

# Essence of Care

Patient-focused benchmarks  
for clinical governance

# Guidance and Benchmarks

April 2003

**Guidance and  
New Communication  
Benchmarks**



**Essence of Care**

Guidance

# INTRODUCTION

This document contains the toolkit for benchmarking the fundamentals of care. This includes the background to *Essence of Care* (page 1), a description of the benchmarking tool (page 3), how to use the benchmarks (page 4) and record forms for developing action and business plans (appendices one to seven). Nine sets of benchmarks are also included. It is intended that health and social care personnel<sup>1</sup> use this document to address issues of concern within their areas of work and or to improve services already provided.

## BACKGROUND

*The NHS Plan (2000)* reinforced the importance of 'getting the basics right' and of improving the patient experience. The *Essence of Care*, launched in February 2001, provides a tool to help practitioners<sup>2</sup> take a patient-focused<sup>3</sup> and structured approach to sharing and comparing practice. It has enabled health care personnel<sup>4</sup> to work with patients to identify best practice and to develop action plans to improve care.

Patients, carers and professionals worked together to agree and describe good quality care and best practice. This resulted in benchmarks covering eight areas of care:

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

It should be recognised that all sets of benchmarks are interrelated. For example, there are elements of *privacy and dignity* that link with *continence and bladder and bowel care*.

<sup>1</sup>It is recognised that people are cared for in a variety of settings. For brevity the term 'health' will be used to include 'social' personnel, care or organisations.

<sup>2</sup>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.

In July 2002 work began to develop further benchmarks focusing on communication between patients and or carers and health care personnel. These were written in response to requests from those taking part in the initial compilation of the *Essence of Care*, as well as many patients, carers and practitioners who have since used the *Essence of Care* toolkit. The new set of benchmarks complement the existing eight sets and relate closely to, for example, the *record keeping* and *privacy and dignity* benchmarks.<sup>5</sup>

The benchmarks have been presented in a revised format that takes account of the experience and comments of those who have been using the *Essence of Care*. Although the format of the original benchmarks has been simplified the *benchmarks of best practice* and *poor practice* remain the same. In addition, the intervening steps to best practice have been removed since these may vary according to local circumstances.

The benchmarks are relevant to all health and social care settings. Therefore, the *Essence of Care* is presented in a generic format in order that it can be used in, for example, primary, secondary and tertiary settings and with all patient and or carer groups, such as in paediatric care, mental health, cancer care, surgery and medicine. It is important that those benchmarking (including patients and carers) agree the indicators that demonstrate best practice within their area of care.

<sup>3</sup>Please note that the term 'patient' also includes 'service-user', 'consumer', 'client', etc. For brevity the term 'patient' will be used to cover all of these unless otherwise stated.

<sup>4</sup>The term personnel refers to any person employed by the care provider who communicates with the patient.

<sup>5</sup>Initially there were two sets of communication benchmarks, one for communication with patients and health care personnel and one for communication with carers and health care personnel. However, at the final review stage it was noted that each set of benchmarks incorporated values that were very important to both patients and carers. In view of this the two sets of benchmarks were merged to provide one stronger set of benchmarks for reviewing wider practice in relation to issues that are pertinent to both patients and carers.

## CONTENT OF BENCHMARKING TOOL

The *Essence of Care* benchmarking toolkit comprises of:

- an **overall patient-focused** outcome that expresses what patients and or carers want from care in a particular area of practice
- a number of **factors** that need to be considered in order to achieve the overall patient-focused outcome

Each factor consists of:

- a patient-focused **benchmark of best practice** which is placed at the extreme right of the continuum
  - a **continuum** between poor and best practice. The benchmark for each factor guides users towards best practice
  - **indicators** for best practice identified by patients, carers and professionals that support the attainment of best practice
- information on how to use the benchmarks
  - accompanying forms to facilitate documentation



## USING CLINICAL BENCHMARKS

*Essence of Care* benchmarking is a process of comparing, sharing and developing practice in order to achieve and sustain best practice. Changes and improvements focus on the *indicators*, since these are the items that patients, carers and professionals believed were important in achieving the benchmarks of best practice. The stages involved in benchmarking are highlighted below broadly they are:

- Stage One - Agree best practice
- Stage Two - Assess clinical area against best practice
- Stage Three - Produce and implement action plan aimed at achieving best practice
- Stage Four - Review achievement towards best practice
- Stage Five - Disseminate improvements and or review action plan
- Stage Six/One - Agree best practice

To assist you the relevant documentation is included in the appendices.

The process can be accomplished using the PDSA cycle (Plan, Do, Study, Act) (see Langley et. al., 1996 cited in Modernisation Agency, 2002) that has been designed to test a 'change idea'. For more information about the model for improvement refer to the *Improvement Leaders Guides on Measurement for Improvement* available at:  
[www.modern.nhs.uk/improvementguides/measurement](http://www.modern.nhs.uk/improvementguides/measurement)

## BENCHMARKING PROCESS

### STAGE      ACTIVITY

ONE	Agree best practice	<ul style="list-style-type: none"><li>◆ Consider the patients' or carers' experiences and outcomes, and how current care is delivered. The clinical governance questions and general indicators<sup>6</sup> (see appendix one and two) may provide useful guidance at this step</li><li>◆ Agree clinical benchmarks to be considered (appendix three)</li><li>◆ Establish a comparison group<sup>7</sup> (appendix four)</li><li>◆ Consider the overall outcome and the benchmarks of best practice</li><li>◆ Using the general indicators (appendix two) and specific indicators agree the evidence that the comparison group consider necessary to be provided in order to achieve the benchmarks of best practice</li></ul>
TWO	Assess clinical area against best practice	<ul style="list-style-type: none"><li>◆ Obtain baseline information by observing practice, using audit and involving patients in the clinical area</li><li>◆ Consider the indicators and provide evidence that represents current achievement towards best practice (appendix three)</li><li>◆ Consider barriers which prevent achievement of best practice (appendix three)</li><li>◆ Compare and share best practice so that good practice is not wasted. Some comparison groups find considering their positions on an E (poor practice) to A (best practice) continuum useful to stimulate discussion</li></ul>

<sup>6</sup>General indicators are common to all sets of benchmarks. Specific indicators are particularly relevant to the factor with which they are identified.

## BENCHMARKING PROCESS

### STAGE      ACTIVITY

THREE	Produce and implement action plan aimed at achieving best practice	<ul style="list-style-type: none"><li>◆ Produce an action plan detailing:<ul style="list-style-type: none"><li>- the changes that need to be made to improve practice</li><li>- who is responsible for leading the changes</li><li>- the time scale in which these should occur</li></ul></li><li>◆ Actions should be realistic, achievable and measurable (appendix five)</li><li>◆ Carry out the action plan</li></ul>
FOUR	Review achievement towards best practice	<ul style="list-style-type: none"><li>◆ Document activities, any improvement, problems and or unexpected observations (appendix six)</li><li>◆ Analyse data and evaluate actions - did the patients' or carers' experiences or outcomes improve? Did service delivery benefit from changes made? (appendices three and six)</li><li>◆ If there is no improvement review activities in action plan</li><li>◆ Share with comparison group</li></ul>
FIVE	Disseminate improvements and or review action plan	<ul style="list-style-type: none"><li>◆ If improvements are identified, disseminate good practice and implement change as widely as appropriate through comparison group and other organisational systems</li><li>◆ Include in organisation's business planning cycle, clinical governance plan and quality report via relevant managers, and clinical governance and quality leads (appendices one and seven)</li></ul>
SIX	Agree best practice	<ul style="list-style-type: none"><li>◆ As stage one</li></ul>

<sup>7</sup>The aim of the comparison group is to compare and share practice likely to contribute to attaining the benchmarks. This is in order that members can support each other in progressing towards best practice. A comparison group may consist of individual health care personnel, members representing a team, members representing an organisation and so on. The group should include individuals who have an interest in achieving best practice as well as individuals who can represent patient and or carer involvement in the process.

## How does *Essence of Care* fit into the clinical governance agenda?

### Consultation and patient involvement

Are patients and or carers involved within the benchmarking process so that they feel empowered to contribute?

Yes/no

Details

Are patients' and or carers' complaints and or adverse incidents, surveys, focus group meetings used within the benchmarking process?

Yes/no

Details

Is feedback on the benchmarking process known to others, such as the PAL's officer, housekeepers, voluntary organisations and stakeholders?

Yes/no

Details

Does the organisation judge the success of partnership working on a regular basis to ensure strategic planning, monitoring and evaluation of services?

Yes/no

Details

Is there a team approach to assessing the appropriateness of the *Essence of Care* benchmarks to meet the needs of patients and or carers?

Yes/no

Details

Does the team identify and recognise the rights and individual or special needs of those who use the service and address them appropriately?

Yes/no

Details

Does the team communicate with patients, including those with particular language and communication needs in relation to the identified benchmarks contained within *Essence of Care*?

Yes/no

Details

## APPENDIX ONE

### Clinical risk management

Is *Essence of Care* part of the risk management programme within your organisation?

Yes/no  
Details

Is environmental and clinical risk identified and how is this taken forward within the clinical risk management agenda?

Yes/no  
Details

Are the findings from the comparison groups taken forward if environmental or clinical risk has been identified?

Yes/no  
Details

Is environmental or clinical risk monitored to ensure sustained improvement to benefit patients and or carers?

Yes/no  
Details

Are incidents in relation to *Essence of Care* reported and acted upon and subsequent action disseminated to the team?

Yes/no  
Details

### Clinical audit

Is *Essence of Care* part of the organisation's clinical audit programme?

Yes/no  
Details

Are the findings notified to the organisation's Board for action?

Yes/no  
Details

Are the findings embedded into changes into clinical practice?

Yes/no  
Details

**Clinical audit** *continued*

Are the clinical team informed of the changes to practice and how is this monitored?

Yes/no

Details

Is there a team approach to implementing the findings from the benchmarks contained within *Essence of Care*?

Yes/no

Details

Is there a forum to identify, take stock and reflect on areas for improvement?

Yes/no

Details

**Research and effectiveness**

Do staff have access to evidence-based information relating to the benchmarking elements contained within *Essence of Care* ?

Yes/no

Details

Is the evidence base updated within the organisation, if so how often?

Yes/no

Details

Are there clear guidelines and or protocols relating to the *Essence of Care* benchmarks for all members of the team?

Yes/no

Details

**Use of information about the patients' and or carers' experience**

Are patient stories used to inform the benchmarking process through the leadership programmes?

Yes/no

Details

Are care plans individualised to meet the fundamental aspects of care?

Yes/no

Details

## APPENDIX ONE

### Use of information about the patients' and or carers' experience *continued*

Are there alert systems within care planning to identify if the needs of patients and or carers are not being met?

Yes/no

Details

In relation to the implementation of the electronic patient record are there alert systems planned to identify if the needs of patients' and or carers are not being met?

Yes/no

Details

Within care pathway development are there mechanisms to identify planned versus actual care given to patients and how the variance will be identified?

Yes/no

Details

### Staffing and staff management

Is there a team training approach to implementing *Essence of Care*?

Yes/no

Details

Is there a forum of discussion to indicate how well the organisation is performing in the clinical aspects of care in relation to the *Essence of Care* toolkit?

Yes/no

Details

Is there an identified lead for *Essence of Care* within each clinical team?

Yes/no

Details

### Education, training and continuing personal and professional development

Is *Essence of Care* part of the organisation's education and training programme?

Yes/no

Details

Are facilitators trained in the basics of delivering the *Essence of Care* programme?

Yes/no

Details

**Education, training and continuing personal and professional development**  
*continued*

Is there adequate training provision across all health care personnel in the use of the *Essence of Care* toolkit?

Yes/no  
Details

Is there a clear understanding of the benchmarking process and how it relates to sustained quality improvement programme within the organisation?

Yes/no  
Details

**Strategic capacity**

Does the organisation have an executive director who has lead responsibility for implementing and monitoring progress on implementation of *Essence of Care*?

Yes/no  
Details

Is *Essence of Care* part of the organisation's business planning process and monitored within the performance management arrangements?

Yes/no  
Details

Is *Essence of Care* part of the clinical governance agenda within the organisation?

Yes/no  
Details

Is *Essence of Care* part of the annual clinical governance development plan?

Yes/no  
Details

Is *Essence of Care* integral to the organisation's annual quality report?

Yes/no  
Details



## APPENDIX TWO

### General indicators for best practice

Whilst using the *Essence of Care* benchmarks the following general points must be considered for each specific area of care:

- patients' and or carers' individual needs or special needs including ethnicity, religion, culture, language, age, physical, sensory, developmental and psychological requirements

In addition you must consider whether:

#### Staffing

- an induction programme is in place which promotes the philosophy of care
- the development needs of health care personnel are met by ongoing review through supervision, appraisal and individual development plans
- there is effective leadership, for example, from modern matrons and other senior members of staff
- systems are in place that promote the sharing of information between health care personnel
- practitioners are proficient in assessing the patients' capacity to consent
- the effectiveness of care is demonstrated

#### Patient and carer involvement

- the opinions of patients and or carers are sought, for example, from the Patient Advice and Liaison Service (PALS), carers' groups and open forum meetings
- the opinions of patients and or carers are used appropriately and feedback mechanisms are in place
- observations of care and patients' or carers' stories are used to inform practice
- patients' and or carers' views or satisfaction surveys are recorded, disseminated and used in practice
- there is evidence of audit, action and feedback from complaints

## Education and training

- practitioners have the necessary skills, which are assessed, to deliver care according to patients' and or carers' individual needs
- education and training are available for all health care personnel which increases awareness of the patients' and or carers' individual needs
- health care personnel are trained to communicate with the multi-disciplinary team
- strategies are in place to ensure that the education and training of health care personnel promotes the giving of accurate and appropriate information
- training for health care personnel is relevant, regular, updated and recorded
- patients' and carers' views are included in 'values and beliefs' training

## Policies and procedures

- confidentiality is covered by policies, health care personnel education and induction programmes
- policies and procedures exist for both verbal and written consent
- evidence-based policies or guidelines are in place which are audited
- cross agency working is co-ordinated by the use of joint working protocols, policies, procedures and guidelines to provide a seamless service
- policies relating to carers are available
- equal opportunity strategies clearly outline responsibilities to support patients and or carers of all ethnic backgrounds and all abilities
- policies support provision for special needs
- the complaints policy is user friendly and accessible

## Resources

- information exists relating to the area of care being considered and its use is evaluated
- information is adapted for different user groups and meets the individual needs of patients and or carers
- resources required to deliver care are available

<b>PRESENTING THE EVIDENCE OF CURRENT PRACTICE</b>	
Name.....	Contact .....
Benchmarks being considered:	
Factos(s)	Evidence required (use general and specific indicators for guidance)

<b>PRESENTING THE EVIDENCE OF CURRENT PRACTICE</b>		
<b>Factor(s)</b>	<b>Current achievement towards best practice</b>	<b>Barriers that prevent achievement of best practice</b>

## APPENDIX FOUR

COMPARISON GROUP INFORMATION		
Comparison group for: (insert name of team/ward/unit/area/directorate/group/trust/region)		
Facilitator:		
Comparison group members:		
Name	Representing	Contact details
Ground rules		

<b>ACTION PLANNING</b>				
What actions have to be taken to achieve best practice?				
Factor(s)	Changes that need to be made to improve practice	Who is responsible for leading the changes	Time scale	Review date

**APPENDIX SIX**

<b>EVALUATION OF ACTIONS</b>					
Factor(s)	Action	Progress report	I* Y/N	P Y/N	UO Y/N

\*Key to table

I = Improvement

P = Problem

UO = Unexpected Outcome

<b>BENCHMARKING INTO BUSINESS PLANNING CYCLE</b>				
Key objectives	Action	Responsibility	Time scale	Cost



# Supporting Material<sup>8</sup>

## This document should be read in conjunction with:

Department of Health (1997) The new NHS: modern, dependable The Stationery Office: London

Department of Health (1998) A first class service: quality in the new NHS  
Department of Health: London

Department of Health (1999) Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and health care Department of Health: London

Department of Health (1999) National service framework for mental health  
Department of Health: London. <http://www.doh.gov.uk/nsf/mentalhealth.htm>

Department of Health (2000) National service framework for coronary heart disease Department of Health: London. <http://www.doh.gov.uk/nsf/coronary.htm>

Department of Health (2000) The management and control of hospital infection: action for the NHS for the management and control of infection in hospitals in England Department of Health: London

Department of Health (2000) The NHS plan: a plan for investment, a plan for reform The Stationery Office: London

Department of Health (2001) Caring for older people: a nursing priority integrating knowledge, practice and values Department of Health: London

Department of Health (2001) Essence of care Department of Health: London

Department of Health (2002) Action for health, health action plans and health facilitation detailed good practice guidance on implementation for learning disability partnership boards Department of Health: London

Department of Health (2002) Addressing inequalities reaching the hard-to-reach groups: National Service Frameworks a practical aid to implementation in primary care Department of Health: London

Human Rights Act (1998) The Stationery Office: London  
<http://www.hms.o.gov.uk/acts/acts1998/19980042.htm>

## Supporting Material *continued*

Medical Devices Agency (1998) Medical device and equipment management in hospital and community-based organisations Device Bulletin: MDA DB 98/01  
Medical Devices Agency: London

Modernisation Agency (2002) Improvement leaders guide to setting up a collaborative programme - process mapping, analysis and redesign Department of Health: London

Modernisation Agency (2002) Spreading and sustaining new practices: sharing the learning from the Cancer Services Collaborative (CSC) Department of Health: London

Modernisation Agency (2003) Spread and sustainability of service improvement: Factors identified by staff leading modernisation programmes Department of Health: London

NHS Executive (1996) Promoting clinical effectiveness: a framework for action in and through the NHS Department of Health: London

NHS Executive (1998) Achieving effective practice: a clinical effectiveness and research information pack for nurses, midwives and health visitors Department of Health: London

NHS Executive (1998) Information for health: an information strategy for the modern NHS 1998-2005: a national strategy for local implementation Department of Health: London

<sup>9</sup>All bibliographies include some of the sources that have been used in constructing the benchmarks and other references that may be helpful to those engaged in the benchmarking process. The bibliography is by no means exhaustive but the sources cited have been reviewed and selected for their relevance to the benchmark statements.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





**Essence of Care**  
Benchmarks for Communication between  
Patients, Carers and Health Care Personnel

## Benchmarks for Communication between Patients, Carers and Health Care Personnel

Agreed patient-focused outcome

**Patients and carers experience effective communication, sensitive to their individual needs and preferences, that promotes high quality care for the patient**

*For the purpose of these benchmarks **communication** is:*

a process that involves a meaningful exchange between at least two people to convey facts, needs, opinions, thoughts, feelings or other information through both verbal and non-verbal means, including face to face exchanges and the written word.

*For the purpose of these benchmarks:*

'**Carers** look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (Carers UK, 2002).

Please note, within these benchmarks it is acknowledged that the term carer can also include young people aged under 18.

***Effective interpersonal communication needs to be considered in the context of:***

- fundamental values including openness, honesty and transparency
- the importance of consent and confidentiality<sup>1</sup>
- the principles of common courtesy
- self awareness and the importance of body language and other non-verbal communication
- skills such as establishing rapport, active and empathic listening, being non-judgemental
- the importance of using straightforward language and avoiding jargon
- the need to adapt approaches to communication, to be sensitive to language and cultural differences (using interpreters where appropriate), to individual developmental needs and disabilities (using aids and appliances as necessary), to the psychological state and the experience of the patient and or carer
- the content of the communication and the situation, such as conveying bad news, dealing with complaints and resolving disputes and hostile situations

*To communicate effectively particular attention needs to be paid to the person's hearing, vision and other physical and cognitive abilities, as well as to their preferred language and possible need for an interpreter.*

<sup>1</sup>Consent and confidentiality are implicit within these benchmarks, see also benchmarks for record keeping factor 7 and privacy and dignity factor 5

Agreed patient-focused outcome

**Patients and carers experience effective communication, sensitive to their individual needs and preferences, that promotes high quality care for the patient**

<b>Factor</b>	<b>Benchmark of best practice</b>
1. Interpersonal skills	All health care personnel demonstrate effective interpersonal skills when communicating with patients and or carers
2. Opportunity for communication	Communication takes place at a time and in an environment that is acceptable to all parties
3. Assessment of communication needs	All patients' and or carers' communication needs are assessed on initial contact and are regularly reassessed. Additional communication support is negotiated and provided when a need is identified
4. Information sharing	Information that is accessible, acceptable, up to date and meets the needs of individuals is shared actively and consistently with all patients and or carers and widely promoted across all communities
5. Resources to aid communication and understanding	Appropriate and effective methods of communication are used actively to promote understanding between patients and or carers and health care personnel



Factor	Benchmark of best practice
6. Assessment to identify principal carer	The principal carer is identified at all times and an assessment is made with them of their needs, involvement, willingness and ability to collaborate with practitioners in order to provide care
7. Empowerment to perform role	All patients and or carers are continuously supported and fully enabled to perform their role safely
8. Co ordination of care	All care providers communicate fully and effectively with each other to ensure that patients and or carers benefit from a comprehensive plan of care which is regularly updated and evaluated
9. Empowerment to communicate needs	All patients and or carers are enabled to communicate their individual needs and preferences at all times
10. Valuing the patients' and or carers' expertise and contribution	Effective communication ensures and demonstrates that the patients' and or carers' expert contribution to patient care is valued, recorded and informs both patient care and health care personnel education with ongoing review
11. Training needs	All the patients' and or carers' information, support and training needs are jointly identified, agreed, met and regularly reviewed

## Factor 1 - Interpersonal skills

Health care personnel do not have the necessary interpersonal skills to communicate with patients and or carers

### Benchmark of best practice

All health care personnel demonstrate effective interpersonal skills when communicating with patients and or carers

E  A

*To communicate effectively particular attention needs to be paid to the patients' and or carers' hearing, vision and other physical and cognitive abilities, as well as to their preferred language and possible need for an interpreter.*

### Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- all health care personnel uphold the principles of common courtesy, especially when faced with challenging questions or working under pressure
- measures are in place to assess and provide feedback on the interpersonal skills of health care personnel
- the individual communication needs of patients and or carers that require specific, and or specialist interpersonal skills, are met

## Factor 2 - Opportunity for communication

The environment and or the time are barriers to effective communication

### Benchmark of best practice

Communication takes place at a time and in an environment that is acceptable to all parties

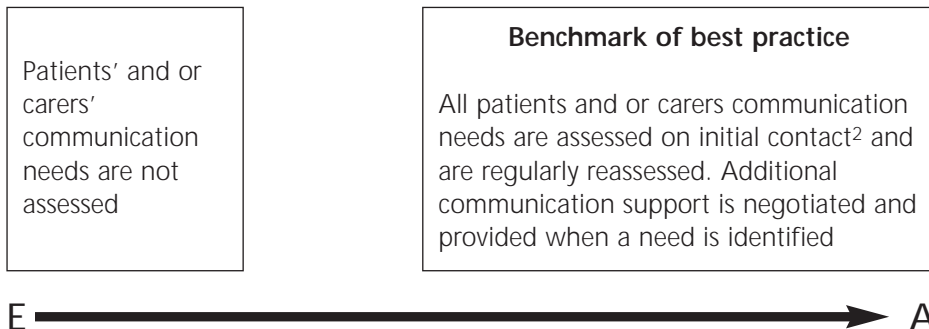


### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- patients and or carers who are physically isolated or unable to communicate directly with significant others are enabled to communicate
- patients and or carers have choice about where they exchange information
- restrictions to communication are explained
- assessment of the needs of patients and or carers identifies where and when communication should take place
- the inclusion of other people when communication occurs is agreed with the patients and or carers
- there is an appropriately furnished, separate and specially designated room (see *privacy and dignity*, factor 7)
- the environment is inclusive and adapted to meet differing communication needs in terms of, for example, lighting, acoustic conditions, hearing loops
- the environment supports communication and audit of the environment, including signage and maps to present information
- appointment times are arranged to facilitate communication
- mechanisms are in place to ensure necessary follow up appointments are made
- advocacy services are engaged according to the wishes of patients and or carers
- patients and or carers are identified in order to discuss treatment and care when face to face communication is not possible, for example by using a password system
- communication between patients and or carers and health care personnel is recorded

## Factor 3 - Assessment of communication needs



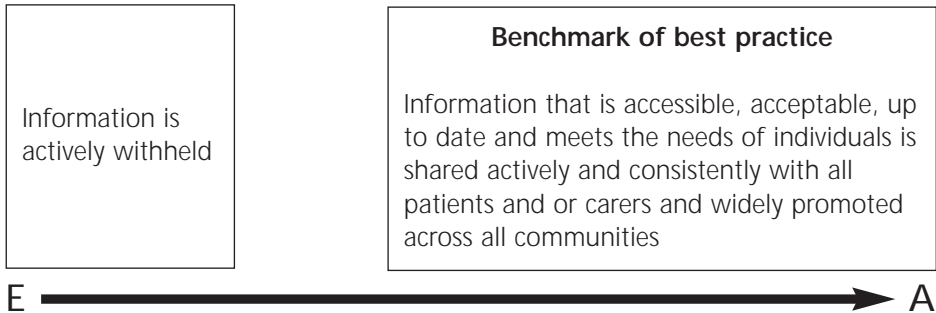
### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- an appropriate member of staff is identified to assess the patients' and or carers' ability to communicate
- you use a concise, evidence-based assessment tool which includes trigger questions if initial assessment has identified a communication need
- assessment is recorded and regularly re-evaluated
- the need for resources to aid communication is identified, provided for and documented

<sup>2</sup>Assessment at initial contact refers to the beginning of each and every episode of care.

## Factor 4 - Information sharing

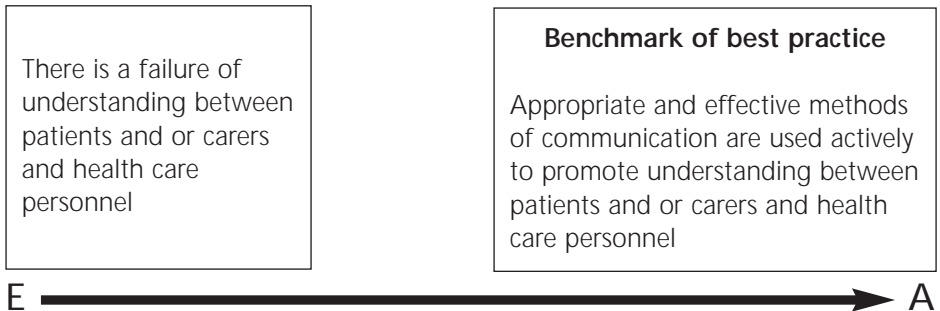


### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- information about support networks is shared actively and widely promoted
- information is explained and provided in an accessible format, for example, diaries, audio cassettes, books, intranet, signed and subtitled videos, large print text and British sign language translations
- patients' and or carers' needs are ascertained or anticipated and appropriate information is provided
- an interpreter service is available at the point of need which includes spoken and sign language where necessary
- contracts for interpretation services follow the principles of best value
- information is kept up to date and factual in plain language format with no jargon or abbreviations
- technical information is given at the required level of understanding
- information given is understood fully and has the same meaning for all involved
- resources such as leaflets, posters, library facilities, information technology (IT) facilities, adaptations and accessible information media are available for patients and or carers to use
- any strategies are in place to reach and engage patients and or carers within all communities, for example through out-reach measures and use of communication media, for example, pamphlets, video, letters, notice boards and television
- information is reviewed by patients and or carers and health care personnel to ensure it is accessible and applicable

## Factor 5 - Resources to aid communication and understanding

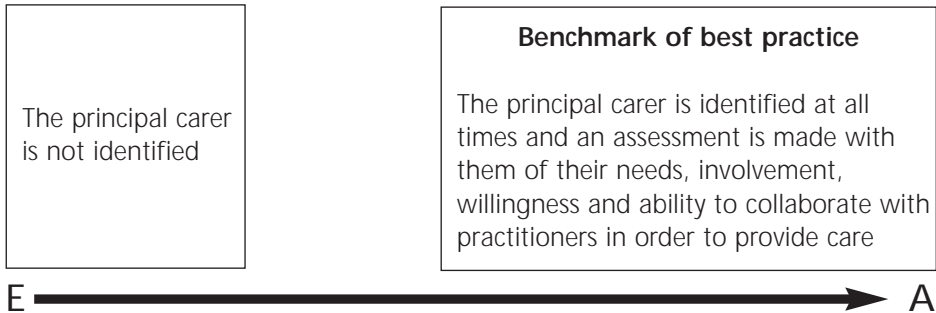


### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- resources are available, for example, hearing loops, text phone, pictures, books, toys, braille and multi lingual literature
- there is an up to date directory of resources that is readily available
- staff support patients and or carers in the use of resources
- patients' and or carers' views about resources are sought and used
- the use of the resources by patients and or carers is monitored and evaluated

## Factor 6 - Assessment to identify principal carer

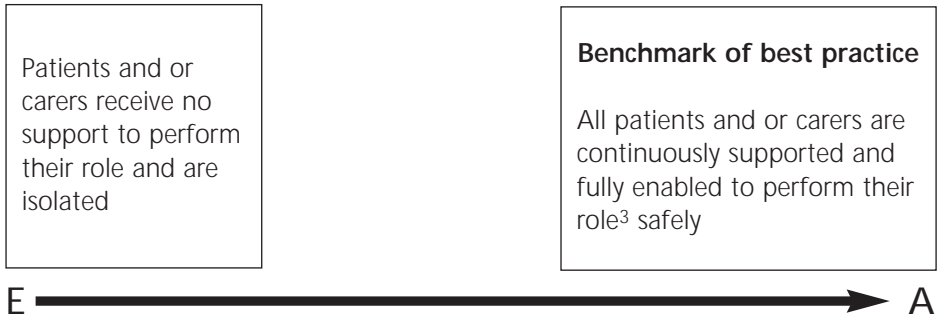


### Indicators of best practice for factor 6

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- the principal carer is identified agreed with the patient and the burden or impact of care is assessed
- explicit or expressed consent from the patient is sought
- the willingness of patients and carers to collaborate is clarified
- a suitably trained professional undertakes the initial assessment
- the current responsibilities of the carer are recorded and regularly evaluated
- the format of the assessment meets the patient's and carer's needs
- patient confidentiality is maintained
- the patients' and or carers' needs are anticipated
- information is obtained from carers to demonstrate their ability and willingness to care
- if the carer is a young person additional support needs are identified if required
- patients and or carers know who to contact first if they have any questions regarding care

## Factor 7 - Empowerment to perform role<sup>3</sup>



### Indicators of best practice for factor 7

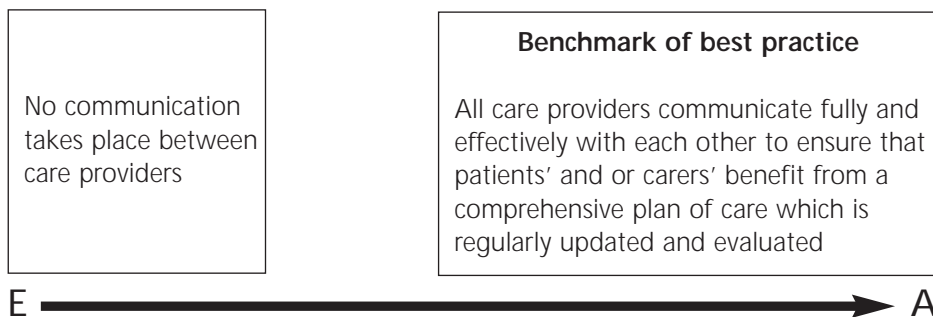
**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- current levels of support are documented
- patients' and or carers' rights to benefits, services and other help are communicated and assistance given
- patients' and or carers' psychological needs are considered and supported
- patients' and or carers' understanding of their role is determined
- patients and or carers are supported in their role
- individual risk assessments are performed and updated frequently
- patients and or carers are involved in risk assessment
- patients' and or carers' limitations are recognised and acted upon and supported
- mechanisms are in place for crisis intervention especially out of hours and at weekends and holidays
- support networks exist and patients and or carers know how to access them

<sup>3</sup>The term role refers to any function that contributes to the delivery of care



## Factor 8 - Co-ordination of care



### Indicators of best practice for factor 8

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the wishes of patients and or carers are listened to, considered and acted upon appropriately
- all care options are explained
- information given is fully understood by all and has the same meaning to everyone involved
- a named professional takes responsibility for the co-ordination of care and patients and or carers can identify their care co-ordinator and the key agencies providing care
- evidence-based pathways exist to provide an integrated approach to care and they are used and reviewed
- records are made available to patients and or carers within appropriate safeguards to ensure confidentiality is maintained and patients and or carers can contribute directly to the clinical record
- patients' and or carers', if willing, take part in 'case reviews'
- multidisciplinary 'case reviews' take place and benefit care, and outcomes are communicated to patients and or care providers

- networking between health care personnel improves staff to staff communication and the sharing of information
- patients and or carers are involved in person-centred planning, the single assessment process and discharge planning
- evidence is available to demonstrate the continuity of information exchange between care providers and giving conflicting information is avoided
- care plans are understandable by all care providers and are free of jargon
- care plans are updated, monitored and evaluated and are available to patients and or carers
- crisis plans are clear, concise and drawn up with patients and or carers

## Factor 9 - Empowerment to communicate needs

Patients and or carers are actively disempowered

**Benchmark of best practice**  
All patients and or carers are enabled to communicate their individual needs and preferences at all times

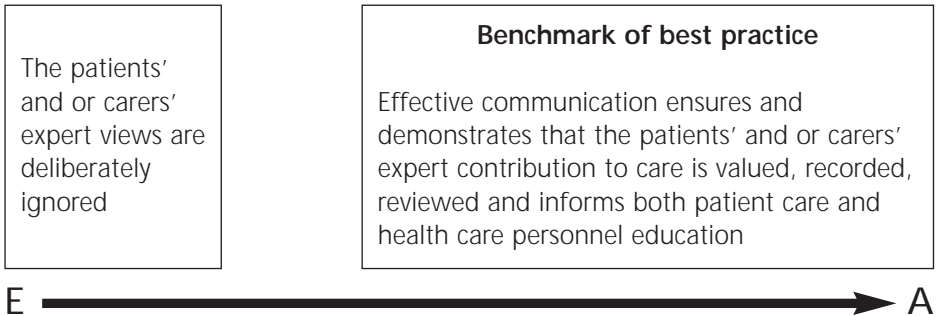


### Indicators of best practice for factor 9

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- health care personnel are proactive in anticipating the needs and preferences of patients and or carers
- sufficient time is given to enable patients and or carers to communicate their needs and preferences
- explicit or expressed consent is obtained and recorded from patients prior to treatment or care
- patients and or carers have access to advocacy
- patients and or carers have access to specialist knowledge and skills, for example, information technology
- technology is available and is used to meet patients' and or carers' needs, for example, electronic prescriptions

## Factor 10 - Valuing the patients' and or carers' expertise and contribution



### Indicators of best practice for factor 10

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- patients' and or carers' views are listened to and acted upon by care providers
- patients' and or carers' expertise is included in assessments
- education received by health care personnel from patients and or carers is recorded and evaluated
- the philosophy used reflects a positive approach to patients' and or carers' involvement
- the patients' and or carers' contribution to care is regularly reviewed, evaluated and documented
- mechanisms are in place to share and act upon examples of good practice by patients and or carers
- patients' and or carers' views are listened to, valued and respected

## Factor 11 - Patients' and or carers' training needs

Patients' and or carers' training needs are ignored

**Benchmark of best practice**  
All the patients' and or carers' information, support and training needs are jointly identified, agreed, met and regularly reviewed



### Indicators of best practice for factor 11

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- the learning needs of patients and or carers are identified
- patients' and or carers' technical competence is assessed
- training plans are developed and agreed with patients and or carers
- training opportunities are available for patients and or carers
- discharge plans show evidence of the support required by patients and or carers
- current directories of training courses and ongoing information are made available to patients and or carers
- training of patients and or carers supports an early discharge
- practitioners are assessed as competent to deliver training to patients and or carers and this is recorded
- any training for carers includes consideration of respite care

# Bibliography

- Banks P, Cheeseman, C and Maggs, S (1998) The carer's compass: directions for improving support to carers King's Fund: London
- British Medical Association (2000) Consent, rights and choices in health care for children and young people BMJ Books: London
- Department of Health (2000) Framework for assessment of children in need and their families: practice guidance The Stationery Office: London
- Department of Health (2001) Caring for older people: a nursing priority Department of Health: London
- Department of Health (2001) Consent: a guide for people with learning disabilities Department of Health: London
- Department of Health (2001) Consent: what you have a right to expect: a guide for adults Department of Health: London
- Department of Health (2001) Consent: what you have a right to expect: a guide for children and young people Department of Health: London
- Department of Health (2001) Consent: what you have a right to expect: a guide for parents Department of Health: London
- Department of Health (2001) Consent: what you have a right to expect: a guide for relatives and carers Department of Health: London
- Department of Health (2001) Good practice in consent implementation guide: consent to examination or treatment Department of Health: London
- Department of Health (2001) Good practice in consent: achieving the NHS Plan commitment to patient-centred consent practice Department of Health: London
- Department of Health (2001) Involving patients and the public in healthcare: response to the listening exercise Department of Health: London
- Department of Health (2001) Reference guide to consent for examination or treatment Department of Health: London
- Department of Health (2001) Seeking consent: working with older people Department of Health: London
- Department of Health (2002) NHS trust-based patient surveys: inpatients: acute hospitals: listening to your patients Department of Health: London
- Department of Health (2002) Patients' survey: NHS acute hospital trusts: guidance document Department of Health: London

- Easterbrook L (1999) When we are very old: reflections on treatment, care and support of older people King's Fund: London
- Farrell C (2001) Patients' views and experiences of NHS cancer services: a review of the literature Commission for Health Improvement/Audit Commission. The Stationery Office: London
- Farrell C (2001) There's no system to the whole procedure: listening to patient views and experiences of NHS cancer services Commission for Health Improvement/Audit Commission. The Stationery Office 2001: London
- Help the Aged (2000) Dignity on the ward: promoting excellence in care: good practice in acute hospital care for older people Help the Aged: London
- Help the Aged (2001) Dignity on the ward: improving the experience of acute hospital care for older people with dementia or confusion: a pocket guide for hospital staff Help the Aged: London
- Langley G, Nolan K, Nolan T, Norman C, Provost L, (1996) The improvement guide: a practical approach to enhancing organisational performance Jossey Bass Publishers: San Francisco
- Modernisation Agency (2002) Improvement leaders guide to setting up a collaborative programme - process mapping, analysis and redesign Department of Health: London
- NHS Executive (2001) Good practice in consent: Achieving the NHS Plan commitment to patient-centred consent practice Health Service Circular 2001/023 Department of Health: Leeds
- NHS Executive (2001) Twelve key points on consent: the law in England NHS Executive: Leeds
- Patel N (2001) Dignity on the ward: towards dignity. Acting on the lessons from hospital experiences of black and minority ethnic older people. A report from the policy research institute on ageing and ethnicity Help the Aged: London

## Internet resources

- Carers UK (2002) [Carers online](http://www.carersonline.org.uk/carersuk/index.html)  
<http://www.carersonline.org.uk/carersuk/index.html> (accessed March 2003)
  
- Department of Health (2001) [The national strategy for carers](http://www.carers.gov.uk/pdfs/care.pdf)  
<http://www.carers.gov.uk/pdfs/care.pdf>
  
- Department of Health (2002) [Carers: government policy on carers](http://www.doh.gov.uk/carers/index.htm)  
<http://www.doh.gov.uk/carers/index.htm>
  
- Department of Health (2002) [Confidentiality](http://www.nhsia.nhs.uk/confidentiality/pages/default.asp)  
<http://www.nhsia.nhs.uk/confidentiality/pages/default.asp> (accessed March 2003)
  
- Department of Health (2002) [Consent](http://www.doh.gov.uk/consent/)  
<http://www.doh.gov.uk/consent/> (accessed March 2003)
  
- Patient UK (2001) [Carers](http://www.patient.co.uk/carers.htm)  
<http://www.patient.co.uk/carers.htm> (accessed March 2003)

Additional bibliography is available on the disc.



NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**



# Original Benchmarks<sup>1</sup>

<sup>1</sup>Please note that the original benchmarks have been re-formatted. However, the content remains faithful to the language originally used by participants and agreed by consensus.

**CONTINENCE**

## **Essence of Care**

Benchmarks for Continence  
and Bladder and Bowel Care

## **Benchmarks for Continence and Bladder and Bowel Care**

Agreed patient-focused outcome

**Patients' bladder and bowel needs are met**

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 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-focused outcome

**Patients' bladder and bowel needs are met**

<b>Factor</b>	<b>Benchmark of best practice</b>
1. Information for patients and or carers and public	Patients and or carers have free access to evidence-based information about bowel and bladder care that has been adapted to meet individual patient needs and or those of their carer
2. Patient access to professional advice regarding continence, and bladder and bowel care	Patients have direct access to professionals who can meet their continence needs and their services are actively promoted
3. Assessment of individual patient	Patients' 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 is completed as described in Page 11, DH 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' care is continuously evaluated and leads either to the patients needs' being met or the modification of the care plan (e.g. referral on)
5. Education for professional assessors and care planners	Patients are assessed and have care planned by professionals who have received specific continence care training and are continuously updated

<b>Factor</b>	<b>Benchmark of best practice</b>
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 and the wider community
7. Patient access to continence supplies	Patients have access to appropriate 'needs specific' supplies to assist in the management of their incontinence
8. Education of the care deliverers	Patients 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 individual needs
10. Patient to patient support	Patients and or carers have the opportunity to access other patients 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

# Factor 1 - Information for patients and or carers and public

Patients and or carers have no evidence based information about bowel and bladder care

**Benchmark of best practice**  
Patients and or carers have free access to evidence-based information about bowel and bladder care that has been adapted to meet individual patient needs and or those of their carer



## Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- information is available including national and local information
- any measures are taken to ensure awareness and access of available information
- networking including links to self-help, user groups and health promotion units is utilised
- an evidence base for information is available and how this is evaluated to ensure it is up to date and consistent



## Factor 2 - Patient access to professional advice regarding continence, and bladder and bowel care

Patients do not have access to professional advice re professionals who can meet their continence needs

### Benchmark of best practice

Patients have direct access to professionals who can meet their continence needs and their services are actively promoted



### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- professional advice and services are available to meet individual needs
- policies, procedures, referral protocols are available to specialist services (See page 14 DH,2000)
- 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)
- any provisions have been made to ensure accessibility to continence services
- self-referral is possible
- response times for referrals or enquiries are met
- there are barriers that prevent needs being met locally such as language, lack of interpreters, waiting lists, products, equipment, lack of knowledge and interpersonal skills and what is being done to address these
- strategies incorporate education and training programme for practitioners to enable them to provide advice
- provisions have been made to ensure accessibility to continence services

## Factor 3 - Assessment of individual patient

Patients are not asked a trigger question related to bladder and bowel continence needs within their general health assessment

### Benchmark of best practice

Patients' 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 is completed as described in Page 11 of DH guidance

E  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 presenting themselves for help with continence problems have automatically given a positive response to the trigger question*

### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- a trigger question determines assessment
- the assessment tool used is evidence based
- the patients' understanding or acceptance of the trigger question is assessed and describe adaptations made to the trigger question used
- the use of trigger questions is promoted amongst colleagues and other team members
- assessment tools are adapted for specific patient groups
- trigger questions are asked as part of for example, the over 75 year assessment, school health checks, post-natal, routine admission, well persons clinics, nursing homes, opportunistic screening
- there is 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' plans of care to meet the bowel and bladder needs identified in the continence assessment

### Benchmark of best practice

The effectiveness of patients' care is continuously evaluated and leads either to the patients' needs being met or the modification of the care plan (e.g. referral on)



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

### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- care plans or care pathways are used and whether outcome are measured
- patients are involved in developing their own care plan and in setting their own outcome measures, including action to remove barriers such as the use of interpreters
- protocols or evidence based guidelines are used for care interventions
- details are used about referral rates, re-referral rates, complaints and patient survey results
- record keeping and evaluation is maintained and audited, including the extent of patient access to records (see record keeping benchmark)
- clinical audit is undertaken and how these results are disseminated and inform practice development

## Factor 5 - Education for professional assessors and care planners

Patients are not assessed or do not have care planned by a health professional

**Benchmark of best practice**  
Patients are assessed and have care planned by professionals who have received specific continence care training and are continuously updated



### Indicators of best practice for factor 5

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- roles and responsibilities are defined for those carrying out assessment and planning of care, state who assesses and plans care
- initial and ongoing education and training opportunities, programmes, policies and training analysis, peer group review, supervision and personal development plans are used
- training packages, information and communication channels are used
- training records are maintained
- the patients' views and expectations are included in any training programme including links with self-help or user groups
- the impact of training is assessed and evaluated
- the education content and outcomes includes consideration of all individual needs

## Factor 6 - Promotion of continence and a healthy bladder and bowel

There is no attempt to promote patients' continence and a healthy bladder and bowel

### Benchmark of best practice

All opportunities are taken to promote continence and a healthy bladder and bowel among patients and the wider community



### Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- risk groups are identified locally for example, antenatal, post natal, special needs, school age children, elderly, disabled, post operative, and post procedure and what you are doing to target these groups. (NB At risk groups identified in DH Good Practice in Continence Services (p8))
- inter-professional or interagency working is assured and how this promotes continence
- 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
- measures to promote continence services, including links with self help user groups and health promotion units, the displaying and use of posters and leaflets
- audits are undertaken, educational links and ongoing research
- links with local user or self help groups are used to raise awareness
- any local awareness initiatives, including use made of national promotional opportunities (e.g. National Continence Week)

## Factor 7 - Patient access to continence supplies

Patients do not have access to supplies that assist in the management of their incontinence

**Benchmark of best practice**  
Patients have access to appropriate 'needs specific' supplies to assist in the management of their incontinence



### Indicators of best practice for factor 7

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- health care personnel are proactive in anticipating the needs and preferences of patients
- sufficient time is given to enable patients to communicate their needs and preferences
- explicit or expressed consent is obtained from patients prior to treatment or care
- patients have access to specialist knowledge and skills
- technology is available and is used to meet patient needs, for example, electronic prescriptions
- the use of services is monitored for example, by regular audit

## Factor 8 - Education of the care deliverers

Patients are cared for by carers with no continence training

### Benchmark of best practice

Patients are cared for by carers who have undertaken continence care training which includes ongoing updating

E  A

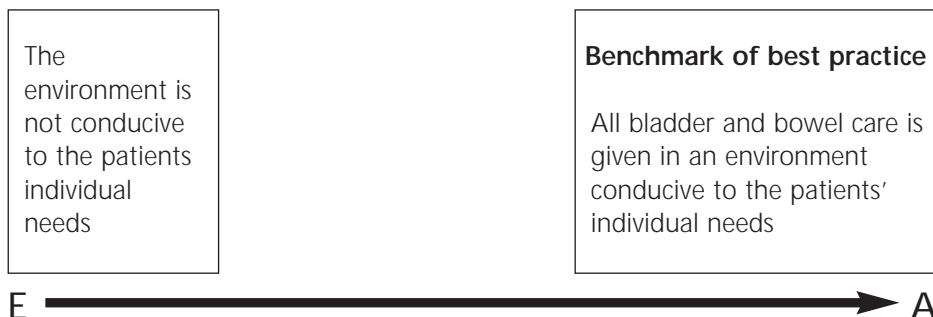
*NB. Education should involve regular practice and peer review e.g. DH Good Practice in Continence Services states that best outcomes for specialist surgery are achieved when surgical teams operate on a critical volume of cases to maintain and improve their expertise*

### Indicators of best practice for factor 8

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- those who give care have their training needs assessed and how this is carried out
- initial and ongoing education and training opportunities or programmes and policies are used
- intended learning outcomes are identified
- peer group review, supervision and personal development plans are used
- service user views and expectations are included in training programmes including links with self-help or user groups
- the impact of training is assessed and evaluated
- training packages, information and communication channels are used
- any NVQ programme is used and the evidence required
- training of patients and or carers, families or support groups takes place

## Factor 9 - A physical and social environment conducive to continence and a healthy bladder and bowel



*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)*

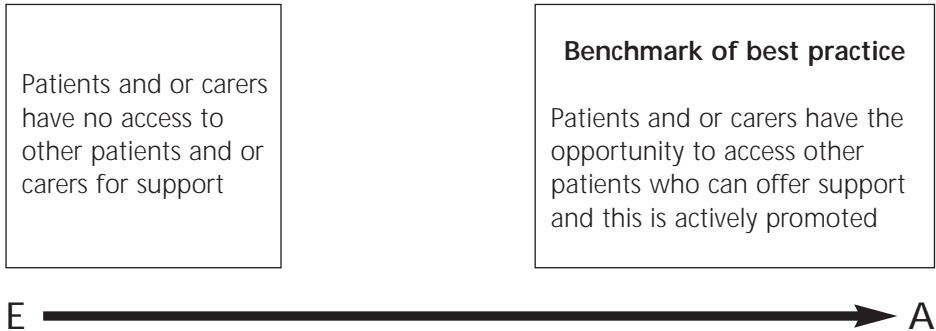
### Indicators of best practice for factor 9

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- attempts are made to make the environment conducive for the individual such as lighting, cleanliness, heating adaptations, curtains meet, doors lock, male/female toilets, hand washing/douche facilities, age related facilities, religious and cultural sensitivities
- individual patient needs are met including privacy and dignity, dietary needs, medications and flexibility of toileting regimes
- patients' views on the environment are sought and acted upon and action taken to remove any barriers
- consultation with specialist continence professionals has taken place in assessing the environment
- the environment is adapted to meet the individual needs of patients for example, with mobility problems



## Factor 10 - Patient to patient support



### Indicators of best practice for factor 10

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- strategies are used to put service users in touch with each other
- service users are aware that they can contact others
- measures have been taken to set up or support a local self-help or user group and whether there are any barriers to this support
- links to local or national patient groups exist
- information about local or national patient groups is given to patients
- any preparation received by the patients and or carers provides support

## Factor 11 - User involvement in service delivery

No user feedback or involvement sought

**Benchmark of best practice**  
Users are always involved in planning and evaluating services, and their input is acted upon

**E**  **A**

*Users whenever possible should be involved in all aspects of care planning and delivery*

*User is patient, relative, family, and carer*

### Indicators of best practice for factor 11

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- methods are 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
- patients' satisfaction with continence services is assessed and how any complaints are addressed
- there is evidence of inter-agency involvement and networking with all stakeholders
- strategies are used to involve users from isolated or hard to reach communities

# Bibliography

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

Additional bibliography used at initial compilation is available on the disc.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





**Essence of Care**  
Benchmarks for Personal and Oral Hygiene

## Benchmarks for Personal and Oral Hygiene

Agreed patient-focused outcome

**Patients personal and oral hygiene needs are met according to their individual and clinical needs**

*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.

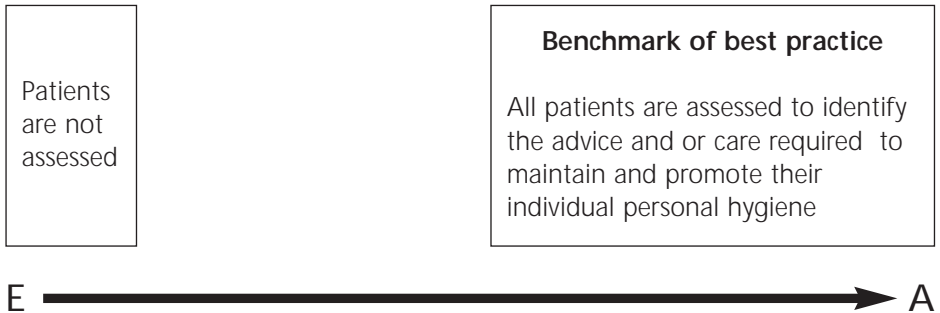
*Healthy mouth* = Clean, functional, and comfortable oral cavity, free from infection.

	<b>Factor</b>	<b>Benchmark of best practice</b>
1a.	Individual assessment of personal hygiene needs	All patients 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 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 and or 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 and or carers and is based on assessment of their individual needs
3.	Environment within which oral and personal hygiene needs are met	Patients have access to an environment that is safe and acceptable to the individual

4.	Provision of toiletries for own personal use	Patients 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 have access to the level of assistance that they require to meet individual personal hygiene needs
5b.	Providing assistance with oral hygiene when required	Patients have access to the level of assistance that they require to meet 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 and or carers are provided with information and 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 and or carers are provided with information and education to meet their individual oral hygiene needs
7a.	Evaluation and reassessment of personal hygiene needs and how effectively these are being met	Patients' care is continuously evaluated, reassessed and the care plan renegotiated
7b.	Evaluation and reassessment of oral hygiene needs and how effectively these are being met	Patients' care is continuously evaluated, reassessed and the care plan renegotiated



## Factor 1a - Individual assessment of personal hygiene needs



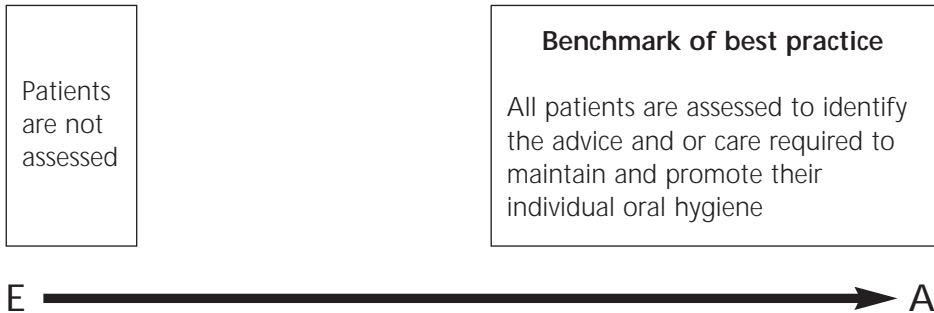
*Unqualified staff, students/patients/carers can assess if they have received the necessary education and training and have been assessed as competent to undertake the assessment, but accountability remains with the registered practitioner.*

### Indicators of best practice for factor 1a

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the assessment undertaken incorporates identification of individual needs and identification of those at risk, for example infection control
- the assessment is performed in a timely manner
- the assessment is recorded and validated tool is used
- the assessed needs are communicated to the multi-professional team for example podiatrists, infection control and the occupational therapist
- education and training in assessment is provided to, and undertaken by all carers

## Factor 1b - Individual assessment of oral hygiene needs



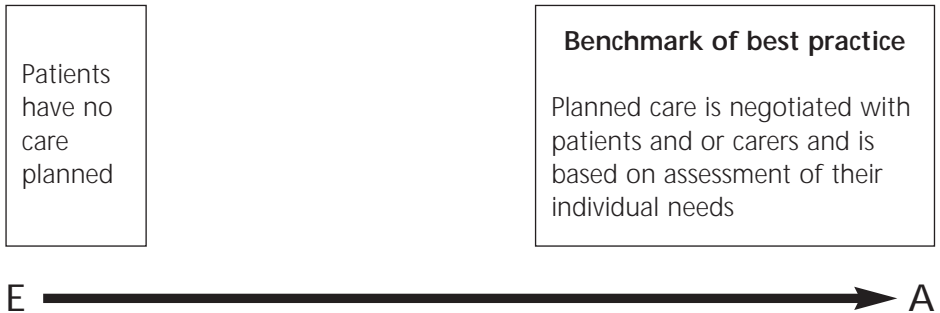
*Unqualified personnel, students and carers can assess if they have received the necessary education and training and have been assessed as competent to undertake the assessment, but accountability remains with the registered practitioner.*

### Indicators of best practice for factor 1b

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the assessment undertaken incorporates identification of individual needs and identification of those at risk for instance infection control
- the assessment is performed in a timely manner
- the assessment is recorded and whether a validated tool is used
- the assessed needs are communicated to the multi-professional team for example the dentist, dental hygienist, infection control, occupational therapist and dietitians
- education and training in assessment is provided and undertaken by all carers

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

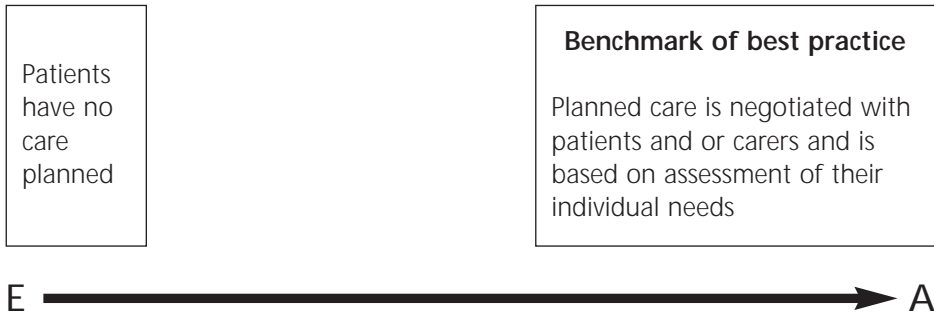


### Indicators of best practice for factor 2a

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- the evidence base for care is apparent, reviewed and kept up to date
- care is negotiated with patients and family carers for example by considering shared care and care to meet individual needs

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



### Indicators of best practice for factor 2b

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- the evidence base for care is apparent, reviewed and kept up to date
- care is negotiated with patients and family carers for example by considering shared care and care to meet individual needs

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

Patients do not have access to a safe and acceptable environment

### Benchmark of best practice

Patients have access to an environment that is safe and acceptable to the individual

E  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 Benchmarks).*

*Safe is a physical and psychological environment that addresses infection control issues for example hand washing, protective clothing, individual bowl for patient use, moving and handling equipment and adaptations to meet individual patient requirements.*

### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- adaptations have been made to the environment (see 'acceptable' above)
- risk factors are taken in to account when ensuring a safe environment for example, water temperature and wet floors
- access is facilitated
- privacy and dignity is assured and how this occurs
- infection control arrangements ensure health care personnel and patients safety

## Factor 4 - Provision of toiletries for own personal use

Patients do not have toiletries for their own personal use

### Benchmark of best practice

Patients are expected to supply their own toiletries but single use toiletries are provided until they can supply their own

E  A

*Toiletries must be for single patient use only.*

*This includes toiletries for personal and oral hygiene (toothpaste, toothbrush, razor).*

### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- toiletries are made available to patients if they do not have their own
- patients are encouraged to provide their own toiletries
- personal use of toiletries is assured and items are not shared
- patients are made aware of what toiletries are required

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

Patients are not offered assistance to meet personal hygiene needs

### Benchmark of best practice

Patients have access to the level of assistance that they require to meet individual personal hygiene needs

E  A

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

### Indicators of best practice for factor 5a

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- individual requirements are met
- there is someone available to provide assistance and what training they have received
- registered practitioners verify the ongoing competence of the unregistered carer when providing assistance
- there is an appropriate level of supervision of unregistered carers
- the level of assistance to be given is communicated to carers for example by discussing the plan of care with patient and carer

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

Patients are not offered assistance to meet their oral hygiene needs

### Benchmark of best practice

Patients have access to the level of assistance that they require to meet their individual oral hygiene needs



*Individual needs includes assisting patients to carry out their oral hygiene requirements as and when they wish for example after meals.*

### Indicators of best practice for factor 5b

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- individual requirements are met
- there is someone available to provide assistance and what training they have received
- registered practitioners verify the ongoing competence of the unregistered carer when providing assistance
- there is an appropriate level of supervision of unregistered carers
- the level of assistance to be given is communicated to carers for example by discussing the plan of care with patient and carer



## 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 are provided with no information or education

### Benchmark of best practice

Patients and or carers are provided with information and education to meet their individual personal hygiene needs

E  A

*Education includes checking and reinforcing understanding.*

### Indicators of best practice for factor 6a

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the range of information, evidence base and format used make it accessible and understandable and culturally appropriate
- there is information to make patient and or carer aware of problems that may occur due to the introduction of a specific treatment, for example, chemotherapy or surgery
- patients' understanding is checked
- 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 are provided with no information or education

**Benchmark of best practice**  
Patients and or carers are provided with information and education to meet their individual oral hygiene needs

E  A

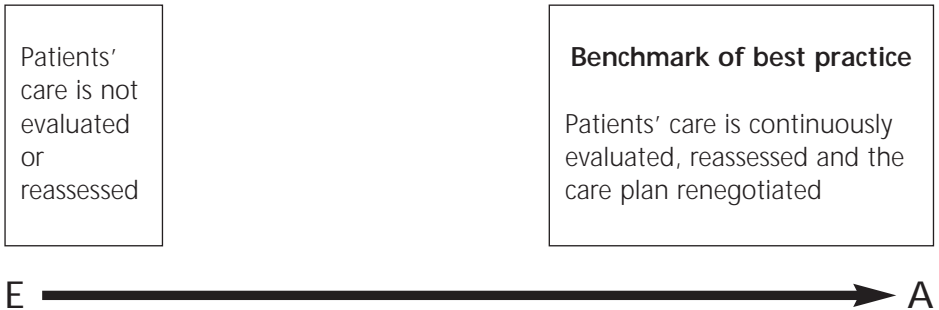
*Education includes checking and reinforcing understanding.*

### Indicators of best practice for factor 6b

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the range of information, evidence base and format used make it accessible and understandable and culturally appropriate
- there is information to make patient and or carer aware of problems that may occur due to the introduction of a specific treatment, for example, chemotherapy and surgery
- patients' understanding is checked
- partnerships with others supports the promotion of personal hygiene

## Factor 7a - Evaluation and reassessment of personal hygiene needs and how effectively these are being met



*Negotiation:- may need to be with carers and or family. If no negotiation with the patient 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 condition/state.*

### Indicators of best practice for factor 7a

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- skills and competencies in evaluation are maintained and monitored
- the documentation and tools used are appropriate and up to date
- communication channels are used for promoting feedback of patients and all carers
- there are triggers for assessment and reassessment and what these are

## Factor 7b - Evaluation and reassessment of oral hygiene needs and how effectively these are being met

Patients care is not evaluated or reassessed

**Benchmark of best practice**  
Patients' care is continuously evaluated, reassessed and the care plan renegotiated

**E**  **A**

*Negotiation:- may need to be with carers and or family. If no negotiation with the patient 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 condition/state.*

### Indicators of best practice for factor 7b

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- skills and competencies in evaluation are maintained and monitored
- the documentation and tools used are appropriate and up to date
- communication channels are used for promoting feedback of patients and all carers
- there are triggers for assessment and reassessment and what these are

# Bibliography

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

Additional bibliography used at initial compilation is available on the disc.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





**Essence of Care**  
Benchmarks for Food & Nutrition



## Benchmarks for Food and Nutrition

Agreed patient-focused outcome

**Patients are enabled to consume food (orally) which meets their individual need**

<b>Factor</b>	<b>Benchmark of best practice</b>
1. Screening and assessment to identify patients nutritional needs	Nutritional screening progresses to further assessment for all patients identified as 'at risk'
2. Planning, implementation and evaluation of care for those patients who require 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 to eat
4. Assistance to eat and drink	Patients receive the care and assistance they require with eating and drinking
5. Obtaining food	Patients and or 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
7. Food availability	Patients 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 in a way that takes into 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 patients to eat to promote their own health                        |

NB nutritional trigger assessment should always be undertaken at initial contact and the need for reassessment of patients 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, 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 the patients physical, religious, cultural, age related and special needs, requirements and requests.

# Factor 1 - Screening and assessment to identify patients nutritional needs

Patients nutritional needs are not ascertained

**Benchmark of best practice**  
Nutritional screening progresses to further assessment for all patients identified as 'at risk'

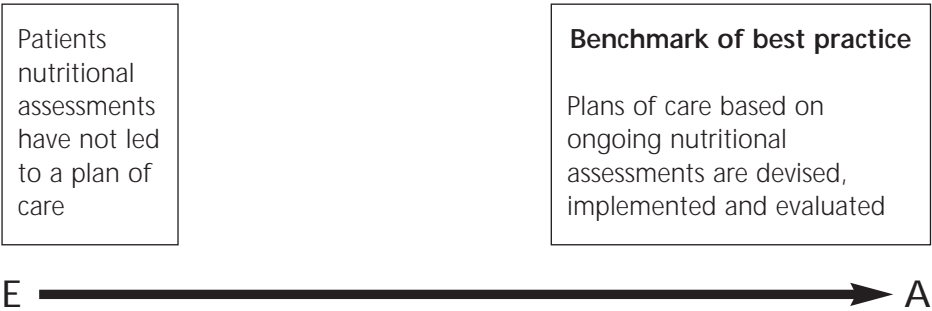


## Indicators of best practice for factor 1

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- there is a clear definition by what is meant of 'at risk' what are the components of screening
- the components of the assessment are evidence based and what these are
- screening takes place within a required time frame and state who carries this out
- triggers promote need for re-assessment and how often screening takes place

## Factor 2 - Planning, implementation and evaluation of care for those patients who require a nutritional assessment



### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- plans are 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
- relevant members of the multidisciplinary team are involved in assessment for instance dietician, nutritionist, speech and language therapists, occupational therapists and physiotherapists
- there are arrangements for evaluation that ensures that changes are made to individual patients plan of care to reflect changes to nutritional requirements
- arrangements for audit exist that leads to changes in practice if necessary
- patient, carer and professional information is available to inform active involvement

## Factor 3 - A conducive environment (acceptable sights, smells and sounds)

Environmental factors prevent patients eating

**Benchmark of best practice**  
The environment is conducive to enabling the individual patients to eat

**E**  **A**

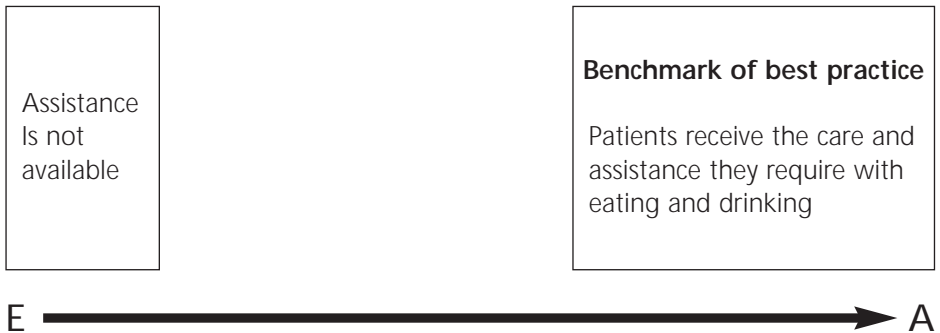
*NB Practitioners are reminded that the environment should be conducive to the individual patient and not necessarily what is conducive to practitioners/ professionals.*

### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- measures are taken to ensure that the environment is conducive to the patients individual needs and considers dining areas, tables, seating, utensils, adapted utensils and washing facilities
- inappropriate activity at meal times such as cleaning and ward rounds are curtailed
- practitioners ensure the environment is conducive including discussion of issues related to ownership and accountability

## Factor 4 - Assistance to eat and drink



*Assistance to include: preparation of patient prior to eating for example, hand washing and positioning of patient, equipment such as feeding utensils, '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.*

### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- there is someone available to provide assistance and what training they have received
- the level of assistance is assessed on every occasion that food and drink is served and by whom
- carers and or relatives are involved in assisting and how this is negotiated
- education programmes are in place to teach patients with specific needs to feed themselves (or to educate their relatives and or carers to feed them)
- a range of equipment, utensils and furniture is available to meet individual patient needs
- independence is promoted and how this is achieved
- other health professionals are involved for example, dietician, nutritionist, catering staff, speech and language therapists, occupational therapist and physiotherapists

## Factor 5 - Obtaining food

No information is provided on how to obtain food

### Benchmark of best practice

Patients and or carers, whatever their communication needs, have sufficient information to enable them to obtain their food



### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- liaison occurs between catering staff and care providers
- there is a range of information available to meet individual needs
- information is shared with patients, relatives and carers
- those assisting with menu completion or obtaining food have had any specific training to ensure their competency in selecting meals to meet the individual needs of the patients
- the timing of ordering supports patient choice

## Factor 6 - Food provided



*Patients' needs linked to Factors 1 & 2.*

*Food not provided by the service may be purchased or brought in by families or carers.*

### Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- choice is ensured that allows patients personal individual preferences to be met
- there are arrangements for ensuring therapeutic and special formulated diets are requested and provided including correct texture and consistency
- the service and staff ensure that patients receive the correct portion size and the food they actually ordered
- staff ensure that food and drink is served at the correct temperature for patient preference and safety
- food is prepared in a way that meets religious needs and how this is provided



## Factor 7 - Food availability

Patients have set meal times – no availability of food between meal times

### **Benchmark of best practice**

Patients have set meal times, are offered a replacement meal if a meal is missed and can access snacks at any time



### **Indicators of best practice for factor 7**

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- snacks are made available
- there is a variety of hot and cold meals and drinks available (NB NHS standard beverage > 7 + 3 meals per day + drinking water)
- hot food is made available outside of meal times and how this is accessed
- any equipment is available to prepare food including precautions taken to ensure food meets safety standards
- food storage and preparation facilities are available and how these are maintained to ensure safe fridge, food handling for example, free from contamination
- arrangements are in place for patients' own food to be brought in and stored
- education and training of staff in food handling and preparation is provided including issues regarding religion and culture

## Factor 8 - Food presentation

Patients are presented with food that is not appealing

### **Benchmark of best practice**

Food is presented to patients in a way that takes into account what appeals to them as individuals

E  A

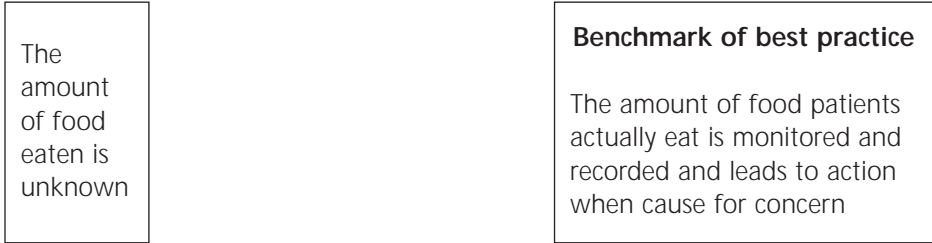
*Appealing: the appearance tempts, makes patients want to eat it.*

### **Indicators of best practice for factor 8**

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the serving method used for example plated or bulk meets the needs of the patient
- all packaging is removed at the appropriate time
- food is served at the patients required temperature
- someone is responsible for ensuring that the food presented is appealing
- efforts are made to ensure that the food served is appealing for example, smell, moulds for purees, personal touches and garnishes
- there is a suitable range of crockery and utensils and how their condition is maintained
- religious and cultural requirements for food presentation are met for example, sealed cutlery and crockery

## Factor 9 - Monitoring



*NB This includes liquid food.*

### Indicators of best practice for factor 9

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- food and fluid intake is documented or recorded and how and where this is recorded, for example, food amounts and frequency charts and whether accuracy is assured and assessed
- patients, carers, practitioners or professionals complete the food and fluid chart
- food is served and empty containers collected by an appropriate person
- any action is taken as a result of monitoring, including by whom

## Factor 10 - Eating to promote health

No attempt is made to encourage patients to eat to promote their own health

### **Benchmark of best practice**

All opportunities are used to encourage patients to eat to promote their own health



*NB this includes patients' who require a therapeutic diet.*

### **Indicators of best practice for factor 10**

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- opportunities are created or used to advise patients on eating to promote their own health for example, discussion, displays and handouts
- religious or cultural needs for a healthy diet are promoted and met
- training is available for staff on the promotion of healthy eating
- multi-agency partnerships exist that encourage clients to eat to promote their own health

# Bibliography

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

Additional bibliography used at initial compilation is available on the disc.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





**Essence of Care**  
Benchmarks for Pressure Ulcers



## Benchmarks for Pressure Ulcers

Agreed patient-focused outcome

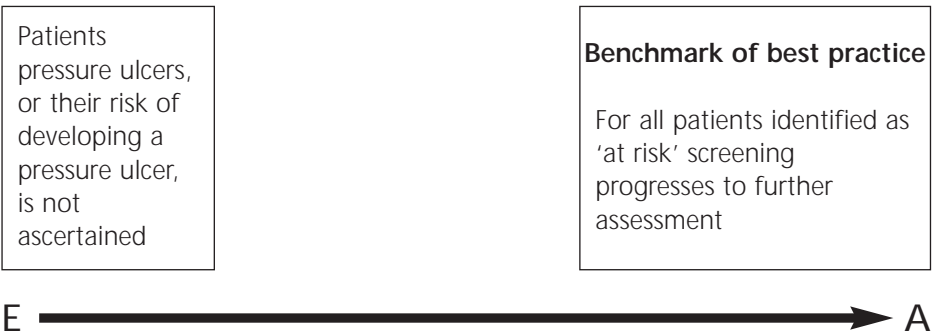
**The condition of the patients' skin will be maintained or improved**

For the purpose of these benchmarks a definition of pressure ulcers (*sometimes referred to as Pressure sore/Bed sore/Decubitus ulcer*) is = identified damage to an individual's skin due to the effects of pressure together with, or independently from a number of other factors for example shearing, friction and moisture.

<b>Factor</b>	<b>Benchmark of best practice</b>
1. Screening and assessment	For all patients identified as 'at risk' screening progresses to further assessment
2. Who undertakes the assessment	Patients are assessed by assessors who have the required specific knowledge and expertise, and have ongoing updating
3. Informing patients and or carers (prevention and treatment)	Patients and or 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 patients and or carers, with evidence of ongoing reassessment

- |    |  |  |
|----|--|--|
| 5. | Pressure ulcer prevention<br>– repositioning                           | The patients need for repositioning has been assessed, documented, met and evaluated with evidence of ongoing reassessment                             |
| 6. | Pressure ulcer prevention<br>– redistributing support surfaces         | Patients at risk of developing pressure ulcers are cared for on pressure redistributing support surfaces that meet individual needs, including comfort |
| 7. | Pressure ulcer prevention<br>– availability of resources and equipment | Patients 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 and or carers   |
| 9. | Evaluation of interventions by a registered practitioner               | An evaluation which incorporates patients and or carers participation in forward planning, is documented   |

# Factor 1 - Screening and assessment



*NB. Screening should always be undertaken at initial contact and the need for reassessment of patients 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 and or tools can be used to identify and quantify the patients 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.*

## Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- patients are assessed as being 'at risk'
- the components of the screening assessment are adequate and what is included in full assessment and what tools are used
- the screening assessment is recorded
- the screening assessment is carried out within an acceptable time frame and who undertakes it
- a manual handling assessment is included
- the evidence base for assessment reflects current evidence

## Factor 2 - Who undertakes the assessment

Patients are assessed by assessors who do not have the required specific knowledge and expertise

**Benchmark of best practice**  
Patients are assessed by assessors who have the required specific knowledge and expertise, and have ongoing updating

**E**  **A**

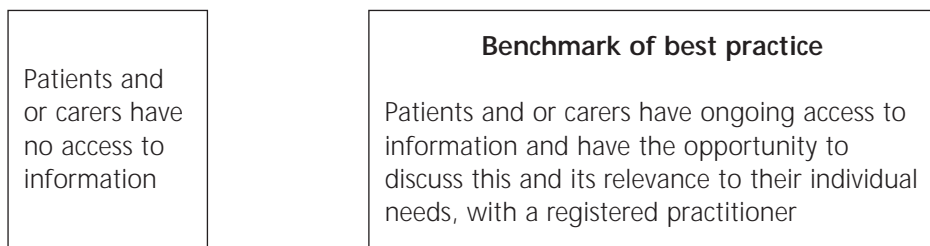
*Practitioners, students, patients and or carers can screen patients if they have received the necessary education and training and have been assessed as competent to undertake the screening, but accountability remains with the registered practitioner. Registered professionals who have received the necessary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

### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the knowledge and expertise for completing screening and assessment is acquired
- knowledge, skills and attitudes are updated on an ongoing basis
- there are mechanisms in place for assessing the competence of the screeners and assessors
- specialist assessment is accessed if required
- assessment is documented and accessed by the caring team

## Factor 3 - Informing patients and or carers (prevention and treatment)



E  A

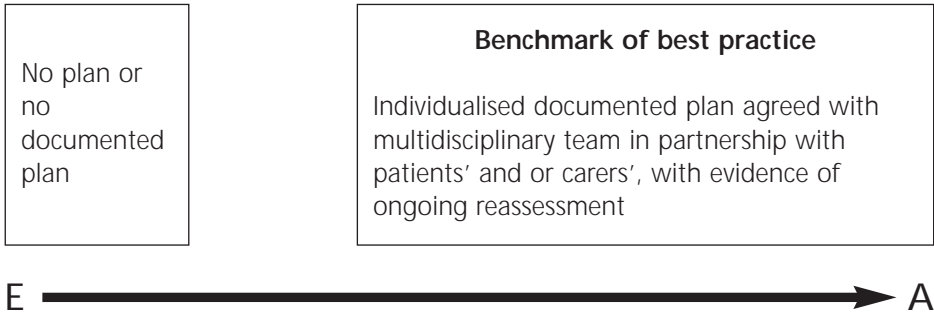
*Professionals have the specific knowledge base to lead an informed discussion with the patient and or carer.*

### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- there is a range of information which is in a format that meets patients' or carers' individual needs such as language, tapes, videos and leaflets
- there is an evidence base for the information
- patients' understanding of information is verified and choices are documented
- the sharing and understanding of information is recorded

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



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

### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the responsibilities of patients, carers and multi-disciplinary team members with regard to treatments, interventions, milestones and targets are negotiated and agreed. This ought to include removal of barriers to effective communication for instance linguistic, age related and special needs
- there is evidence that all plans are underpinned by best evidence
- there are mechanisms in place to ensure review of plans and evaluation

## Factor 5 - Pressure ulcer prevention - repositioning

The patients' need for repositioning has not been assessed

### Benchmark of best practice

The patients' need for repositioning has been assessed, documented, met and evaluated with evidence of ongoing reassessment

E  A

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

### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- equipment is available to enable correct moving and handling and positioning including pillows for example
- information for re-positioning is available for patients and or carers
- policies or guidelines are in use regarding, for example, health and safety, manual handling and use of equipment

## Factor 6 - Pressure ulcer prevention - redistributing support surfaces

Patients at risk of developing pressure ulcers are not given the opportunity of being placed on pressure redistributing support surfaces

**Benchmark of best practice**

Patients at risk of developing pressure ulcers are cared for on pressure redistributing support surfaces that meet individual needs, including comfort

E  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.*

### Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- any redistributing support surfaces are used and whether this is recorded
- there are any arrangements for cleansing, maintaining and replacing equipment
- there are infection control policies in place and their relevance to surface cleaning
- patients' comfort is assessed and assured
- there is a process for ordering, delivery and monitoring of support surfaces
- any patient information is available including consideration of information to meet individual needs



## Factor 7 - Pressure ulcer prevention - availability of resources and equipment

Patients are not provided with any pressure ulcer prevention equipment

### Benchmark of best practice

Patients have all the equipment they require to meet their individual needs

E  A

*Equipment:- for example, pressure redistributing equipment including seating, mattresses, specialist beds, bed frames, electric profiling bed frames, moving and handling, hoists, footwear and insoles.  
Types of dressing evidenced as a preventative measure are included.*

### Indicators of best practice for factor 7

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- a range of equipment is available and what this comprises
- there are any barriers that limit access to or use of equipment
- arrangements for equipment cleanliness, repair, maintenance and replacement are in place
- infection control policies are in place and their relevance to equipment cleaning
- there is a process for ordering, delivering and monitoring of equipment
- patients 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

**Benchmark of best practice**  
The plan is fully implemented in partnership with the multidisciplinary team, patients and or carers



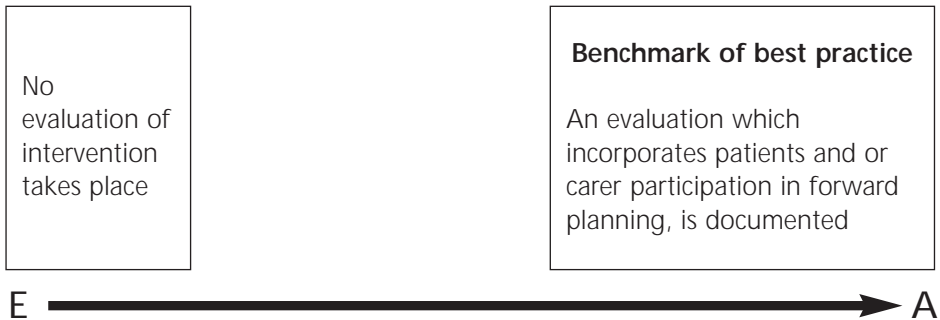
*NB. The inability to implement the plan leads to re-assessment*

### Indicators of best practice for factor 8

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- there are any barriers to the implementation of planned care and how variance is recorded
- the multidisciplinary team is involved and how involvement is documented
- patients and or carers are involved and how this is carried out
- there is any evidence of patient and or carer training

## Factor 9 - Evaluation of interventions by a registered practitioner



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

### Indicators of best practice for factor 9

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- patients' and or carers' are actively involved and how this is achieved
- documentation reflects accurate and timely evaluation, for example, audit of records
- guidelines and policies are in use that support forward planning

# Bibliography

- University of Leeds Nuffield Institute for Health: University of York NHS Centre for Reviews and Dissemination (1995) The prevention and treatment of pressure sores Effective Health Care. 2 (1)
- National institute for clinical excellence (2001) Inherited clinical guideline B Pressure ulcer risk assessment and prevention National Institute for Clinical Excellence: London
- NHS Executive (1994) Pressure sores: a preventable problem Department of Health VFM update 12

Additional bibliography used at initial compilation is available on the disc.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**







*Modernisation Agency*

**Essence of Care**  
Benchmarks for Privacy & Dignity

## Benchmarks for Privacy and Dignity

Agreed patient-focused outcome

**Patients benefit from care that is focused upon respect for the individual**

<b>Factor</b>	<b>Benchmark of best practice</b>
1. Attitudes and behaviours	Patients feel that they matter all of the time
2. Personal world and personal identity	Patients experience care in an environment that actively encompasses individual values, beliefs and personal relationships
3. Personal boundaries and space	Patients personal space is actively promoted by all staff
4. Communicating with staff and patients	Communication between staff and patients takes place in a manner which respects their individuality
5. Privacy of patient-confidentiality of patient information	Patient information is shared to enable care, with their consent
6. Privacy, dignity and modesty	Patients' care actively promotes their privacy and dignity, and protects their modesty
7. Availability of an area for complete privacy	Patients and or carers can access an area that safely provides privacy

*Privacy* = Freedom from intrusion

*Dignity* = Being worthy of respect



## Factor 1 - Attitudes and behaviours

Patients experience deliberate negative and offensive attitude and behaviour

**Benchmark of best practice**  
Patients feel that they matter all of the time



### Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- good attitudes and behaviour are promoted and assured, including consideration of non verbal behaviour and body language
- issues about attitude and behaviour towards minority groups are addressed with individual staff using for example induction programmes
- partnerships exist which support the promotion of good attitudes and behaviours

## Factor 2 - Personal world and personal identity

Patients individual values, beliefs and personal relationships are never explored

### Benchmark of best practice

Patients experience care in an environment that actively encompasses respect for individual values, beliefs and personal relationships

E  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)*

### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- stereotypical views are challenged
- valuing of diversities is demonstrated
- individual needs and choices are ascertained and continuously reviewed

## Factor 3 - Personal boundaries and space

Patients personal boundaries are deliberately invaded

**Benchmark of best practice**  
Patients' personal space is actively promoted by all staff

E  A

*(Link specifically to Privacy and Dignity - Factor 6 & 7)*

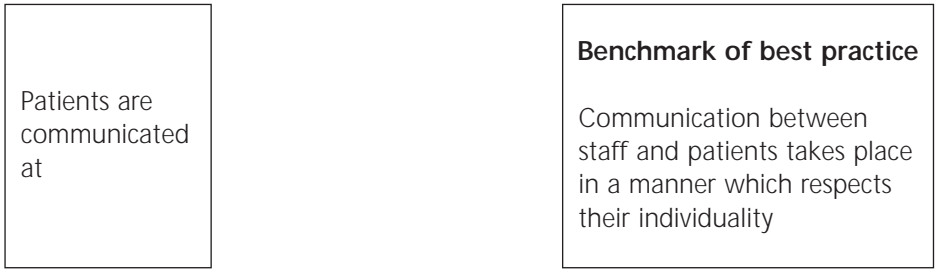
*Personal Space: Patients set boundaries for psychological, physical, emotional and spiritual contact.*

### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the name the patient wants to be called is agreed
- the acceptability of personal contact (touch) is identified with individual patients
- patients' personal boundaries are identified and communicated to others for example using the patients own language
- personal space is respected and protected for individuals
- strategies are in place to prevent disturbing or interrupting patients, for example, knocking before entering
- privacy is effectively maintained, for example, using curtains, screens, walls, rooms, blankets, appropriate clothing and appropriate positioning of patient
- single sex facilities are provided and whether there is access to segregated or age specific toilet and washing facilities
- clinical risk is handled in relation to privacy
- privacy is achieved at times when the presence of others is required

## Factor 4 - Communicating with staff and patients



E  A

*Communicated at: Talked at, talked over, assumptions made regarding the patients' 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 for example format .*

*Manner: How the communication takes place.*

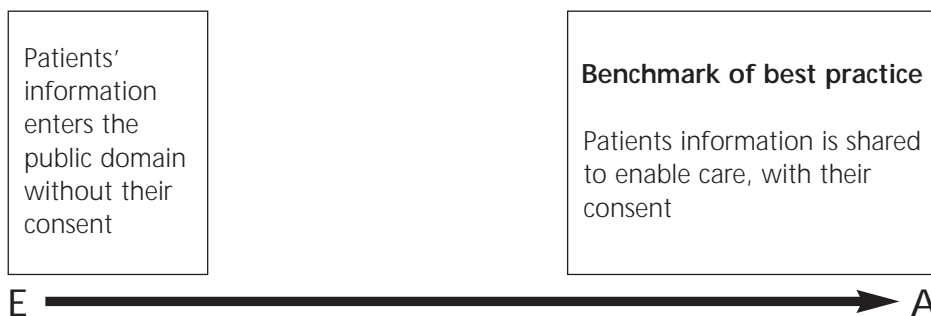
*Pace and level: Speed, repetition and explanation to ensure understanding.*

### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- access to translation and interpretation is available and how the quality is maintained
- information is adapted to meet the needs of individual patients
- appropriate records of communication exchanges are maintained

## Factor 5 - Privacy of patient-confidentiality of patient information



*NB this includes 'careless talk'.*

*See benchmark on Record Keeping for issues regarding written records for instance storage and access to documentation.*

### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- patients' informed consent is sought when special measures are required to overcome communication barriers for example when using trained interpreters
- precautions are taken to prevent information being shared inappropriately for example telephone conversations being overheard, computer screens being viewed and white boards being read
- procedures are in place for sending or receiving patient information for example hand-over procedures, consultant and or teaching rounds, admission procedures, telephone calls, calling patients in outpatients and breaking bad news

## Factor 6 - Privacy, dignity and modesty

Patients privacy, dignity and modesty are not considered

### Benchmark of best practice

Patients' care actively promotes their privacy and dignity and protects their modesty

E  A

*Privacy - Freedom from intrusion.*

*Dignity:- Being worthy of respect.*

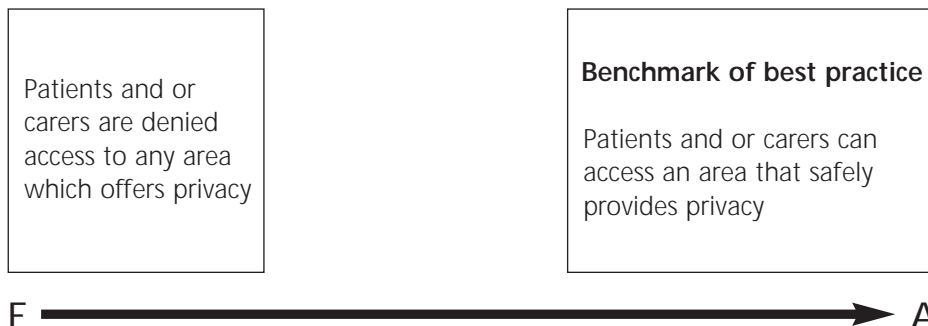
*Modesty:- Not being embarrassed.*

### Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- patients are protected from unwanted public view for example by using curtains, screens, walls, clothes and covers
- appropriate clothing is available for patients who cannot wear their own clothes
- policies are in place for patients to have access to their own clothes
- patients' can have a private telephone conversation
- modesty is achieved for those moving between differing care environments

## Factor 7 - Availability of an area for complete privacy



*Access 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 Intensive therapy unit, child protection.*

*Privacy includes comfort and sound proofing.*

### Indicators of best practice for factor 7

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- a private area is created in patients' homes as well as in health service settings when required
- patients are aware of the availability of a 'quiet' and or private space and how this is achieved
- barriers exist that restrict the provision of an area of privacy
- private areas are available
- clinical risk is handled in relation to complete privacy

# Bibliography

- Department of Health (1999) For the record: managing records in NHS trusts and health authorities. Department of Health: London (Health Service Circular: HSC 1999/053).
- Department of Health (1999) Caldicott guardians Department of Health: London (Health Service Circular: HSC 1999/012).
- Dimond B (1999) Patients' rights, responsibilities and the nurse 2nd ed Salisbury Quay Books
- Human Rights Act 1998 (1998) The Stationery Office: London <http://www.hmso.gov.uk/acts/acts1998/19980042.htm>
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) Code of professional conduct for the nurse, midwife and health visitor 3rd ed United Kingdom Central Council for Nursing, Midwifery and Health Visiting: London
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1996) Guidelines for professional practice United Kingdom Central Council for Nursing, Midwifery and Health Visiting: London
- University of Sheffield School of Nursing and Midwifery (1999) Dignity on the ward: promoting excellence in care: good practice in acute hospital care for older people Help the Aged: London
- University of Sheffield School of Nursing and Midwifery (1999) Dignity on the ward: The future of hospital care for older people Help the Aged: London
- University of Sheffield School of Nursing and Midwifery (2000) Dignity on the ward: Advocacy with older people Help the Aged: London



NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





**Essence of Care**  
Benchmarks for Record Keeping

# Benchmarks for 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)*

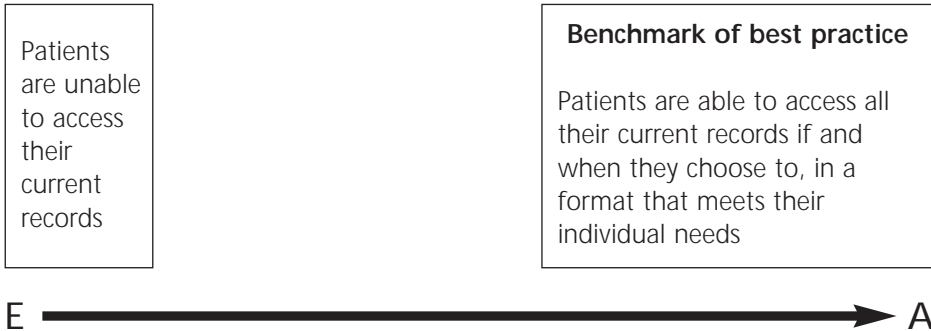
## Benchmarks for Record Keeping

Agreed patient-focused outcome

**Patients benefit from records that demonstrate effective communications which support and inform high quality care**

<b>Factor</b>	<b>Benchmark of best practice</b>
1. Access to current health care records	Patients 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 and professional partnership	Patients are actively involved in continuously negotiating and influencing their care
3. Integration of records – across professional and organisational boundaries	Patients have a single, structured, multi-professional and agency record which supports integrated care
4. Holding life long records	Patients hold a single, lifelong, multi-professional and 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' 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 and confidentiality	Patients' records are safeguarded through explicit measures with an active and timely review process

## Factor 1 - Access to current health care records



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

### Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- access to records is prevented or promoted, including how, where and when records are accessed
- any cost is associated with obtaining access
- there are systems in place for storage and retrieval
- there are any public awareness strategies
- any individual patient communication needs are accommodated

## Factor 2 - Integration - patient and professional partnership

Patients' care is prescribed without discussion or without negotiation with patients and or carers

### Benchmark of best practice

Patients are actively involved in continuously negotiating and influencing their care

E  A

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

### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- evidence of discussions or negotiations are recorded
- there is evidence available to demonstrate that discussions influenced actions
- the rationale for care and its consequences and alternatives are explained to patients and or carers

## Factor 3 - Integration of records - across professional and organisational boundaries

Patients have no record of care

**Benchmark of best practice**  
Patients have a single, structured, multi-professional and agency record which supports integrated care

**E**  **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.*

### Indicators of best practice for factor 3

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- records are made user friendly and whether any special needs are met
- records are kept jargon free, abbreviation free and unambiguous
- relevant stakeholders are identified and involved and how this is achieved
- single records are able to be accessed and how
- evidence is available regarding the auditing of records against regulatory professional standards and or guidance for record keeping



## Factor 4 - Holding life long records

Patients have multiple records held by a variety of professions and agencies

### **Benchmark of best practice**

Patients hold a single, lifelong, multi-professional and agency record

E  A

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

### **Indicators of best practice for factor 4**

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- this is resourced and how
- training and education provision is available to support this
- this works across private organisations and agencies and for transient populations
- this is achieved, for example, by patient held records
- relevant professionals can access these records and how they can do this

## Factor 5 - High quality practice - evidence-based guidance

There are no documents available in support of high quality practice

**Benchmark of best practice**  
Evidence-based guidance detailing best practice is available and has an active and timely review process

E  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.*

### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- supporting evidence is used and what this is
- the level of evidence-base used in compiling guidance and the mechanisms for determining best practice is rigorous for instance systematic reviews
- evidence-based guidance is compiled accepted and utilised by inter-disciplinary teams
- users are involved in the development of evidence based guidance, including mechanisms for involvement for more vulnerable groups for example older people, children, mentally ill, learning disability and minority ethnic communities
- a systematic review process is used and this ensures guidance remains based upon the latest evidence
- robust and rigorous audit reviews are undertaken

## Factor 6 - High quality practice

Patients' records fail to demonstrate rationale or reference to evidence based guidance or documents describing best practice

### Benchmark of best practice

Patients' 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  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.*

## Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- evidence-based guidance or supporting documents are used
- variance is recorded and how
- recorded variance is analysed and used to inform changes in specific patient records and supporting information.
- there is evidence of robust and rigorous clinical audit review for example peer review of quality and content of documentation

## Factor 7 - Security and confidentiality

Patients records are not safeguarded

**Benchmark of best practice**  
Patients records are safeguarded through explicit measures with an active and timely review process.

E  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.*

### Indicators of best practice for factor 7

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- guidelines are available to ensure that all staff safeguard access to records (HSC 1999/053 p 3.9)
- 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)
- arrangements are in place 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

# 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 favouring 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 " Health 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)

# Bibliography

- Access to Health Records Act 1990 (1990) Chapter 23 The Stationery Office: London
- Audit Commission for Local Authorities and the National Health Service in England and Wales (1995) Setting the records straight: a study of hospital medical records The Stationery Office: London
- *Data Protection Act 1998* (1998) Chapter 29 The Stationery Office: London <http://www.hmso.gov.uk/acts/acts1998/19980029.htm>
- *Data Protection Act 1994* (1994) Chapter 35 The Stationery Office: London
- Department of Health (1998) Improving clinical communications Clinical systems group Department of Health: Wetherby
- Department of Health (1999) For the record: managing records in NHS trusts and health authorities Department of Health: London (Health Service Circular: HSC 1999/053)
- Department of Health Caldicott guardians (1999) Department of Health: London (Health Service Circular: HSC 1999/012)
- Department of Health NHS Executive (1998) Information for health: an information strategy for the modern NHS 1998-2005: a national strategy for local implementation Department of Health: London
- Human Rights Act 1998 (1998) The Stationery Office: London <http://www.hmso.gov.uk/acts/acts1998/19980042.htm>
- Moloney R and Maggs C (1999) A systematic review of the relationships between written manual nursing care planning, record keeping and patient outcomes Journal of Advanced Nursing 30 51-57
- NHS Training Directorate (1993) Keeping the records straight: a guide to record keeping for nurses, midwives and health visitors Bristol NHS Training Directorate
- *Public Records Act 1958* (1958) The Stationery Office: London
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1998) Guidelines for records and record keeping United Kingdom Central Council for Nursing, Midwifery and Health Visiting: London

Additional bibliography used at initial compilation is available on the disc.



NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





## **Essence of Care**

Benchmarks for Safety of Clients with  
Mental Health Needs in Acute Mental  
Health and General Hospital Settings

For the purpose of these benchmarks:

*Safe* = freedom from physical, mental, verbal abuse and or injury to self and others.

*Secure* = emotional safety

*Relational security* = clients needs are met through the development of trusting and genuinely therapeutic relationships with the client by members of the care team within safe and fully explained boundaries

*Engagement* = 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

**Benchmarks for Safety of Clients with Mental Health Needs  
in Acute Mental Health and General Hospital Settings**

Agreed client-focused outcome

**Everyone feels safe, secure and supported with experiences  
that promote clear pathways to well being**

	<b>Factor</b>	<b>Benchmark of best practice</b>
1	Orientation to the health environment	All clients are fully orientated to the health environment, in order to help them feel safe
2	Assessment of risk of clients with mental health needs harming self	Clients have a comprehensive, ongoing assessment of risk to self with full involvement of client to reduce potential for harm
3	Assessment of risk of clients with mental health needs harming others	Clients have a comprehensive, ongoing assessment of risk to others with full involvement of client to reduce potential for harming others
4	Balancing observation and privacy in a safe environment	Clients are cared for in an environment that balances safe observation and privacy
5	Meeting clients safety needs	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 related to harm and abuse	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

# Factor 1 - Orientation to the health environment

Clients are not orientated to their care setting. Therefore they do not feel safe

**Benchmark of best practice**  
All clients are fully orientated to the environment, in order to help them feel safe



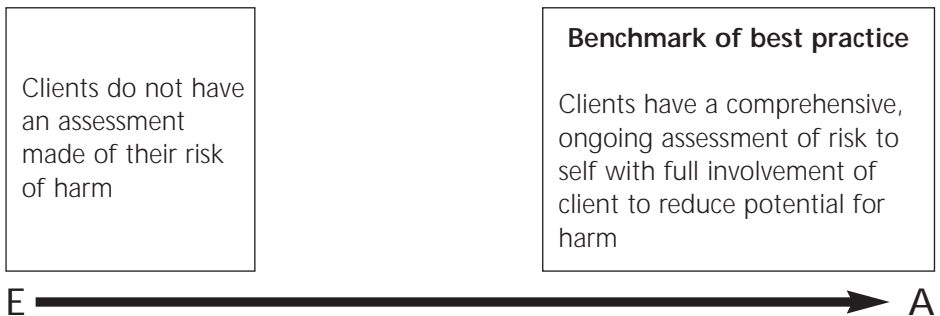
*Full orientation: - made familiar with and understand the philosophy, people, services, environment, policies/processes/ procedures and physical layout, know how to access key worker and relevant information*

## Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- clients are orientated and how orientation is focused around the client groups' cognitive skills
- somebody is responsible for orientating the client to the ward which can include staff and other clients
- specific action is taken to make women and other vulnerable service users feel safe and secure
- resource materials such as booklets and videos are used to promote orientation
- appropriate topics are covered in the orientation
- a person is identified who talks through what will happen to them and who will be initially looking after them
- key workers are identified and whether consideration is given to individual needs

## Factor 2 - Assessment of risk of clients with mental health needs harming self



### Indicators of best practice for factor 2

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- the key indicators of risk are included in the risk assessment tool questions
- assessment is undertaken by inpatient and community teams prior to discharge and whether this includes assessment of risk and joint case review which includes discharge planning
- users are involved in the training of staff, to ensure that assessment and management is appropriate and sensitive to specific needs, for instance, religion and culture, age related needs, human rights, child protection, previous, history of life events: and to specific treatments such as medication and ECT
- knowledge of a clients' history, social context and significant events since admission are ascertained, recorded and shared
- staffs attitudes to self harm are ascertained, measured and supported
- any outside user agencies are used to act as support or information for clients who self harm such as the national self harm network, SHOUT, black and minority ethnic voluntary organisations
- procedures are in place to ascertain presence of and to identify misuse of alcohol and drugs

## Factor 3 - Assessment of risk of clients with mental health needs harming others

Clients do not have an assessment made of their risk of harming others

**Benchmark of best practice**  
Clients have a comprehensive, ongoing assessment of risk to others with full involvement of client to reduce potential for harming others



### Indicators of best practice for factor 3

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- the risk assessment questions asked and tool used include the key indicators of risk
- assessment is undertaken by inpatient and community teams prior to discharge and whether this includes assessment of risk and joint case review
- knowledge of a client's history, social context and significant events since admission are ascertained, recorded and shared (including sharing and liaison between general and mental health areas)
- health care personnel attitudes to harm are ascertained, measured and supported and how this is done
- outside user agencies are used to act as a support or information mechanism
- procedures are in place to ascertain presence of and to identify misuse of alcohol and drugs
- further support is available for example, Rape Crisis, Incest Survives and The Samaritans



## Factor 4 - Balancing observation and privacy in a safe environment

Clients are not accorded privacy nor cared for in an environment that allows safe observation

### Benchmark of best practice

Clients are cared for in an environment that balances safe observation and privacy



### Indicators of best practice for factor 4

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- there is an up to date observation policy, who is involved, for instance, the multi disciplinary team and whether this is audited. This should include who observes the client and the qualifications, for example, qualified or unqualified, the status awarded the task and how it is ensured that observations are supportive and therapeutic
- resources allow the increased observation of clients in the evening and at night and prior to discharge
- the skill mix, roles and attention to gender of practitioners have been adapted to release them to carry out clinical observations, for example, administrative support
- opportunities are taken for maintaining privacy and dignity during observations
- you inform or educate the client regarding the observational processes and how their satisfaction with these processes are ascertained
- carers' satisfaction with observation and privacy is ascertained
- the privacy of women and other vulnerable groups are secured
- environmental safety checks are made regarding removal of any obstructions to observation and preventing access to means of suicide and, for example, window opening, safety glass, structures that could be used in suicide by hanging, safe storage of drugs and other harmful products and the effective administration of drugs to prevent stockpiling

## Factor 5 - Meeting clients safety needs

Clients ongoing safety needs are not considered

### Benchmark of best practice

Clients are regularly and actively involved in identifying care that meets their safety needs

E  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)*

### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- safety needs are addressed in the care plan and regularly considered in care reviews and how this is achieved
- clients are encouraged to express any safety and security concerns
- the quality of care plan documentation is assessed and audited and how this is done
- clients are involved in negotiating choice of primary nurse for example, gender
- the client has a copy of the care plan in a format that they understand, and how clients can demonstrate that they understand, input into and are in agreement with it (gain ownership). If not why?
- communication barriers are overcome and how this is achieved
- known clients 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
- further support is sought from agencies such as Rape Crisis, Incest Survives and the Samaritans

## Factor 6 - A positive culture to learn from complaints and adverse incidents related to harm and abuse

Clients do not feel able to report adverse incidents and complaints

### Benchmark of best practice

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  A

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

### Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the complaint procedure is made user friendly, accessible, and useable, particularly for vulnerable groups and how barriers to communication are overcome
- systems are in place for staff, practitioners or carers to report practitioners who are abusive or harmful
- critical incidents such as acts of violence, aggression, seclusion and procedures and policies are audited, including ensuring that action is taken if required
- risk related information is collected and used in determining resources and monitoring performance and to inform training
- outside agencies or advocates or user groups are involved in audit of complaints and critical incidents and evaluation of services
- when critical incident reviews occur, there are client and staffing debriefing arrangements in place and how these influence practice

## Bibliography

- Department of Health (1998) Mental health nursing: "addressing acute concerns" Report by Standing nursing and midwifery advisory committee  
Department of Health: London
- Department of Health (1999) National confidential inquiry into suicide and homicide by people with mental illness Safer services Department of Health: London
- Department of Health (1999) National service framework for mental health  
Department of Health: London  
<http://www.doh.gov.uk/nsf/mentalhealth.htm>
- Department of Health (1999) National service framework for mental health: executive summary Department of Health: London  
<http://www.doh.gov.uk/nsf/mhexecsum.htm>
- Department of Health (1999) Social Services Inspectorate. Effective care co-ordination in mental health services: modernising the care programme approach: a policy booklet Department of Health: London
- Department of Health, Welsh Office (1999) Code of practice: Mental Health Act 1983 Revised edition The Stationery Office: London
- Department of Health (1995) Building bridges: a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people Department of Health: London
- Sailas E, Fenton M (2000) Seclusion and restraint for people with serious mental illnesses (Cochrane Review) In: The Cochrane Librar, Issue 3 Oxford Update Software
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1998) Guidelines for mental health and learning disabilities nursing: a guide to working with vulnerable clients United Kingdom Central Council for Nursing, Midwifery and Health Visiting: London
- University of Sheffield School of Nursing and Midwifery (1999) Dignity on the ward: promoting excellence in care: good practice in acute hospital care for older people Help the Aged: London
- University of Sheffield School of Nursing and Midwifery (1999) Dignity on the ward: The future of hospital care for older people Help the Aged: London
- University of Sheffield School of Nursing and Midwifery (2000) Dignity on the ward: Advocacy with older people Help the Aged: London

Additional bibliography used at initial compilation is available on the disc.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**





**Essence of Care**

Benchmarks for Principles of Self-Care

## Benchmarks for Principles of Self-Care

Agreed patient-focused outcome

### **Patients have control over their own health 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)

	<b>Factor</b>	<b>Benchmark of best practice</b>
1.	Choice about self-care	Patients are enabled to make choices about self-care and those choices are respected
2.	Assessment of self-care ability	Patients' self-care abilities are continuously assessed and inform care management



Factor	Benchmark of best practice
3. Assessing possible risks for patients and or carers when undertaking self-care	A comprehensive ongoing risk assessment is undertaken and all involved in management of self-care including patients and or carers are aware of inherent risks and how these may most appropriately be addressed
4. Knowledge and skills to manage self-care	Patients and or carers and advocates have the knowledge and skills to manage all aspects of self-care
5. Responsibilities for self-care	Patients and practitioners are working in partnership to establish their responsibilities in meeting self-care needs
6. Access to services to support self-care	Patients and or carers and advocates understand and can access the services that organisations can provide
7. Environmental factors to support self-care	The environment promotes patients ability to self-care
8. Access to resources to enable self-care	Patients 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

## Factor 1 - Choice about self-care

Patients are told how care is to be delivered

### **Benchmark of best practice**

Patients are enabled to make choices about self-care and those choices are respected

**E**  **A**

*NB Link to risk assessment*

*Choices are fully informed and include consideration of all agencies*

## Indicators of best practice for factor 1

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- patients are made aware of all the available self and provided care options
- options are discussed and when and where this discussion occurs
- information is available to inform patient care
- the consistency of the information provided by practitioners is ensured
- monitoring that is undertaken ensures that care does reflect patient choice

## Factor 2 - Assessment of self-care ability

Patients' assessment does not identify self-care abilities

**Benchmark of best practice**  
Patients' self-care abilities are continuously assessed and inform care management

E  A

*Assessment is at every stage undertaken in partnership with patients and or carers and takes in to account individual needs.*

### Indicators of best practice for factor 2

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- assessment is undertaken including considering the format for obtaining and recording information regarding self-care abilities on an ongoing basis
- assessment informs and is reflected in care activity
- care plans are arrived at and used
- self-care assessment links to individualised care pathways/plans
- training is focused to assess self-care ability

## Factor 3 - Assessing possible risks for patients and or carers when undertaking self-care

When considering self-care there is no assessment of possible risk to the patient and or carer

### Benchmark of best practice

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

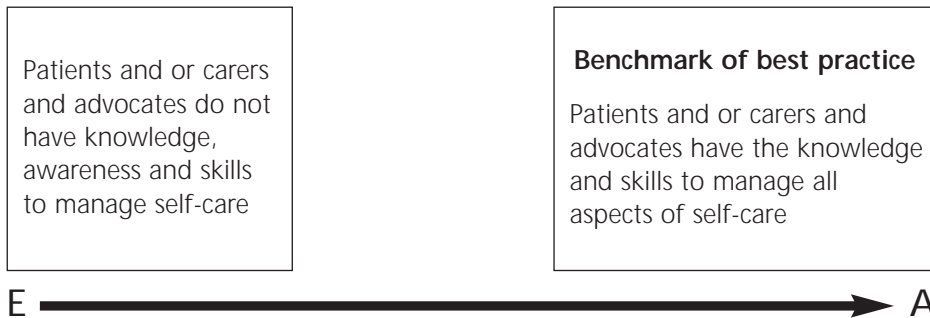


### Indicators of best practice for factor 3

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- patients acceptance of risk is documented
- training and education has been provided to practitioners, carers and patients in relation to risk assessment and acceptability of risk for individual and special needs care
- the risk assessment tool in use includes for example a core list of issues and training received by assessors
- the risk assessment tool is updated according to change in law or practice
- critical incidents and complaints are recorded, monitored, analysed and acted upon
- the frequency of risk assessment is appropriate
- risks are addressed
- the risk assessment is linked to the care plan

## Factor 4 - Knowledge and skills to manage self-care

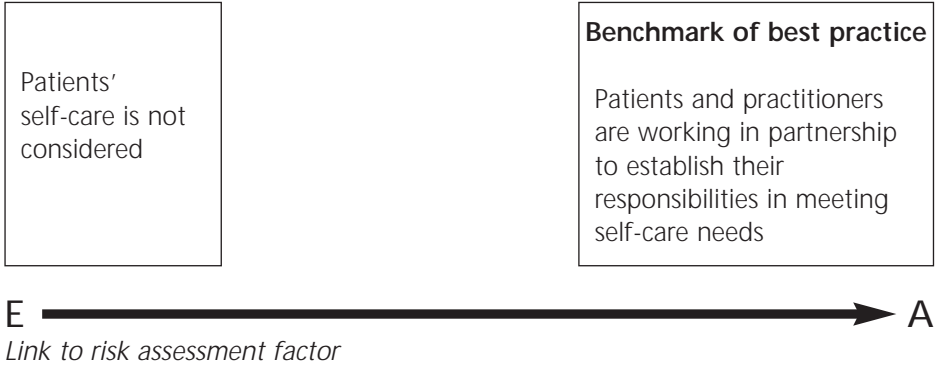


### Indicators of best practice for factor 4

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- education programmes and packages exist for patients and both formal and informal carers to ensure that patients and carers have the knowledge and skills to manage all aspects of self-care
- this education pack is used and how is its use monitored
- the information given to patients and carers about how to access assistance in the case of emergency or when the ability to self-care is compromised for example by giving contact details
- patients and or carers knowledge and skills are assessed
- there is online information available

## Factor 5 - Responsibilities for self-care



### Indicators of best practice for factor 5

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- multi-agency working occurs
- the documentation ensures comprehensive assessment and promotes partnership with patients, for example, by having shared contracts of care, holding own records and plans, and by meeting individual needs
- patients direct input into any meetings is assured
- the monitoring of partnership arrangements takes place

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

Patients and or carers and their advocates do not know the services that organisations can provide or that would meet their needs

**Benchmark of best practice**  
Patients and or carers and advocates understand and can access the services that organisations can provide

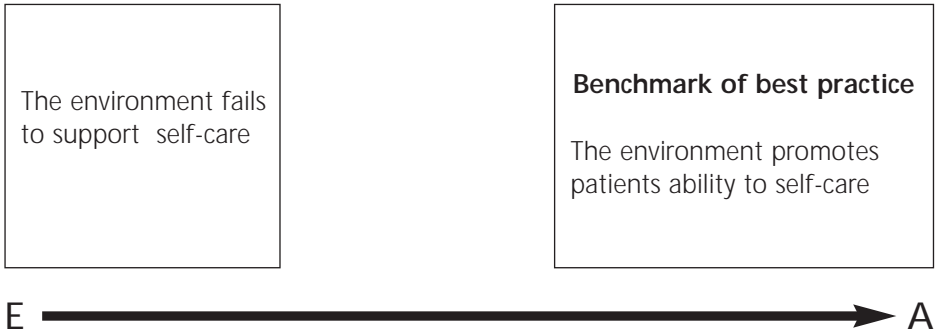


### Indicators of best practice for factor 6

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- the list of services available within the area are identified and whether it includes for example, health, social services, voluntary services and organisations, tradesmen and complementary therapies, which are sensitive to individual needs
- audits of patients and or carers awareness of service availability, access and uptake are undertaken
- the list of services available within the area are made available
- information and the formats available are jargon free, in different languages and for example in Braille and large print and available on the world wide web
- how services are accessed is known, for example, by using community health councils, Citizen's Advice Bureau, NHS Direct, and NHS online
- practical barriers to self-care are overcome

## Factor 7 - Environmental factors to support self-care



### Indicators of best practice for factor 7

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- there are situations where the environment fails to support self-care
- measures are taken to promote an environment that supports self-care
- self-care in relation to cultural and religious needs are met
- users of the services are involved to ensure the environment promotes self-care



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

Patients can not access resources to meet their individual self-care needs

**Benchmark of best practice**  
Patients can access resources that enable them to meet their individual self-care needs

**E**  **A**

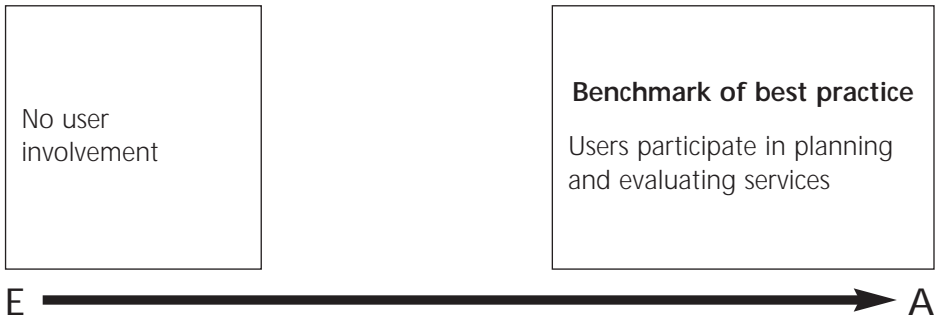
*Resources include equipment, drugs, qualified and or trained and experienced staff (NHS, statutory and voluntary services)*

### Indicators of best practice for factor 8

**To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:**

- resources are available and how they are made available
- decisions re the allocation of resources are made when there are insufficient to meet the needs of all clients
- barriers exist to access to resources and why this is
- there are arrangements for immediate access to resources that can facilitate early discharge

## Factor 9 - User involvement in service delivery that promotes self-care



### Indicators of best practice for factor 9

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider whether:

- users are involved, how views are sought
- there is inter-agency involvement and networking with all stakeholders
- patients satisfaction is assessed and any complaints are addressed

# Bibliography

- Banks I (2000) The NHS Direct Healthcare Guide NHS Direct: London
- Chapple A, Rogers A (1999) 'Self-care' and it's relevance to developing a demand management strategies a review of qualitative research Health and Social Care in the Community17 445-454
- Department of Health (1999) Opportunities for improving access to care Access to care steering group NHS Executive Eastern Region: Milton Keynes
- Department of Health (1999) The new NHS information pack.  
Department of Health: London
- Orem D (1991) Nursing: concepts of practice 4th edition Mosby-Year Book:  
St. Louis

Additional bibliography used at initial compilation is available on the disc.

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London SW1A 2NS

Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

**The NHS Modernisation Agency is  
part of the Department of Health**







## Contact details:

John Badham  
National Director for Essence of Care  
National Clinical Governance Support Team  
[john.badham@manchester.nhs.uk](mailto:john.badham@manchester.nhs.uk)

Maria Sinfield  
National Programme Manager, Essence of Care  
National Clinical Governance Support Team  
[maria.sinfield@manchester.nhs.uk](mailto:maria.sinfield@manchester.nhs.uk)

NHS Modernisation Agency  
Richmond House  
79 Whitehall  
London  
SW1A 2NS  
Web address: [www.modern.nhs.uk](http://www.modern.nhs.uk)

The NHS Modernisation Agency is  
part of the Department of Health

