

**BOD 119/2014**

(Agenda Item: 6)

**Report to the Meeting of the**

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**24 October 2014**

**Quality and Safety Report:**

**Quarterly Clinical Effectiveness Report**

**Executive Summary**

**1. Introduction**

Ensuring that services are clinically effective is a key responsibility for clinical services, in order to ensure that patients recover in the shortest time possible, thus reducing the length of time of emotional and physical distress for patients and promoting recovery. This report outlines achieved standards of care performance in all three clinical directorates, primarily in Quarter 2 (August 2014 to end October 2014). It includes reports on clinical audit, essential standards audits for our inpatient wards, and audits of community team quality standards.

The paper also provides a monthly general update on quality and safety including infection prevention and control, CQC outcomes and individual safety and quality issues.

**2 Clinical Audit**

Ten Trust wide audits were reported on in Q2, of these four were rated as good, four were identified as requiring improvement (although one of these was rated as excellent in Children’s and families and good in older adult mental health wards). One of the audits was not rated and one was for data collection only.

Summaries of six of our major audits are outlined in Appendix 1 - these cover a significant proportion of clinical activity within the three directorates..

Essential inpatient standards – 24 mental health wards

Community Hospital Standards in ten community hospital wards

Pressure ulcer management in the District Nursing Service

Infection Prevention and Control Standards

Care Programme Approach Standards in community mental health teams

Learning Disability reasonable adjustment

**2.1 Inpatient standards of care**

Twenty two out of twenty four mental health wards completed the Essential Standards Audit which was published in August 2014. Data was not received from Ashurst and Cotswold House Oxford. This month saw the introduction of 8 new standards for the Mental Health Act. The overall results for the baseline audit rating varied - three were rated as poor, 2 fair and two good. The other standards showed an improvement in 9 standards; 6 standards remained the same and there was a reduced level of performance in 14 standards, this is disappointing given the investment made to improve ward leadership. We are aware that some in-patient areas continuing to experience lower staffing levels than planned which may be a contributory factor to the issues with lower performance. All results have been communicated to clinical areas, and modern matrons and senior managers have developed actions, to address the identified area for improvement.

***Essential Standards Mental Health Inpatient wards – August 2014***

The Essential Standards audit evaluates the care provided in the inpatient units against 40 standards of care. The audit involves 19 standards related to patient experience of care and 21 standards related to clinical care provided by staff.

The overall sample size is 110, although this varies from question to question. Some standards were not relevant to some patients because of factors like the specific nature of the mental health problem they are suffering from and the patients’ presentation at the time of data collection. The compliance to a standard is based on the number of patients to whom the standard is applicable at the time of data collection.

The tool has been reviewed in June 2014 and some new questions are added, for which previous data will not be available. Some of the wards have used the older version of the tool and this is noted.

**2.2 Community Hospital Audit Tool (CHAT)** - **summary overview**

**This audit takes place quarterly in all ten wards**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Overall results by site** | **Quarter 1 2013/14** | **Quarter 2 2013/14** | **Quarter 3 2013/14** | **Quarter 4 2013/14** | **Quarter1 2014/15** | **Quarter2 2014/15** |
| Abingdon Wd 1 | 67% | 80% | 80% | 87% | 91% | 93% |
| Abingdon Wd 2 | 67% | 83% | 79% | 85% | 90% | 75% |
| Bicester | 91% | 95% | 91% | 87% | 93% | 90% |
| City | 94% | 95% | 73% | 79% | 83% | 88% |
| Didcot | 89% | 98% | No data | 89% | 98% | 98% |
| Townlands | No data | 90% | 85% | 94% | 100% | 97% |
| Wallingford | 80% | 78% | 87% | 90% | 94% | 90% |
| Wantage | 80% | 82% | 82% | 94% | 83% | 88% |
| Witney – Linfoot | 79% | 78% | 84% | 81% | 96% | 85% |
| Witney – Wenrisc | 76% | 73% | 81% | 79% | 97% | 85% |
| **OVERALL RATING** | **Good** | **Good** | **Good** | **Good** | **Good** | **Good** |

Sites were rated Good overall with the exception of Didcot and Townlands which were rated Excellent and Abingdon Ward 2 which in Q2 dropped to requiring improvement. This is an improvement upon the results from last year and has occurred despite challenges within the community hospitals in terms of staffing and dependency of patients. Despite the generally good results, areas for improvement are:

1. Comprehensiveness of assessment in patients with falls risks: Falls continue to be an area of significant risk within the community hospitals and accounts for the majority of incidents reported. Whilst the directorate attended to some poor performance in this area last year there is still some room for improvement. This has been an area identified in the action plans accompanying the audits undertaken and is monitored through the biannual quality assurance reviews. Safer Care work has commenced in some wards.
2. The comprehensiveness of assessments of patients with pressure ulcer risk. The incidence of avoidable pressure related damage is very low within the community hospitals. In addition the majority of pressure related damage recorded results from pressure damaged acquired by patients before they are admitted to the ward. Nonetheless the risks of pressure related harm resulting in patients with frailty in the community hospital setting is significant and despite generally good results in all areas this was an area identified as requiring improvement across all ward areas.
3. Regular review of Care plans: Whilst care planning was generally thought to be good, the regularity of review of care plans and the patients involvement within the process of review was found to be an area requiring improvement.

**Abingdon Ward 2**- Requiring Improvement

There have been concerns regarding Abingdon Ward 2 in Q1 and Q2 2014. The concerns relate to the staffing difficulties prompted by sickness and resignation of staff leading to 24% depletion in staff. To address this, temporary staffing solutions of ‘long line agency’ staff were employed and six beds temporarily closed. Recruitment is ongoing and sickness has improved. Coincidentally the average length of stay for patients has dropped enabling the same episodes of care to be delivered on the ward with a reduced bed stock. The specific areas requiring attention are Falls and Nutritional risk assessments with subsequent care planning based upon the outcomes. In addition the personalisation of care plans and degree to which patients are involved within the care planning process and review.

**2.3 Prevention and management of pressure ulcers in the District Nursing Service.**

This audit showed some areas of improvement, but some standards had not improved. The outcome requires improvement for a further year.

Improvements were made from last audit particularly around:

* pressure damage prevention care planning increased to 96% (up 24%)
* photographing of ulcers increased to previous target of 70% (up 15%)
* discussion of risks and benefits of pressure ulcer treatment discussed with patient increased to 83% (up 28%)
* Incident reporting of category 2 and above pressure ulcers increased to 83% (up 38%)
* Dressings prescribed in line with guidelines increased to 96% (up 21%)

However, there are a number of areas for improvement, as this audit is still rated as requires improvement, including nutritional planning following assessment; recording assessments and ensuring information leaflets are explained to patients; contacting tissue viability if healing rates have not been achieved

**2.4 Care Programme Approach Audit in Community Mental health Teams**

This summary below provides information on the quarterly audit on CPA. The results are based on data collected from mental health teams and wards across all directorates in Quarter 1. The results for quarter 1 are based on the revised CPA audit tool which was reviewed and approved for use by clinicians across all services.

Table provides an audit rating by service:

|  |  |  |
| --- | --- | --- |
| **Directorate** | **Audit rating for Q3 2013/14** | **Audit rating for Q1 14/15** |
| Adult Mental Health | Good | Requires improvement |
| Forensic | Good | Good |
| Older people | No data | Requires improvement |
| Children & Young People (CYP) | Requires improvement | Requires improvement |
| **Overall Trust wide audit rating** | **No overall rating\*** | **Requires improvement** |

\*

Areas for improvement include patient involvement in care planning and crisis plans and involvement of relatives and sharing plans with relatives and GPs.

**2.5 Access to healthcare for people with a Learning Disability (Oxon Community Division)**

This audit has not yet taken place and national guidance is awaited (see below).

**Conclusion**

The above audit results highlight that there are some areas of good practice and assurance around clinical standards, although a number of audits continue to identify a number of areas where improvement is required. It is known that some services are in transition and transformation of teams is bedding down. Services such as District Nursing, Community mental health teams and all inpatient wards are managing higher than usual levels of demand and staffing to planned levels and adapting to new models of care.

**3. Mental Health Act Inspections by the CQC**

CQC MHA ward inspections identify 2 areas where doctors practice requires improvement on ward inspections. These are in relation to S17 leave and recording capacity in respect of first administration of treatment.

**3.1 S17 Leave**

Where more than seven (7) days continuous home leave is being authorised by the Responsible Clinician (RC) for patients detained under S3, the RC must first consider whether the patient should go onto supervised community treatment (SCT) instead. The MHA Code of Practice 21.10 states:

**“The requirement to consider SCT does not mean that the responsible clinician cannot use longer-term leave if that is the more suitable option, but the responsible clinician will need to be able to show that both options have been duly considered. The decision, and the reasons for it, should be recorded in the patient’s notes.”**

The Trust’s S17 leave forms have been designed in such a way as to enable the RC to record both that the two options have been considered and the reason why SCT is not being considered at this time. The leave forms are uploaded to RIO which meets the requirement to record in the patient notes.

Presently, where an RC fails to complete the necessary information, the MHA office will send a reminder and will continue to chase the provision of this information.

In future, the MHA office will send out one reminder only to the RC, copying in the Trust’s Medical Director and relevant Clinical Director.

**3.2 First Administration of Treatment – Detained Patients**

MHA CoP 23.37 states:

**“Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient’s consent should still be sought before treatment is given, wherever practicable. The patient’s consent or refusal should be recorded in their notes, as should the treating clinician’s assessment of the patient’s capacity to consent.”**

The CQC visiting commissioners expect to see a clear statement of detained patient capacity to consent to the first administration of treatment. The MHA office has created a standard form (which meets the approval of the CQC commissioners) for doctors to complete in respect of each patient who is detained and this is emailed to the doctor by the MHA office. Once completed and returned the MHA office upload to RIO.

There are many occasions where the forms are not being completed, nor is there adequate assessment of the patient’s capacity recorded in the progress notes. The MHA office does chase for responses but these are often not forthcoming for the duration of the patient’s detention.

In future, the MHA office will not send out reminders, but will send regular updates on outstanding forms to the Trust’s Medical Director and relevant Clinical Director.

**3.3 Care Quality Commission (Section 120) Visits**

Cotswold House, Marlborough 30 May 2014

Ruby Ward 4 July 2014

Statutory Matters:

Recording rights presentation

Copies of leave forms

Consent to Treatment

Non-Statutory Matters:

Confidentiality at Nurses station

Care plans recording patient views

Care planning, patient participation

Recording capacity

Accuracy of records

**4. Infection Prevention and Control Report – July/August2014**

**4.1 Infection Prevention and Control Update**

**Community health services**

***Clostridium difficile***

There has been one case of *Clostridium difficile* infection (CDI) in community hospitals in July 2014 and no cases in mental health services. There were no cases in August and one new case in September.

There have been three CDI cases up until end of Q2 against the end of year threshold of 8.

The Trust continues to be involved with a monthly CDI health economy review meeting with the OUH, Public Health England and OCCG commissioners. At this meeting all CDI cases across the health economy are presented and all cases so far have been deemed unavoidable.

Below is a summary of the review meetings for the cases.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Month | Location | Running total of cases | Avoidable/  Unavoidable | Running total of Avoidable |
| April 2014 | Ward2, Abingdon | 1 | Unavoidable | 0 |
| Didcot CCG case | 1 | Unavoidable | 0 |
| May 2014 | No cases | 1 |  | 0 |
| June 2014 | No cases | 1 |  | 0 |
| July 2014 | Didcot hospital | 2 | Unavoidable | 0 |
| August 2014 | No cases | 2 |  | 0 |
| September | Didcot hospital | 3 | Unavoidable | 0 |

**MRSA bacteraemia/MSSA bacteraemia**

There have been no MRSA/MSSA bacteraemias in either community or mental health services in July and August.

**E.Coli bacteraemias**

There have been 2 cases of *E.coli* bacteraemias in July identified. Both cases were admitted via EMU at Abingdon hospital to Ward 2. However the blood cultures were taken in EMU on admission to the Trust and therefore pre 48 hours and community acquisition cases.

There was also an *E.coli* bacteraemia in August identified at City ward. This case was attributable to the Trust and believed to be associated with the urinary tract as the primary source.

Full RCA’s were completed and all appropriate action was taken. There is no target for these infections but it is a mandatory reported infection.

**Outbreaks**

No outbreaks in community hospitals or mental health wards.

5. **Learning Disability essential standards**.

Audits of the care of people with learning disabilities and reasonable adjustments have been incorporated into the Trust annual audit programme. The baseline audit tool has been reviewed and will be applied during October to identify accessibility of the services. Actions will be identified by the end of November.

The Trust has been working in close partnership with Southern Health Learning Disabilities Trust and the Oxford University Hospitals NHS Trust to develop robust tracking and flagging mechanisms that enable people with learning disabilities that come into contact with our services to be identified. Progress in the past month has seen the completion of the database for the identification of people with learning disabilities that are on the caseload of Southern Health. Previously, consent has been gained from individuals that comprise the Learning Disabilities Fragility Network of most vulnerable people with learning disabilities in Oxfordshire to share personal details with the aim of making reasonable adjustments to their care. This has now been extended to a wider group.Individuals with learning disabilities on this database can now be tracked on the Rio Electronic Patient Record and an Omnivo report has been run that enables an audit of records to be undertaken that can provide evidence that reasonable adjustments have taken place at an individual patient level as well as at a service level.

Southern Health indicated that an audit of reasonable adjustments would not be accurate if undertaken before they had cleansed the data available following a significant information governance SIRI related to the Connor Sparrowhawk case and the audit of reasonable adjustments in older adult’s services planned for August/ September 2014 will now take place in October and report in November 2014.

**Recommendation**

For information

**Authors**

Sue Haynes Head of Nursing, Mental Health Adult

Marie Pritchard Head of Performance and Quality Older peoples services

Jane Kershaw Head of Registration and Quality

Helen Bosely Infection Prevention & Control Matron

Ros Alstead Director of Nursing

**Exec Sponsor**

Ros Alstead, Director of Nursing & Clinical Standards & Dr Clive Meux, Medical Director

**Appendix 1**

**Clinical Effectiveness Quarterly Report.**

**Section 1 Clinical Audit**

**1.1 Changes to the Trust wide Clinical Audit plan for 2014/15**

**1.2 Additions to the Trust wide audit plan for 2014/15**

There are four additions to the Trust wide audit plan that were previously approved by CEC and IGC.

1. Resuscitation & Anaphylaxis – the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommends that every Cardiopulmonary Resuscitation (CPR) attempt is reported through the healthcare organisation’s patient safety incident reporting systems. This information must be reported to the organisation’s Board on a regular basis. Organisations must review local audit data regularly against published standards. This will be met through regular reports on resuscitation to the CEC and an Annual Report to the Quality Committee.
2. Do Not Attempt CPR (DNACPR) - Audit of DNACPR policies is mandatory (Health Services Circular 2000/028). Resuscitation Council (UK).
3. Trust wide Antimicrobial Prescribing audit - previously only carried out as a local audit in Community Hospitals. The scope of the audit has been widened to include older adult mental health wards.
4. Mental Capacity Act audit – recently reported and rated as non-compliant for Community Hospitals and Older Adult Mental Health wards.

**1.3 Audits removed from Trust wide audit plan for 2014/15**

Since the last report to CEC the following audits have been removed from the Trust wide audit plan:

1. POMH-UK Topic 6: Assessment of Side Effects of Depot medication - removed from the POMH national audit programme as there was too much overlap with the National CQUIN Indicator 1 - identifying and acting on cardio metabolic risk factors. This topic will be included in the POMH 2015/16 national audit programme.
2. Audit of service users who ’Do Not Attend’ (DNA) to check that the DNA policy is being followed around the proactive follow up and steps taken to try and manage risk. This audit appeared in the Schedule 6 contract with Oxfordshire Clinical Commissioning Group (OCCG). Further discussions were held with OCCG as the Trust has previously identified this as a topic for audit in 2013/14 and the audit was rated as good. OCCG have agreed to remove it from their Schedule 6 contract.
3. Completion of Pressure Ulcer assessment within 6 hours of admission (and will have actions identified on the key risk factors and any preventative measures implemented within 2 days) - removed from Trust wide audit plan as this is a Key Performance Indicator (KPI) and will be monitored through the Older People's local audit plan.
4. District nursing service audit of assessment, care planning and evaluation – this audit should not have been recorded as a separate audit on the Trust wide audit plan as the data is collected as part of the District Nursing documentation audit.
5. With the changes to the Trust wide audit plan the total number of audits has reduced from 42 at the start of the year to 36.

**1.4 Action Plan Monitoring**

Monthly scheduled reports are now produced for the directorates to review their outstanding audit actions at their governance meetings. A report on the number of actions outstanding was run in August 2014 and a comparison of percentages of outstanding actions is provided in table 3 below. Overall there has been a reduction in the number of out-of-date actions from 20% to 16%.

Table 3 - Percentage of actions out of date

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Division** | **Total number of actions** | **Number of actions completed** | **Number of actions in date** | **Number of actions out of date** | **% out of date**  **Jun 14** | **% out of date**  **Aug 14** |
| Trust wide actions relating to all directorates | 42 | 26 | 16 | 0 | 22% | 0% |
| Adult Mental Health | 93 | 63 | 9 | 21 | 30% | 23% |
| Oxon Community Services | 57 | 34 | 12 | 11 | 13% | 19% |
| Older Adult | 31 | 26 | 0 | 5 | 8% | 16% |
| Specialised Services | 30 | 17 | 10 | 3 | 14% | 10% |
| Children & Young People | 35 | 19 | 10 | 6 | 15% | 17% |
| **TOTAL** | **288** | **185** | **94** | **46** | **20%** | **16%** |

* 1. **Summary of the results from the clinical audits reported and rated since the last CEC report in June 2014 (Table 4)**

Table 4

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Audit Name** | **Audit cycle** | **Previous audit rating** | **Current audit rating** | **Date action plan to be developed by** | **Date action plan submitted** |
| 2013/14 (Pg 6) | POMH-UK Topic 4b Prescribing anti dementia drugs | Baseline | N/A Baseline | Requires improvement | 23/6/14 | In place |
| 2013/14 (Pg 10) | Inpatient Physical Health Assessments: |  |  |  |  |  |
|  | Older Adult Mental Health wards | Baseline | N/A Baseline | Good | 7/10/14 |  |
|  | Forensics | Baseline | N/A Baseline | Requires Improvement | 7/10/14 |  |
|  | Adult Mental Health | Baseline | N/A Baseline | Requires improvement | 7/10/14 |  |
|  | Children & Families | Baseline | N/A Baseline | Excellent | 7/10/14 |  |
| 2013/14 (Pg 16) | National Audit of Intermediate Care | Baseline | N/A Baseline | Not rated as an information gathering exercise | 30/4/14 | 26/6/14 |
| 2013/14 (Pg 20) | Outpatient Clinic Letter Turnaround Time in Swindon CAMHS and Eating Disorder Services | Re-audit | Requires improvement | Good | In place | In place |
| 2013/14 (Pg 21) | Prevention and management of pressure ulcers in the District Nursing service Q4 results | Re-audit | Requires improvement | Requires improvement | In place | In place |
| 2014/15 (Pg 26) | Controlled Drugs audit  Results for Quarter 3 2013/14 & Quarter 1 2014/15 | Re-audit | Requires improvement | Good | 3/10/14 |  |
| 2014/15 (Pg 29) | Infection Control audit summary for quarter 1 | Re-audit | Good | Good | Developed at the time of the audit | N/A |
| 2012/13 (Pg 36) | Access to healthcare for people with a Learning Disability | Baseline | N/A Baseline | Not rated | N/A – see page 36 | |
| **Year** | **Audit Name** | **Audit cycle** | **Previous audit rating** | **Current audit rating** | **Date action plan to be developed by** | **Date action plan submitted** |
| 2014/15 (Pg 37) | Community Hospitals Assessment Tool (CHAT) Quarter 1 results | Re-audit | Good | Good | Previous action plan being reviewed | |
| 2014/15 (Pg 41) | CPA audit – 2014/15 Q1 results | Re-audit | Adult Mental Health = Good | Requires improvement | 19/9/14 | |
| Forensic = Good |
| CAMHS = Requires improvement |

A summary of results for each audit is provided in appendix 1, full reports for each of the audits and action plans can be obtained from the Quality & Audit Team. [Clinical.audit@oxfordhealth.nhs.uk](mailto:Clinical.audit@oxfordhealth.nhs.uk)

**1.6. Essential Standards Mental Health Inpatient wards – August 2014**

Data was received from 22 out of 24 wards. Data was not received from Ashurst and Cotswold House Oxford.

Essential Standards audit evaluates the care provided in the inpatient units against 40 standards of care. The audit involves 19 standards related to patient experience of care and 21 standards related to clinical care provided by staff.

The overall sample size is 110, although this varies from question to question. Some standards were not relevant to some patients because of factors like the specific nature of the mental health problem they are suffering from and the patients’ presentation at the time of data collection. The compliance to a standard is based on the number of patients to whom the standard is applicable at the time of data collection.

The tool has been reviewed in June 2014 and some new questions are added, for which previous data will not be available. Some of the wards have used the older version of the tool and this is noted.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Audit Rating** | Excellent | **Good** | Requires Improvement | Unacceptable |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Essential Standards Audit** | | | | | | | | | | | | | |
| **Key =** | Excellent = 100% |  | Good = 90-99% |  | Fair 75%-89% | |  | | Poor = <74% | | |  | **Position against last month’s performance.** |
| **Orientation** | | | | | **Oct-13** | **Dec-13** | | **Feb-14** | **Apr-14** | **Jun-**  **14** | **Aug-14** | |  |
| Patient information given out on admission to the ward (n=67) | | | | | 95% | 98% | | 93% | 89% | 92% | 94% | | **+** |
| Patients state that they have been orientated to the ward and are aware of ward routine including rights and restrictions (n=68) | | | | | 91% | 96% | | 93% | 96% | 99% | 100% | | **+** |
| **Physical Health** | | | | |  |  | |  |  |  |  | |  |
| Patient has received a physical health assessment completed within 24 hours of admission (n=102) | | | | | 100% | 99% | | 98% | 95% | 98% | 98% | | **=** |
| Patients physical health needs are identified at assessment and included in care plan (n=91) | | | | | 100% | 97% | | 92% | 97% | 94% | 96% | | **+** |
| Patient has been screened for VTE within 24 hours of admission (n=97) | | | | | 98% | 89% | | 91% | 93% | 86% | 88% | | **+** |
| **Capacity and Consent** | | | | |  |  | |  |  |  |  | |  |
| Is it documented the patients capacity has been assessed/ reviewed either at or since the last ward round? (n=99) | | | | | 84% | 86% | | 85% | 90% | 83% | 81% | | **-** |
| Is it documented consent to treatment/medication has been discussed with the patient either at or since the last ward round (n=97) | | | | | 90% | 88% | | 89% | 92% | 85% | 86% | | **+** |
| **MHA\*** | | | | | **Oct-13** | **Dec-13** | | **Feb-14** | **Apr-14** | **Jun-14** | **Aug-14** | |  |
| Where appropriate, there is a record that the patient’s rights have been read in accordance with section 132 and understood?(n=64) | | | | |  |  | |  |  |  | 89% | | **New Rating** |
| Is there a current section 17 leave form (FS17 form)?(n=55) | | | | |  |  | |  |  |  | 96% | | **New Rating** |
| Is the current Section 17 leave form (FS17 form) been uploaded onto Rio?(n=52) | | | | |  |  | |  |  |  | 62% | | **New Rating** |
| Have all previous forms been crossed through and uploaded onto Rio?(n=52) | | | | |  |  | |  |  |  | 73% | | **New Rating** |
| Is there evidence that the patient has been given a copy of the section 17 leave form?(n=53) | | | | |  |  | |  |  |  | 75% | | **New Rating** |
| Is there evidence of liaison with the patient's carers, relatives or other relevant parties regarding the patient's section 17 leave?(n=41) | | | | |  |  | |  |  |  | 71% | | **New Rating** |
| If detained is an up to date T2 or T3 filed with the meds card? (T2 forms only needed for patients detained for more than 3 months)(n=56) | | | | |  |  | |  |  |  | 98% | | **New Rating** |
| **Care Planning** | | | | |  |  | |  |  |  |  | |  |
| Evidence of Family / Carer / Next of Kin involvement in care as appropriate (n=103) | | | | | 88% | 95% | | 91% | 97% | 97% | 96% | | **-** |
| Patient reports being involved in care planning (n=103) | | | | | 84% | 96% | | 81% | 74% | 80% | 83% | | **+** |
| There is evidence of patient involvement in care planning in the electronic records(n=82)\* | | | | |  |  | |  |  |  | 87% | |  |
| Care plan is up to date and relevant to the current needs of the patient (n=110) | | | | | 89% | 89% | | 88% | 83% | 91% | 82% | | **-** |
| Does the patient have a "knowing me form" completed as part of assessment process (OA only) (n=8) | | | | | 100% | 83% | | 75% | 78% | 100% | 75% | | **-** |
| **Risk Assessment** | | | | |  |  | |  |  |  |  | |  |
| Risk assessment AND management plan are up to date and relevant to current needs of the patient (n=109) | | | | | 88% | 85% | | 86% | 88% | 92% | 83% | | **-** |
| Current level of risk highlighted through patient status at a glance/ safety board (excludes Forensics) (n=80) | | | | | 93% | 92% | | 97% | 93% | 91% | 91% | | **=** |
| **Safety** | | | | |  |  | |  |  |  |  | |  |
| Patients report they feel staff have done everything they can to make them feel safe on the ward? (n=105) | | | | | 92% | 96% | | 89% | 85% | 90% | 91% | | **+** |
| **Medication** | | | | |  |  | |  |  |  |  | |  |
| Do the patients recall ever being told why they are taking their medication? (n=103) | | | | | 96% | 99% | | 98% | 92% | 98% | 97% | | **-** |
| Is the patient’s current medication regime clearly documented in the progress notes?(n=82)\* | | | | |  |  | |  |  |  | 60% | |  |
| Do they know what the side effects are? (n=102) | | | | | 79% | 89% | | 83% | 85% | 93% | 93% | | **=** |
| **Communication** | | | | | **Oct-13** | **Dec-13** | | **Feb-14** | **Apr-14** | **Jun-14** | **Aug-14** | |  |
| Patients report that they are spending individual time with staff on a regular basis (n=106) | | | | | 90% | 97% | | 90% | 84% | 89% | 88% | | **-** |
| Evidence of one to one meetings with patients are clearly documented in the nursing notes (n=108) | | | | | 93% | 92% | | 85% | 90% | 92% | 91% | | **-** |
| Patients are able to state who their key nurse is (n=98) | | | | | 82% | 92% | | 84% | 85% | 82% | 86% | | **+** |
| **Dignity & Respect** | | | | |  |  | |  |  |  |  | |  |
| Patients report that staff are courteous towards them (n=110) | | | | | 84% | 91% | | 90% | 89% | 88% | 88% | | **=** |
| Staff always knock on patients bedroom doors prior to entering (n=110) | | | | | 83% | 90% | | 92% | 93% | 93% | 86% | | **-** |
| **Discharge Planning** | | | | |  |  | |  |  |  |  | |  |
| Where appropriate patients report that they are involved in their discharge planning (n=63) | | | | | 96% | 92% | | 89% | 89% | 91% | 89% | | **-** |
| It is documented that the ward have contacted the care coordinator for discharge planning (n=72) | | | | | 95% | 96% | | 97% | 96% | 94% | 97% | | **+** |
| **Nutrition & Hydration** | | | | |  |  | |  |  |  |  | |  |
| The patient was seen by the dietician on assessment (to develop meal plan) (Eating Disorder Units only) (n=15) | | | | | 100% | 100% | | 100% | 100% | 100% | 100% | | **=** |
| Nutritional needs assessment completed (exclude Eating Disorder Units) (n=88) | | | | | 73% | 50% | | 53% | 64% | 75% | 75% | | **=** |
| Patients are given a choice of food that meets their specific needs (exclude Eating Disorder Units) (n=86) | | | | | 97% | 95% | | 100% | 98% | 95% | 100% | | **+** |
| **Observation** | | | | |  |  | |  |  |  |  | |  |
| Date and level of observation clearly documented (N/A if patient not on level 2,3 or 4) (n= 37) | | | | | 93% | 93% | | 89% | 85% | 98% | 95% | | **-** |
| Where appropriate patients on close observations can explain why these are in place (n=23) | | | | | 86% | 93% | | 100% | 81% | 97% | 87% | | **-** |
| Is there evidence that the observation records are fully completed for the previous 24 hours( levels 1-4 as appropriate)?(n=69)\* | | | | |  |  | |  |  |  | 97% | |  |
| **Patient Involvement** | | | | |  |  | |  |  |  |  | |  |
| Patients report that they have been involved in therapeutic activities in the last week (n=106) | | | | | 92% | 98% | | 94% | 88% | 95% | 93% | | **-** |
| Care plan identifies appropriate therapeutic activities related to patient need (n=103) | | | | | 92% | 87% | | 82% | 81% | 91% | 89% | | **-** |

The above table shows the overall Trust ratings for the Essential Standards audit. This month saw the introduction of 8 new standards for the Mental Health Act. The overall results for the baseline audit rating varied - three were rated as poor, 2 fair and two good. There was an improvement in 9 standards, 6 standards remained the same and there was a reduced level of performance in 14 standards, this is disappointing given the investment made to improve ward leadership. All results have been communicated to directorates and ward teams, and action plans for improvement are in place with the new ward leadership teams

**1.7.. Summary of a number of Audit Results and actions taken ( this sample reflects a large number of teams it is not the whole audit programme)**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Name** | Prevention and management of pressure ulcers in the District Nursing service | **Date of report** | May 2014 |
| **Rating** | 2012/13 Quarter 4 = Requires improvement | **Audit Cycle** | Re-audit |
| 2013/14 Quarter 4 = Requires improvement |
| **Key results** | | | |
| This summary relates to District Nursing patients only, within the Community Division, for Quarter 4, 2013-14. The records chosen for the purpose of auditing were the paper District Nursing notes of 30 patients, as historically agreed within the service. The patients were selected from patients who were admitted to the caseload during the quarter to be included, or who developed a pressure ulcer during the quarter to be included. The majority selected are those who have a pressure ulcer at the time of auditing (usually towards the end of the quarter when the audit is due). In this audit, 26/30 patients had pressure damage risk and 23/30 patients had a pressure ulcer.   * Usually this is broken down into 5 sets of notes per locality to give an even spread across the county * The breakdown of responses for this quarter however, were as follows:   + North locality - 5   + North-East locality - 7   + Central locality - 3   + South-East locality - 6   + South-West locality - 2   + West locality - 7   Areas on previous action plan were around improving care related to:   * Wound mapping * Wound assessment * Pain assessment * Photographing ulcers * Lower limb assessment   This was to be achieved via a comms plan. However, the subsequent comms opportunities became more limited due capacity issues in the DN service during the audit period. Another action was to improve leadership around pressure damage in the DN service. This has been achieved through the introduction of Tissue Viability Resource Nurse role.  Whilst the target for all areas in this audit is 100%, this was not met in regard to the vast majority of standards. However, the overall standard has improved since the previous audit a year ago, particularly in relation to pressure damage prevention indicators. In view of the current issues with DN workforce capacity, only the most significant standards in terms of potential associated harm to the patient have been selected for specific action plan development. The selection and resulting action plan was discussed and agreed with the Tissue Viability Clinical Lead.  Improvements were made from last audit particularly around:   * pressure damage prevention care planning increased to 96% (up 24%) * photographing of ulcers increased to previous target of 70% (up 15%) * discussion of risks and benefits of pressure ulcer treatment discussed with patient increased to 83% (up 28%) * Incident reporting of category 2 and above pressure ulcers increased to 83% (up 38%) * A holistic assessment increased to 97% this features as a recommendation in SIRIs   Improvements required  There are a number of areas for improvement as this audit still is rated as requires improvement including nutritional planning following assessment. recording assessments and ensuring information leaflets are explained to patients, contacting tissue viability if healing rates have not been achieved   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Results against standards** | **Q4**  **2012-13** | **2012/13**  **Audit rating** | **Q4**  **2013-14** | **2013/14 Audit rating** |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 1. Dressings prescribed in line with guidelines increased to 96% (up 21%) has a holistic assessment been completed? (including social history) | 93% | | Good | 97% | Excellent | | 1. Is the patient’s medical history recorded? | 77% | | Requires improvement | 90% | Good | | 1. Is the MUST score recorded? | 90% | | Good | 86% | Good | | 1. Has appropriate action been taken on the basis of the MUST score? | 81% | | Unacceptable | 44% | Unacceptable | | 1. Is the review date for MUST score identified? | 70% | | Requires improvement | 52% | Requires improvement | | * 1. Has the MUST review taken place as planned? | 63% | | Requires improvement | 54% | Requires improvement | | 1. Has a Walsall risk assessment been completed at first visit (community nurses)? | 100% | | Excellent | 93% | Good | | 1. Have additional pressure damage risks been assessed: | |  | | | | | 1. positioning and posture? | 83% | | Good | 86% | Good | | 1. History of pressure ulcers? | 60% | | Requires improvement | 71% | Requires improvement | | 1. Impact of medical history and medications? | 63% | | Requires improvement | 78% | Requires improvement | | 1. Have appropriate dates/frequency for review of the pressure ulcer risk assessment been identified? | 63% | | Requires improvement | 93% | Good | | * 1. Have these reviews been completed? | 84% | | Good | 54% | Requires improvement | | 1. Is this patient at risk of pressure damage? | 25 pts | |  | 28 pts |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Results against standards** | **2012-13** | **2012/13**  **Audit rating** | **2013-14** | **2013/14 Audit rating** | | * 1. Based on pressure damage risks identified, have appropriate actions been documented on the pressure damage prevention care plan to reduce risk? | 89% | Good | 92% | Good | | * 1. Does the pressure damage prevention careplan include a positioning/re-positioning regime? | 56% | Requires improvement | 68% | Requires improvement | | * 1. Is there evidence that the pressure damage prevention plan of care has been discussed and agreed with the patient? | 100% | Excellent | 100% | Excellent | | 1. Is it documented that verbal advice and the pressure damage prevention leaflet has been given to patient/carers? (Only tick yes if both have been given) | 80% | Good | 69% | Requires improvement | | 1. Did the patient require the use of pressure relieving equipment? | 20 pts |  | 28 pts |  | | * Did the equipment provided comply with NICE guidance CG 29 (see below) | 100% | Excellent | 80% | Good | | * Was the required equipment provided in a timely manner (within 5 days if routine or 24hrs if urgent/patient already had appropriate equipment in place)? | 96% | Excellent | 88% | Good | | * Are the dates for ordering, receiving and reviewing pressure relieving equipment recorded? | 67% | Requires improvement | 35% | Unacceptable | | * Has it been recorded that verbal and written advice (i.e. tissue viability leaflet “Patient’s guide to equipment”) has been given to patient/carer re. what to do in event of equipment failure/ problems? | 52% | Requires improvement | 50% | Unacceptable | | 1. Has the patient got a pressure ulcer? | 20 pts |  | 23 pts |  | | * 1. Has the pressure ulcer been formally assessed using the wound assessment form? | 50% | Requires improvement | 57% | Requires improvement | | b. If wound assessment has been used does it include details re: |  |  |  |  | | 1. Cause of the ulcer? | 100% | Excellent | 77% | Requires improvement | | 1. Site/ location of the ulcer? | 100% | Excellent | 100% | Excellent | | 1. Dimensions of the ulcer in cm2? | 90% | Good | 69% | Requires improvement |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Results against standards** | **2012-13** | **2012/13**  **Audit rating** | **2013-14** | **2013/14 Audit rating** | | 1. Category of the ulcer (using the European Pressure Ulcer Advisory Panel Classification System (EPUAP 2009)? | 100% | Excellent | 92% | Good | | 1. Exudate amount and type? | 100% | Excellent | 62% | Requires improvement | | 1. Wound bed appearance/tissue type? | 90% | Good | 69% | Requires improvement | | 1. Condition of the surrounding skin? | 100% | Excellent | 69% | Requires improvement | | 1. Odour? | 90% | Good | 54% | Requires improvement | | 1. Signs of infection? | 80% | Good | 69% | Requires improvement | | 1. Undermining/tracking (i.e. Fistula / sinus) | 25% | Unacceptable | 0% (n=1) | Unacceptable | | 1. Has the pressure ulcer been photographed? | 55% | Requires improvement | 70% | Requires improvement | | * 1. Have any photographs been labelled with patient details, location of ulcer and date? | 64% | Requires improvement | 94% | Good | | * 1. Has consent to any photographs been documented? | 36% | Unacceptable | 56% | Requires improvement | | 1. Has wound area been mapped (i.e. traced on acetate)? | 50% | Requires improvement | 43% | Unacceptable | | 1. Does the patient have a pressure ulcer on their legs or feet? | 10 pts |  | 12 pts |  | | 1. Has a pain assessment been completed regarding the pressure ulcer? | 40% | Unacceptable | 38% | Unacceptable | | 1. Is there a plan related to wound pain? | Question not included |  | 25% | Unacceptable | | **Results against standards** | **2012-13** | **2012/13**  **Audit rating** | **2013-14** | **2013/14 Audit rating** | | 1. Is there a care plan in place for the management of pressure ulcers? | 80% | Good | 100% | Excellent | | 1. Are dressings prescribed in line with the Trust wound management guidelines? | 75% | Requires improvement | 96% | Excellent | | 1. Is there evidence that the risks and benefits of proposed treatment options for the pressure ulcer have been discussed with the patient? | 55% | Requires improvement | 83% | Good | | 1. Is the pressure ulcer healing as expected? | Question not included |  | 78% | Requires improvement | | 1. If the pressure ulcer is not healing as expected, has contact with Tissue Viability Team been made? |  | 20% | Unacceptable | | 1. If the Tissue Viability Team was contacted was advice given by TV documented? | 67% | Requires improvement | 0% (n=1) | Unacceptable | | 1. Was advice given by Tissue Viability actioned? | 50% | Requires improvement | 100% | Excellent | | 1. If any pressure ulcer present (grade 2 or above) has a safeguard incident report been completed? | 45% | Unacceptable | 83% | Good | | * 1. If the incident report has been completed has the incident report index number been recorded in the patient’s notes? | 100% | Excellent | 79% | Requires improvement | | | | |
| **Agreed Actions** | | | |
| A new role in the DN service has recently been introduced to improve standards generally around tissue viability care – the Tissue Viability Resource Nurse role. This involves registered nurses in each cluster having additional leadership and tissue viability training to enable them to take the lead with improving quality standards around all tissue viability related care in their clusters. They will also serve as an escalation point for ground level staff to escalate TV related issues to. So far 18 nurses have been trained, and are working through the relevant TV competencies. They will take a lead in delivering the action plan below and in raising standards generally around pressure damage.   |  |  |  | | --- | --- | --- | | **Action** | **Name of person responsible** | **Date to be completed by** | | Tissue Viability Resource Nurses to agree plan to improve care at May TV ReN group to improve standards around - Use of wound assessment form, Wound mapping & Lower limb assessment | Clinical Leads | End June 2014 | | District Nursing students to attend local clinical reference forums to present pain assessment research work and upload range of pain assessment tools to DN documentation link | Clinical Leads | End August 2014 | | | | |

1.7.

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Name** | Infection Control Audit Summary – 2014/15 quarter 1 results | **Date of report** | July 14 |
| **Rating** | Good | **Audit Cycle** | Re-audit |
| **Key results** | | | |
| The Infection Control audit programme consists of three audits:   1. Environmental audits 2. Hand Hygiene audits 3. ATP equipment swabs results   **Environmental audits**  An average score for each quarter is calculated by using the average of the overall score for each of the wards/departments audited within that quarter.   * Overall average score for Quarter 1 = 88%   A total of 29 environmental audits were undertaken during quarter 1 and 6 areas failed to achieve an overall score of more than 85% and will require re-auditing in quarter 2.  Table below provides a list of the overall scores achieved for the environmental audits undertaken during quarter 1.   |  |  | | --- | --- | | **Trust area** | **Q1 - Overall %** | | **Older People’s Directorate** |  | | Abingdon Ward 1 | 93% | | Abingdon Ward 2 | 99% | | Didcot | 94% | | City Community Hospital | 97% | | Wallingford | 95% | | Wantage | 91% | | Witney – Linfoot | 89% | | Witney EMU | 91% | | Witney MIU | 84% | | **Older Adult Mental Health Wards** |  | | Amber | 93% | | Cherwell | 91% | | Sandford | 90% | | **Adult Services** |  | | Elms Day Hospital | 78% | | Warneford Day Hospital | 75% | | Whiteleaf Day Hospital | 73% | | Warneford ECT | 94% | | Whiteleaf ECT | 93% | | Allen | 82% | | Ashurst | 90% | | Sapphire | 91% | | Vaughan Thomas | 86% | | Wintle | 79% | | Ruby | 84% | | **Forensic Wards** |  | | Lambourne | 94% | | Kennet | 86% | | Kestrel | 85% | | Kingfisher | 86% | | Wenric | 88% |   In terms of infection control risk the inpatient areas and EMU/MIU’s represent the high risk areas for the Trust. In quarter 1 four of the higher risk areas failed to achieve more than 85% on initial audit.   1. Witney MIU 2. Allen 3. Wintle 4. Ruby   For the inpatient wards and EMU/MIUs where they achieved more than 85% overall compliance in the audit further analysis was undertaken to review the high risk areas to identify any issues. Four themes emerged:   1. Staff observed not wearing tottles (mental health wards) 2. Staff observed not bare below elbow (mental health wards) 3. Record of weekly medical device clean was either not in place or not up-to-date 4. The record of mattress and pillow cleaning and integrity checks was either not in place or had not been kept up-to-date   **Hand Hygiene audit**  Bi-monthly hand hygiene audits. These audits are undertaken on the wards by the link nurse identified for leading on infection control audits.   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Community Hospitals/MIU/EMU** | **May 13** | **Jul 13** | **Sep 13** | **Nov 13** | **Jan 14** | **Mar 14** | **May 14** | | Overall average compliance Hand Hygiene | 100% | 100% | 100% | 99% | 98% | 98% | 97% | | Overall average compliance Bare Below Elbows | 100% | 100% | 98% | 100% | 100% | 100% | 99% |  |  |  | | --- | --- | | **Month** | **Participation** | | Jan 14 | 96% - no data from Fiennes | | Mar 14 | 85% - no data from Highfield, Phoenix, Portland & Wintle | | May 14 | 96% - no data from Wintle |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Mental Health Inpatient Wards/Units** | **May 13** | **Jul 13** | **Sep 13** | **Nov 13** | **Jan 14** | **Mar 14** | **May 14** | | % of staff 'bare below elbow' | 93% | 96% | 95% | 93% | 92% | 95% | 92% | | % of staff carrying a tottle | 87% | 92% | 88% | 87% | 89% | 91% | 88% | | % of staff not wearing jewellery | 97% | 99% | 99% | 97% | 97% | 98% | 96% | | % of staff with no nail varnish, extensions or long nails | 97% | 97% | 96% | 95% | 95% | 98% | 96% | | Overall compliance with hand washing technique | 93% | 95% | 95% | 94% | 95% | 94% | 96% |   **ATP Results**  ATP is adenosine triphosphate and this is the energy found in all animal, vegetable, bacteria, yeast and mould cells. ATP rapid hygiene testing is a technology used to detect the presence of organic residues left on surfaces, in addition to microorganisms. These have been left on a surface after inadequate cleaning and or sanitation and provide the nutrients with the micro organisms to grow. Visual inspection is best for detecting dust and environmental swabbing is best at detecting contamination on patient equipment, surfaces and commodes.  ATP clean trace system identifies visually clean items and provides accurate data on standards of cleanliness   |  |  |  |  | | --- | --- | --- | --- | | **Quarter 1 Older People’s Services** | **Red** | **Amber** | **Green** | | Domestic overall average scores | 4.5% | 3.5% | 92% | |  |  |  |  | | Nursing overall average scores | 3.5% | 4.5% | 92% | | | | |
| **Agreed Actions** | | | |
| Areas scoring below 100% compliance in the Environmental audits are provided with a list of actions to be implemented by the Infection Prevention Control Team and action plans are monitored. Individual action plans are too detailed to include in this report and are minor actions such as displaying posters and replenishing stock that can be actioned quickly by the area. | | | |

1.8.

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Name** | Access to healthcare for people with a Learning Disability (Oxon Community Division) | **Date of report** | No formal report |
| **Rating** | Not applicable | **Audit Cycle** | Baseline |
| **Key results** | | | |
| * This is a summary to provide CEC with an update of why Oxon Community Division did not formally report this audit during 2013/14. The data set was too small to draw any conclusions from and the division did not produce a formal report for the reasons outlined below.   This was a baseline audit that was originally undertaken in 2012/13 and its aim was to review the access to health care services provided by the Trust for people with a learning disability. There were difficulties in the design of the audit as there were issues around setting a sample size and actually identifying an audit sample. It was not possible to identify an audit sample from the Trust’s Electronic Health Record system RiO as patients with a learning disability are not routinely recorded using an ICD10 code for a secondary diagnosis.   * In the adult mental health division team managers were asked to manually identify people with a learning disability and this only identified a sample of 14 people. The results from this audit were reported during 2012/13 and it was not rated as this was prior to the introduction of the rating system. * For the community division district nursing teams were asked to manually identify people on their caseloads with a learning disability. There was a lack of response from teams (21% response rate) and only 1 case was identified for inclusion in the audit. From the one case reviewed it implies that assessment of learning disability needs and mental capacity might be an area in which the service could improve.   It is recognised nationally that this is an issue for all Trusts and as a result the Royal College of Physicians carried out a feasibility study during 2013/14.  The feasibility study had an active advisory group, whose role was to oversee the audit and advise on all aspects of the project including methodology, audit standards and validated audit tools. The national feasibility study was completed in April 2014 and the report is due to be published soon. This will give Trusts guidance in the following areas:   * reasonable adjustments * physical and mental health assessments * staff training * improved communication with patients and carers * other issues relating to the health care of people with learning disabilities | | | |
| **Agreed Actions** | | | |
| The audit has been recorded on the Trust wide audit plan for 2014/15. The publication of the report on the feasibility study of conducting a national audit on this topic will be used to agree a robust methodology and standards for the audit to be undertaken during 2014/15. | | | |

1.9.

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Name** | Community Hospitals Assessment Tool (CHAT) | **Date of report** | July 2014 |
| **Rating** | Quarter 4 2013/14 = Good  Quarter 1 2014/15 = Good | **Audit Cycle** | Re-audit |
| **Key results** | | | |
| This is a new audit tool incorporating elements from the previous CHAT and Documentation audits. This audit is completed once per quarter by all Community Hospital inpatient wards.   |  |  |  | | --- | --- | --- | |  | **% Compliance** | **Overall audit rating** | | Quarter 1 2013/14 | 81% | Good | | Quarter 2 2013/14 | 85% | Good | | Quarter 3 2013/14 | 82% | Good | | Quarter 4 2013/14 | 86% | Good | | Quarter 1 2014/15 | 93% | Good |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Overall results by site** | **Quarter 1 2013/14** | **Quarter 2 2013/14** | **Quarter 3 2013/14** | **Quarter 4 2013/14** | **Quarter1 2014/15** | | Abingdon Wd 1 | 67% | 80% | 80% | 87% | 91% | | Abingdon Wd 2 | 67% | 83% | 79% | 85% | 90% | | Bicester | 91% | 95% | 91% | 87% | 93% | | City | 94% | 95% | 73% | 79% | 83% | | Didcot | 89% | 98% | No data | 89% | 98% | | Townlands | No data | 90% | 85% | 94% | 100% | | Wallingford | 80% | 78% | 87% | 90% | 94% | | Wantage | 80% | 82% | 82% | 94% | 83% | | Witney – Linfoot | 79% | 78% | 84% | 81% | 96% | | Witney – Wenrisc | 76% | 73% | 81% | 79% | 97% | | **OVERALL RATING** | **Good** | **Good** | **Good** | **Good** | **Good** |   At the last CEC meeting it was requested that additional analysis was undertaken as there were areas of concern even though the overall rating of the audit was good. The areas identified for improvement were around the review of risk assessments and care plans. The table below demonstrates improvement in these areas. Further action required around the weekly review of care plans.   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Results over time for areas identified by CEC for further analysis** | **Q1 2013/14** | **Q2 2013/14** | **Q3 2013/14** | **Q4 2013/14** | **Q1 2014/15** | **Q1 Audit Rating** | | 28. If there is a falls risk, has a care plan been put in place? | 62% | 69% | 57% | 62% | 81% | Good | | 29. If there is a pressure ulcer risk, has a care plan been put in place? | 61% | 52% | 54% | 65% | 88% | Good | | 30. If there is a MUST risk, has a care plan been put in place? | 64% | 64% | 54% | 69% | 88% | Good | | 32. Have the care plans been reviewed weekly? | 63% | 62% | 50% | 41% | 73% | Requires improvement |     A full breakdown of results over time are provided in the tables below.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Standards of documentation – Patient Information** | **Q1 12/13** | **Q2 12/13** | **Q3 12/13** | **Q4 12/13** | **Q1 14/15** | | 1. Is the patient's name recorded on the front of the admission pack? | 93% | 100% | 93% | 100% | 100% | | 2. Is the patient’s date of birth recorded on the front page? | 93% | 100% | 100% | 100% | 98% | | 3. Is the patient's NHS number recorded on the front page? | 99% | 98% | 98% | 97% | 97% | | 4. Is the patient's address been recorded on the front page? | 97% | 97% | 97% | 99% | 98% | | 5. Is the patient's contact number (home or mobile) recorded on page 1 for contact post-discharge? | 72% | 72% | 71% | 78% | 91% | | 6. Are the address and contact number for the NOK recorded? | 100% | 92% | 91% | 97% | 93% | | 7. Is the patient’s medical history recorded? | 100% | 100% | 100% | 100% | 100% | | 8. Are allergies recorded in the records, on the patient name band (red), and on the drug chart? | 86% | 93% | 93% | 91% | 96% | | 9. Is the patient's GP surgery recorded? | 83% | 89% | 89% | 91% | 93% | | 10. Is the Named Nurse recorded? | 38% | 83% | 83% | 89% |  | | **Standards of documentation – Assessments** |  |  |  |  |  | | 11. Has the Moving & Handling assessment been completed and updated appropriately? | 83% | 91% | 85% | 89% | 94% | | 12. Has the Falls assessment been completed? | 89% | 84% | 85% | 93% | 99% | | 13. Was a Bed Rail assessment completed? | 64% | 75% | 69% | 88% | 85% | | 14. Was the MUST score recorded within 72 hours of admission? | 83% | 78% | 65% | 81% | 90% | | 15. Has appropriate action been taken on the basis of the MUST score? | 95% | 84% | 78% | 80% | 86% | | 16. Was the Walsall score recorded within 6 hours of admission? | 93% | 88% | 83% | 88% | 93% | | 17. If no to 16, has the Walsall been recorded within 24 hours of admission? | 87% | 70% | 76% | 79% | 94% | | 18. Has appropriate action been taken (equipment issued and circled)? | 87% | 93% | 75% | 92% | 84% | | 19. Has the Continence assessment been completed? | 74% | 78% | 75% | 87% | 84% | | 20. Has the Memory screening been completed (This may be in doctor clerking)? | 65% | 64% | 62% | 73% | 86% | | 21. Has the Hospital Anxiety & Depression screening tool been completed for over-65 generic rehab patients? | 32% | 28% | 14% | 48% |  | | 22. Is the 24 hour Care Plan completed, or are equivalent care plans in place within 24 hours? | 83% | 91% | 81% | 92% | 96% |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Standards of documentation – Reassessments – Need to be added to notes (C)** | **Q1 12/13** | **Q2 12/13** | **Q3 12/13** | **Q4 12/13** | **Q1 14/15** | | 23. Has the Walsall been reassessed on a weekly basis? | 63% | 76% | 63% | 66% | 86% | | 24. Has the MUST been reassessed on a weekly basis? | 85% | 93% | 89% | 90% | 95% | | **Standards of documentation – Care Plans** |  |  |  |  |  | | 25. Is there a care plan for personal hygiene? | 90% | 97% | 96% | 94% | 98% | | 26. Is there a care plan for mobility? | 93% | 99% | 95% | 92% | 98% | | 27. Is there a care plan for continence? | 87% | 94% | 84% | 88% | 90% | | 28. Is there a care plan for night care needs? | 91% | 94% | 92% | 92% | 98% | | 29. Have the care plans been created with the patient? | 91% | 93% | 85% | 81% | 91% | | 30. If there is a falls risk, has a care plan been put in place? | 62% | 69% | 57% | 62% | 81% | | 31. If there is a pressure ulcer risk, has a care plan been put in place? | 61% | 52% | 54% | 65% | 88% | | 32. If there is a MUST risk, has a care plan been put in place? | 64% | 64% | 54% | 69% | 88% | | 33. Have the care plans been personalised? | 94% | 99% | 97% | 97% | 98% | | 34. Have the care plans been reviewed weekly? | 63% | 62% | 50% | 41% | 73% | | 35. Are the care plans signed and dated? | 96% | 98% | 93% | 87% | 96% | | **Standards – Patient Experience** |  |  |  |  |  | | 37. Is P & D maintained during personal care? | **Not in Q1 audit tool** | 100% | 100% | 100% | 100% | | 38. Do staff communicate clearly & respectfully with you? | 98% | 100% | 100% | 100% | | 39. Were you asked how you would like to be addressed? | 98% | 100% | 94% | 98% | | 40. Was this preference recorded? | 95% | 98% | 90% | 97% | | 41. Do you know who is looking after you today? | 86% | 88% | 87% | 90% | | 42. Do you know what the plans are for your discharge? | 76% | 79% | 77% | 91% | | **Standards - General Observations** | **Q1** | **Q2** | **Q3** |  |  | | 43. Do all staff look professional? | **Not in Q1 audit tool** | 100% | 100% | 100% |  | | 44. Is there an up-to-date staff photo board? | 50% | 67% | 67% |  | | 45. Is the PSAG board up to date? | 90% | 100% | 89% |  | | 46. Are staff aware of core details of all patients on the ward? | 100% | 100% | 100% |  | | 47. Are call bells answered within 2 minutes? | 80% | 89% | 100% |  | | | | |
| **Agreed Actions** | | | |
| Review of previous action plan due back 29/8/14 | | | |

1.8.

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Name** | CPA audit | **Date of report** | July 2014 |
| **Rating** | Quarter 1 2014/15 = Requires improvement | **Audit Cycle** | Re-audit |
| **Key results** | | | |
| The summary provides information on the quarterly audit on CPA which reviews the quality of care provided to patients who are on CPA. The results are based on data collected from mental health teams and wards across all directorates in Quarter 1. The results for quarter 1 are based on the revised CPA audit tool which was reviewed and approved for use by clinicians across all services.  Table below provides an audit rating by service   |  |  |  | | --- | --- | --- | | **Directorate** | **Audit rating for Q3 2013/14** | **Audit rating for Q1 14/15** | | Adult Mental Health | Good | Requires improvement | | Forensic | Good | Good | | Older people | No data | Requires improvement | | Children & Young People (CYP) | Requires improvement | Requires improvement | | **Overall Trust wide audit rating** | **No overall rating\*** | **Requires improvement** |   \*No overall Trust wide rating for Q3 results as services were using different audit tools and it was not possible to calculate an overall rating.  **Methodology**  The data was collected from the Adult Mental Health Directorate, Children and Young Persons Directorate (CYP) and Older Peoples Directorate. Although Forensic wards are part of the Adult Mental Health Directorate, results are reported separately as per request from Head of Nursing.  A new tool was used for data collection from this Quarter onwards and hence comparison of results with previous quarters is not available. Data was collected by team managers.  **Sample Size**  There are 22451 patients in total currently on CPA at the time of writing this report. This number does not include patients who were discharged at any point in Quarter 1. The sample size for this audit is 370; this is a 95% confidence interval for the population size of 22451. The table below shows the sample size from each directorate. Sample was selected randomly by the team managers.   |  |  | | --- | --- | | **Directorate** | **Total** | | | Adult Mental Health | **98** | | Forensic | **37** | | Older people | **60** | | CYP | **175** | | **Total** | **370** |   **Results**  Compliance against each standard is calculated on the basis of the number of service users for whom the standard is applicable. For cases where there is incomplete data or the response has been recorded as not applicable they have been excluded from the calculations which will explain the differing sample sizes for each standard.  **CPA Metrics**  Results show that compliance is rated as ‘excellent’ for two metrics – care co-ordinator identified (98%) and current risk assessment and management plan (95%). Forensics teams have 100% compliance in all standards.  The other two metrics (care plan less than 12 months old & care plan reviewed in last 6 months) are rated as ‘good’ and the standard which shows compliance to the four metrics is rated as’ requires improvement’. The standard which has the lowest compliance is care plan reviewed in last 6 months (86%) and for that standard AMH has the lowest compliance (80%) across the directorates.   | **CPA Metrics questions** | **Adult MH**  **(n=98)** | **Forensic**  **(n=37)** | **CYP**  **(n=175)** | **Older People (n=60)** | **Trust figure**  **(n=370)** | **Rating** | | --- | --- | --- | --- | --- | --- | --- | | Care co-ordinator identified | 99% | 100% | 98% | 100% | 98% | Excellent | | CPA car plan less than 12 months old | 95% | 100% | 89% | 93% | 92% | Good | | Current risk assessment and management plan less than 12 months old | 97% | 100% | 94% | 93% | 95% | Excellent | | Care plan been reviewed in last 6 months | 80% | 100% | 85% | 93% | 86% | Good | | All four metrics in place | 78% | 100% | 74% | 87% | 79% | Requires improvement |   The audit reviews the four principles which form the basis of the CPA:   * Assessment * Care planning * Care Co–ordination * Review  | **CPA Assessment** | **Adult MH**  **(n=98)** | **Forensic**  **(n=37)** | **CYP**  **(n=175)** | **Older People (n=60)** | **Trust figure**  **(n=370)** | **Rating** | | --- | --- | --- | --- | --- | --- | --- | | Documented evidence of an initial assessment | 67% | 95% | 95% | 93% | 87% | Good | | Does the assessment include the following: | | | | | | | | History including personal and family background (parental responsibility if any) | 94% | 86% | 93% | 89% | 92% | Good | | Psychiatric, social and Psychological functioning | 94% | 91% | 94% | 98% | 94% | Good | | Mental health needs | 99% | 94% | 95% | 95% | 95% | Excellent | | Social care needs | 88% | 81% | 88% | 85% | 86% | Good | | Physical health needs | 79% | 89% | 80% | 83% | 81% | Good | | Housing situation | 95% | 81% | 82% | 81% | 85% | Good | | Parental/child care responsibility | 76% | 58% | 85% | 93% | 81% | Good | | Historical and current risk to self and others | 94% | 100% | 97% | 79% | 94% | Good | | Substance misuse | 72% | 88% | 71% | 50% | 72% | Requires improvement | | Medication | 94% | 85% | 79% | 76% | 83% | Good | | Employment, education and training needs | 75% | 67% | 84% | 100% | 80% | Good | | Equality and diversity issues | 53% | 68% | 61% | 33% | 58% | Requires improvement | | Assessment showing evidence that service users view have been noted | 75% | 80% | 87% | 87% | 83% | Good | | Evidence that role of family/carers have been noted in assessment | 67% | 84% | 95% | 93% | 88% | Good | | Evidence that consent for sharing information is sought from service user | 31% | 58% | 81% | 30% | 60% | Requires improvement | | When consent is given by service user, evidence that family/carer is involved in assessment | 56% | 91% | 98% | 100% | 93% | Good | | Clear summary of assessment/formulation identifying strengths /needs  (updated within last 6 months on Rio core assessment) | 28% | 54% | 85% | 58% | 63% | Requires improvement |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **CPA Care Planning** | **Adult MH**  **(n=98)** | **Forensic**  **(n=37)** | **CYP**  **(n=175)** | **Older People (n=60)** | **Trust figure**  **(n=370)** | **Rating** | | Care plan present | 98% | 100% | 93% | 98% | 96% | Excellent | | Care plan addressing strengths and needs identified in most recent assessment | 88% | 97% | 84% | 88% | 87% | Good | | Relapse indicators identified | 91% | 97% | 64% | 64% | 75% | Requires improvement | | Clear contingency and crisis plan | 86% | 97% | 68% | 71% | 77% | Requires improvement | | CPA review done within last year | 91% | 100% | 87% | 98% | 91% | Good | | Care plan showing a clear description of the problem | 92% | 100% | 91% | 93% | 93% | Good | | Care plan showing a clear description of action to be taken | 92% | 100% | 90% | 92% | 92% | Good | | Care plan clearly stating the person responsible for the action | 90% | 100% | 87% | 86% | 89% | Good | | Care plan showing clear and well defined goals and outcomes | 83% | 97% | 82% | 90% | 85% | Good | | Physical health needs identified | 73% | 72% | 48% | 80% | 64% | Requires improvement | | Physical health needs addressed in care plan, when identified | 99% | 100% | 91% | 85% | 94% | Good | | Service user involved in developing care plan | 85% | 100% | 84% | 74% | 85% | Good | | Family/carer involvement in developing care plan | 54% | 45% | 79% | 67% | 68% | Requires improvement | | Service user offered/given copy of care plan | 36% | 57% | 53% | 33% | 46% | Unacceptable | | Care plan shared with GP | 40% | 23% | 65% | 41% | 52% | Requires improvement | | Evidence that service user has given consent to share care plan with family/carer | 35% | 41% | 63% | 21% | 47% | Unacceptable | | Care plan shared with family/carer, when consent is given | 57% | 60% | 91% | 100% | 81% | Good | | | | |
| **Agreed Actions** | | | |
| Review of actions plans due back from services by 19th September 2014 | | | |