Factor 1b: - Individual assessment of oral hygiene needs

Patients/ clients are **not assessed**.	Patients/ clients are **assessed** when their illness, disability or vulnerability may compromise their oral hygiene **but the assessment is not used** to identify advice and/or care required	All patients/ clients are **assessed** to identify the advice and/or care required to maintain and promote their individual oral hygiene
E	**D** **C** **B**	**A**

Unqualified staff, students / patients / carers can assess if they have received the necessary education and training and have been assessed as competent to undertake the assessment, but accountability remains with the registered practitioner.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe the assessment undertaken and how this incorporates identification of individual needs e.g. religious/ cultural needs, physical ability, age related and identification of those at risk e.g. infection control.
State when the assessment is performed
State where the assessment is recorded and the validated tool in use (if any)
State how the assessed needs are communicated to the multi-professional team i.e. dentist, dental hygienist, infection control, OT, dietitians
State education and training in assessment provided/undertaken by all carers.

THE ESSENCE OF CARE

Patient –focussed benchmarking for health care practitioners

February 2001

Foreword

I am delighted to write a foreword to *The Essence of Care*, a practical toolkit for nurses and others. It focuses on those core and essential aspects of care that quite rightly matter so much to patients and their carers, yet which rarely attract the attention they should during the quality improvement process.

I am confident that *The Essence of Care* will prove to be a valuable resource to help improve quality, not least because it has been developed as a result of the active participation of many hundreds of health professionals, and more importantly, patients, service users and their carers and representatives.

The benchmark standards have been widely tested and endorsed. I commend them to you and hope that they will soon become an integral part of the clinical governance agenda and contribute greatly to quality improvement across the NHS.

Code A

Sarah Mullally
Chief Nursing Officer

CONTENTS

This document should be read in conjunction with :-

- Department of Health. *The management and control of hospital infection: action for the NHS for the management and control of infection in hospitals in England.* London: Department of Health, 2000. (Health Service Circular: HSC 1999/002).
- Department of Health. *The NHS Plan: a plan for investment, a plan for reform.* London: The Stationery Office, 2000. (Cm. 4818-I).
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- Department of Health. *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare.* London: Department of Health, 1999.
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Ellis JM. Paediatric benchmarking: a success story. *VFM Update* 1995; **17**:6-7.

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Harrington H. *The complete benchmarking implementation guide: total benchmarking management.* New York/London: McGraw-Hill, 1996.

Mitchell L. Benchmarking, benchmarks, or best practices? Applying quality improvement principles to decrease surgical turnaround time. *Best Practices and Benchmarking in Healthcare* 1996; **1**: 70-74.

Introduction

The Essence of Care arose from a commitment in *Making a Difference* - the national nursing, midwifery and health visiting strategy - to explore the benefits of benchmarking to help improve the quality of what might be described as the fundamental and essential aspects of care. More recently *The NHS Plan* has reinforced the importance of getting the basics right and of improving the patient experience.

The Essence of Care has been designed to support the measures to improve quality, set out in *A First Class Service*, and will contribute to the introduction of clinical governance at local level.

The benchmarking process outlined in *The Essence of Care* helps practitioners[1] to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.

The approach is fundamentally qualitative and involves the identification of patient focused best practice in what might be described as the softer aspects of care, but which are nevertheless crucial to the quality of care patients' experience. A variety of types of evidence have been used – not only research-derived knowledge – to establish the benchmark standards, including key sources such as national guidance and policies. The benchmark standards have been tested, refined and endorsed during a process of consensus agreement involving over 2,000 patients, professionals, and user group representatives. It is important to emphasise that the evidence cited is presented as a starting point. Comparison groups will need to be alert to, and to take full account of, new evidence as it becomes available.

Facilitators have been trained and are available in every region to help NHS organisations to establish comparison groups and to use *The Essence of Care* pack.

What the pack contains

The Essence of Care contains benchmarking tools related to eight aspects of care. This list is by no means an exhaustive account of every fundamental aspect of care, but it represents those elements identified by patients and professionals as crucial to the quality of a patient's care experience. They are:

- Principles of self-care
- Food and Nutrition
- Personal and oral hygiene
- Continence and bladder and bowel care
- Pressure ulcers
- Record keeping
- Safety of patients with mental health needs in acute mental health and general hospital settings
- Privacy and dignity

[1] Terminology can be problematic. In *The Essence of Care* the term 'professional' refers to any registered health care practitioner regulated by a professional statutory body. The term 'practitioner' refers to any health care employee delivering direct patient care. Unless otherwise stated, the term 'carer' refers to both formal and informal carers, including families, relatives and significant others.

The Essence of Care

For each of these *The Essence of Care* benchmarking tool includes:

1. An overall statement, which expresses what patients/clients/consumers want from care (PATIENT / CLIENT FOCUSED OUTCOME).

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2. Suggested INDICATORS OR INFORMATION that is currently gathered which may indicate action is required to improve poor practice or that good practice exists which should be shared with others.

3. Elements of practice that support the attainment of the patient / client focused outcome (FACTORS).

4. Key Sources: Policy documents, references, the evidence base used in compilation.

5. Patient / Client focused best practice in each of the factors, THE BENCHMARK – which is placed at the extreme right of a series of statements and allotted an A score.

6. A scoring continuum for each factor. These statements guide practitioners in awarding their own practice a score, and provide stepping stones for practitioners to consider taking, in order to achieve best practice.

Diagrammatic presentation of benchmark statements
Factor 1

Worst practice statement	Statements of practice that step towards best practice	Statements of practice that step towards best practice	Best practice statement
E	D	C	B	A

7. Finally, there is space for the identification of evidence that comparison group members agree would justify an A score in their particular area of practice (for like to like comparison).
   (Possible categories / types of evidence that comparison groups may find it useful to consider are displayed under each factor in the document)

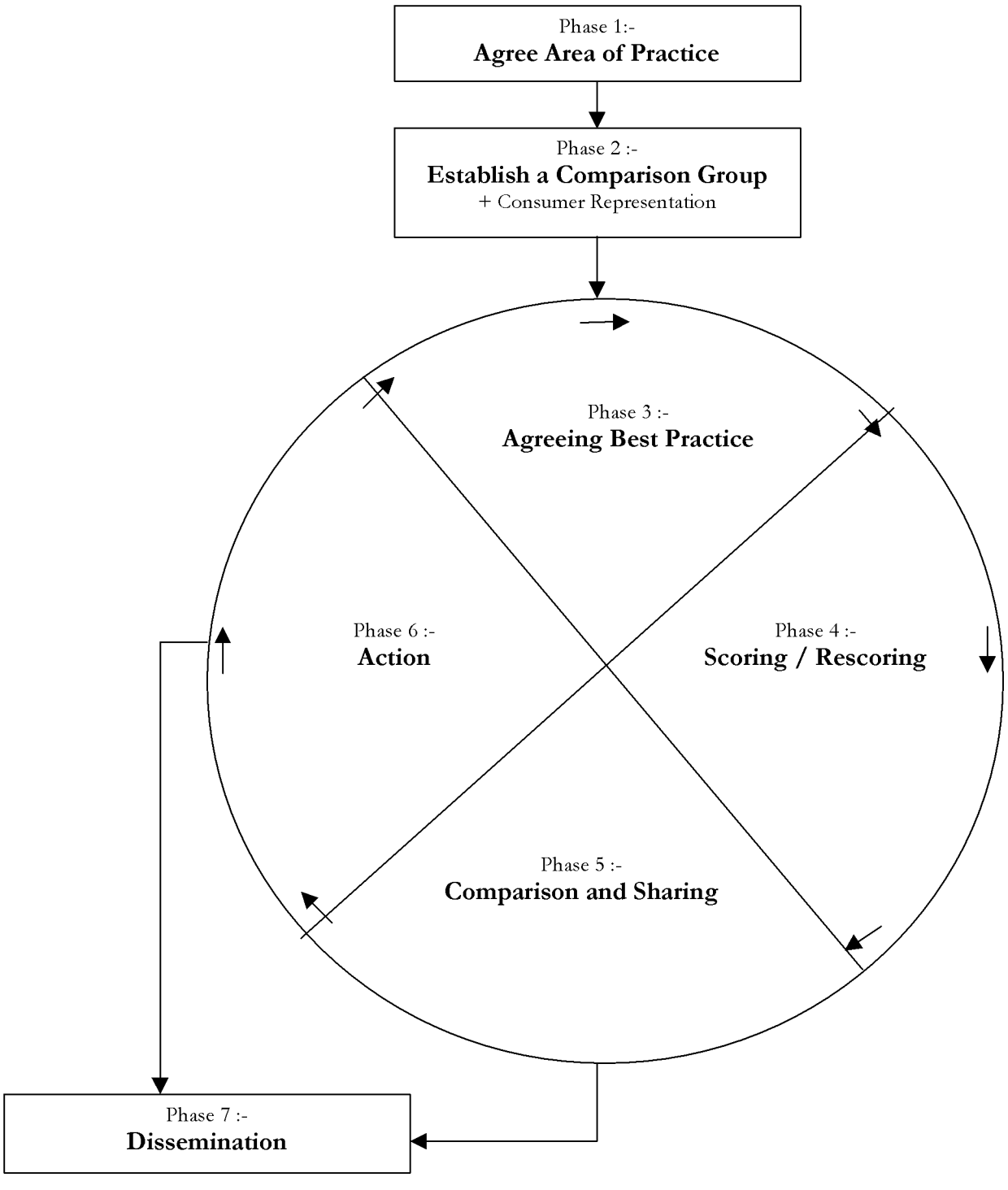
8. Statements around best practice were identified by patients / clients, consumers and professionals and are attached to help stimulate comparison group discussions.

After each benchmark the pack contains examples of documentation to support use of the benchmarking tool :-

- Comparison Group Information
- Scoring sheet
- Comparison Group Collated Scores
- Action Planned to Develop Practice

USING THE TOOL

Phases of Essence of Care Benchmarking



USING THE TOOL

WARD / TEAM – PRACTICE LEVEL COMPARISON GROUP
- To promote consistency in practice structured comparison and sharing commences from individual practitioner level

Phase 1 Agree fundamental aspect of care areas to be considered

Stage 1.1: - Ward / team leader considers if any concerns around a particular area of practice

Stage 1.2: - Analyse indicators / information available - for any specific concerns about the quality of patient / client care provided by the ward/ team e.g. audit results, Patient surveys, complaints, adverse incidents, etc.

Stage 1.3: - Consider good practice that should be shared for wider benefit.

Phase 2 Establish a comparison group

Stage 2.1: - Consider what meetings that already exist could be used for structured benchmarking activity (team meetings, ward meetings, clinical supervision sessions)

Stage 2.2: - Identify membership - to include everybody who could have a possible impact on the patient / client experience: -

- Practitioners from within team (preferably every team / ward member).
- Patient/client representation e.g. patient forums
- Multi-professional colleagues
- Support staff e.g. housekeepers, home helps, cleaners, catering, porters, etc.
- Academic/Researcher input

Stage 2.3: - Arrange the first meeting or re-organise the meeting to be used.

Stage 2.4: -Agree the Vision of the group.

Stage 2.5: -Agree ground rules: - (e.g. membership, where to meet, when to meet and length, honesty, sharing, confidentiality).

Stage 2.6: -Agree comparison group lead member to co-ordinate activity on a particular aspect of care and who will represent comparison group at the higher level comparison group.

Phase 3 Agreeing best practice (for like to like comparison)

Stage 3.1: - Comparison group members are asked to consider, for each factor, what practice would justify a claim of attainment of the patient focused best practice benchmark (an A score).

Stage 3.2: - Discussion within comparison group to reach agreement between practitioners and patient / client representatives about what evidence would justify an A score in this comparison groups area of practice.

Stage 3.3: - The agreed evidence required to justify an A score for this comparison group is noted in the evidence box under each factor.

Phase 4 Scoring

Stage 4.1: - Practitioners asked to score the benchmark guided by the justification evidence statements compiled in Phase 3.

Stage 4.2: - Practitioners state why score was chosen.

Stage 4.3: - Results Collated (anonmysed as agreed in comparison group ground rules)

E.g. for a team of practitioners: -

Score	Practitioner	Justification for Score
A	X	
C	Y	
E	Z	

Phase 5 Comparison and Sharing

Stage 5.1: - Each member considers their own scores (comparison) and identifies factors where development effort will be focused.
Stage 5.2: - Members with higher scores present and share their own practice
Stage 5.3: - Members with lower scores use comments and examples of higher scorers practice to help them compile action plans to change practice.
Stage 5.4: - Team compile a team action plan to support consistently good practice
Stage 5.5: - Date for re-score agreed

Phase 6 Action

Stage 6.1: - Team action plan built in to Team/ Ward Development Plan.
Stage 6.2: -Practice Develops

Return to Phase 3: -

Discussion within comparison group to review if, in light of recently published policies / research / evidence, the evidence agreed at Phase 3 would still justify an A score in this comparison groups area of practice.

Return to Phase 4: -

Re-score after the agreed time period

Return to Phase 5: -

Re-score results compared with original scores to show if practice has developed.

Return to Phase 6

Phase 7 Dissemination

As examples of good practice are identified, all opportunities should be made to disseminate these to a wider audience

USING THE TOOL

SPECIFIC PRACTITIONER INPUT IN BENCHMARKING ACTIVITY

Phase 4 Scoring

Stage 4.1: - Practitioners consider their own practice for each factor and score along the benchmark continuum guided by the justification evidence statements for an A score compiled in Phase 3

Stage 4.2: - Practitioners state why the score was chosen

Stage 4.3: - Results submitted for collation (anonymysed as agreed in comparison group ground rules)

Phase 5 Comparison and Sharing

Stage 5.1: - Each practitioner considers their own scores in comparison with the scores of others and identifies factors where development effort will be focused.

Stage 5.2: - Practitioners with higher scores present and share their own practice

Stage 5.3: - Practitioners with lower scores use comments and examples of higher scorers practice to help them compile their action plan to change practice.

Stage 5.4: - Practitioner compile an action plan

Stage 5.5: - Date for re-score noted

Phase 6 Action

Stage 6.1: - The action plan is integrated into the individuals Professional Development Plan, Personal Professional Portfolio and can be used at Clinical Supervision.

Stage 6.2: - Plan implemented to develop practice.

Return to Phase 4 to Re-score after the agreed time period

Phase 7 Dissemination

As examples of good practice are identified, all opportunities should be made to disseminate these to a wider audience

USING THE TOOL

PATIENT/CLIENT/CONSUMER REPRESENTATION

Patient/client involvement is essential for successful essence of care benchmarking activity but practicalities will vary in each comparison group.

The principles for patient/client representation/ involvement in benchmarking activity include: -

- Identification of areas for benchmarking activity reflects the interests/ concerns of patients/clients (Phase 1).

- Patient/client representation in the agreement of what evidence should be offered to justify attainment of the benchmarks of best practice (an A score) (Phase 3)

- Patient/client representation in the acceptance of evidence offered in justification of an A score. (There is the opportunity to support and challenge evidence that is being offered as patient focused best practice) (Phase 5).

- Patient / client representatives support the compilation of action plans to ensure the focus remains upon a quality patient experience (Phase 6).

- Patient/ client feedback informs the evaluation of benchmarking activity.

- Patient / client involvement in the dissemination of good practice examples (Phase 7)

The principles for selection/preparation/involvement of patient/client representatives in benchmarking activity include: -

- Voluntary input
- Volunteers have realistic expectations of what is achievable through benchmarking
- Travel and carer expenses met
- Training opportunities offered to address specific learning needs

USING THE TOOL

DIRECTORATE/PRIMARY CARE GROUP LEVEL COMPARISON GROUP - to build on practice level benchmarking activity

Phase 1 Agree fundamental aspect of care areas to be considered

Stage 1.1: - Identify concerns around any particular area of practice from analysis of information received.

Stage 1.2: - Identify area of practice where team / ward benchmarking activity has highlighted inconsistent quality of care across the Directorate / PCG or has identified examples of good practice.

Phase 2 Establish a comparison group

Stage 2.1: - Consider what meetings that already exist could be used for structured benchmarking activity (Directorate meetings, Primary Care Group meetings)

Stage 2.2: - Identify membership - to include all with a possible impact on the patient /client experience: -

- Practice Level Comparison Group lead member to represent each team/ward/unit benchmarking comparison group within Directorate/Primary Care Group.
- Patient/client representation e.g. patient forums
- Multi-professional colleagues
- Support staff e.g. housekeepers, home helps, cleaners, catering, porters, etc.
- Academic / Researcher input

Stage 2.3: - Arrange the first meeting or re-organise the meeting to be used

Stage 2.4: -Agree the Vision of the group

Stage 2.5: -Agree ground rules: - (e.g. membership, where to meet, when to meet and length, honesty, sharing, confidentiality)

Stage 2.6: -Agree comparison group lead member to co-ordinate activity on a particular aspect of care and who will represent comparison group at the Trust / higher-level comparison group.

Phase 3 Agreeing best practice for like to like comparison

Stage 3.1: - Comparison Group Lead members representing the practice level benchmarking comparison groups present the evidence base accepted as justifying best practice in their practice level benchmarking comparison group.

Stage 3.2: - Discussion within comparison group leads to agreement between practitioners and patient/client representatives about what evidence would justify an A score in this Directorate/PCG comparison group.

Stage 3.3: - The agreed evidence required to justify an A score for this Directorate/PCG comparison groups members is noted in the evidence box under each factor.

Phase 4 Scoring

Stage 4.1: - All members asked to use the justification evidence statements compiled in Phase 3 to score the benchmark in their team/ward

Stage 4.2: - Results collated to provide the range of scores for the ward/ team and to give the best score for the team / ward justified by evidence offered.

Stage 4.3: - Results Collated (anonymysed as agreed in comparison group ground rules)
e.g. for a Directorate / PCG: -

Best Score	Range	Team/Ward	Justification for Score
A	A-E	M	
C	C-D	N	
E	E	P	

Phase 5 Comparison and Sharing

Stage 5.1: - Each member considers the scores (comparison) and identifies factors where development effort will be focused.
Stage 5.2: - Members with higher scores present and share the practice of their team.
Stage 5.3: - Members with lower scores use comments and examples of higher scorers to help them compile action plans for their teams.
Stage 5.4: - An action plan to support team development is compiled
Stage 5.5: - Date for re-score agreed

Phase 6 Action

Stage 6.1: - Team / ward and Directorate / PCG action plans built in to Development Plans.
Stage 6.2: -Plan implemented to develop practice

Return to Phase 3: -

Discussion within comparison group to review if in light of the recent research practitioners and patient /client representatives agree that the evidence agreed at Phase 3 would still justify an A score in this comparison groups area of practice.

Return to Phase 4: -

Re-score after the agreed time period

Return to Phase 5: -

Re-score results compared with original scores to show if practice has developed.

Return to Phase 6: -

Phase 7 Dissemination

As examples of good practice are identified, all opportunities should be made to disseminate these to a wider audience

USING THE TOOL

TRUST LEVEL COMPARISON GROUP
- to build on Directorate / Primary Care Group and Practice Level benchmarking activity

Phase 1 Agree fundamental aspect of care areas to be considered

Stage 1.1: - Identify concerns around any particular area of practice from analysis of information received and performance assessment.

Stage 1.2: - Identify area of practice where lower level benchmarking activity has highlighted inconsistent quality of care across the Trust or has identified examples of good practice.

Phase 2 Establish a comparison group

Stage 2.1: - Consider what meetings that already exist could be used for structured benchmarking activity (e.g. Clinical Development meetings)

Stage 2.2: - Identify membership - to include all with a possible impact on the patient experience: -

- Practitioner to represent each Directorate or lower level benchmarking comparison group within the Trust.
- Patient / client representation e.g. patient forums
- Multi-professional colleagues
- Support staff e.g. housekeepers, home helps, carers, cleaners, catering, porters, etc.
- Academic / Researcher input

Stage 2.3: - Arrange the first meeting or re-organise the meeting to be used

Stage 2.4: -Agree the Vision of the group

Stage 2.5: -Agree ground rules: - (e.g. membership, where to meet, when to meet and length, honesty, sharing, confidentiality)

Stage 2.6: -Agree comparison group lead member to co-ordinate activity on a particular aspect of care and who will represent comparison group at Regional level.

Phase 3 Agreeing best practice

Stage 3.1: - Members representing the Directorate / lower level benchmarking comparison groups present the evidence base accepted as justifying best practice in the lower level benchmarking comparison groups.

Stage 3.2: - Discussion within comparison group leads to agreement between practitioners and patient / client representatives about what evidence would justify an A score in this Trust comparison group.

Stage 3.3: - The agreed evidence required to justify an A score for this Trust comparison groups members is noted in the evidence box under each factor.

Phase 4 Scoring

Stage 4.1: - All members asked to now use the justification evidence statements compiled in Phase 3 to score the benchmark in their area of practice

Stage 4.2: - All members state why scores were chosen.
Stage 4.3: - Results Collated (anonymysed as agreed in comparison group ground rules)

Best Score	Range	Directorate / Team	Justification for Score
A	A-E	M	
C	C-D	N	
E	E	P	

Phase 5: - Comparison and Sharing

Stage 5.1: - Each member considers the scores (comparison) and identifies factors where development effort will be focused.
Stage 5.2: - Members with higher scores present and share the practice of their Directorate / team.
Stage 5.3: - Members with lower scores use comments and examples of higher scorers to help them compile action plans for their Directorates.
Stage 5.4: - An action plan to support Directorate / team development is compiled for the Trust
Stage 5.5: - Date for re-score agreed

Phase 6 Action

Stage 6.1: - Trust action plans built in to Development Plans.
Stage 6.2: -Plan implemented to develop practice

Return to Phase 3: -

Discussion within comparison group to review if in light of the recent research practitioners and patient/client representatives agree that the evidence agreed at Phase 3 would still justify an A score in this comparison groups area of practice.

Return to Phase 4: -

Re-score after the agreed time period

Return to Phase 5: -

Re-score results compared with original scores to show if practice has developed.

Return to Phase 6

Phase 7 Dissemination

Stage 7.1: - Dissemination of good practice through Web, publications, workshops.
Stage 7.2: - Share with Regional colleague's examples of good practice
Stage 7.3: - Provide Regional Office with examples of good practice

USING THE TOOL

REGIONAL BENCHMARKING ACTIVITY

This will vary in each Region.

The principles however include: -

- Identifying and disseminating examples of good practice identified through benchmarking activity, across the Region and Nationally (e.g. via conferences, networks, web sites, local databases)

- Encouraging the use of benchmarking as a possible tool to improve the quality of patient/client care.

- Informing the Regional and National Research and Development strategy and activity.

Regional Offices may become aware of excellent or poor practice via: -

Clinical Governance Reports	&/or
Trust visits, conferences, invitations etc.	&/or
Performance Management Reports	&/or
Independent Reviews	&/or
Serious untoward incidents	&/or
Caldicott Reports	&/or
Commission for Health Improvement Reports	&/or
Correspondence patients/public	&/or
Press / media reports	&/or

EXAMPLE

COMPARISON GROUP INFORMATION

(For use in Phase 2)

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region) *Ward 4 – Medicine Older People*		
Comparison Group Lead Member:- Jo Abel		
Comparison Group Members:-		
Name	**Representing**	**Contact details**
Jo Abel – Sister	*Nurses Ward 4*	*Ext:- 5432* *E-mail:- JA@nhs.com*
John Brown	*Ward 4 Nursing comparison group leader*	*Ext:-9753* *E-mail:- JM@nhs.com*
Mr. and Mrs. Connor	*Patients & families/carers*	*16 New Way, Edgefield*
Julie Davies	*Housekeeping service*	*C/o ward 4* *E-mail:-JD@nhs.com*
Johnathan Evans	*Portering service*	*Ext.:- 6543* *E-mail:-JE@nhs.com*
Jodie Fellows	*Student nurse – base placement ward 4*	*Ext. :- 5432* *E-mail:-JF@nhs.com*
Jack Gordon	*Pastoral care services*	*Ext :- 7654*
Janice Howell	*Patients Forum*	*Ext :- 8765*
Joshua Ingham	*Complaints Manager*	*Ext. :- 9876*
Jeffrey Jones	*Medical Social Worker*	*Ext.:- 02932.897654* *E-mail:-JJ@ss.com*
Jane King	*Sister, Outpatients*	*Ext:9765*
Jeffrey Law	*District Nursing Service*	*Ext.:- 9865*
Jan Mallow	*Doctors, Medicine*	*Pager 234* *E-mail:-JB@nhs.com*

Facilitator:- *Amy Armitage*
Agreed Vision *To use the benchmarks to identify examples of good practice that can be shared in order to continuously improve the quality of care received by the older people in our care.*
Ground Rules:
• *Fortnightly 3 hour meetings*
• *To be held in Seminar Room:- ward 6*
• *Tea and Coffee and biscuits to be provided*
• *All efforts to be made to attend. Apologies to be sent*
• *Honesty and openness*
• *All members bring with them examples of the best practice they are aware of.*
• *Scores to be submitted on the dates agreed*
• *Comparison group agreement before any wider dissemination or publication*
•
•

Comparison group meetings:-			
Date	Time	Location	Aspects of care to be discussed
6.1.01	*1-4p.m.*	*Ward 6 Seminar Room*	*Privacy and Dignity* *Nutrition*
20.1.01	*1-4p.m.*	*Ward 6 Seminar Room*	*Continence* *Principles of Self-care*
6.2.01	*1-4p.m.*	*Ward 6 Seminar Room*	*Pressure Ulcer* *Record Keeping*

EXAMPLE

(Compiled by comparison group for each factor to guide members in justifying an A score)

(For use in Phase 3)

Factor 1: - Attitudes and behaviours

Patients / clients experience **deliberate** negative and offensive attitude and behaviour	Patients / clients experience **thoughtless** behaviour and careless insensitive attitude	Patients / clients **experience a sensitive, empathetic attitude on an ad hoc basis** (at certain incidents/event)	Patients /client's feel that they **matter** all of the time.
E	**D**	**C**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: (To be completed by comparison group members for like to like comparison)
Vision states acceptance of individuality of patient
Admission procedure and assessment documentation includes the opportunity for each patient to express what concerns and upsets them and what they would find comforting.
Staff induction pack includes interpersonal training by patient group to explore with staff the special needs of the client group and role play with patient representatives to consider effective non- verbal behaviour that demonstrates respect for patients
Weekly 'tea party' held for staff, patients and carers to socialise and to express concerns.
All staff are empowered by the ward sister to correct behaviour as it occurs – then report in confidence to the Sister for monitoring
Complaints collated and fed back to nursing staff at ward team meetings.

Statements to stimulate comparison group discussion around best practice:-
State how effective leadership is assured
Describe how good attitudes and behaviour are promoted and assured (including consideration of non verbal behaviour and body language)
State how these issues (including attitudes and behaviour towards minority groups, e.g. black and minority ethnic communities) are addressed with individual staff e.g. induction programmes, preceptorship, Individual Performance Review / Appraisal
State the philosophy/ strategies that support practice (e.g. mission statements)
State how patient/client views are sought and used e.g. focus groups, surveys, partnership strategies, feedback groups, advocacy arrangements
State what policies are in place to address specific ethnic/cultural/religious/spiritual/ linguistic, age related and particular needs
State the process for monitoring, feedback and actioning of complaints
State how partnerships with others will support the promotion of good attitudes and behaviours.

EXAMPLE

SCORING SHEET

(For use in Phase 4)

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust) *Ward 4*		
Comparison Group Lead Member:- *Jo Abel*	**Date to be scored:-** *16/01/01* **By:-** *John Brown* _____ (insert name)	**Date form to be returned:-** *18/01/01*

Scored by:-	**Date Scored:-**	**Copied:- Y/N**	**Posted on :-**
John Brown	*16/01 /01*	*Y*	*16/ 01 / 01*

Date Comparison group meeting to share good practice and compile action plan: - *20 / 01 / 01* **To be attended by :-** *John Brown* (insert name)	**Re-score date agreed :-** *20 / 07 / 01*

SCORE : *D*	**1:- Attitudes and behaviours** Why score chosen / How Justified?	
Vision does express concern but only available in manager's office.		*Documentation if completed only referred to by nurses*
Section in assessment documentation asks what concerns patient has but rarely filled in		
No consistency in patients experiences – depends who is on duty		
SCORE : *D*	**2 :- Personal world / Personal identity** Why score chosen / How Justified?	
Little knowledge of specific privacy needs and concerns of Pakistani, Muslim community who make up 40% client group		*There are no provisions at ward level for religious observances of main client groups*
Only question asked on admission relatives to 'religion', no clarification of individual values and beliefs		*No note made of important relationships/ others – only a 'family tree' in medical notes*

EXAMPLE

COMPARISON GROUP COLLATED SCORES

(For use in Phase 5)

PRIVACY AND DIGNITY

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust) *Ward 4*		**Date scored:-** *- -/01/01*	**Date of Comparison Group meeting:-** *20/ 01 / 01*
1:-A= Patients /clients feel that they matter all of the time			
Score Order A-E	**Member** (name/code)	*WHY SCORE CHOSEN / HOW JUSTIFIED?*	
A	*Jeffrey Law*	*All patients have their own individual records that state their concerns and the approach to care they want to receive.* *Patients and carers are involved in all care decisions*	
A			
B			
B	*Julie Davies*	*Housekeeper induction includes sessions and role play on listening and non- verbal communication* *All are treated with respect*	
C			
D	*John Brown*	*Vision does express concern but only available in manager's office.* *Section in assessment documentation asks what concerns patient has but rarely filled in* *No consistency in patients experiences – depends who is on duty* *Documentation if completed only referred to by nurses*	
D			
E			
E			
E			
E			
E		*Consistently raised in patient complaints as an issue. Not yet actioned*	

EXAMPLE

ACTION PLANNED TO DEVELOP PRACTICE

(For use in Phase 6)

PRIVACY AND DIGNITY

COMPILED BY: - John Brown Date: - *20 / 01 / 01*

FOR: - (Self / Team / Trust / Regi Ward 4 Team

AIM:- PATIENT FOCUSED BEST PRACTICE = *Better understanding of the specific values and beliefs of older people within the community which will allow us to deliver care that makes patients feel that they matter.*	Related factors *1,2*

ACTION REQUIRED	**BY WHOM**	**DATE TO COMPLETE**	REFLECTION
Get a copy of Help the Aged report	*Vera*	*01/02/01*	
Ask Help the Aged to speak at a ward training day	*Walter*	*ASAP*	*Arranged – 06/02/01*
Review with patients/carers questions asked by all professionals on admission	*Jo & self*	*30/02/01*	
Review how individual requirements documented so accessed by all professionals	*Jo and team*	*30/02/01*	

PRINCIPLES OF SELF-CARE

Self-care = ***the choices people make and the actions people take on their own behalf in the interest of maintaining their health and wellbeing.***
Care can be delivered by individuals, family, friends, carers, affinity groups and the wider community by themselves, for themselves. 90% of all health care episodes includes self-care.
Self-care can be categorized in various ways. One possible categorization is:

- self-management of health (lifestyle);
- self-management of health status information (monitoring and diagnosis);
- self-management of care choices (decisions);
- self-management of illness (treatment, care and rehabilitation)

Agreed Patient/client Focused Outcome		
Patients / clients have control over their own health care		
Indicators / Information that highlights concerns which may trigger the need for benchmarking activity:		
Patient Satisfaction Surveys Complaints figures and analysis Length of Stay figures Patient Support group feedback Risk Assessment Documentation Audit Specialist user group surveys Teenage pregnancy rates		Re-admission rates Educational audits/ student placement feedback Litigation / Clinical Negligence Scheme for Trusts Professional Concern Media Reports Commission for Health Improvement Reports
	FACTOR	BENCHMARK OF BEST PRACTICE
1.	Choice about self-care	Patients/ clients are **enabled** to make choices about their self-care and those choices are respected
2.	Assessment of self-care ability	Patients/clients self-care abilities are **continuously assessed and inform** care management
3.	Assessing possible risks for patient/client , carers when undertaking self-care	A comprehensive **ongoing** risk assessment is undertaken and all involved in management of self-care including patients/clients and carers are **aware of inherent risks and how these may most appropriately be addressed**
4.	Knowledge and skills to manage self-care	Patients /clients /carers and advocates have the **knowledge and skills to manage all** aspects of self-care
5.	Responsibilities for self-care	Patients / clients and practitioners are working in **partnership to establish their responsibilities** in meeting self-care needs
6.	Access to services to support self-care	Patients / clients/ carers and their advocates **understand and can access** the services that organisations can provide
7.	Environmental factors to support self-care	The **environment promotes** patients / clients ability to self-care
8.	Access to resources to enable self-care	Patients / clients **can access resources** that enable them to meet their individual self-care needs
9.	User involvement in service delivery that promotes self-care	Users **participate** in planning and evaluating services

Key Sources

- Access to Care Steering Group. *Opportunities for improving access to care*. Milton Keynes: Department of Health. NHS Executive. Eastern Region, 1999.
- Banks I. *The NHS Direct healthcare guide*. London: NHS Direct, 2000
- Chapple A, Rogers A.. 'Self-care' and it's relevance to developing a demand management strategies: a review of qualitative research *Health and Social Care in the Community* 1999;**17**:445-454
- Department of Health. *The new NHS information pack*. London: Department of Health, 1999.
- Orem D. *Nursing: concepts of practice*. 4th edition. St. Louis: Mosby-Year Book, 1991.

(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

The Essence of Care

Factor 1: - Choice about Self-Care

Patients /clients are told how care is to be delivered.	Patients clients are provided with **restricted options** re self-care possibilities to choose from	Patients /clients are **provided with** the full range of options re self-care possibilities to choose from.	Patients /clients are provided with the full range of options re self-care possibilities to choose from and are **supported in decision making** by their chosen others	Patients/ clients are **enabled** to make choices about their self-care and those choices are respected
E	**D**	**C**	**B**	**A**

NB Link to risk assessment

Choices are fully informed and include consideration of all agencies

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patients/clients are made aware of all the available self and provided care options
State when and where options are discussed
State how patient/client wishes are taken into account including religious/cultural needs.
State policies and procedures in place to enable patients to self-care e.g. self medication programmes and audit and monitoring that occurs
State training received by staff to ensure all possible self-care options are presented to patients/clients
State how the format of the information meets individual needs e.g. religious/cultural /linguistic and age related needs
State what information is available to inform patient care.
State how consistency in the information provided by staff is ensured.
State monitoring that is undertaken to ensure care does reflect patients choice

Factor 2: - Assessment of self-care ability

Patient/clients **assessment does not identify** self-care abilities	Patients/clients are only assessed as to their self-care ability on **initial contact**	Patients/clients self-care abilities are **continuously assessed and inform** care management.
E	**D** **C** **B**	**A**

Assessment is at every stage undertaken in partnership with patient/client and carers and takes in to account individual needs e.g. ethnic/cultural needs, age related and special needs.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State guidelines/ procedures policies that support assessment
State how assessment is undertaken including format for obtaining and recording information re self-care abilities on an ongoing basis
State how assessment informs and is reflected in care activity
State how care plans are arrived at and used.
State how self-care assessment links to individualised care pathways/plans
State how training is focused to assess self-care ability

Factor 3: - Assessing possible risks for patient/client, carers when undertaking self-care.

When considering self-care there is **no assessment** of possible risk to the patient/client /carer	A **risk assessment is undertaken** but it does **not involve** patients/ clients / carers	A **comprehensive risk assessment** is undertaken and all involved in management of self-care including patients/clients and carers are aware of inherent risks and how these can be addressed	A comprehensive **ongoing** risk assessment is undertaken and all involved in management of self-care including patients/clients and carers are **aware of inherent risks and how these may most appropriately be addressed**
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patients acceptance of risk is documented
State what training and education has been provided to practitioners, carers and patients in relation to risk assessment and acceptability of risk for individualisation e.g. sensitive to culture/religion, age related, special needs care.
State the risk assessment tool in use e.g. Core list of issues and training received by assessors.
State how the risk assessment tool is and updated according to change in law/practice.
State how critical incidents /complaints are recorded, monitored, analysed and acted upon.
State the frequency of risk assessment
State how risks are addressed
State how the risk assessment is linked to the care plan

Factor 4: - Knowledge and Skills to manage self-care

Patients/ clients/carers and advocates **do not have knowledge / awareness and skills** to manage self-care	Patients/ clients, carers and advocates **have the practical skills** to manage self-care but **not the knowledge** to support these	Patients/clients , carers and advocates have the **knowledge and skills** to manage **some** aspects of self-care	Patients /clients /carers and advocates have the **knowledge and skills to manage all** aspects of self-care.
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the education programmes and packages (for patients/formal and informal carers) to ensure patients/clients and carers have the knowledge and skills to manage all aspects of self-care
State how this education pack is used
State the information given to patients/clients and carers to access assistance in the case of emergency or ability to self-care is compromised e.g. contact details
State how patients/carers knowledge and skills are assessed
State how patients/clients ethnicity/religious/cultural/linguistic, age related and special needs are taken in to account.
Discuss online information available

Factor 5: - Responsibilities for self-care

Patients / clients self-care is **not considered**	Patients/ clients and practitioners each **make assumptions** about what aspects of care they each have responsibility for.	Patients / clients and practitioners are **working in partnership** to establish their responsibilities in meeting self-care needs
E **D** **C** **B**		**A**

Link to Risk assessment factor

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe the multi-agency working that occurs
State the documentation that ensures comprehensive assessment and that promotes partnership with patients/clients e.g. shared contracts of care, holding own records and plans, meeting religious/cultural/linguistic sensitivity, age related and special needs.
State how patients/clients direct input is assured
Describe the monitoring of partnership arrangements

Factor 6: - Access to services to support self-care

Patients /Clients carers and their advocates **do not know** the services that organisations can provide or that would meet their needs	Patients/ Clients / carers and their advocates know the services that can be provided but there are **barriers** to access	Patients / clients/ carer and their advocates **understand and can access** the services that organisations can provide
E	**D** **C** **B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how the list of services available within the area are identified and what it includes e.g. health, social services, voluntary services and organisations, tradesmen, complementary therapies, sensitive to religion/culture/language and age related and special needs services
State how audits of patients/clients, carers and advocates awareness of service availability, access and uptake are undertaken
State how the list of services available within the area are made available
State information and formats available e.g. jargon free, different languages, Braille / large print, Web, etc.
State how services are accessed e.g. CHC's, Citizen's Advice Bureau, NHS Direct, NHS online etc.
State how practical barriers to self-care are overcome.

Factor 7: - Environmental factors to support self-care

The environment **fails** to support self-care	**Some aspects** of the environment fail to support self-care	The environment **supports** the patients/clients ability to self-care	The environment **promotes** patients / clients ability to self-care
E	**D**	**C**	**B**	**A**

Environment: - takes into account individual physical, sensory, mental, ethnic/cultural, social (leisure & finance) and spiritual needs.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the situations where the environment fails to support self-care
State measures taken to promote an environment that supports self-care.
State how self-care in relation to cultural and religious needs are met
State how you involve users of the services to ensure the environment promotes self-care

Factor 8: - Access to resources to enable self-care

Patients /Clients **can not access resources** to meet their individual self-care needs		Resources that enable patients / clients to meet their individual needs exist but there are **barriers** to access		Patients / clients **can access resources** that enable them to meet their individual self-care needs
E	**D**	**C**	**B**	**A**

Resources include equipment, drugs, qualified and or trained and experience staff. (NHS, statutory and voluntary services)

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State what resources are available and how they are made available
State how decisions re the allocation of resources are made when there are insufficient to meet the needs of all clients.
State what and why barriers exist to access to resources.
State arrangements for immediate access to resources that can facilitate early discharge.

Factor 9: - User Involvement in service delivery that promotes self-care

No user involvement	**User feedback** on the **service they have used** is sought	**User views on planning and evaluating** services are sometimes used	Users **participate** in planning and evaluating services
E	**D**	**C**	**B**	**A**

Users should be involved in all aspects of care planning and delivery
User is patient/client, relative, family, and carer

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how users are involved, how views are sought.
State methods used to secure user involvement e.g. focus groups, user forums, patients council, etc to include consideration of ethnic/cultural/religious /linguistic and age related and special needs issues
State inter-agency involvement, networking with all stakeholders.
State how patients/clients satisfaction in assessed and any complaints are addressed

COMPARISON GROUP INFORMATION

For: -
PRINCIPLES OF SELF-CARE

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

Facilitator:-
Agreed Vision
Ground Rules:
•
•
•
•
•
•
•
•
•
•

Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

SCORING SHEET

PRINCIPLES OF SELF-CARE

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____(insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Choice about self-care** Why score chosen / How Justified?

SCORE :	**2 :- Assessment of self-care ability** Why score chosen / How Justified?

SCORE :	**3:- Assessing possible risks for patient/client , carers when undertaking self-care** Why score chosen / How Justified?

SCORE :	**4 :- Knowledge and skills to manage self-care** Why score chosen / How Justified?

SCORE :	**5 :- Responsibilities for self-care** Why score chosen / How Justified?
SCORE :	**6 :- Access to services to support self-care** Why score chosen / How Justified?
SCORE :	**7 :- Environmental factors to support self-care** Why score chosen / How Justified?
SCORE :	**8 :- Access to resources to enable self-care** Why score chosen / How Justified?
SCORE :	**9:- User involvement in service delivery that promotes self** Why score chosen / How Justified?

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COMPARISON GROUP COLLATED SCORES

PRINCIPLES OF SELF-CARE

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= Patients/ clients are enabled to make choices about their self-care and those choices are respected

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Patients/clients self-care abilities are continuously assessed and inform care management

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= A comprehensive ongoing risk assessment is undertaken and all involved in management of self-care including patients/clients and carers are aware of inherent risks and how these may most appropriately be addressed

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

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4:-A= Patients /clients /carers and advocates have the knowledge and skills to manage all aspects of self-care		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= Patients/clients and practitioners working in partnership to establish their responsibilities in meeting self-care needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= Patients/clients/carers and their advocates understand and can access the services that organisations can provide		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

7:- A= The environment promotes patients / clients ability to self-care		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
8:- A= Patients / clients can access resources that enable them to meet their individual self-care needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
9:- A= Users participate in planning and evaluating services		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

PRINCIPLES OF SELF-CARE

COMPILED BY: - _____ __ / __ / __

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

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AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

PERSONAL AND ORAL HYGIENE

Personal Hygiene = Physical act of cleansing the body to ensure that the skin, hair and nails are maintained in an optimum condition.
Oral hygiene =Effective removal of plaque and debris to ensure the structures and tissues of the mouth are kept in a healthy condition
Healthy mouth = Clean, functional, and comfortable oral cavity, free from infection.

Agreed Patient/client Focused Outcome

Overall outcome:-

Patients/clients personal and oral hygiene needs are met according to their individual and clinical needs.

Personal Hygiene:-
Patients' / clients are clean, comfortable and their appearance maintained according to their personal preference and religious/cultural needs
Oral Hygiene:-
Patients/clients mouths are clean and optimum comfort and function are maintained.

Indicators / Information that highlights concerns which may trigger the need for benchmarking activity:

Patient Satisfaction Surveys	Equipment Usage (including laundry)
Consumer reports	Professional Concerns
Complaints figures and analysis	Educational audits/ student placement feedback
Critical Incident analysis	Litigation / Clinical Negligence Scheme for Trusts
Infection control audits	Media Reports
Documentation audits	Commission for Health Improvement Reports
Environmental audits e.g. curtains, single sex facilities	

	FACTOR	BENCHMARK OF BEST PRACTICE
1a.	Individual Assessment of personal hygiene needs	All patients/ clients are **assessed** to identify the advice and/or care required to maintain and promote their individual personal hygiene
1b.	Individual assessment of oral hygiene needs	All patients/ clients are **assessed** to identify the advice and/or care required to maintain and promote their individual oral hygiene
2a.	Care for personal hygiene negotiated and planned based on assessment	Planned care is **negotiated** with patients / clients and / or their carers and is based on assessment of their individual needs
2b.	Care for oral hygiene negotiated and planned based on assessment	Planned care is **negotiated** with patients / clients and / or their carers and is based on assessment of their individual needs
3.	Environment within which oral and personal hygiene needs are met	Patients/ clients have access to an environment that **is safe and acceptable** to the individual
4.	Provision of Toiletries for own personal use	Patients/ clients are expected to supply their own toiletries **but** single use toiletries are provided until they can supply their own
5a.	Providing assistance with personal hygiene when required	Patients / clients have access to the level of assistance that they require to meet their **individual** personal hygiene needs
5b.	Providing assistance with oral hygiene when required	Patients / clients have access to the level of assistance that they require to meet their **individual** oral hygiene needs

6a.	Information and education to support patients in meeting personal hygiene needs: particularly if these are changing or are having to be met in unfamiliar surroundings.	Patients/clients and/ or carers are provided with information/ education **to meet their individual personal hygiene needs**
6b.	Information and education to support patients in meeting oral hygiene needs**:** particularly if these are changing or are having to be met in unfamiliar surroundings.	Patients/clients and/ or carers are provided with information/ education **to meet their individual oral hygiene needs**
7a.	Evaluation/ Reassessment of personal hygiene and how effectively these are being met.	Patients/ clients care is **continuously** evaluated, reassessed and the care plan **renegotiated**
7b.	Evaluation/ Reassessment of oral hygiene needs and how effectively these are being met.	Patients/ clients care is **continuously** evaluated, reassessed and the care plan **renegotiated**

Key Sources

- British Society for Disability and Oral Health. *Guidelines for oral health care for long-stay patients and residents.* Revised edition. London: British Society for Disability and Oral Health, 2000.
- British Society for Disability and Oral Health. *Guidelines for the development of local standards of oral health care for dependent, dysphagic, critically and terminally ill patients.* Revised edition. London: British Society for Disability and Oral Health, 2000.
- British Society for Disability and Oral Health. *The development of standards for domiciliary dental care services: guidelines and recommendations.* Revised edition. London: British Society for Disability and Oral Health, 2000.
- British Society for Disability and Oral Health. *Oral health care for people with mental health problems: guidelines and recommendations.* Revised edition. London: British Society for Disability and Oral Health, 2000.
- British Society for Disability and Oral Health. G*uidelines for oral health care for people with a physical disability.* Revised edition. London: British Society for Disability and Oral Health, 2000.
- Mallett J, Dougherty L. eds. *The Royal Marsden NHS Trust manual of clinical nursing procedures. Fifth edition.* Oxford: Blackwell Science, 2000.

(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

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Factor 1a: - Individual Assessment of personal hygiene needs

Patients /clients are **not assessed**	Patients /clients are **assessed** when their illness, disability or vulnerability may compromise their personal hygiene.	All patients/ clients are **assessed** to identify the advice and/or care required to maintain and promote their individual personal hygiene

E **D** **C** **B** **A**

Unqualified staff, students / patients / carers can assess if they have received the necessary education and training and have been assessed as competent to undertake the assessment, but accountability remains with the registered practitioner.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe the assessment undertaken and how this incorporates identification of individual needs e.g. religious/cultural needs, physical ability, age related and identification of those at risk e.g. infection control.
State when the assessment is performed
State where the assessment is recorded and the validated tool in use (if any)
State how the assessed needs are communicated to the multi-professional team i.e. podiatrists, infection control, OT,
State education and training in assessment provided/undertaken by all carers.

Factor 2a: - Care for personal hygiene negotiated and planned based on assessment

Patients/ clients have **no care planned**.	Planned Care is not **based on assessment** of patients/clients individual needs.	Planned Care is **based on assessment** of patients/clients individual needs.	Planned care is **negotiated** with patients / clients and/or their carers and is based on assessment of their individual needs
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the evidence base for care and how this is reviewed and kept up to date.
State how care is negotiated with patients/clients and family carers e.g. shared care, care to meet religious / cultural and age related needs
Describe the training and education staff receive to enable patients / clients to consider care options available. (including understanding the needs of minority groups e.g. black and minority ethnic communities)

Factor 2b: - Care for oral hygiene negotiated and planned based on assessment.

Patients/ clients have **no care planned**	Planned Care is **not based on assessment** of patients/clients individual needs.	Planned Care is **based on assessment** of patients/clients individual needs.	Planned care is **negotiated** with patients / clients and/or their carers based on assessment of their individual needs
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the evidence base for care and how this is reviewed and kept up to date.
State how care is negotiated with patients/clients and family carers e.g. shared care, care to meet ethnic/ cultural and age related needs
Describe the training and education staff receive to enable patients / clients to consider care options available.

Factor 3: - Environment within which oral and personal hygiene needs are met.

Patients/ clients **do not have access** to a safe and acceptable environment	Patients/ clients have access to an environment that is **safe but is not acceptable** to the individual	Patients/ clients have access to an environment that is **safe and acceptable** to the individual
E	**D C B**	**A**

Access must include assistance to enter and use an area and information on location of facilities in an understandable format
Acceptable includes consideration of others, maintenance of privacy, dignity and the meeting of cultural/ religious and age related and special needs. (See Privacy and Dignity Benchmark).
Safe is a physical and psychological environment that addresses infection control issues e.g. Hand washing, protective clothing, individual bowl for patient/client use, moving and handling equipment and adaptations to meet individual patient requirements.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe adaptations that have been made to the environment (see 'acceptable' above)
State risk factors taken in to account when ensuring a safe environment (i.e. water temperature, wet floor)
State how access is facilitated
State how privacy and dignity are assured and ongoing training of staff
State how religious/cultural/ethnic and special needs are met and ongoing training of staff.
State infection control arrangements that ensure health care worker and patient/ client safety

Factor 4: - Provision of Toiletries for own personal use.

Patients/ clients **do not have toiletries** for their own personal use	Patients/ clients have toiletries for their **own personal use only if they provide them**	Patients/ clients are expected to supply their own toiletries **but** single use toiletries are provided until they can supply their own
E	**D**	**C**	**B**	**A**

Toiletries must be for single patient/client use only.
This includes toiletries for personal and oral hygiene (toothpaste, toothbrush)

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State what toiletries are temporarily provided by the health service
State how toiletries are made available to patients/clients if they do not have their own
State how patients/clients are encouraged to provide their own toiletries
State how personal use is assured
State how clients are made aware of what toiletries are required

Factor 5a: - Providing assistance with personal hygiene when required

Patients/ clients are **not offered assistance** to meet their personal hygiene needs	Patients/ clients have access to assistance to meet their personal hygiene needs **but** it is **not individualised**	Patients / clients have access to the level of assistance that they require to meet their **individual** personal hygiene needs
E **D** **C** **B**		**A**

Individual needs includes assisting patients / clients to carry out their personal hygiene requirements as and when they wish e.g. washing hands before and after meals, after using a bedpan/ commode/ toilet, after reading newspapers etc.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how individual requirements are met
State whom assists, why and how
State how registered practitioners verify the ongoing competence of the unregistered carer when providing assistance.
State the level of supervision of unregistered carers
State how the level of assistance is communicated to carers (plan of care)
State the training/development staff receive

Factor 5b: - Providing assistance with oral hygiene when required

Patients/ clients are **not offered assistance** to meet their oral hygiene needs	Patients/ clients have access to assistance to meet their oral hygiene needs **but** it is **not individualised**	Patients / clients have access to the level of assistance that they require to meet their **individual** oral hygiene needs
E	**D** **C** **B**	**A**

Individual needs includes assisting patients / clients to carry out their oral hygiene requirements as and when they wish e.g. after meals.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how individual requirements are met
State whom assists
State how registered practitioners assure the competence of the unregistered carer when providing assistance.
State the level of supervision of unregistered carers
State how the level of assistance is communicated to carers
State the training/development staff receive

Factor 6a: - Information and education to support patients in meeting personal hygiene needs: particularly if these are changing or are having to be met in unfamiliar surroundings.

Patients/ clients are provided with **no information** or education	Patients/ clients **have access** to general information but no education	Patients / clients are **given general** information and education		Patients/clients and/ or carers are provided with information/ education **to meet their individual personal hygiene needs**
E	**D**	**C**	**B**	**A**

Education includes checking and reinforcing understanding.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State range of information, evidence base and format used to make it accessible and understandable and culturally appropriate.
State information to make patient/client/carer aware of problems that may occur due to the introduction of a specific treatment e.g. chemotherapy, surgery etc.
State how patients' understanding is checked.
State how partnerships with others supports the promotion of personal hygiene

Factor 6b: - Information and education to support patients in meeting oral hygiene needs: particularly if these are changing or are having to be met in unfamiliar surroundings.

Patients/ clients are provided with **no information** or education	Patients/ clients **have access** to general information but no education	Patients/ clients are **given general** information and education	Patients/clients and/ or carers are provided with information/ education **to meet their individual oral hygiene needs**
E	**D**	**C**	**B**	**A**

Education includes checking and reinforcing understanding.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State range of information, evidence base and format used to make it accessible and understandable and culturally appropriate.
State information to make patient/client/carer aware of problems that may occur due to the introduction of a specific treatment e.g. chemotherapy, surgery etc.
State how patients' understanding is checked.
State how partnerships with others supports the promotion of personal hygiene

Factor 7a: - Evaluation / Reassessment of personal hygiene needs and how effectively these are being met

Patients/ clients care is **not evaluated or reassessed.**	Patients/ clients care is **evaluated** but the patient/client is not reassessed	Patients/ clients care is evaluated and the patient/ client **reassessed**.	Patients/ clients care is **continuously** evaluated, the patient /client reassessed but the care plan is **not renegotiated**.	Patients/ clients care is **continuously** evaluated, reassessed and the care plan **renegotiated.**
E	**D**	**C**	**B**	**A**

Negotiation: - may need to be with carers/ family. If no negotiation with the patient /client or carers is possible negotiation implies that care is delivered according to multidisciplinary evidence based guidelines.
Evaluation of the effectiveness of treatment and care given
Reassessment = the patients/clients condition/ state.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how skills and competencies are maintained and monitored
State documentation / tools used
State communication channels used for promoting feedback of patients/ clients and all carers
State triggers for assessment and reassessment

Factor 7b: - Evaluation / Reassessment of oral hygiene needs and how effectively these are being met

Patients/ clients care is **not evaluated or reassessed.**	Patients/ clients care is **evaluated** but the patient/client is not reassessed	Patients/ clients care is evaluated and the patient/ client **reassessed**.	Patients/ clients care is **continuously** evaluated, the patient /client reassessed but the care plan is **not renegotiated**.	Patients/ clients care is continuously evaluated, reassessed and the care plan **renegotiated.**
E	**D**	**C**	**B**	**A**

Negotiation: - may need to be with carers/ family. If no negotiation with patient/ client or carers is possible negotiation implies that care is delivered according to multidisciplinary evidence based guidelines.
Evaluation of the effectiveness of treatment and care given
Reassessment = the patients/clients condition/ state.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how skills and competencies are maintained and monitored.
State documentation / tools used
State communication channels used for promoting feedback for patients/ clients and all carers
State triggers for assessment and reassessment

COMPARISON GROUP INFORMATION

For: -
PERSONAL AND ORAL HYGIENE

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

Facilitator:-
Agreed Vision
Ground Rules:
•
•
•
•
•
•
•
•
•
•

Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

SCORING SHEET

PERSONAL AND ORAL HYGIENE

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____(insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1a :-Individual Assessment of personal hygiene needs** Why score chosen / How Justified?

SCORE :	**1b :-Individual Assessment of oral hygiene needs** Why score chosen / How Justified?

SCORE :	**2a:- Care for personal hygiene negotiated and planned based on assessment** Why score chosen / How Justified?

SCORE :	**2b :- Care for oral hygiene negotiated and planned based on assessment** Why score chosen / How Justified?

SCORE :	**3 :- Environment within which personal and oral hygiene needs are met** Why score chosen / How Justified?

SCORE :	**4 :- Provision of Toiletries for own personal use** Why score chosen / How Justified?
SCORE :	**5a :- Providing assistance with personal hygiene when required** Why score chosen / How Justified?
SCORE :	**5b :- Providing assistance with oral hygiene when required** Why score chosen / How Justified?
SCORE :	**6a: - Information and education to support patients in meeting personal hygiene needs: particularly if these are changing or….in unfamiliar surroundings.** Why score chosen / How Justified?
SCORE :	**6b: - Information and education to support patients in meeting oral hygiene needs: particularly if these are changing or ….in unfamiliar surroundings.** Why score chosen / How Justified?
SCORE :	**7a: - Evaluation/ Reassessment of personal hygiene and how effectively these are being met.** Why score chosen / How Justified?
SCORE :	**7b: - Evaluation/ Reassessment of oral hygiene needs and how effectively these are being met.** Why score chosen / How Justified?

The Essence of Care

COMPARISON GROUP COLLATED SCORES

PERSONAL AND ORAL HYGIENE

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1a:-A= All patients/ clients are assessed to identify the advice and/or care required to maintain and promote their individual personal hygiene

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

1b:-A= All patients/ clients are assessed to identify the advice and/or care required to maintain and promote their individual oral hygiene

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2a:-A= Planned care is negotiated with patients / clients and / or their carers and is based on assessment of their individual needs

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

The Essence of Care

2b:-A= Planned care is negotiated with patients / clients and / or their carers and is based on assessment of their individual needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
3:-A= Patients/ clients have access to an environment that is safe and acceptable to the individual		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
4:-A= Patients/ clients are expected to supply their own toiletries but single use toiletries are provided until they can supply their own		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

The Essence of Care

5a:-A= Patients / clients have access to the level of assistance that they require to meet their individual personal hygiene needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5b:- A= Patients / clients have access to the level of assistance that they require to meet their individual oral hygiene needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6a:- A= Patients/clients and/ or carers are provided with information/ education to meet their individual personal hygiene needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

6b:- A= Patients/clients and/ or carers are provided with information/ education to meet their individual oral hygiene needs		
Score Order A-E	***Member*** (name/code)	*Why score chosen / How justified?*
7a:- A= Patients/ clients care is continuously evaluated, reassessed and the care plan renegotiated		
Score Order A-E	***Member*** (name/code)	*Why score chosen / How justified?*
7b:- A= Patients/ clients care is continuously evaluated, reassessed and the care plan renegotiated		
Score Order A-E	***Member*** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

PERSONAL AND ORAL HYGIENE

COMPILED BY: - _____ __ / __ / __

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

FOOD AND NUTRITION

Food includes drinks

Agreed Patient Client Focused Outcome		
Patients / Clients are enabled to consume food (orally)which meets their individual need		
Indicators / Information that highlights concerns which may trigger the need for benchmarking activity:		
Patient Satisfaction Surveys Complaints figures and analysis Audit results – including catering audit, nutritional risk assessments, documentation audit, environmental audit (including dining facilities). Contract monitoring e.g. wastage of food, food handling and/ food hygiene training records		Ordering of dietary supplements / special diets Audit of available equipment and utensils Educational audits/ student placement feedback Litigation / Clinical Negligence Scheme for Trusts Professional concern Media reports Commission for Health Improvement Reports
	FACTOR	BENCHMARK OF BEST PRACTICE
1.	Screening / Assessment to identify patients/clients nutritional needs	Nutritional screening progresses to **further assessment for all** patients/clients identified as **'at risk'**
2.	Planning, implementation and evaluation of care for those patients who required a nutritional assessment	Plans of care based on **ongoing** nutritional assessments are devised, implemented and evaluated
3.	A conducive environment (Acceptable sights, smells and sounds)	The environment is **conducive to** enabling the **individual** patients/clients to eat
4.	Assistance to eat and drink	Patients/clients **receive the care and assistance** they require with eating and drinking
5.	Obtaining food	Patients/clients/carers, **whatever their communication needs,** have sufficient information to enable them to obtain their food
6.	Food provided	Food that is **provided by the service** meets the needs of individual patients/clients
7.	Food availability	Patients / clients have set meal times, are **offered a replacement meal if a meal is missed and can access snacks at any time**
8.	Food presentation	Food is presented to patients /clients in a way that takes in to account what **appeals to them as individuals**
9.	Monitoring	The amount of food patients actually eat is **monitored, recorded** and leads to **action** when cause for concern
10.	Eating to promote health	**All opportunities** are used to encourage the patients/clients to eat to **promote** their own **health**

Key Sources

- Allison SP. ed. *Hospital food as treatment.* Maidenhead: British Association for Parenteral and Enteral Nutrition, 1999.
- Burke A. *Hungry in hospital?* London: Association of Community Health Councils for England and Wales, 1997.
- Bond S. ed. *Eating matters.* Newcastle upon Tyne: Centre for Health Services Research, University of Newcastle, 1997.
- Department of Health. *Nutrition guidelines for hospital catering.* London: Department of Health, 1995.
- Department of Health. NHS Executive. *Hospital catering: delivering a quality service.* London: Department of Health, 1996.
- Elia M. ed. *Guidelines for Detection and Management of Malnutrition.* Maidenhead: Malnutrition Advisory Group, British Association for Parenteral and Enteral Nutrition, 2000.

(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

Factor 1: - Screening / Assessment to identify patients/ clients nutritional needs

Patients/ clients nutritional needs are **not ascertained**	Nutritional **screening** of patients/clients is **not consistently** undertaken	Nutritional screening is undertaken for all clients / patients but **no more detailed assessment** is made of those patients/clients identified as 'at risk'.	Nutritional screening progresses to **further assessment for all** patients/clients identified as '**at risk**'.
E	**D**	**C**	**B**	**A**

NB nutritional trigger assessment should always be undertaken at initial contact and the need for reassessment of patients/ clients should be continuously considered.
Section 3.4 of Eating Matters (p53).
Screening: - A process of identifying patients who are already malnourished or who are at risk of becoming so. Those at high level of risk require referral for a further comprehensive nutritional assessment.
(Unqualified staff, students / patients / carers can screen patients if they have received the necessary education and training and have been assessed as competent to undertake the assessment, but accountability remains with the registered practitioner)
Assessment: - is a more detailed process in which a range of specific methods can be used to identify and quantify impairment of nutritional status
(Assessment is undertaken by registered practitioners who have received the necessary education and training and have been assessed as competent to undertake the level of assessment required e.g. registered nurse, dietitian)
Protocols: -for screening and assessment can indicate the procedures involved in each process, when they should be used and by whom
Assessment should take in to account patients/clients physical, religious/cultural, age related and special needs, requirements and requests.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the components of screening and the definition of 'at risk'
State the components of the assessment and the evidence base.
State who completes the screening.
State when the screening is undertaken
State who completes the nutritional assessment.
State the timing of assessment, frequency, trigger to re-assess
State protocols in use

Factor 2: - Planning, implementation and evaluation of care for those patients/clients who required a nutritional assessment

Patients/clients nutritional assessments have **not led to a plan of care**	Plans of care based on the nutritional assessments are **devised but not implemented.**	Plans of care based on the nutritional assessments are **devised and implemented**	Plans of care based on the nutritional assessments are devised, implemented and **evaluated**	Plans of care based on **ongoing** nutritional assessments are devised, implemented and evaluated
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State plans used that ensure consideration of the involvement of all members of the caring team including patients / relatives and carers in the planning, implementation and evaluation of care
State which members of the multidisciplinary team are involved in assessment e.g. Dietitian, Nutritionist, Speech and Language Therapists, Occupational Therapists, Physiotherapists
State arrangements for evaluation that ensures that changes are made to the individual patients/ clients plan of care to reflect changes to nutritional requirements
State arrangements for audit that leads to changes in practice
Describe patient/client, carer and professional information that is available to inform active involvement

Factor 3: - A Conducive Environment (Acceptable sights, smells and sounds)

Environmental factors **prevent** the patients/clients eating	**Attempts** are made to create an environment where the patients/clients feels able to eat	The **environment is conducive** to enabling the individual patients/clients to eat

E **D** **C** **B** **A**

NB Practitioners are reminded that the environment should be conducive to the individual patient/client and not necessarily what is conducive to practitioners/professionals.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the measures taken to ensure that the environment is conducive to the patient/client (including consideration of ethnic/ religious/cultural, age related and special needs e.g. dining areas, tables, seating, utensils, adapted utensils, washing facilities, etc. Curtailment of inappropriate activity at meal times e.g. cleaning, ward rounds).
State the roles played by the qualified and unqualified staff in ensuring that the environment is conducive (including discussion of issues related to ownership and accountability)

Factor 4: - Assistance to eat and drink

Assistance is not available	Assistance is available but the patients'/clients are **not consistently receiving** assistance	Patients/clients **receive** the care and assistance they require with eating and drinking
E	**D C B**	**A**

Assistance to include: preparation of patient prior to eating (e.g. hand washing, positioning of patient), equipment (feeding utensils etc) 'hands on' assistance, re-training of patients to enable patients to feed themselves.
Key issues: maintaining patients' dignity and helping patients in a sensitive way taking into account ethnic/ cultural, age related and special needs.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State who is available to provide assistance and training that they have received.
State who assesses the level of assistance required on every occasion that food or drink is served.
State how carers/ relatives are involved in assisting and how this is negotiated
State education programmes in place to teach patients with specific needs to feed themselves (or to educate their relatives/carers to feed them)
State the range of equipment/ utensils/ furniture available to meet individual patient/ client needs (including ethnic/cultural needs)
State how independence is promoted
State the involvement of other health professionals e.g. Dietitian, Nutritionist, Catering staff, Speech and Language Therapists, Occupational therapist, physiotherapist

Factor 5: - Obtaining food

No information is provided on how to obtain food	Only **limited** information is provided on how to obtain food	There is **sufficient information** available but only some patients/clients receive it to enable them to obtain their food	Patients/clients, relatives carers, **whatever their communication needs,** have sufficient information to enable them to obtain their food
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the range of information available
Describe the liaison that occurs between catering staff and care providers
State the format of information available to meet ethnic/cultural/linguistic, age specific and special needs
State how information is shared with patients/ clients, relatives and carers
State who assists in menu completion / obtaining food and any specific training they have had, to ensure their competency in selecting meals to meet the individual needs of the patients/clients
State the timing of ordering to support patient/client choice

Factor 6: - Food provided

Food does **not meet** patients/clients individual needs	Food meets individual patients/clients needs but is **not provided** by the service.	Food that is **provided by the service** meets the needs of individual patients/clients
E	**D** **C** **B**	**A**

(Patients/Clients needs – linked to Factors 1 and 2)
Food not provided by the service may be purchased or brought in by families/carers.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient /Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how choice is ensured that allows patients/ clients personal, age related and cultural/religious preferences to be met
State the arrangements for ensuring therapeutic and special formulated diets are requested and provided including correct texture and consistency.
State how the service and staff ensure that patients/clients receive the correct portion size and the food they actually ordered
State how staff ensure that food and drink is served at the correct temperature for patient preference and safety
State who provides the food (and if it is prepared in a way that meets religious needs)

Factor 7: - Food Availability

Patients / clients have **set meal times** – no availability of food in between meal times	Patients / clients **have set meal times and are offered snacks at set times**	Patients / clients **have set meal times and can access snacks at any time**	Patients / clients have set meal times, are offered a replacement meal if a meal is missed **and can access snacks at any time.**
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how snacks are made available
State the variety of hot and cold meals and drinks available (NB NHS standard beverage > 7 + 3 meals per day + drinking water)
State how hot food is made available outside of meal times
State what equipment is available to prepare food including precautions taken to ensure food meets safety standards.
State food storage and preparation facilities and how these are maintained to ensure safe (i.e. free from contamination) fridge, food handling
State arrangements for patient's own food to be brought and stored.
State education and training of staff in food handling and preparation (including issues re: religion/culture)

Factor 8: - Food Presentation

Patients / clients are presented with food that is **not appealing.**	Food is presented to be **appealing to** patients/ clients	Food is presented to patients /clients in a way that takes in to account what **appeals to them as individuals**
E	**D** **C** **B**	**A**

Appealing: the appearance tempts, makes patients/clients want to eat it.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the serving method used e.g. plated, bulk
State at what point all packaging is removed
State how it is ensured that food is served at the patient/client required temperature
State who ensures that the food presented is appealing
State efforts made to ensure that the food served is appealing (e.g. smell, moulds for purees, personal touches, garnished)
State if crockery or plastic utensils used, and how the condition of utensils e.g. table mats are maintained
State how religious/cultural requirements for food presentation are met e.g. sealed cutlery and crockery.

Factor 9: - Monitoring of food intake when cause for concern

The amount of food eaten is **unknown**	The amount of food patients/clients actually eat is **monitored but not recorded when cause for concern.**	The amount of food patients/clients actually eat is **monitored and recorded when cause for concern.**	The amount of food patients actually eat is **monitored and recorded and leads to action when cause for concern.**	
E	**D**	**C**	**B**	**A**

NB This includes liquid food

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State what and where food and fluid intake is documented /recorded e.g. food amounts, frequency charts, etc and how accuracy is assured and assessed.
State who completes the food and fluid charts e.g. practitioners, professionals, patients / clients, carers etc
State who gives out food and drinks
State who collects empty containers
Describe the action taken as a resulting of monitoring, including by whom

Factor 10: - Patients Eating to Promote their own Health

No attempt is made to encourage the patients/clients to eat to promote their own health	**Some attempt** is made to encourage the patients/clients to eat to promote their own health	**All opportunities** are used to encourage the patients/clients to eat to **promote** their own **health.**
E	**D** **C** **B**	**A**

NB this includes patients/clients' who require a therapeutic diet

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State opportunities created or used to advise patients on eating to promote their own health e.g. Discussion? Displays? Handouts?
State how religious/cultural needs for a healthy diet are promoted and met
State training available for staff on the promotion of healthy eating
Describe multi-agency partnerships that encourage clients to eat to promote their own health

COMPARISON GROUP INFORMATION

For: -
FOOD AND NUTRITION

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

Facilitator:-
Agreed Vision
Ground Rules:
•
•
•
•
•
•
•
•
•
•

Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

SCORING SHEET

FOOD AND NUTRITION

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____(insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Screening / Assessment to identify patients/clients nutritional needs** Why score chosen / How Justified?

SCORE :	**2 :- Planning, implementation and evaluation of care for those patients who required a nutritional assessment** Why score chosen / How Justified?

SCORE :	**3:- A conducive environment (Acceptable sights, smells and sounds)** Why score chosen / How Justified?

SCORE :	**4 :- Assistance to eat and drink** Why score chosen / How Justified?

SCORE :	**5 :- Obtaining food** Why score chosen / How Justified?
SCORE :	**6 :- Food provided** Why score chosen / How Justified?
SCORE :	**7 :- Food availability** Why score chosen / How Justified?
SCORE :	**8 :- Food presentation** Why score chosen / How Justified?
SCORE :	**9:- Monitoring** Why score chosen / How Justified?
SCORE :	**10:- Eating to promote health** Why score chosen / How Justified?

COMPARISON GROUP COLLATED SCORES

FOOD AND NUTRITION

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= Nutritional screening progresses to further assessment for all patients/clients identified as 'at risk'		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Plans of care based on ongoing nutritional assessments are devised, implemented and evaluated		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= The environment is conducive to enabling the individual patients/clients to eat		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

The Essence of Care

4:-A= Patients/clients receive the care and assistance they require with eating and drinking		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= Patients/clients/carers, whatever their communication needs, have sufficient information to enable them to obtain their food		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= Food that is provided by the service meets the needs of individual patients/clients		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

The Essence of Care

7:-A= Patients / clients have set meal times, are offered a replacement meal if a meal is missed and can access snacks at any time		
Score Order A-E	**Member** (name/code)	*Why score chosen /How justified?*
8:- A= Food is presented to patients /clients in a way that takes in to account what appeals to them as individuals		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
9:- A= The amount of food patients actually eat is monitored, recorded and leads to action when cause for concern		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

10:- A= All opportunities are used to encourage the patients/clients to eat to promote their own health		
Score Order A-E	***Member*** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

FOOD AND NUTRITION

COMPILED BY: - _____ __ / __ / __

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

CONTINENCE AND BLADDER AND BOWEL CARE

The patient focused outcome will be achieved when accountable practitioners / professionals ensure that practice reflects the benchmarks of best practice and all carers are committed to the delivery of quality care.
Continence = control of bladder and bowel function
Continence Care = the total care package tailored to meet the individual needs of patients/ clients with bladder and bowel problems. (This could include strategies to prevent incontinence, assessment investigation, conservative and surgical intervention and methods to manage intractable incontinence)

Agreed Patient Client Focused Outcome		
Patients/Clients bladder and bowel needs are met		
Indicators / Information that highlights concerns which may trigger the need for benchmarking activity:		
Patient Satisfaction Surveys Complaints figures and analysis Audit - Continence / Product usage Audit documentation / guidance Educational audits/ student placement feedback		Professional Concern Media reports Litigation / Clinical Negligence Scheme for Trusts Commission for Health Improvement Reports
	FACTOR	BENCHMARK OF BEST PRACTICE
1	Information for patients/clients/carers	Patients / clients / carers have free access to evidence based information about bowel and bladder care that has been **adapted to meet individual patient/** client **needs** and/or those of their carer
2	Patient /Client access to Professional Advice re Continence, and Bladder and Bowel Care	Patients/ clients have **direct access** to professionals who can meet their continence needs and their services **are actively promoted**
3	Assessment of individual patient/client	Patients / clients positive responses to the trigger question **always leads** to an offer of an initial bladder and bowel continence assessment which if accepted by the patient/client is completed as described in Page 11, DOH 2000
4	Planning, implementation and evaluation of care based on the bladder and bowel assessment (To be completed only if an assessment has been performed)	The effectiveness of patients / clients care is **continuously evaluated** and leads either to the patients /clients needs being met or the modification of the care plan (e.g. referral on)
5	Education for assessors and care planners	Patients/ clients are assessed and have care planned by professionals who have received specific continence care training and are **continuously updated**.
6	Promotion of Continence and a healthy bladder and bowel	All opportunities are taken to promote continence and a healthy bladder and bowel among patients/clients **and the wider community.**
7	Patient /Client access to Continence supplies	Patients/ clients **have access** to appropriate 'needs specific' supplies to assist in the management of their incontinence

8	Education of the care deliverers	Patients / clients are cared for by carers who have undertaken continence care training which includes **ongoing updating**
9	A Physical and Social Environment Conducive to continence and a healthy bladder and bowel	All bladder and bowel care is given in an **environment conducive to the patients/clients individual needs**
10	Patient to Patient Support	Patients / clients / cares have the opportunity to access other patients / clients / cares who can offer support and this is **actively promoted**
11	User Involvement in service delivery	**Users are always involved in planning and evaluating services, and their input is acted upon**

Key Sources

- Brocklehurst, J et al (ed). *Health outcome indicators: urinary incontinence: report of a working group to the Department of Health*. Oxford: National Centre for Health Outcomes Development, 1999.
- Brocklehurst, J et al (ed*). Report to the Department of Health Working Group on outcome indicators for urinary incontinence*. Oxford: National Centre for Health Outcomes Development, 1997.
- Department of Health. *Good practice in continence services*. Leeds: Department of Health, 2000. http://www.doh.gov.uk/continenceservices.htm

(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

Factor 1: - Information for patients/clients/carers/public

Patients / clients / carers / public have **no evidence based information** about bowel and bladder care	Patients/clients/carers /public have **restricted access** or have to request evidence based information about bowel and bladder care	Patients / clients /carers / public have **free access to general evidence based information** about bowel and bladder care.	Patients / clients / carers/public have free access to evidence based information about bowel and bladder care that has been **adapted to meet individual patient/** client **needs** and/or those of their carers
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State information available (including information produced nationally and locally).
State how the information is adapted for different user groups and the individual needs of patients (e.g. ethnicity /cultural, religious/ linguistic, age, special needs or sensory impairments) e.g. fact sheets, poster, leaflets, patient records, video, translated materials
State how user acceptability of information is audited/ surveyed/analysed and how feedback is utilised.
State measures taken to ensure awareness and access of available information.
Describe networking including links to self-help/ user groups and health promotion units.
State evidence base for information and how this is evaluated to ensure it is up to date and consistent

Factor 2: - Patient /Client access to Professional Advice re Continence, and Bladder and Bowel Care

Patients / clients **do not have access to professional advice** re professionals who can meet their continence needs	There are **barriers** to patients / clients having access to professionals whom can meet their continence needs.	Patients/ clients **have direct access** to professionals who can meet their continence needs but their services are **not actively promoted**.	Patients/ clients have **direct access** to professionals who can meet their continence needs and their services **are actively promoted**
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State professional advice and services available (including ethnic/cultural and age specific professional access and times available)
Describe Policies / Procedures / Referral Protocols available to specialist services (See page 14 DOH 2000)
State where professional advice on continence needs is available locally including strategies to access isolated communities (include recently developed services e.g. NHS Direct/ On line/ Walk in Centre access)
State what provisions have been made to ensure accessibility to continence services.
State if self-referral is possible
State time for response to referrals / enquiries
State the average time a new referral waits before first appointment.
Give examples of barriers that prevent needs being met locally e.g. language / lack of interpreters / waiting lists / products / equipment / lack of knowledge/ interpersonal skills etc. State what you are doing to overcome each barrier
State a strategy that incorporates the education and training programme for professionals to enable them to provide advice.
State what provisions have been made to ensure accessibility to continence services

Factor 3: - Assessment of individual patient/client

Patients / clients are **not asked a trigger question related to bladder and bowel continence** needs within their general health assessment	Patients / clients **are asked a trigger question** related to bladder and bowel continence as part of their general health assessment, but even though **a positive response is given, no further action is taken**	Patients / clients **positive response to the trigger question , sometimes leads** to an offer of an initial bladder and bowel continence assessment (as described in Page 11 of DOH guidance)	Patients / clients positive response to the trigger question **always leads** to an offer of an initial bladder and bowel continence assessment which if accepted by the patient/client is completed as described in Page 11 of DOH guidance
E	**D**	**C**	**B**	**A**

Trigger question – should be asked at all initial contacts e.g. *Does your bladder or bowel ever/ sometimes cause you problems?*
A positive response = *Yes, sometimes my bladder/ bowel does cause me problems.*
NB All Patients/ clients presenting themselves for help with continence problems have automatically given a positive response to the trigger question

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how the trigger question determines assessment.
State the evidence base of the assessment tool used.
State in what contexts / settings the trigger question is not used and why.
Describe how the clients' understanding/ acceptance of the trigger question is assessed. Describe adaptations made to the trigger question used.
Describe how you are promoting the use of the trigger question amongst colleagues/other team members.
State how the assessment tool is adapted for specific patient/client groups.
State the context in which the trigger question is asked e.g. part of the over 75 year old assessment, School health checks, Post-natal, routine admission, Well Persons clinics, Nursing homes, opportunistic screening.
State evidence of audit to ascertain if and when trigger questions were asked.

Factor 4: - Planning, implementation and evaluation of care based on the bladder and bowel assessment (To be completed only if an assessment has been performed)

There are **no patients/clients plans of care** to meet the bowel and bladder needs identified in the continence assessments	Patients/clients care is planned but there is **no evidence of implementation**	Patients /clients care is planned and implemented but there is **no evidence of evaluation**	The effectiveness of patients / clients care is **continuously evaluated** and leads either to the patients /clients needs being met or the modification of the care plan (e.g. referral on)
E	**D**	**C**	**B**	**A**

NB It is expected that care is evidence based and planned jointly with the patient/client, family/ carers.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State care plans/ care pathways used and outcome measures used.
Describe how patient/client is involved in developing their own care plan and in setting their own outcome measures, including action to remove barriers e.g. use of interpreters
State protocols/ evidence based guidelines used for care interventions
State referral rates/ re-referral rates / complaints rates/ patient survey results
Describe how record keeping and evaluation is maintained and audited, including the extent of patient/ client access to records (see record keeping benchmark).
State clinical audit undertaken and how results have been disseminated and inform practice development.

Factor 5: - Education for professional assessors and care planners.

Patients /clients are **not assessed or do not have care planned by a health professional**	Patients / clients are assessed and have care planned by **professionals with no specific continence training**	Patients /clients are assessed and have care planned by **professionals with specific continence training**	Patients/ clients are assessed and have care planned by professionals who have received specific continence care training and are **continuously updated**.
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/Client needs (include ethnic/cultural/age related/special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State who assesses and plans care (role and responsibilities)
State initial and ongoing education and training opportunities/ programmes/policies and training analysis used
State use of peer group review/ supervision and personal development plans
State training packages / information and communication channels used
State how training records are maintained
Describe how service user views and expectations are included in your training programme including links with self-help / user groups.
Describe how you assess and evaluate the impact of training.
State education content (e.g. not just product related) and outcomes (including consideration of religious/cultural/linguistic, age related, special and infection control needs.

Factor 6: - Promotion of Continence and a healthy bladder and bowel

There is no attempt to promote patients/ clients' continence and a healthy bladder and bowel.	**Some attempt is made** to promote patients'/clients continence and a healthy bladder and bowel.	**All opportunities are taken** to promote patients /clients continence and a healthy bladder and bowel		All opportunities are taken to promote continence and a healthy bladder and bowel among patients/clients **and the wider community.**
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how at risk groups are identified locally and describe what you are doing to target these groups. (NB At risk groups identified in DH Good Practice in Continence Services (p8))
State how inter-professional/ interagency working assured and how this promotes continence
State the content (evidence base) and format of promotion strategies e.g. videos/ written including how they are used to promote knowledge and understanding within the wider community, including hard to reach communities e.g. black and minority ethnic communities
State how risk groups are identified e.g. antenatal, post-natal, special needs, school age children, elderly, disabled, post operative, and post procedure.
Describe measures to promote continence services, including links with self help/ user groups and health promotion units, the displaying and use of posters and leaflets
State audits undertaken, educational links and ongoing research
Describe how you use links with local user/self help groups to raise awareness
Describe any local awareness initiatives, including use made of national promotional opportunities (e.g. National Continence Week).

Factor 7: - Patient /Client access to Continence supplies

Patients / clients **do not have access to** supplies that assist in the management of their incontinence	There are **barriers** to patients/ clients having access to supplies that assist in the management of their incontinence	Patients/ clients **have access** to appropriate 'needs specific' supplies to assist in the management of their incontinence
E	**D C B**	**A**

NB DH Good Practice in Continence Services states that supplies should be available to all in need, after initial assessment.
Supplies include - continence aids, equipment, pads etc.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State Policies / Procedures for obtaining supplies /equipment
State the maintenance arrangements for equipment (including arrangements for retrieval).
State the arrangements for acquisition and delivery of supplies to the patient / client including response time.
State barriers that exist to obtaining supplies e.g. limited range or restrictions on the amount of supplies
State arrangements for equipment cleanliness, maintenance and replacement
State how user feedback is sought on supplies provided, including quantity, quality and delivery mechanisms. Describe how this feedback is used.
State the average time a new referral waits before having access to supplies.
State how patient/ client satisfaction of the services is assessed

Factor 8: - Education of the care deliverers

Patients /clients are cared for by carers with **no continence training**	Patients /clients are cared for by carers with training but **no evidence of updating**			Patients / clients are cared for by carers who have undertaken continence care training which includes **ongoing updating**
E	**D**	**C**	**B**	**A**

NB Education should involve regular practice and peer review e.g. DH Good Practice in Continence Services states that best outcomes for specialist surgery are achieved when surgical teams operate on a critical volume of cases to maintain and improve their expertise.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient/Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State who delivers care
State how training needs are assessed
State initial and ongoing education and training opportunities/ programmes/policies used
State the intended learning outcomes
State use of peer group review/ supervision and personal development plans
Describe how service user views and expectations are included in your training programme including links with self-help/ user groups.
Describe how you assess and evaluate the impact of training.
Describe training packages / information and communication channels used.
State how training records are maintained
State education content (e.g. to include role of all professionals and not just product related) (Include consideration given to religious/cultural/linguistic, age related and special needs and infection control).
If used state NVQ programmes and evidence required
State training of patients/clients carers/ families and support groups

Factor 9: -A Physical and Social Environment Conducive to continence and a healthy bladder and bowel.

The environment is **not conducive** to the patients/ clients individual needs	Attempts have been made to make the **general** environment conducive	Attempts have been made to make the environment conducive to patients/ clients **individual** needs	All bladder and bowel care is given in an **environment conducive to the patients/clients individual needs**
E	**D**	**C**	**B**	**A**

NB Consideration of individual needs is paramount however this may need to be balanced with meeting the needs of other users of the same facility.
(Use with Privacy and Dignity Benchmark)

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State what attempts are made to make the environment conducive for the individual: - lighting, cleanliness, heating adaptations curtains draw, doors lock, male/female toilets, hand washing/douche facilities, age related facilities, religious/cultural sensitivities.
State how patients/clients satisfaction in assessed and any complaints are addressed
Describe how individual patient/client needs are met e.g. dignity and privacy, self-care involvement, religious/cultural awareness, dietary needs, medications, flexibility of toileting regimes.
Describe how patients/ clients views on the environment are sought and acted upon and action taken to remove any barriers
State what consultation with specialist continence professionals has taken place in assessing the environment.
State how the environment is adapted to meet the individual needs of patients/clients e.g. with mobility problems

Factor 10: - Patient to Patient Support

Patients /clients / carers have **no access** to other patients/ Clients / carers for support	Patients/ clients / carers **have the opportunity to access** other patients/ clients / carers but this is not actively promoted	Patients/clients/carers have the opportunity to access other patients/clients who can offer support and this is **actively promoted**
E	**D** **C** **B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic/cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe strategies used to put service users in touch with each other.
State methods used to make service users aware that they can contact others
Describe measures taken to set up or support a local self-help/user group. state barriers to support
Describe links to existing local or national patient groups
State what information about local or national patient groups is given to service users
State the preparation received by the patients/ clients/carers providing the support

Factor 11: - User Involvement in service delivery

No user feedback or involvement sought	**User feedback** is sought but not acted upon	**User feedback is always sought and sometimes acted upon**	**Users are always involved in planning and evaluating services, and their input is acted upon.**
E	**D**	**C**	**B**	**A**

Users whenever possible should be involved in all aspects of care planning and delivery
User is patient/client, relative, family, and carer

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how users are involved, how views are sought.
State methods used to secure user involvement e.g. focus groups, user forums, patients council, etc to include consideration of religious/cultural/language and age related and special needs issues
State how patients/clients satisfaction with continence services is assessed
State inter-agency involvement, networking with all stakeholders.
Describe strategies used to involve users from isolated/hard to reach communities
State how patients/clients satisfaction is assessed and any complaints are addressed

COMPARISON GROUP INFORMATION

For: -
CONTINENCE AND BLADDER AND BOWEL CARE

Comparison Group for:- (insert name of team/ward/unit/area/directorate/ group/trust/region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

Facilitator:-
Agreed Vision
Ground Rules:
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Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

SCORING SHEET

CONTINENCE AND BLADDER AND BOWEL CARE

Score relates to practice by/on/in:- (Self/Team/Practice/Ward/Area/ Directorate/Trust)		
Comparison Group Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / --

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____ (insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Information for patients/clients/carers** Why score chosen / How justified?

SCORE :	**2 :- Patient /Client access to Professional Advice re Continence, and Bladder and Bowel Care** Why score chosen / How justified?

SCORE :	**3:- Assessment of individual patient/client** Why score chosen / How justified?

SCORE :	**4 :- Planning, implementation and evaluation of care based on the bladder and bowel assessment** Why score chosen / How justified?

SCORE :	**5 :- Education for assessors and care planners** Why score chosen / How justified?
SCORE :	**6 :- Promotion of Continence and a healthy bladder and bowel** Why score chosen / How justified?
SCORE :	**7 :- Patient /Client access to Continence supplies** Why score chosen / How justified?
SCORE :	**8 :- Education of the care deliverers** Why score chosen / How justified?
SCORE :	**9:- A Physical and Social Environment Conducive to continence and a healthy bladder and bowel** Why score chosen / How justified?
SCORE :	**10:- Patient to Patient Support** Why score chosen / How justified?
SCORE :	**11:- User Involvement in service delivery** Why score chosen / How justified?

COMPARISON GROUP COLLATED SCORES

CONTINENCE AND BLADDER AND BOWEL CARE

Comparison Group:- (Self/ Team/Practice/ Ward/ Area/Directorate/Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= Patients / clients / carers have free access to evidence based information about bladder and bowel care that has been adapted to meet individual patient/ client needs and/or those of their carer

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Patients/ clients have direct access to professionals who can meet their continence needs and their services are actively promoted

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= Patients / clients positive responses to the trigger question always leads to an offer of an initial bladder and bowel continence assessment which if accepted by the patient/client is completed

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

The Essence of Care

4:-A= The effectiveness of patients / clients care is continuously evaluated and leads either to the patients /clients needs being met or the modification of the care plan (e.g. referral on)		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= Patients/ clients are assessed and have care planned by professionals who have received specific continence care training and are continuously updated		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= All opportunities are taken to promote continence and a healthy bladder and bowel among patients/clients and the wider community		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

7:-A= Patients/ clients have access to appropriate 'needs specific' supplies to assist in the management of their incontinence		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
8:- A= Patients / clients are cared for by carers who have undertaken continence care training which includes ongoing updating		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
9:- A= All bladder and bowel care is given in an environment conducive to the patients/clients individual needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

10:- A= Patients / clients / cares have the opportunity to access other patients / clients / cares who can offer support and this is actively promoted		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
11:- A= Users are always involved in planning and evaluating services, and their input is acted upon		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

CONTINENCE AND BLADDER AND BOWEL CARE

COMPILED BY: - _____ - _ _ / _ _ / _ _

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

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AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
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ACTION REQUIRED	By whom	Date to complete	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	**REFLECTION**

PRESSURE ULCERS

Definition.
Pressure ulcer (sometimes referred to as Pressure sore/Bed sore/Decubitus ulcer) = identified damage to an individual's skin due to the effects of pressure together with, or independently from a number of other factors e.g. shearing, friction, moisture etc.

Agreed Patient/Client Focused Outcome		
The condition of the patients/clients skin will be maintained or improved		
Indicators/Information that highlights concerns which may trigger the need for benchmarking activity:		
Audits-Documentation/Care pathways/ guidance Pressure Ulcer –incidence & prevalence figures Product usage/availability Patient Satisfaction Surveys Complaints figures and analysis Educational audits/ student placement feedback		Litigation / Clinical Negligence Scheme for Trusts Professional Concern Media Reports Commission for Health Improvement reports
	FACTOR	BENCHMARK OF BEST PRACTICE
1.	Screening / Assessment	**For all** patients/clients identified as **'at risk'** screening **progresses to further assessment**
2.	Who undertakes the assessment	Patients / clients are assessed by **assessors** who have the required **specific knowledge and expertise**, and have **ongoing updating**
3.	Informing patients/clients/carers (Prevention and Treatment)	Patients/clients and carers have ongoing **access to information** and have the **opportunity to discuss** this and its relevance to their individual needs, with a registered practitioner
4.	Individualised plan for prevention and treatment of pressure ulcers	**Individualised** documented **plan** agreed with multidisciplinary team **in partnership** with patient/client /carers, with **evidence of ongoing reassessment**
5.	Pressure ulcer prevention – Repositioning	The patients/clients need for repositioning has been assessed/ documented / met/ evaluated with evidence of **ongoing reassessment**
6.	Pressure ulcer prevention – Redistributing Support Surfaces	Patients at risk of developing pressure ulcers **are cared for on** pressure redistributing support surface that meet their individual needs, including comfort
7.	Pressure ulcer prevention – Availability of Resources – Equipment	Patients / clients have **all the equipment they require** to meet their individual needs
8.	Implementation of individualised plan	The plan is **fully implemented in partnership** with the multidisciplinary team/ patients/clients / carers
9.	Evaluation of interventions by a registered practitioner	An evaluation which incorporates patients/clients /carers **participation in forward planning,** is documented

Key Sources

- Department of Health. NHS Executive. Pressure sores: a preventable problem. *VFM Update* 1994; 12.
- *Risk assessment and prevention of pressure ulcers : a clinical practice guideline* [in press].
- University of Leeds. Nuffield Institute for Health, University of York. NHS Centre for Reviews and Dissemination. The prevention and treatment of pressure sores. *Effective Health Care* 1995; 2:1.

(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

Factor 1: - Screening/ Assessment

Patients/ clients pressure ulcers, or their risk of developing a pressure ulcer is **not ascertained**	Patients/clients are **not consistently screened** for the presence of, or risk of developing, pressure ulcers.	Patients / clients are screened but this does not lead to **more detailed assessment** of those patients/clients identified as 'at risk'.		For all patients/clients identified as 'at risk' screening **progresses to further assessment**
E	**D**	**C**	**B**	**A**

NB Screening should always be undertaken at initial contact and the need for reassessment of patients/ clients should be continuously considered.
Screening: - A process of identifying patients whom already have or who are at risk of developing a pressure ulcer. It requires sufficient knowledge for clinical judgement. Those at high level of risk require referral for a further comprehensive assessment.
Assessment: - is a formal, comprehensive and systematic process in which a range of specific methods / tools can be used to identify and quantify the patients/clients risk.
At Risk: - individuals who have, as a result of screening, been identified as having or as being vulnerable to the development of pressure ulcers

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patients/ clients are assessed as being 'at risk'
State the components of the screening assessment
State who completes the screening assessment and how this is recorded
State when the screening assessment is undertaken
State who completes the full assessment
State what is included in full assessment and assessment tools used.
State if a manual handling assessment is included
State the evidence base for assessment and how this is updated to reflect current evidence

Factor 2: - Who undertakes the Assessment

Patients / clients are assessed by **assessors who do not have the required specific knowledge and expertise**	Some patients/clients are assessed by assessors who have **some training**	Patients / clients are assessed by **assessors who have the required specific knowledge and expertise**	Patients / clients are assessed by assessors who have the required specific knowledge and expertise and have **ongoing updating**
E	**D**	**C**	**B**	**A**

Unqualified staff, students / patients / carers can screen patients if they have received the necessary education and training and have been assessed as competent to undertake the screening, but accountability remains with the registered practitioner. Registered practitioner who have received the necessary education and training and have been assessed as competent undertake the assessment

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how knowledge and expertise is acquired (for screening and assessment)
State the way in which knowledge, skills and attitudes are updated on an ongoing basis
State the mechanisms for assessing competence of the screeners and assessors
Describe how specialist assessment is accessed if required.
State how assessment is documented and accessed by caring team.

Factor 3: - Informing patients/ clients and carers (Prevention and Treatment)

Patients/ clients and carers have **no access to information**	Patients/ clients and carers have **access to relevant information but no opportunity to discuss** with a registered practitioner	Patients/clients and carers have access to information and have had the opportunity to **discuss this and its relevance to their individual needs** with a registered practitioner.	Patients/clients and carers have **ongoing access** to information and have the opportunity to discuss this and its relevance to their individual needs with a registered practitioner.
E	**D**	**C**	**B**	**A**

Registered practitioner has the specific knowledge base to lead an informed discussion with the patient / client / carer.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the range and format available to meet patient/client/carer individual needs including religious/cultural/linguistic , age related and special needs (language/tapes/videos/leaflets)
State the evidence base for the information
State how patients understanding of information is verified and choices documented
State how the sharing and understanding of information is recorded.
State the ongoing training and education received by registered practitioners to enable them to access, share, explain and explore information (including orientation and during supervision and PDP)

Factor 4: - Individualised plan for prevention and treatment of pressure ulcers

No plan or no documented plan	Documented plan **not individualised** based on patient/client assessment	Documented plan is **individualised** but does not include agreement from multidisciplinary team in partnership with patient/client / carers.	Individualised documented plan agreed with multidisciplinary team **in partnership** with patient/client / carers.	**Individualised** documented **plan** agreed with multidisciplinary team **in partnership** with patient/client / carers, **with evidence of ongoing reassessment**.
E	**D**	**C**	**B**	**A**

Plan – centred on correction or minimisation of intrinsic and extrinsic factors.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe how responsibilities (of patients/clients/ carers/ multi-disciplinary team members) with regard to treatments, interventions, milestones and targets are negotiated and agreed. (including removal of barriers to effective communication e.g. linguistic, age related and special needs)
State the evidence that all plans are underpinned by best evidence
State the mechanisms in place to ensure review of plans and evaluation

Factor 5: - Pressure ulcer prevention -Repositioning

The patients/clients **need for repositioning has not been assessed**	The patients/clients need for repositioning has been assessed and documented but **not met**	The patients/clients need for repositioning has been assessed/ documented and **met**	The patients/clients need for repositioning has been assessed/ documented / met and **evaluated**	The patients/clients need for repositioning has been assessed/ documented / met/ evaluated with evidence of **ongoing reassessment**
E	**D**	**C**	**B**	**A**

NB Repositioning applies to patients/clients being cared for on any type of surface.
Equipment should be used effectively to avoid any damage to the patient/client /carer as a result of repositioning

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State equipment available to enable correct moving and handling and positioning including pillows etc
State training and education programmes in place
State patient / carer information available for re-positioning
State policies/ guidelines in use re Health and Safety, manual handling, equipment use etc.

Factor 6: - Pressure ulcer prevention –redistributing support surfaces

Patients/clients at risk of developing pressure ulcers are **not given the opportunity** of being placed on pressure redistributing support surfaces.	Patients at risk of developing pressure ulcers **have the opportunity** to be placed on pressure redistributing support surfaces	Patients at risk of developing pressure ulcers **are cared for on** pressure redistributing support surfaces that meet their individual needs (including comfort)
E	**D** **C** **B**	**A**

Pressure redistributing/reducing support surfaces: - Static and active pieces of equipment i.e. mattresses, cushions that assist in spreading the patients body weight in order to minimise the effects of pressure.
At risk patients :-Individuals who have been identified as vulnerable to the development of pressure ulcers as a result of initial screening / full assessment and informed clinical judgement see Factor 1

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State what redistributing support surfaces are used. State records kept
State arrangements for surfaces cleanliness and maintenance and replacement
State the infection control policies in place and its relevance to surfaces cleaning
State how person's comfort is assessed and assured
State the process for ordering, delivery and monitoring of support surfaces
State the patient information available including consideration of information to meet religious/cultural and special needs.

Factor 7: - Pressure Ulcer Prevention – Availability of Resources -Equipment

Patients/clients are **not provided** with any pressure ulcer prevention equipment	Patients/clients **are provided** with equipment but it is **not the equipment required to meet their individual needs**	Patients/clients are provided with a **limited range** of the equipment required to meet their individual needs	Patients / clients have **the equipment they require** to meet their individual needs
E	**D**	**C**	**B**	**A**

Equipment: - e.g. pressure redistributing equipment including: - seating / mattresses / specialist beds / bed frames / electric profiling bed frames/ moving and handling/ hoists/ footwear / insoles.
Types of Dressing evidenced as a preventative measure are included

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the range of equipment available
State the barriers that limit access to or use of equipment
State policies in place for use of equipment
State arrangements for equipment cleanliness repair maintenance and replacement
State the infection control policies in place and its relevance to equipment cleaning
State the process for ordering, delivery and monitoring of equipment
State how patients/clients are made aware of the equipment available and how to safely use it

Factor 8: - Implementation of individualised plan

No care given or not given according to plan	**Some elements** of care are given according to plan	The plan is **implemented but not in partnership** with the multi- disciplinary team and patient/client / carers.		The plan is **fully implemented in partnership** with the multidisciplinary team/ patients/clients / carers.
E	**D**	**C**	**B**	**A**

NB The inability to implement the plan leads to re-assessment

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State barriers to the implementation of planned care and how variance is recorded
State how multidisciplinary team is involved and involvement is documented
State how patients / clients are involved
State how carers are involved.
State evidence of patient/carer training
State how religious/cultural /linguistic and special needs are addressed.

Factor 9: - Evaluation of interventions by a registered practitioner

No evaluation of interventions takes place	Evaluation takes place but **not documented**	**Evaluation is documented** but there is **no forward planning**	An evaluation which includes **forward planning but patient/ client / carer views are not taken into account**	An evaluation which **incorporates patients/clients/ carer participation** in forward planning, is documented
E	**D**	**C**	**B**	**A**

NB The non-registered practitioner/ patient / carer can state care delivered and report on progress made but is not expected to evaluate the effectiveness of intervention.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patient/ clients/ carers are involved / participate.
State how documentation reflects accurate and timely evaluation e.g. audit of records
State guidelines and policies in use that support forward planning

COMPARISON GROUP INFORMATION

For: -
PRESSURE ULCERS

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

Facilitator:-
Agreed Vision
Ground Rules:
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Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

The Essence of Care

SCORING SHEET

PRESSURE ULCERS

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____ (insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Screening / Assessment** Why score chosen / How Justified?

SCORE :	**2 :- Who undertakes the assessment** Why score chosen / How Justified?

SCORE :	**3:- Informing patients/clients/carers (Prevention and Treatment)** Why score chosen / How Justified?

SCORE :	**4 :- Individualised plan for prevention and treatment of pressure ulcers** Why score chosen / How Justified?

SCORE :	**5 :- Pressure ulcer prevention – Repositioning** Why score chosen / How Justified?
SCORE :	**6 :- Pressure ulcer prevention – Redistributing Support Surfaces** Why score chosen / How Justified?
SCORE :	**7 :- Pressure ulcer prevention – Availability of Resources – Equipment** Why score chosen / How Justified?
SCORE :	**8 :- Implementation of individualised plan** Why score chosen / How Justified?
SCORE :	**9:- Evaluation of interventions by a registered practitioner** Why score chosen / How Justified?

The Essence of Care

COMPARISON GROUP COLLATED SCORES

PRESSURE ULCERS

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= For all patients/clients identified as 'at risk' screening progresses to further assessment

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Patients / clients are assessed by assessors who have the required specific knowledge and expertise, and have ongoing updating

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= Patients/clients and carers have ongoing access to information and have the opportunity to discuss this and its relevance to their individual needs, with a registered practitioner

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

4:-A= Individualised documented plan agreed with multidisciplinary team in partnership with patient/client /carers, with evidence of ongoing reassessment		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= The patients/clients need for repositioning has been assessed/ documented / met/ evaluated with evidence of ongoing reassessment		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= Patients at risk of developing pressure ulcers are cared for on pressure redistributing support surface that meet their individual needs, including comfort		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

7:-A= Patients / clients have all the equipment they require to meet their individual needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
8:- A= The plan is fully implemented in partnership with the multidisciplinary team/ patients/clients / carers		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
9:- A= An evaluation which incorporates patients/clients /carers participation in forward planning, is documented		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

The Essence of Care

ACTION PLANNED TO DEVELOP PRACTICE

PRESSURE ULCERS

COMPILED BY: - _____ - _ _ / _ _ / _ _

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

The Essence of Care

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SAFETY OF CLIENTS / PATIENTS WITH MENTAL HEALTH NEEDS

in Acute Mental Health and General Hospital Settings.

Safe = freedom from physical, mental, verbal abuse and/ or injury to self and others.
Secure = *emotional safety*.
Relational security = patients needs are met through the development of trusting and genuinely therapeutic relationships with the patient/client by members of the care team within safe and fully explained boundaries.
Engagement = patients / clients have staff who connect with them continuously, in an atmosphere of genuine regard, instilling feelings of well being, safety, security and sanctuary
Harm = to injure, hurt or abuse
NB: This benchmark was completed specifically for use in Acute NHS general settings but may be applied to any care setting

Agreed Patient / Client Focused Outcome	
Everyone feels safe, secure and supported with experiences that promote clear pathways to well being.	
Indicators / Information that highlights concerns which may trigger the need for benchmarking activity:	
Suicide figures Self harm Patient Satisfaction Surveys - Patient representative group concerns Complaints figures and analysis - service users/carers/staff Audit – Care Programme Approach documentation, national audit of violence, risk assessment, Observing national policy Patient/carers absences Incidents - Violence self/others, (serious & near misses) aggression self/others	Recruitment & Retention of staff in Acute Mental health settings Staff - Sickness/Stress/Injuries in acute mental health settings. Educational audits/ student placement feedback Litigation / Clinical Negligence Scheme for Trusts Professional concerns Media reports Commission for Health Improvement reports

	FACTOR	**BENCHMARK OF BEST PRACTICE**
1.	Orientation to the health environment	All patients/clients are **fully orientated** to the environment, in order to help them feel safe
2.	Assessment of risk of patients/clients with mental health needs harming self	Patients/clients **have a comprehensive, ongoing assessment** of risk to self with full involvement of patient to reduce potential for harm
3.	Assessment of risk of patients/clients with mental health needs harming others	Patients/clients **have a comprehensive, ongoing assessment** of risk to others with full involvement of patient to reduce potential for harming others
4.	Balancing observation and privacy in a safe environment	Patients/clients are cared for in an environment that **balances safe observation and privacy**
5.	Meeting patients/clients safety needs	Patients/clients **are regularly and actively involved** in identifying care that meets their safety needs
6.	A positive culture to learn from complaints and adverse incidents	There is a **no blame culture which allows a vigorous investigation of complaints and adverse incidents and near misses and ensures that lessons are learnt and acted upon**

Key Sources

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(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

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Factor 1: - Orientation to the Health Environment

Patients/clients are **not orientated** to their care environment/setting Therefore they do not feel safe	Patients/clients are **insufficiently orientated** to the environment/setting to help them feel safe	All patients/clients are **fully orientated** to the environment, in order to help them feel safe.
E	**D C B**	**A**

Full orientation: - made familiar with and understand the philosophy, people, services, environment, policies/processes/ procedures and physical layout, know how to access key worker and relevant information

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patients/clients are orientated. State how orientation is focused around patient / client group cognitive skills.
State who orientates the client to the ward; (include staff and other patients/clients).
State the ongoing training and education received by staff to provide them with the required social and communication skills to orientate patients/clients
State what resource materials (i.e. booklets, videos) are used to promote orientation
State what topics are covered in the orientation.
State who talks through what will happen to them and who will be initially looking after them.
State how key workers are identified and whether consideration given to gender, ethnicity, religious, cultural and linguistic issues.
State feedback mechanisms available for patients/clients and relatives
State what specific action is taken to make women and other vulnerable service users feel safe and secure

Factor 2: - Assessment of Risk of patients/clients with mental health needs harming self

Patients/clients **do not have an assessment** made of their risk of harm	Patients/clients have an assessment but it **does not involve them** in planning to reduce their risk of harm	Patients/clients have an assessment of risk to self but only **some patients/clients are involved** in planning to reduce their potential for harm	Patients/clients **have a comprehensive, ongoing assessment** of risk to self with full involvement of patient to reduce potential for harm
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the risk assessment questions asked and tool used and whether the key indicators of risk are included
State training undertaken to improve the skills of front line staff in the recognition, assessment and management of risk and how often it is updated. State if users are involved in the training of staff, to ensure that assessment and management is appropriate and sensitive to specific needs e.g. religion and culture, age related needs, human rights, child protection, previous, history of life events: and to specific treatments e.g. medication, ECT
State how knowledge of a patient's history, social context and significant events since admission are ascertained, recorded and shared
State how staffs attitudes to self harm are ascertained/ measured and supported
State what outside user agencies are used to act as a support/ information for patients/clients who self harm e.g. national self harm network, SHOUT, black and minority ethnic Voluntary Organisations
State what procedures are in place to ascertain presence of and to identify misuse of alcohol and drugs.
State what further support is available e.g. Rape Crisis, Incest Survives, Samaritans
State assessment undertaken by inpatient and community teams prior to discharge and whether this includes assessment of risk and joint case review (to include discharge planning)

Factor 3: - Assessment of Risk of patient/client with mental health needs harming others

Patients/clients **do not have an assessment** made of their risk of harming others	Patients/clients have an assessment but it **does not involve them** in planning to reduce their risk of harming others	Patients/clients have an assessment of risk but only **some patients/clients are involved** in planning to reduce their potential for harming others		Patients/clients **have a comprehensive, ongoing assessment** of risk to others with full involvement of patient to reduce potential for harming others
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the risk assessment questions asked and tool used and whether the key indicators of risk are included
State training undertaken to improve the skills of front line staff in the recognition, assessment and management of risk and how often it is updated. State if users are involved in the training of staff, to ensure that assessment and management is appropriate and sensitive to specific needs e.g. religion and culture, age related needs, human rights, child protection.
State how knowledge of a patient's history, social context and significant events since admission are ascertained, recorded and shared (including sharing and liaison between general and mental health areas)
State how staffs attitudes to harm are ascertained/ measured and supported
State what outside user agencies are used to act as a support/ information
State what procedures are in place to ascertain presence of and to identify misuse of alcohol and drugs.
State what further support is available e.g. Rape Crisis, Incest Survives, Samaritans
State assessment undertaken by inpatient and community teams prior to discharge and whether this includes assessment of risk and joint case review

Factor 4: - Balancing Observation and Privacy in a Safe Environment

Patients / clients are **not accorded privacy nor cared for in an environment that allows safe observation**	Patients / clients are cared for in an environment that **allows either safe observation or privacy**	Patients/clients are cared for in an environment that **balances safe observation and privacy**
E	**D C B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State if there is an up to date observation policy, who is involved (e.g. MDT) and if this is audited. This should include who observes the patient/ client (e.g. qualified/unqualified, the status awarded the task and how it is ensured that observations are supportive and therapeutic)
State if the observation policy is a feature of training / updated.
State if resources allow the increased observation of patients in the evening and at night and prior to discharge
State how staff skill mix, staff roles and attention to gender of staff have been adapted to release staff to carry out clinical observations e.g. administrative support
State what opportunities there are for privacy and maintaining dignity during observations
Describe how you inform/ educate the client regarding the observational processes and how their satisfaction with these processes are ascertained
State how carers satisfaction with observation and privacy is ascertained
State how the privacy of women and other vulnerable groups are secured
State what environmental safety checks are made re removal of any obstructions to observation and preventing access to means of suicide and e.g. window opening, safety glass, structures that could be used in suicide by hanging, safe storage of drugs and other harmful products, effective administration of drugs to prevent stockpiling.

Factor 5: - Meeting patients / clients safety needs

Patients/ clients ongoing **safety needs are not considered**	Patients/ clients safety needs are **initially identified** but there is no evidence of further review or up dating	Patients / clients individual safety needs **are identified and there is evidence of further review**		Patients/clients **are regularly and actively involved** in identifying care that meets their safety needs
E	**D**	**C**	**B**	**A**

Review: - Care plan review intervals should be agreed individually and reviewed/evaluated as stated in the care plan
NB Negotiated evidence based care plans and personal crisis plans are an integral part of the Care Programme Approach (1999)

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how safety needs are addressed in the care plan and regularly considered in care reviews
Describe how clients are encouraged to express any safety and security concerns
State how the quality of care plan documentation is assessed and audited
State whether the patient has a copy of the care plan in a format that they understand, how patients/clients can demonstrate that they understand, input into and are in agreement with it (gain ownership). If not why? How are communication barriers overcome?
State how known patients are enabled to detail personal crisis plans and preferences when well, where these are recorded and kept and how these are taken into account and used during an acute crisis
State how patients/clients are involved in negotiating choice of 1° nurse e.g. gender

Factor 6: - A Positive Culture to Learn from Complaints and Adverse Incidents related to harm and abuse

Patients/clients but **do not feel able to report adverse incidents and complaints**	Patients/clients report adverse incidents and complaints but **action is rarely taken**	Patients/clients report adverse incidents and complaints and **action is sometimes taken**	There is a **no blame culture which allows a vigorous investigation of complaints and adverse incidents and near misses and ensures that lessons are learnt and acted upon**
E	**D**	**C**	**B**	**A**

Adverse Incidents/Experiences – may involve actual or implied harm and includes physical, sexual, psychological, verbal and emotional abuse.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the systems in place for monitoring complaints, critical incidents and near misses
Describe how complaints procedure is made user friendly, accessible, and useable. Particularly for vulnerable groups and how barriers to communication are overcome e.g. language/literacy/communication channels
State systems in place for staff or patients/clients/users/carers to report staff who are abusive/ harmful
State how critical incidents (acts of violence/aggression/seclusion/ and procedures /policies are audited, including ensuring action taken if required.
State how risk related information is collected and used in determining resources and monitoring performance and to inform training
Describe how outside agencies/ advocates/ user groups are involved in audit of complaints and critical incidents and evaluation of services.
Describe critical incident reviews that occur, what patient and staffing debriefing arrangements are in place and how these influence practice.
State debriefing arrangements - surgery for complaints

COMPARISON GROUP INFORMATION

For: -
SAFETY OF PATIENT/ CLIENTS WITH MENTAL HEALTH NEEDS

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

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Facilitator:-
Agreed Vision
Ground Rules:
•
•
•
•
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•
•
•
•
•

Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

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SCORING SHEET

For
SAFETY OF CLIENTS / PATIENTS WITH MENTAL HEALTH NEEDS

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____ (insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Orientation to the health environment** Why score chosen / How Justified?

SCORE :	**2 :- Assessment of risk of patients/clients with mental health needs harming self** Why score chosen / How Justified?

SCORE :	**3:- Assessment of risk of patients/clients with mental health needs harming others** Why score chosen / How Justified?

SCORE :	**4 :- Balancing observation and privacy in a safe environment** Why score chosen / How Justified?

SCORE :	**5 :- Meeting patients/clients safety needs** Why score chosen / How Justified?
SCORE :	**6 :- A positive culture to learn from complaints and adverse incidents** Why score chosen / How Justified?

COMPARISON GROUP COLLATED SCORES

SAFETY OF CLIENTS / PATIENTS WITH MENTAL HEALTH NEEDS

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= All patients/clients are fully orientated to the environment, in order to help them feel safe

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Patients/clients have a comprehensive, ongoing assessment of risk to self with full involvement of patient to reduce potential for harm

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= Patients/clients have a comprehensive, ongoing assessment of risk to others with full involvement of patient to reduce potential for harming others

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

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4:-A= Patients/clients are cared for in an environment that balances safe observation and privacy		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= Patients/clients are regularly and actively involved in identifying care that meets their safety needs		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= There is a no blame culture which allows a vigorous investigation of complaints and adverse incidents and near misses and ensures that lessons are learnt and acted upon		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

SAFETY OF PATIENTS / CLIENTS WITH MENTAL HEALTH NEEDS

COMPILED BY: - Date:- _ _ / _ _ / _ _

FOR:- (Self / Team / Trust / Region)

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

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AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

RECORD KEEPING

Benchmarks within this document are focused upon meeting patients' and clients' needs and are guided by, but not dependent upon, or limited by, the examples of legislative and government guidance shown in Italics throughout the document and in the appendices.
The benchmarks of best practice identified are applicable to any health care setting and within any health care delivery system.
It is accepted that all records must be legible, accurate, signed with designation stated, dated, timed, contemporaneous, be able to provide a chronology of events and use only agreed abbreviations.
A Health Record is defined in section 68 (2) Data Protection Act 1998
'(a) consists of any information relating to the physical or mental health or condition of an individual' and
'(b) has been made by or on behalf of a health professional in connection with the care of that individual' checked and correct
Health Service Records support: -
Patient care and continuity of care
Evidence based clinical practice (For the Record HSC 1999/053)

Agreed Patient Client Focused Outcome

Patients / clients benefit from records that demonstrate effective communications which support and inform high quality care.

Indicators / Information that highlights concerns which may trigger the need for benchmarking activity:

Patient Satisfaction Surveys Complaints figures and analysis Critical incident analysis Documentation audit Information technology and information management systems audit	Litigation/ Clinical Negligence Scheme for Trusts Information Technology & Management training records Educational Audits / Student placement feedback Information Technology expenditure Commission for Health Improvement Reports

	FACTOR	BENCHMARK OF BEST PRACTICE
1.	Access to current health care records	Patients/clients are **able** to access all their current records if and when they choose to, in a format that meets their individual needs
2.	Integration – Patient/professional partnership	Patient /clients are **actively involved in continuously negotiating and influencing** their care
3.	Integration of records – across professional and organisational boundaries	Patients/clients have a **single, structured, multi-professional / agency** record which supports **integrated** care
4.	Holding life long records	**Patients/clients hold** a single, lifelong, multi-professional/ agency record
5	High quality practice – evidence based guidance	Evidence based guidance detailing best practice is available and has an **active and timely review process**
6.	High quality practice	Patients/ clients records demonstrate that their care **follows evidence based guidance or supporting documents** describing best practice, or that there is an **explanation of any variance**
7.	Security / confidentiality	**Patients/clients records are safeguarded** through **explicit** measures with an active and timely review process

Key Sources

- *Access to Health Records Act 1990*. Chapter 23. London: The Stationery Office, 1990.
- Audit Commission for Local Authorities and the National Health Service in England and Wales. *Setting the records straight: a study of hospital medical records*. London: The Stationery Office, 1995.
- Clinical Systems Group. *Improving clinical communications*. Wetherby: Department of Health, 1998.
- *Data protection Act 1998*. Chapter 29. London: The Stationery Office, 1998. http://www.hmso.gov.uk/acts/acts1998/19980029.htm
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- Department of Health. *For the record: managing records in NHS trusts and health authorities*. London: Department of Health, 1999. (Health Service Circular: HSC 1999/053).
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- Moloney R, Maggs C. A systematic review of the relationships between written manual nursing care planning, record keeping and patient outcomes. *Journal of Advanced Nursing* 1999; **30**: 51-57.
- NHS Training Directorate. *Keeping the records straight: a guide to record keeping for nurses, midwives and health visitors*. Bristol: NHS Training Directorate, 1993.
- *Public Records Act 1958*. London: The Stationery Office, 1958.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Guidelines for records and record keeping*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1998.

(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

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Factor 1: - Access to current health care records

Patients/clients are **unable to access** their current records	Patients/clients are **enabled** to access their current records	Patients/clients are **able** to access all their current records if and when they choose to, in a format that meets their individual needs
E	**D C B**	**A**

(See appendix A for questions and answers related to access to records)

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how access is prevented or promoted (including how, where and when records are accessed)
State cost associated with obtaining access.
State systems for storage and retrieval.
State public awareness strategies
State how special patient communication needs are accommodated e.g. language, religious, cultural, age related and special needs
State how staff development needs are assessed and met

Factor 2: - Integration –Patient/Professional Partnership

Records demonstrate: -

Patients/clients care is **prescribed without discussion or without negotiation** with patient/clients and carers	Patients/clients care is prescribed **after discussion but without negotiation** with patient/clients and carers	Patient /clients are **actively involved in continuously negotiating and influencing** their care
E	**D** **C** **B**	**A**

Carers are involved at the request of the patient/ client or if patient/ client is unable to communicate/participate in planning and negotiating their own care

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how evidence of discussions / negotiations are recorded
Describe evidence available to demonstrate that discussions influenced actions
State how the rationale for care and its consequences and alternatives are explained to patients/ clients and carers
State how risk assessment is recorded

Factor 3: - Integration of records – across professional and organisational boundaries

Patients/clients have **no record** of care	For each episode of care patients/clients have a **separate record** compiled by each **different** health profession involved in their care.	Patient/clients have a **single record** which has contributions from different professionals involved in their care but they are **not integrated** (i.e. records entered by one discipline do not influence/ inform others contribution to care).	Patients/clients have a **single, structured, multi-professional / agency** record which supports **integrated** care.
E	**D**	**C**	**B**	**A**

Single Record – One file/ one record with levels of access according to those who 'need to know'
Structure – this may include how ease of access is assured e.g. consideration of chronological entries for client episode or clear linkages/cross references between parts of records
Consider requirements for record keeping as stated by all regulatory professional bodies

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
Describe the common format and how records are made user friendly e.g. how language, religious, cultural, age related and special needs are met
State how it is ensured that records are jargon free, abbreviation free and unambiguous
Describe how relevant stakeholders are identified and involved
Describe how single records are accessed
State evidence available re the auditing of records against regulatory professional standards and / or guidance for record keeping

Factor 4: - Holding life long records

Patients/clients have **multiple** records held by a **variety** of professions and agencies	Patients/clients have **multiple** records held by a **single** agency	Patients/clients have a **single lifelong**, multi-professional/ agency record held by a single organisation		**Patients/clients hold** a single, lifelong, multi-professional/ agency record
E	**D**	**C**	**B**	**A**

Location held - may be virtual (IT, smart card, etc.) and/or physical record (e.g. paper based)

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how this is resourced
State training and education provision to support this
State how this works across private organisations and agencies and for transient populations
Describe how this is achieved e.g. patient held records and how professionals can access these records.

Factor 5: - High Quality Practice – evidence based guidance

There are **no documents** available in support of high quality practice	**Evidence based guidance** detailing best practice is available but there is **no review** process	Evidence based guidance detailing best practice is available and has an **active and timely review process**
E	**D** **C** **B**	**A**

Evidence based guidance = clinical guidelines, policies, procedures, protocols, consensus statements, NICE guidance etc. which are based on best available evidence and have user involvement in their development.
Review Process = locally defined process of reviewing documents taking into account professionals / users/ clients/ patients/ carers views and best available published evidence.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State supporting evidence used
State the level of evidence base used in compiling guidance and the mechanisms for determining best practice e.g. systematic reviews
State how it is ensured that evidence based guidance is inter- disciplinary compiled, accepted and utilised
State the involvement of users in the development of evidence based guidance, including mechanisms for involvement for more vulnerable groups e.g. older people, children, mentally ill, learning disability and minority ethnic communities
Describe the systematic review process used and how it is ensured that guidance remains based upon the latest evidence
Describe the robust and rigorous audit reviews undertaken
State if evidence based guidance is designed for direct use by patients/ clients

Factor 6: - High Quality Practice

Patient / client records **fail** to demonstrate rationale or reference to evidence based guidance or documents describing best practice	Patients /clients records are designed to **support the integrated use** of evidence based guidance and supporting documents of best practice	Patients/ clients records demonstrate that their care **follows evidence based guidance or supporting documents** describing best practice, or that there is an **explanation of any variance**
E	**D** **C** **B**	**A**

NB Attainment of best practice in this factor is dependent upon attainment of best practice in Factor 5
Evidence based guidance / supporting documents describing best practice, = clinical guidelines, policies, procedures, protocols, consensus statements, etc. which are based on best available evidence and have user involvement in their development e.g. local work, published guidelines, Royal Colleges, NICE, etc. They should have local ownership, review and implementation procedures.
Integrated use of evidence based guidance / supporting documents = may include care pathways, proforma's and checklists as part of the predetermined documentation.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the evidence based guidance / supporting documents used
State how variance is recorded
State how variance recorded is analysed and used to inform changes in specific patient records and supporting information.
State what evidence there is of robust and rigorous clinical audit review e.g. peer review of quality and content of documentation

Factor 7: - Security / Confidentiality

Patients and clients records are **not safeguarded**	Patients and clients records are safeguarded through **implicit** arrangements	Patients and clients records are safeguarded through **explicit** measures	Patients and clients records are safeguarded through **explicit** measures with an **active and timely review** process.
E	**D**	**C**	**B**	**A**

Explicit measures =Includes policies, procedures and clarification of levels of access (this includes electronic levels of access) and the role of Caldicott Guardians.
Implicit = includes measures undertaken by individual practitioners that are not subject to formal policies or procedures.
Active and timely review process = including complaints audit, surveys, Caldicott audits and reviews, etc.
Authorised = Professional who the patients could reasonably expect to have access to their records, for the purposes of their care and /or have given their explicit permission.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State what guidelines are available to ensure that all staff safeguard access to records (HSC 1999/053 p 3.9)
State how patients are made fully aware that NHS staff and sometimes staff of other agencies need to have strictly controlled access to such information, anonymised wherever possible in order to deliver / plan and manage services effectively (HSC 96/18)
State the arrangements for ensuring that patients are personally made aware of the purposes to which information about them may be put as well as ways in which they can exercise choice.
State how records are stored whilst in use and archived.
Describe mechanisms used for identifying those who 'need to know' and how access is limited to the relevant parts of the records rather than the whole record.
Describe the robust and rigorous audits and Caldicott reviews undertaken.

Appendix A: - Useful questions and answers.

Why does the benchmark not offer advice regarding content or framework for documentation?

Record keeping is an integral part of practice. It is not separate from the care process and it is not an optional extra to be fitted in if circumstances allow (UKCC1998).
What should be documented and how it should be documented e.g. legible, accurate and up to date, etc. is how records MUST be. It would be inappropriate to have stepping stones for attainment.

Are records confidential?

The legal obligations of healthcare professionals who deal with confidential information supplied to them by patients is now largely codified by statute. In particular, the introduction of the Data Protection Act 1998 which implements the 1995 European Community Data Protection Directive means that the use of personal information held on manual as well as computer records is governed by statute.

All NHS bodies have a common law duty of confidentiality. Personal information about patients held by health professionals is subject to a legal duty of confidence and should not be disclosed without the consent of the "subject". Imparting any information without the consent of the subject would be a breach of confidence

Confidentiality should only be broken in exceptional circumstances and only after very careful consideration that such actions can be justified. The categories where a breach of confidence may be justified include giving evidence in court, statements made in the paramount interests of a child to legitimate inquirers, and in the public interest. The courts normally balance the public interests favoring confidentiality against those advising disclosure in the particular circumstances of each case.

- *The Trust should ensure that local procedures are in place relating to confidentiality and setting out the principles governing the appropriate sharing of information, as per the Health Service Circular HSC 2000/009: Data Protection Act 1998:*
- *In certain circumstances, it may be necessary to disclose or exchange personal information about an individual. This will need to be in accordance with the Data Protection Act 1998.*
- *Article 8 of the Human Rights Act 1998 will guarantee an individual's right to respect for his private family and family life, his home and correspondence. An individual's medical records forms an intimate part of his or her private life and the disclosure of such records unless it can be justified will constitute a breach of Article 8.*

Who can see records? (of living individuals)

The patient, in other words the "subject" of the record may request to see his/ her records if it is considered to be in the patient's best interests and the request has been made in writing. The NHS Trust, for the purposes of the Data protection Act 1998 is the 'Data Controller'.

Do patients/clients have to pay to see their own records?

If the patient (subject) wishes only to have sight of the records but make no permanent copy, then a fee MAY not be charged. A maximum fee of £50.00 may be charged for granting the subject access to manual or to a mixture of manual and automated records where the patient (subject) requires a copy of the information in permanent form.

Who can access records after a patient dies?

Where the patient has died the patient's personal representative and any person who may have a claim arising out of the patient's death can apply to access the subject's records.

Who is classed as a health professional?

The Data Protection Act 1998 s69 (1) defines "Heath professional" as: -
(1)(a) a registered medical practitioner
(b) a registered dentists as defined by section 53(1) of the Dentists Act 1984
(c) a registered optician as defined by section 36(1) of the Opticians Act 1989
(d) a registered pharmaceutical chemist as defined by section 24(1) of the Pharmacy Act 1954 or a registered person as defined by Article 2(2) of the Pharmacy
(Northern Ireland) Order 1976

(e) a registered nurse, midwife or health visitor
(f) a registered osteopath as defined by section 41 of the Osteopaths Act 1993
(g) a registered chiropractor as defined by section 43 of the Chiropractors Act 1994
(h) any person who is registered as a member of a profession to which the Professions Supplementary to Medicine Act 1960 for the time being extends
(i) a clinical psychologists, child psychotherapist or speech therapist
(j) a music therapist employed by a health service body, and
(k) a scientist employed by such a body as head of a department

What is a Caldicott Guardian?

The Caldicott Review recommended that guardians of patient information should be created to safeguard and govern the uses made of confidential patient information within the NHS organisations. Caldicott guardians are appointed in each Health Authority, Special Health Authorities, NHS Trust and PCG's. (HSC 1999/012)

COMPARISON GROUP INFORMATION

For: -
RECORD KEEPING

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

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Facilitator:-
Agreed Vision
Ground Rules:
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Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

SCORING SHEET

RECORD KEEPING

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____ (insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Access to current health care records** Why score chosen / How Justified?

SCORE :	**2 :- Integration –Patient/professional partnership** Why score chosen / How Justified?

SCORE :	**3:- Integration of records – across professional and organisational boundaries** Why score chosen / How Justified?

SCORE :	**4 :- Holding life long records** Why score chosen / How Justified?

SCORE :	**5 :- High quality practice – evidence based guidance** Why score chosen / How Justified?
SCORE :	**6 :- High quality practice** Why score chosen / How Justified?
SCORE :	**7 :- Security / confidentiality** Why score chosen / How Justified?

COMPARISON GROUP COLLATED SCORES

RECORD KEEPING

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= Patients/clients are able to access all their current records if and when they choose to, in a format that meets their individual needs

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Patient /clients are actively involved in continuously negotiating and influencing their care

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= Patients/clients have a single, structured, multi-professional / agency record which supports integrated care

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

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4:-A= Patients/clients hold a single, lifelong, multi-professional/ agency record		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= Evidence based guidance detailing best practice is available and has an active and timely review process		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= Patients/ clients records demonstrate that their care follows evidence based guidance, or supporting documents describing best practice, or that there is an explanation of any variance		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

7:-A= Patients/clients records are safeguarded through explicit measures with an active and timely review process		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

RECORD KEEPING

COMPILED BY: - _____ __ / __ / __

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

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AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	By whom	Date to complete	REFLECTION

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PRIVACY AND DIGNITY

Privacy = Freedom from intrusion
Dignity = Being worthy of respect

Agreed Patient Client Focused Outcome		
Patients / Clients benefit from care that is focused upon respect for the individual		
Indicators / Information that highlights concerns which may trigger the need for benchmarking activity :		
Patient / Client Satisfaction Surveys Complaints figures and analysis Patient/ client diary analysis Audit results of related policies/ standards e.g. environmental audits, accommodation audits, pastoral care audits, interpreter usage, Patients Charter/ Guide audits Risk assessments		Educational audits/ student placement feedback Litigation / Clinical Negligence Scheme for Trusts Professional Concerns Media Reports Commission for Health Improvements reports
	FACTOR	BENCHMARK OF BEST PRACTICE
1.	Attitudes and behaviours	Patients /clients **feel that they matter** all of the time.
2.	Personal world / Personal identity	Patients/clients experience care in an environment that **actively encompasses** individual values, beliefs and personal relationships
3.	Personal boundaries / space	Patients / Clients personal space is **actively promoted by all staff**
4.	Communicating with patients/clients	Communication between patients / clients takes place in a **manner which respects their individuality**
5.	Privacy of patient – confidentiality of client information	Patient /client information is **shared to enable care, with** their **consent**
6.	Privacy, Dignity and Modesty	Patients/clients cared **actively promotes their privacy and dignity , and protects their modesty**
7.	Availability of an area for complete privacy	Patients / clients / carers **can access** an area that safely provides privacy

Key Sources

- Department of Health. *For the record: managing records in NHS trusts and health authorities.* London: Department of Health, 1999. (Health Service Circular: HSC 1999/053).
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- United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Code of professional conduct for the nurse, midwife and health visitor.* 3rd ed. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1992.
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(Additional sources /references used at initial compilation can be accessed on the Web site or disc)

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Factor 1: - Attitudes and behaviours

Patients / clients experience **deliberate** negative and offensive attitude and behaviour	Patients / clients experience **thoughtless** behaviour and careless insensitive attitude	Patients / clients **experience a sensitive, empathetic attitude on an ad hoc basis** (at certain incidents/event)		Patients /client's feel that they **matter** all of the time.
E	**D**	**C**	**B**	**A**

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how effective leadership is assured
Describe how good attitudes and behaviour are promoted and assured (including consideration of non verbal behaviour and body language)
State how these issues (including attitudes and behaviour towards minority groups, e.g. black and minority ethnic communities) are addressed with individual staff e.g. induction programmes, preceptorship, Individual Performance Review / Appraisal
State the philosophy/ strategies that support practice (e.g. mission statements)
State how patient/client views are sought and used e.g. focus groups, surveys, partnership strategies, feedback groups, advocacy arrangements
State what policies are in place to address specific ethnic/cultural/religious/spiritual/ linguistic, age related and particular needs
State the process for monitoring, feedback and actioning of complaints
State how partnerships with others will support the promotion of good attitudes and behaviours.

Factor 2: - Personal world / Personal Identity

Patients /clients individual values, beliefs and personal relationships are **never explored**	Patients /clients individual values, beliefs and personal relationships **are considered but not acted upon**	Patients /clients **experience care** from individual practitioners that is relevant, sensitive and responsive to individual values, beliefs and personal relationships.		Patients / clients experience care in an environment that **actively encompasses** respect for individual values, beliefs and personal relationships.
E	**D**	**C**	**B**	**A**

Personal World: - 'To look at a patient holistically, not only have they got physical needs, but social, spiritual and emotional needs, and they live in the context of who they are, their family, their lifestyle. All of that is going to affect how they respond to the illness they have'. *(Liane Jones: Handle with care, a year in the life of 12 nurses)*

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how stereotype views are challenged.
State how the valuing of diversities is demonstrated
State how individuals needs and choices are ascertained and continuously reviewed
State education and training available to increase staff awareness
State what policies are in use regarding values and beliefs e.g. religious, cultural, sexual, age and special needs equality

Factor 3: - Personal boundaries / space

Patients/ clients personal boundaries are **deliberately invaded**	Patients / clients personal boundaries are **thoughtlessly invaded**	Patients / clients personal boundaries/space is **respected**	Patients / clients personal space is **actively promoted** by all staff
E	**D**	**C**	**B**	**A**

(Link specifically to Privacy and Dignity - Factor 6 & 7)
Personal Space: Patient /client sets boundaries for psychological, physical, emotional and spiritual contact.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how the name the patient / client wants to be called is agreed
State how the acceptability of personal contact (touch) is identified with individual patients /clients
State how the patient's /client's personal boundaries are identified and communicated to others (including the use of patients own language).
State how personal space is respected and protected for individuals
State the philosophy of care and what policies and procedures, education and training is in place to prevent disturbing, interrupting patients e.g. knocking before entering, sign on closed curtains requesting practitioners/professionals and staff seek permission of patient before entering
State how privacy is effectively maintained e.g. curtains, screens, walls, rooms, use of blankets, appropriate clothing, appropriate positioning of patient etc.
State the provision of single sex facilities, access to segregated toilet and washing facilities, age specific facilities
State how clinical risk is handled in relation to privacy.
State how privacy is achieved at times when the presence of others is required
State what type of clothing is available for patients who cannot wear their own clothes, how is their modesty protected
State what policies are in place for patients to have access to their own clothes
State how modesty is achieved for those in transit to differing care environments
State policies in place for chaperoning of patients. State evidence of audit
Describe how the use of policies and procedures and evidence based guidelines are audited

Factor 4: - Communicating with patients/clients

Patients/ clients are **communicated at.**	Patients / clients are **communicated with** but the means of communication **fails to take in to account their individual needs**.	Communication between staff and patients / clients takes place in a **manner which respects their individuality**
E	**D C B**	**A**

Communicated at: Talked at, talked over, assumptions made re the patient's level of understanding.
Communicated with: Listened to, individual needs and views taken in to account, respected as a person, demonstrates caring and concern, correct pace and level and means e.g. format
Manner: How the communication takes place
Pace and level: Speed, repetition and explanation to ensure understanding

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patients/clients views and needs are ascertained and recorded
State how special needs are met (e.g. ethnic / cultural needs, sensory and physical disability, age related needs)
State access to translation and interpretation and how the quality is maintained
State how information is adapted to meet the needs of individual patients
State the education, training and ongoing reflection opportunities that are in place to develop and enhance communication skills (including verbal and non verbal communication and the use of interpreters) and state what records are maintained

Factor 5: - Privacy of patient – confidentiality of client information

Patients /clients information **enters the public domain without** their **consent.**	Patients /clients information is shared **to enable care,** but without their consent	Patient /client information is shared to enable care, **with** their consent,
E	**D** **C** **B**	**A**

NB this includes 'careless talk'
See benchmark on Record Keeping for issues re written records e.g. storage and access to documentation.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how patient /client consent is sought to ensure informed and special measures to overcome communication barriers e.g. use of trained interpreters
State how confidentiality is assured e.g. policies in use
State the precautions that are taken to prevent information being shared e.g. telephone conversation being overheard, computer screens being viewed, white boards being read
State how confidentiality is covered in multidisciplinary training and education including induction programmes, preceptorship, supervision and PDP's.
State procedures for sending /receiving patient information e.g. hand-over procedures, consultant and/or teaching rounds, admission procedures, telephone calls, calling patients in outpatients, breaking bad news etc
State evidence of audit of complaints and how matters of confidentiality are addressed

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Factor 6: - Privacy / Dignity / Modesty

Patients / clients privacy, dignity and modesty are **not considered**	Patients / clients privacy, dignity and modesty **is considered at times of care** / treatment interventions.	Patients / clients privacy, dignity and modesty is considered at times of care / treatment interventions **and on request.**	Patients / clients care **actively promotes** their privacy and dignity and **protects** their modesty.
E	**D**	**C**	**B**	**A**

Privacy: - Freedom from intrusion
Dignity: - Being worthy of respect
Modesty: - Not being embarrassed

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State the philosophy and strategies that exist to actively promote privacy and dignity and to protect a patients/clients dignity.
Describe the training, education and ongoing review of professional practice in relation to the promotion of a patients/clients privacy and dignity and protection of their modesty (including supervision, appraisal and PDP's and awareness of specific needs).
Describe how patients are protected from unwanted public view e.g. curtains, screens, walls, clothes/covers, etc.
State what type of clothing is available for patients who cannot wear their own clothes, how is their modesty protected
State what policies are in place for patients to have access to their own clothes
Describe how privacy in access to a telephone is achieved

Factor 7: - Availability of an area for privacy

Patients / clients are **denied** access to any area which offers privacy.	Patients / clients have access to an area that provides privacy when receiving care or treatment			Patients / clients can access an area that safely provides privacy
E	**D**	**C**	**B**	**A**

Access includes includes physical facilities e.g. quiet room, access to gardens, for patients and relatives, but should be conducive to different needs e.g. if patient on ITU, child protection.
Privacy includes comfort and sound proofing etc.

Evidence which comparison group members agree would justify best practice (A):-
Possibly to include - 1.Policies, Procedures and Guidelines + 2. Staffing and workforce + 3.Education, training & development + 4. Information/ Communication + 5.Resources: - Facilities & Equipment + 6. Specificity to Patient / Client needs (include ethnic / cultural / age related/ special needs) + 7. Partnership working with clients, carers, multidisciplinary teams, social care, etc.
Evidence: *(To be completed by comparison group members for like to like comparison)*

Statements to stimulate comparison group discussion around best practice:-
State how an area is created (in patients /clients homes as well as health service settings)
State how and when patients /clients are informed of the availability of 'quiet' and /or private space. E.g. at orientation, in leaflet, at admission etc.
State the barriers that exist that restrict the provision of an area of privacy
State the areas available
State how clinical risk is handled in relation to complete privacy

COMPARISON GROUP INFORMATION

For: -
PRIVACY AND DIGNITY

Comparison Group for:- (insert name of team / ward / unit / area / directorate/ group / trust / region)		
Comparison Group Lead Member:-		
Comparison Group Members:-		
Name	**Representing**	**Contact details**

Facilitator:-
Agreed Vision
Ground Rules:
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Comparison group meetings:-			
Date	Time	Location	Aspect/s of care to be discussed

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SCORING SHEET

PRIVACY AND DIGNITY

Score relates to practice by / on / in:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)		
Comparison Group Lead Member:-	**Date to be scored:-** - -/- -/ - - **By:-** _____ (insert name)	**Date form to be returned:-** - -/ - - / - -

Scored by:-	**Date Scored:-** - -/ - - / - -	**Copied:- Y/N**	**Posted on :-** - - / - - / - -

Date Comparison group meeting to share good practice and compile action plan: - - - / - - / - - **To be attended by :-** _____ (insert name)	**Re-score date agreed :-** - -/ - - / - -

SCORE :	**1:- Attitudes and behaviours** Why score chosen / How Justified?
SCORE :	**2 :- Personal world / Personal identity** Why score chosen / How Justified?
SCORE :	**3:- Personal boundaries / space** Why score chosen / How Justified?
SCORE :	**4 :- Communicating with patients/clients** Why score chosen / How Justified?

SCORE :	**5 :- Privacy of patient – confidentiality of client information** Why score chosen / How Justified?
SCORE :	**6 :- Privacy, Dignity and Modesty** Why score chosen / How Justified?
SCORE :	**7 :- Availability of an area for complete privacy** Why score chosen / How Justified?

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COMPARISON GROUP COLLATED SCORES

PRIVACY AND DIGNITY

Comparison Group:- (Self/ Team / Practice / Ward / Area/ Directorate/ Trust)	Date scored:- - -/- -/ - -	Date of Comparison Group meeting:- - -/ - - / - -

1:-A= Patients /clients feel that they matter all of the time

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

2:-A= Patients/clients experience care in an environment that actively encompasses individual values, beliefs and personal relationships

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

3:-A= Patients / Clients personal space is actively promoted by all staff

Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

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4:-A= Communication between patients / clients takes place in a manner which respects their individuality		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
5:-A= Patient /client information is shared to enable care, with their consent		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*
6:-A= Patients/clients cared actively promotes their privacy and dignity , and protects their modesty		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

7:-A= Patients / clients / carers can access an area that safely provides privacy		
Score Order A-E	**Member** (name/code)	*Why score chosen / How justified?*

ACTION PLANNED TO DEVELOP PRACTICE

PRIVACY AND DIGNITY

COMPILED BY: - _____ - _ _ / _ _ / _ _

FOR: - (Self / Team / Trust / Region) _____

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

AIM:- PATIENT FOCUSED BEST PRACTICE =			Related factors
ACTION REQUIRED	**By whom**	**Date to complete**	**REFLECTION**

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