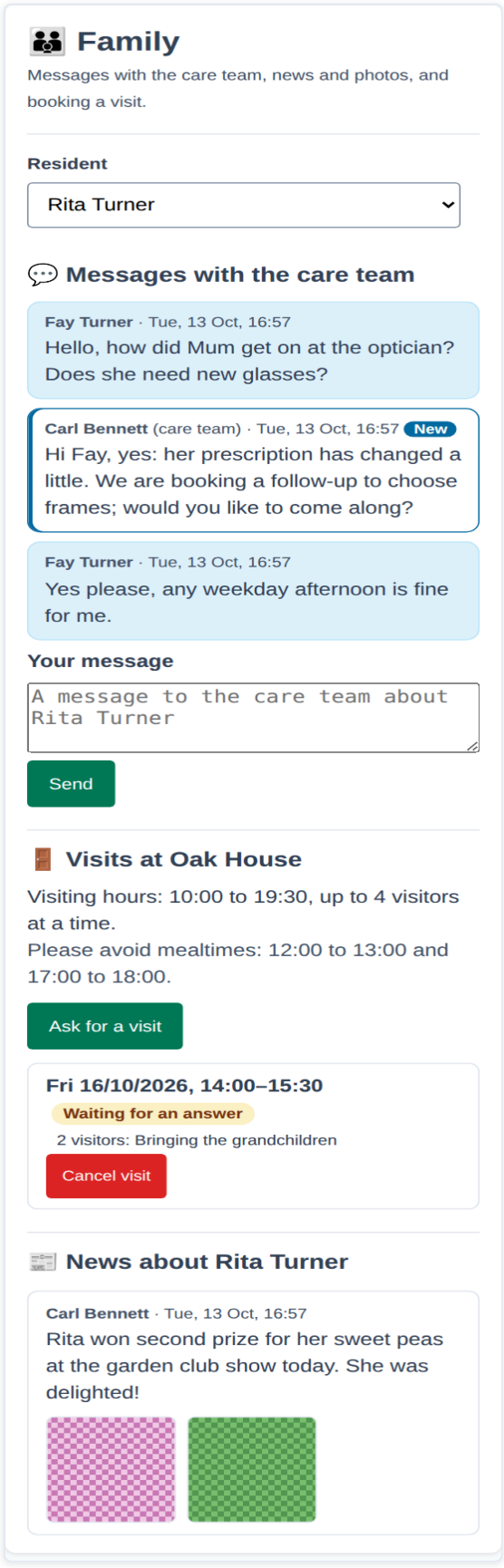


Figure 185. The Family tab on a phone.

Messages. Write to the care team under *Messages with the care team* and press **Send**. You'll get a notification (the bell at the top) when they reply.

News and photos. Updates from the care team appear under *News*. Tap a photo to see it full size.

Visits. Press **Ask for a visit**, choose the day, the times (within the visiting hours shown) and how many people are coming, and add anything the team should know. The team will confirm it or suggest another time; if they suggest one, press **Accept the new time** or **Cancel visit**. You can cancel a visit at any time.

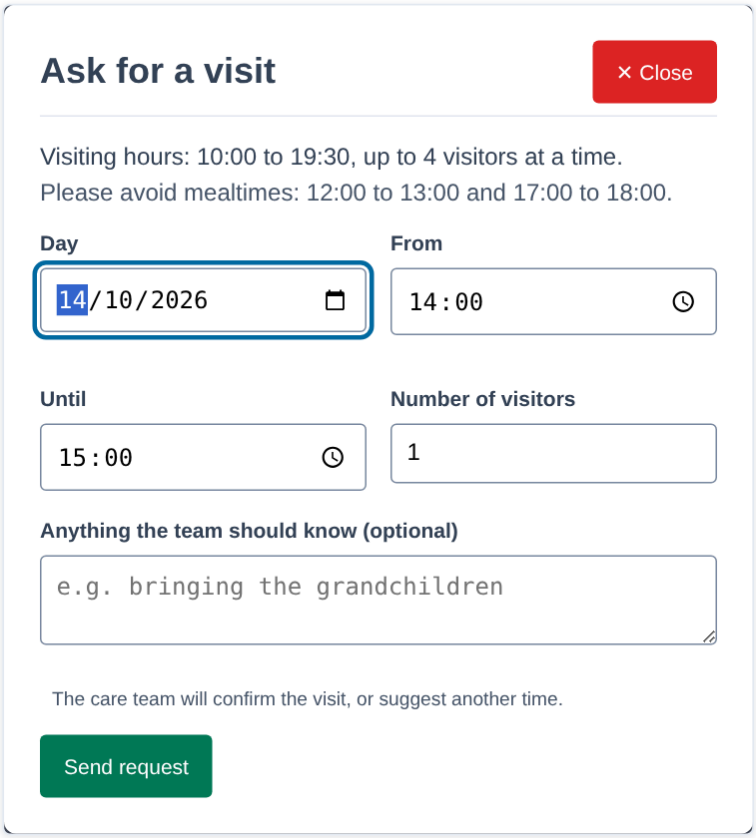


Figure 186. Asking for a visit.

Complaints and compliments. At the bottom of the Family tab, under *Complaints and compliments*, choose *A complaint* or *A compliment*, write a few words and what happened, say how you would like a reply, and press **Send**. A complaint is looked into by a manager, who will reply to you; you'll get a notification when it has been acknowledged and when it is closed, and the list there shows how it is going.

Events. When the care team invites you to an event (a trip out, a party), you get a notification and usually an email. Open **Events**, open the event and press **Reply**: choose Accept or Decline, how you'll travel, how many tickets you need (yourself included) and the names of anyone coming with you. If there is a cost, you are sent your own invoice for your tickets. The Dashboard shows your upcoming events.

Dark mode. Tap the round button with your initials at the top right, then **Dark mode**, to switch to dark colours, which some people find easier to read in the evening. Do the same to switch back. It's remembered on your account. The same menu has **Log out**.

Keeping it private. Don't share your password, and sign out on a shared device. You are signed out automatically after 30 minutes without using it.

29. Glossary

Acknowledge
To confirm you have read a shift handover.

Amended
A record that has been changed; its earlier versions are kept.

Audit log
The record of who did what and when (chapter 26).

Best interests
A decision made for someone who lacks capacity for it, taking account of their wishes and the views of people close to them, and choosing the less restrictive option (section 14.3).

Care provider
A role for senior care staff (chapter 1).

Cash count
Two members of staff counting a resident's cash and recording what they found, to check it matches the account (section 18.2).

Controlled drug (CD)
A medicine with extra legal controls, such as morphine. Each dose is witnessed and the stock is kept in a register (section 16.5).

Bristol stool type
A scale from 1 (hard lumps) to 7 (watery) used to describe bowel movements (section 13.2).

Bradford factor
A measure of sickness absence: the number of spells squared, times the days off, over 12 months (section 6.3).

Commissioner return
A list of each resident's placements in a period, with days of care, fees and what was invoiced, for the local authority or ICB that funds them (section 25.2).

CQC
The Care Quality Commission, which regulates care in England.

DNACPR
Do not attempt cardiopulmonary resuscitation: a clinician's decision, recorded on a form, that CPR should not be attempted (section 14.1).

DoLS
Deprivation of Liberty Safeguards: the authorisation needed when someone who lacks capacity to consent is deprived of their liberty in a care home (section 14.2).

DBS
The Disclosure and Barring Service check for people working with vulnerable adults.

Edit window
How long staff can change records they wrote (7 days unless changed).

Dark mode
Dark backgrounds with light text, switched on and off in the account menu (your initials, top right); each person's own choice (section 2.3).

CSV
: A simple spreadsheet file (comma-separated values) that Excel and other programs open and save (chapter 25).

Default Care Provider
: The member of staff whose details sign a residence's invoices (sections 9.2 and 22.3).

eMAR
: Electronic medication administration record: the record of each dose given or not given (chapter 16).

EHR
: Electronic health record: the client record (section 7.2).

Event
: An outing or activity with invitations, replies, travel and, if it costs anything, invoices for those going (chapter 17).

Legionella
: Bacteria that can grow in water systems and cause a serious lung infection. Keeping hot water hot and cold water cold, and flushing little-used outlets, controls it (section 20.2).

Leave year
: The 12 months a holiday allowance covers, starting on the day your care provider chooses (section 6.1).

LPA
: Lasting power of attorney: someone the resident chose, while they had capacity, to make decisions for them about health and welfare or money (section 14.4).

MAR chart
: A month of one resident's medicines and doses on one page (section 16.4).

MUST
: The Malnutrition Universal Screening Tool: a score from BMI, recent weight loss and acute illness; 2 or more is high risk (section 13.2).

NEWS2
: The National Early Warning Score: a score from vital signs showing how unwell someone may be, and how urgently to get help (section 13.2).

Occupancy
: The share of a residence's places filled over a period (chapter 23).

Open shift
: A shift with nobody on it yet.

Policy version
: One issue of a policy, with its document. Staff confirm they have read the current version; a new version needs reading again (chapter 21).

Pre-admission assessment
: An assessment of someone's needs before they move in, deciding whether the home can meet them (section 19.3).

PRN
: "When required": a medicine given only when needed, within limits (section 16.3).

ReSPECT
: A form recording a person's priorities for care and clinical recommendations for an emergency, including about CPR (section 14.1).

Quality statement
: One of the 34 commitments in CQC's Single Assessment Framework.

Retention period
: How long records are kept before they can be deleted (section 27.8).

SAR
: Subject Access Request: a person's right to a copy of the information held about them (section 7.7).

Strike through
: How a wrong dose record or monitoring chart entry is corrected: it stays, crossed out with the reason, and is recorded again.

Sleep-in
: A night shift where the staff member sleeps at the residence; counted separately in the hours report.

Witness
: A second trained member of staff who confirms a controlled drug dose or stock entry with their own password.

TMV
: Thermostatic mixing valve: a valve that blends hot and cold water to a safe temperature at a bath, shower or basin, so residents can't be scalded (section 20.2).

Two-factor login
: Signing in with a password and a code from an authenticator app (section 2.2).