REPORT ON A SCOPING EXERCISE TO IDENTIFY PRIORITY TOPICS FOR NATIONAL AUDIT ON THE ESSENCE OF CARE

APPENDICES TO FINAL REPORT

FEBRUARY 2008

Lynne Currie
Linda Watterson

RCN Learning & Development Institute
Whichford House Building 1400
Parkway Court
Oxford Business Park
Cowley
Oxford
OX2 2JY

Tel: 01865 787133
Fax: 01867 787149
Email: eoc@rcn.org.uk

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APPENDIX 1: LIST OF ALL NHS TRUSTS AND CHARITABLE ORGANISATIONS INVITED TO PARTICIPATE IN THE CONSULTATION

NHS ORGANISATIONS BY REGION IN ENGLAND:

LONDON
Chelsea and Westminster Hospital NHS Foundation Trust
Haringey Teaching Primary Care Trust
King's College Hospital NHS Foundation Trust
Lewisham Hospital NHS Trust
Newham Primary Care Trust
St George's Healthcare NHS Trust
University College London Hospitals NHS Foundation Trust
Whittington Hospital NHS Trust

NORTH EAST
City Hospitals Sunderland NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
County Durham Primary Care Trust
Gateshead Primary Care Trust
Queen Elizabeth Hospital NHS Trust
Newcastle Primary Care Trust
Northumbria Healthcare NHS Foundation Trust

NORTH WEST
Bolton Hospitals NHS Trust
Bolton Primary Care Trust
Central Manchester Primary Care Trust
Cumbria Primary Care Trust
North Cumbria Acute Hospitals NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust

SOUTH WEST
Dorset Healthcare NHS Foundation Trust
Devon Primary Care Trust
Great Western Ambulance Service NHS Trust
United Bristol Healthcare NHS Trust
Salisbury NHS Foundation Trust
Swindon and Marlborough NHS Trust

WEST MIDLANDS
Birmingham East and North Primary Care Trust
Dudley Primary Care Trust
Coventry Teaching Primary Care Trust
Heartlands Hospital NHS Trust
University Hospitals Coventry and Warwickshire NHS Trust
Royal Wolverhampton Hospitals NHS Trust
South Warwickshire General Hospitals NHS Trust

South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust

YORKSHIRE & HUMBERSIDE

Bradford Teaching Hospitals NHS Foundation Trust
Hull Teaching Primary Care Trust
Leeds Primary Care Trust
Leeds Teaching Hospitals NHS Trust
North Yorkshire and York Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Rotherham NHS Foundation Trust
Rotherham Primary Care Trust
Yorkshire Ambulance Service NHS Trust
York Hospital NHS Trust

NHS ORGANISATIONS IN WALES

Bro Morgannwg NHS Trust
Carmenthshire NHS Trust
Gwent Healthcare NHS Trust

CHARITABLE ORGANISATIONS:

Action for Sick Children
Age Concern - Birmingham
Age Concern - Camden
Age Concern - Cardiff
Age Concern - Exeter
Age Concern - Leeds
Board of Community Health Council in Wales
Carers UK
Children in Wales
Council for Disabled Children
Help the Aged
MIND
Multiple Sclerosis Trust
National Children's Bureau
National Pensioners Convention
National Rheumatoid Arthritis Society
Older People's Advisory Group
Parkinson's Disease Society
Patients Association
Stroke Association

APPENDIX 2: LETTERS OF INVITATION

Royal College of Nursing
RCN Institute
Whichford House Building 1440
Parkway Court
Oxford Business Park
Oxford OX4 2JY

Linda Watterson
Programme Manager: Evaluating & Improving

Telephone 01865 787 127
Fax 01865 246 787
Mobile
Pager
Email linda.watterson@rcn.org.uk

Date

REF/RCNLETTER/NOR001/CE/DNS/CGL

Dear Colleague

Re: Identifying National Priorities for Clinical Audit on the Fundamentals of Care

The Healthcare Commission has chosen the Royal College of Nursing Institute to identify priorities for a national audit on fundamentals of care. Any national audits endorsed by the Healthcare Commission will contribute the annual review. I am aware that all NHS Boards will be considering how best to give greater priority to the issues of essential care for patients.

To ensure that we focus on the issues that are of greatest importance to patients and professionals, we are undertaking a wide-ranging consultation across England and Wales with key stakeholders (eg. frontline clinical staff from nursing, medicine and allied health professionals, senior staff, non-executive board members, patients and carers). A small number of NHS Trusts in each region have been selected to participate in workshops as part of the consultation. Your Trust has been selected and we would be grateful if you would identify stakeholders to represent your organisation at a workshop taking place in **(place)** on (**date and venue**).

We would be grateful if you could arrange for the attached form to be completed and returned to us no later than 1200am on Friday 9th November 2007.

We will submit our report and recommendations to the Healthcare Commission by February 2008.

Please be aware that places at the workshops are limited and will be allocated on a first come, first served basis. We very much hope you will get involved in this important work and we look forward to hearing from you.

Yours sincerely

Linda Watterson

Programme Manager: Evaluating & Improving

RCN Institute

Enc

Please complete and return this form, to arrive no later than Friday 9th November to Lynne Currie, Project Manager: Evaluating & Improving, RCN Institute, Whichford House, Building 1400, Parkway Court, Oxford Business Park, Oxford, OX4 2JY, or email the details to eoc@rcn.org.uk.

Organisation:
Nursing Representative: Address: Email: Tel No.
Medical Representative: Address: Email: Tel No:
AHP Representative: Address: Email: Tel No:
PPI Forum Representative: Address: Email: Tel No:
Non-Executive Representative: Address: Email: Tel No:
Management Representative: Address: Email Tel No:

Royal College of Nursing
RCN Institute
Whichford House Building 1440
Parkway Court
Oxford Business Park
Oxford OX4 2JY

Linda Watterson
Programme Manager: Evaluating & Improving

Telephone 01865 787 127
Fax 01865 246 787
Mobile
Pager
Email linda.watterson@rcn.org.uk

Date

Dear

Re: Identifying the fundamentals of care

The Healthcare Commission has funded the Royal College of Nursing Institute to identify priorities for a national audit on fundamentals of care. Clinical audit, together with outcomes monitoring are two closely related activities that seek to improve patients' experiences and health through the systematic review of healthcare delivery, and any national audits endorsed by the Healthcare Commission will form part of the NHS annual health check.

To ensure that we focus on the issues that are of greatest importance to patients we are undertaking a wide-ranging consultation across England and Wales with key stakeholders. Your organisation has been selected and we would be grateful if you would identify stakeholders to represent your organisation at a workshop taking place in (place) on (date and venue).

We will submit our report and recommendations to the Healthcare Commission by February 2008.

Please use the attached form at the bottom of this letter to indicate who will represent your organisation at the workshop. We would be grateful if this information was returned to us no later than 1200am on Friday 9th November 2007.

Please be aware that places at the workshops are limited and will be allocated on a first come, first served basis. We very much hope your organisation will get involved in this important work and we look forward to hearing from you. If it is not feasible for your representatives to attend the workshop they can participate via electronic means by registering their interest at eoc@rcn.org.uk.

Yours sincerely

Linda Watterson

Programme Manager: Evaluating & Improving

RCN Institute

Enc

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Organisation:
Our representative is: Name Address   Tel No. Email:

APPENDIX 3: INFORMATION CASCADED ACROSS RCN DEPARTMENTS AND BRANCH OFFICES

Royal College of Nursing
RCN Institute
Whichford House Building 1440
Parkway Court
Oxford Business Park
Oxford OX4 2JY

Linda Watterson
Programme Manager: Evaluating & Improving

Telephone 01865 787 127
Fax 01865 246 787
Mobile
Pager
Email linda.watterson@rcn.org.uk

1st November 2007

REF/NSEAEOC/001/07

Dear Colleague

Re: Identifying Priority Topics for National Audit on the Fundamentals of Care

The Healthcare Commission has chosen the Royal College of Nursing Institute to undertake a scoping exercise with a wide range of stakeholders in England and Wales to identify priorities for a national audit on the fundamentals of care.

To ensure that we focus on the issues that are of greatest importance to patients and professionals, we are undertaking a wide-ranging consultation across England and Wales with key stakeholders, including: frontline clinical staff from nursing, medicine and allied health professionals, senior staff, management, non-executive board members, patients and carers.

We will submit our report and recommendations to the Healthcare Commission by February 2008.

Following advice from the project steering group we have randomly selected a number of NHS Trusts to send representatives to a number of workshops being held across England and Wales. These workshops will take place on:

21st November 2007	Novartis, Portland Place, London
22nd November 2007	58-62 Hagley Road, RCN Birmingham
26th November 2007	11-15 Dix's Field, RCN Exeter
11th December 2007	Ty Maeth, RCN Cardiff
12th December 2007	Centenary Gallery, University of Leeds

Participants attending the workshops will be asked to identify and rank, in order of importance, the key aspects of care needed to improve safety and quality, as well as a range of key measurable audit questions.

Because it has not been possible, either within the timescale, the budget constraints, or within the restraints of the scope set by the Healthcare Commission to undertake workshops across the United Kingdom, we are extending the consultation to allow people to participate via electronic means. This will be facilitated through the provision of an electronic link on the RCN web page, which will direct those wishing to participate to complete an electronic form and return it to eoc@rcn.org.uk.

At the end of the consultation phase the ideas generated from both the workshops and the electronic participation will be collated and analysed by the project steering group and will form a major part of the final report and recommendations to the Healthcare Commission.

I have enclosed some additional information, in the form of Q's and A's about the project and I would be very grateful if you could cascade this information to your members to give them an opportunity to participate in the consultation.

Yours sincerely,

Linda Watterson

Programme Manager: Evaluating & Improving

RCN Institute

Enc.

Identifying National Audit Topics for Fundamentals of Care: A Scoping Exercise

Q. What is the project about?

A. The project aims are to

- Identify a ranked list of priority topics related to the fundamentals of care.

- Consider which topics are most feasible for national clinical audit and most likely to result in improvements in the quality and safety of patient care.

- Identify links to existing information systems and to consider the most streamlined and cost effective approach to data collection.

Q. Who is undertaking the work?

A. The core team consists of staff working in the Learning & Improving team at the RCN Institute in Oxford: Linda Watterson and Lynne Currie. They are supported by a multidisciplinary project steering group. Members of the steering group include representatives from Age Concern, the Continence Foundation, the National Patient Safety Agency, nursing, medicine, and management.

Q. What is the role of the steering group?

A. The steering group has been convened to oversee the project. It also provides assistance and support in identifying and gaining access to the widest possible range of stakeholders with whom the consultation process will be undertaken.

Q. What is the role of the Healthcare Commission?

A. The role of the Healthcare Commission is to advise the core team and the steering group, and to act on the recommendations set out in the final report.

Q. How will the project be undertaken?

A. The project has several steps:

- Formation of the steering groups, which has been done.

- Engaging a range of key stakeholders: through utilising a multidisciplinary approach we want to include patients, carers and their representatives, frontline clinical staff, senior staff, managers and non-executives in identifying valid, measurable national level audit questions

- Stakeholder workshops: invitations are being sent to a random selection of Trusts/others to attend one of five regional workshops. The workshop programme will be devised by the core team and the steering group and will match the specification set out by the Heatlhcare Commission

- Stakeholder email/postal participation: Anyone can participate via email to identify potential priority topics for national audit, together with an associated list of measurable audit questions. A final list will be compiled from the responses identified through the workshops and the electronic consultation. The final list of ranked items will be considered by the core team and the steering group in determining our recommendations to the Healthcare Commission.

- The compilation of a final report

Q What are the main outputs of the project?

A. The project will generate the following outputs:

- A final report and recommendations for consideration by the Healthcare Commission, which will outline which topics, are considered most feasible for national clinical audit and most likely to result in improvements in the quality and safety of patient care.

Q. How many workshops are being undertaken?

A. We have organised five workshops across England & Wales, and these include: London (21/11/07); Birmingham (22/11/07); Exeter (26/11/07); Cardiff (11/12/07); and Leeds (12/12/07). ***(The Exeter seminar was cancelled and re-scheduled in Bath on 8/1/2008)***

Q. How are people invited to attend a workshop?

A. We have written to a random selection of NHS trusts in England and Wales asking their Chief Executive, Director of Nursing and Clinical Governance Lead to identify representatives from nursing, medicine, professionals allied to medicine, management and non-executive to attend a regional workshop. We have also written to a wide range of patient groups and health related charities to send representatives to the workshops. In addition, anyone can register their interest in attending a workshop by registering at eoc@rcn.org.uk. However, given the limited number of workshop places available it is envisaged that the majority of people participating in the identification of priority topics for national audit will participate via electronic means.

Q. If I am unable to attend a workshop how can I participate in the electronic consultation?

A: Details of the electronic consultation will be made available through the RCN web pages. Additionally, you can send an email to eoc@rcn.org.uk to register your interest in participating in the project.

Q: How was the timescale decided?

A: The timescale for the scoping exercise was stipulated by the Healthcare Commission.

Q: Who is funding this work?

A: The Healthcare Commission tendered for this project. The RCN's proposals were successful in being awarded the contract and funding for this work.

Q: What do the RCN hope will be the result of this project?

A: We hope that the work will enable a wide range of stakeholders to reflect their views about what topics can usefully be the subject of National Clinical Audit in a way that will support real improvements in care

Q: What can I do to support this work?

A: You can promote the work widely to both RCN colleagues and multidisciplinary colleagues. We really want to access a wide range of responses from across healthcare. If your Trust has received an invitation to participate in the workshops, encourage your Director of Nursing, Chief Executive, and your Clinical Governance Lead to nominate a multi-professional team to attend.

APPENDIX 4: LIST OF PARTICIPANTS ATTENDING WORKSHOPS

First name	Surname	Representative for	Organisation	Workshop
1. Joy	Akehurst	Management	South of Tyne NHS Trust	Leeds
2. Alison	Banerjee	Nursing	West Middlesex University Hospital	London
3. Ashley	Barcenilla	Allied Health Professions	Llanyfravon House, Gwent	Cardiff
4. Audrie	Beaver	Management	Wiltshire Primary Care Trust	Bath
5. Harni	Bharaj	Medicine	Royal Bolton NHS Trust	Leeds
6. Carol	Black	Nursing	Swindon & Marlborough NHS Trust	Bath
7. Vanessa	Bourne	Patient/Public	Patients Association	London
8. Inaki	Bovill	Medicine	Chelsea & Westminster Hospital	
9. Mary	Buffrey	Nursing	Carmarthenshire NHS Trust	Cardiff
10. Barry	Bull	Non- Executive	Salisbury NHS Trust	Bath
11. Sue	Bulmer	Medicine	South of Tyne NHS Trust	Leeds
12. Pat	Burton	Patient	Royal Wolverhampton Hospital NHS Trust	Birmingham
13. Audrey	Callum	Patient/Public	National Rheumatoid Arthritis Society	London
14. Lindsay	Courtney	Allied Health Professions	South of Tyne NHS Trust	Leeds
15. Christine	Cowley	Nursing	North East Wales	Cardiff
16. Caroline	Crimp	Patient	Association of Sick Children in Hospital, Wales	Cardiff
17. Sue	Cross	Patient	Working in Patient Projects, NHS	London
18. Lisa	Cummins	Management	University Hospital	Birmingham
19. Esther	Curry	Management	Singleton Hospital	Cardiff
20. Clive	Davies	Patient/Public	Princess of Wales Hospital	Cardiff
21. Trevor	Davies	Patient	Swindon & Marlborough NHS Trust	Bath
22. Heather	Devey	Nursing	Royals United Hospital	Bath
23. Iris	Fitzgibbon	Nursing	Royal Wolverhampton Hospital NHW Trust	Birmingham

24. Rachel	Gdesis	Allied Health Professions	Princess of Wales Hospital	Cardiff
25. Marion	Gilchrist	Nursing	Pennine Acute NHS Trust	Leeds
26. Mumtaz	Goolam	Nursing	Southmead Hospital	Birmingham
27. Megan	Greenahele	Allied Health Professions	Salisbury NHS Trust	Bath
28. Julie	Gripton	Allied Health Professions	East & West Birmingham, PCT	Birmingham
29. Suzanne	Hardy	Nursing	Worcestershire Royal Hospital	Birmingham
30. Hazel	Hardyman	Patient	Salisbury NHS Foundation Trust	Bath
31. Gerard	Hargreaves	Allied Health Professions	Newcastle Primary Care Trust	Leeds
32. Pat	Healy	Patient/Public	National Pensioners Conventions	London
33. Juliet	Higginson	Management	Kings College Hospital	London
34. Jill	Hollis	Management	South of Tyne NHS Trust	Leeds
35. Fiona	Hunter	Nursing	Kings College, London	London
36. Debbie	Hutchinson	Nursing	Kings College Hospital	London
37. Katie	Hutt	Management	St Georges Hospital	London
38. Anne	Jennings	Nursing	Sheffield Teaching Hospital NHS	Leeds
39. Val	Jones	Nursing	Birmingham, East & North Primary Care Trust	Birmingham
40. Anne	Kelly	Nursing	Pennine Acute NHS Trust	Leeds
41. Amanda	Kilshaw	Nursing	Wythenshawe Hospital	Birmingham
41. Joan	Lewis	Patient/Public	Cardiff Community Health Council	Cardiff
42. Lisa	Marson	Nursing	Dudley Primary Care Trust	Birmingham
43. Penny	Martin	Allied Health Professions	Royal Bolton Hospital	Leeds
44. Julie	Mason	Nursing	Leeds Partnership Foundation Hospital NHS Trust	Leeds
45. Alison	McNally	Patient/Carer	South of Tyne NHS Trust	Leeds
46. Sue	Merrick	Allied Health Professions	Royal Wolverhampton Hospital NHS Trust	Birmingham
47. Jackie	Moon	Management	Newcastle Primary Care Trust	Leeds

48. Chris	Morris	Nursing	RJAH Orthopaedic Hospital	London
49. David	Murray	Patient	Age Concern, Gwent	Cardiff
50. Maria	Nearey	Nursing	Bradford Teaching Hospital NHS Trust	Leeds
51. Jacqui	Parkin	Non-Executive	Queen Elizabeth Hospital	Leeds
52. Kay	Pagan		Bedfordshire Hospital	Leeds
53. Jo	Prytherch	Nursing	Central Clinic, Swansea	Cardiff
54. Susan	Pugh	Nursing	RJAH Orthopaedic Hospital	London
55. Jo	Richmond	Nursing	Heartland Hospital	Leeds
56. Sue	Riley	Nursing	Chelsea & Westminster	London
57. Nichola	Russell	Nursing	Queens Elizabeth Hospital	Leeds
58. Jean	Schofield	Management	Sheffield Teaching Hospital NHS	Leeds
59. Kim	Shield	Nursing	Derbyshire Mental Health Service	Birmingham
60. Anil	Seiger	Management	Royal College of Physicians	Cardiff
61. Rosemary	Smart	Patient/Public	Worcestershire Royal Acute Hospital	Birmingham
62. Jane	Smith	Nursing	Worcestershire Royal Acute Hospital	Birmingham
63. P	Stokes	Patient	Community Health Council, Gwent	Cardiff
64. Jenny	Stott	Nursing	Booth Hall Children's Hospital	Leeds
65. Kim	Swain	Nursing	Derby Mental Health Services	Birmingham
66. Karen	Taylor	Nursing	University Hospital	Birmingham
67. Lorraine	Thomas	Management	Birmingham, East & North Primary Care Trust	Birmingham
68. Natalie	Tidy	Management	Bolton NHS Direct	Leeds
69. Susan	Wade	Nursing	North of Tyne NHS Trust	Leeds
70. Jane	Warne	Nursing	Wiltshire Primary Care Trust	Bath
71. Linda	Webb	Allied Health Professions	Swindon & Marlborough NHS Trust	Bath
72. Joanne	Woolley	Nursing	Wythenshawe Hospital, Manchester	Birmingham
73. Viv	Williams	Management	Swindon & Marl-borough NHS Trust	Bath

APPENDIX 5: GROUP PROCESS USED IN WORKSHOPS

Summary of Nominal Group Technique

Nominal group technique (NGT) was the group process used in the workshops to identify a priority list of audit topics together with a number of key audit questions. NGT was developed by researchers in the late 1960's and has been shown to be superior to other group problem identification methods. It has been defined as a structured meeting which provides an orderly procedure for obtaining qualitative information from target groups who have been chosen because they are closely associated with the problem area. NGT is a method for generating ideas, establishing priorities and clarifying and aggregating the judgements of several individuals.

NGT:

- stimulates the production of creative thinking
- avoids any evaluation or elaboration during the generation of ideas
- provides participants with time and opportunity to reflect on the question they are being asked
- records all ideas thus giving voice to any minority or conflicting or incompatible ideas
- avoids dominance of group output by strong personalities
- allows participants the opportunity to influence the direction of the outcome
- alleviates any hidden agendas or covert political group dynamics

The strengths of NGT have been described as:

- easy to learn and use
- productive
- time saving
- anonymous voting

The weaknesses of NGT have been described as:

- can appear to be too mechanical
- cross-fertilisation of ideas may not occur
- democratic rather than consensual

The NGT process contains a number of steps:

Step 1: Introduction
Step 2: Asking the nominal question
Step 3: Silent generation of ideas
Step 4: Round robin recording
Step 5: Clarification of ideas
Step 6: Ranking or voting on ideas recorded

In the NGT process used in this project all participants were given 100 points to use when voting on the list of ideas that were generated and recorded in Steps 3 and 4. The nominal question asked of all workshop participants was to list all their ideas about the priorities for a national audit related to Essence of Care.

APPENDIX 6: WORKSHOP PROGRAMME

1030-1045	Coffee & Registration
1045-1100	Welcome & Introduction
1100-1130	Discussion
1130-1135	Introduction to group work
1135-1200	Group work: Generating priority audit topics
1200-1215	Group work: Collecting, clarifying and listing all topics identified
1215-1230	Group work: 1st ranking of the topics identified
1230-1315	Lunch
1315-1345	Discussion on 1st ranked topics
1345-1415	Group work: generating 3 key audit questions around the ranked priority topics
1415-1445	Discussion and agreement on the audit questions
1445-1500	Next steps & Close

APPENDIX 7: ELECTRONIC QUESTIONNAIRE

1. Please tell us your role in healthcare: (highlight only one item on this list)
    - nurse
    - doctor
    - manager
    - allied health professional
    - non-executive board member
    - patient
    - carer
    - other (please state)
2. If you work in healthcare please indicate your area of work: (highlight only one item on this list)
    - acute care
    - primary care
    - independent sector
    - other (please state)
3. If you are involved in an area of special interest, please tell us what this is (eg. continence care; Age Concern)
4. From the list below, please identify which topics you think are important for national audit: (highlight all that apply)
    - Continence, Bladder and Bowel Care
    - Personal & Oral Hygiene
    - Food & Nutrition
    - Pressure Ulcers
    - Privacy & Dignity
    - Record Keeping
    - Safety of clients with mental health needs in acute hospital settings
    - Principles of Self-Care
    - Communication between patients, carers and healthcare personnel
    - Promoting health
    - Environment
5. From your list identify your top three priority topics.
6. Please list up to three questions you would ask in order to assess whether good care was being delivered within your three priority topic areas:
   Under Priority Topic 1:
   Question 1
   Question 2
   Question 3
   Under Priority Topic 2:
   Question 1
   Question 2
   Question 3
   Under Priority Topic 3:
   Question 1
   Question 2
   Question 3
7. If you have any additional comments on priority audit topics related to Essence of Care, please use the box below.
8. Please tell us where you heard about this project: (highlight all that apply)

APPENDIX 8 IDENTIFIED KEY MESSAGES, AUDIT TOPICS, AUDIT QUESTIONS GENERATED FROM STAGES 2 AND 3

BATH WORKSHOP

Key Messages
• Transfer of information • Discharge Information • Communication- Multidisciplinary • How does this fit with other national agendas? • How does the Health Care Commission work with DH targets/work etc? • It's an opportunity to look at quality • How does it fit with Essence of Care document?

Topics/ideas identified (Scores in brackets)
1.Food and nutrition (280) **2.Communication (165)** **3.Discharge planning (85)** **4.Safety needs of mental health patients in acute hospitals (85)** **5.Ensuring patients is centre of care (not 'done to'), sharing results, decisions (65)** 6.Education of staff training needs - audit/clinical governance, change (50) 7.Patient empowerment - ask questions, raise concerns (40) 8.Need for help- (Evaluation of care mechanism) food self care, toilet assistance etc (40) 9.Support for patients to self care/ maintain own hygiene, dignity (40) 10.Patients falls (35) 11.Patient dependency and minimum staffing levels (30) 12.Patient agreed decision- patient preferred options/ outcomes (25) 13.Medication review on admission & discharge TTO's to be clearly labelled, sufficient and timely (25) 14. Information - before, during and after (20) 15.Time to talk- patients and families speaking to professionals (20) 16.How multi dis team encourages patients to maintain potential physical abilities (15) 17. Extent of support for patients to maintain independence (15) 18.Safe informed care- informed communication, risk reduction (10) 20.Planning 'bid decisions' (10) **Topics/ideas identified that were linked to the final score for Food and Nutrition** Food and drink availability outside mealtimes Protected mealtimes Nutrition/food consumed, specialist diets, multidisciplinary team responsibilities, patient's ability to feed or their need for assistance Food and nutrition - identifying and meeting individual needs **Topics/ideas that were linked to the final score for Communication** Communication - best practice sharing to improve Communication across GP/social agencies interface and the promotion of timely discharge Communication - multi agency communication/record, look at single assessment, specialist record

Communication across second, primary and social care
Communication - discharge/ infection control, following inter-professional communication
Extent to which communication happens with patients on integral care pathway
Does the multi disciplinary team read each other notes

Topics/ideas identified but not scored

Availability of advice e.g. drop in verbal/ written screening, advice re support at home
Clinical cleaning
Continence
Environment
Holistic assessment of continence and patient negotiated care plans
Mental capacity act - how implemented
New waste management guidelines
Oral and personal hygiene
Pressure ulcers
Privacy and dignity
Promoting health
Record keeping
Response to audit outcomes/ findings
Self care
Visitor policy - what contents, how is it controlled, is it flexible

Audit Questions for Food & Nutrition

- Screening and actions taken from this - documentation to show this
- Documented care plan/ recording food intake
- Regular review/reassessment of plan
- Do they have protected mealtimes policy?
- Do they have assistance for feeding?
- Patient/carers perspective
- Menu analysis
- Food availability (particularly outside meal times and patient snacks)
- Assessment of need/diet
- Assessment of preference to include culture
- Assessment of capability to feed themselves or not
- Availability of food between meal times
- Assessment of quality
- Record keeping of intake (food and fluid)
- Adherence to meal times and protected meal times
- Multidisciplinary team responsibility to food and nutrition
- Feedback to rest of multidisciplinary team re this

Audit Questions for Communication

- Assessment of communication needs
- Evidence of MDT meetings/case conferences/discharge planning
- Patient/relative perspectives
- Patient consent

- Written information
- Monitoring of complaints
- Type of clinical notes (unified notes/single episode notes)
- Are patients involved in care planning
- Are patients given protected 'talk' time to find out how they are feeling,
- To give opportunity to ask questions and give feedback, to talk without fear or victimization
- Are patients given 'named' nurses or teams
- Evaluate multidisciplinary teams goals - for assessment, continuity of care, discharge
- Is Information shared between service 1st/2nd/GP/ social services
- Consultant availability when booking appointments
- Leaflet for Information - person available to explain if required
- Shared record

BIRMINGHAM WORKSHOP

Key Messages

- Driven by transparent information
- Very little feedback
- High impact work - good - positive nurses can relate to it
- Need to get better at sharing good practice
- Some trusts have district audit monies - why not all trusts - funded by PCT's in Manchester
- Involve pre registration universities - must be part of their training.
- Patient complaints - identifying themes
- Communication
- Privacy and dignity
- Infection control
- Nutrition
- Mental Health - adolescents in pathways
- Could we develop EoC national network - web page
- Future audits has to have meaning - qualitative perspective - observation techniques
- Voluntary benchmarks need to be involved
- Use 'mystery shopper/visitors' technique
- Concentrate on patient experience
- Depth or breadth?
- Differs between organisation
- Extra work (must be linked closely to existing work audits)
- Audit priorities need to reflect the different priorities of the different care environment
- Need to rationalise other systems with EoC for standard setting, monitoring performance, data collection
- Transferability to primary care mental health
- Needs to be integrated - standards for better health into existing data collection. Other organisational procrdures, HCC standards.
- Adequate range and scope
- Too much nursing responsibility
- Organisational tool versus clinical practice
- Not enough drive nationally - change to fundamental of care - AHP's feel like add on
- How do we ensure sharing nationally
- Sharing' is continuous - good practice is shared

- Need a dedicated co-ordinator
- Shared database - shows trends and action plans
- Link with complaints database
- Web page
- News letter 'e' discussion groups
- Need to escalate method - nationally
- Shared tools
- Led from the tool

Topics/ideas identified (Scores in brackets)

1. Communication (295)
2. Record- keeping (230)
3. Food and Nutrition (170)
4. Privacy and dignity (160)
5. Self care/ Mental health (100)
6. Promoting health (70)
7.Depression parents/ cares impact on children/ elderly (70)
8.Awareness of 'disability' in all its forms (70)
9. Accountability - NMC code of conduct (65)
10. Self care (55)
11. Transfer of care- communication/ referring across (45)
12.Pain management- pain management tool scale (45)
13. Environment (40)
14.Friendly environment- smile/greet (40)
15. End of life care (35)
16. Aspects of safe environment (35)
17. Assured leadership for valid challenge (30)
18. Noise at night (25)
19. Initial screening of patients and follow up (20)
20.Ongoing rehab- periodic reassessments (stroke) (20)
21.Interface aspects of tissue viability (10)
22.Confidentiality- care and sharing info (10)
23. Needs of patients with dementia (5)
24. Identify patients without visitors (5)

Topics/ideas that were linked to the final score for Record Keeping

Documentation
Documentation - training the multidisciplinary team and making them do it
Documentation - single assessment/multi disciplinary assessment/record
Recording patient choice - looking at deviations from best practice

Topics/ideas that were linked to the final score for Food and Nutrition

Customer service
Patients to be fed liquids
Nutrition- focus on actual needs

Topics/ideas that were linked to the final score for Privacy and Dignity

Privacy and dignity - observations combined with environment
Privacy and dignity - clothing provided
Privacy and dignity - vulnerable audits
Privacy and dignity - care

Topics/ideas that was included with the final score for Self Care

Self care - promote clients abilities appropriate level
Self care - empowered

Topics/ideas that were linked to the final score for communication

Communication - customer care
Communication - time available
Communication - negotiating skills, bad news, care goals
Communication - attitudes and behaviours
Communication - complaints problem
Printed communication – procedures

Topics/ideas that were linked to the final score for Promoting Health

Promoting health - health of staff
Care 'promoting health' skills all professional all environment
Promoting health - joined up planning

Topics/ideas identified but not scored
Continence Oral and personal hygiene Pressure ulcers Safety needs of mental health patients in acute hospitals Pre-op assessment Infection prevention Medication review Leadership Realistic view of how quickly change can be demonstrated Free parking - children's parents/ carers Facilitated complaints Nutrition - weight Tissue viability during post/surgery Observations - appropriate timing Care of family unit

Audit Questions for Privacy & Dignity
• No mixed sex wards • Patients are clothed appropriately at all times • Beds have curtains that meet • Staff are required to know that curtains are not sound proof

- Private areas are available for sensitive discussion
- Patients records are stored securely
- Nurses stations - care of information
- Computer screens are not visible to others
- Are patients asked what their preferred name is?
- Are patients referred to by their preferred name?
- Do you have only single sex wards?
- Do care settings regularly observe care practice to ensure that patients' modesty, privacy and dignity is maintained?
- 1:1 interviews and surgery and patients
- Look at culture, gender
- How are intimate procedures approached?

Audit Questions for Food & Nutrition

- Do staff check if patients are capable of feeding themselves?
- Is a nutritional screening carried out for every patient?
- Does assessment/screening identify a need?
- Menu card and food is accessible to the patients
- Is culturally sensitive food available for patients
- Staff training in feeding patients sensitively/ including cultural awareness
- Sensitivity around independent feeding
- Protected mealtimes is in place
- System to ensure patients can receive snacks/ foods if food is missed or they need extra
- Are patients getting fresh water to drink
- Are staff aware of the patients' need for fluids?
- Is the nutrition provided related to the needs of patients
- Is there a nutrition care plan - NICE guidelines
- Is there a protected meal themes plan
- Measure quality of the food
- Are specific cultural needs met for practice
- How many patients are prepared for their meals
- How can each ward guarantee that they are feeding patients properly - what evidence can they provide
- Are all patients weighed?
- And those at risk further assessed?

Audit Questions for Communications

- Not understanding may be the problem - use of interpreter service
- Training in communication skills/customer care/ giving bad news
- Training in use of communication aids (learning loop)
- Resources rarely available - out of hours
- Documentation of communication needs
- Complaints, comments cards, survey, patients feedback responded to frequency of use of learning loop
- Discharge/transfer planning includes communication skills needs documentation includes key information
- Has the trust evidence of action relating to national surveys?
- Evidence of communication training within setting/customer care, breaking bad news

• Numbers of staff attending communication training • Evidence of compliance with communication standards • Is standardised information given to all patients • Written communication is more measurable • Verbal communication is poorly documented • Pre communication skills taught • Identify themes you want to look at first • Lets start to act on findings from the national patient surveys

Audit Questions for Record Keeping
• Discharge/ transfer documentation includes key information • Key standard information included on assessment/documentation • Author of entry in record is identifiable • Regular record keeping audits carried out for basic of record keeping and quality of information • Look at results of documentation audit currently in use • Measure adherence to record keeping policy • Is it recorded that a patient has had their care explained to them • Introduce electronic scanning • Are staff trained to undertake assessments relevant to their area? • Are records legible and do they meet legal requirements? • Is the care plan being implemented? • Is there evidence of patient involvement?

CARDIFF WORKSHOP

Key Messages
• Children • How is it sold to nurses • Non-clinical needs - care needs eg equipment, documents • Clean environment • Uniform • Meals/Nutrition – Assistants - Volunteers • Everyone's job • Document prior to today • Nurses 'fear' or lack of experience • Ward managers role - responsibility in delivering FoC • Ownership of audit • FOC document not well known • Litigation - not known lead nurses • 'fed up with audit- another survey • Subject - can it be measured • Nurses - patients perception • Patient centred - not service driven • Patient centred - improving outcomes (outputs) • Dignity • Respect • Safety & cleanliness

- Kindness (empathy, understanding)
- Confidentiality
- Privacy
- Communication
- Giving sufficient time
- Choice
- Continuity of care
- Team work - As a team - in the patient interest
- Linkage with relatives, primary care, social Care etc
- Reliability of procedures (admission/discharge)
- Audit of patient pathways
- Promotion of judgement

Topics/ideas identified (Scores in brackets)
1. Shift to patient centred approach (88) 2. Communication and Information (80) 3. Board level ownership/how organisation's deliver fundamentals of care links to stakeholders (63) 4. Pathway structure/journey/interfaces (62) 5. Transfer of information on care needs – following patient though journey (50) 6. Check understanding of fundamentals as well as training all staff (49) 7. Ensuring comfort and alleviating pain (48) 8. Rest and sleep (48) 9. Privacy and dignity (47) 10. Staffing levels (45) 11. Effect of culture on care (40) 12. Environment (35) 13. Need to go across all settings (31) 14. Involvement of carers in providing care (support, opting in) (30) 15. Respecting people (28) 16. Consensus of care values to underpin any audit, gear measures to all prof's (25) 17. Record keeping (25) 18. Training in communication skills especially diagnosis , children/young people (24) 19. Involvement of children and young people - making informed decisions, giving feedback, novel communication mechanism (target) (24) 20. Development of outcomes measurement and odds (20) 21. Identifying constraint barriers to provision of good care (19) 22. Celebrate current performance as well as improvement planning (19) 23. Ensuring safety (18) 24. Promoting independence (18) 25. Stick to basics - application of good skills (17) 26. Discharge packages- appropriate and timely (16) 27. Avoid bureaucracy- rapid feedback, too many layer of paperwork (15) 28. Meaningful assessment/ appropriate assessors (15) 29 Responsibility , accountability (14) 30. Enable local sites to identify own priorities (11) 31. Initial assessment – inclusion of wider emotions and social aspects (9) 32. Clear identification of staff policy (8) 33. Patient Identification- appropriate (6) 34. Data collection (who?) How do findings reach back into trusts? (5)

35. Fundamental rather than basic (5)
36. Need to get to frontline experience (5)
37. Nursing involvement in monitoring, assessment serving (4)
38. Preventing pressure sores (3)
39. Personal hygiene and food care (3)
40. Relationships (3)
41. Eating and Drinking (3)
42. Oral health and hygiene (3)
43. Toilet needs (3)
44. Present/existing documents (does it achieve purpose) (1)

Topics/ideas that were linked to the final score for "check understanding of fundamentals as well as training all staff"
Knowledge of EoC/ Fundamentals/steering group reps
Shared training for all disciplines - better communication, shared ideas, what training has been received

Topics/ideas that were linked to the final score for "privacy and dignity"
Well being and dignity

Topics/ideas that interlinked with the final score for "enable local sites to identify own priorities"
Adaptable for local use

Topics/ideas identified but not scored
Appropriate data gathering (how ? documents, patient experience, target staff differently use RCN bulletin, payroll)
Check understanding of fundamentals as well as training all staff
Clear goals
Each trust should have FoC lead
Inclusive criteria - staff, patient, carers (wide as possible)
Make links between outcomes and recruitment
Promoting health
Quality management system
Standards of hand washing facilities
What is patient centred care - meaning to people

Audit Questions

- Are standards transferable between care settings?
- Don't want to re-invent the wheel
- Does one size fit all?
- Identify the gaps in audit
- Need to make links to national standards/information we have
- Need joined up thinking/joined up audit?
- Trend monitoring re complaints/incident reports
- Need a local focus group for the data convection
- Fell down because notes did not follow patients across primary/acute care
- Needs to be a 2 way process, primary/acute, acute/primary
- Needs to be understandable e.g. communication with a deaf person

- Staff awareness of FoC/other
- Training outcomes - how do you / would you capture these?
- Change the quantitative and quantitative data measurement
- Linking audit to agreed standards/resolutions
- Need a commonality of understanding across all groups in healthcare
- What problems are you working on that you have identified from the data you have collected?

LEEDS WORKSHOP

Key Messages

- Replication of audit
- Audits - raised awareness promotes funding
- National audit - ticking the boxes
- Relevance of audit when across different domains
- Core points - specific areas for different care settings, getting the right people involved
- Feedback
- Simplicity of the tool
- Consumer information - public domain, hospital choice - communication results
- Timing of audit - linking to action plan, re-auditing
- Sharing 'good practice' - between organisations
- National audit
  Pros
  - Highlights deficiencies
  - Openness in a competitive market
  - Would draw an independent sector

  Cons:
  - Key messages must be correct
  - If too large may lose engagement
- Findings of audit must be shared widely
- Organisations 'named/shamed' and re-audit
- EoC benchmarks to be embedded to other national priorities and complementary to them eg. equality diversity - privacy and dignity - Infection control - personal hygiene
- Need to re-brand Essence to Fundamental
- Currently EoC very focused on acute care rather than primary care - needs addressing!
- ? Any links community care standards
- National Patient Safety Agency
- NHS Litigation Authority
- Raise profile of EoC
- Raise profile, everyone needs to be involved
- Simple to implement – need for feedback
- Need to have firm focus
- Some topics encourage 'silo' thinking - topics that span across pathways
- ? Is this a national data colleting system
- Lose local focus
- ? Any use of information for comparison – across organisations
- How to share good practice
- What is current good practice - what is already out there?

Topics/ideas identified (Scores in brackets)
1.Food and nutrition (238) 2.Privacy and dignity (180) 3.Patient driven priority focus (125) 4.Patient safety (115) 5.Staff attitudes and behaviour (103) 6.Use evidence based standards, multiple sources of data (80) 7.Balanced score card of EoC- consistent set for all organisations (80) 8.Pain- meaningful (80) 9.Communication across care pathways (65) 10.Communication in the care process, overlap with privacy and dignity (65) 11.Communication (65) 12.Opportunity to included personal responsibility for health – self care, health .promotions (65) 13.Relevance to all (55) 14.Key topics from patient complaints (55) 15.Respect (55) 16.Promoting health (45) 17.Clarity of purpose/ benefit (40) 18.Simple/easy to use audit tool (35) 19.Record keeping (32) 20.Ability of organisation to learn from patients (30) 21.Aspects of multidisciplinary care (30) 22.Assessment practice (30) 23.Owned by staff (30) 24.Cross reference with other priorities avoid duplication (25) 25.Identify good practice prior to national audit , agreed national standards 26.(sharp, clear focus) (25) 26.Board level involvement and support (25) 27.Prevention of infection across all sectors (20) 28.Focus on patients outcome (20) 29.Health promotion- consistent message along care pathway (20) 30.Environment (20) 31.Assistance to eat (18) 32.Oral and Personal hygiene (17) 33.Incorporate into everyday work, continuous collection(15) 34.Draw together all the current data.(10) 35.Continence (10) 36.Scoring more helpful than benchmarking making results meaningful (10) 37.Draw key questions from all EoC benchmarks to create one (10) 38.Applicability- problems of trying to be generic (10) 39.Screening for malnutrition (9)

Topics/ideas identified but not scored
Across whole care pathway Audit record keeping at time of change (IT etc) Evidence of activity around standards for health care Falls prevention Focus on quality of delivery - end result Focus on service/ specific client groups

Importance of feedback- clear bench marking, support learning Integrate into public health Lose acute focus - needs to cover all sections Needs to drive change by assessing ability of team response Pick on aspects not currently being done Pre registration training – content? Pressure ulcers Safety needs of mental health patients in acute hospitals Self care Time factor

Audit Questions on Food & Nutrition
• Is there an assessment of nutrition at 'entry points' to service (age appropriate, ethnic consideration etc)? • Is there an appropriate pathway for identified problems? • Is there a plan of care, a plan of evaluation? • What does the patient think? • Screening - LTC and patients in outpatient care • Referral pathways- resource (malnourished/obese) • Choice - special diets, preference of food, time, availability, location • Assistance – with menus, with eating, access to fluids • Suitable trained staff available • Complaints – learning from

Audit Questions on Privacy & Dignity
• Suitable environment - side rooms, single sex wards, own home aspects, private discussion room • Meet and great • Confidentiality

Audit Questions on Patient Safety
• Is there a clear mechanism to identify safety issues and priorities • Have you audited safety issues in your area

LONDON WORKSHOP

Key Messages
• EoC needs to be linked/ triangulated with other activities to evaluate quality • Observations of care are powerful • Patients stories/views are important • User involvement in improvement can be difficult to do • Engagement of key/ senior staff • Board level involvement in solutions • EoC - starting point for an action plan

• Need to look at what is really working - not just series of tick boxes • Staff struggle with how to make the change • One size fits all • Framework rather than audit • Has to be simple/have indicators/targets • Culture of ignoring things • Evaluation of EoC - no generic audit • Needs framework • Leadership • Simple streamline - no audit • Focus on action • Observe practice - action planning • Bind it together • Effective performance - meetings • Perception of care (NICE) • Confidence in care • We do data collection/we don't do audit • Who is responsible for the results

Topics/Ideas identified (Scores in brackets)
1.Privacy and dignity (215) 2.Moves to pull all EoC together (core benchmarks), and to consider drawing together other sources of information, since there are clear priorities (165) 3.Environment (150) 4.Communication (130) 5.Training/education (105) 6.Leadership (100) 7.Patients needs/ wants/ patients assessed outcome (65) 8.Focus on actions/ intervention that makes the difference (60) 9.Continuity of care (60) 10.Combination with primary care (60) 11.practice- sharing best practice (50) 12.Food and nutrition (40) 13.Continence (30) 14.Self care (30) 15.Team involvement/nursing values/culture/ vales- EoC & process (25) 16. Re-banding of EoC - the words, is 'audit' the problem? (20) 17.No national audit (20) 18.Safety needs for any patient (20) 19.Safety needs of mental health patients in acute hospitals (15) 20.Cut back/ simply paperwork (15) 21.Reduce Infection (15) 22.Oral and Personal hygiene (10) 23.Pressure Ulcers (10) 24.Record keeping (10) 25.Multi discussion, framework- observation framework (10) 26.Observation framework - do as you would be done by (5)

Topics/Ideas Identified but not scored
Audit fatigue/ revitalise EoC Follower ship/ Communication Need to consult older people what they want Not sure national audit is the right tool – if national then NOT just data collection Personal hygiene Promoting health

Audit Questions for Privacy & Dignity
• Getting to call the patient by their first name • Identifying from each patient whether they require a religious diet and then provide it • Asking the patient whether they would like to access their religion whilst in hospital • Use of mixed sex bays • Is the patient shown respect • Personal care • Commence • Record keeping • Communication – meet and greet • Diagnosis and treatment • Transport around the site • Food and nutrition • Use existing national tool • Is environment fit for purpose • PEAT/DDA inspection/ Spot check HCC • Ergonomics

Audit questions for Environment
• Is the ward clean and clutter free? • Does the ward smell clean and fresh? • Were you welcomed? • Are the staff professionally dressed?

APPENDIX 9: LETTER SENT TO PARTICIPANTS AT STAGE 4

Royal College of Nursing
RCN Institute
Whichford House Building 1440
Parkway Court
Oxford Business Park
Oxford OX4 2JY

Linda Watterson
Programme Manager: Evaluating & Improving

Fax 01865 246 787
Mobile 07739 877 251
Email linda.watterson@rcn.org.uk

Date: 17th January 2008

Dear Colleague

Re: Priorities national audit: Identifying Key Questions – Stage 4 consultation

Thank you for your participation in the workshops helping us to identify priority topics for a national audit related to Essence of Care/Fundamentals of Care.

We now have the overall results from all the workshops and I am writing as promised to share these with you and to ask if you could provide us with your views on the two options that will be taken forward in the final report for consideration by the Healthcare Commission.

Based on the key messages coming from the workshops, the steering group feels that a national audit could either focus on one topic (the highest ranked topic), or it could encompass a group of some of the highest ranked topics. You will see on the attached form that we have outlined these options in more detail. Both options will be included in the final report, so we are not asking you to choose between them, but to give us your considered opinion on both. We would also like you to help us identify the key criteria that are essential for each of them

I would be most grateful if you could complete the form overleaf and return via email to nicola.pidduck@rcn.org,uk no later than Tuesday 22nd January 2008.

Thank you again for your interest and input into the project as a whole and for taking the time to complete this final stage of the consultation.

We look forward to hearing your views.

Yours sincerely,

Linda Watterson

Programme Manager: Evaluating & Improving

RCN Institute

Enc.

Priorities for National Audit: Identifying the key questions

Outcomes of the workshops and e survey

Priority topics

Taking the outcome of the voting at all the workshops, together with our findings from the e-survey (the consultation), the top three audit topics have been clearly identified as (1) Food and Nutrition; (2) Communication; and (3) Privacy and Dignity. As we have a clear outcome there is no need for a further round of voting. A full list of ranked topics will be included in the final report.

Audit focus

From the discussions at the workshops and further debate within the steering group, we have concluded that a national audit could either:

- focus on one specific topic (Audit Option 1)

OR

- focus on the top three audit topics identified (Audit Option 2)

Both options will be explored in the final report.

Next steps

We now want to establish the key criteria that could be incorporated in a national audit. The key messages from the consultation suggested that any audit would need to:

- collect data that is meaningful and useful at Board level to encourage organisations to address the issues raised
- the results of the audit should provide a 'springboard' from which local action could be identified, agreed and implemented to facilitate improvements
- the audit should encourage benchmarking and sharing of good practice

On the attached form we ask you a series of questions related to the two options for audit that we have identified.

In answering these questions please bear in mind the key messages above. Also consider whether your question is relevant, understandable, measurable and achievable. Please also consider what kind of data would need to be collected in order to answer your question, how easy it would be to collect this data, and who should collect it.

If you have any queries on completing the attached form please email nicola.pidduck@rcn.org.uk.

Priorities for National Audit: Stage 4 Consultation: Identifying the key questions, key success factors and key challenges

Please complete and return this form to nicola.pidduck@rcn.org,uk by (date to be confirmed).

Audit Option 1

This option considers and audit on Food and Nutrition, the topic identified as the most important by participants in the consultation. In this option we would be seeking to construct a specific national audit looking at high impact interventions aimed at improving the quality of care around food and nutrition.

Question 1 – Audit Option 1

Think about food and nutrition and specific activities which you think underpin good care in this area. In your opinion, if you could only ask three questions to find out about the way fundamental care is being delivered, what would they be?

Question 2 – Audit Option 1

Please tell us what you think the key success factor would be in undertaking an audit on food and nutrition?

Question 3 – Audit Option 1

Please tell what you think the key challenge would be in undertaking an audit on food and nutrition?

Audit Option 2

This option considers the top three priority topics identified in the consultation which are identified above. In this option we would be seeking to construct a specific national audit looking at high impact interventions aimed at improving the quality of care bringing together questions around food and nutrition, communication and privacy and dignity.

Question 1: Audit Option 2

Think about food and nutrition, communication and privacy and dignity and any specific activities which you think underpin good care in these areas. Because this option is about undertaking a much wider audit in relation to food and nutrition, communication and privacy and dignity, we are asking for a greater number of questions. In your opinion which are the five questions to ask about the way fundamental care is being delivered in these three areas what would they be?

Question 2: Audit Option 2

Please tell us what you think the key success factor would be in undertaking an audit on food and nutrition, communication and privacy and dignity?

Question 3: Audit Option 2

Please tell us what you the key challenge would be in undertaking an audit on food and nutrition, communication and privacy and dignity?

APPENDIX 10: AUDIT QUESTIONS IDENTIFIED AT STAGE 4 OF THE CONSULTATION

Audit Option 1: Food and nutrition

1. Has nutrition screening been completed for every patient within 24 hrs of admission?
2. Are identified nutritional problems identified in a care plan?
3. Are all patients requiring assistance with eating and drinking able to receive assistance within 5mins of their meal being served?

1. Are patients' nutritional needs assessed on admission and if still inpatient reviewed?
2. What priority is given to meal times on the wards ie no doctors, staff available to feed patients?
3. Who monitors the quality of the food and are patients views taken in to account

1.How is nutrition decided for a specific group of patients?
2. How are patients that are unable to feed themselves helped?
3. What strategies to you have in place to ensure that patients are feeding adequately?

1. Are all patients nutritionally screened on admission and for those identified as at risk, is there a care plan to address their individual needs?
2. Are mealtimes protected providing an environment conducive to support & encourage the patient to eat/drink with sufficient staff (paid and volunteers) available at mealtimes to support patients requiring assistance?
3. Are catering adequately resourced with staff and finances to provide nutritionally adequate food and achieve the Standards for Better Health. This data could be collected from patient records, on the spot observation for monitoring patient receipt and consumption of food, service organisation questionnaire. Data collectors would be a combination of matrons and managers for service organisation, nurses and dieticians for patient care

1. How do you identify a patient's specific needs dietary needs?
2. How do you communicate that information ensures these needs are met?

1. All patients have a nutritional screen carried out as per NICE guidelines using a validated screening tool that has been approved for use throughout the organisation
2. If a need is identified, a plan of care to address individual needs is carried out
3. All patients are given appropriate resources and offered assistance to eat as required (observation/patient questionnaire)

1. Are Nutrition Screening Questions always asked for new patients?
2. Is a Protected Mealtimes Policy enforced how do you know?
3. Do the Essence of Care Nutrition Benchmarks underpin your trusts Nutrition Policy?
4. What system is in place to ensure that patients receive the assistance they require to eat their food and how is this measured?

1. Has a risk assessment been undertaken using the MUST tool (NICE CG32)?
2. Are high risk patients (MUST score of 2 or more) referred to an appropriate healthcare professional?
3. Does the care plan include weight, monitoring of fluid balance, modified diet requirements, assistance with feeding etc

1. Are all patients assessed as to their nutrition needs?
2. Obtaining food and food availability
3. Promotion of Healthy eating

1. Is there a screening tool in place?
2. Is there a care pathway in place?
3. Is there staff training

1. Is the food suitable/available to everyone.
2. Are options available e.g. Vegetarian/religious constraints
3. Is consumption/waste monitored – how & where?

1. Is a screening tool used for all patients- do they have documented action plans if needed?
2. Patient choice - are patients able to have adequate choice at meal times and availability of food away from meal times?
3. How are patients identified that might have difficulty with feeding themselves and what is done to remedy this to ensure their needs are met

1. Is nutrition included in the original assessment
2. Do you use the single assessment process for sharing information ?
3. Has a nutritional management plan been started if risk has been identified ?

1. Are patient's nutritional needs assessed/regularly evaluated to inform their plan of care
2. Are patients offered choice and do they receive this
3. Is food prepared safely?

1. Are patient being fed / receiving nutritional food
2. Is the food reflective of their needs (food type and presentation)
3. Are they being assisted when required / is there an offer of assistance if required?

1. Are patients'/residents' weights recorded (all settings)
2. Are patients/residents screened for risk of under-nutrition
3. Patients/residents with problems eating are identified and offered assistance

1. Do staff understand the importance of meals as part of the total care the patient receives?
Does the ward have a mechanism in place to identify vulnerable patients who need assistance with their meals?
3. For nutritionally at risk patients is food intake monitored, recorded and linked to care plans?

1. All inpatients receive a nutritional assessment, followed by the implementation and evaluation of a care plan, within a specified time limit after admission.
2. Patient mealtimes are protected
3. The implementation of the coloured tray project

1. Is each patient assessed for risk of malnutrition?
2. If the patient is assessed as being at risk of malnutrition or is already malnourished, does the patient have a care plan?
3. Does the patient receive individual assistance to eat and drink?

1. Is an initial nutritional screening carried out on all patients?

2. Patients mealtimes are protected from unnecessary interference?
3. All patients requiring support with feeding, receive it in a timely and appropriate manner?

1 Have all patients had a nutritional assessment
2. If deemed at risk have the patients got a care plan developed
3. Have all patients been weighed on admission

1. Are all patients asked preliminary screening questions and the responses documented:- Have you lost any weight unintentionally in last 3mths?-Are you underweight? - - Have you got any problems with appetite or eating?
2. Full nutritional screening completed if yes to one or more of the above questions
3. Are there processes in place to ensure that the patients' usual meal times protected?

Audit Option 2: Merged audit on food and nutrition, communication and privacy and dignity

1. Is there evidence that every patient has had his or her fundamental needs assessed on admission, using documentation based on Fundamentals of Care? (Document check)
2. Is there evidence that all members of the care team are involved in communicating patient needs to other members of the team? Eg. do HCSWs document as well as report verbally if they have concerns / notice a change in patient needs. (Document checks and ask HCSW's)
3. Where possible are patients / carers involved in assessment of their needs and subsequent care planning? (Ask patients/ ask carers)
4. Are patients aware that they can ask for discussions with nurses and other care staff to take place away from the bed area?
5. Are front line workers who deliver Fundamental Care able to access training programmes that explore and promote best practice in these key areas?

1. Are patients nutritional needs assessed on admission and if still inpatient reviewed?
2. What priority is given to meal times on the wards ie no doctors, staff available to feed patients?
3. Who monitors the quality of the food and are patients views taken in to account
4.Is privacy & Dignity and patients cultural needs adequately maintained during bath time and toileting?
5. Do you have a Public Patient Involvement strategy that is being implemented?

1. What is your priority for good patient care?
2. How are your patients rights protected?
3. What training and education does your staff have on food and nutrition, communication and privacy and dignity
4. What strategies do you have to ensure the above is carried out effectively?

1. Are all patients nutritionally screened on admission and for those identified as at risk, is there a care plan to address their individual needs?
2. Do staff involve patients (families and carers) in decisions about their care?
3. Do staff provide clear information for patients regarding diagnosis, treatment/tests and discharge arrangements? (this question could be in relation to a range of multidisciplinary staff – Medical, Nursing, AHP)
4. Do staff respect patients dignity in relation to personal hygiene eg .bathrooms, toilets, correct use of curtains?

5. Are hospital gowns available in the right size and style for individual patient needs?
Data would need to be collected for questions 2 to 5 by observation and patient survey. This could be done by clinical staff from a different ward area, lay patient representatives or postal survey.

1. Were you given enough time to talk and ask questions about your condition / treatment?
2. Were you treated with privacy and dignity by the administrative staff, nursing team, therapy teams, consultants / doctors?
3. Were you asked if you had any specific dietary needs?
4. Were your dietary needs met? Yes No Comments
5. Were you given written information to explain your treatment, procedure, condition more clearly?

1. All staff have access to training for interpersonal skill
2. Patient's communication needs are part of the initial assessment process
3. All patients are given a nutritional screen carried out as per Nice guidance using a validated screening tool that has bee approved for use throughout the organisation
4. All patients are given appropriate resources and offered assistance to eat as required
5. There are opportunities for patients/carers/service users to comment on their care and are there mechanisms in place to ensure these are acted upon

1. Is there evidence of assessment of support needs for feeding, communication and personal care?
2. Does care plan include referral to appropriate healthcare professional for advice and treatment?
3. Is the ward/clinic environment appropriate to ensure the privacy and dignity of service users are respected (would need to include a checklist of indicators of best practice)?
4. Questions on provision of information in different formats to meet communication needs

1. Assessment of standards
2. Action plans and evaluation
3. Patient/Service user experience/ involvement
4. Evidence of achievement and plans to build on new knowledge
5. Risk - where care is identified as below par and detrimental to individuals

1. Are patients treated as individuals to ensure their specific dietary communication and privacy and dignity needs are being met?
2. In privacy/dignity any standards may be open for interpretation, so setting concrete measures might pose a challenge, but from a patient perspective this is so worth doing!

1. Are all patients assessed as to their nutrition needs?
2. Do you ensure that the environment is conducive to effective communication?
3. Is information accessible, acceptable, up to date and meets the needs of the patient
4. Is patients' personal space actively promoted by all staff
Is patients' information shared with their consent?

1. Assessment tool in place.
2. Care pathway
3. Are staff trained?
4. Policy for outlining good practice

5. Patient involvement.

1. Does the patient feel fundamental care is being delivered?
2. If not why (personalities apart)?
3. Is the privacy/dignity available in all situations?
4. Is the most efficient communication system being used?
5. If not how can 'communication' be carried out/improved

1. How are the patients, and their families' views and satisfaction with the service offered sought?
2. How are these views fed back and have improvements been made
3. Patient choice- are patients able to have adequate choice at meal times and availability of food away from meal times?
4. What methods are used to ensure communication is effective and how are patients/relatives views used to improve these methods
5. How would you identify patient's issues around privacy and dignity- what improvements could be implemented?

1. Does your organisation have an essence of care lead practitioner/ named dignity champions?
2 .In the last year which audits/benchmarks have been completed within your organisation relating to communication etc (please include audit template)
3. Which professional groups are involved in essence of care audits eg. nursing (please specific each group)
4. Does your organisation have a dignity in care strategy?
5.Does your organisation have a named director with responsibility for dignity in care ?

1. Are patient's nutritional needs assessed/regularly evaluated to inform their plan of care?
2. Do patients feel involved in making decisions about their care?
3. Is patient care individualised?
4. Do nurses communicate with patients effectively?
5. Do patients feel safe and cared for?

1. Are patients'/residents' weights recorded (all settings)
2. Is food and nutrition discussed/considered for each patient at each handover, ward round etc
3. Nursing, medical and AHP documentation is all in the same records
4. Are curtains/doors used and respected by others?
5. Are there mixed bays. Are bathroom located close to each bay (ie so men/women, don't have to walk through / across a women's/men's bay)

1. Documented evidence of nutritional assessment followed by care planning – implementation and evaluation
2. Protected meal times
3. Documented evidence of patient views are sought on the use of mixed sex facilities
4. Documented evidence of assessment followed by care planning, implementation and evaluation of specific patient communication needs e.g. sight, hearing, and language
5. Documented evidence that patients believe their views are included in assessment, care planning, implementation and evaluation of their individual care needs

1. Are patients involved in their care?

2. Do patients feel that care is given in a manner which maintains their dignity?
3. Do staff include the patient in conversations or exclude them?
4. Do staff use appropriate language when communicating with patients?
5.Are patients oriented to their clinical area (particularly to location of bathrooms/toilets)?

1. Is an initial nutritional screening carried out on all patients?
2. Patient's mealtimes are protected from unnecessary interference?
3. Can the patient identify who is responsible for their care on a daily basis?
4. Does the patient state that they are shown respect by staff members?
5. Clinical care is provided in an area/space that provides privacy for the patient?

1. When patients are deemed at risk is care planned and reviewed for these areas.
2. Communication between patients, carers and professionals is documented
3. Are food charts completed?
4. Is there a suitable private place for patients to have bad news broken to them
5. What systems are in place to monitor the issues at a local and Trust level to give assurance that there is a proactive approach to care

1. Are all patients asked preliminary screening questions and the responses documented:- Have you lost any weight unintentionally in last 3mths?-Are you underweight? - - Have you got any problems with appetite or eating?
2. Are there processes in place to ensure that the patients' usual meal times protected?
3. Do all healthcare professionals introduce themselves to the patient - imparting name, profession and reason for the interaction?
4. Do all healthcare professionals introduce themselves to the patient - imparting name, profession and reason for the interaction?
5. Local policies to safeguard the confidentiality of all patient information are followed.
6. Patients report that their treatment (in the most general sense of the word) takes into account their individual needs