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

A REPORT FOR THE HEALTHCARE COMMISSION

FEBRUARY 2008

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ACKNOWLEDGEMENTS

We would like to take this opportunity to extend our thanks and gratitude to all the people who attended the Essence of Care workshops in England and Wales and to all those who gave us their views via the electronic consultation. We would also like to thank the Healthcare Commission for the opportunity to undertake this project. We are also grateful for the assistance of all RCN staff that helped us cascade information about the project across the organisation, with special thanks to Mike Wakeman of the RCN Web Team for his help and support.

Finally our thanks go to the members of the steering committee for their wise counsel, advice and support and to Nicola Pidduck for her administrative skills in organising the workshops and supporting the writing up of the final report.

Lynne Currie & Linda Watterson
February 2008

EXECUTIVE SUMMARY

This work was undertaken between October 2007 and February 2008 by the Royal College of Nursing with advice and support provided by a multi-disciplinary steering committee.

Objectives

1. To consult with key stakeholders on the identification of priority audit topics related to Essence of Care
2. To make recommendations about those topics considered the most important and most feasible for national clinical audit, most likely to result in improvements in patient care, to identify any links to existing information systems, and to consider the most efficient and effective approaches to data collection.
3. To synthesise the findings from the scoping exercise into a final report to include an appraisal of options of a national audit on essence of care.

Stages of consultation

The work was undertaken in five stages: 1) the literature review; 2) consultation with key stakeholders through workshops; 3) key stakeholder consultation through e-survey; 4) second consultation with key stakeholders from stage 2 via email; and 5) preparation of the final report.

Priorities identified

The top three priority topics for a national audit on essence of care were identified as:
Food and Nutrition, Communication, and Privacy and Dignity.

Recommendation

The report sets out detailed criteria for three options: 1) a national audit on food and nutrition; 2) a national audit on communication; and 3) a national audit of privacy and dignity. The project team and steering group recommend funding a national audit on food and nutrition. This is based on the topic being identified as a key priority by government and stakeholders, and more clearly underpinned by a robust evidence base, including NICE recommendations.

Themes emerging from consultation with key stakeholders

Essence / fundamentals of care topics were viewed positively and seen as relevant and highly topical. A wide range of additional topical concerns were elicited during discussions. There is a requirement for a robustly developed, core funded audit in this area in order to make significant improvements in the quality of patient care. This could enhance work currently being undertaken at local level.

Stakeholders regarded clinical audit as "high impact" and a fundamental part of a clinician's workload, requiring protected time and training. Undertaken properly it helps organisations effectively target action plans, share and benchmark best practice. It must incorporate clear mechanisms for prompt feed back of results to participating staff. A streamlined, easy to use format is needed. However, it must not be 'a series of tick boxes' which overburden staff with excessive data gathering, and should not replicate data collection elsewhere. To give a real picture of the current situation, it should include the use of qualitative data, including elements of the patients' experience, observations of practice and staffs' attitudes and behaviours.

Participants considered that successful national audit required overt external support (e.g. from Healthcare Commission) and strong commitment within organisations at senior management /board level with an explicit statement of support and funding to ensure results are acted upon. They also emphasised collaboration and partnership working.

1. LITERATURE REVIEW

Introduction

In the original tender to undertake a scope for a national audit on Essence of Care (Watterson, 2007) the purpose of the literature review was identified as determining current evidence on the impact of implementing Essence of Care. What the initial review highlighted was a range of published articles, primarily in the nursing press, focusing on a number of local initiatives on the implementation of Essence of Care around nutrition (Oxtoby, 2004; Foster et al., 2005; Vere-Jones, 2006; Richmond, 2007); continence care (Cotton, 2004; Thomas et al., 2006; Gilbert, 2005); privacy and dignity (Price, 2004; Denner, 2004; Birrell et al., 2006); care of older people (Sturdy, 2004); disability (Stoker & Sayers, 2004); handover (Fenton, 2006); multiple sclerosis (Embrey et al., 2003); patient records (Terry, 2004); post-anaesthetic care (Dearden & Hewitt, 2004); pressure ulcers (Birchell et al., 2004); and teamwork (Sandiford, 2004).

In an article reporting on a successful regional initiative on Essence of Care, Chambers & Jolly (2002) conclude by suggesting that whilst it has huge potential to make improvements in the quality of patient care, unless it is firmly placed on the agenda of all NHS chief executives it risks becoming just an element of 'spin' imposed on a failing NHS and will fall short of becoming embedded in clinical practice.

Developments in England: Essence of Care

In England Essence of Care evolved from examples of effective sharing, a comparison of practice and a commitment to put clinical governance at the heart of plans for quality improvement (DH, 1999). Benchmarks around fundamental aspects of the patient's experience were developed through a coming together of patients, carers and professionals. Complaints, Ombudsman's Reports and professional concerns were also considered alongside material from consensus groups and patients stories collected by the Royal College of Nursing Leadership Programme (RCN 2007a).

This work placed patients central to the debate and highlighted areas of care that were of concern to patients. Following the roll out of the Essence of Care in England in 2001 (DH, 2001), there have been some additions to the list of benchmarks (DH, 2006, DH, 2007). The benchmarks currently include:

- Continence and bladder and bowel care
- Personal and oral hygiene
- Food and nutrition
- Pressure ulcers
- Privacy and dignity
- Record keeping
- Safety of clients with mental health needs in acute mental health and general hospital settings
- Principles of self-care
- Communication between patients, carers and health care personnel
- Promoting health
- Environment

A further benchmark on pain is expected in the near future.

It is worth noting that to date there has been no common approach to using the Essence of Care benchmarks, and there have been no explicit criteria for NHS organisations in England to adopt the benchmarks. Nonetheless, the benchmarks have been quite widely adopted within NHS organisations, albeit with different emphases and approaches. In April 2005 the responsibility for Essence of Care in England was devolved to Strategic Health Authorities (GMEC, 2007).

Developments in Wales: Fundamentals of Care

The fundamentals of care initiative undertaken in Wales emerged as a result of a number of issues including the fragmented nature of care provision across different care settings; an emphasis in the past on service efficiency and cost rather than quality; the common themes arising from patients complaints and patients compliments; the increasing expectations of users of the service; the requirement to work in collaboration and partnership across boundaries, organisations and agencies; a lack of clarity in relation of what users of the service should expect; increasing emphasis on regulation and performance; and an awareness of the essence of care initiative taking place in England (WAG, 2003: 3).

Currently the responsibility for implementing the Fundamentals of Care in Wales lies with the Welsh Assembly Government. All NHS organisations in Wales are reviewed to see how they are meeting the requirements laid down in the fundamentals of care document and this review is linked to the Healthcare Standards for Wales (WAG, 2005).

The practice indicators identified in the fundamentals of care document are identified as being integrated with educational, commissioning and performance management frameworks for the NHS, Social Services and the Care Standards Inspectorate (WAG, 2003). The practice indicators are:

- Communication and information
- Respecting people
- Ensuring safety
- Promoting independence
- Relationships
- Rest and sleep
- Ensuring comfort, alleviating pain
- Personal hygiene, appearance and foot care
- Eating and drinking
- Oral health and hygiene
- Toilet needs
- Preventing pressure sores

Need for a national focus

Given the ubiquitous and often inter-related nature of the benchmarks and practice indicators within *Essence of Care* (DH, 2001) and *Fundamentals of Care* (WAG, 2003) it is difficult to identify any specific care pathways, or any specific topics upon which all key stakeholders may wish to focus on at a national level. It is hoped that the results of this scoping exercise will clear identify the priorities for a national audit around the fundamentals of care.

The literature review identified a number of articles reporting on work undertaken on a range of topics identified in *Essence of Care* (DH, 2001) and a summary of some of these are offered as examples to highlight the extent to which concerns remain over the quality and safety of patient care.

Communication

Communication has been identified as especially important in relation to patient safety and has been cited as a key interpersonal skill for healthcare professionals (Fletcher et al, 2002; Yule et al, 2006). Recent inpatient surveys have concluded that patients continue to report deficiencies in communication with healthcare professionals (Healthcare Commission, 2006a; Maxfield et al, 2005). In addition, recent investigations into maternity services in the NHS have concluded that communication remains a very serious issue for midwifes (Healthcare Commission, 2004; 2005; 2006b; Smith & Dixon, 2007).

In the most recent *State of Healthcare Report* (Healthcare Commission, 2007a) poor communication continues to be identified by patients as problematic (Healthcare Commission, 2007a). What patients say they want in relation to communication and information is for doctors to provide clear explanations and answers in a format they can understand, clear explanations about the benefits and risks of treatments, and for healthcare professionals to be open and honest.(Healthcare Commission, 2007a).

In a systematic review undertaken on communication between patients and healthcare professionals about medicines, researchers report that doctors tend to dominate in doctor-patient communication encounters and that the behaviours and attitudes of healthcare staff can impede as well as enhance patient involvement in the communication process (Stevenson et al., 2004). This finding was also reported in a study exploring communication and dignity with older people in health and social care settings (Woolhead et al., 2006) Stevenson et al (2004) suggest that while practitioners need to listen carefully and empathetically, much of the research they identified in their review on patient-professional communication describes an unbalanced relationship which continues to be rooted in paternalistic interactions. Woolhead et al (2006) argue that whilst healthcare professionals appeared to be aware of good communicative practices they failed to implement them. In addition to a lack of awareness and effort, lack of time, lack of staff and resources, regulation and bureaucracy were cited as barriers to effective communication (Woolhead et al., 2006).

Continence

In a recent national audit undertaken by the Royal College of Physicians (RCP, 2006) the authors raise concerns over the patchy integration of continence care services and the often poor approach to the clinical management of continence. Whilst catheter use is limited in primary care and care homes, their use in secondary care to manage incontinence is reported at 31%. Healthcare Associated Infection (HCAI) of the urinary tract accounts for around 23% of all HCAI's, with 80% of these being traceable to indwelling urinary catheters (DH, 2003). Audit and benchmarking have been reported as promoting improvements in continence care (Mangnall et al 2006) and tools exist which support the promotion of increased patient participation in the evaluation of care, for example people with Parkinson's Disease (Thomas et al, 2006; RCN 2007b).

Nutrition

Whilst approximately 20% patients are said to be clinically malnourished on admission to hospital (Edington et al, 2000) concerns have been raised about nutritional support within healthcare organisations (Age Concern 2006). The report *Hungry to be Heard* argues that 4 in every 10 older patients arrive at hospital malnourished, patients aged 80 are five times more likely to be malnourished, the result being that *"…six out of 10 older people are at risk of becoming malnourished, or their situation getting worse, in hospital"* (Age Concern, 2006: 4). The authors suggest that this situation is particularly serious because malnourished patients are more likely to stay in hospital for longer, experience complications, and need more interventions and medications.

A recent survey by the British Association of Parenteral and Enteral Nutrition (BAPEN, 2006) estimated that the cost of malnutrition to the UK NHS is around £7.3 billion a year, with over half this cost being expended on people aged 65 years and over. The research from BAPEN also suggests that it is not just the older adult that is risk of malnutrition, however, malnutrition continues to be under-recognised and under-treated (cited in DH, 2007b: 6).

Nutrition is the subject of Council of Europe guidance (Council of Europe, 2003) it is the focus of a current RCN campaign *Nutrition Now* (RCN, 2007c), and it is supported by a joint action plan from the Department of Health and Nutrition Summit stakeholders (DH. 2007b).

There is reported evidence that Essence of Care benchmarking used in conjunction with audit to monitor malnutrition levels and nutrition screening is being used effectively to tackle concerns around nutrition in healthcare (Foster et al 2005).

Recent research on nutritional screening and assessment has highlighted that whilst there is a number of published screening and assessment tools available, many of these have not been subject to rigorous testing. The authors suggest that further research needs to consider a more standardised approach to the use of these tools (Green & Watson, 2005).

Whilst the national guideline on nutrition support for adults from the National Institute for Health and Clinical Excellence (NICE) describes the Malnutrition Universal Screening Tool (the MUST tool) it falls short of recommending its use, stating "S*creening should assess body mass index (BMI) and percentage unintentional weight loss and should also consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of future impaired nutrient intake. The Malnutrition Universal Screening Tool (MUST), for example, may be used to do this*" (NICE, 2006: 69).

Assessments undertaken by the Patient Environment Action Teams ask trusts about their compliance with protected mealtimes, nutritional screening, availability and choice of food (NPSA, 2007a). In addition, the National Patient Safety Agency (NPSA, 2007b) has undertaken a Nutritional Screening project with nurses and dieticians from 10 acute NHS Trusts which identified the barriers to compliance with nutritional screening as:

- lack of equipment (weighing scales and height measures)
- lack of leadership
- lack of clarity relating to screening and assessment
- dependency of patients
- credibility and usability of available screening tools

- lack of education and training for medical and nursing staff
- not mandatory

The key findings from NPSA investigation showed that the majority of patients were not weighed on admission to hospital, any recent weight loss or reduced appetite was not assessed on admission, and patients were unaware that they should have a nutritional assessment completed on admission (NPSA, 2007b).

Pressure Ulcers

The numbers of pressure ulcers that develop while patients are in hospital has been identified as an indicator of the quality of care, and whilst 70% of NHS Trusts collect prevalence data on pressure ulcers, data collection methods vary widely (Healthcare Commission, 2005). However, clinical audit and feedback of results have been used successfully in the Netherlands to reduce the prevalence of pressure ulcers (Bours et al 2004).

Research in the USA indicates that collecting data that is useful for benchmarking specific clinical practices like the management of pressure ulcers can be achieved through the use of prevalence studies (Amlung et al, 2001). The authors of this study argue that benchmarking supports the measurement and identification of inconsistencies in patient care practices, and can also be used to identify gaps in performance, put more effective processes in place, and help to monitor and maintain improvements in patient outcomes.

Privacy and Dignity

The enactment of the Human Rights Act in 1998 resulted in the Department of Health emphasising the importance of healthcare practitioners respecting the privacy and dignity of patients in NHS care settings (DH, 2000; 2001). A study employing non-participant observation on the maintenance of patient dignity in intensive care settings (Turnock & Kelleher, 2001) found that whilst patient dignity was maintained in almost one-third of observed cases, more intimate areas such as bosom and genitalia were exposed in over 40% of cases. Furthermore, the researchers reported a number of significant factors influencing exposure which included gender and age, where patients who were female and younger (<60 years) were more likely to be exposed. Recommendations to clinical practice included: greater vigilance by nurses while clothing and screening patients; removal of any unnecessary equipment that may cause gaps in screens; encouraging staff to ask permission before entering a screened area; assessing patient privacy and dignity needs by involving patients and their families; recording privacy and dignity needs in the care plan (Turnock & Kelleher, 2001).

A study exploring nurses' and patients' perceptions of dignity (Walsh et al., 2002) found there were few guidelines available for nurses to use in order to safeguard patients dignity. The characteristics identified around dignity by both nurses and patients were broadly similar, and included: respect, privacy, control, choice, humour and matter-of-factness. In a concept analysis of dignity Griffin-Helsin (2005) argues that healthcare professionals need to recognise that they themselves need dignity in order to promote the dignity of others.

Research with older patients highlighted dignity as a multi-faceted concept which included: dignity of identity (self-respect/esteem, integrity and trust); human rights (equality and choice); and autonomy (independence and control) (Woolhead et al., 2005). Patients gave examples of where they felt their dignity had been jeopardised whilst in hospital including: the loss of self-

esteem as a result of being patronised, being excluded from decision-making, and being treated as an object. In addition, patients felt they experienced a lack of integrity which resulted in a lack of trust and feelings of increased vulnerability. The researchers argue that patient centred care for patients in relation to maintaining their dignity is specifically linked to communication, privacy, personal identity and feelings of vulnerability (Woolhead et al., 2005).

In a recent review entitled *Caring for Dignity* (Healthcare Commission, 2007b) investigators found that while there are some indications that dignity, privacy and nutrition are achieving higher levels of priorities in many NHS organisations, there remains a clear need for improvements. The report makes a number of recommendations for boards, wards, strategic health authorities, voluntary organisations and policymakers.

The challenge of implementation

It has been suggested that embracing Essence of Care across healthcare is fundamental in order to achieve the delivery of clinical governance, as well as an implicit belief that this is relatively easy to achieve (Badham et al, 2006). The authors of the Greater Manchester Essence of Care Project (GMEC) however argue that whilst a particular strength of Essence of Care is its emphasis on healthcare professionals working at the frontline, the resources required for effective implementation are often dependent upon local Trust priorities, which can result in fragmentation (GMEC, 2007). While there is some evidence of effective implementation activities in local areas (Nightingale & Stevens 2006; Lambeth PCT 2006) regional or national implementation activity has been identified as rare (GMEC, 2007).

Whilst identifying clinical benchmarking as having the potential to become the gold standard against which the fundamentals of care can be judged, Chambers & Jolly (2002) caution that embedding Essence of Care into the quality framework for the NHS requires continued commitment, resources, joined up thinking across healthcare agencies, and commitment and support at senior management level, a view echoed in the recent review on *Caring for Dignity* (Healthcare Commission, 2007b).

Data collection, data use, feedback and sharing best practice

A recent mapping exercise undertaken across the United Kingdom by the Royal College of Nursing and others to identify the types of data being collected on the nursing contribution to quality, and how such data was being used, indicated both a need and a desire for nationally recognised benchmarking data, especially in relation to the Essence of Care topics (Watterson & Currie, 2005). Nurses also identified data collection around outcomes, processes, staff activities, performance, patient safety and patient experiences.

The nurses who took part in the mapping exercise reported a clear enthusiasm for a forum in which they could share best practice and support national collaborations in defining and using data at a national level (Watterson & Currie, 2005). Other commentators have identified a range of activity utilising Essence of Care in association with complementary audit projects and data collection on aspects of patient safety and patient experience (Walker & Etches, 2007; Watterson, 2004).

A national perspective

From the work described above it appears there is much interest and support for projects that seek to define overarching audit questions and provide a clear, transparent national perspective on fundamental care in specific areas without replicating work that has already been undertaken. Such a national perspective would provide a crucial starting point from which staff at regional and local level could review their data collection activities in order to pinpoint areas of good practice that could be shared, as well as identify any areas of practice requiring improvement.

To support healthcare professionals to deliver care that does not deviate or vary across geographical boundaries there have been a number of developments in England and Wales aimed at raising quality and reducing variations in practice (DH, 2003, 2006: WAG, 2004, 2005). *Standards for Better Health* (DH, 2006) describes the level of quality that all health care providers in England are expected to meet across a range of domains, whilst *Healthcare Standards for Wales* (WAG, 2005) have been developed to promote the delivery of quality services across the NHS in Wales.

The English standards are grouped around six domains: safety; clinical- and cost-effectiveness; governance; patient focus; accessible and responsive care; environment; and public health and they form a fundamental element of the external review of NHS organisations carried out by the Healthcare Commission. The Welsh standards are grouped under four domains: patient experience; clinical outcomes; healthcare governance; and public health, and they provide a framework for self assessment and external review and investigation by Healthcare Inspectorate Wales.

In planning a national audit on Essence of Care it will be important to ensure that the audit is underpinned, and supported by the English and Welsh national standards. It is also important to acknowledge that any national audit developed in relation to Essence of Care should, where appropriate, review practice to monitor how or whether it conforms to national guidance and recommendations.

2. PROJECT BRIEF

Introduction

Essence of Care (DH, 2001), and *Fundamentals of Care* (WAG, 2003) are two widely utilised resources in the NHS which underpin measures to improve the quality of patient care. The benchmarks included in *Essence of Care*, and the practice indicators outlined in *Fundamentals of Care* are patient focused, they enable staff to share and compare current practice, they provide a means of identifying both best practice and the actions necessary to improve areas of poor practice (DH, 2007). National clinical audit can provide an overarching indication of the impact of *Essence of Care* and *Fundamentals of Care* in improving care as it is experienced by the patient and can promote much wider improvements in patient care.

As part of its National Clinical Audit Programme the Healthcare Commission commissioned the Royal College of Nursing (RCN) to undertake a scoping project on the feasibility of undertaking a national audit linked to the *Essence of Care* benchmarks and the *Fundamentals of Care* practice indicators. It was agreed that a key element of the work would be to ensure that all key stakeholder groups were consulted and involved in the scoping work.

Royal College of Nursing

The mission of the RCN is to represent nurses and nursing, promote excellence in practice and shape health policies. With a membership approaching 400,000 members the RCN is the largest professional association of nursing staff and students in the UK and is an influential voice for nursing. It is a leading player in the development of nursing policy and practice, standards of care and is committed to providing quality services for patients in collaboration with interdisciplinary teams.

The RCN is actively involved in leading clinical audit and service improvement in partnership with the professional bodies of the other disciplines involved in healthcare and working in partnership with service users. Projects are informed by the full range of clinical expertise and close working relationships with healthcare staff working at local, regional and national level. Projects increasingly include the direct collection of patient stories highlighting individual experiences of care which are then utilised to inform educational and implementation projects. This includes the implementation of systems that supports rapid feedback of audit results to participants and enables sustained action planning and changes in the workplace. The RCN also manages the National Collaborating Centre for Nursing and Supportive Care (NCCNSC) that develops national clinical guidelines on behalf of the National Institute for Health and Clinical Excellence (NICE).

National Clinical Audit and Patient Outcome's Project (NCAPOP)/Healthcare Quality Improvement Partnership

Since the scoping exercise began in October 2007, the Department of Health has now announced details of the new consortium that will run the National Clinical Audit and Patient Outcome's Programme (NCAPOP). The management of NCAPOP has been awarded to a consortium comprising the Academy of Medical Royal Colleges, the Royal College of Nursing and the Long Term Conditions Alliance, and this will be known as the Healthcare Quality Improvement Partnership, and the contract will commence on 1st April 2008.

Project Objectives

The scoping project had three objectives:

1. Consultation with key stakeholders including staff involved at all stages of patient pathways, patient representatives and staff representing local clinical audit departments.
2. To make recommendations about which topics are considered most important and most feasible for national clinical audit and most likely to result in improvements to patient care. The project will also identify links to existing information systems and consider the most efficient and effective approaches to data collection.
3. To synthesise the findings from the scoping exercise into a final report which follows the guidance from the Healthcare Commission as set out in the Structure of Scoping Papers and Management Plans. The final report will include an appraisal of options for a national audit for consideration by the Healthcare Commission.

Project Team

The scoping work was undertaken by the Evaluating and Improving Team (LC & LW), based within the RCN's Learning and Development Department, and advice and support was provided by a multi-disciplinary steering committee.

The scoping exercise was coordinated by the Evaluating and Improving Team and included a Programme Manager, Project Lead and Administrator based within the Resources for Learning and Development Department, Royal College of Nursing. The project team were supported by a multidisciplinary steering committee which was convened to oversee the project.

Project Steering Committee

Members of the steering committee were drawn from a number of organisations and included those with relevant expertise, clinical knowledge, access to current best evidence for care, and knowledge and experience of clinical audit (Table 2.1). The steering committee members provided invaluable assistance and support in identifying and gaining access to the widest possible range of key stakeholders. The steering committee met three times during the project.

In addition, the core team and the steering committee were advised by the Healthcare Commission in ensuring that all key stakeholders were consulted.

Project time scale

The project was undertaken within the five months specified by the Healthcare Commission. Table 2.2 details the process steps taken during the project timescale.

Table 2.1: Steering committee membership

Philip HURST	Policy Manager, Health & Social Care Team	Age Concern, England
Caroline LECKO	Nutrition Lead	National Patient Safety Agency
Anil SEIGER	Manager, Clinical Effectiveness and Evaluation Unit	Royal College of Physicians
Maria SINFIELD	Head of Clinical Practice	Royal Bolton Hospital NHS Trust
Hilary WALKER	Deputy Director of Nursing	Royal Wolverhampton NHS Trust
Judith WARDLE	Policy Director	Continence Foundation
Katherine Murphy	Director of Communications	Patients Association

Table 2.2: Timetable of events

Steering committee convened and 1st meeting undertaken. Commencement of literature review.	Oct 2007
Letters of invitation sent out to stakeholders. Workshops 1 (London) and 2 (Birmingham) undertaken. Rollout of information on scoping project cascaded across RCN Electronic consultation goes live.	Nov 2007
Workshop 3 (Cardiff) and 4 (Leeds) undertaken. Ongoing literature review.	Dec 2007
Collate findings from literature review and begin drafting report Workshop 5 (Bath) undertaken. Electronic consultation closes. Analysis of initials findings discussed at 2nd steering committee meeting. Further consultation was undertaken. Ongoing literature review.	Jan 2008
Final report sent to Healthcare Commission	Feb 2008

3. METHODS USED IN THE SCOPING EXERCISE

Introduction

This report is co-authored by the Project Lead (LC) and the Programme Manager (LW) of the Evaluating & Improving based within the RCN's Department for Resources for Learning and Development in Oxford, with advice and support from the steering committee.

There were five stages involved in the scoping exercise:

Stage 1: Literature review

The literature review was undertaken to determine current available evidence on the impact of implementing Essence of Care with a view to determining those areas of most benefit when considering a national audit. The literature review was ongoing throughout the duration of project, and following identification of the top three priority audit topics, focused on published recommendations related to these topics.

Stage 2: Consultation with key stakeholders

A process of consultation about priorities for national audit related to Essence of Care/Fundamentals of Care was undertaken. The purpose of the consultation was to gather stakeholders' claims, concerns and issues about the most useful and suitable topics for national audit, to establish which topics they identified as priorities, what kinds of audit questions they believed to be most useful and valid, and to identify a range of options appraisal for consideration by the Healthcare Commission.

The steering committee advised on how best to ensure that invitations to participate in the consultation were circulated as extensively as possible, which proved invaluable to the project team. Every effort was extended to ensure we had the widest possible range of stakeholders participating in the five workshops and the e-survey.

A number of NHS Trusts were randomly selected to take part in the consultation as were a wide range of charitable organisations (Appendix 1). Invitation letters to NHS were sent separately to the Chief Executive Officer, the Director of Nursing Services, and where appropriate the Clinical Governance Lead and letters of invitation to charitable organisations were sent to the Chief Executive Officer (Appendix 2).

In addition, information relating to the scoping project was cascaded across all RCN departments and RCN offices throughout the United Kingdom, and details of the project were posted on the RCN Intranet which included a direct link to the electronic questionnaire (see Appendix 3 for more details). Furthermore, links to the questionnaire were also posted on the websites of the National Patient Safety Agency and the Royal College of Physicians.

The programme manager (LW) and the project lead (LC) facilitated five workshops with key stakeholders across England and Wales, with admin support provided by the team administrator (NP). Participants involved in the workshops included various healthcare professionals including frontline nursing and medical staff and allied health professionals, senior nursing and medical staff, management, non-executive Trust directors, patient representatives and representatives from various charities. A total number of 73 participants

were involved in the five workshops, and details of all participants attending the workshops can be found in Appendix 4.

The content of the workshops was devised collaboratively by the project team and the steering committee and covered all the elements listed in the original Healthcare Commission specification. For details of the group process used in the workshops see Appendix 5, and for details of the workshop programme see Appendix 6.

Stage 3: Electronic consultation

In order to widen the opportunity for participating in the consultation even further an electronic questionnaire was developed by the project team and was made accessible via the RCN's website. This questionnaire provided a mechanism by which anyone with an interest in participating could send us their views about priority audit topics related to Essence of care together with a list of key audit questions. The items listed on the questionnaire broadly followed the content of the workshops. A list of the questions used in the electronic consultation is provided in Appendix 7. The number of participants completing the e-survey was 189, and table 3.1 provides a breakdown of these. The full content related to claims, issues, concerns, topics and audit questions generated from the consultation are listed in Appendix 8.

Table 3.1 Breakdown of respondents completing the e-survey

Allied Health Professional	5
Doctor	7
Manager	17
Nurse	144
Other	14
Patient/Carer	2
Total	189

Stage 4: Further consultation

Following the completion of the workshops and the electronic consultation the emergent claims, issues, concerns, together with the emergent audit priorities and audit questions were brought together for discussion by the project team and the steering committee. Following this meeting the top three priority audit topics identified from the full consultation were shared via email with workshop participants. At this stage we asked participants to provide us with their key questions for a national audit around the three topics that had emerged as top priorities, and we also asked them to tell us what they felt would be a key success factor and a key challenge in developing a national audit around these topics (see Appendices 9 and 10).

Stage 5: Production of final report

The final report was developed by the project team with advice and support from the steering committee. The report addresses all the issues required by the Healthcare Commission Specification and Guidance. This report was submitted to the Healthcare Commission on 29th February 2008.

4. FINDINGS FROM THE CONSULTATION

Introduction

This section of the report describes the findings from the scoping exercise. The term 'essence of care' is used in the remainder of this report and encapsulates the principles and benchmarks described in both the English document *Essence of Care* (DH, 2001) and the Welsh document *Fundamentals of Care* (Welsh Assembly Government, 2003).

First we describe a number of claims, concerns and issues particularly identified around implementing essence of care and clinical audit generally. Second we outline the findings in relation to the list of audit priorities and describe a range of audit questions identified around the top three audit priorities. Finally, we discuss the findings in relation to the recommendations from the literature.

Claims, concerns and issues

Essence of Care Topics

Many participants at the workshops viewed essence of care in a positive light, with some commenting that the original benchmark topics remained relevant. They also acknowledged the importance of the more recent topics, some of which were identified as being highly topical at the time of the consultation. These latter topics were described by some participants as "hot topics" and included communication, privacy and dignity, infection control (which is not strictly an essence of care topic, but could be said to be incorporated within 'environment'), nutrition and mental health. Some participants argued that the English document *Essence of Care* should be re-branded as fundamentals of care.

National support and commitment

Participants suggested the need for a national drive to promote essence of care which emphasised the importance of greater joined up collaboration and partnerships between the Healthcare Commission, the National Patient Safety Agency, the National Health Service Litigation Authority (NHSLA), NICE, the Royal Colleges, other healthcare professional associations, charitable organisations, patient associations, and all NHS and independent healthcare organisations. It was felt that such collaboration and partnership would go some way to ensure that any national audit related to essence of care was given the status, priority and support it deserves.

Furthermore, participants felt that involvement in a national audit on essence of care would make explicit organisational commitment to quality improvement and could be signposted by organisations' during their Healthcare Commission review as evidence of active engagement in working towards Standards for Better Health. Active involvement in a national audit would be seen as evidence of an organisation's ability to proactively manage any challenges falling out of the annual patient surveys, any trend data on patient safety emanating from the NPSA's National Reporting and Learning System, and any relevant information on patient complaints coming out of the National Health Service Litigation Authority (NHSLA), Office of the Ombudsman, charities, and patient organisations.

In addition participants suggested that national support for audit should provide opportunities to develop an interdisciplinary national network for essence of care with a dedicated website that could be utilised as a repository for shared national audit tools related to essence of care topics, clearly identified essence of care co-ordinators, discussion forums and a regular newsletter.

Organisational support and commitment

Some participants felt that the burden of implementing essence of care currently lay with nursing, that there was "too much nursing responsibility", and that the implementation of essence of care should be seen as part of "everyone's job". Participants argued that the successful implementation of essence of care required the "engagement of key/senior staff, and board level involvement in solutions". Furthermore, participants suggested that for essence of care to deliver what it promises there needs to be an acknowledgement at board level that it is the starting point for an action plan focused on quality improvement solutions, and there needs to be an explicit statement of support and funding for its implementation. Furthermore, organisations need to make an explicit statement that clinical audit is a fundamental part of a clinician's workload and not an 'add on'. Time for, and training on audit should therefore be made available to support this. Participants also felt that organisations should employ a professional whose key role is to co-ordinate the implementation of essence of care.

Integration

Some participants clearly identified the potential of a robustly developed, core funded, integrated audit as having the wherewithal to make significant improvements in the quality of patient care. For example, participants identified audit as being "high impact work"; and undertaken properly it can help healthcare organisations develop targeted "action planning" aimed at improving services, "share best practice" and "benchmark best practice".

A common theme discerned from the findings from all of the workshops was participants' concerns about ensuring that the development of a national audit must pay particular attention to integrating the audit with current national initiatives targeted towards raising the standard of care throughout the National Health Service (NHS). The national initiatives identified by participants included *Standards for Better Health* (DH, 2006); *Healthcare Standards for Wales* (WAG, 2005); clinical guidelines developed by the National Institute for Health and Clinical Effectiveness (NICE), as well as ensuring any relevant information arising from the annual patient surveys and any trend information available in relation to patients complaints was utilised in the development of any national clinical audit.

In contrast to these positive assertions about the potential power of a national audit, participants were vocal about their current negative experiences of audit. There was a clear concern to avoid over-burdening staff with data gathering requirements that might duplicate current work. One of the key concerns related to this issue came from participants' experiences and perceptions of the way clinical audit is currently implemented in the NHS. Many talked about how audit was generally viewed by clinical staff as a "tick box exercise"; how they continued to struggle with a belief that there could be "a one size fits all" audit; that the reality is 'we don't do audit we do data collection"; audit is "extra work"; audit is not "service driven"; it is "not relevant"; there is little "ownership" of audit at a clinical level; and there is "very little feedback" and "little change" or improvement as a result of audit.

Pre-registration curriculum

Some participants felt that audit training should be part of the curriculum in universities offering pre-registration courses for all healthcare professionals.

Development of a national audit tool

There was a perception that any national audit needed to be more than just a series of tick boxes. Any national audit tool needs to be streamlined and easy to use. It should include simple indicators or targets, and it should clearly identify who is responsible for what. In addition there was a strong feeling that a national audit tool should include the use of qualitative data, which includes elements of the patients' experience, and it should also incorporate observations of practice and staffs attitudes and behaviours.

Participants felt strongly that any national audit should not replicate data collection collected by other audit tools, but it should be flexible enough to allow for local and regional adaptation, and the questions it asks should be relevant, understandable and measurable. Where necessary a national audit tool should cover all aspects of the patient's pathway which may mean the audit has to span the acute, primary and independent care sectors. Additionally a national audit tool should focus on actions for improvement and should incorporate clear mechanisms for feeding back the results to staff in the participating organisation.

Results: Priority Topics

The final top three topics were decided by drawing together the top five priority topics identified during stages 2 and 3 of the consultation (see Tables 4.1 & 4.2).Table 4.3 lists the overall top five priority topics identified through combining the scores from the stage 2 and stage 3 consultations.

As a result of these findings the top three priority topics: (1) "Food and Nutrition"; (2) "Communication" and (3) "Privacy and Dignity" will be outlined as options appraisals for a national audit for consideration by the Healthcare Commission.

Appendix 9 shows the full breadth of the topics identified during the consultation and highlights the wide range of the fundamental or key care issues proposed by participants. However, the use of the voting as advocated through nominal group technique clearly helped us identify the core topics that participants felt were the greatest priorities for a national audit around essence of care.

Table 4.1: Overall priority topics for national audit as a result of consultation

Priority audit topics	Combined number of points allocated:
1. Food and nutrition	832
2. Communication	752
3. Privacy and dignity	555
4. Patient focus/patient control	278
5. Record keeping	230

Once we had established the priority audit topics throughout the various stages of the consultation we asked participants to suggest key audit questions against these priorities. All the audit questions identified in stages 2 and 3 of the consultation can be found in Appendix 9. Of the 73 workshop participants who were sent the information requested in the stage 4 consultation, 22 returned their completed forms within the timescale identified (the full list of audit questions identified in stage 4 of the consultation are listed in Appendix 11). The resulting number of audit questions identified in the consultation around the three priority topics was 727: 297 on food and nutrition; 252 on communication; and 179 on privacy and dignity

Following the removal of all duplicated audit questions the remaining key audit questions have been categorised in themes (see Table 4.4) and will be utilised in the options appraisals for a national audit on Food and Nutrition; Communication; and Privacy and Dignity (see Section 5).

Results: Key Audit Questions

Additional information received with regard to the key success factors and key challenges to implementing a national audit on the three essence of care priority topics that participants identified in stage 4 will also be considered in the options appraisals (see Tables 4.5. and 4.6 – please note all duplication has been removed). Comments received from participants in relation to audit option 2 are listed in Table 4.7)

Discussion on findings

The clear identification of food and nutrition, communication and privacy and dignity as the top three priority topics for national audit are a testament to stakeholders' concern to prioritise topics that not only have a great resonance for them in terms of their experiences, they are also highly topical and relevant, and subject to a wide range of developments occurring at a national level across the United Kingdom.

Stakeholders reported some areas of concern around the potential for national audit to deliver improvements in the quality of health services, but this was centred on the way audits were implemented across the NHS, rather than any inherent problem with audit per se. Whilst for some of the participants it was difficult to see the relevance or usefulness of the many audits they were being asked to participate in, the majority recognised the value that accrues as a result of audits that are well planned, relevant, easy to use, and facilitate immediate results.

A key issue for stakeholders centred on support and commitment from the board for national audit activities around the essence of care topic areas. There was an overriding belief that where senior management support and commitment was explicit this was a highly motivating factor in getting clinicians to sign up and own national audit. In those areas where essence of care auditing and benchmarking activities have become embedded within clinical practice it has been because of commitment, support and leadership from the Chief Executive, the Board and senior healthcare managers.

Whilst there were concerns voiced about the potential for poor audit results to show organisations in a bad light, the majority of stakeholders recognised that well planned national audits supported and implemented effectively, which resulted in action plans with clearly assigned responsibilities and timescales, are the 'carrot' for quality improvement, rather than the stick.

Table 4.2: Top five priority audit topics identified at Stage 2 consultation

Workshop:	Priority Audit Topics:	Number of points allocated:
Overall	1. Food and nutrition 2. Communication 3. Privacy and dignity 4. Patient focus/patient control 5. Record keeping	738 670 555 278 230
Bath	1. Food and nutrition 2. Communication 3. Discharge planning 4. Safety needs of mental health patients 5. Putting patients at the centre of care	280 165 85 85 65
Birmingham	1. Communication 2. Record keeping 3. Food and nutrition 4. Privacy and dignity 5. Self care/mental health	295 230 170 160 100
Cardiff	1. Shift to patient control 2. Communication and information 3. How its delivered 4. Pathway structure 5. Inclusive criteria	88 80 63 62 50
Leeds	1. Food and nutrition 2. Privacy and dignity 3. Patient focus 4. Patient safety 5. Staff attitudes	288 180 125 115 103
London	1. Privacy and dignity 2. Pulling it altogether 3. Environment 4. Communication 5. Training/Education	215 165 150 130 105

Table 4.3: The top five priority audit topics identified at stage 3 consultation

	Priority audit topics	Number of points allocated:
e-survey	1. Food and nutrition 2. Communication 3. Record keeping 4. Pressure ulcers 5. Privacy and dignity	94 82 74 67 59

Table 4.4: Themes assigned to audit questions

Food and nutrition:	Communication:	Privacy and dignity:
Alternative menu provision	Assessment	Assessment
Assessment	Documentation	Patient satisfaction
Assistance	Patient satisfaction	Staff perception
Care/action planning	Staff perception	
Documentation		
Measurement of food intake		
Patient satisfaction		
Protected meal times		
Referral		
Staff perception		

One thing that perhaps needs to be more clearly articulated is the different purposes and functions of national audit. National audit takes a very broad brush approach and asks a small number of key questions about a topic area. These questions aim to elicit how organisations comply with national standards and guidance related to the topic area, and the aggregated audit results are analysed to provide an overall picture of compliance with standards and guidance across health services. The benefits of these aggregated audit results mean that organisations are able to benchmark their performance against the national average, which can help them to more effectively target their quality improvement activities, and can also facilitate 'escalating up' to Board level any priority areas that may require additional resources in order to improve services as a result of the audit findings.

The comprehensive work that is undertaken at local level when implementing essence of care potentially provides a rich source of detail to supplement a participating organisation's analysis of its national audit results.

Involvement in national audit also provides organisations with a mechanism for reporting improvements in practice across key priorities areas that can be very beneficial when linked to the annual health checks/performance reviews undertaken by the Healthcare Commission.

To summarise, the key benefits to organisations being involved in national audit is that it offers a mechanism to compare and benchmarking their compliance against the national standard and provides immediate, anonymised results. This allows staff working in a participating organisation to know where they are in the aggregated tables of results, but they would not be recognisable to other organisations.

Table 4.5: Key success factors identified in delivering a national audit on essence of care

Food and Nutrition	Need for observation at meal times Staffing levels appropriate at protected meal times to assist patients in eating and drinking as appropriate Ensuring that patients receive an adequate diet to aid their recovery All patients are given a nutritional assessment on admission All patients identified at risk of malnutrition have an action/care plan/nutritional management plan Regular review/monitoring of action/care plans takes place and is documented Adequately resourced catering Ongoing education and training for multidisciplinary care team Collect data on the patient/carer perspective Ongoing risk assessment around food and nutrition Willing, motivated staff who deliver care/action plans that improve patient outcome Documented improvements in patients nutritional status Clear, explicit, comparable, meaningful measures to show how patients receive the nutritional they require Standardised data collection that has an impact on service delivery and improvements Documented evidence that all patients are weighed at regular intervals Raising staff awareness of the importance of patient nutrition Increased patient satisfaction around meal times in the annual patient surveys
Food and nutrition, communication, privacy and dignity	Where possible audit data is collected by appropriately trained nursing staff that are responsible for providing evidence based practice in these areas. Increased patient satisfaction around the fundamentals of care Exceeding patient's expectations of the service (good customer care) Achievement of basic standards and basic assurances – pass or fail – supplemented with an action plan to improve care provision Need to ensure the participation of a wide range of NHS organisations by offering them an opportunity to participate in relevant sections as appropriate. Formal feedback on audit results showing improvements in care delivery Categorisation of patients into age groups would provide evidence of different patient attitudes towards mixed sex wards, nutrition, hygiene, etc. Willing, motivated staff who deliver care/actions plans that improve patient outcomes

	Clearly identified co-ordinators/champions in these areas of care Need for effective clinical leadership and role modelling One set of patient records used by all healthcare professionals Ensure the involvement of the multidisciplinary team in the audit and the feedback of results - not just nursing Reduction in patient complaints Increased patient satisfaction with these areas of key as evidence in the findings from the annual patient surveys Observational audit identifies appropriate care is provided these areas

Table 4.6: Key Challenges identified in delivering a national audit on essence of care

Food and Nutrition	Audit results may vary depending on number/dependency levels of patients leading to the potential for the audit to reflect badly in some areas. Patients nutritional needs vary in different clinical areas and these areas will not be able to use the same audit tool Audit overload - areas already audited against Welsh Standard 23 and Healthcare Standard 9 Difficult to assess true activity without observing patient/staff behaviour at meal times Ensuring the audit leads to improvements in practice. Despite numerous documents/reports/national guidance and earlier work quality of care around food & nutrition does not seem to have improved. Staff must recognise that good nutritional care is as essential as good medication Narrow the audit down to make improvements in one or two key areas Ensuring all patients are given the nutrition they need and are offered assistance to eat as necessary Auditing community settings difficult as documentation is not held in one place Undertaking an audit on food and nutrition in the community setting can be challenging due to patients' interpretation, and because the healthcare professional has less influence on the patients eating habits when they are at home Gathering accurate information Complying with budget constraints in giving choice/variety Time, just another audit, staff feeling that they make no real difference to overall patient outcomes Widely different documentation across the country Facilitating appropriate action plans on the basis of audit results Undertaking real time observations - use "secret visitors" maybe an approach that is adopted if a true picture is to be acquired

	Locating evidence Achieving demonstrable change in a climate of pressure and "priorities" Developing an audit tool that is relevant across all organisations and sectors Ensuring a standardised approach in the interpretation of the audit questions Ensuring that independent practitioners undertake the audit and self assessment is undertaken prior to external assessment Ensuring that any national audit is more than superficial
Food and nutrition, communication, privacy and dignity	Broadening the focus to three aspects of care may dilute impact in a climate of competing priorities Audit tool will need to be clear, easy to complete, it will be difficult to devise an one-size-fits all audit tool Audit overload as areas are already audited against Welsh Standard 8, 23 and Healthcare Standard 8, 9, 10 Difficult to address the key issues across three topics at the same time. Challenges around identifying appropriate measures, an objective data collection method, and keeping the amount of data collected to a practical size Time – may be better to concentrate on one area and get it right before auditing another area. Patient overload in relation to the questionnaires and surveys they are being asked to complete, another may produce fewer responses – which could be remedied by adding questions onto the existing national patient surveys How to include an audit of community settings Getting people to provide evidence or examples of care/practice rather than assuming they have met criteria Variations in service models between organisations Reduction of subjectivity Encouraging staff to embrace the audit Gathering enough information Ensuring a large enough cross-section of subjects/sample Time and staff feeling that they make no real difference to patient outcomes. Getting all participants to complete in timely fashion Identifying named staff within each organisation Prioritising the actions required and facilitating their implementation particularly if this relies on external contractors Finding evidence Involving the multidisciplinary team in the audit and the results Ensuring a standardised approach to the interpretation of the audit Identifying key questions that are generic to all organisations and settings

Table 4.7: Comments received from participants on a combined national audit on food and nutrition, communication and privacy and dignity

I don't think we should merge the audits. Methodologically they are likely to adopt very different approaches and I don't think a very large audit encompassing all aspects described is "do-able".
I would personally not do three priority topics at once.
I found it difficult to identify 5 questions as the topics are so varied
Having consulted with nursing and dietetic colleagues in the organisation for the content of my response they all felt strongly that audit option 2 was not a feasible option!
I feel that audit questions should be based on or adapted from the practice indicators in the Fundamentals of Care document

5. OPTIONS APPRAISALS FOR PROPOSED NATIONAL AUDIT

What follows is an outline of the options appraisals for the three priority topics for a national audit on essence of care as identified by stakeholders in the consultation.

This outline provides information on the following:

- the nature of the issue
- the purpose of the audit
- how services might be engaged
- the information technology implications of the audits
- suggestions about the issues that might be covered by the audit
- an overview of the methods and of the benefits and costs to organisations that might decided to participate in the audits
- rating of audit against a set of criteria (outlined in Table 5.1)

Please note: It is beyond the remit of this scoping exercise to provide a detailed set of audit standards or measurable criteria, to design data collection tools or to prepare a detailed specification of the data collection process. These responsibilities will be undertaken as appropriate if and when the Healthcare Quality Improvement Partnership decides to commission a national audit related to essence of care.

Table 5.1 Rating of audit against criteria

Criterion 1:	The extent to which the topic is viewed as a national priority area (eg as indicated by strength of evidence from the consultation with patients and healthcare professionals, DH initiatives, patients perspectives, professional organisations activities).
Criterion 2:	The strength of evidence around the topic and the extent to which this links the topic to patient outcomes.
Criterion 3:	The extent to which the topic can be measured through a national audit.
Criterion 4:	The extent to which existing national/regional/local data collection systems support a national audit on the topic.
Criterion 5:	Evidence about the extent to which the topic is amendable to change.
Criterion 6:	The range of uses to which audit findings might be applied.
Criterion 7:	Potential barriers to data collection and improvements based on the audit findings.
Criterion 8:	The criteria contained in the Healthcare Commission Clinical Audit and Patient Outcomes self assessment form for national clinical audits.

A score of 2 = fully meets these criterion; a score of 1 = partly meets each criterion; a score of 0 = does not meet criterion

Options Appraisal 1: A National Audit of Food and Nutrition

Rationale

Approximately 20% patients are clinically malnourished on admission to hospital (Edington et al, 2000). *Hungry to be Heard* (Age Concern, 2006) argues that 4 in every 10 older patients arrive at hospital malnourished, patients aged 80 are five times more likely to be malnourished, and six out of 10 older people are at risk of further malnutrition once they are in hospital. Research indicates that both malnourished medical and surgical patients have more complications (McCamish, 1993); whilst Elia et al., (2005 argue that malnourished patients remain in hospital up to 30% longer than patients who are well nourished.

A survey by the British Association of Parenteral and Enteral Nutrition (BAPEN, 2006) estimated that the cost of malnutrition to the UK NHS is around £7.3 billion a year, with over half this cost being expended on people aged 65 years and over. And yet, malnutrition continues to be under-recognised and under-treated (cited in DH, 2007b: 6). Nutrition is also the subject of Council of Europe guidance (Council of Europe, 2003) and is the focus of a current RCN campaign entitled *Nutrition Now* (RCN, 2007c; Carlowe, 2008).

Recent research on nutritional screening and assessment has highlighted that whilst there are a number of published screening and assessment tools available, many of these have not been subject rigorous testing, and the authors argue that further research needs to consider a more standardised approach to the use of these tools (Green & Watson, 2005). While the NICE clinical guideline on nutrition support for adults identifies the Malnutrition Universal Assessment Tool it falls short of recommending its use, and states *"Screening should assess body mass index (BMI) and percentage unintentional weight loss and should also consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of future impaired nutrient intake. The Malnutrition Universal Screening Tool (MUST), for example, may be used to do this"* (NICE, 2006: 69).

In October 2007 the Department of Health collaborated with a wide range of stakeholders to address the action required to improve patient nutrition. The result of this collaboration is the joint action plan on improving nutritional care (DH, 2007b) which sets out five key priorities for action together with a range of developments to support these priorities (see Table 5.2)

Table 5.2: Nutrition Action Plan: Priorities and Supporting Developments (Source: DH, 2007b: 3-4)

PRIORITIES:	SUPPORTING DEVELOPMENTS:
1. **Raising awareness** of the link between nutrition and good health and the prevention of malnutrition. 2. Ensuring the availability of **accessible guidance** that is appropriate and user-friendly. **3.** Encouraging **nutritional screening** for everyone using health and social care services, especially for those **groups who are known to be vulnerable.** 4. Encourage **provision and access to relevant training** for front-line staff and managers on the **importance of nutrition** on good health and nutritional care. 5. **Clarifying standards** and **strengthening inspection and regulation**.	1. Supporting and promoting the Council of Europe Alliance (UK) 10 key characteristics of good nutritional care in hospitals (www.bda.uk.com). 2. An on-line training session on nutritional care and assistance available to all NHS and social care staff from May 2008. 3. Commitment from the Nursing and Midwifery Council (NMC) that Essential Skill Clusters that include nutrition principles will be required to be assessed in practice as part of student nurse training from September 2008. 4. A research study exploring malnutrition on admission to hospital and care homes across the UK undertaken by **the British Association for Parenteral and Enteral Nutrition (BAPEN)**. 5. BAPEN's web-based information resource entitled *Organisation of food and nutrition support in hospitals* to support those tasked with overseeing nutritional care in ensuring the appropriate infrastructure, process and resources are in place. 6. Development by the Department of Health and Social Care Institute of Excellence of a range of good practice on nutritional care as part of the **Dignity in Care online practice guide**.

<table>
<tr><th colspan="2">Audit 1: A national audit of food and nutrition</th></tr>
<tr><td>Overview:
The audit would capture information about patients at the point of care, it would provide a measure of performance against standards that would also provide a baseline for future re-audit. The unit of analysis for the audit would be the individual ward, the nursing home, or the primary care trust. Data would be collected on:
- Whether a nutritional screening has been completed for every patient on admission
- Whether there is documented evidence that the action plan has been implemented
- Whether nutritional assessments are reviewed and monitored for patients assessed as 'at risk'
- Whether there is documented evidence that information about patients' individual nutritional needs have been communicated to the patient
- Whether patients who require assistance with eating or drinking receive assistance to eat and drink
- Whether there is a protected meal time policy on the ward
- Whether patients are able to eat their meal in an environment that is free from interruptions
- Whether patients are asked for their views on the food they receive whilst in hospital/care home
- Whether patients were provided with a choice of food as appropriate to their needs
- Whether meals and/or snacks are available for patients outside of normal meal times
- Whether the amount of food the patient eats is recorded
- Whether staff demonstrate competency in ensuring patients get the nutrition they need
- Whether there is documented evidence of communication about patient's nutrition across the clinical team
Core methods of data capture include:
- documentation
- observations of practice
- patient questionnaire
- staff questionnaire
The depth and breadth of the data required for this audit makes it important to ensure that data is captured using the four methods identified as this would ensure a mix of both qualitative and quantitative data, would build up a more complete picture of food and nutrition care and would enable better measurement of performance against standards, including NICE recommendations. Using all four methods of data capture would also ensure the engagement of all stakeholders thus ensuring a greater likelihood that service improvements would be maximised. In addition, multiple data capture methods supports the triangulation of findings.</td><td>Supporting evidence:
NICE Recommendations 1.1.1 – 1.1.9.
Essence of Care Benchmarks for Food and Nutrition.
Fundamentals of Care Practice Indicators for Eating and Drinking.
Standards for Better Health C15a-b, D, D11a.
Healthcare Standards for Wales: Standard 9a-b.
National Minimum Standards for Care Homes for Older People: Standard 16.
Care Homes for Older People National Minimum Standards: Standards 12-15.
Hungry to be heard: Steps 1-7.
Improving nutritional care: Action plan for tackling issues around nutrition and hydration.
Protected Mealtime Review (NPSA, 2006).
PEAT Assessment for compliance on protected mealtimes, nutritional screening and availability and choice of food.</td></tr>
<tr><td colspan="2">Methods of engaging services:
All NHS and independent providers of acute, primary and community services in England and Wales would be invited to participate in the audit. Clear criteria would be provided for organisations wishing to participate, which would include a formal commitment from the Board. A period of time will be allocated to allow organisations to prepare for their participation prior to data collection.</td></tr>
<tr><td colspan="2">IT Implications:</td></tr>
</table>

All data would be entered via a web-based link and will require that organisations have access to lap top computers to enable direct data entry – thus relinquishing the need for a paper-based audit.		
Overall costs versus benefits for participating organisations **Benefits** ▸ Important, systematically collected information on the quality of care around food and nutrition can be fed back to local areas and be used to inform the organisation's annual health check. ▸ Opportunities for participating organisations to benchmark nationally with similar services ▸ Feedback from patients and carers to staff about important aspects of the quality of care provided around food and nutrition ▸ A raising of the profile of food and nutrition care ▸ Locally customised recommendations about the actions required to improve the quality of care ▸ The potential for clinical audit activity to become rooted in everyday clinical practice **Costs** ▸ The audit would require a dedicated auditor to coordinate and support data collection ▸ In addition, clinical staff would be required to be trained in data collection methods, participate in national audit events to present and consider findings and in contributing to local data collection.		
Rating of audit against criteria		
Criterion:	**Rating:**	**Comment:**
The topic is a national priority	2	Topic is clearly identified as a national priority.
There is evidence that the topic is linked to better patient outcomes	2	NICE Guideline CG 32 makes this connection.
The topic can be measured through clinical audit	2	As identified from consultation and steering committee.
Existing data collection systems support an audit on this topic	1	Will require new data collection systems to be developed.
The topic is amenable to change	1	Will require support from all relevant stakeholders.
There are a range of uses to which the audit findings might be put	2	As identified from consultation and steering committee.
There are few potential barriers to both data collection and improvements based on the findings	1	Will require support from all relevant stakeholders.
The topic meets the criteria contained in the Healthcare Commissions' Clinical Audit and Patient Outcomes self-assessment form for national clinical audits.	2	

Strategies to maximise participation

Full participation in a national audit on food and nutrition would only be achieved if those managing the audit worked at two levels:

- top down to ensure the support and commitment of the Board
- bottom up to ensure that clinical staff are committed to the continuous collection of data.

The following strategies could be considered:

Top-down:

- A letter of invitation to participate is co-signed by the Healthcare Quality Improvement Partnership
- Food and nutrition audit is presented in a way that coincides with local priorities
- Participating organisations are asked to sign a 'memorandum of understanding' which commits them to supporting their local project team(s)
- Local teams are asked to submit action plans
- Findings from the audit contribute to a demonstration of an organisation's adherence to Standards for Better Health, and Healthcare Standards for Wales.

Bottom-up

- Food and nutrition audit is presented in a way that coincides with local priorities
- Local teams are fully supported by their organisation throughout the data collection period
- The organisation is encouraged to appoint a champion to lead the local project team
- The local project team is supported by a multi-stakeholder project team which includes patients and healthcare professionals
- Organisations are encouraged to support their local team(s) to take forward any service improvements identified through the audit
- The data collection methods are user friendly and easy to use
- The time scales for data collection are feasible and realistic
- There is clear and prompt feedback of local findings to all staff
- The benchmarking of local data with other participating organisations and with national findings is supported
- Clarity is achieved about how local essence of care work supports and connects to the national audit and does not duplicate work.

Implications for Information Technology

To support the collection of data from various sources (eg documentation, observations of practice, patient and staff questionnaires) there is a need to utilise a web-based audit application. Such an application would not only provide participating organisations with immediate results, it would also facilitate a paperless audit. As a result of this, organisation's wishing to participant in the national audit may need to have access to lap top computers to enable direct data entry from a range of different sources.

Governance

This audit has a broad range of stakeholders (see Table 5.3). We recommend that all would be involved either actively as steering group members, or passively, as recipients of minutes of the steering group, regular updates, or newsletters.

Table 5.3 Stakeholders for a national audit of food

Type of Stakeholder:	Examples:
DH England; Welsh Assembly Government	Audit Commission Chief Medical Officers Chief Nursing Officers Commission for Social Care Inspection Healthcare Commission Healthcare Quality Improvement Partnership (HQIP) National Director for Patients and the Public National Patient Safety Agency NHS Confederation Heatlhcare Inspectorate, Wales
Commissioners	Local authorities Primary care trusts
Royal Colleges and specialist societies	Academy of Royal Colleges British Dietetic Association Help the Aged Royal College of General Practitioners Royal College of Nursing Royal College of Physicians Royal College of Psychiatrists The Stroke Association
Service user and/or carer representatives	Action for Sick Children Age Concern, England Age Concern, Wales Alzheimer's Society Carers UK England Children in Wales Commission for Patient & Public Involvement in Health Community Health Councils Wales Council for Disabled Children Help the Aged MIND MIND Cymru 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 United Kingdom Advocacy Network

Communications

(a) Communications plan

Stakeholders	Benefit	Methods	Key dates	By whom
General public	Increased public awareness. Earlier detection of malnutrition.	Press feature articles Audit website HQIP website	At launch At publication of findings	Project Management Team. HQIP
Patients/carers	Improved quality of care. Improved quality of outcome. Patient/carer experience being listened to.	Patient leaflet Audit website HQIP website Other websites	From launch throughout duration of project	Project Management Team. HQIP
Primary care trusts	Focus on area of growing concern. Feedback on local performance against standards. Comparison with national benchmarks. Contribute towards regulatory function. Demonstrable improvements in patient care. Support guideline implementation.	Letter of invitation to join audit Access to audit materials and results via audit website Regular newsletters	From registration onto audit and throughout duration of the project	Project Management Team. HQIP
Provider services	Focus on area of growing concern. Feedback on local performance against standards. Comparison with national benchmarks. Contribute towards regulatory function. Demonstrable improvements in patient care. Support guideline implementation.	Letter of invitation to join audit Access to audit materials and results via audit website Regular newsletters	From registration onto audit and throughout duration of the project	Project Management Team. HQIP
Royal Colleges and specialist services	Co-ordinate existing initiatives. Enhance collaborative working. Increase clinician support for audit.	Access to audit materials and results via audit website Regular newsletters Website/newsletter articles Key college events	At launch throughout duration of project	Project Management Team.
DH England; Welsh Assembly Government	Co-ordinate existing initiatives. Information on what is happening locally.	Progress reports Audit website HQIP website	At launch throughout duration of project	Project Management Team.
Healthcare Quality Improvement Partnership	Project adherence to specified timescale.	Regular meetings Monitoring information	On-going	Project Management Team.

(b) Sharing information

We suggest that the bulk of project-related information should be accessible via a website and should be in the public arena. This would include the following:

- audit tool(s)
- guidance notes
- newsletters
- national reports

We recommend that the ground rules covering the use and sharing of data and reports with the Healthcare Quality Improvement Partnership are fully agreed within the project management team at the outset of the project and are communicated to all participating organisations. This is important to engender a culture of openness and to encourage local ownership of the quality improvement process.

(c) Proposals for the use of findings by the Healthcare Quality Improvement Partnership

The audits funded by the Healthcare Quality Improvement Partnership aim to maximise engagement with local services and clinicians. As such, the recruitment of participants must be actively supported by the HQIP. National audits offer a unique opportunity to gather systematic national data about a variety of aspects of health service provision from the perspective of a wide range of stakeholders. We hope that the HQIP will explore ways of ensuring that the findings from this audit would feedback into Healthcare Commission's annual health checks, quality improvement reviews, and as evidence of an organisation's adherence with Standards for Better Health (DH, 2004) and Healthcare Standards for Wales (WAG.2005),and compliance with the NICE guideline on nutrition support for adults (NICE, 2006).

Options Appraisal 2: A National Audit of Communication

Rationale for audit:

Recent inpatient surveys show that patients continue to report deficiencies in communication with healthcare professionals (Healthcare Commission, 2006a; Maxfield et al, 2005), with recent investigations into maternity services in the NHS concluding that communication remains a very serious issue for midwifes (Healthcare Commission, 2004; 2005; 2006b; Smith & Dixon, 2007).

In the most recent *State of Healthcare Report* (Healthcare Commission, 2007a) poor communication continues to be identified by patients as problematic (Healthcare Commission, 2007). What patients say they want in relation to communication and information is for doctors to provide clear explanations and answers in a format they can understand, clear explanations about the benefits and risks of treatments, and for healthcare professionals to be open and honest.(Healthcare Commission, 2007). Furthermore, communication has been identified as crucial in relation to patient safety and has been cited as a key interpersonal skill for healthcare professionals (Fletcher et al, 2002; Yule et al, 2006).

Research on communication in healthcare reports that doctors tend to dominate in doctor-patient communications and that the behaviours and attitudes of healthcare staff can impede as well as enhance the patient's involvement in the communication process (Stevenson et al., 2004). Similar findings were reported by Woolhead et al., (2006), whilst Stevenson et al (2004) suggest that practitioners need to listen carefully and empathetically, and that much patient-professional communication remains an unbalanced relationship rooted in paternalism. Woolhead et al (2006) argue that whilst healthcare professionals appeared to be aware of good communicative practices they failed to implement them, and in addition to a lack of awareness and effort, they also cited lack of time, lack of staff and resources, regulation and bureaucracy as barriers to effective communication

<table>
<tr><th colspan="2">Audit 1: A national audit of communication</th></tr>
<tr><td>Overview:
This audit would capture information about patients at the point of care, it would provide a measure of performance against standards that would also provide a baseline for future re-audit. The unit of analysis for the audit would be the individual ward, the nursing home, or the primary care trust. Data would be collected on:
- Whether patients communication needs have been assessed on admission
- Whether services are accessed to meet the needs of individual patients
- Whether there is documented evidence showing that all members of the multi-disciplinary care team are involved in communicating patients' needs within the team
- Whether patients and/or their carers/relatives are involved in decisions about care and treatment
- Whether patients and/or their carers/relatives were provided with clear information about diagnosis, treatment, tests and discharge arrangements
- Whether the ward environment aids communication between patients and staff
- Whether patients were given opportunities to discuss their care and treatment options with staff in an appropriate environment
- Whether patients feel that staff use appropriate language when communicating
- Whether patients felt they have been referred to by their preferred name and/or title
- Whether staff receive training in communication and/or interpersonal skills
The core methods of data capture would be utilised including:
- documentation
- observations of practice
- patient questionnaire
- staff questionnaire
The depth and breadth of the data required for this audit makes it important to ensure that data is captured using the four methods identified as this would ensure a mix of both qualitative and quantitative data, would build up a more complete picture of food and nutrition care and would enable better measurement of performance against standards, including NICE recommendations. Using all four methods of data capture would also ensure the engagement of all stakeholders thus ensuring a greater likelihood that service improvements would be maximised. In addition, multiple data capture methods supports the triangulation of findings.</td><td>Supporting evidence:
Essence of Care Benchmarks for Communication.
Fundamentals of Care Practice Indicators for Communication and Information.
Standards for Better Health C1b; D1; C14; C16; D9; C17.
Healthcare Standards for Wales: Standards 6a-c; 8d.
National Minimum Standards for Care Homes for Older People: Standards 1-6.
Care Homes for Older People National Minimum Standards: Standards1-7.</td></tr>
<tr><td colspan="2">Methods of engaging services:
All NHS and independent providers of acute, primary and community services in England and Wales would be invited to participate in the audit. Clear criteria would be provided for organisations wishing to participate, which would include a formal commitment from the Board. A period of time will be allocated to allow organisations to prepare fore their participation prior to data collection.</td></tr>
<tr><td colspan="2">IT Implications:
All data would be entered via a web-based link and will require that organisations have access to lap top computers to enable direct data entry – thus relinquishing the need for a paper-based audit.</td></tr>
</table>

Overall costs versus benefits for participating organisations Benefits ▸ Important and systematically collected information about the quality of care around communication can be fed back to local areas and to the Healthcare Commission as part of an organisation's annual Health Check ▸ Opportunities for participating organisations to benchmark nationally with similar services ▸ Feedback from patients and carers to staff about important aspects of the quality of care provided around communication ▸ A raising of the profile of communicating with patients ▸ Locally customised recommendations about the actions required to improve the quality of care ▸ The potential for clinical audit activity to become rooted in everyday clinical practice Costs ▸ The audit would require a dedicated auditor to coordinate and support data collection ▸ In addition, clinical staff would be required to be trained in data collection methods, participate in national audit events to present and consider findings and in contributing to local data collection.		
Rating of audit against criteria		
Criterion:	**Rating:**	**Comment:**
The topic is a national priority	1	Topic clearly identified as a priority by stakeholders in the consultation.
There is evidence that the topic is linked to better patient outcomes	0	
The topic can be measured through clinical audit	2	As identified from consultation and steering committee.
Existing data collection systems support an audit on this topic	1	Will require new data collection systems to be developed.
The topic is amenable to change	1	Will require support from all relevant stakeholders.
There a range of uses to which the audit findings might be put	2	As identified from consultation and steering committee.
There are few potential barriers to both data collection and improvements based on the findings	1	Will require support from all relevant stakeholders.
The topic meets the criteria contained in the Healthcare Commissions' Clinical Audit and Patient Outcomes self-assessment form for national clinical audits.	2	

Stakeholders

As for Audit Appraisal 1

Strategies to maximise participation

As for Audit Appraisal 1

Implications for Information Technology

As for Audit Appraisal 1

Communications (a-c)

As for Audit Appraisal 1

Options Appraisal 3: A National Audit of Privacy and Dignity

Rationale

The Human Rights Act of 1998 resulted in the Department of Health emphasising the importance of healthcare practitioners respecting the privacy and dignity of patients in NHS care settings (DH, 2000; 2001). A recent report from the Joint Committee on Human Rights (JCHR, 2007) considered the human rights of older people in healthcare and identified a number of recommendations on: the treatment of older people in hospitals and care homes; understanding how the Human Rights Act applies to older people in healthcare; the Department of Health's leadership; the implementation of the Human Rights Act by service providers; Health and Social Care Inspectorates and NICE; the role of staff in protecting human rights; and empowering older people.

Several research studies have explored patient dignity in a number of settings (Turnock & Kelleher, 2001; Walsh et al., 2002; Griffin-Helsin, 2005; Woolhead et al., 2005) and have found that in many cases patients' dignity was not being maintained. Woolhead et al (2005) identified dignity as a multi-faceted concept which included: dignity of identity (self-respect/esteem, integrity and trust); human rights (equality and choice); and autonomy (independence and control). Patients provided examples of where they felt their dignity had been jeopardised whilst in hospital, which included: the loss of self-esteem as a result of being patronised, being excluded from decision-making, and being treated as an object. In addition, patients felt they experienced a lack of integrity which resulted in a lack of trust and feelings of increased vulnerability. The authors suggest that patient centred care for patients in relation to maintaining their dignity is specifically linked to communication, privacy, personal identity and feelings of vulnerability (Woolhead et al., 2005).

In a recent review entitled *Caring for Dignity* (Healthcare Commission, 2007b) investigators found that while there are some indications that dignity, privacy and nutrition are achieving higher levels of priorities in many NHS organisations, there remains a clear need for improvements. The authors make a number of recommendations for boards, wards, strategic health authorities, voluntary organisations and policymakers.

<table>
<tr><td colspan="2">Audit 1: A national audit of privacy and dignity</td></tr>
<tr><td>Overview:
This audit would capture information about patients at the point of care, it would provide a measure of performance against standards that would also provide a baseline for future re-audit. The unit of analysis for the audit would be the individual ward, the nursing home, or the primary care trust. Data would be collected on:
- Whether the patient felt their privacy and dignity was maintained at all times
- Whether the patient felt they were treated as an individual at all times
- Whether the patient felt they were treated with respect at all times
The core methods of data capture would be utilised including:
- documentation
- observations of practice
- patient questionnaire
- staff questionnaire
The depth and breadth of the data required for this audit makes it important to ensure that data is captured using the four methods identified as this would ensure a mix of both qualitative and quantitative data, would build up a more complete picture of food and nutrition care and would enable better measurement of performance against standards, including NICE recommendations. Using all four methods of data capture would also ensure the engagement of all stakeholders thus ensuring a greater likelihood that service improvements would be maximised. In addition, multiple data capture methods supports the triangulation of findings.</td><td>Supporting evidence:
Essence of Care Benchmarks for Privacy and Dignity.
Fundamentals of Care Practice Indicators for Respecting people and promoting independence.
Standards for Better Health: D2c; C13a-b; C20a-b; D12a.
Healthcare Standards for Wales: Standards 4b; 8a; 8c..
Care Homes For Older People: National Minimum Standards: Standards 7-11.
National Minimum Standards for Care Homes for Older People: Standards 14; 33-40.
Caring for Dignity Recommendations.
House of Lords House of Commons Joint Committee on Human Rights Recommendations 1-10.</td></tr>
<tr><td colspan="2">Methods of engaging services:
All NHS and independent providers of acute, primary and community services in England and Wales would be invited to participate in the audit. Clear criteria would be provided for organisations wishing to participate, which would include a formal commitment from the Board. A period of time will be allocated to allow organisations to prepare fore their participation prior to data collection.</td></tr>
<tr><td colspan="2">IT Implications:
All data would be entered via a web-based link and will require that organisations have access to lap top computers to enable direct data entry – thus relinquishing the need for a paper-based audit.</td></tr>
<tr><td colspan="2">Overall costs versus benefits for participating organisations
Benefits
▸ Important and systematically collected information about the quality of care around privacy and dignity can be fed back to local areas and to the Healthcare Commission as part of an organisation's annual Health Check
▸ Opportunities for participating organisations to benchmark nationally with similar services
▸ Feedback from patients and carers to staff about important aspects of the quality of care provided
▸ A raising of the profile of privacy and dignity
▸ Locally customised recommendations about the actions required to improve the quality of care around privacy and dignity
▸ The potential for clinical audit activity to become rooted in everyday clinical practice</td></tr>
</table>

Costs		
▸ The audit would require a dedicated auditor to coordinate and support data collection ▸ In addition, clinical staff would be required to be trained in data collection methods, participate in national audit events to present and consider findings and in contributing to local data collection.		
Rating of audit against criteria		
Criterion:	**Rating:**	**Comment:**
The topic is a national priority	2	Topic is clearly identified as a national priority.
There is evidence that the topic is linked to better patient outcomes	0	
The topic can be measured through clinical audit	2	As identified from consultation and steering committee.
Existing data collection systems support an audit on this topic	1	Will require new data collection systems to be developed.
The topic is amenable to change	1	Will require support from all relevant stakeholders.
There a range of uses to which the audit findings might be put	2	As identified from consultation and steering committee.
There are few potential barriers to both data collection and improvements based on the findings	1	Will require support from all relevant stakeholders.
The topic meets the criteria contained in the Healthcare Commissions' Clinical Audit and Patient Outcomes self-assessment form for national clinical audits.	2	

Stakeholders

As for Audit Appraisal 1

Strategies to maximise participation

As for Audit Appraisal 1

Implications for Information Technology

As for Audit Appraisal 1

Communications (a-c)

As for Audit Appraisal 1

6. RECOMMENDATION

The Project Team recommends Options Appraisal 1, a national audit on food and nutrition. This recommendation is endorsed by the members of the Steering Committee, and it is made on the basis that food and nutrition was identified at the greatest priority by stakeholders, and it is underpinned by a strong evidence base, including recommendations from NICE.

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