LEVEL 3

Care Assurance Report

.....Ward

June 2019

Care Assurance Ratings

Bronze	**Each Standard achieves at least 75% compliance**
Silver	**Each Standard achieves at least 85% compliance**
Gold	**Each Standard achieves at least 95% compliance**
Exemplary Award	**3 consecutive Gold assessments achieved in succession**

Care Assurance

Overall Rating

About this report
This report sets out the findings from our local unannounced Level 3 Care Assurance inspection in .....Ward NHS Dumfries & Galloway during April/May.

Ward
Ward ..... is an .....bed.....care of .....ward.

Unannounced Inspection
Eight senior members of staff reviewed NHS Dumfries and Galloway Local Care Assurance Standards which are based on the Care of the Older People in Hospital Standards, Food Fluid and Nutritional Standards, 10 Dementia Care Actions in Hospitals, Pressure Ulcer Care all linking with the Dimensions of Leading Better Care.

The Standards are a mix of asking patients about their experience, reviewing their records and interviewing staff.

Staff were found to be welcoming and the majority of assessors were able to identify the nurse in charge easily. The the ward was well lit and tidy; one assessor noted how relaxed and calm the atmosphere was during their visit. All assessors noted caring conversations taking place between staff and patients and all patients observed had their nurse call system within reach.

There have been no further Leadership Walkrounds since the date of previous report.

We would like to thank all staff for their assistance during the inspection.

Result of the local unannounced inspection.

Standard	**March 2018**	**November 2018**	**May 2019**
Falls	**85%**	**95%**	**95%**
Pressure Area Care	**92%**	**100%**	**94%**
Food Fluid and Nutrition	**89%**	**98%**	**92%**
Relationship Centred Care	**67%**	**89%**	**100%**
Cognition	**55%**	**86%**	**98%**
Medicine	**88%**	**96%**	**96%**
Discharge / Transfer	**56%**	**100%**	**100%**
Staff and Skill Mix	**78%**	**80%**	**96%**
Infection control	**85%**	**98%**	**99%**

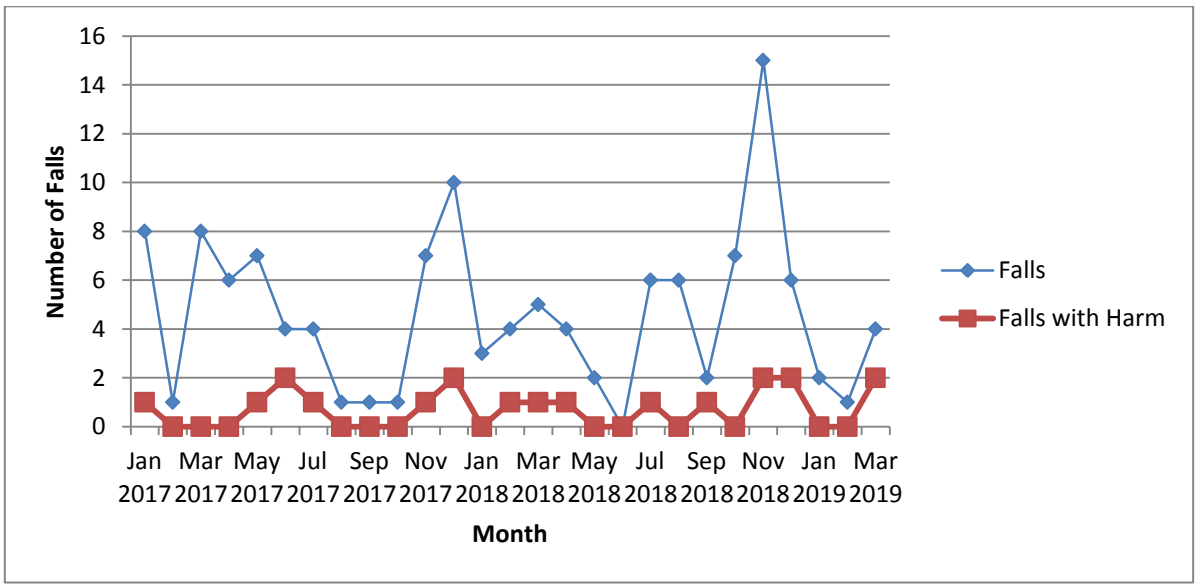
Indicates improvement from previous Level 3 Care Assurance

Ensuring Safe and Effective Clinical Practice

Standard 1 – Falls

	Falls				
		Sample	**N/A**	**Compliance**	**Percentage**
1.1	Patients are aware of how to use the nurse call system or if unable to use an alternative system is in place for calling for assistance.	**5**		5	**100%**
1.2	Patients, and where appropriate, relatives /carers are encouraged to actively participate in minimising the risk of falls i.e. by providing and using appropriate foot wear, glasses, mobility aids, flexible visiting etc	**5**		5	**100%**
1.3	Patients who are identified at risk of falls (and where appropriate relatives/carers) are provided with information on falls prevention either verbally or Falls Prevention Leaflet **and this has been recorded in the patient record.**	**5**		4	**80%**
1.4	Where appropriate relatives/carers are informed, at the earliest opportunity, when a fall occurs, including the outcome of the fall and any actions taken to minimise further risk **and this is recorded in the patient record.**	**5**	2	2	**67%**
1.5	Patients have a falls risk assessment completed within 4 hours of admission or transfer (12hrs for cottage hospitals) or if unable to perform, the reason is documented in patient record.	**5**		5	**100%**
1.6	Patients have a mobility and safer handling risk assessment and plan completed within 4 hours of admission. (12 hrs for cottage hospitals) or if unable to perform, the reason is documented in patient record.	**5**		5	**100%**
1.7	Patients who have been identified as being at risk of falls have a falls care plan in place which can include: Footwear, Walking aid, de-cluttering around the bed space, Chair / bed height is suitable for the patient, Bed rail assessment (evidence if bed rail not to be used is recorded and evidence of alternative arrangements in place), Glasses/hearing aid (if applicable), Frequency of observation, Elements individual to the person, Falls prevention leaflet, Multidisciplinary team review (continence, cognitive, delirium screen, postural hypotension, arrhythmias, medication review).	**5**		5	**100%**
1.8	The patients falls care plan has been updated and is relevant to the patient today, which includes actions required to minimise the risk.	**5**		5	**100%**
1.9	The Active Patient Care prescription reflects the patients risk of falls?	**5**		5	**100%**

1.10	Active Patient Care has been completed accurately (all elements) according to prescribed care.	**5**		3	**60%**
1.11	Patients who are more vulnerable to falls or have had a fall within the last 6 months have Multi-disciplinary Assessment completed: 1. Cognitive Assess't; 2. Delirium screen; 3. Assess't of continence; 4. Assess't of postural hypotension and arrhythmias; 5. Medication review	**5**		5	**100%**
1.12	Patients who are more vulnerable to falls or who have fallen are identified in the team safety huddle, ward handovers and on the SBARs	**5**	1	4	**100%**
1.13	Following a patient fall in a hospital setting, has the Post Falls Bundle been fully completed?	**5**	4	1	**100%**
1.14	Following a patient fall, the lessons learned are shared across the team, including the information from the Adverse Event Investigation?	**3**		3	**100%**
1.15	Ask the staff how they have updated their knowledge on falls prevention in the last 6 months	**3**		3	**100%**
1.16	Staff understand their role and responsibilities on how to prevent a fall and how to manage a patient fall - (Falls prevention, Falls bundles, care plans, recording Adverse Event and prescription of Active Patient Care)	**3**		3	**100%**
1.17	Staff are aware of how to contact specialist advice and support in relation to falls (e.g. Physio, podiatry, Clinical Educators etc.)	**3**		3	**100%**
1.18	If a patient has had a fall, ask staff what information should be recorded on Datix.	**3**		3	**100%**
	Overall Percentage				**95%**

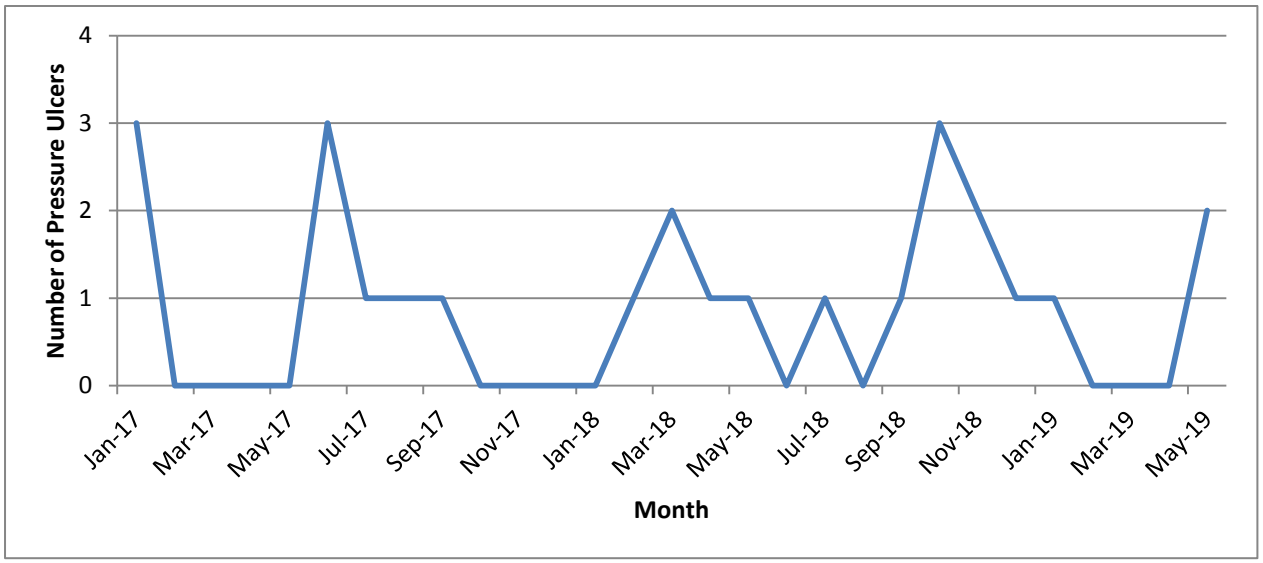


Standard 2 – Patient Safety and Pressure Area Care

	Pressure Area Care				
		Sample	**N/A**	**Compliance**	**Percentage**
2.1	Where the patient has been identified at risk of pressure ulcers the patient or where appropriate relatives / carers are given information on pressure ulcer prevention either verbally or leaflet **and this is recorded in the patient record.**	**5**		5	**100%**
2.2	Patient, and where appropriate relatives/carers, are informed of any pressure damage that occurs **and this is recorded in patient record.**	**5**	2	0	**0%**
2.3	The Adapted Waterlow Pressure Area Risk Assessment is completed within 4 hours of admission or transfer (12 hrs for cottage hospitals) or if unable to perform, the reason is documented in patient record.	**5**		5	**100%**
2.4	Patients scoring 10 or more on the Adapted Waterlow Risk Assessment have a personalised care plan detailing what actions are required to reduce the risk of developing a pressure ulcer e.g regular walks, pressure relieving equipment.	**5**		5	**100%**
2.5	There is evidence of ongoing risk assessment on at least a weekly basis.	**5**		5	**100%**
2.6	Active Patient Care is prescribed appropriate to pressure ulcer risk.	**5**		5	**100%**
2.7	Active Patient Care has been completed accurately (all elements) according to prescribed care	**5**		5	**100%**
2.8	Patients with a pressure ulcer have their pressure ulcer recorded on the patient wound management document.	**5**	2	3	**100%**
2.9	Each pressure ulcer has a wound assessment chart.	**5**	2	3	**100%**
2.10	Each pressure ulcer has a wound treatment and evaluation plan.	**5**	2	3	**100%**
2.11	All grades of pressure ulcers have been reported and recorded on Datix.	**5**	2	3	**100%**

2.12	Mattresses are checked for signs of damage in line with NHS Dumfries & Galloway guidelines.	**5**		5	**100%**
2.13	Staff undertake education and development relating to: pressure ulcer risk assessment, prevention, management, Active Patient Care	**3**		3	**100%**
2.14	Staff are aware of how to access specialist pressure relieving equipment both in and out of hours.	**3**		3	**100%**
2.15	All ward acquired pressure ulcers are discussed with ward team to identify if anything could have been done to prevent the pressure ulcer. If yes, what was their learning?	**3**		3	**100%**
2.16	Patients known to be at risk of or have a pressure ulcer are easily identified.	**3**		3	**100%**
2.17	The pressure relieving equipment including seating is used appropriately to meet individual needs.	**3**		3	**100%**

Overall Percentage	**94%**



Standard 3 – Food Fluid and Nutrition

	Food, Fluid and Nutrition				
		Sample	**N/A**	**Compliance**	**Percentage**
3.1	Are drinks within reach of the patient?	**5**		5	**100%**
3.2	Patients are offered the opportunity to clean their hands prior to mealtimes. (Handwipes)	**5**		5	**100%**
3.3	Patients are offered assistance with their meals if required.	**5**	1	4	**100%**
3.4	Has the MUST been completed within 4 hours of admission or transfer (12 hours for cottage hospitals) **including Specific Dietary Needs?**	**5**		5	**100%**
3.5	Has the MUST been updated at least weekly and is accurate?	**5**		2	**40%**
3.6	Patients have a completed person centred care plan reflecting their Nutritional Care Assessment, if applicable.	**5**		5	**100%**
3.7	Patients who have alternative nutritional supplements and or nutritional feeds are given them as prescribed.	**5**	4	1	**100%**
3.8	Food and Fluid Balance charts are accurately recorded.	**5**	5		**#N/A**
3.9	Can staff describe what is meant by "Supported Meal Times"?	**3**		3	**100%**
3.10	Patients nutritional care requirements are added to the Nutritional Care Plan Action Sheet in the ward kitchen or on the patients board in their room, indicating any required textured diet, snacks, supplements, crockery etc.	**3**		3	**100%**
3.11	Staff are aware how to access supplementary menus . (on ipad for DGRI or hard copies in Cottage hospitals)	**3**		3	**100%**
3.12	Staff are aware how to access picture menus from the intranet (or hard copies for Cottage Hospitals).	**3**	3		**#N/A**

3.13	Snacks are available to patients 24 hours a day as required.	**3**		3	**100%**
3.14	Staff are able to explain the process on how they ensure snacks are given to patients.	**3**		3	**100%**
3.15	Staff are able to explain the guidelines for managing a hypoglycaemic attack? (including frequency of Blood Glucose Monitoring).	**3**		3	**100%**
3.16	Staff can clearly identify patients who are nil by mouth.	**3**		3	**100%**
3.17	Staff are aware how to refer patients with swallowing difficulties to the SALT team.	**3**		3	**100%**
3.18	Staff are aware of when, how and what information is required to refer patients to the dietician.	**3**		3	**100%**
3.19	Staff are aware how to obtain an alert tray for patients who need assistance with their meals (Red napkins for DGRI).	**3**	3		**#N/A**
3.2	Patients are given assistance, where needed, to complete their menu card.	**3**		3	**100%**
3.21	Patients are offered the correct texture of food and fluids as per SALT assessment.	**3**		3	**100%**
3.22	Are staff able to explain the guidelines for contrasting crockery?	**3**		2	**67%**
3.23	Staff are aware of how to obtain contrasting crockery for patients with visual or cognitive impairment.	**3**		1	**33%**
	Overall Percentage				**92%**

Enhancing the Patients Experience

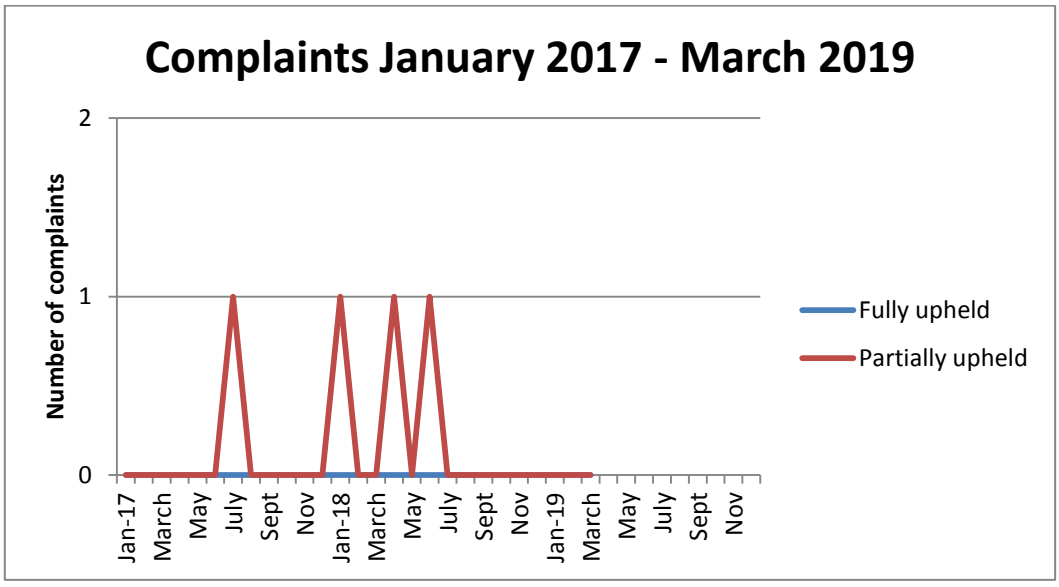
Standard 4 – Relationship Centred Care

	Relationship Centred Care				
		Sample	**N/A**	**Compliance**	**Percentage**
4.1	Patients are addressed by their preferred name.	**5**		5	**100%**
4.2	Patients, relatives and carers are orientated to the ward environment on admission and are given information on how to call for assistance, where toilets are, meal times, visiting times, etc.	**5**		5	**100%**
4.3	Patients receive information leaflets / verbal information appropriate to their care needs / diagnosis.	**5**		5	**100%**
4.4	All care decisions are made with the patient and if appropriate, relative, carer or the Power Of Attorney and all care plans / patient records reflect this.	**5**		5	**100%**
4.5	If appropriate, patients and their relatives/carers are aware there is a Dementia or Learning Disability Champion available within the ward / hospital.	**5**	4	1	**100%**
4.6	Patients / Carers are made aware of open visiting.	**5**		5	**100%**
4.7	Are patients, or, if appropriate, relatives and / or carers fully aware of why patients have been transferred to another area **and this is documented in the patient record.**	**5**		5	**100%**
4.8	The 5 Must Do Principles of Care is completed within 4 hours of admission (12 hours for cottage hospital) or if unable to complete the reason is documented in patient record.	**5**		5	**100%**
4.9	A care plan is completed with the patient on elements identified within the 5 Must Do Principles of Care.	**5**		5	**100%**
4.10	All patients communication issues have been recorded on the 'Patient Information Record'.	**5**	3	2	**100%**
4.11	Any communication issues identified have an appropriate person centred care plan.	**5**	3	2	**100%**

4.12	Ceilings of care / Treatment Escalation Plan are fully discussed with the patient and / or relative / carer and the discussion is clearly documented.	**5**		5	**100%**
4.13	If a patient is for DNACPR is this fully discussed with the patient and, if appropriate, relative / carer or Power of Attorney. All discussions are clearly documented in the patient record.	**5**		5	**100%**
4.14	If a patient is for DNACPR, is the document fully completed and review date recorded.	**5**	1	4	**100%**
4.15	For patients who have a 'Health Passport' eg 'This is Me', 'Dementia/Learning Disabilities Passport', 'Anticipatory Care Plan' is this easily accessible?	**5**	4	1	**100%**
4.16	Staff use the Health Passports to provide person centred care and this is documented in the patient care plan.	**5**	4	1	**100%**
4.17	Staff are aware of how to access support for patients spiritual needs.	**3**		3	**100%**
4.18	Patient / relatives / carers feedback is gathered on a regular basis and shared with the team monthly.	**3**		3	**100%**
4.19	Staff are given the opportunity to feed back on their own experiences of working on the ward / hospital.	**3**		3	**100%**

Overall Percentage	**100%**

Complaints– 1 Jan 17 to 31 March 19



Caring Observation

An independent staff member completed a 30 minute caring observation on the 20th May 2019.

Ward Environment

The ward was found to be welcoming, clean and tidy and well lit.
All the patients observed had their drinks, nurse call bell and walking aids close to them.
A clock with the day, month and year was visible.

Person Centred Care

Patients appeared to be clean and were appropriately dressed.
All staff addressed the patients by preferred name.
A patient commented that "the staff are lovely", however they "would have liked to have been given more information at the beginning", although also felt they "could have asked too for this".
The patient also stated they were offered handwipes at meal times and were given assistance when they required it.

What have we done well?	What could we do to improve your experience?
• Provided good care for my mum. • You tried to get me better. • Feeding me well. • Everyone has been very good to me. • Everyone is brilliant. • You remember the time. • I get a nice smile from everyone and that matters to me. • I get a quick response when i press my care call. • Good food. • Staff are friendly and go above and beyond. • Staff have been very good with me. • Everything is very good, all the nurses are good too. • Helping me progress I could hardly walk when I came in – now look at me! • Good food. • Care is very good. • I am well looked after and well fed. • Conversation with nurses is good.	• Evening meal x 2 was dry – mum needs moist. • Get me home sooner. I have been waiting so long for care at home. • Stop clock watching. • I would like to have a single room. • Source care package quicker. • To have own television. • Environment not very warm. (Environment was made warmer by closing windows,portable radiator and patient was rechecked.) • More staff as I see the ward is very busy at moment.

Standard 5 – Cognition

	Cognition				
		Sample	**N/A**	**Compliance**	**Percentage**
5.1	Does the ward use the 'Forget Me Not' identifier and how?	**5**		5	**100%**
5.2	If the patient has a diagnosis of dementia, delirium, depression or cognitive impairment, is this recorded in the notes?	**5**	1	3	**75%**
5.3	Has the Patient Information Record been completed? (it is required to request a copy of the POA/Guardianship document where there is one indicated- it is the responsibility of the Attorney to provide the document – our responsibility is to ask and make reasonable attempts and record our actions)	**5**		5	**100%**
5.4	If they have a diagnosis of dementia, is there a completed This is Me, Getting to Know Me or other health passport?	**5**	2	3	**100%**
5.5	If the patient has a Power Of Attorney or Welfare Guardian, is there a copy of the printed document in the patient's records? If there is a registered Power of Attorney, regardless or whether or not it is invoked, it must be in the patient record.	**5**	3	2	**100%**
5.6	All patients over 65 years old or where clinically indicated under 65 years old have they had a 4AT assessment on admission (Note: 4AT is recommended by the Scottish Delirium Association to be completed on admission to both DGRI and community hospitals and if there has been a sudden change)	**5**		5	**100%**
5.7	If the patient lacks capacity, is there a Section 47 form completed?	**5**	3	2	**100%**
5.8	If there is a Section 47 form, is it accompanied by an Annex 5 treatment form?	**5**	3	2	**100%**
5.9	Patients identified as being frail do they have a comprehensive geriatric assessment completed within 24 hours (falls, mobility, functional assessment, cognition, continence)?	**5**		5	**100%**
5.10	If the patient has a diagnosis of dementia, delirium, depression or cognitive impairment, is there a cognition care plan in place?	**5**	3	2	**100%**

Overall Percentage	**98%**

Standard 6 – Medicine

	Medicine				
		Sample	**N/A**	**Compliance**	**Percentage**
6.1	Patients receive analgesia in a time scale that is acceptable to them.	**5**	2	3	**100%**
6.2	Patients or where appropriate the patients relatives/carers/ Power Of Attorney understand the reason why medicines are being administered.	**5**		4	**80%**
6.3	Discharge letters and medications are explained to the patient, carer and or relative on discharge.	**5**	5		**#N/A**
6.4	IV infusions are stored in accordance with NHS Dumfries & Galloway policy.	**1**	1		**#N/A**
6.5	All medicines stored within the drug trolleys (lockers within DGRI) are locked in accordance with NHS Dumfries and Galloway policy.	**1**		1	**100%**
6.6	The drug fridge is locked in accordance with NHS Dumfries and Galloway policy.	**1**		1	**100%**
6.7	All patients have a wrist band in situ which includes their full name and CHI number.	**5**		5	**100%**
6.8	Has a Pain assessment tool been used to assess the patient's pain?	**5**	2	2	**67%**
6.9	Medicines reconciliation has been completed within 24 hours of admission including Stop, Withhold, Continue.	**5**	2	3	**100%**
6.10	Medicine prescription charts are legible, signed and dated.	**5**		5	**100%**
6.11	Medicine administered is accurately documented including reason for omission	**5**		5	**100%**
6.12	Are IV medications given as prescribed and recorded and signed as being administered?	**5**	5		**#N/A**
6.13	IV medication and fluid infusions are labelled as per prescription.	**5**	5		**#N/A**
6.14	IV medication and fluid infusions are given at the rate prescribed.	**5**	5		**#N/A**
6.15	If the patient has a cannula, is it covered with a dressing which clearly indicates the date it was inserted?	**5**	5		**#N/A**
6.16	Has the PVC bundle been accurately completed?	**5**	5		**#N/A**
6.17	Staff are aware of the 5 Rights of medicine administration.	**3**		3	**100%**
6.18	Staff receive appropriate training relating to medicines administration.	**3**		3	**100%**

6.19	Staff are aware of how they can access support for any medicine queries.	**3**		3	**100%**
6.20	Measures are taken to minimise interruptions during the medicine administration process.	**3**		3	**100%**
6.21	Controlled drugs are administered in line with legal and organisational policies.	**3**		3	**100%**
6.22	Oxygen / Oxygen cylinders / flow meters and suction are checked according to NHS Dumfries & Galloway policy.	**3**		3	100%

Overall Percentage	**96%**

Standard 7 – Discharge and Transfer

	Discharge/transfer				
		Sample	**N/A**	**Compliance**	**Percentage**
7.1	There is written evidence within the patient record that the patient or where appropriate Power of Attorney / Guardian/ Family have been included in decision/ discussions regarding discharge/ transfer.	**5**		5	**100%**
7.2	Discharge planning is commenced on admission and updated as clinically indicated.	**5**		5	**100%**
7.3	Any newly diagnosed episodes of cognitive impairment or depression identified during admission is clearly documented on the discharge letter, including the diagnosis and any residual symptoms.	**5**	5		**#N/A**
7.4	Staff are aware of how to access equipment for patients being discharged home.	**3**		3	**100%**
7.5	Staff are aware of how to access advice and support for carers	**3**		3	**100%**
7.6	Staff are able to explain when and what they discuss around discharge/transfer with the patient.	**3**		3	**100%**
7.7	Staff are aware of how to organise rapid discharge for patients who wish to die in a homely setting.	**3**		3	**100%**
	Overall Percentage				**100%**

Managing and Developing the Performance of the Team

Standard 8 - Staff and Skill Mix

	Staff and Skill Mix				
		Sample	**N/A**	**Compliance**	**Percentage**
8.1	Staff are adhering to the Dumfries and Galloway "Staff Dress and Uniform Policy".	**3**		3	**100%**
8.2	Do staff meet safe staffing levels on the ward at all times in accordance with The Nursing and Midwifery Quality Roster Policy?	**3**		3	**100%**
8.3	Are staff aware of any Adverse Events within the last 6 months?	**3**		3	**100%**
8.4	If yes, can staff describe what **Level** of Adverse Event was this? (ie Level 1 = permanent /significant harm Level2 = Temporary Harm Level 3 =Near miss/No harm to patient)	**3**		3	**100%**
8.5	What was their learning from the Adverse Event and were they involved in the action plan?	**3**		3	**100%**
8.6	Are staff aware of any written complaints within the last 6 months?	**3**	3		**#N/A**
8.7	If yes, what was their learning, were they involved in any action plans?	**3**	3		**#N/A**
8.8	Are staff aware of the quality improvement projects occurring within their ward / hospital and can discuss or show evidence of this work?	**3**	1	2	**100%**
8.9	Are staff aware of the "Respect, Our Code of Positive Behaviour" Policy?	**3**	1	2	**100%**
8.1	Ask staff what they would do if they were aware of bullying or abuse of any type.	**3**	1	2	**100%**

Topic	**Compliance**
Mandatory Training overall (April 2019)	84%
NMC (April 2019)	100%
Eksf / ADR- T**URAS appraisal now implemented, unable to get data at present**	N/A
Return to Work interviews (April 2019)	100%
SCN attendance at SCN meeting (November 2018-April 2019)	100%
Level 1 compliance (November 2018-April 2019)	84%
Level 2 compliance (November 2018-April 2019)	83%
Number of Dementia Champions	2
Percentage of mentors for Student nurses	88%
Overall Percentage	**96%**

Standard 9 – Infection Control

Topic	Percentage
Bare Below Elbow	100%
SCIPS	100%
Hand Hygiene	Not completed at time of report
IPS	98%
HAI National Standards	Not completed at time of report
IPC snap shot	Not completed at time of report
Patient Perception	Not completed at time of report
The patient understands why they have been isolated	N/A

Overall Percentage	**99%**