The Christie

Care
Observation
Documentation
Experience

Quality Scheme

Celebrating Excellence in Care

Contents

Contacts

If you have a query on the standards or assessment process, which is not covered by this manual, please contact your ward manager or link nurse in the first instance. If you then require further support contact the Quality & Standards Team.

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Introduction

The Christie specialises in cancer treatment, research and education and is the largest cancer centre in Europe. Treating 40,000 patients a year from across the UK, it became the first UK centre to be officially accredited as a comprehensive cancer centre and has its own dedicated hospital charity. The Christie employs 2,500 staff, all of whom are determined to provide the best possible cancer care and patient experience.

Whilst acknowledging the unassailable importance of The Francis, Cavendish, Berwick and Keogh Reports as major drivers for quality and change across the NHS, The Christie has a long standing ethos of quality being central to all that it does.

Our organisation is committed to improving quality and delivering safe, effective and personal care, within a culture of learning and continuous service improvement. The Christie CODE Quality Scheme is our framework for measuring the quality of CARE provided to patients by OBSERVATION, clear DOCUMENTATION and patient and staff EXPERIENCE.

We strive to strengthen professional leadership, empower doctors, nurses, allied health professionals and all our other clinical and non-clinical staff to lead and deliver quality improvements. This builds on the positive and proactive work that has already been undertaken to maintain patient safety, deliver effective treatments and enhance the patient experience. We will continue in our drive to improve the quality of care for our patients whilst ensuring cost effectiveness and efficiency through the creative use of finite resources. And as with everything we do at The Christie our service is underpinned by meaningful communication and the provision of care by compassionate, committed, and competent staff.

Jackie Bird

Jackie Bird
Executive Director of Nursing & Quality

Principles underpinning the CODE quality scheme

- To put patients at the centre of everything we do
- To celebrate excellence
- To demonstrate commitment to quality improvement
- To have methodological rigour and draw on the evidence base in the development of standards and in the process used to assess levels of performance
- To share best practice
- To be inclusive of all multi-disciplinary staff who make a substantial contribution to the delivery of clinical care
- To engage learners in the quality improvement process for better patient care
- To demonstrate The Christie Commitment

Measurement approach

The CODE quality scheme applies a range of measurement approaches based on The Christie CODE fundamentals of care standards, including:

- Structured and unstructured interviews with patients and carers
- Structured and unstructured interviews with staff of all grades and disciplines
- Observation of practice
- Inspection of facilities and care environments
- Case presentations to quality scheme panel

Why the CODE quality scheme has been developed

The CODE quality scheme is designed to:

- Improve the quality and safety of the care provided to patients and support offered to staff
- Provide a framework within which to focus activities in order to support the delivery of quality improvements in patient care , organisational governance and the safety of patients
- Contribute to embedding quality improvement into the organisations culture
- Reflect the areas requiring further intervention and enable wards teams to determine how to manage their own patient care concerns
- Encourage and support ward teams in taking a proactive approach to quality improvement
- To embed The Christie fundamental of care standards into the organisation

How the standards were developed and reviewed

The standards contained within this manual are reviewed and updated annually as a minimum. A revised version is published on the Quality & Standards intranet page.

The standards were originally developed to underpin the quality walk round schedule. The 12 initial standards covered the fundamental of nursing care. Each standard is based on current evidence of best practice, national legislation, and regulatory guidance. During the development of the quality scheme 2 additional standards were written for management and leadership.

Stakeholders involved in the development and review process

A wide range of Christie staff, medical, nursing and allied health professionals, contributed to, and were consulted on, the development of the standards and the assessment process.

The Standards

14 standards of fundamental care, clinical leadership and management must be met to a defined level to achieve **Gold Embrace Quality Scheme Accreditation**

- Care Environment & Infection Prevention and Control
- Communication
- Falls Prevention
- Leadership
- Management
- Medicines Management
- Nutrition & Hydration
- Pain
- Personal Care
- Pressure Ulcer Prevention
- Privacy & Dignity
- Record Keeping
- Safeguarding
- Sleep & Rest

Assessment levels and timescales

Each of the 14 standards contains a number of statements which describe the care we would expect patients to receive at The Christie.

Compliance against these standards will be measured in a variety of ways in order to gather a full picture of the care delivered at ward level. This includes:

- 11 patient questionnaires
- A staff questionnaire
- Data extraction from the clinical web portal (CWP)
- Inspection within the clinical area
- Datix reports
- Electronic Staff Record (ESR)
- Ward dashboards
- School of Oncology database
- Audit results
- Harms data (100 days free from non attributable harm – Pressure ulcer grade 2+, fall (moderate), MRSA & Clostridium Difficile

Compliance against each statement will be scored, resulting in a rating of **Gold**, **Green** or **Red** for that particular standard.

The individual ratings are then aggregated to provide an overall rating for the ward.

Gold status = 10 or more gold standards, no red standards

Green status = All standards green or gold

Red status = One or more standards red

Example standard and score

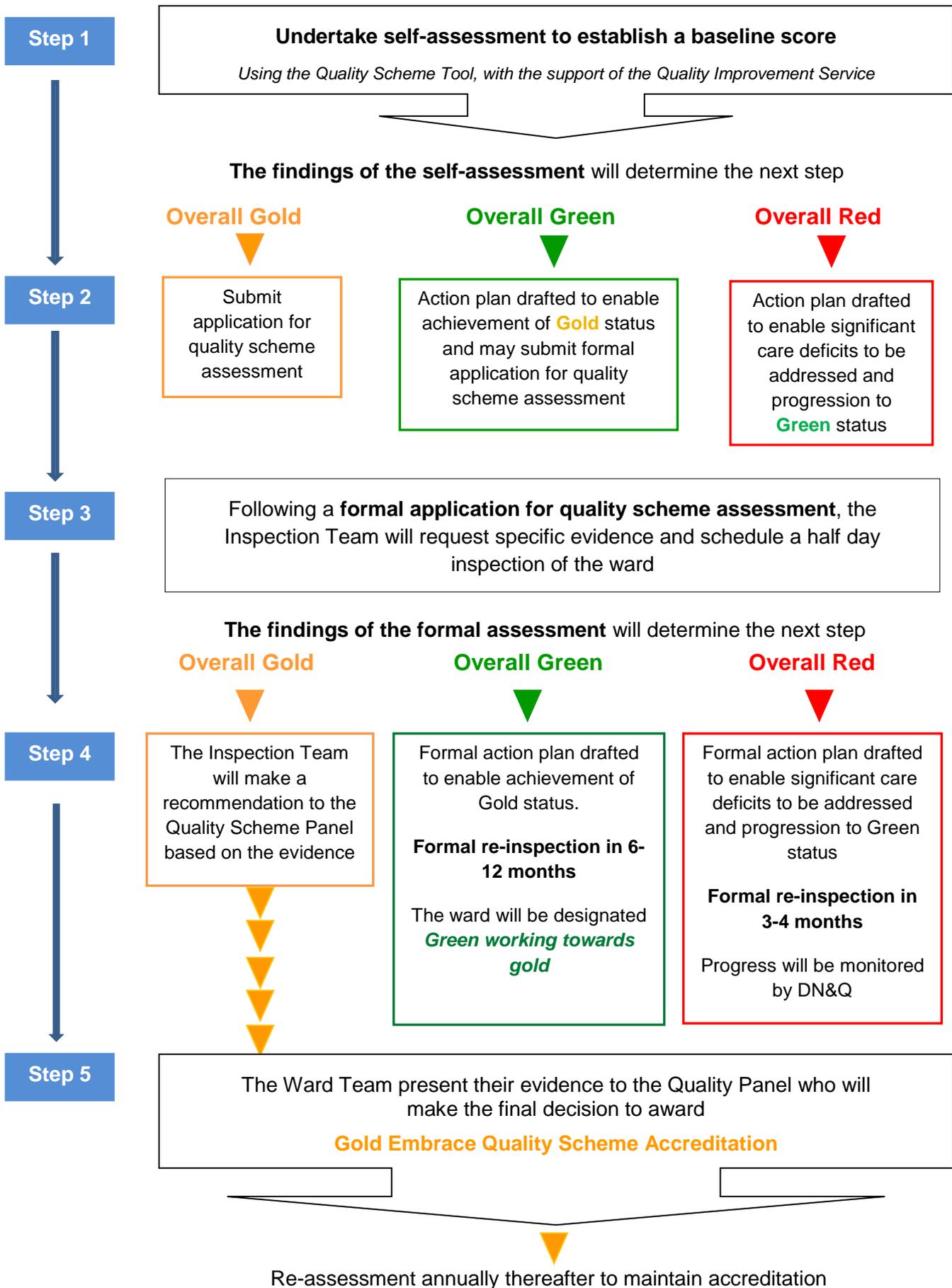| Medicines Management							Overall % score for statement
Standard Statements	**Evidence Measures** PEQ - Patient Experience Question Dtx - Datix data [Yes=100% No = 0%] Ob - Observation [Yes=100% No = 0%] DQ - Documentation Question SEQ - Staff Experience Question						(Average of all measures scores) **GGR Rating** Gold ≥ 90% Green 80-89% Red < 80%
1 Patients have their medicines at the times they need them, and in a safe way	PEQ4	PEQ5	PEQ7	SEQ2			91
	90	100	100	75			

Timescales

Initial baseline assessment will be completed within 6 months

Work towards **Gold** status can take up to 12 – 18 months

Standards at **Gold** level must be maintained for 100 days before applying for **Gold** quality status

Quality process – a step by step guide

Step 1 — Undertake self-assessment to establish a baseline score

Using the Quality Scheme Tool, with the support of the Quality Improvement Service

The findings of the self-assessment will determine the next step

Overall Gold ▼ **Overall Green** ▼ **Overall Red** ▼

Step 2

Overall Gold	Overall Green	Overall Red
Submit application for quality scheme assessment	Action plan drafted to enable achievement of **Gold** status and may submit formal application for quality scheme assessment	Action plan drafted to enable significant care deficits to be addressed and progression to **Green** status

Step 3 — Following a **formal application for quality scheme assessment**, the Inspection Team will request specific evidence and schedule a half day inspection of the ward

The findings of the formal assessment will determine the next step

Overall Gold ▼ **Overall Green** ▼ **Overall Red** ▼

Step 4

Overall Gold	Overall Green	Overall Red
The Inspection Team will make a recommendation to the Quality Scheme Panel based on the evidence	Formal action plan drafted to enable achievement of Gold status. **Formal re-inspection in 6-12 months** The ward will be designated *Green working towards gold*	Formal action plan drafted to enable significant care deficits to be addressed and progression to Green status **Formal re-inspection in 3-4 months** Progress will be monitored by DN&Q

Step 5 — The Ward Team present their evidence to the Quality Panel who will make the final decision to award

Gold Embrace Quality Scheme Accreditation

▼

Re-assessment annually thereafter to maintain accreditation

Establishing the baseline

The ward team with the support of the quality and standards team will establish their baseline score by utilising the data collection tools and inputting the results into the electronic evidence tool.

The electronic evidence tool will automatically generate an on-going rating to enable the team to see their progress towards Gold status.

Application for quality scheme assessment

Once the ward is satisfied that they have sufficient evidence to meet the standards for gold status and have 100 harm free days they can apply for a formal inspection by contacting the quality and standards team.

Quality scheme inspection

A team of no more than 10 members will undertake a ward based inspection, which will take approximately half a day. During the inspection the team will use the standard tools to 'test' the evidence provided by the ward team.

The team will comprise of:

Quality & Standards Team

Medical Representative

Allied Health Professional Representative

Night Manager (to undertake night-time inspection)

A trust governor

Advanced Nurse (CNS/AP)

General Staff Nurse

Student Nurse/Practice Education Facilitator

Recommendation to the quality scheme panel

Following a successful inspection the Quality & Standards Team will recommend the ward team is put forward to the quality scheme panel.

The quality scheme panel will comprise of:

Director of Nursing & Quality

Medical Director or delegated deputy

Non-Executive Director

Director of Finance & Business Development or delegated deputy

Director of Human Resources or delegated deputy

Patient Representative

'Quality Scheme Panels' will be held at set dates twice a year.

The team will be expected to present evidence to support their application for **Gold** accreditation to the quality scheme panel.

The quality scheme panel will collectively assess the evidence and the presentation made by the team in order to judge if the area has met the requirements of a **Gold** status accreditation.

Achievement of Gold Status

The ward will be recognised across the Trust as having achieved a **Gold** status standard of care.

This will be recognised by:

- An engraved plaque denoting the achievement at ward level
- A certificate and Trust pin badge for every member of the ward team
- The procurement of a piece of equipment/activity chosen by the ward team that will enhance the working environment of the staff or the experience for patients (i.e. new décor, drinks machine etc.)

Care Environment & Infection Prevention and Control

Elements

Cleanliness
Safety
Atmosphere

Standards of Care Statements

○ Patients feel comfortable, safe, reassured, confident and welcome

○ Patients experience care in a tidy, well-maintained area

○ Patients experience care in a consistently clean environment

○ Patients feel confident that infection control precautions are in place

○ Patient's personal environment is managed to meet their needs

Evidence Base & Other Relevant Documents

○ Essence of Care (2010) – Care Environment Benchmark

○ NHS Institute for Innovation and Improvement (2012) – The 15 Step Challenge

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Was your first impression of the ward when you arrived a positive one?

Q2. When you first arrived on the ward did the ward staff make you feel welcome?

Q3. When you first arrived, were you made familiar with the ward?

Q4. Is the tidiness and general maintenance of the ward (décor, fixtures and fittings etc.) of an acceptable standard?

Q5. In your opinion is the ward clean?

Q6. Do staff try to ensure that the ward temperature is as comfortable as possible for you given the constraints of the ward environment?

Q7. Do you feel confident that infection control measures are in place and followed (e.g. staff wash their hands between delivering care to different patients, equipment is cleaned between use)?

Q8. Do you feel that the ward is as quiet as it possibly could be at night?

Q9. In general, are the staff approachable, courteous and friendly?

Q10. In general, are the staff visible and easily accessible on the ward?

Q11. In general, do the staff respond to your needs in a supportive, timely and willing manner?

Q12. In general, are staff neat, tidy and professional in appearance?

Q13. Are you confident about the competence of ward staff to do their jobs?

Q14. Overall, do you have a positive impression of the ward in which you are receiving your

care?

Observation (Ob)

1. Do ward staff immediately welcome patients & carers into the ward?

2. Do ward staff respond to patients' or carers requests for assistance in a timely and willing manner?

3. Are staff visible, well presented (in keeping with uniform policy), professional and easily identifiable?

4. Is the ward environment tidy, clutter free, and well maintained?

5. Is the ward clean and free from avoidable, unwanted odours?

6. Are patients' bed areas clean, tidy and clutter free; and enable safe care delivery?

7. Is ward 'traffic' and noise managed effectively to minimise disruption and allow patients adequate rest?

8. Are meal-times protected from unnecessary interruption?

9. Infection Control precautions are in place?

Audits

1. IPC – Environment audit

2. IPC – Ward kitchen audit

3. IPC – Sharps handling & disposal audit

4. Saving lives – Hand hygiene

5. Saving lives – Preventing surgical site infection

6. Saving lives – IV cannula insertion

7. Saving lives – IV cannula on-going care

8. Saving lives – CVC on-going care

9. Surviving sepsis guidelines

Outcomes

o   No Accredited C.Dif for 100 days

o   No MRSA bacteraemia for 100 days

Communication	Elements
	Verbal Non-verbal Written Provision of Information

Standards of Care Statements

○ Patients' communication needs are assessed on admission and re-evaluated on a regular basis

○ Equipment and resources to aid communication are identified and provided for (including interpreter service

○ Information is provided to patients in accessible format (e.g. audio, video, large print text, easy read text, text in other languages etc.)

○ Patients are enabled to communicate their individual needs and preferences at all times

○ The views of patients and carers are listened to, valued and respected and used to improve practice and care

○ Staff demonstrate effective interpersonal skills when communicating with patients and carers

○ Communication is managed effectively and sensitively including potentially difficult communications such as breaking bad news or in hostile situations

○ Staff are courteous at all times

○ Staff use body language appropriately and effectively in non-verbal communications

○ Staff communicate in an open and honest way

○ Staff are non-judgemental in their communications

○ Staff use straightforward language when communicating with patients and carers

○ Communication is adapted to meet the needs of patients and carers (taking into consideration physical and cognitive factors, emotional state of patient/carer, and providing for other languages)

○ The ward/department environment provides for different communication needs (lighting, privacy, acoustic conditions etc.)

○ Confidentiality is protected during communications

○ Staff communicate fully and effectively with each other, to ensure seamless care for the patient (including verbal and written communication)

Evidence Base & Other Relevant Documents

○ Essence of Care (2010) – Communication Benchmark

○ Being Open Policy

○ Policy for Breaking Bad News to Patients and Carers

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Do you feel that on this ward you are listened to and your views are valued and respected?

Q2. Is information provided to you in ways and forms that you can understand? (e.g. written information that meets your needs, use of straightforward language when explaining things)?

Q3. Have you found staff to be courteous and appropriately sensitive when they talk with you?

Q4. Do you feel that staff are open and honest when they talk with you?

Q5. Do you feel that staff make every effort to protect your privacy during conversations with you?

Q6. Overall are you happy with how staff communicate with you?

Observation (Ob)

1. Staff introduce themselves when answering the telephone and are polite/courteous

2. During face to face communication with patients, staff demonstrate effective interpersonal skills

3. Confidentiality is respected during communications

4. Inter-staff communications – for example during handover – are adequately comprehensive and effective for enabling seamless care to be delivered

Documentation (D)

Q1. An assessment of communication needs has been undertaken on admission

Q2. Nursing documentation reflects on-going re-evaluation of the patient's communication needs for those identified as having communication issues on initial assessment

Q3. Equipment or resources to aid communication are identified as appropriate

Q4. There is documentary evidence that the interpreter service was used if appropriate

Staff Experience (SE)

Q1 Do you feel the nursing documentation system provides a means of effective written communication between staff on the delivery of care to the patient?

Falls Prevention

Standards of Care Statements

○ Patients are orientated to the clinical environment on admission

○ Patients are falls risk-assessed on admission

○ A falls prevention care plan is initiated for patient assessed to be at-risk

○ Patients' falls histories are documented on admission and they are asked about any fears, anxieties, worries, concerns regarding falling or that they might fall Patients are asked on admission about any fears, anxieties, worries, concerns regarding falling or that they might fall

○ Incontinence, urinary or bowel frequency and/or urgency are detected during the admission assessment of patients and factored into falls prevention care planning

○ Patients are falls re-risk assessed a minimum of weekly

○ Patients are re-risk assessed

  • Following a fall
  • If and when the patient's condition changes significantly
  • Post-operatively
  • Following transfer from one ward /dept to another

○ Patients' personal property and nurse call bell are within easy reach

○ Patients' footwear is appropriate and safe

○ Public areas in the ward/department are hazard and clutter free

○ Any unavoidable/unintentional hazards (e.g. wet floor surfaces during cleaning) are clearly sign posted

○ Patients' moving and handling requirements are clearly documented in the nursing care plan

○ Patients are provided with requisite walking aids

○ Patients at risk of confusion/showing signs of confusion (including those with known or suspected dementia) have a confusion checklist completed daily and a care plan initiated as appropriate

Evidence Base & Other Relevant Documents

○ Royal College of Physicians (2012) Implementing FallSafe: Care bundles to reduce inpatient falls

○ NICE Guidance CG21: The assessment and prevention of falls in older people

○ Slips, Trips and Falls Policy

○ High Impact Action: Staying Safe, Preventing Falls

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. When you were admitted to the ward were you told where things were? e.g. the toilets, bathroom, dayroom, etc.

Q2. When you were admitted to the ward were you asked about whether you have had any previous falls or dizzy spells, either at home or in hospital?

Q3. When you were admitted to the ward were you asked whether you had any anxieties or worries about falling?

Q4. Do you feel safe from the risk of falling when moving around the ward?

Q5. Do you feel that you have the necessary equipment to help you move safely around the ward (e.g. walking stick or frame)?

Q6. Do you feel that you receive the necessary help from staff to enable you to move safely around the ward?

Observation (Ob)

1. Patient/public areas are hazard and clutter free

2. Unavoidable hazards e.g. wet floor during cleaning, are clearly sign-posted

3. Patients have safe, appropriate foot wear

4. Patient call bells are in easy reach

Documentation (D)

Q1. A falls risk assessment has been undertaken on admission

Q2. A falls prevention care plan has been initiated for patients identified to be at risk

Q3. The patient's falls history has been documented

Q4. The patient has been re-risk assessed a minimum of every 7 days

Q5. The patient has been re-risk assessed following a fall, or a significant change in condition, pre-operatively or following transfer from another ward/department

Q6. A moving and handling assessment has been undertaken on admission

Q7. A confusion check list is completed daily where the patient is at risk or showing signs of confusion

Q8. A care plan is documented where the patient is confused

Q9. The patient assessment and care plan reflect that relevant bowel or bladder issues e.g. urgency, frequency etc. have been factored into falls prevention care

Audits

o   Annual Falls Audit

Outcome

o   No moderate falls or greater for 100 days

Leadership	Elements
	Advanced study Link nurses Mentorship

Standards of Care Statements

○ The ward leader supports staff and fosters a professional environment

○ The ward team is well structured and organised

○ All staff present themselves professionally in adherence with the work-wear policy

○ Staff are aware of trust and ward level initiatives and activity

○ There are sufficient numbers of qualified mentors to support learners in practice

○ There are sufficient nurses to represent the ward on all link nurse programmes

○ All staff have appropriate knowledge commensurate with their level of experience of the main treatments and procedures taking place on the ward

○ Staff are encouraged and supported to achieve higher academic qualifications

○ The ward team demonstrate a commitment to on-going quality improvement

○ The ward team demonstrates engagement at an organisational level by attending relevant operational or multi-professional strategic forums (committees, task groups etc.) within the trust

Evidence Base & Other Relevant Documents

○ CQC Essential Standards of Quality & Safety

○ Whistle Blowing Policy

○ Workforce Essential Training Policy

Measures to evidence compliance with this standard

Observation (Ob)

1. Does the ward appear organised and well-structured? There is evidence of structure and organisation within the ward team e.g. mini-teams, clear patient allocation, shift co-ordinator identified etc.

2. Are all staff presenting themselves professionally in adherence with the work-wear policy, and wearing a clear staff ID badge

3. There is evidence to support engagement with the link nurse programme? (time allocated on off-duty rota, link nurse folders, information presentations, etc.)

4. Staff have appropriate knowledge commensurate with their level of experience of the main treatments and procedures taking place on the ward. (Can staff explain the main treatments and procedures that take place on the ward?)

5. Is there clear evidence of quality improvement activity?

6. The ward team demonstrates engagement at organisational level by attending relevant operational & strategic multi-professional forums (committees, task groups, etc.) within the

trust.

Staff Experience (SE)

Q1. Do you/would you feel supported in raising concerns with your ward leader?

Q2. Where substantiated are staff concerns acted upon?

Q3. Do you feel supported by your ward leader in your day to day working?

Q4. Are you aware of trust-wide or ward level initiatives/activities?

Q5. At your annual appraisal did you discuss the opportunity to undertake work related courses/further academic qualifications?

Q6. Have you been supported in undertaking further training/qualifications if you wished to?

Q7. Do you believe that the ward team is committed to quality improvement?

Q8. 'Link Nurses' only: Are you allowed time & opportunity to engage in link worker activities e.g. attend meetings, brief and engage ward colleagues as required, develop information, monitor activity etc.?

Training Support (SoO)

1. There are sufficient numbers of qualified mentors to support learners in practice.

Management

Elements

Staffing
Sickness/absence
Essential training
Safety thermometer
Open and honest care

Standards of Care Statements

○ The right number of staff with the right skills are available for each shift

○ Staffing rota's are published 4 weeks in advance and any deficits are escalated to the senior team

○ Planned vs actual staffing numbers are published on the ward for each shift

○ Sickness and unplanned absence is at a minimum and within the expected trust agreed range

○ Compliance with essential training is recognised and maintained

○ Safety thermometer data is collected and acted upon to ensure patients are free from harm

○ The ward team learn lessons from patient feedback, concerns and complaints

○ A registered nurse takes part in every consultant ward round

○ Staff are aware of the number of harms occurring on the ward each month and are actively working towards reducing future harms

○ Staff are aware of the friends and family test score and any actions required to address concerns

○ Staff understand the importance of the Care Quality Commission (CQC)

Evidence Base & Other Relevant Documents

○ CQC Essential Standards of Quality & Safety

○ Workforce Essential Training Policy

○ Hard Truths

Measures to evidence compliance with this standard

Observation (Ob)

1. Is there a registered nurse in attendance at every observed consultant ward round?

Staff Experience (SE)

Q1. 'Registered Nurses' only: Are you informed or involved with discussions & outcomes of consultant ward rounds?

Q2. If asked, could you state which four harms are monitored via the safety thermometer?

Q3. Can you state how many of the harms occurred on the ward last month?

Q4. If asked, would you know what your current Friends and Family Test score is?

Q5. Do you feel you understand the role of the Care Quality Commission?

Q6. Do you receive information on patient feedback, concerns and complaints?

Q7. Do you know how the ward team uses this feedback?

Dashboard Data (DshB)

Q1. The right numbers of staff with the right skills are available for each shift.

Q2. Staffing rotas are published 4 weeks in advance and any deficits are escalated to the senior team.

Q3. Planned vs actual staffing numbers are published on the ward for each shift.

Q4. Sickness and unplanned absence is at a minimum and within the expected trust agreed range.

Q5. Compliance with essential training is recognised and maintained.

Q6. Safety thermometer data is collected and acted upon to ensure patients are free from harm.

Medicines Management

Standards of Care Statements

- Patients have their medicines at the times they need them, and in a safe way

- Wherever possible patients have information about the medicine prescribed for them, including the risks

- In patients must be issued with a printed identification wristband, which must be checked against the prescription chart (and where possible with the patient) before any medication is administered

- Patients prescribed medication must take into account their:
  - age
  - existing medical conditions and medications
  - choices, lifestyle, cultural and religious beliefs
  - allergies and intolerances
  - previous adverse drug reactions

- Patient's medication prescription must be accurate and up to date, reviewed and changed as their needs change

- Medicines must be prescribed and administered by staff with the competency and skill to do so

- Medication must not be omitted without and clear documented reason and every effort must be made to ensure patients receive the appropriate medication on time, every time

- A clear record of administration must be maintained using a Trust prescription chart

- All medication errors must be reported as soon as possible using the trust approved process

- Medicines must be handled safely, securely and appropriately

- Safe storage of medicines must be maintained and any breaches in medication security immediately reported

Evidence Base & Other Relevant Documents

- CQC Outcome 9 (management of medicines)

- NHSLA Risk Management Standards 2013/14 Criterion 5.10

- Medicines Practice Operational Policy

- Medication Safety Thermometer

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Are you happy that you understand about the medicines you are taking? For example what they are for and when you should take them.

Q2. If during your current stay you have had a new medicine given to you, has it been explained to your satisfaction why you are having it?

Q3. Do you feel that there is someone you can ask about your medication if you need to?

Q4. Do you receive your medication when you need it?

Q5. Are you confident that you are taking all the medication that you think you should be?

Q6. Do you feel involved in any decisions made about your medication?

Q7. Overall, are you satisfied with the care you receive in regards to your medication?

Observation (Ob)

1. Is the treatment door locked?

2. Medicines are not left out on the patients' locker/bed table?

3. Nurses are not interrupted during the medication round?

4. Are red aprons worn when administering medicines?

5. Are patient wristbands checked against the prescription chart at the point of administration?

6. Are all medications administered by registered staff?

Documentation (D)

Q1. Is the prescription chart legible?

Q2. Has the chart been reviewed by a pharmacist sign and dated in green ink in the designated pharmacy box

Q3. Has the drug allergy status been completed in the relevant section of the prescription chart?

Q4. If any medicines have been omitted for more than 24 hours, is there a clear rationale documented in the medical or nursing notes as to why the medication has been omitted?

Staff Experience (SE)

Q1. 'Registered Nurses' only: Are you confident in your knowledge of the medications you administer so you are able to explain them to the patients?

Q2. Registered Nurses' only: Do you always have access to the medicines or are they always available on the ward within a reasonable time to care for patients?

Audits

o   Annual Safe Medicines Storage Audit

o   Medication Error Reporting through Datix

Nutrition & Hydration

Standards of Care Statements

- All patients (except those who have been commenced on the care of the dying pathway) have a nutrition screen on admission

- In-patients are re-screened a minimum of weekly thereafter

- Any food allergy that the patient has is identified & documented on admission, and a red wrist band initiated

- A menu folder is available at each bed end

- Patients are made aware of the menu folder on admission

- All in-patients have a personalised* care plan for nutritional needs (*including assistance required to eat & drink, special diets etc)

- Actions (based on screen scores) described in the core nutrition plan, are delivered

- If the screen score $\geq$ 15, the patient is referred to the dietitian on the same working day using the referral form available on the intranet

- The dietary and fluid intake of patients is observed and monitored

- Food intake charts (where applicable) are completed accurately

- Fluid balance charts (where applicable) are completed accurately

- Protected meal times are in place (in accordance with policy) to protect patients from unnecessary interruptions during the midday and evening meals; and enable an environment that is conducive to a better meal-time experience and optimum nutrition & fluid intake

- Patients are aware of the availability of snacks, and meal alternatives and these are delivered as requested

- Feeding regimens for patients receiving nutrition through non-oral routes are delivered as prescribed and accurately documented

- Patients' care is planned, implemented, continuously evaluated and revised to meet their individual needs and preferences for food and drink

Evidence Base & Other Relevant Documents

- Essence of Care (2010) – Food and Drink Benchmark

- NICE Guidance CG32: Nutrition Support in Adults Nutrition Policy

- CQC Outcome 5 (meeting nutritional need)

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Do you always get the help and assistance you need to eat and drink?

Q2. Are you aware that snacks/refreshments are available other than at set mealtimes?

Q3. Are any special dietary needs you have being met? (e.g. Vegetarian, Kosher, Halal, liquidised)

Q4. If you ever missed a meal (e.g. off the ward having treatment) were you offered a replacement, even if you declined it?

Q5. Do you have any food allergies? If Yes, are you wearing a red wrist band?

Q6. Do you always have access to fresh water when you want it?

Q7. Are you aware of the food menu and the choices available to you?

Observation (Ob)

1. A menu is readily available for the patient

2. Protected mealtimes (for lunch and evening meal) are in operation (as per policy and SOP)

Documentation (D)

Q1. A nutrition screen has been undertaken on admission

Q2. Nutrition screens have been undertaken a minimum of every 7 days

Q3. An individualised nutrition plan is documented

Q4. Food intake records (where in use) are completed correctly

Q5. Fluid balance records (where in use) are completed accurately

Q6. A referral has been made to the dietetic service where the screening score is ≥ 15

Q7. Non-oral feeding regimens are accurately recorded in accordance with the prescription

Q8. Nursing documentation reflects that care is continuously evaluated and revised as necessary to meet the patients individual nutrition & hydration needs

Audits

o   Annual Enteral Feed Audit

o   Protected Mealtime Audit

o   Nutrition Screen Audit

Pain

Elements

Assessment & re-evaluation
Care and Management

Standards of Care Statements

○ Patients are assessed on admission to identify any pain that they have which is in turn comprehensively assessed

○ Assessment of the patient's pain includes site, quality and pattern of the pain, date of onset, things that exacerbate or ease the pain, current pain management and level of patient's pain using a recognised pain scoring system

○ On-going assessments of the patient's pain are undertaken at regular intervals commensurate with individual needs (this should be a minimum of every shift)

○ Patients with pain have a pain management care plan

○ Analgesia is administered as prescribed and its effectiveness reviewed; with medications revised as appropriate

○ Patient requests for pain relief are addressed in a timely manner

○ The pain team/palliative care and symptom control team are involved in the management of the patient's pain as appropriate

○ Patients are involved as much as they want to be in decisions about their pain management

○ Patients have confidence in their pain management plan

○ The care and management of the patient's pain is continuously evaluated and revised to meet patient need and preference

Evidence Base & Other Relevant Documents

○ Essence of Care (2010) – Prevention of Pain Benchmark

○ CQC Outcome 4 (Care and welfare of people who use services)

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. When you have pain and inform a staff member, do you receive pain relief promptly?

Q2. How often do the nurses ask you about your pain?

Q3. Do you have confidence in the way that your pain is being managed?

Q4. Are you involved as much as you want to be in decisions about managing your pain?

Documentation (D)

Q1. An assessment of the patient's pain has been undertaken on admission

Q2. The patient's pain is comprehensively assessed including site, quality and pattern of the pain, date of onset, things that exacerbate or ease the pain, current pain management and

level of patient's pain using a recognised pain scoring system

Q3. A pain management care plan has been initiated

Q4. The patient's pain is continually re-evaluated (minimum of every shift)

Q5. Analgesia is administered as prescribed

Q6. A pain team referral has been considered and acted upon as appropriate

Q7. Nursing documentation reflects that care is continuously evaluated and revised as necessary to meet the patients individual pain management needs

Personal Care

Standards of Care Statements

○ Patients are assessed on admission to identify care required to maintain & promote their personal (washing/dressing/bathing/showering/washing hair) & oral hygiene

○ An oral assessment is carried out as part of the admission process and performed regularly thereafter

○ The oral assessment includes oral care history e.g. routine, oral pain, excessive/discoloured mucous, etc. and inspection of oral cavity incl. lips, tongue, gums, mucosa, teeth etc.

○ Patients with, or at risk of, oral health problems have at least daily oral inspections e.g. patients receiving mucositis-inducing treatments, patients nil-by-mouth, patients receiving enteral/parenteral feeds

○ Patients with mucositis have it graded and recorded daily using a recognised grading system (RTOG)

○ Patients are assessed to identify bladder and/or bowel care required

○ Care is planned, implemented, continuously evaluated and revised to meet personal hygiene, oral hygiene and bladder/bowel care needs and preferences

○ Patients have toiletries to meet their personal care needs and preferences

○ Patients receive the care and assistance they require to meet their personal care needs and preferences under the supervision of the registered nurse

○ Patients with, or at risk of, mucositis are provided with appropriate mouth care products & instruction in line with Oral Care Policy

○ All elements of personal care are delivered in a safe environment appropriate to the patient's needs and preferences

○ All elements of personal care are delivered in ways that protect the patient's privacy & dignity

Evidence Base & Other Relevant Documents

○ Essence of Care (2010) - Personal Hygiene Benchmark

○ CQC Outcome 1 (Respecting and involving people who use services)

○ CQC Outcome 4 (Care and welfare of people who use services)

○ Oral Care Policy

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Do you receive the care and help you need and want with washing/showering/bathing, dressing and mouth/teeth/denture care?

Q2. Do you have all the toiletries you need? If 'No, are you provided with what you need?

Q3. Do you receive the care and help you need and want with using the toilet, commode, or bedpan?

Q4. Do you receive the care and help you need and want with any bowel or bladder problems you may have?

Q5. Overall, do you feel that your privacy, dignity and modesty are respected when you are receiving or attending to your personal care?

Documentation (D)

Q1. A personal and oral care assessment has been documented on admission

Q2. An oral inspection/assessment has been documented on admission (preferably using an assessment tool)

Q3. An oral assessment has been documented daily (for patients receiving mucositis-inducing treatments or who are nil-by-mouth or are receiving enteral/parenteral feeding)

Q4. The patients care plan reflects the patient's needs & requirements concerning personal and oral care as identified in the assessment

Q5. The nursing documentation provides evidence of on-going evaluation and review of personal and oral care

Q6. A bowel and bladder assessment has been documented on admission

Q7. The patients care plan reflects the patient's needs & requirements concerning bowel and bladder related care as identified in the assessment

Staff Experience (SE)

Q1 'Registered Nurses' only: Are you familiar with the care of oral mucositis within The Oral Care Policy?

Pressure Ulcer Prevention	Elements
	Prevention
	Management

Standards of Care Statements

- Patients are pressure ulcer risk assessed using a recognised tool within 6 hours of admission

- Patients are pressure ulcer re-risk assessed a minimum of weekly

- Patients are nutrition screened within 48 hours of admission

- Patients are re-nutrition screened a minimum of weekly

- Patient are mobility & manual handling assessed on admission

- Patients have a full skin assessment/inspection on admission

- Patients' skin (particularly over bony prominences) is regularly inspected thereafter

- Patients assessed to be at risk of pressure ulcers (or admitted with existing ulcers) have an evidence-based prevention & management care plan

- Patients have evidence-based, individualised nutrition care plans

- Pressure damage is recorded immediately on detection (using Medway pro-forma)

- Grade 2 or above damage is Incidence reported

- Incidence reported ulcers that developed >72 hours after admission are root cause analysed

- Patients with pressure damage have appropriate evidence-based wound management care plans

- Appropriate pressure relieving equipment is in place commensurate with level of risk and individual requirements

- Re-positioning regimens are documented for patients who are unable to re-position independently

- Patients are regularly assisted to re-position (or encouraged to regularly re-position themselves if independently able to do so)

- Patient moving and handling is conducted so as to prevent friction & shearing

- Unavoidable skin moisture is minimised

- Pressure ulcer prevention & management care is continuously evaluated and revised to meet patient need and preference

Evidence Base & Other Relevant Documents

- Essence of Care (2010) – Prevention & Management of Pressure Ulcers Benchmark

- NICE Guidance CG29: Pressure Ulcer Management

- High Impact Action: Your Skin Matters

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Do nurses regularly check or ask you about the condition of your skin? (for example ask you if you have noticed any sore or discoloured areas)

Q2. Have you been provided with any information about pressure sores and how to prevent them, such as regularly changing position?

Q3. On average, how frequently do the nurses assist you to change position?

Q4. Do you feel that you are assisted to change your position often enough?

Documentation (D)

Q1. A risk assessment has been undertaken within 6 hours of admission

Q2. Risk assessments have been undertaken a minimum of every 7 days

Q3. A pressure ulcer prevention care plan has been initiated

Q4. An individualised nutrition plan is documented

Q5. Documentation records that regular skin inspections carried out (or there is documentary evidence that patient undertaking own checks and reporting to staff)

Q6. A re-positioning regime is evident for patients unable to re-position independently

Q7. A wound plan is documented for any ulcers in situ

Q8. Pressure ulcer evaluations are supported by a photograph

Outcomes

o   No Grade 2, 3 or 4 attributable pressure ulcers for 100 days

Other

1. Pressure damage is recorded immediately on detection (using EPR proforma)

2. G2 or above ulcers are incident reported - those that developed >72hours post admission are root cause analysed (Datix data)

Privacy & Dignity	Elements
	General Equality & Diversity Eliminating Mixed-sex Accommodation

Standards of Care Statements

○ Patients feel that they matter all of the time

○ Care encompasses the patient's values, beliefs and personal relationships

○ Patient diversity is recognised, acknowledged and respected; and provision of equal and inclusive access to care, treatment and services is ensured

○ Patients' personal space is protected by staff

○ Staff communicate with patients in ways that respects their individuality

○ Care is delivered with compassion and kindness. Behaviours towards the patient and the delivery of their care reflects an understanding or empathy for the patient in their circumstance or situation

○ Patients and their family/carers are treated courteously at all times

○ Patients' confidentiality is maintained

○ Care is delivered to ensure patients' privacy & dignity; and protects their modesty

○ Patients feel that they are involved in decisions about their care and treatment as much as they want to be

○ Patients will (except when it is in their overall best interest) only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area

○ Patients do not have to go through opposite sex areas to access the bathroom or toilet

Evidence Base & Other Relevant Documents

○ Essence of Care (2010) – Respect & Dignity Benchmark

○ CQC Outcome 1 (respecting and involving people who use services)

○ CQC Outcome 4 (Care and welfare of people who use services)

○ Privacy & Dignity and Delivering Same-sex Accommodation Policy

○ Equality & Diversity Policy

○ DH (2012) Compassion in Practice

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. In general, do staff address you by your preferred name/title?

Q2. In general, do staff introduce themselves when you meet them for the first time?

Q3. In general, do you feel you are given enough privacy when care is being delivered to you by the staff?

Q4. Would you agree that staff never talk in front of you as though you weren't there?

Q5. Are you involved as much as you want to be in decisions about your care & treatment?

Q6. When you ask important questions are they answered in a way that is understandable to you?

Q7. Are you satisfied with how long it takes someone to come when you press the 'call button'?

Q8. Overall, do you feel you are treated with respect and dignity by the staff?

Observation (Ob)

1. Is privacy, dignity and patient modesty being maintained during care delivery and generally on the ward?

2. Nurses & other members of the healthcare team never talk over the patient as if they weren't there

3. Do nurses & other members of the healthcare team use the patient's preferred form of address? e.g. Mrs, Mr, John etc.

4. Are patient buzzers answered promptly?

5. Do staff answer the telephone promptly, politely and professionally, introducing themselves?

6. Do staff demonstrate behaviours that value patient individuality and make patients feel that they matter?

7. Confidentiality of patients is protected

8. Same-sex accommodation is provided to patients (including toileting/bathroom facilities and access)

9. Patients' family & carers are afforded courtesy and respect

Record Keeping	Elements
	Electronic
	Paper

Standards of Care Statements

○ A clear and accurate record of the discussions had with patients, the assessments made, the treatment, care and medicines given and their effectiveness, is maintained

○ Pro-formas/record documents are used as required; and populated correctly and thoroughly as designed and intended, so as to ensure compliance with the first standard statement. This includes EPR nursing documentation, care plans, MEWS charts, Fluid Balance Charts, Drug Charts etc.

○ Metrics are utilised in care evaluations where appropriate

○ Records are completed as soon as possible after an event has occurred (no later than the end of shift)

○ Entries on paper are legible and in black ink

○ The confidentiality of patient records is maintained at all times

○ The registered nurse is responsible and accountable for the quality of the nursing care record

Evidence Base & Other Relevant Documents

○ Essence of Care (2010) – Record Keeping Benchmark

○ CQC Outcome 1 (Respecting and involving people who use services)

○ CQC Outcome 4 (Care and welfare of people who use services)

○ NHSLA Standards 2012/13: 1.8 Health Record-Keeping Standards

○ NMC Code: Satandard for conduct, performance and ethics for nurses and midwives (Record Keeping)

○ Health Records Policy

Measures to evidence compliance with this standard

Documentation (D)

Q1. Entries on paper are legible and in black ink

Q2. Metrics are used (as appropriate) to support the care evaluation

Q3. Use of clinical proformas is evident in the EPR

Q4. Required proforma fields are populated

Q5. All relevant charts and records e.g. MEWS, fluid balance, stool chart are thoroughly and accurately populated

Observation (Ob)

1. Are paper records used and housed so as to prevent casual/unauthorised viewing?

2. Are electronic records used and housed so as to prevent casual/unauthorised viewing?

Safeguarding

Standards of Care Statements

- ○ Staff are able to recognise & identify vulnerable patients and the potential for occurrence of abuse or neglect

- ○ Staff are aware of different types of abuse and know what to do in the face of concerns of abuse or neglect

- ○ Diversity is respected and there is an absence of discrimination in the delivery of care/service

- ○ Care is delivered with due regard to patients' human rights

- ○ Patients' special care needs are met where applicable (e.g. care is delivered with due regard to 'Traffic Light Passport' if applicable)

- ○ Staff are compliant in safeguarding training requirements

- ○ Staff are compliant in MCA and DoLS training requirements

- ○ Patients feel safe

- ○ Patients feel that they are able to express their concerns

- ○ Patients (or, as applicable, their carers) feel they are as involved as they wish to be in decisions about their care and treatment

Evidence Base & Other Relevant Documents

- ○ CQC Outcome 7

- ○ Mental capacity act and deprivation of liberty safeguards (DoLS) policy

- ○ Safeguarding policy for children, young people and adults

- ○ Elderabuse (2004): Safeguarding adults - A national framework of standards for good practice & outcomes in adult protection work

- ○ Whistle blowing policy

- ○ Human rights policy

- ○ Safeguarding Adults: The role of Health Service Practitioners (2011).

- ○ Working together to safeguard children (2013)

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Overall, do you have confidence and trust in the nurses treating/looking after you?

Q2. Do you feel able to approach a staff member when you have any worries, fears or concerns?

Q3.	Have you always felt safe during your stay on this ward?
Q4.	Are you involved as much as you want to be in decisions about your care & treatment?
Q5.	Do you feel that your individual needs have been met by staff?
Q6.	Overall, do you feel that you have received the care & attention you needed during your stay?

Observation (Ob)

1. Is privacy, dignity and patient modesty being maintained during care delivery and generally on the ward?

2. Nurses & other members of the healthcare team talk to patients respectfully at all times

3. Are patient buzzers answered promptly?

4. Care is delivered with compassion and due regard to patients' human rights

5. Do staff demonstrate behaviours that value patient individuality and does not discriminate?

Staff Experience (SE)

Q1. Do you feel you would be supported if you raised a safeguarding concern?

Q2. If asked, would you be able to say who the safeguarding lead nurse is?

Q3. Do you know which types of patients on the ward are particularly vulnerable?

Other

o   Staff are compliant with safeguarding training requirements (ESR)

o   Staff are compliant with MCA & DoLS training requirements (ESR)

Sleep & Rest

Standards of Care Statements

○ Patients are assessed to identify physiological or psychological factors affecting the quality of their sleep and rest (e.g. pain, anxiety, medication)

○ A care plan is initiated for patients experiencing sleep disturbance

○ As far a possible all nursing procedures that must to be carried out during sleep periods are grouped together to minimise disturbance of the patient

○ Where possible nursing care is organised in ways that promote sleep and rest, for example appropriate timing of medicine rounds and delivery of drinks

○ Nursing staff act to assist and enable patients to sleep

○ The ward environment is managed to promote sleep at night including lighting, temperature, closed doors etc.

○ Ward staff wear rubber soled shoes to reduce noise

○ Soft-close bins and quiet apron dispensers are in use on the ward

○ Medical equipment alarms are responded to promptly

○ Staff talking is conducted at a low volume during the night

○ Rest periods for patients are encouraged, protected and factored into the day

Evidence Base & Other Relevant Documents

○ Hilton P. (2004) Fundamental Nursing Skills

Measures to evidence compliance with this standard

Patient Experience (PE)

Q1. Have the staff asked you if you ever have difficulty sleeping at night?

Q2. Is the level of ward lighting and temperature OK for you to sleep at night?

Q3. Are staff as quiet as they possibly could be at night?

Q4. If you are awake during the night do the staff offer you assistance to help you get back to sleep? (e.g. offer you a hot drink, a biscuit, a chat, pain relief, re-positioning, etc.)

Q5. Are you satisfied with how long it takes someone to come when you press the 'call button' at night?

Q6. Do you have the opportunity to rest during the day if you wish to?

Q7. Overall, do you feel you that staff do everything they can to enable patients to rest and sleep at night?

Observation (Ob)

1. Are the doors to the ward closed?

2. Does the ward appear calm & quiet?

3. Do the majority of patients appear to be sleeping?

4. Are the doors to side rooms closed (unless requested by the patient to remain open)?

5. Is equipment used and managed in such a way as to minimise noise?

6. Are staff minimising noise as much as possible?

7. Are call buzzers answered promptly?

8. Staff organise care to minimise disturbance of patients as far as possible

Quality Scheme Status

Overarching Standard	Status (Gold/Green/Red)
Care Environment & Infection Prevention and Control	
Communication	
Falls Prevention	
Leadership	
Management	
Medicines Management	
Nutrition & Hydration	
Pain	
Personal Care	
Pressure Ulcer Prevention	
Privacy & Dignity	
Record Keeping	
Safeguarding	
Sleep & Rest	

Gold Standards	
Green Standards	
Red Standards	
Ward Status	

Recommended for Gold Status Accreditation	

Appendix 1: Action Plan for Improvement

Ward Accreditation Scheme - Action Plan for Improvement

Area of Weaker Performance

Standard	Standard Statement	Measure(s)	Level of Action for Improvement (Tick)	Improvement Lead
			Minor changes in practice	
			Moderate changes in practice	
			Major changes in practice	

Quality Improvement Service support requested?   Yes ☐   No ☐

Action	Responsibility	Timescale	Measure of Success

Area of Weaker Performance

Standard	Standard Statement	Measure(s)	Level of Action for Improvement (Tick)	Improvement Lead
			Minor changes in practice	
			Moderate changes in practice	
			Major changes in practice	

Quality Improvement Service support requested?   Yes ☐   No ☐

Action	Responsibility	Timescale	Measure of Success