**Guidance document to accompany CCAAT v12:**

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| **Combined Care Assurance Audit Tool (CCAAT) v12 Guidance Notes** | | **Comments** |
| This CCAAT v12 guidance document is designed to provide the auditor with information to enable effective completion of the CCAAT document v12. This guidance is broken down in to the relevant sections and should be referred to when completing all fields within the CCAAT v12  It should be used in conjunction with the “Guidance for Care Assurance Visits April 2018 v02” and the “15 Steps – NHS England) which provides preparatory advice prior to undertaking a Combined Care Assurance Visit.  Across the whole CCAAT v12 document, all fields that require to be completed are shaded pale pink this will change to white when data has been entered. This will assist the auditor with progression through the CCAAT v12 completion.  Pop ups will appear in relevant areas advising of correct completion. Where needed, the pop up will appear regarding the entering of free text in the comments sections.  Throughout the CCAAT, there are questions which relate directly to medical responsibilities. These will be added to the overall medical compliance score.  The Red / Amber / Green / Gold (RAGG) scoring is aligned with other audit tools currently utilised within NHSGGC. The scoring is as follows:  Red: <66%, Amber: 66% – 79%, Green: 80% – 90% and Gold: 91%>  Optimum navigation and document scrolling is dependent on the screen resolution and zoom level chosen by the user. The default view is set at 70%; however, this view is user choice and should be altered as required. | |  |
| **Introduction – Welcoming Ward Section** | | |
| **Today’s Date** | The Quality Assurance section requires the date in the format dd/mm/yy or dd-mm-yy to allow Excel to perform calculations. |  |
| **Calm / organised and safe** | It is recognised that this is a subjective set of questions. However, since the responses to these questions are RAGG scored, it is important to give an explanation for your answer.  E.g. A ward may appear quiet but not necessarily organised or it may be very busy but there is obvious organisation. |  |
| **Number of Patient/Carer conversations with auditor(s):** | How many conversations that we as the auditor(s) instigate in order to get a feel for the care experience of patients |  |
| **Quality Assurance** | | |
|  | You are asked to enter today’s date at the top of the form to aid calculations. Excel requires the date to allow it to perform calculations that sum up the days since a given incident (pressure ulcers and falls)  Falls and Pressure Ulcer Occurrence are now live on the NHSGGC CAIR dashboard. If you do not have access to this the nurse in charge should be able to access the system and provide the data.  SPSP frequency of observations (NEWS compliance) is not currently audited in all areas at present so an “I” may be used if the ward being audited does not currently measure this. However, if the ward does measure NEWS compliance then evidence should be made available to the auditor(s)  The SCN/ CN or Nurse in Charge should be able to access all the necessary information for the Quality Assurance Section assessment in preparation for your feedback discussion. Please ensure you actually see the supporting evidence. |  |
| **Section 1** | | |
| 1.5 | This allows a Y/N/I input in the event that there are no visitors within the ward at the time of the audit |  |
| 1.9 | Not all wards utilise “What Matters to Me” laminates. If the ward does use the laminates, then >90% should be completed. If the ward does not use the laminates however, then there must be clear evidence of person centred care appropriate to the patients’ needs and requirements. E.g. Particular needs and desires entered in the nursing documentation or a statement regarding bathing preferences.  Although this is a subjective observation, the Person Centred Care evidence utilised should be detailed in the comments section. |  |
| **Section 2** | | |
| 2.2 | These examples are not exhaustive - for illustration and prompting only. |  |
| **Section 3** | | |
| 3.1, 3.2 and 3.3 | These 3 audit statements are calculated using the RAGG scoring system. They are separated into a subtotal for the Medical Assurance Compliance Score Section at the end of the CCAAT v12. Having the medical responsibility questions calculated separately allows for distinct compliance scores for both Nursing assurance and Medical assurance. |  |
| 3.2 | If AWI section 47 is in place, a treatment plan has been completed including documented evidence that their treatment plan has been discussed with the patient/ relative(s) / carer(s): This may be documented on the 4 page document but also in medical notes, This is the part that underpins the act and will really make the difference to the patient’s care. |  |
| 3.4 | Not necessarily a sole medical responsibility (however, usually only signed by medical staff in hospital) |  |
| 3.5 | Power of Attorney (POA) /Guardian: POA can be indicated in the MAR and there should be evidence of copy request, if applicable.  If it is scanned onto Clinical Portal from previous admissions, and is still valid, i.e. it has not been withdrawn, then this will suffice. It should be located in the Legal Documents tab on Clinical Portal. |  |
| **Section 4** | | |
| **Part A**  **4.1 - 4.12** | Initial Assessment and Documentation compliance within 24 hours:  This section refers to the initial admission 24 hour assessment period and whether the “My Admission Record” (page 1-3 of MAR) is fully completed within the appropriate time frame, the completion of the My Assessment Record (pages 4-12 of MAR) and whether it has been completed appropriately within 24 hours of admission.  The ‘Risk Assessments/Other Documentation’ page (page 13 of MAR) should clearly indicate the additional NHSGGC documents that are required to be completed for the patient and all fields should be completed.  The ward being audited, however, may not have been the admission ward and as such the RAGG scoring for this section is counted separately and displayed, but not added to the overall combined score at the end of the document. This allows for further data analysis if required.  There will be occasions that the patient (or NOK/Carer) cannot provide the information needed for full assessment (due to e.g. cognitive impairment, delirium or presenting condition etc). There should be written acknowledgment of this of this in the MAR or the patient’s notes. |  |
| 4.1 | Please indicate the admitting Sector, Site and ward in the appropriate box at the top of the section. This box allows free test and a suggested format pop-up will appear. |  |
| 4.4 | A Pressure Ulcer risk assessment must be completed within 8 hours in line with Tissue Viability guidelines |  |
| 4.5 | A MUST assessment should be carried out within 24 hours of a patient being admitted to hospital. It is understood that a patient may have been transferred from another area that hadn’t carried out this assessment within the appropriate time frame. If this is the case then an “I” should be used. The originating ward should be documented in 4.14  Conversely, the patient may have been admitted to the ward currently being audited and the MUST still has not been calculated with the appropriate time frame – if this is the case then “N” should be entered. This can be entered in the comments section at the end |  |
| 4.6 | Although an actual weight should be entered on the MUST chart, there is also a section for the patient’s reported weight. The patient/ carer or relative should be asked this on admission and the results recorded. If it has been noted on the MUST chart that this could not be provided, then please enter I. If nothing has been documented regarding this, then you have assume that the patient, carer or relative has not been asked and therefore the answer to this will be “N”. |  |
| 4.8 | If the MUST chart does not have the actual weight recorded, is there evidence that staff have accessed Clinical Portal / Trakcare / Skygateway for previous details or have sought to assess the risk of malnutrition by other means? **i.e.** Mid Upper Arm Circumference (MUAC) Click [here](http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Greater%20Glasgow%20and%20Clyde%20Services/FFN/Documents/Alternative%20Measurements.pdf) for further information |  |
| **Part B 4.15 -4.27** | Ongoing care planning and documentation |  |
| 4.15-4.16 | Careplan document review: Care discussed with patient– has this box been completed? Relative or carer involvement – has this been indicated on the care plan? |  |
| 4.17 | There should be some documented evidence that the care plan has been reviewed daily. This may be in the careplan itself or in the nursing documentation. |  |
| **Nutritional Care Assessment Tool 4.26– 4.34** | Nutritional Care:  The Nutritional Care Assessment Tool has been incorporated into CCAAT v12 and as such will now be RAGG scored.  (The 24 hour MUST assessment is in Section 4 (Part A) to assess compliance of initial assessment documentation completion) |  |
| 4.26 | Rescreening is appropriate within the first 7 days if there is no actual prior weight or if wards have made this a standard requirement i.e. Older Peoples and Stroke Services |  |
| **Section 5** | | |
| 5.1 -5.2 | A comprehensive geriatric assessment is not a single document, there should be written evidence in the medical notes of an assessment of needs with an agreed care plan, referral or review (with multidisciplinary input if required) and agreed pre-requisites for discharge. |  |
| **Section 6** | | |
|  | Guidance on medicines reconciliation and accessing information can be found [here](http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/eHealth/eHT/Pages/MedicinesReconciliationandIDL.aspx) |  |
| 6.1 -6.3 | This section covers medical responsibility questions and will be RAGG scored for the Medical Compliance section at the end of the CCAAT v12 document and calculated into the overall Combined Score. |  |
| 6.4 -6.5 | Y, N or I may be used. |  |
| 6.6 | This is a Y/N answer only – a registered nurse can either explain the process for checking discharge medicines, or they cannot. |  |
| **Section 7** | | |
| 7.2 | When reviewing “The must do for me” section in the care round checklist, a **✓** or a “N/A” is not sufficient. These do not demonstrate that there has been any interaction between the nurse and patient. There should be clear acknowledgements that this question has been asked and answered.  If the patient is unable to be involved in this, then this too should be documented. |  |
| 7.3 | A missed parameter or incorrect aggregate score does not demonstrate appropriate completion |  |
| 7.4 | If the NEWS score aggregate indicates an escalation:  Is the aggregate correctly calculated using the scoring tool on the NEWS chart?  Is the escalation and Clinical Response appropriate to the aggregate values?  Has this escalation and intervention been clearly documented in the nursing notes? |  |
| 7.6 | In NHSGGC the Bristol stool chart is the only corporately agreed bowel assessment chart. If the area being audited is using a locally designed tool – this is not acceptable and therefore cannot be audited appropriately. |  |
| 7.8 | Different pain assessment tools may be utilised in the area being audited: e.g. The Abbey Pain Scale for those patients unable to verbally communicate their pain level, the NHSGGC Generic pain Assessment Tool or a Patient Controlled Analgesia (PCA) chart.  If a pain assessment is appropriate for the patient being reviewed, this should at least be documented on the NEWS chart if no other pain assessment tool is utilised. |  |
| **Section 8** | | |
| 8.1 | Auditing the completion of a 4AT and TIME checklist within 24 hours of hospital admission or transfer to current ward cover and ongoing transfers |  |
| 8.2 | This question is auditing the documented evidence that an assessment has been carried out if indicated by the 4AT. Circling the “**NO** “or “**UNSURE**” on the TIME checklist would count as evidence. This evidence can be in the patient's notes or on the TIME checklist. As indicated on the TIME Checklist, this is a joint responsibility of both nursing and medical staff |  |
| 8.3 | If delirium is diagnosed, sections I, M and E of the TIME Checklist should be reviewed and actioned, with evidence of this documented in the patient's notes. (Medical or nursing)  The TIME document is a checklist to remind staff of the appropriate actions to take. If the discussion is documented in the clinical notes but not on the TIME document, then this may be counted as evidence. |  |
| 8.2 and 8.3 | These questions have joint responsibility answers and will be added to the overall combined score |  |
| 8.5 | There is a”Y/ N ONLY” answer for this; there would not be an “I”. The question asks if this patient is SQiD positive, this is being highlighted. This can only be answered as Y or N. |  |
| **Section 9** | | |
| All | This section has a combination of “Y/ N / I” and “Y/ N Only” answers, depending on the question being asked. |  |
| **Section 10** | | |
| 10.6 | This is a medical responsibility question and as such will be noted in the medical scoring section and added to the combined score |  |
| **Section 11** | | |
| 11.1 and 11.2 | Comprehensive geriatric assessment (CGA) evidence may take different forms. Depending on the speciality of the ward, there may be specific documentation that relates to the ancillary services that are utilised in preparation for rehabilitation / discharge preparation. If appropriate, there should be specific reference to these services and / or documented evidence in the medical notes of a review by a geriatrician or an eCAN / eCAN (elderly care & assessment nurse/ elderly care & orthopaedic nurse. |  |
| **Section 12** | | |
| 12.1 | An addressograph label on the discharge checklist is not sufficient evidence of the checklist being commenced. This document may be part of an admission pack that is prepared for the patient. There should be some clear indication on the checklist that it has been commenced |  |
| **Section 13** | | |
|  | Patient Movement: Depending on the circumstances of a patient’s admission to hospital, there will be occasions that a patient will be admitted to the ward being audited after 22:00, e.g. from A&E and AMU etc. For this reason this section is looking at **more** than 2 transfers, the times of transfer and that the reasons for transfer have been documented accordingly  Times of transfer may be out with the audited ward’s control and as such this is scored and displayed separately at the end of the audit tool. This allows for further data analysis if required. |  |
| **Section 14** | | |
| All | This section has “Y / N” answers only. Either the staff member (not necessarily an RGN), is able to provide answers to these questions or not. |  |
| **Section 15** | | |
| 15.4 | All patients should be offered the opportunity to clean their hands and if necessary, assistance and positioning support provided |  |
| **Scoring Section** | | |
| All | The Scoring Compliance is automatically calculated throughout the document and the final scores are displayed here. The Overall Combined Compliance Score are the Medical and Nursing scores combined.  Section 4 (Part A) is displayed separately and not included in the overall combined score. This score is the compliance score of the initial admitting ward(s). |  |