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Essence of Care

Patient-focused benchmarks for clinical governance

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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[1] 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[2] take a patient-focused[3] and structured approach to sharing and comparing practice. It has enabled health care personnel[4] 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.*

[1]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.
[2]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.[5]

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.

[3]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.
[4]The term personnel refers to any person employed by the care provider who communicates with the patient.
[5]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

BENCHMARKING PROCESS

STAGE	ACTIVITY	
ONE	Agree best practice	◆ Consider the patients' or carers' experiences and outcomes, and how current care is delivered. The clinical governance questions and general indicators[6] (see appendix one and two) may provide useful guidance at this step ◆ Agree clinical benchmarks to be considered (appendix three) ◆ Establish a comparison group[7] (appendix four) ◆ Consider the overall outcome and the benchmarks of best practice ◆ 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
TWO	Assess clinical area against best practice	◆ Obtain baseline information by observing practice, using audit and involving patients in the clinical area ◆ Consider the indicators and provide evidence that represents current achievement towards best practice (appendix three) ◆ Consider barriers which prevent achievement of best practice (appendix three) ◆ 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

[6]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	◆ Produce an action plan detailing: - the changes that need to be made to improve practice - who is responsible for leading the changes - the time scale in which these should occur ◆ Actions should be realistic, achievable and measurable (appendix five) ◆ Carry out the action plan
FOUR	Review achievement towards best practice	◆ Document activities, any improvement, problems and or unexpected observations (appendix six) ◆ 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) ◆ If there is no improvement review activities in action plan ◆ Share with comparison group
FIVE	Disseminate improvements and or review action plan	◆ If improvements are identified, disseminate good practice and implement change as widely as appropriate through comparison group and other organisational systems ◆ 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)
SIX	Agree best practice	◆ As stage one

[7]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.

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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

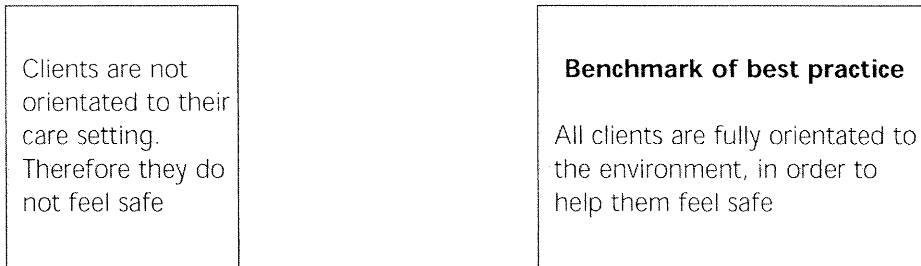
Benchmarks for Safety of Clients with Mental Health Needs
in Acute Mental Health and General Hospital Settings

Agreed client-focused outcome

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

	Factor	Benchmark of best practice
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



E ⟶ A

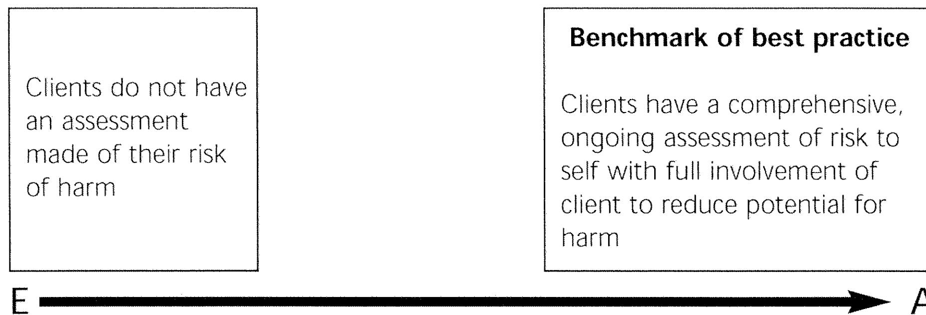
Full orientation: - made familiar with and understand the philosophy, people, services, environment, policies/processes/ procedures and physical layout, know how to access key worker and relevant information

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

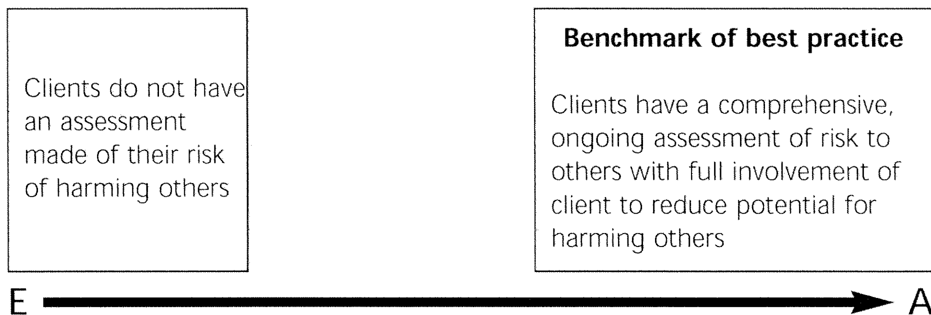


Indicators of best practice for factor 2

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

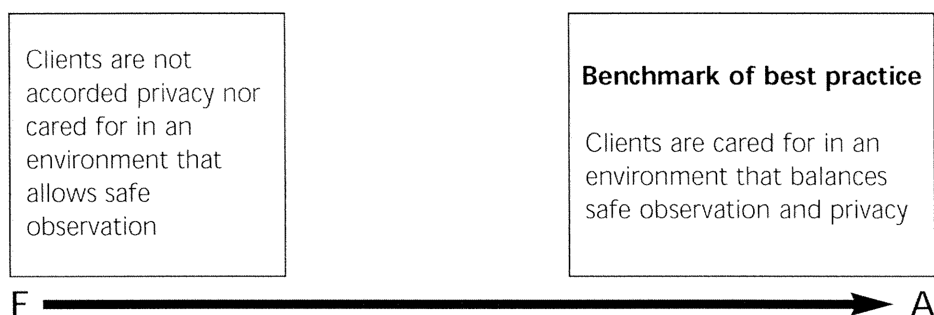


Indicators of best practice for factor 3

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

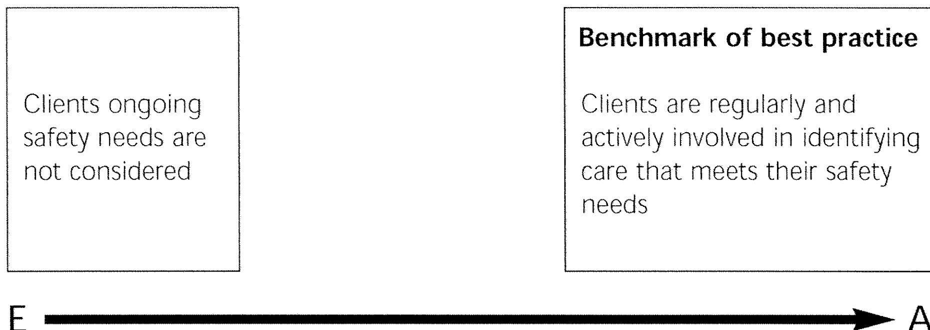


Indicators of best practice for factor 4

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



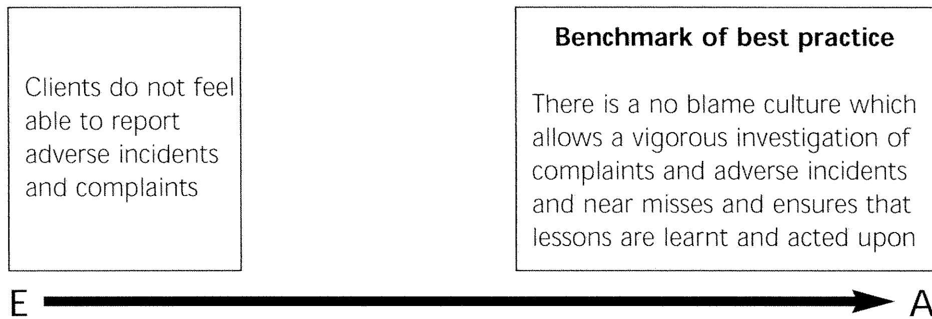
Review: - Care plan review intervals should be agreed individually and reviewed/evaluated as stated in the care plan
NB: Negotiated evidence based care plans and personal crisis plans are an integral part of the Care Programme Approach (1999)

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 acheived
- 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



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