Name of area/ward N+S Assessment ED.

Name of hospital UHW

Name/initials of peer reviewer [redacted]

Case tracking

Standard 3.4 and 3.5 - Record keeping; information governance and communications technology

Standard 2.2; 2.3; 2.5; 2.7; 6.1; – Preventing pressure and tissue damage; falls prevention; safeguarding; planning care to promote independence; nutrition and hydration

Contents

Initial observations of patient records/notes 3
Safeguarding – Mental capacity and DOLS* 4
Nutrition and hydration 9
Sepsis 15
Preventing pressure and tissue damage 19
Falls prevention 26
Pain management 31
Assessment 35
Planning care to promote independence 41
Delivery and effectiveness and evaluation 48
Ward management 50
Case tracking – Part 2: How do patient records compare to practice? 54
General observations on record keeping 55
Summary/conclusion on record keeping 56

The purpose of this case tracking exercise is to assess whether what is written in the care plan is translated into the care provided to the patient. You may need to speak to staff to assist you to understand patient records. Once you have reviewed the records, you will need to check this against what you find on the ward. Please use the section 'How do patient records compare to practice?' further below to record your findings around this.

Guidance for choosing patient records – speak to the inspection manager about how many records would be appropriate and for which patients e.g. someone recently discharged if you are unsure.

Case tracking – Part 1: Review of patient records

Please record the patient identifiers for each patient record you review.

Patient	Patient identifier
A	B054382F (S)
B	A115740B (S)
C	A374680N (N)
D	A172512E (N)
E	

Where aspects of the case tracking areas are not applicable – please clearly state this as N/A. Do not just leave the area blank.

Date

Time

Signature

Areas to consider	Comments
Initial observations of patient records/notes	
Are notes clear and easy to navigate? What is the structure/layout like? How have notes been organised? If you were an agency staff – would you be able to look after the patient from their notes?	The risk assessment booklet 'A' contains all key assessments + documentation + Each pt folder contains the booklet 'A' any bundle information and contemporaneous clinical + therapy records as well as nursing documentation. There is no standardised sequence of documentation across the pt records sampled eg Booklet A, Clinical Notes, Therapy notes etc. Therefore navigation can be challenging if pts are admitted for extended periods. Care plans + evaluation of care is limited in term of the documentation reviewed. However the comprehensive nature the Risk A Booklet would be very useful to enable agency staff to provide safe care if they were robustly completed. The standard of documentation is regrettably poor. Overall Pt identifier is used on front cover only as a general rule.

Date: 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Safeguarding – Mental capacity and DOLS*						
Are there mental capacity assessments in place on admission?	NO	* NO	NO	yes		PCB - Acute confusional state secondary to infection / head injury (CT head undertaken) but no evidence of memory test / capacity assessment <u>Overall</u> mental capacity assessments do not form part of the overall Booklet A admission documentation. This is particularly noted in (S). The (N) has a slightly different document which contains the supplementary information in the "generic assessment" document. Recording of the Mental capacity is therefore better on (N).

Date

Time 22.6.22

Signature

Areas to consider	A	B	C	D	E	Comments
Safeguarding – Mental capacity and DOLS*						
Are there clear records on decisions around patient's mental capacity and any DOLS authorisations?	yes.	NO	NO	NO		pt was identified a (N) unit attempting to leave ward. At that point Mental capacity assessment was not undertaken. Clinical team called to review pt + DOLS consideration [illegible] + issue re DOLS + capacity highlighted by HIN team [illegible]

Date 22·6·22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Safeguarding – Mental capacity and DOLS*						
Are the DOLS authorisations valid and up-to-date?	NA	NA	NA	NA		

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Safeguarding – Mental capacity and DOLS*						
What recommendations have been made on DOLS authorisations and are these in place?	NA.	NA.	NA.	ND		

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Safeguarding – Mental capacity and DOLS*						
What is your overall assessment on safeguarding and records around DOLS and mental capacity? Why have you come to that conclusion?						

Date 22·6·22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Nutrition and hydration						
Is a nutritional risk assessment being completed for all patients within 24 hour of admission?	NO	NO	yes	NO		There is limited evidence overall that nutritional risk assessments are being undertake in a timely manner. This is particularly the case for the (S) unit

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Nutrition and hydration						
Where appropriate, is food/fluid intake being monitored?	YES	NO	N/A	NO		Although there was no nutritional risk assessment completed for pt A, there was evidence in nursing record that intake was being "observed" however this was not recorded on AW food chart + therefore consistency in measuring + evaluating intake was limited.

Date 22-6-22 Time Signature

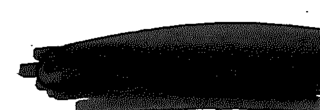
Areas to consider	A	B	C	D	E	Comments
Nutrition and hydration						
Has a care plan been developed and a referral been made to dietician or SALT if appropriate?	NA	NA	NA	NO		

Date Time Signature

22.6.22

Areas to consider	A	B	C	D	E	Comments
Nutrition and hydration						
Is there an oral care plan in place?	NO	NO	NO	NO		Oral hygiene assessments and plans are not evidenced on the unit within the casenotes reviewed. There is no reference within the nursing daily care records to indicate that mouth care has been provided. The units should introduce the AW Oral Care Assessment + Management plan

Date 22-6-22 Time Signature



Areas to consider	A	B	C	D	E	Comments
Nutrition and hydration						
Are patients who are nil by mouth being assessed appropriately?	NA	NA	NA	ND		unable to ascertain as pts were taking diet + fluids.

Date 22.6.22 Time Signature

Areas to consider	Comments
Nutrition and hydration	
What is your overall assessment of nutrition and hydration? Why have you come to that conclusion?	Completion of the nutritional risk assessment tool contained in Booklet A is not consistently completed within the 24 hr of admission. Some of the case notes reviewed evidenced a delay in completion in excess of 24 hrs. Triggers for completion of assessment were sometimes not acted upon eg. a patient with cognitive impairment on (N) unit did not have a timely assessment despite it being documented elsewhere in the AA section of the document that she was known to have a poor appetite at home + give her food to the dog. This should've triggered commencement of the AW Food Chart

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Sepsis						
Where appropriate has sepsis been considered? Has screening been carried out where appropriate (e.g. National Early Warning Score; Inpatient screening and action tool)?	Yes	Yes.	NO	Yes		Pt B – NEWS ing. Consistently since admission on ~~to~~ 19.6.22. fluctuating between 8 – 2 (progressively improving) evidence that Sepsis screening undertaken. Pt D NEWS. Although clinical notes are evidencing review of temperature + good screening consideration + assessment of potential sepsis – (particularly notable in Patient B who showed indication of delirium) there is no evidence of a "sepsis specific screening tool" NEWS charts are used consistently throughout units Ⓢ + Ⓝ.

Date 22-6-22 Time Signature

Is there a sepsis pathway in place with associated Sepsis Six care bundle? How do staff ensure consistent, effective, clinical management of cases?	NO	NO	NO	NO		A-B actions being taken appropriately but not documented as a bundle See previous response

Date 22.6.22 Time Signature

Have appropriate actions been taken in relation to sepsis? Have staff acted promptly and followed their local protocol? (Where applicable).	NA.	NO	NA	NA		Pt B. Good Clinical Management Plan in place + Treatment escalation plan in notes. Evidence of concerns re daughter. Acute Confusional state noted + acted upon

Date 22.6.22

Time

Signature

Areas to consider	Comments
What is your overall view around sepsis? Why have you come to that conclusion?	

Date 22-6-22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Preventing pressure and tissue damage						
Are patients assessed for pressure ulcer risk on admission?	Yes.	Yes.	Yes	Yes		There is good evidence that the Purpose T risk assessment for pressure ulcers is being consistently applied across unit (N) + (S) Body Maps are also consistently used. Implementation of skin bundles + documentation of prevention care i.e. equipment provided, turning regimes need to be documented in care plans consistently. Staff report having insufficient time to complete documentation despite delivering the care + are aware of how vulnerable this is to the organisation themselves + their pts

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Preventing pressure and tissue damage						
Is there evidence of appropriate skin assessment?	yes	yes	No	yes		Pr c 5ap Pt states Pt intact. No evidence of visual inspection. Pt is on bed rest due to ? NOF# following inpatient fall. Although risk assessment completed there is no evidence that pressure ulcer care is being provided in timely manner + no evaluation. Pt is high risk due to ? NOF# following inpatient fall

Date   Time   Signature

22-6-22

Areas to consider	A	B	C	D	E	Comments
Preventing pressure and tissue damage						
Is there an appropriate care plan developed and documented in line with risk assessment score?	Yes	NO.	NO	NO		R B. identified as at risk no evidence of PU care plan – (Body map complete) See previous responses

Date 22·6·22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Preventing pressure and tissue damage						
Is there evidence of frequent repositioning day and night? i.e. SKIN Bundle, Repositioning, Turning charts, Carer's Log etc.?	~~NA~~ NO	NO	NO	NO		See previous response • Skin Bundle + pressure ulcer prevention + reduction actions plans must be implemented with immediate effect • Turning clocks to be introduced to ensure timely care. • Development of pt / carer information leaflets for P.U prevention • clear documentation of any equipment / TVN referrals • Visual inspection of PU areas

Date 22.6.22 Time Signature [redacted]

Areas to consider	A	B	C	D	E	Comments
Preventing pressure and tissue damage						
Is there ongoing monitoring of pressure areas?	~~NA~~ NO.	NO	NO	NO		Ongoing evidence of monitoring is inconsistent as previously identified. There is also a reliance on pts "reported" status of their pressure areas rather than a "visual inspection" by nursing staff. Visual inspection + written confirmation in notes is highly recommended for implementation with immediate effect

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Preventing pressure and tissue damage						
Has a referral been made to the tissue viability nurse if appropriate?	N/A.	NA.	NO	NA		Of the notes reviewed none indicated any pressure damage which would trigger TVN referral. However limited documentation means that assurance that p.ulcer damage is not occurring cannot be provided.

Date 22.6.22 Time Signature

Areas to consider	Comments
Preventing pressure and tissue damage	
What is your overall view on pressure and tissue damage prevention and care? Why have you come to that conclusion?	A deep dive audit of pressure ulcer care assessment, plans + actual damage should be undertaken by the TVN in conjunction with unit staff + Senior Nurse in order to identify incidence/prevalence of P.U damage occurring on admission + prior to admission This should be cross referenced against OHW incident reporting systems (DATIX) There is no evidence that 'Safety crosses' or "day interval' between pressure ulcer development is in use. This should be considered for introduction

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Falls prevention						
Have initial falls risk assessments been documented for any patient in hospital with intention to assess or admit for greater than 6 hours?	NO	NO	Yes	Yes		Pt B multiple falls ↑ (?) on admission RA not completed! Pt C falls RA completed but no actions identified despite pt ? NOF # as inpatient fall. Pt D admitted following fall no action plan.

Date 22-6-22 Time Signature [redacted]

Areas to consider	A	B	C	D	E	Comments
Falls prevention						
Is there a specialist falls service?						

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Falls prevention						
Where the patient is at risk of falls, is there up-to-date plan of care, tailored to the patient (not generic) which is being implemented and evaluated?	yes	NO	NO	NO		Pt C - inpatient fall ? NOF# Pt falls risk assessments + Multi Factoral Risk Assessment is not being effectively utilized as remedial action plan when falls risk factors are identified • mitigating factors + actions to be taken / already taken should be documented on the action plan to provide a individual action plan that is patient focussed!

Date 22·6·22 Time Signature [redacted]

Areas to consider	A	B	C	D	E	Comments
Falls prevention						
Where applicable, is reassessment undertaken if an individual has fallen, been transferred to a new area or whose condition has changed?	NA.	ND	NA	ND		N/A —

Date 22.6.22 Time Signature

Areas to consider	Comments
Falls prevention	
What is your overall assessment on falls prevention? Why have you come to that conclusion?	The falls risk assessment tool is not being used appropriately when a patient is identified as at risk of falling i.e. remediating actions are not identified Triggers such as multiple falls at home or as inpatient do not always translate to a timely assessment eg Pt B had fallen at home but no risk assessment undertaken All patients ✓ falls history must have risk assessment completed + associated action plan.

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Pain management						
Is there evidence that pain is being measured, actioned and evaluated? E.g. are pain assessment tools in place, actioned and reviewed/evaluated?	NO	NO	NO	NO		Ptc pain assessment completed but no evidence of review. No medication chart ? analgesia given post inpatient fall ? NOF#

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Pain management						
Do patients have an up to date pain score?	NO	NO	yes	NO		Pain assessments do not appear to be routinely undertaken on admission or throughout period of care. Pain scores should be undertaken to provide a baseline + enable effective evaluation of pain + associated analgesic response as appropriate

Date Time Signature

22-6-22

Areas to consider	A	B	C	D	E	Comments
Pain management						
Are pain scores being managed? E.g. use of suitable analgesic and administered on a regular basis as opposed to 'as required' (PRN)	NO.	NO	?	NO		As previous response

Date 22-6-22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Pain management						
What is your overall assessment on pain management? Why have you come to that conclusion?						There is limited evidence that pain is being effectively managed. Pain assessment is not documented and therefore there is limited opportunity to effectively evaluate analgesic response. Pain Assessments are not completed.

Date Time Signature

22.6.22

Areas to consider	A	B	C	D	E	Comments
Assessment						
Do patients have their needs promptly assessed on admission?	NO	NO	NO	NO		Pt B admitted 19.6. – Assessments 21.6.22 Pt C admitted 12.50hr 21.6.22 Poor standards of documentation + incompleteness of Booklet A means that it is impossible to determine if pts needs are being promptly + comprehensively assessed. This is compounded by lack of evidence regarding evaluation of care – i.e. no assessment so unable to evaluate.

Date 22-6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Assessment						
Have other relevant risk assessments been undertaken?	No.	NO	NO	NO		Booklet contains (RASTA) • NEWS. • General Demographics • Medications and administration Allergies + GP next of kin details Living arrangements - Visual Infusion Phlebitis tool. Pain assessment Fluid Balance Patient Orientated Meds. Assessment Property disclaimer Purpose T. + Body Map Attending Assessment MRFA Tool. WAASP. Continence + Stool Chart.

Date 22-6-22 Time Signature [redacted]

Areas to consider	A	B	C	D	E	Comments
Assessment						
Do patient records reflect the risks identified and the actions required?	NA.	NO	NO.	NO		Pt B - No WAASP - feeds food to dog + poor appetite

Date 22.6.22 Time Signature

Has the patient's language choice/preference been recorded as being asked?	~~N/A~~, NO	NO	NO	NO		There is no evidence that pts language preferences ~~are~~ being recorded. ∴ Non Compliant to W.LA requirements. To be addressed in line w/ statutory requirements w/ effect

Date

Time

Signature

22.6.22

Has the patient's language choice/preference been recorded as a decision?	~~NA~~ NO	NO	NO	NO		See previous response

Date 22.6.22 Time Signature

Is there evidence to show what action has been taken to address any language need? e.g. translation service provided if needed or asked for	~~NA~~ NO	NO.	NO	NO		See previous page

Date 22.6.22 Time Signature [redacted]

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
Is all the care given documented in the patients care plan/records?	NO 1st entry 21.6.22 @ 11.30 but admitted 02.20 21.6.22	NO 1st admitted 19.6.22 Plan doesn't reflect needs → acuity	NO Pt admitted 12.50 @ 21.6.22	NO.		Staff report difficulties in maintaining contemporaneous records that reflects the level of care + pt contact provided This must be addressed ✓ immediate effect. Intentional rounds introduce as a recommendation

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
Are decisions being documented such as Do Not Attempt to Resuscitate (DNAR)?	NA.	yes.	NO.	yes. Partial		Pt B Appropriate evidence of discussion + decision making There is evidence that Ceiling of Care / DNACPR Considerations are being discussed with pts + family However although Conversation with pt D took place an DNACPR form has not been Completed

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
Are care plans based on individualised patient need?	NCP.	No	NO	NO		There are no care plans due to the short period of time that pts stay on the unit (reported by staff) Care care plans could be considered for introduction

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
Is there clear evidence of transfer of care/ discharge planning?	Yes.	NO	NO	Yes.		Where appropriate there is evidence that discharge arrangements for home discharge are being considered in a timely manner

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
If a patient is about to be discharged – is there evidence of appropriate packages in place, e.g. district nurse referral?	NA.	NA.	NA	NA		

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
Is it recorded that the patient is medically fit to be discharged?	NA.	NA.	NA	yes		

Date Time Signature

22.6.22

Areas to consider	A	B	C	D	E	Comments
Planning care to promote independence						
Is care planned in a way that promotes independence?	NA.	NA.	NO	NO		There are no care plans. Observed on the units. N + S.

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Delivery and effectiveness and evaluation						
Is the effectiveness of care evaluated regularly?	?	N	N.	N		Pt B clinically yes - Nursing less so. Without care plans evaluation of care is negated.

Date 22.6.22 Time Signature [redacted]

Areas to consider	A	B	C	D	E	Comments
Delivery and effectiveness and evaluation						
Are the patients' records up to date and completed immediately after care and treatment?	Yes (observed)					

Date 22.6.22 Time Signature

Areas to consider	A	B	C	D	E	Comments
Ward management						
Is the handwriting in patient records legible?	yes	yes	yes	yes		

Date 22.6.22

Time

Signature

Areas to consider	A	B	C	D	E	Comments
Ward management						
Are all entries signed, dated and the time of entry included?	yes	yes	yes	~~yes~~ no		

Date 22.6.22

Time

Signature

Areas to consider	A	B	C	D	E	Comments
Ward management						
Is there evidence of a written hand over?	yes	yes	no	no.		

Date Time Signature

22.6.22

Areas to consider	A	B	C	D	E	Comments
Ward management						
Is there evidence that other members of the MDT team contribute to the patients care plan? Is this clear?	Yes	Yes	Yes	Yes		All nursing, clinical + AHP records are contemporaneously held in a single pt folder However there is no overarching care plan.

Date

Time

Signature

22-6-22

Case tracking – Part 2: How do patient records compare to practice?

Check how the records correspond to what is actually happening with the patients you have patient on the ward. For example, if the records state that patients need a particular piece of equipment is this in place?

Patient	Finding *Prompts: Include any good practice, suggestions and areas for improvement*	What is the evidence to support this? *Prompts: Where did you see this?*
A	Good clinical plan in place + clinical + nursing notes colocated in file. Evidence of nurse record keeping + standard of documentation poor + needs timely completion of assessments, booklets etc.	
B		
C		
D		
E		

Date Time Signature

General observations on record keeping

Areas to consider	Finding *Prompts: Include any good practice, suggestions and areas for improvement*	What is the evidence to support this? *Prompts: Where did you see this? E.g. which records*
What is the overall quality of patient records? Consider the following: • **Clear accountability** and evidence of how decisions relating to patient care were made • **Good quality** in terms of accuracy, being up to date, complete, understandable and contemporaneous • **Easy access** for people when requested and appropriate disposal of records? • **Secure storage** and compliance with Data Protection Act 1998 • **Effective records management system**, including IT system?		

Date Time Signature

Summary/conclusion on record keeping

Areas to consider	Finding *Prompts: Include any good practice, suggestions and areas for improvement*	What is the evidence to support this? Prompts: Where did you see this? E.g. which records
Overall, what is the quality of patient records/care plans? Are there recurring themes/issues? Are there any areas of particular good practice shown?	Overall the quality of PCR + care plans are suboptimal to the provision of safe + effective care. As previously discussed. o Risk assessments not completed in timely manner o No care plans. o Poor evaluation of care + treatments.	

Date 22.6.22

Time

Signature

ADDITIONAL NOTES

(Tick as applicable)

- Staff interview
- Patient interview/discussion
- Other observation

Area/ward	
Workbook reference – page/section	
Name of interviewee/role/identifier	
Time and date	

Date Time Signature

ADDITIONAL NOTES

(Tick as applicable)

- Staff interview
- Patient interview/discussion
- Other observation

Area/ward	
Workbook reference – page/section	
Name of interviewee/role/identifier	
Time and date	

Date Time Signature