## THE CARE PROCESS

Assessment, Planning, Implementation and Evaluation in Healthcare



ESSENTIALS

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## THIS BOOK IS DEDICATED TO GORDON HUGHES, WHO SADLY PASSED AWAY ON 21 OCTOBER 2018

# THE CARE PROCESS

Assessment, Planning, Implementation and Evaluation in Healthcare

MEL NEWTON, ANNE LLEWELLYN AND SALLY HAYES



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## **Acknowledgements**

We would firstly and most wholeheartedly like to give our thanks to the real Frank and Lizzie, who will remain anonymous but to whom we owe a debt of gratitude for the inspiration we needed to bring this book to life. Thanks also to our students, who continue to inspire us to be the best we can in supporting them to be the best they can!

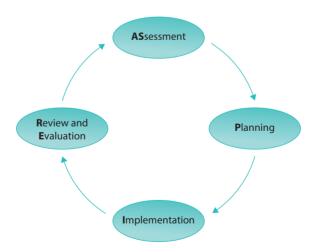
## Introduction

#### The content, coverage and approach of this book

This concise textbook is intended as an introductory text, which focuses on fundamental principles and practice of the care process for nursing students, health support workers and nursing associates. It is set out as a workbook, using case narratives to stimulate reflective learning and ground theoretical perspectives. The book can therefore be used as an independent study tool or as a core text within a particular module.

One way of conceptualising the care process is demonstrated by Sutton (2006), who uses the acronym ASPIRE to identify the different elements within the care process. Despite being published almost two decades ago, this model remains highly relevant:

- ASsessment
- Planning
- Implementation
- Review and Evaluation.



Diagrammatic representation of the cyclical process of care.

This is a cyclical and continuous process in which needs are assessed and reassessed according to ongoing evaluation. The process requires addressing a number

of questions in order to undertake an assessment of need and to gather the information required to plan care and interventions. Essentially, nursing practice involves problem-solving and identifying solutions to problems, whether the individual is admitted to hospital for a short-planned operation, or receives time-limited care within the primary care sector, or they have longer-term health and/or social care needs. The care process involves a series of stages and good assessment is essential for the identification of the problem as well as setting goals and planning interventions. If we fail to assess properly, there is a risk of basing interventions on guesswork or adopting a ritualised approach to the care process.

You will be familiar with this process from other areas of our lives where we may adopt this cyclical approach to decision-making in relation to more mundane activities than providing nursing care. Imagine, for example, you are planning a visit to a friend in hospital in a distant place. You will follow a process, which includes the need to assess, plan, implement and evaluate. In the assessment, the relevant factors may be:

- Where is the hospital and how long will it take to get there and visit your friend?
- What method of transport will be the best to use and what time can you visit?
- Do you need to let her or her family know you will be visiting?
- Are there practical things you need to consider such as child care or accommodation to enable you to visit?

You will need to consider issues of finance and available resources. Planning will therefore involve matching the resources to the available options, planning the method of transport to be used and timings. All of these factors will depend on available budget and personal preferences. Implementation will focus on the visit itself and, although there may not be a formal evaluation, consideration of how it went, what worked well and what did not will influence whether you would use the same approach for a future visit.

#### Professional standards for nursing care and the influence of policy

The importance of this systematic and cyclical approach to care for nursing practice is demonstrated in the professional requirements for competency and proficiency.

The Nursing and Midwifery Council (NMC) governs registration for professional practice and the progression to nursing branch programmes. This body sets the standards of conduct and for the assessment and establishment of professional competency. The expected conduct of registered nurses is set out in *The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates* (NMC, 2018a) and organised into four expectations:

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust.

Throughout the book there are examples in each chapter of how your practice can be developed to meet these expectations.

Standards or proficiencies are set out and focus on the cyclical process of care delivery and, as such, require nurses to demonstrate competence in the assessment, planning and implementation of nursing care within ethical, legal and policy frameworks.

In 2017, the Nursing and Midwifery Council (NMC) consulted on and updated their Standards of Proficiency for Registered Nurses that were then introduced in January 2019. These proficiencies are required for entry to the register, enabling registrants to practise as qualified practitioners. The proficiencies are grouped under seven 'platforms' which focus on the holistic needs of service users and identify achievement of learning outcomes in relation to (NMC, 2018b):

- Being an accountable professional
- Promoting health and preventing ill health
- Assessing needs and planning care
- Providing and evaluating care
- Leading and managing nursing care and working in teams
- Improving safety and quality of care
- Coordinating care.

Running alongside the wider professional context and process of ASPIRE it is important to recognise the policy (political) context of healthcare. Policy is set by the Department of Health and essentially sets national strategy and overall direction for the NHS. Policy is important to the ASPIRE process as it influences the work of health and social care practitioners at all levels. For example, policy impacts on diverse areas of practice from the amount of resources that are available to fund (or not fund) a service, to the types of practitioners that are legally enabled or 'legitimised' to undertake certain tasks and roles.

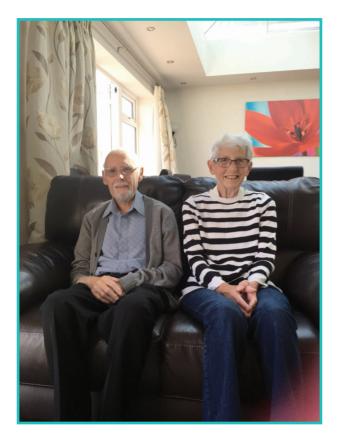
#### Our approach

The book has been designed to support and extend students' learning, introducing key concepts in relation to this ASPIRE process. Each chapter has clearly defined learning outcomes and a guide to further learning. A case study of Frank and Lizzie is employed throughout the book, as this represents a complex but not atypical case that will help you to apply the theoretical aspects of the ASPIRE framework to practice. This case is based on a real case study (see below) and both Frank and Lizzie and their next of kin have given informed consent for it to be used. Some biographical details have been changed (including names) to protect anonymity, but the care elements are based on fact.

Other case studies are also used throughout the book to demonstrate the breadth of patients and service user groups that nurses encounter. These are fictional, although some elements of them may be derived from real situations to ensure authenticity. The biographical data and details of locations are all fictional and any resemblance to reality is accidental and coincidental. Throughout the book, you will also find structured activities linked to the case studies to engage the reader and help them to understand relevance to their practice.

#### Meet Frank and Lizzie

Frank and Lizzie are both 83 and have been happily married for 61 years. They live in a two-bedroomed bungalow on the outskirts of a small town and until recently have lived very independently.



Frank left school at the age of 14 with no qualifications. Although not diagnosed at the time, he is profoundly dyslexic and still has great difficulty reading and writing. However, he has always been extremely practical, and he built their summerhouse as well as fitting the kitchen and bathroom. Throughout his life Frank has had a number of jobs, including farm worker, milkman and taxi driver. Lizzie has worked as a nurse as well as supporting Frank in their taxi business. As committed Salvationists, they ran a homeless shelter for the Salvation Army for a period of time and Frank ended his career as a prison chaplain working with young offenders. He formally retired from this role when he was 80.

Frank and Lizzie have always worked hard together to provide for their four children as well as disadvantaged people in the community. They have one son and three daughters, all of whom now have families of their own. Their son is their eldest child and lives some distance away, although he is in regular contact with them and visits them when he can. Their eldest daughter lives about 5 miles away and they see her

regularly. She provides a lot of support, including helping them with their shopping and cleaning. Their middle daughter also lives fairly locally to them, but they see little of her. Their youngest child lives some distance away, but is also in regular contact and visits at least once a month.

Not long ago, Lizzie broke her ankle and shortly afterwards suffered a detached retina. This has affected her confidence and she has become increasingly dependent on Frank. She enjoyed reading and walking the dog, but since the death of their beloved Yorkshire terrier, she has become progressively less mobile and now has frequent falls. She lacks confidence socially and has always been forgetful, but over the last year her memory has dramatically deteriorated and she now has difficulty making decisions.

Frank enjoyed good health until three years ago, when he was diagnosed with Parkinson's disease and early-stage dementia. At the age of 81 he had to give up driving due to the tremors associated with his Parkinson's disease, which has impacted greatly on Frank and Lizzie's ability to be independent – they have become increasingly reliant on their eldest daughter to take them shopping and to appointments.

Last year, Frank was diagnosed with skin cancer and had a tumour removed from his face. However, the cancer spread and six months later he had to have a large tumour removed from his neck, which resulted in some nerve damage, leaving him with partial paralysis of one side of his face. This has particularly affected his mouth and his ability to eat, drink and talk. He has had courses of both radiotherapy and chemotherapy and has had further tumours removed from his scalp. Preoperatively, he had to have a number of teeth removed and he now has dentures, which make his mouth sore. He has been deaf for some years and wears hearing aids in both ears.

Over the last year, Frank's tremors have got significantly worse and he now finds it difficult to hold anything and struggles to cut food and get it into his mouth. In addition, the paralysis of his mouth has led to problems with dribbling, which is a constant source of embarrassment for Frank. He has lost a lot of weight and looks malnourished and frail.

Lizzie worries about the future and how they will cope. Their lives have changed dramatically. They can no longer get out to the local town because Frank can't drive. Frank doesn't enjoy reading because of his dyslexia, and although Lizzie was once an avid reader, she no longer has the concentration to read a book. Frank's garden was his pride and joy, but he is no longer able to tend it due to his difficulty in holding implements and making fine motor movements. They still attend Salvation Army services when they can get someone to pick them up, but no longer feel able to play the active role that has always been a fundamental part of their lives.

In *Appendix 3* you will find a Single Assessment Process form completed for Frank as an example (see also *Chapter 4*).

#### **Chapter outlines**

Chapter 1 sets the scene by exploring definitions of health, exploring health behaviours and examining elements of the historical development of health and social care with reference to the biomedical and social models of healthcare. The chapter considers the importance of user and carer perspectives in health and social care delivery, exploring the concept of power within these relationships. This traces the origins of why the care process looks as it does by examining the role of the individuals and their specific roles as 'service user', 'carer' or 'professional practitioner'. The relationship between health and social care is also scrutinised, emphasising the importance of joint working between health and social care agencies in the provision of holistic person-centred care.

We make reference to politics and key policy drivers in health and social care, exploring the factors that influence policy and policy-making including the increasing focus on quality and the important issues about resources and finance and issues such as personalisation, risk and safeguarding. An understanding of the policy context is essential in understanding the care process, because it dictates the very manner in which ASPIRE is undertaken through funding and the establishment of national, regional and local policy targets and standards.

Communication and decision-making underpin all stages of the ASPIRE process and are discussed in *Chapters 2* and *3*, respectively. *Chapters 4* to *7* then explore the important skills used to undertake the process of care through consideration of the four-stepped process of ASPIRE – Assessment, Planning, Implementation, and Review and Evaluation. Finally, *Chapter 8* concludes the discussion by considering the future context of, and challenges for, your nursing practice.

## Chapter 7

## **Review and evaluation**

#### **LEARNING OUTCOMES**

This chapter covers the following key issues:

- Evaluation and review of health and social care
- Quality drivers for contemporary health and social care policy
- Professionalism and professional standards
- The implementation of evidence-based practice into everyday working practice
- Benchmarking
- Critical incident analysis and reflective practice
- · Theory and models of quality assurance
- The tools of quality assurance
- Standard setting
- Regulation and monitoring
- Audit
- Patient surveys and feedback

By the end of this chapter you should be able to:

- undertake evaluation of individual care interventions with the involvement of the patient
- understand the importance of evaluation and reviewing care at individual and service level
- discuss the tools and techniques that healthcare practitioners use to evaluate and review practice and services
- explain why it is important that health and social care is quality assured.

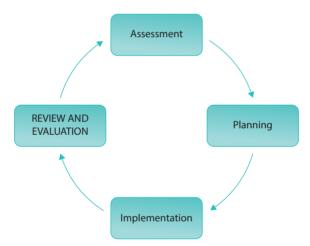
While many elements of the NMC platforms that make up the standards of proficiency for registered nurses are covered, this chapter has particular reference to (NMC, 2018b):

- Platform 4: Providing and evaluating care
- Platform 6: Improving safety and quality of care

For further detailed mapping please see *Appendix 1* – Detailed mapping to *Future Nurse: standards of proficiency for registered nurses.* 

#### 7.1 Introduction

The final stage of the care process as described by Sutton (2006) is review and evaluation (*Figure 7.1*). As stated, however, the process is cyclical and continuous, as review and evaluation may lead onto further assessment, starting the process again. Evaluation is not a one-off activity but is ongoing. It is a process, where needs are continuously assessed and reassessed according to ongoing evaluation.



**Figure 7.1** The final phase of the ASPIRE process.

Evaluating the effectiveness of care delivery for individuals, specific services and for society is important on a number of levels:

- Evaluation contributes to the evidence base on both an individual and population level and helps to ensure the right care interventions are used with the right individuals.
- Evaluation supports the policy drivers for the improvement of care delivery on both service and national level.
- Evaluation helps to improve care delivery in terms of quality, efficiency and effectiveness as well as safety and the prevention of health and social care disasters.

Since the inception of the NHS (and indeed before) there have been numerous documents concerned with the quality of care for patients. There is also much focus

on the financial necessity to improve efficiency. This was reflected as long ago as the publication of *Clinical Governance: quality in the new NHS* (NHS Executive, 1999), and Lord Darzi's report (Department of Health, 2008a), which required professionals to improve clinical behaviours in order to improve clinical outcomes for patients. More recently, *Leading Change, Adding Value* (Department of Health, 2016) has been published as a framework to evaluate the impact of clinical outcomes based on ten commitments:

- 1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff.
- 2. We will increase the visibility of nursing and midwifery leadership and input in prevention.
- 3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health.
- 4. We will be centred on individuals experiencing high value care.
- 5. We will work in partnership with individuals, their families, carers and others important to them.
- 6. We will actively respond to what matters most to our staff and colleagues.
- 7. We will lead and drive research to evidence the impact of what we do.
- 8. We will have the right education, training and development to enhance our skills, knowledge and understanding.
- 9. We will have the right staff in the right places and at the right time.
- 10. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

#### 7.2 The purpose of evaluation

Evaluation simply means to assess the value of something, and this raises an interesting question – valuable in terms of what (Brophy et al., 2008)? This is dependent of course on who carries out the evaluation and why it is being carried out. Within healthcare, evaluation will normally be carried out to answer the question of whether the care intervention has worked and whether the 'cost' was worth it. The difficulty is that, depending on who is concerned with the evaluation (the individual service user, the practitioner, the service provider or those who commission [pay for] the service) the question of 'is it worth it?' may have different answers. This complexity is demonstrated in *Activity 7.1*.

#### **ACTIVITY 7.1**



Herceptin is a drug now commonly prescribed as a pharmaceutical intervention for breast cancer. However, this was not always the case. Use the BBC news website to investigate the case regarding a Court of Appeal for Ms Rogers to access the drug (e.g. see <a href="http://news.bbc.co.uk/1/hi/health/4684852.stm">http://news.bbc.co.uk/1/hi/health/4684852.stm</a>).

Whose different perspectives in terms of evaluating the use of this drug were reported and how did they differ before the ruling to allow Ms Rogers to receive the drug?

Can you find more recent cases of this type of public debate where individual benefit and national cost implications are being played out?

In Leading Change, Adding Value (Department of Health, 2016) the six Cs (care, compassion, courage, communication, commitment and competence), which are a central plank of the 'Compassion in Practice' policy drawn up under the leadership of the then Chief Nursing Officer for England, are used to focus care provision across the three main principles of improving:

- health and wellbeing
- care and quality
- funding and efficiency.

The aim is to provide better outcomes, better experiences and better use of resources. In order to achieve this, care providers are asked to identify "proposed areas of unwarranted variation to be addressed" so that a standardised high-quality care provision is given.

Importantly, however, evaluations should be systematic both in terms of the process and reporting. This means that they are carried out in such a way that allows other people to follow the same process and understand how it was written up and how the results of the evaluation have been analysed (Brophy *et al.*, 2008).

#### 7.3 **Evaluating individual care**

For individual service user interventions, care evaluation is about reviewing the effectiveness of care and serves two purposes:

- 1. It enables the healthcare practitioner to ascertain whether the desired outcomes for the client have been achieved.
- It acts as an opportunity to review the entire process and determine whether the
  assessment was accurate and complete, any diagnostic element was correct, the
  goals of the intervention were realistic and achievable and the resulting process
  of implementation was successful (Hogston, 2007).

Of course the service user is not a silent partner in this process as they are not passive recipients of care. This means that healthcare practitioners must ensure that, as with every stage of ASPIRE, the voice of the service user is heard at the evaluation and review stage (see *Chapter 4*).

To review the care that is given at an individual level, it is useful to follow a series of questions about each stage of the care process. Hogston (2007) suggests a number of questions (see *Table 7.1*), which were formulated to think about nursing care.

#### **Table 7.1** Reviewing the Nursing Care Plan

- 1. Have the short-term goals been met?
- 2. If so, has the diagnosis or 'problem' been resolved so that it no longer needs to be addressed?
- 3. If the answer is no, then why have the care goals not been met? Did they meet the MACROS criteria? (see *Section 5.2*)
- 4. Was the planned care intervention realistic, explicit, evidence-based, prioritised, involved and goal-centred? (REEPIG see *Section 5.1.1*)
- 5. Was the method of intervention appropriate?
- 6. Was there effective communication within and between the care team?
- 7. Was the client satisfied with their care?

#### 7.4 Quality assurance of individual care

The continuing process of review and evaluation informs the quality of care experienced by service users. Quality assurance at an individual level is determined by several factors.

#### 7.4.1 Professional standards

The NMC is responsible for setting standards for the assessment of those wishing to enter the register and stay on it – essentially the establishment of professional competency and proficiency.

There are now seven platforms within the new standards of proficiency for registered nurses (NMC 2018b; published 2018 but introduced January 2019), which:

- represent the knowledge, skills and attributes that all registered nurses must demonstrate when caring for people of all ages and across all care settings
- reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care
- provide a benchmark for nurses from the EEA, EU and overseas wishing to join the register
- provide a benchmark for those who plan to return to practice after a period of absence.

The seven platforms (which are mapped throughout this book) are:

- 1. Being an accountable professional
- 2. Promoting health and preventing ill health
- Assessing needs and planning care
- 4. Providing and evaluating care
- 5. Leading and managing nursing care and working in teams
- 6. Improving safety and quality of care
- 7. Coordinating care.

The NMC has also published standards for pre-registration nursing programmes. When read together with Future Nurse: standards of proficiency for registered nurses

these give a complete picture of what nurses and midwives need to know and be able to do by the time they register, and the NMC's expectations of universities and their practice learning partners for delivering NMC-approved programmes for nurses and midwives. These focus on:

- learning culture
- educational governance and quality
- student empowerment
- educators and assessors
- curricula and assessment

For more information see www.nmc.org.

In additional, the NMC will (from 2019) become the regulator for nursing associates (see <a href="www.nmc.org.uk/news/news-and-updates/landmark-moment-as-nmc-becomes-regulator-for-nursing-associates">www.nmc.org.uk/news/news-and-updates/landmark-moment-as-nmc-becomes-regulator-for-nursing-associates</a>).

#### 7.4.2 Implementing evidence-based practice

Clinical or non-clinical guidelines are documents that guide decisions within services based on the examination of current evidence and best practice. They summarise the consensus regarding specific interventions and also some of the practical issues involved with their implementation. They address important questions related to clinical and non-clinical practice and identify all possible options and outcomes, sometimes following decision trees or algorithms which point to decision points and possible courses of action. Guidelines are important in setting the standards for care interventions in order to improve the quality of care, and also to enable equity of provision and to ensure that the most effective and efficient treatments are used.

The National Institute for Health and Care Excellence (NICE) is an independent organisation that provides national guidance and advice to improve outcomes for people using the NHS and other public health and social care services by (see <a href="https://www.nice.org.uk/guidance">www.nice.org.uk/guidance</a>):

- producing evidence-based guidance and advice for health, public health and social care practitioners
- developing quality standards and performance metrics for those providing and commissioning health, public health and social care services
- providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

NICE carries out assessments of the most appropriate practice, taking into account both patient outcomes and the financial impact using the concept of quality-adjusted life years (QALYs). Guideline Development Groups consisting of medical professionals, representatives of patient and carer groups and technical experts work together to assess the evidence base and best practice and, after a consultation period, issue guidance.

#### **ACTIVITY 7.2: FRANK**



Consider Frank's diagnosis of Parkinson's disease. Visit <a href="www.nice.org.uk/guidance/conditions-and-diseases/neurological-conditions/parkinson-s-disease">www.nice.org.uk/guidance/conditions-and-diseases/neurological-conditions/parkinson-s-disease</a> and consider the latest quality statements concerning the care of adults with this disease.

From the list of related NICE standards, which ones do you feel hold relevance in Frank's case?

#### 7.4.3 Benchmarking

Benchmarking is the process of comparing the quality of what one organisation or service does against what another organisation or service does. It enables current practice to be measured against best practice and evaluated in terms of whether changes or improvements need to be made.

One example is the Essence of Care benchmarks (<a href="www.gov.uk/government/">www.gov.uk/government/</a> publications/essence-of-care-2010), which were first introduced in 2001 and have been frequently revised. Essence of Care 2010 is a versatile tool that can be used in a number of ways at individual and organisation level. For the evaluation and quality assurance of individual care, it can be used as a checklist of what patients, carers and staff agree is best practice in areas as diverse as:

- bladder, bowel and continence care
- care environment
- communication
- food and drink
- prevention and management of pain
- personal hygiene
- prevention and management of pressure ulcers
- promoting health and wellbeing
- record-keeping
- respect and dignity
- safety
- self-care.

There are many advantages of benchmarking and the RCN has summarised these as (Royal College of Nursing, 2017):

- providing a systematic approach to the assessment of practice
- promoting reflective practice
- providing an avenue for change in clinical practice
- ensuring pockets of innovative practice are not wasted
- reducing repetition of effort and resources
- reducing fragmentation/geographical variations in care
- providing evidence for additional resources
- facilitating multidisciplinary team building and networking
- providing a forum for open and shared learning
- being practitioner-led, and giving a sense of ownership

- accelerating quality improvement
- improving the transition of patients across complex organisational care pathways
- contributing to the NMC revalidation process (NMC, 2018a) in both reflection and CPD elements.

#### 7.4.4 Critical incident analysis and reflective practice

Critical incident analysis involves reflecting on either good or bad practice to give insight into that practice and is not explicitly concerned with identification of ineffective or incompetent practice. This is because learning can be achieved through the identification and reflection on actions that have had positive outcomes for the care recipient. The use of critical incident analysis as a tool to improve caregiving depends on the ability of individuals to reflect upon and question practice and therefore to recognise either a dissonance between the care given and the required outcome for the care recipient, or conversely to recognise why good outcomes were achieved (Hayes and Llewellyn, 2008).

Reflective learning is a crucial part of knowledge development for professional practice, where knowledge is processed through experience. Schön's (1984) model of reflection in action has been influential in many approaches to professional development and the process by which practitioners create meaning through the observation and analysis of issues and themes that arise in practice settings.

Reflective practice is a process that must be undertaken by all Registered Nurses both personally and through the process of clinical supervision. The process of reflective practice is being used by different professional groups, with the aim of improving care through changing practice.

Reflection, however, is not new to any level of intelligent thought. Dewey defines reflective thought as that which results from an event in life that provokes or arouses a state of perplexity or uncertainty and leads the individual to search for possible explanations or solutions (Dewey, 1933). This can be applied throughout the human experience. It could be argued that it is what makes us human. Human beings plan and take actions to achieve certain outcomes, monitoring ongoing action and its consequence to make sure we achieve what we planned for!

Johns (2004) incorporated Carper's (1978) 'ways of knowing' into a model of reflection to allow the practitioner to appreciate personal, ethical and empirical influences on the experience, thereby framing learning through reflection. Johns describes (believing definition impels authority) reflection as:

... a fusion of sensing, perceiving and intuitive thinking related to a specific experience to develop insights into self and practice. It is a vision-driven process, concerned with taking action towards knowing and realising desirable practice. (2004, pp. 2–3).

Gibbs' (1988) seminal work on the reflective cycle clearly demonstrates the cyclical and continual process of reflection (*Figure 7.2*).

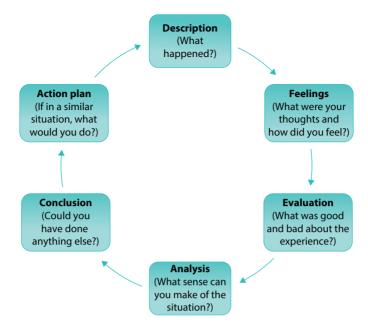


Figure 7.2 Gibbs' reflective cycle (1988).

The following scenario shows how Gibbs' reflective cycle might be used in practice.

### REFLECTION: LIZZIE

#### What happened?

Lizzie was admitted to the A&E Department with a suspected stroke. I was the Nursing Assistant who was caring for her and making the initial assessment.

#### **Feelings**

I was really nervous as I had not experienced this situation before. Lizzie looked a lot like my Grandma who had just died.

#### **Evaluation**

I was pleased that I could help Lizzie and I felt close to her but it was also a bit off-putting because she reminded me of my Grandma. I felt like crying at one point and needed to leave the room.

#### **Analysis**

I know that I need to stay professional and give everyone the same kind of care and respect dignity and not make judgements about people based on appearances.

#### REFLECTION: LIZZIE - (continued)



#### Conclusion

Instead of getting upset, I could have talked to the Nurse in Charge to explain that Lizzie looked like my Grandma and that she had just died. It might have been better to have someone more experienced with me.

#### **Action plan**

If a similar situation arises, I will definitely speak to someone to explain. I don't want other members of staff to think I am an emotional wreck and it is important that I am professional in front of relatives so that they have confidence in me.

#### 7.5 Quality assurance of services

Much of the quality of care experienced by the individual service user is dependent on factors that are broader than the individual practitioner who is implementing the care. Quality assurance refers to planned and systematic processes that try to provide confidence in an activity or intervention or in a service or organisation's suitability for its intended purpose. Quality assurance activities aim to ensure that the services will meet requirements in a systematic, reliable way (Hayes and Llewellyn, 2008).

#### 7.5.1 Structure, process and outcome

In a seminal work, Donabedian (1988) described a model of quality assurance for the evaluation of healthcare, which describes three aspects to specifying and measuring quality: structure, process and outcome. All three are considered equally important in measuring the quality of care provided by an organisation and they are complementary and should be used collectively to monitor quality of care.

- Structure refers to human and physical resource and can include staff and policy.
- Process refers to the methods of working, so may include the procedures for allocating resources or implementing guidelines.
- Outcomes refer to the effect of both the structure and the process, the result of a number of individual 'outputs'. The outcome relating to a clinical guideline being introduced, for example, would be improved patient care with improved clinical outcomes (Hayes and Llewellyn, 2008).

#### 7.5.2 Quality perspectives

Hayes and Llewellyn (2008) also interpreted a model initially proposed by Huycke and All (2000) for the quality of healthcare provision (*Table 7.2*):

Perspective	Focus
<b>Providers</b> (healthcare organisations)	The process and outcomes of care, including having the knowledge to deliver care and achieving the required healthcare outcomes (e.g. meeting waiting list targets)
<b>Payers</b> (taxpayers or private insurance)	The affordability and access to care according to need
Public	Standards and regulations set by the government

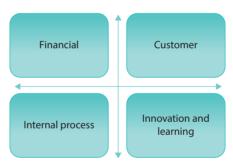
**Table 7.2** Model of quality perspectives (adapted from Hayes and Llewellyn, 2008)

#### 7.5.3 The balanced score card approach

**Patients** 

Another approach to quality assurance often used to evaluate whole organisations is using the balanced score card, first conceived by Kaplan and Norton in 1996. This involves grouping performance measures in general categories (perspectives) and is believed to aid organisations in the gathering and selection of the appropriate performance measures, thus contributing to quality assurance. Four general perspectives are proposed (*Figure 7.3*).

Subjective view of the quality of care



**Figure 7.3** *Balanced score card approach.* 

- The financial perspective within health and social care services may be one of remaining within budget and the questions that therefore need to be asked are about affordability and sustainability of interventions.
- The customer or service user perspective describes the satisfaction of the service user who receives the services.
- The internal process perspective is concerned with the processes that create and deliver the services, and considers all the activities and key processes required in order for the company or organisation to excel at providing the service effectively.
- The innovation and learning perspective focuses on the skills and capabilities that are required to deliver the required services. This is about the people who work within the services and asks whether they are trained and educated to do the job required of them, and whether the information systems are effective in enabling the organisations to keep up-to-date and informed (Kaplan and Norton, 1996).

#### 7.5.4 Service evaluation

To assess the efficiency of a service there are different questions that can be asked:

- Is the service cost-effective?
- Are the interventions affordable and sustainable?
- Are the service users satisfied with provision (the family and friends test)?
- What do staff think about their service (staff satisfaction surveys)?

#### 7.5.5 Regulation and monitoring

The Care Quality Commission (CQC) was established by the Health and Social Care Act 2008 (Department of Health, 2008b) and is responsible for regulating the quality of health and social care (see *Table 7.3*) and looking after the interests of individuals detained under the Mental Health Act (2007) (Department of Health, 2007; Care Quality Commission, 2008).

The CQC is responsible for registering, reviewing and inspecting services and where providers of services fail to meet the legal requirements of their registration, it has the legal powers to take action against them. The aim is therefore to enable services to improve by ensuring that essential quality and safety standards are met and where shortcomings are identified, to use enforcement powers to force organisations to improve their standards.

**Table 7.3** Care Quality Commission – 'How we do our job'

The way we regulate care services involves:

- registering people that apply to us to provide services.
- using data, evidence and information throughout our work.
- using feedback you've given us to help us reach our judgements.
- inspections carried out by experts.
- publishing information on our judgements. In most cases we also publish a rating to help you choose care.
- taking action when we judge that services need to improve or to make sure those responsible for poor care are held accountable for it.

From www.cqc.org.uk/what-we-do/how-we-do-our-job/how-we-do-our-job

#### 7.5.6 The audit cycle

Audit is at the heart of quality improvement, as it can be used as a tool to review and improve all services by:

- providing the mechanisms for reviewing the quality of everyday care
- building on a long history of healthcare professionals reviewing case notes and seeking ways to serve their patients better
- addressing quality issues systematically and explicitly, providing reliable information
- confirming the quality of services and highlighting the need for improvement.

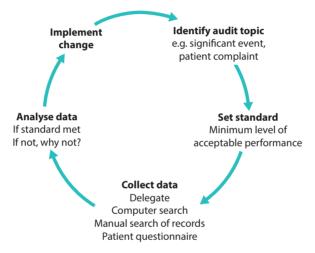
(adapted from National Institute for Clinical Excellence, 2002)

#### Clinical audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery.

Clinical audit can be described as a cycle or a spiral. Within the cycle there are stages that follow a systematic process of establishing best practice, measuring care against criteria, taking action to improve care, and monitoring to sustain improvement. The spiral suggests that as the process continues, each cycle aspires to a higher level of quality (National Institute for Clinical Excellence, 2002).

Figure 7.4 shows an example of the audit cycle (www.qualityinoptometry.co.uk).



**Figure 7.4** *The audit cycle.* 

#### **ACTIVITY 7.3**



You work as a Nursing Associate in a GP practice and the manager has asked you to be involved in an audit about patient satisfaction. She would like to gather some data around how patients rate your service when you have provided some aspect of care for them. The topic area is about communication and you need to think about the best ways to get some honest and useful feedback about your service provision, so that you can continually improve care to patients.

What ideas can you think about?

Are there any constraints to getting valuable information?

Use SMART (see Chapter 5) to design a short and easy-to-complete survey.

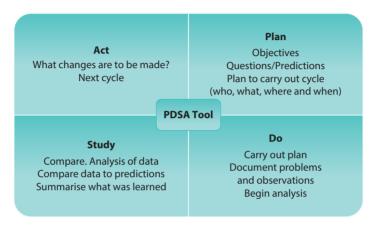
Try to think about how you would get Frank and Lizzie to provide information.

#### Implementing change

The Plan, Do, Study, Act (PDSA) model is a basic service improvement model and is a common tool for implementing change (*Figure 7.5*). The four stages of the PDSA cycle are:

- Plan the change to be tested or implemented
- **Do** carry out the test or change
- **Study** data before and after the change and reflect on what was learned
- **Act** plan the next change cycle or full implementation.

(NHS Institute for Innovation and Improvement, 2011)



**Figure 7.5** Diagrammatic representation of the PDSA tool.

#### **ACTIVITY 7.4: FRANK AND LIZZIE**



Think back to Frank and Lizzie.

As you know, Lizzie is feeling more and more socially isolated as her and Frank's physical and mental health deteriorates. Plan a single intervention that may help them to feel less isolated and follow the PDSA cycle to evaluate your approach.

The NHS has also designed its Change Model to assist in improving services (see <a href="https://www.england.nhs.uk/sustainableimprovement/change-model/">www.england.nhs.uk/sustainableimprovement/change-model/</a>). The three key ideas on which the NHS Change Model is based are worth considering to ensure that any change is effective and sustainable as an improvement. They are:

- 1. Intrinsic and extrinsic motivators for change
- 2. Anatomy and physiology of change
- 3. Balancing commitment and compliance.

#### **ACTIVITY 7.5**



Visit the NHS Change Model website (www.england.nhs.uk/sustainableimprovement/change-model/) for resources, webinars and forums – which are constantly being updated.

The Change Model frequently asked questions page provides a standard slide set, and a downloadable picture of the NHS Change Model.

You can also contribute to discussions on Twitter using #nhschange.

#### 7.5.7 Serious incident analysis and service user safety

Recognition that incidents or adverse care events cannot be eliminated from complex modern healthcare has been an important step in recent years in learning from such events to improve future service user safety. Indeed one of the things that might result in an audit being undertaken is an Untoward Incident. In 2000 the Department of Health published its paper 'Organisation with a Memory' (Department of Health, 2000) to formalise the process of collecting and analysing accurate data on adverse healthcare events, leading to the creation in 2001 of the National Patient Safety Agency (NPSA). The NPSA has the responsibility of improving the safety and quality of patient care through reporting, analysing and disseminating the lessons of adverse events and 'near misses' involving NHS patients.

The format for doing so is based on the process of:

- gathering information on the root cause of the incident (i.e. identify the factors that led to the hazard occurring)
- learning from it (i.e. study and consult widely)
- acting to prevent it happening again (identify interventions which may prevent reoccurrence) and so preventing or reducing risk.

#### **ACTIVITY 7.6**



All clinical areas receive relevant national patient safety incident reports (NaPSIRs). Research the latest one to be circulated to your clinical area. What happened and what changes are expected as a result of the alert?

In addition to the NPSA, the Medicines and Healthcare products Regulatory Agency (MHRA) was created and is the government agency responsible for ensuring that medicines and medical devices work and are acceptably safe.

#### **ACTIVITY 7.7**



The MHRA monitors safety and quality standards of medicines and medical devices in several ways, for example regular inspections to ensure good and safe practice in:

- manufacturers and suppliers of medicines and medical devices
- medicines distribution and storage
- clinical trials
- clinical inspecting systems for devices
- laboratories testing medicines
- auditing notified bodies
- blood establishments.

Visit the MHRA website (www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency) and investigate in what other ways it contributes to the safety of service users.

Family members often witness the care given to patients and may judge the care to be good or below the standard expected. This can inform the quality assessment of care or it may become even more significant. The science behind ergonomics or human factors is an emerging discipline for healthcare and lessons learned in other industries (especially aviation) have started to become embedded. Martin Bromiley's wife Elaine was admitted to hospital for routine surgery and died as a result of 'human factors'. Martin was an aircraft pilot and was familiar with the science of human factors and wanted answers to questions about the death of his wife. He has become a pioneer for human factors in healthcare and founded the charity Clinical Human Factors Group (CHFG), which champions patient safety.

#### **ACTIVITY 7.8**



Search online for Martin Bromiley and look at the CHFG website (<a href="www.chfg.org/">www.chfg.org/</a>) to find more information on human factors in healthcare. Identify one human factor that you have seen contributing to poor care. What action could be taken to prevent that happening again?

#### 7.5.8 Serious child safeguarding practice reviews

Serious child safeguarding cases are those in which abuse or neglect of a child is known or suspected and the child has died or been seriously harmed. The nature of Child Safeguarding Practice reviews is set out in Chapter 4 of the document *Working Together to Safeguard Children* (HM Government, 2018).

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgement should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

The purpose of serious child safeguarding reviews is to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children
- identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and consequentially
- improve inter-agency working and better safeguard and promote the welfare of children.

Serious safeguarding practice reviews may also be undertaken where an adult has died and there is suspicion or evidence of neglect or abuse, as in the case of Steven Hoskin, who was a 39-year-old man with learning disabilities. He was subjected to systematic abuse by carers, who hauled him round his bedsit with a dog collar, burned him with cigarettes and eventually made him cling to a viaduct, where he fell to his death after being kicked in the face and having his hands

stamped on. Although Steven Hoskin was known to social services, insufficient action was taken to safeguard him from this abuse.

#### **ACTIVITY 7.9**



Read the summary of the serious case review into a child in Camden by scanning the QR code on the right, or visiting bit.ly/Activity7-9.

What lessons can be learned to improve future practice?



There are Safeguarding Adults Boards that work strategically to improve the provision of care for vulnerable adults (see <a href="www.tsab.org.uk/">www.tsab.org.uk/</a> as an example of a regional adult safeguarding board).

#### 7.5.9 Service user and carer surveys and feedback

Service user and carer satisfaction is one factor taken into consideration for judging quality of care, and service user and carer surveys and feedback are being increasingly used in healthcare services. Organisations can gather user feedback in a variety of ways including surveys (Friends and Family), audits, comments and complaints, focus groups and interviews. Health and social care organisations are mandated to undertake user surveys and actively seek feedback. By constantly and systematically surveying care, a detailed picture of the experience of service users is drawn. National surveys are valuable as they allow local organisations to compare the performance of similar organisations across the country. It also means it is possible to identify the things that really matter to service users. The Picker Institute, for example, which is commissioned to survey the NHS, has found that the things that are most important to service users are (Picker Institute, 2009):

- fast and reliable health advice
- effective treatments delivered by trusted professionals
- participation in decisions and respect for preferences
- clear, comprehensive information and support for self-care
- attention to physical and environmental needs
- emotional support, empathy and respect
- involvement of and support for family and carers
- continuity of care and smooth transitions.

In addition to service user and carer surveys, Patient Reported Outcome Measures (PROMs) are a method of collecting information on the quality of clinical care as reported by service users themselves. Service users answer the same set of questions on their quality of life before and after an operation and the comparable data is then used to calculate a numerical value for the improvement to their health. The focus for this approach started with all licensed providers of hip replacements and reports can be seen at the NHS website (<a href="https://www.digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms">www.digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms</a>).

#### **CHAPTER SUMMARY**



This chapter focused on the evaluation and review stage of ASPIRE. It is essential that healthcare practitioners understand the importance of evaluating health and social care at individual service user level, organisational level and national level. There are many contemporary policy drivers and a plethora of tools and techniques that can be used in order to ensure that care is effectively quality assured and evaluated.

Reflection			
Identify at least three things that you have learned from this chapter.	1		
	2		
	3		
How do you plan to use this knowledge within clinical practice?	1		
Miowicage Willing chinear practice.			
	2		
	3		
How will you evaluate the effectiveness of your plan?	1		
checuveness of your plan.			
	2		
	3		
What further knowledge and evidence do you need?	1		
	2		
	3		

#### **FURTHER READING**

Aveyard, H. and Sharp, P. (2017) *A Beginner's Guide to Evidence Based Practice in Health and Social Care*, 3rd edition. London: Open University Press.

This is the book for anyone who has ever wondered what evidence-based practice is, how to relate it to practice or use it in academic work. It provides a step-by-step guide to what we mean by evidence-based practice and how to apply this concept to your practice and learning.

Fully updated in this edition, this book uses simple and easy-to-understand language to help those new to the topic.

Brophy, S., Snooks, H. and Griffiths, L. (2008) *Small-Scale Evaluation in Health: a practical guide*. London: Sage.

Setting out the basics of designing, conducting and analysing an evaluation study in healthcare, the authors take a practical approach, assuming no previous knowledge or experience of evaluation. All the basics are covered, including: how to plan an evaluation; research governance and ethics; understanding data; interpreting findings; writing a report. Case studies are included throughout to demonstrate evaluation in action, and self-learning courses give the reader an opportunity to develop their skills further in the methods and analysis involved in evaluation.

Conklin, T. (2012) *Pre-Accident Investigations: an introduction to organizational safety.* Boca Raton, FL: CRC Press.

This is a new way to explore why untoward events happen and embraces concepts from human factors science.

Health Education England, short film 'Raising Concerns':

#### www.youtube.com/watch?v=zjau1Ey0di8

Heaslip, V. and Lindsay, B. (2019) *Research and Evidence-Based Practice*. Banbury: Lantern Publishing.

This accessible and easy-to-read text enables students to understand what research is and how it can provide evidence for practice. It uses clear explanations, key case studies, questions and activities to explore the principles of research needed for students to develop their own evidence-based practice. It covers areas such as why research is carried out and why it matters, and gives thorough guidance on how to search and review the literature in order to evaluate the quality of research. It explores how research projects are designed and participants recruited, how data is collected and analysed, and how research findings are communicated. It also covers important areas related to the cost and funding of research, ethics, and how

to review evidence and use it to improve the quality of care. For the student, it has a practical and applied approach that enables the development of ways to both demonstrate the understanding of research and evidence, and to develop and promote best practice in health and social care.

Teeswide Safeguarding Adults Board website:

www.tsab.org.uk/

The NHS Change Model:

www.england.nhs.uk/sustainableimprovement/change-model/