

Essence of Care 2010



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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE



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Foreword

from Dame Christine Beasley, DBE, Chief Nursing Officer
and Karen Middleton, Chief Health Professions Officer

People who use our services rightly expect high-quality care and support. Those who are responsible for the provision of this care need to be able to assure themselves that the care and support they give is the best it can be wherever services are provided. *Essence of Care 2010*, as the national benchmarking system, has been updated to ensure it meets the needs of a range of professionals working in a variety of care settings. Refreshing the *Essence of Care* benchmarks reflects the feedback of service users and frontline staff.



Christine Beasley



Karen Middleton

The first *Essence of Care* benchmarks were introduced over a decade ago. They were originally developed to address the fundamentals of care and this is still at the heart of the current 12 benchmarks. *Essence of Care* is used by frontline staff in health and social care settings. Regulators also increasingly use it to assess the focus and commitment of organizations in providing high-quality care.

The importance of providing high-quality care and assessing that quality has become increasingly central to the provision of services in the twenty-first century. Updating *Essence of Care* allows all healthcare professionals to revisit their services using the best evidence available. A new benchmark for pain reduction has now been developed in response to requests from patients and frontline staff.

We hope you find *Essence of Care 2010* a valuable resource, which supports you in continually improving your practice.

Christine Beasley *Karen Middleton*

Introduction

The original *Essence of Care* benchmarks were created 10 years ago, with the first launch in February 2001. They are a tool to help healthcare practitioners take a patient-focused and structured approach to sharing and comparing practice. (By practitioners, we mean any health or social care employee delivering direct patient care.)

The original benchmarks were reformatted and benchmarks for communication were added in 2003. Since then, two further sets of benchmarks on promoting health and well-being (2006) and care environment (2007) have been added to the range.

Following feedback from people using services and practitioners, it has been agreed that pain management is an area of care that should be supported by a set of benchmarks, and this is reflected in the new *Essence of Care 2010* benchmarks.

The updated *Essence of Care 2010* supports and reflects a number of the themes in *Equality and Excellence: Liberating the NHS* and provides a suite of benchmarks to drive forward best practice in delivering the fundamentals of care and improving the experiences of people who use services.

How to use Essence of Care 2010



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Quick Start

The following is a 'quick start' guide for using the *Essence of Care 2010* to improve practice and care.

Identify which aspect of practice and/or care needs improvement

Questions to ask:

- What do *people* requiring care and/or their carers complain or raise issues about most?
- Why have incidents or accidents happened?
- What areas have national or local surveys highlighted as being of concern?
- For example, have there been any complaints about *people* requiring care not being helped to eat?

Look at the benchmarks, factors and indicators to see what people requiring care and carers say needs to be in place

Things to think about:

- Are there any benchmarks that link with the area of concern identified above? For example, Benchmarks for Food and Drink.
- Are there any factors that link with the specific area of concern? For example, '*People* receive the care and assistance they require with eating and drinking' (Assistance – Factor 9).
- Review the indicators for practical ideas of how to achieve the factors. For example, 'A system is in place to identify that *people* requiring assistance to eat and drink receive it' (indicator 9b).

Review and change practice and/or care

- Ascertain whether current practice meets the indicators. For example, identify whether there is a system in place that identifies *people* requiring assistance to eat and drink. If current practice does not meet the indicators change practice so that it does. For example, introduce a system where food is delivered on red trays for *people* requiring assistance.

Evaluate practice and/or care from perspective of people requiring care, their carers and staff

Questions to ask:

- Do *people* requiring care and/or their carers think that care has improved? Are they happy with the standard of care? For example, are *people* and/or carers satisfied with the assistance given to help *people* eat and drink? Is there evidence that *people* requiring care are well nourished?

Establish improved practice and care or revise further

- Establish improved practice and care across the team, organisation or organisations or improve practice and care further where it does not meet the indicators.

How to use Essence of Care 2010

Essence of Care 2010 identifies best practice and highlights how this can be achieved. *Essence of Care 2010* was developed in partnership with *people*¹ and carers² and as such reflects the views of their health and social care needs and preferences.

It is important to note at this point that *Essence of Care 2010* is a very versatile tool that can be used in a number of ways and at different levels. For example, it can be used as:

- a *quality assurance or benchmarking tool* (see below)
- a reference document or checklist – *Essence of Care 2010* includes what *people, carers and staff*³ agree is best practice and care and this can, therefore, be referred to in order to understand *people's* and carers' perspectives and what might need to be improved to accommodate these
- an *audit tool* – as a foundation and focus for audit data collection tools used to assess practice and care (linked to above)
- a *dissemination tool* – to spread current good practice and care across organisations
- a *root cause analysis tool* – when examining incidents and complaints or addressing risks
- an *education tool* – to educate and train staff of all levels about *people's* and carers needs and preferences, and to highlight the areas where specific competencies are required to provide care
- to provide *evidence of compliance with registration criteria* for the Care Quality Commission

1 For simplicity, the term '*people requiring care*' is shorted to *people* (in italics). *People* includes babies, children, young *people* under the age of 18 years and adults. This is consistent for all sets of benchmarks except those covering the Care Environment.

2 The term '*carers*', refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Carers can include children and young *people* aged under 18 years.

3 The term '*staff*' refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

- to provide *evidence of achievement and best practice and care* – for example, to the regulator or Health Service Ombudsman, for the National Cleaning Standards, when using the National Service Frameworks, or in commissioning assurance.

Essence of Care 2010 can be used by individuals, teams, directorates, and within and across organisations of all sizes. It can also be used locally or strategically, or ideally, both. It has universal application.

When using *Essence of Care 2010* it is important to remember to:

- make it work for *people* and their carers
 - focus on areas of concern for *people* and carers
 - use *Essence of Care 2010* flexibly to make improvements
 - ensure involvement from *people*, carers and all staff concerned with the delivery of care
- make it work for staff and/organisations
 - save time and effort and integrate *Essence of Care 2010* work with other projects and initiatives, such as those required for the National Cleaning Standards, reports for regulators, infection control guidance, mixed sex accommodation guidance, Dignity Champions work, governance, Patient Environment Action Teams' guidance, National Institute for Health and Clinical Excellence (NICE) guidance, electronic handover, and Better Metrics Projects, etc
 - use within commissioning assurance
- do not reinvent the wheel – be 'smart'
 - share and compare best practice and care (locally, nationally, other team's work etc)
 - where possible use evidence already in existence (for example, current audit data)
 - use valid tools that already exist and
 - use evidence gathered for one set of benchmarks, for instance those concerning, 'Respect and Dignity', to provide evidence for other sets of benchmarks such as 'Communication' and 'Food and Drink'. This applies both to goals that are more specific as well as goals that cover topics such as diversity, consent and confidentiality, *people's* involvement, leadership, education and training etc.

Much of *Essence of Care 2010* is centred on benchmarks and benchmarking for practice and care. The following text discusses this in more depth. In addition, there are more detailed ideas and tips on 'Using *Essence of Care 2010* Benchmarks' in Appendix One and 'Making Changes Possible and Sustainable' in Appendix Two.

Why is benchmarking practice and care necessary?

Many *people* have care that is very effective and appropriate to their needs and preferences. There are lots of examples of compliments being written or made to health and social services staff. However, practice and care is not correct all of the time and, therefore, needs improvement. Poor care is evidenced by, for instance, complaints, untoward incidents, and increased death and illness rates. Therefore, staff, teams and/organisations need to look at how they are working in order to improve practice and care.

Benchmarking is important because it is a systematic process that can be used to improve practice and care.

What is a benchmark and benchmarking?

In the context of this document a **benchmark** is:

'a standard of best practice and care by which current practice and care is assessed or measured.'

Following from this **benchmarking** is:

'a systematic process in which current practice and care are compared to, and amended to attain, best practice and care.'

Briefly the steps involved are:

- **establish priorities** for improving practice and care within the environment or organisation
- **establish and agree best** (evidence-based) practice and care for *people* within the organisation
- ascertain current practice and care
- **compare the differences**, and identify the gaps and barriers between, current and best practice and care and identify achievements
- **develop a plan** of what goals need to be met to achieve best practice and care, that is, working out what needs to be done and how
- **implement the plan** (that is, change things, for example, activity, perspective, approach, culture, education and training, environment, etc) to meet the goals
- **evaluate** practice and care by assessing and measuring whether goals have been met
- **establish improved practice and care** across a team, or organisation(s)
- **establish priorities and further goals** to continuously improve quality of practice and care, that is, go through the steps again.

(see also Appendices One and Two)

Focus of Essence of Care 2010 benchmarks

The benchmarks are focused on 12 topics. These were chosen because the evidence indicated that *people* were unhappy with these fundamental aspects of care. The 12 sets of benchmarks are:

- 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 Well-being
- Record Keeping
- Respect and Dignity
- Safety
- Self Care

The overall person outcomes, specific factors and indicators (or goals) within the benchmarks have been developed, reviewed extensively and agreed by *people*, carers, association representatives and staff as vital to providing best practice and care. The result is sets of benchmarks which are truly person-focused. This is because the areas covered are important to *people* and carers, and the indicators are focused on what *people* and carers say they want and expect.

Where can the Essence of Care 2010 benchmarks be used?

These benchmarks are designed to be used wherever health and social care is planned, managed and/or delivered. For example, it can be used in the following settings and environments:

- *people's* homes
- hospitals
- day centres
- clinics
- care homes
- ambulances
- prisons
- GPs' surgeries
- schools

In the following areas:

- care for acutely ill *people*
- care for chronically ill *people*
- emergency care
- long term care
- short term care
- care of *people* with learning disabilities
- care of children and young *people*
- care of *people* with a range of conditions such as cancer, diabetes, medical and surgical problems
- care of *people* with wounds
- care in pregnancy
- care of *people* with mental health problems
- care of *people* who are terminally ill
- care of *people* who are in pain
- care of *people* who are vulnerable

and in the settings and areas in which you work.

Content of Essence of Care 2010 benchmarks

The *Essence of Care 2010* benchmarks comprise:

- an **overall person-focused outcome** that expresses what *people* and carers want from care in a particular area of practice
- **definitions** of terms as appropriate
- **general** indicators, or goals, for best practice
- a number of **factors**, or topics, that need to be considered in order to achieve the overall person-focused outcome

Each factor consists of:

- a person-focused statement of **best practice and care** which is placed at the extreme right of the continuum
- a statement of **poor practice and care** which is placed at the extreme left of the continuum
- indicators, or goals, identified by *people*, carers, association representatives and staff that support the attainment of best practice and care

An example is shown on the next page.

Example of overall outcome, factor and indicator

Benchmarks for Prevention and Management of Pain

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

Factor 1 – Access



Indicators of best practice for factor 1

The following indicators support best practice for managing pain:

- a. *general indicators (see page 4 in each benchmark) are considered in relation to this factor*
- b. up-to-date information about pain management and services, and how to access them, is readily available in all care environments and (where applicable) given in advance of care. Information is provided in a suitable format and in plain language
- c.
- d. *add your local indicators here*

APPENDIX ONE

Ideas and tips

Essence of Care 2010 benchmarking is a systematic process in which the current practice and care of health and social organisations, teams or individual staff are compared to, and amended to attain, best practice and care. Changes and improvements focus on the indicators, or goals, within the factors, since these are the items that *people*, carers and staff believe are important for achieving best practice and care.

This section includes ideas and tips that have proved useful in taking forward the Essence of Care. It is *not* an exhaustive list of activities that must be followed.

The steps involved are listed in the tables on the following pages:

Steps for Benchmarking:

Step	Activity	Ideas and Examples
<p>Step One</p>	<p>Establish priorities for improving practice and care within the environment or organisation</p>	<p>Be strategic in choosing a set of benchmarks (or a factor or an indicator) on which to focus effort that is relevant and appropriate.</p> <p>Decisions on what to focus on should be based on evidence such as:</p> <ul style="list-style-type: none"> ■ increased concerns about practice and care highlighted by <i>people</i>, carers and/or staff ■ lack of satisfaction of <i>people</i> or carers (for example, collected during surveys) ■ increased risk to safety of <i>people</i>, carers and/or staff (for example, collected as the result of incidents) ■ increased or high number of complaints ■ identification of recently published evidence of best practice and care; ■ identification of an exemplar of good practice and care within the organisation ■ new guidance from organisations such as National Institute for Health and Clinical Excellence (NICE), the National Specifications of Cleanliness in the NHS in relation to Patient Environment Action Teams (PEAT) from the National Patient Safety Agency, or within commissioning assurance or from the Social Care Institute of Excellence. <p>This step is very important for <i>gaining support for improvement throughout the organisation</i>. This is because a wise decision can tie together the expectations of <i>people</i> and carers to the goals of teams, organisations, commissioners or local authorities.</p>

Step	Activity	Ideas and Examples
		<p>For example, the following expectations and goals could be addressed in part via the Benchmarks for Prevention and Management of Pressure Ulcers (such as Factor 1, indicator b):</p> <ul style="list-style-type: none"> ■ <i>people</i> do not expect to develop pressure ulcers in a care environment ■ the team wants to identify and manage more effectively the care of <i>people</i> at risk of developing pressure ulcers ■ the organisation wants to reduce the incidence of pressure ulcers and manage the use of pressure redistributing equipment more efficiently ■ the commissioning organisations or local authority want to improve overall well-being of the population within an area ■ the government wants to deliver maximum improvement in health and well-being outcomes within resources. <p>N.B. Be strategic – the links between expectations of <i>people</i> and carers, as well as the goals of staff, teams, organisations, commissioners and local authorities and government priorities may need to be highlighted to those concerned.</p>

Step	Activity	Ideas and Examples
		<p>It may be appropriate for the organisation to set up an Essence of Care 2010 Steering Group. This steering group can provide strategic focus and direction for the <i>Essence of Care 2010</i> initiative and support staff throughout the organisation(s) to improve the fundamental aspects of care. The steering group can also be used to monitor progress, facilitate evaluation and report on benchmarking activities to the board. In addition, the steering group could have a remit to ensure that the Essence of Care 2010 initiative is integrated with the organisation's other priorities and committees. Lead members can liaise with other organisations at regional and national levels to share good practice, ideas and to disseminate methods of improvement. the Steering Group could have a remit to ensure that the <i>Essence of Care 2010</i> initiative is integrated with the organisation's other priorities and committees.</p>
		<p>ESSENCE OF CARE 2010 STEERING GROUPS</p> <p>Essence of Care 2010 Steering Group membership can include:</p> <ul style="list-style-type: none"> ■ <i>people and/or carers</i> ■ representatives from associations, such as Age UK ■ experts in changing practice (for instance, lead members of the practice development, service improvement, integrated governance and/or quality teams) ■ commissioners of services ■ staff who work directly with <i>people and/or carers</i> ■ senior managers of services ■ support service staff ■ board members

Step	Activity	Ideas and Examples
		<p>Remember: Consider resource implications – there is no bottomless pot of money!</p>
<p>Step Two</p>	<p>Establish and agree best (evidence-based) practice and care for <i>people</i> within the organisation</p>	<p>Guidance for best practice and care is provided by the specific and general indicators (goals) that <i>people</i> and carers have stated are important from their perspectives. Some of these goals are about putting processes in place and others are the outcomes that <i>people</i> and carers want and expect.</p> <p>Examples of goals are:</p> <ul style="list-style-type: none"> ■ <i>people</i> are addressed as they wish and spoken to using their preferred name (Benchmarks for Respect and Dignity, factor 4, Indicator b) ■ resources to aid communication and understanding are available, for example, hearing loops, text phone, large print text, pictures, books, toys, Braille, multilingual literature and other electronic methods of communication (Benchmarks for Communication, factor 5, indicator b) ■ incidents, such as acts of violence, aggression and seclusion are reviewed and evaluated and the knowledge is used to improve care (Benchmarks for Safety, factor 6, indicator d) ■ <i>people</i> and carers know how to access services and resources, for example, by using the Citizen’s Advice Bureau, NHS Direct etc (Benchmarks for Self Care, factor 6, indicator c) ■ <i>people</i> who are identified initially as having pressure ulcers or who are vulnerable to the development of pressure ulcers should receive a full assessment using an evidence-based tool (Benchmarks for Prevention and Management of Pressure Ulcers, factor 1, indicator d).

Step	Activity	Ideas and Examples
		<p>N.B. Not all the goals are applicable to all health and social settings and environments and others may need to be adapted.</p> <p>It is often important to agree what constitutes best practice and care across a team, an organisation or organisations in order to ensure improvements are achieved and sustainable across health or social care settings. For instance:</p> <ul style="list-style-type: none"> ■ in relation to pressure ulcer management and goals, agreement may have to be reached about what is meant by the term <i>'vulnerable to development of pressure ulcers'</i> and what constitutes a <i>'full assessment'</i> or an <i>'evidence-based tool'</i>. This may involve setting up an 'Expert Working Group' (see below) to put forward standards and assessment tools which can then be agreed throughout the team, an organisation or organisations ■ the goal of <i>'nature and quality of lighting and use of colour in furnishings and decorations support a therapeutic and/or healing environment'</i> (Benchmarks for Care Environment, factor 3, indicator c) would require an 'Expert Working Group' of people and carers as well as a range of staff including those delivering care and those managing the physical environment, such as estate management staff etc. In addition, staff managing budgets would need to be involved to support or sanction any cost ■ the goal of <i>'barriers to accessing information, services and support have been identified and are being addressed'</i> (Benchmarks for the Promoting Health and Well-being, factor 5, indicator c) may require an 'Expert Working Group' in order to ascertain the barriers and how best to address them.

Step	Activity	Ideas and Examples
		<p>EXPERT WORKING GROUPS</p> <p>Expert Working Group membership can include:</p> <ul style="list-style-type: none"> ■ <i>people</i> and/or carers ■ representatives from associations, such as Age UK ■ experts in the topic under review (for instance, if developing best practice and care for <i>people</i> who do not speak English, representatives from organisations that provide competent interpreters could be involved) ■ staff who work directly with <i>people</i> and/or carers ■ managers of services ■ support service staff ■ board members, trustees and governors
		<p>Therefore, this step usually necessitates the work of a group with some expertise or knowledge of the topic under review (n.b. this invariably includes <i>people</i> and/or carers), in order to discuss and define best practice and care. In addition, some members of the group also need to have an overall view of the management of care in a particular area and other members will have the authority (or access to authority) to obtain agreement for the group's decisions from the relevant committees within their organisation(s).</p>

Step	Activity	Ideas and Examples
Step Three	Ascertain current practice and care	<p>Current practice and care can be ascertained in a number of ways. For example:</p> <ul style="list-style-type: none"> ■ observation of care (such as whether <i>people</i> are spoken to using their preferred name, or whether they have the necessary communication aids) ■ reviewing documentation (such as to ascertain whether incidents are reviewed, evaluated and used to improve care, or whether those who are vulnerable to developing pressure ulcers receive a full assessment) ■ monitoring access to services (such as local interpreting services or NHS Direct) ■ monitoring outcomes of care (such as prevalence and incidence of pressure ulcers) ■ surveys of <i>people's</i> and carers' views and satisfaction (such as attitude and helpfulness of staff). <p>It is important to decide how (criteria and method) current practice and care will be measured or assessed. There may be standard ways of achieving this (such as the National Patient Survey Programme or existing services user surveys) or local criteria and methods may need to be used. For example, what criteria will be used to assess whether <i>people</i> are spoken to using their preferred name? It could be the number of times that a person's referred name was used as a percentage of how they were referred to during an episode of care; or a person's perception of whether their preferred name was used 'not at all', 'sometimes', 'mostly' or 'all the time' etc. The method used could be observation and taking notes, or recording events by camera, or by asking <i>people</i> or staff. It is imperative that the criteria and method used reflect the topic under investigation that is, <i>is what is being measured or assessed what is supposed to being measured or assessed?</i></p>

Step	Activity	Ideas and Examples
		<p>The Better Metrics Project (Health Care Commission 2007) and State of the Art Metrics for Nursing: A Rapid Appraisal (National Nursing Research Unit, King's College London 2008) may provide some useful ideas in terms of measurement.</p> <p>Remember to keep the evidence!</p>
<p>Step Four</p>	<p>Compare the differences, and identify the gaps and barriers, between current and best practice and care and identify achievements</p>	<p>Use the evidence collected on current practice and care to assess achievement towards best practice and care. Evidence can include that collected from, for example, the National Patient Survey, PEAT programmes, other national and local initiatives. Do not duplicate!</p> <p>Identify the gaps. For example, if only 50 percent of reception staff speak to <i>people</i> using their preferred name, there is evidently a gap between this and best practice and care where everyone is spoken to using their preferred name.</p> <p>Identify barriers to best practice and care. To continue to use the example above – in order to identify why reception staff are not using a person's preferred name a manager may choose to discuss this with the staff members. The barriers may turn out to be that the preferred name was not asked for or was not entered into the computer database by the staff assessing the person.</p>

Step	Activity	Ideas and Examples
Step Five	<p>Develop a plan of what goals need to be met to achieve best practice and care that is, working out what needs to be done and how</p>	<p>Produce an action plan detailing:</p> <ul style="list-style-type: none"> ■ the changes that need to be made to meet goals (for instance, the computer needs to indicate the need for a 'preferred name' to be entered onto a person's records) ■ any resource implications and how these will be met (for example, how much time the above would take to organise and to enter) ■ who is responsible for leading the changes ■ the time scale in which these should occur. <p>Actions should be:</p> <ul style="list-style-type: none"> ■ realistic ■ achievable (but do not let that limit your vision of what is <i>possible</i>) ■ measurable or assessable. <p>N.B. The 'Essence of Care 2010 Steering Group' and/or 'Expert Working Group' (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations. Think differently! It is important to consider practice and care from people's and carers' points of view (see also Thinking Differently, NHS Institute for Innovation and Improvement, 2007).</p>

Step	Activity	Ideas and Examples
Step Six	<p>Implement the plan (that is, change things, for example, activity, perspective, approach, culture, education and training, environment etc) to meet the goals</p>	<p>Carry out the plan.</p> <p>Keep the evidence (document, document, document):</p> <ul style="list-style-type: none"> ■ activities ■ any improvements ■ problems ■ unexpected observations. <p>N.B. The 'Essence of Care 2010 Steering Group' and/or 'Expert Working Group' (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations.</p>
Step Seven	<p>Evaluate practice and care by assessing and measuring whether goals have been met</p>	<p>Analyse data and evaluate actions:</p> <ul style="list-style-type: none"> ■ Did the experiences or outcomes of people and carers improve? ■ Did service delivery benefit from changes made? ■ If there is no improvement review activities in the action plan. <p>N.B. The 'Essence of Care 2010 Steering Group' and/or 'Expert Working Group' (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations</p>

Step	Activity	Ideas and Examples
Step Eight	Establish improved practice and care across a team, or organisation(s)	<p>If improvements are identified, disseminate good practice and care and implement the changes as widely as appropriate through other organisational systems.</p> <p>Include in the business planning cycle, integrated governance plan and quality initiatives and reports of teams, organisations or commissioning bodies via relevant leads. Can also be included in annual reporting to the regulator.</p> <p>N.B. The 'Essence of Care Steering Group' and/or 'Expert Working Group' (see Steps One and Two) can be used to facilitate the above within a team, an organisation or organisations</p>
Step Nine/ One etc	Establish priorities and further goals to continuously improve quality of practice and care, that is, go through the steps again	As above

The process can be accomplished using the PDSA cycle (Plan, Do, Study, Act) see Langley GJ, Nolan KM, Norman CL, Provost LP and Nolan TW (1996) *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* Jossey-Bass Publishers: USA cited in Modernisation Agency, 2002).

APPENDIX TWO

Making changes possible and sustainable: Ideas and tips

Things to put in place:

	Organisation	Team	Individual
Culture	<p>The culture of the organisation actively supports benchmarking the fundamental aspects of practice and care.</p> <p><i>People's</i> and carers' involvement and perspectives are ensured wherever the fundamental aspects of care are considered.</p>	<p>The culture of the team actively supports benchmarking the fundamental aspects of practice and care.</p> <p><i>People's</i> and carers' involvement and perspectives are ensured wherever the fundamental aspects of care are considered.</p>	<p>Individual staff actively support benchmarking the fundamental aspects of practice and care.</p> <p><i>People's</i> and carers' involvement and perspectives are ensured wherever the fundamental aspects of care are considered.</p>
Structure	<p>There is an organisation-wide structure that supports benchmarking the fundamental aspects of practice and care.</p>	<p>Teams and team leaders are an integral part of the organisation-wide structure.</p>	<p>Individuals liaise with their local teams and team leaders and, as appropriate, with organisation and commissioning teams.</p>

	Organisation	Team	Individual
Mechanisms	<p>Organisation-wide mechanisms are in place to manage the benchmarking process and to integrate this with other quality initiatives and priorities.</p>	<p>Team mechanisms are in place to manage the benchmarking process locally and to integrate this with other quality initiatives.</p>	<p>Individuals manage relevant parts of the benchmarking process. This may involve activities such as taking part in audits, surveys etc.</p>
Responsibility	<p>The organisation takes action to meet its responsibilities in terms of benchmarking the fundamental aspects of practice and care.</p> <p>The chief executive officer (CEO) (or registered person in a social care service) is ultimately responsible for ensuring that the fundamental aspects of practice and care are met.</p>	<p>The team takes action to meet its responsibilities in terms of benchmarking the fundamental aspects of practice and care.</p> <p>The team leader is ultimately responsible for ensuring that the fundamental aspects of practice and care are met within their team.</p>	<p>Every member of staff is responsible for supporting activity towards benchmarking and delivering the fundamental aspects of practice and care.</p>

	Organisation	Team	Individual
Leadership	There is a designated post or role at senior management level to lead the Essence of Care Initiative. The post-holder is the link between commissioners, the board, managers, team leaders and staff working directly with <i>people</i> and carers.	There is a specifically designated role to lead the Essence of Care Initiative within teams.	Individuals have access to support and advice from the designated leader and also support the leader in their work.
Commissioning Assurance	Benchmarks of the fundamental aspects of practice and care are central and integral to how services are planned, commissioned and delivered.	Teams are able to demonstrate that fundamental aspects of care are part of how services are planned and delivered.	Individuals contribute to the planning and delivery of the fundamentals of care
Resources	Sufficient human and financial resources are provided to sustain the benchmarking process in the fundamental aspects of care and to maintain improvements in care.	Teams can provide evidence of probity in managing human and financial resources to support improvements in the fundamental aspects of care.	Individuals can provide evidence of probity in delivery of care to support improvements in the fundamental aspects of care.

Essence of Care 2010

Benchmarks for Bladder,
Bowel and Continence Care



Document Purpose	Best Practice Guidance
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Author	DEPARTMENT OF HEALTH
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

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



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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor. These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Bladder, Bowel and Continence Care

Agreed person-focused outcome

People's bladder and bowel care needs are met

Definitions

For the purpose of these benchmarks, **continence** is:

people's control of their bladder and bowel function

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those 'who look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *People* aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People's bladder and bowel care needs are met

Factor	Best practice
1. Information	<i>People</i> and carers have easy access to evidence-based information about bowel and bladder care that is adapted to meet their needs and preferences
2. Advice	<i>People</i> and carers have direct access to staff who can advise them on continence management
3. Screening and assessment	<i>People</i> receive bladder and bowel continence screening and assessment (where appropriate)
4. Planning, implementation, evaluation and revision of care	<i>People's</i> care is planned, implemented, continuously evaluated and revised to meet individual bladder and bowel care needs and preferences
5. Promotion of continence and healthy bladder and bowel	All opportunities are taken to promote continence, and a healthy bladder and bowel among <i>people</i> and in the wider community
6. Access to products and devices	<i>People</i> and carers have access to 'needs specific' products and devices to assist in the management of bladder and bowel incontinence
7. Environment	All bladder and bowel care is given in an environment appropriate to <i>people's</i> needs and preferences
8. Support	<i>People</i> and carers have the opportunity to access other <i>people</i> and carers with similar continence problems who can offer support

Factor 1

Information

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers have no evidence-based information about bowel and bladder care

BEST PRACTICE

People and carers have easy access to evidence-based information about bowel and bladder care that is adapted to meet needs and preferences

Indicators of best practice for factor 1

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. evidence-based, up-to-date and consistent information concerning bladder and bowel care is available to people, carers and the public
- c. initiatives are taken to ensure awareness and access of available information
- d. information relating to networks, including links to self-help, user groups and health promotion units, is available
- e. *add your local indicators here*

Factor 2

Advice

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have access to staff who can advise them on continence management

BEST PRACTICE

People and carers have direct access to staff who can advise them on continence management

Indicators of best practice for factor 2

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. expert advice and services on continence are available to meet *people's needs*
- c. policies, procedures, guidelines, referral protocols and care pathways are available to generalist and specialist continence services
- d. self-referral mechanisms are in place and are accessible
- e. education and training programmes for staff and carers to enable them to provide advice are in evidence
- f. *add your local indicators here*

Factor 3

Screening and assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's continence needs are not assessed

BEST PRACTICE

People receive a bladder and bowel continence screening and assessment, where appropriate

Indicators of best practice for factor 3

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. opportunities to allow *people* to discuss bladder and bowel concerns is provided at all relevant consultations
- c. *people's* positive response to a question concerning any difficulties or urgency associated with the function of their bladder or bowel (for example, a 'trigger question') always leads to an offer of an initial bladder and bowel continence assessment
- d. *people's* understanding or acceptance of a 'trigger question' is assessed
- e. reassurance is given (as appropriate) to *people* that bladder and/or bowel incontinence is not an uncommon problem

- f. the use of 'trigger questions' is promoted amongst colleagues and other team members
- g. assessment tools are evidence-based and adapted for specific groups
- h. strategies are in place to ensure access to continence services that are delivered locally
- i. staff undertaking screening and assessing must be acceptable to *people*
- j. staff are competent to carry out preliminary assessment of continence
- k. there is evidence of audits to ascertain if, and when, 'trigger questions' were asked and whether appropriate assessment of needs took place
- l. *add your local indicators here*

Factor 4

Planning, implementation, evaluation and revision of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have a plan of care

BEST PRACTICE

People's care is planned, implemented, continuously evaluated and revised to meet individual bladder and bowel care needs and preferences

Indicators of best practice for factor 4

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *planning, implementing, evaluating and revising care are evidence-based and involve people and their carers (where appropriate), as well as all relevant members of staff*
- c. *people are referred to other services as appropriate*
- d. *care plans or care pathways are used and outcomes are measured using an evidence-based tool*
- e. *people are involved in developing their own care plan and in setting their own outcome measures*

- f. regimes to support appropriate bladder and bowel emptying and care are designed to meet the needs and choices of *people*
- g. up-to-date protocols or evidence-based guidelines are used for care interventions, including guidance for bladder and bowel emptying regimes (where appropriate)
- h. data of referral rates, re-referral rates, complaints and *people* survey results are used to improve care
- i. dietary and medication needs are met
- j. staff undertaking planning, implementing, evaluating and the revision of care must be acceptable to *people*
- k. audits are undertaken and the results are disseminated and inform practice development
- l. *add your local indicators here*

Factor 5

Promotion of continence and healthy bladder and bowel

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

There is no attempt to promote *people's* continence and a healthy bladder and bowel

BEST PRACTICE

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

Indicators of best practice for factor 5

The following indicators support best practice in bladder, bowel and continence care:

- a. general indicators (see page 4) are considered in relation to this factor
- b. groups at risk of developing continence problems are identified locally
- c. inter-professional or inter-agency working to promote *people's* continence and health bladder and bowel is demonstrated
- d. strategies for the promotion of continence, and healthy bladder and bowel in the wider community is demonstrated
- e. promotion strategies, for example, DVDs and other methods of electronic communication, and written information, are used to promote knowledge and understanding within the wider community

- f. initiatives to promote continence services, including links with self-help, user groups and health promotion units, are in place
- g. risk assessment, root cause analysis, audits and education are undertaken and, with research evidence, used to improve care
- h. *add your local indicators here*

Factor 6

Access to products and devices

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers do not have access to products and devices that assist in the management of bladder and bowel incontinence

BEST PRACTICE

People and carers have access to 'needs specific' products and devices to assist in the management of bladder and bowel incontinence

Indicators of best practice for factor 6

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people's* need for continence products and devices are anticipated, and product information and assessment is offered or initiated in a timely fashion
- c. *people's* needs and preferences for continence products and devices are assessed and choices met (as appropriate)
- d. *people's* needs and preferences for continence products and devices are evaluated and reassessed regularly
- e. sufficient time is given to enable *people* to communicate their needs and preferences

- f. explicit or expressed valid consent is obtained from *people* prior to treatment or care
- g. *people* have access to expert knowledge and skills
- h. products and devices are adequate, safe and of good quality
- i. use of services is monitored, for example, by regular audit
- j. *add your local indicators here*

Factor 7

Environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

The environment is not conducive to meeting *people's* needs

BEST PRACTICE

All bladder and bowel care is given in an environment appropriate to *people's* needs and preferences

Indicators of best practice for factor 7

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. all attempts are made to make the environment appropriate, accessible and acceptable for *people's* care, such as lighting, cleanliness, heating, toilets, hand washing and bidet facilities
- c. sufficient space is available for managing continence
- d. all attempts are made to meet *people's* privacy and dignity needs
- e. toileting regimes are designed to meet the needs of *people*
- f. *people's* views on the environment are sought and acted upon and action taken as appropriate
- g. specialist continence experts are involved in assessing the environment
- h. *add your local indicators here*

Factor 8

Support

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers have no access to other people and carers for support

BEST PRACTICE

People and carers have the opportunity to access other people and carers with similar continence problems who can offer support

Indicators of best practice for factor 8

The following indicators support best practice in bladder, bowel and continence care:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. strategies are used to put *people* and carers with similar problems in touch with each other, if desired
- c. initiatives are taken to set up or support a local self-help or user group
- d. links to local or national groups exist and information about groups is given to *people*
- e. support received by *people* and carers is evaluated
- f. *add your local indicators here*

Essence of Care 2010

Benchmarks for Care Environment



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Benchmarks for Care Environment



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- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

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- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

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- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Care Environment

Agreed person-focused outcome

People are confident that the care environment meets their needs and preferences

Definitions

For the purpose of these benchmarks, the **care environment** is defined as:

an area where care takes place. For example, this could be a building or a vehicle.

The term **people** refers to all people, other than staff, who are visiting or are resident in the care environment.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **personal environment** is defined as the immediate area in which an individual receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People are confident that the care environment meets their needs and preferences

Factor	Best practice
1. Access to the care environment	<i>People</i> can access the care environment easily and safely
2. Culture – ‘How it feels’	<i>People</i> feel comfortable, safe, reassured, confident and welcome
3. Well-maintained environment	<i>People</i> experience care in a tidy and well-maintained area
4. Clean environment	<i>People</i> experience care in a consistently clean environment
5. Infection control precautions	<i>People</i> feel confident that infection control precautions are in place
6. Personal environment	<i>People’s</i> personal environment is managed to meet their needs
7. Linen and furnishings	<i>People’s</i> care is supported by effective use of linen and furnishings

Factor 1

Access to the care environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People have great difficulty accessing the care environment

BEST PRACTICE

People can access the care environment easily and safely

Indicators of best practice for factor 1

The following indicators support best practice for the care environment:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. up-to-date information about the care environment, facilities and how to access them, is readily available and given in advance (where applicable)
- c. parking and 'set down' points are near care areas (where possible) and transport (including links with public transport) is available for those who need it
- d. car parking charges are kept to a minimum and access is given to the hospital travel costs scheme
- e. the entrance of the care environment is obvious, clearly sign posted, safe, welcoming, and easily reached and entered

- f. a reception and/or helpdesk and/or help lines are in place to assist people in navigating through the environment (where applicable)
- g. all staff are responsive, welcoming and provide directions to people
- h. signage and maps are clear, consistent, logical and easy to understand
- i. the environment is easy to move around, encourages independence of all people and assistance is available as required
- j. facilities are colour coded (where appropriate) and/or nationally recognised symbols used to assist with recognition
- k. resources are available to facilitate communication
- l. systems for eradicating, minimising and managing queuing and waiting (for example, appointment systems, use of tickets etc) are consistent and easy to understand. Places are available for rest and/or privacy
- m. facilities for refreshments are available at all times for people
- n. all relevant health and safety risk assessments have been completed
- o. *add your local indicators here*

Factor 2

Culture – ‘How it feels’

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People feel uncomfortable, afraid, ignored, vulnerable and abandoned

BEST PRACTICE

People feel comfortable, safe, reassured, confident and welcome

Indicators of best practice for factor 2

The following indicators support best practice for the care environment:

- a. general indicators (see page 4) are considered in relation to this factor
- b. the environment feels pleasant, calm, secure, safe and reassuring
- c. people are welcomed immediately into the area. If staff are not present there are clear instructions informing them in a friendly manner where to wait, or who to contact and how, and what facilities are available for their use
- d. people know who is ‘in charge’
- e. people are familiarised with their surroundings in a polite and friendly manner
- f. people feel that staff are consistently approachable, courteous, trustworthy, friendly, responsive to their needs and supportive of their rights

- g. people know who is looking after them and staff introduce themselves to people on initial contact
- h. staff respond to people's requests for assistance in a timely and willing manner
- i. complaints, compliments, people's stories, observations of care and other experiences are sought actively and used to improve care
- j. staff are visible, well presented, professional and easily identifiable
- k. a uniform policy and/or dress code is enforced
- l. people are confident that all staff are competent to do their job
- m. team working is evident and is demonstrated by good relationships between staff
- n. a learning culture for staff, students, people and carers is evident
- o. *add your local indicators here*

Factor 3

Well-maintained environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People experience care in a cluttered and poorly maintained environment

BEST PRACTICE

People experience care in a tidy and well-maintained area

Indicators of best practice for factor 3

The following indicators support best practice for the care environment:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a good first impression is created by a tidy and well-maintained care environment
- c. the nature and quality of lighting and use of colour in furnishings and decorations support a therapeutic and/or healing environment
- d. furnishings (for example, chairs, wall coverings, floors, carpets, doors) are all in good repair and have no stains or marks
- e. notice boards are up-to-date, uncluttered, attractive, easy to read and at an appropriate height
- f. there is no litter and bins are readily available

- g. the area is the appropriate temperature, has natural daylight (where possible) and lighting can be controlled by people receiving care (where appropriate)
- h. toilet, bathroom and shower areas are free from clutter
- i. corridors, doors and exits are clear and free from clutter
- j. storage facilities are managed to best effect and equipment is put away in the correct location after use
- k. systems are in place to remove unwanted items for timely and appropriate disposal
- l. there is sufficient storage for people's belongings
- m. waste disposal is managed well according to legislation
- n. linen and laundry segregation, storage and disposal are managed well and appropriately
- o. staff ensure and maintain tidiness
- p. people, people's representatives and carers are encouraged to participate in the monitoring of tidiness
- q. co-ordination of activities associated with tidiness and maintenance are the responsibility of a specified role, such as that of a housekeeper or designated other. Repairs are carried out promptly where applicable
- r. an improvement programme is in place that is appropriate and monitored regularly
- s. *add your local indicators here*

Factor 4

Clean environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People experience care in a dirty environment

BEST PRACTICE

People experience care in a consistently clean environment

Indicators of best practice for factor 4

The following indicators support best practice for the care environment:

- a. general indicators (see page 4) are considered in relation to this factor
- b. the internal and external areas are clean and there are no avoidable or unwanted odours
- c. cleaning arrangements are flexible to meet the needs of people requiring care
- d. adequate hand washing facilities are available
- e. regular routines for cleaning and managing waste are in place and meet the national standard
- f. all areas are checked for cleanliness on a regular basis
- g. cleaning equipment is readily available and stored appropriately. The national colour code system for cleaning equipment is in place

- h. strategies are in place to ensure all equipment is systematically checked, cleaned and collected
- i. management, co-ordination and monitoring of cleanliness is clearly defined and the responsibility of an identified member of staff
- j. the area meets Patient Environment Action Team (PEAT) requirements
- k. regular cleanliness audits take place, staff know the results of these, and findings are acted upon
- l. people are enabled to raise concerns about cleanliness and request that action is taken
- m. systems are in place to deal with spillages and emergency clearance 24 hours a day
- n. the infection control team ratify cleaning regimes
- o. *add your local indicators here*

Factor 5

Infection control precautions

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are exposed to, and/or witness, activities that compromise prevention of infection and infection control

BEST PRACTICE

People feel confident that infection control precautions are in place

Indicators of best practice for factor 5

The following indicators support best practice for the care environment:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. people are informed of what they should expect to see and do in relation to infection control measures and are empowered to challenge staff where there are poor hygiene practices
- c. people are informed why specific infection control precautions are taken
- d. clear notices and instructions for people in relation to hygiene and infection control are present and obviously placed
- e. a policy is in place to ensure that people are informed, and provided with information in an appropriate format, if they have an infection
- f. staff clean their hands, as per policy, between tasks and care
- g. equipment is cleaned appropriately between use by different people

- h. staff wear personal protective equipment (PPE) as appropriate, changing between dirty and clean tasks and each episode of care
- i. an infection control and visitors' policy is in place that is followed and regularly reviewed
- j. systems are in place to replace mattresses, mattress covers, baby changing mats, exercise mats, exercise mattresses, cushions, commodes and curtains as appropriate
- k. systems to manage the risk of infection, such as negative pressure systems, are in place (if applicable)
- l. systems are in place to ensure that appropriate initiatives can be implemented to control an outbreak of infection and for protective isolation
- m. audits of infection control precautions and practices are completed and action taken by the accountable manager and relevant staff as required in relation to the results
- n. staff receive education in relation to infection control that is ratified by the infection control team (or appropriate designated person)
- o. the infection control team (or appropriate designated person) are involved in the design of new builds and developments in order to minimise the risk of infection and cross-infection
- p. *add your local indicators here*

Factor 6

Personal environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

There is no recognition of people's personal environment

BEST PRACTICE

People's personal environment is managed to meet their needs

Indicators of best practice for factor 6

The following indicators support best practice for the care environment:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. people's personal environment is assessed, and where possible (and, in private accommodation where agreed), adapted to suit their individual needs and preferences
- c. people do not have to share sleeping accommodation or washing and toilet facilities with members of the opposite gender
- d. lighting, temperature, noise, ventilation and security are managed to suit people and the décor and flooring are appropriate to the age and needs of the group of people requiring care
- e. furniture is appropriate for the user and can be cleaned effectively
- f. sufficient seating and, where appropriate, beds or accommodation are readily available and have accessible space for wheelchairs as necessary

- g. where appropriate recreational space is available and people have the opportunity to engage in communal activities and experiences
- h. people have access to fresh air and outside spaces (where appropriate)
- i. staff recognise and promote the need for quiet and rest periods, particularly at night
- j. visiting guidelines are in clear view and are reviewed regularly
- k. telephones, calls, televisions, music, visitors and admissions are managed effectively to minimise disruption
- l. staff conversations are appropriate and quiet
- m. people's belongings are kept secure and accessible
- n. people's meal times are protected from unnecessary interruptions
- o. people's bed linen is clean and changed as required. If clothing is supplied or laundered, including nightwear, it is clean and in good repair
- p. *add your local indicators here*

Factor 7

Linens and furnishings

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's care is compromised owing to lack of use of linen and furnishings

BEST PRACTICE

People's care is supported by effective use of linen and furnishings

Indicators of best practice for factor 7

The following indicators support best practice for the care environment:

- a. general indicators (see page 4) are considered in relation to this factor
- b. people have sufficient and appropriate supplies to meet their needs
- c. ordering mechanisms are in place to ensure adequate supplies and minimise wastage
- d. there is clarity around how linen and furnishings are ordered, maintained and stored
- e. ordering and maintenance is the responsibility of a designated role, such as that of a housekeeper

- f. sustainable procurement, local suppliers and co-working with the voluntary sector is considered
- g. systems are in place to monitor, condemn and replace furnishings and floor coverings
- h. *add your local indicators here*

Essence of Care 2010

Benchmarks for Communication



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Benchmarks for Communication



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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

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Benchmarks for Communication

Agreed person-centred outcome

People and their carers experience effective communication

Definitions

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

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

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *people* aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People and their carers experience effective communication

Factor	Best practice
1. Interpersonal skills	All staff demonstrate effective interpersonal skills
2. Opportunity for communication	Communication takes place at a time and in an environment that is acceptable to all parties
3. Assessment of communication needs	All communication needs are assessed on initial contact and are regularly reassessed. Additional communication support is negotiated and provided when a need is identified or requested
4. Information sharing	Information that is accessible, acceptable, accurate and meets needs is shared actively and consistently with all <i>people</i> and carers and widely promoted across all communities
5. Resources to aid communication and understanding	Appropriate and effective methods are used to enable <i>people</i> and carers to communicate
6. Identification and assessment of principal carer	The principal carer is identified at all times and an assessment is made with them of their needs, involvement, willingness and ability to collaborate with staff in order to provide care
7. Empowerment to perform role	<i>People</i> and carers are continuously supported and fully enabled to perform their role safely
8. Co-ordination of care	All staff communicate fully and effectively with each other to ensure that <i>people</i> and carers benefit from a comprehensive and agreed plan of care which is regularly updated and evaluated
9. Empowerment to communicate needs	<i>People</i> and carers are enabled to communicate their individual needs and preferences at all times

10. Valuing <i>people's</i> and carers' expertise and contribution	Effective communication ensures that the <i>people's</i> and carers' expert contributions to care are valued, recorded and acted upon and reviewed with staff
11. <i>People's</i> and/or carers' education needs	<i>People's</i> and carers' information, support and education needs are jointly identified, agreed, met and regularly reviewed

Factor 1

Interpersonal skills

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Staff do not have the necessary interpersonal skills

BEST PRACTICE

All staff demonstrate effective interpersonal skills

Indicators of best practice for factor 1

The following indicators support best practice for communication:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. communication is managed effectively and sensitively, including potentially difficult communication such as conveying bad news, dealing with complaints and resolving disputes and hostile situations
- c. all staff are courteous, especially when faced with challenging situations
- d. staff are aware of the importance of body language and effectively use non-verbal communication to facilitate communication
- e. communication is adapted to meet the needs of *people*, carers and groups. This includes consideration of their emotional state, hearing, vision and other physical and cognitive abilities and developmental needs, as well as their preferred language and possible need for an interpreter and translator

- f. communication is open, honest and transparent
- g. staff are able to establish rapport, undertake active and empathic listening, and are non-judgemental
- h. straightforward language is used when communicating with *people* and carers
- i. initiatives are in place to assess and provide feedback on the interpersonal skills of staff, such as through the use of audits on the views of *people* and carers
- j. *add your local indicators here*

Factor 2

Opportunity for communication

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

The environment and/or time are barriers to effective communication

BEST PRACTICE

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

Indicators of best practice for factor 2

The following indicators support best practice for communication:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people* and carers who are physically isolated (for example, those who are in prison) or unable to communicate directly with significant others are enabled to communicate
- c. *people* and carers who are at risk from isolation are identified and enabled to communicate and express themselves
- d. *people* and carers have choice about where they communicate and who is present (where appropriate)
- e. the inclusion of other individuals when communication occurs is agreed with *people* and carers

- f. the environment is inclusive and adapted to meet differing communication needs in terms of, for example, lighting, privacy, acoustic conditions, hearing loops
- g. appointment times are arranged to facilitate communication
- h. systems for effective communication are in place to ensure continuity of care, such as follow-up appointments
- i. advocacy services are made available according to the wishes of *people* and carers
- j. opportunity exists for communication when *people*, carers and/or staff are not face to face. Confidentiality is maintained, for example, by the use of passwords
- k. *add your local indicators here*

Factor 3

Assessment of communication needs

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Communication needs are not assessed

BEST PRACTICE

All communication needs are assessed on initial contact and regularly reassessed. Additional communication support is negotiated and provided when a need is identified or requested

Indicators of best practice for factor 3

The following indicators support best practice for communication:

- a. general indicators (see page 4) are considered in relation to this factor
- b. an appropriate member of staff is identified to assess *people's* and carers' ability to communicate
- c. communication needs are assessed at the beginning of each and every episode of care
- d. a comprehensive, evidence-based assessment tool is used when a communication need is identified
- e. assessment is recorded and regularly re-evaluated
- f. a care plan is agreed which meets the communication needs of *people* and/or carers

- g. audit of assessment of communication needs is undertaken and the results used to improve practice
- h. the need for equipment and resources to aid communication is identified, provided for and documented
- i. *add your local indicators here*

Factor 4

Information sharing

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Information is actively withheld

BEST PRACTICE

Information that is accessible, acceptable, accurate and meets needs is shared actively and consistently with all people and carers and widely promoted across all communities

Indicators of best practice for factor 4

The following indicators support best practice for communication:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. information about support networks is shared actively and widely promoted
- c. information is explained and provided in an accessible format, for example, diaries, audio cassettes, books, intranet, signed and subtitled videos, large print text and British sign language translations, leaflets, posters, information technology facilities
- d. communication needs are ascertained or anticipated and appropriate information is provided
- e. an interpreter service is available at the point of need, which includes spoken and sign language where necessary

- f. information is kept up-to-date and factual in plain language format with no jargon or abbreviations
- g. information given is understood and has the same meaning for all involved
- h. strategies are in place to reach and engage *people* and carers within all communities, for example, through out-reach initiatives and use of communication media
- i. information is reviewed by *people*, carers, and staff to ensure it is accessible and applicable
- j. audits are undertaken to assess whether *people* and carers have the information they require. The results are used to improve practice.
- k. *add your local indicators here*

Factor 5

Resources to aid communication and understanding

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

No resources are available to aid communication and understanding

BEST PRACTICE

Appropriate and effective methods are available to enable *people* and carers to communicate

Indicators of best practice for factor 5

The following indicators support best practice for communication:

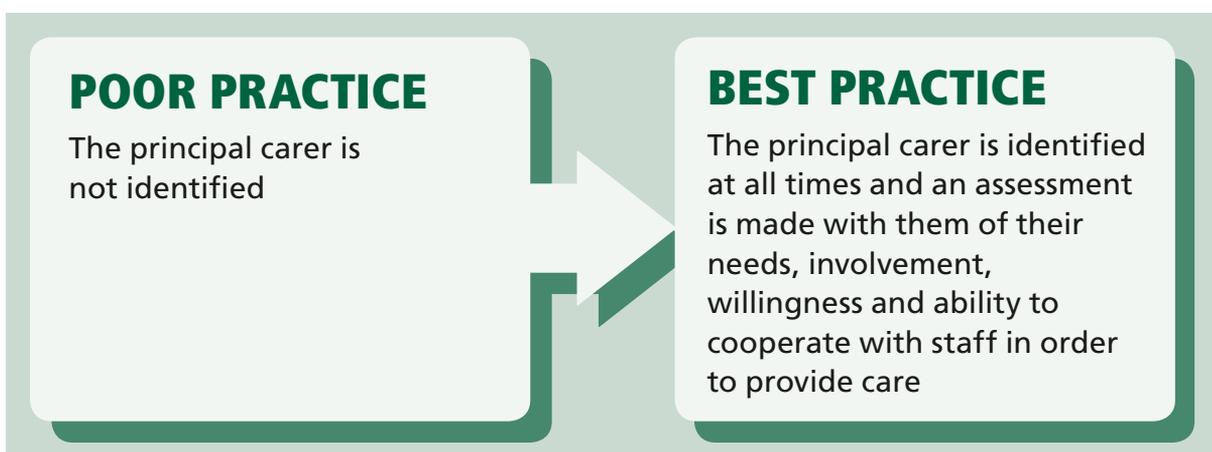
- a. *general indicators (see page 4)* are considered in relation to this factor
- b. resources to aid communication and understanding are available, for example, hearing loops, text phone, large print text, pictures, books, toys, Braille and multilingual literature and other electronic methods of communication
- c. there is an up-to-date directory of resources that is readily available
- d. staff support *people* and carers in the use of resources
- e. the views of *people* and carers on resources are sought and used to improve services

- f. the use of the resources is monitored and evaluated, for example, by the use of audit
- g. *add your local indicators here*

Factor 6

Identification and assessment of principal carer

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 6

The following indicators support best practice for communication:

- a. general indicators (see page 4) are considered in relation to this factor
- b. the principal carer is identified and agreed with individual *people*.
The burden or impact of care is assessed
- c. explicit or expressed valid consent is sought from individual *people* for care to be provided
- d. willingness of carers to collaborate is clarified
- e. the current responsibilities of the carer are recorded and regularly evaluated
- f. the format of the assessment meets needs
- g. the confidentiality of *people* and carers is maintained

- h. carers' communication needs are anticipated
- i. information is obtained from carers to demonstrate their ability and willingness to care. The information is used in planning care
- j. if the carer is a child or young person, additional support needs are identified (if required)
- k. *people* and carers know who to contact first if they have any questions regarding care
- l. *add your local indicators here*

Factor 7

Empowerment to perform role

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers receive no support to perform their role and are isolated

BEST PRACTICE

People and carers are continuously supported and fully enabled to perform their role safely

Indicators of best practice for factor 7

The following indicators support best practice for communication:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. current levels of support are documented and shared with other staff
- c. rights to benefits, welfare and services and other help are communicated and appropriate assistance given
- d. psychological needs are considered and supported
- e. *people's* and carers understanding of their roles is determined
- f. *people* and carers are supported in their roles
- g. individual risk assessments are performed and updated frequently
- h. *people* and carers are involved in risk assessment
- i. *people* and carers limitations are recognised and acted upon and supported

- j. mechanisms are in place for crisis intervention especially out of hours and at weekends and holidays
- k. support networks exist and *people* and carers know how to access them
- l. *add your local indicators here*

Factor 8

Co-ordination of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

No communication takes place between staff

BEST PRACTICE

All staff communicate fully and effectively with each other, to ensure that people and carers benefit from a comprehensive and agreed plan of care which is regularly updated and evaluated

Indicators of best practice for factor 8

The following indicators support best practice for communication:

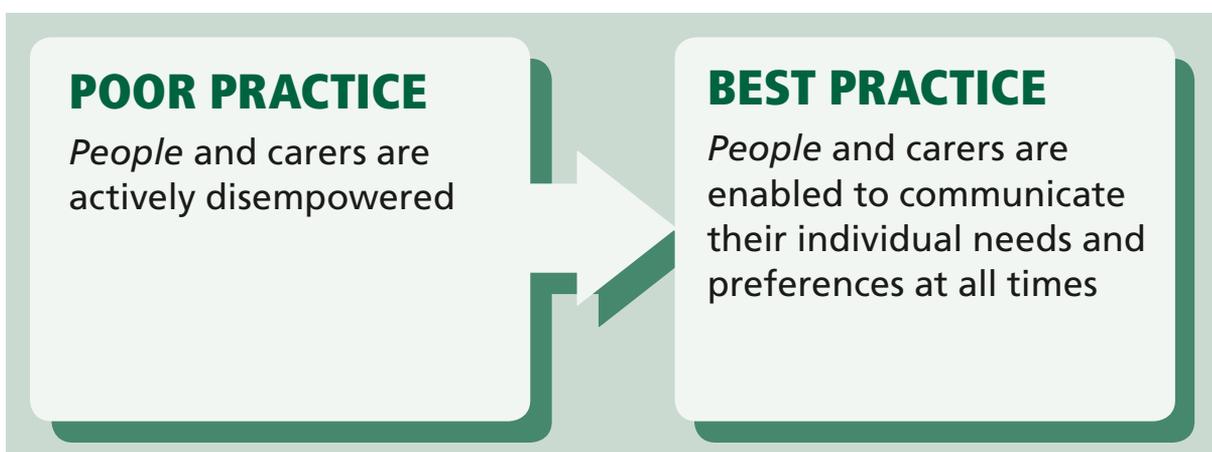
- a. *general indicators* (see page 4) are considered in relation to this factor
- b. the wishes of *people* and carers are listened to, considered and acted upon appropriately
- c. all care options are explained
- d. information given is fully understood by all staff and/organisations and has the same meaning to everyone involved
- e. an identified member of staff takes responsibility for the co-ordination of care and *people* and carers can identify their care co-ordinator and the key agencies providing care
- f. evidence-based pathways exist to provide an integrated approach to care and they are used and reviewed

- g. records are made available to *people* and carers within appropriate safeguards to ensure confidentiality is maintained and *people* and carers can contribute directly to the care record
- h. *people* and carers (where appropriate) are partners in the review of their care management
- i. multidisciplinary 'case reviews' take place and benefit care, and outcomes are communicated to *people* and carers and/or staff
- j. *people* and carers are involved as partners in person-focused assessment, planning, implementation, evaluation and revision of care
- k. evidence is available to demonstrate the continuity of information exchange between staff and giving conflicting information is avoided
- l. care plans are understandable by all staff and are free of jargon
- m. care plans are updated, monitored and evaluated and are available to *people* and carers
- n. crisis plans are clear, concise and drawn up with *people* and carers
- o. *add your local indicators here*

Factor 9

Empowerment to communicate needs

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 9

The following indicators support best practice for communication:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. staff are proactive in anticipating the needs and preferences of *people* and carers
- c. sufficient time is given to enable *people* and carers to communicate their needs and preferences
- d. explicit or expressed valid consent is obtained from *people* prior to treatment or care
- e. *people* and carers have access to advocacy services
- f. *people* and carers have access to specialist knowledge and skills to make their needs and preferences known, for example, information technology

- g. technology is available and is used to meet *people* and carers needs, for example, electronic prescriptions
- h. *add your local indicators here*

Factor 10

Valuing *people's* and carers' expertise and contribution

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 10

The following indicators support best practice for communication:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. the views of *people* and carers are listened to, valued and respected and used to improve practice and care
- c. *people's* and carers' expertise is included in assessments
- d. education received by staff from *people* and carers is evaluated
- e. the philosophy used reflects a positive approach to *people's* and carers' involvement
- f. *people's* and carers' contribution to care is regularly reviewed and evaluated

- g. mechanisms are in place to share and act upon examples of good practice by *people* and carers. For example, the Expert Patients Programme
- h. feedback is sought to ascertain if *people* and carers feel listened to, valued and respected and whether their views are used to improve practice and care. The results are then used to make improvements
- i. (i) *add your local indicators here*

Factor 11

People's and/or carers' education needs

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's and carers' education needs are ignored

BEST PRACTICE

People's and carers' information, support and education needs are jointly identified, agreed, met and regularly reviewed

Indicators of best practice for factor 11

The following indicators support best practice for communication:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *learning needs of people and carers are identified*
- c. *people's and carers' technical competence and understanding are assessed*
- d. *education plans are developed and agreed with people and carers*
- e. *education opportunities are available for people and carers*
- f. *discharge plans show evidence of the support required by people and carers*
- g. *current directories of education courses and ongoing information are made available to people and carers*

- h. education of *people* and carers supports an early discharge
- i. practitioners are assessed as competent to deliver education to *people* and carers
- j. any education for carers includes consideration of respite care
- k. *add your local indicators here*

Notes

Essence of Care 2010

Benchmarks for Food and Drink



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Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for Food and Drink



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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon*
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Food and Drink

Agreed person-focused outcome

People are enabled to consume food and drink (orally) which meets their needs and preferences

Definitions

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *People* aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People are enabled to consume food and drink (orally) which meets their needs and preferences

Factor	Benchmark of best practice
1. Promoting health	<i>People</i> are encouraged to eat and drink in a way that promotes health
2. Information	<i>People</i> and carers have sufficient information to enable them to obtain their food and drink
3. Availability	<i>People</i> can access food and drink at any time according to their needs and preferences
4. Provision	<i>People</i> are provided with food and drink that meets their individual needs and preferences
5. Presentation	<i>People's</i> food and drink is presented in a way that is appealing to them
6. Environment	<i>People</i> feel the environment is conducive to eating and drinking
7. Screening and assessment	<i>People</i> who are screened on initial contact and identified at risk receive a full nutritional assessment
8. Planning, implementation, evaluation and revision of care	<i>People's</i> care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink
9. Assistance	<i>People</i> receive the care and assistance they require with eating and drinking
10. Monitoring	<i>People's</i> food and drink intake is monitored and recorded

Factor 1

Promoting health

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

No attempt is made to encourage people to eat and drink to promote their own health

BEST PRACTICE

People are encouraged to eat and drink in a way that promotes their health

Indicators of best practice for factor 1

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. opportunities are created or used to advise *people* on eating and drinking to promote their own health, for example, discussion, displays and handouts
- c. staff in different areas work together to support *people* to eat and drink in a way that promotes health including, where necessary, to prevent inappropriate weight loss or gain
- d. education is available for staff in the promotion of healthy eating
- e. *add your local indicators here*

Factor 2

Information

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

No information is provided on how to obtain food and drink

BEST PRACTICE

People and carers have sufficient information to enable them to obtain their food and drink

Indicators of best practice for factor 2

The following indicators support best practice for eating and drinking needs and preferences:

- a. general indicators (see page 4) are considered in relation to this factor
- b. a range of information is available in a user-friendly format to meet *people's* nutritional needs and this is shared with *people*, carers and staff
- c. those assisting with the completion of menus or the obtaining of food have had training to ensure their competency in selecting meals to meet needs
- d. the timing for placing food and drink orders with a centralised kitchen supports *people's* choice
- e. *add your local indicators here*

Factor 3

Availability

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People cannot access food and drink

BEST PRACTICE

People can access food and drink at any time according to their needs and preferences

Indicators of best practice for factor 3

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a variety of hot and cold meals and drinks are available that meet *people's* needs and preferences
- c. hot and cold food and drink are available and provided outside meal times
- d. snacks are available
- e. food storage and preparation facilities that meet the requirements of national guidance are available
- f. facilities are available to store food brought in, for example, by carers and friends
- g. *add your local indicators here*

Factor 4

Provision

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Food and drink does not meet people's needs

BEST PRACTICE

People are provided with food and drink that meets their individual needs and preferences

Indicators of best practice for factor 4

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4)* are considered in relation to this factor
- b. there is a choice of food and drink that ensures that *people's* needs and preferences are met. This includes provision of nutritional food and drink for those at risk of malnourishment at home or in the community
- c. there are arrangements for ensuring therapeutic and special formulated diets are provided, including food and drink of the appropriate texture and consistency
- d. *people* are provided with the food they ordered in the appropriate portion size

- e. quality of nutrition care is supported by close working of catering staff and care providers
- f. catering and care providers work together to ensure *people's* individual needs and preferences are met
- g. *add your local indicators here*

Factor 5

Presentation

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are presented with food that is not appealing

BEST PRACTICE

People's food and drink are presented in a way that is appealing to them

Indicators of best practice for factor 5

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. the serving method used meets *people's* needs and preferences, for example, whether on a plate or in a container
- c. food and drink packaging is removed at the appropriate time
- d. food is served at a temperature to ensure safety and to meet *people's* preferences
- e. serving and presentation are the responsibility of a specific member of staff to ensure food and drink are appealing
- f. a suitable range of crockery and utensils is available
- g. *add your local indicators here*

Factor 6

Environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Environmental factors prevent people eating and drinking

BEST PRACTICE

People feel the environment is conducive to eating and drinking

Indicators of best practice for factor 6

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. measures are taken to ensure that the environment is conducive to *people's* needs. This includes consideration of dining areas, tables and seating
- c. assistance with using toilet facilities and hand washing is offered prior to eating and drinking
- d. inappropriate activity at meal times, such as cleaning and routine activities, are curtailed, for example, as in the 'protected meal times' initiative
- e. *add your local indicators here*

Factor 7

Screening and assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's nutritional needs are not ascertained

BEST PRACTICE

People who are screened on initial contact and identified at risk receive a full nutritional assessment

Indicators of best practice for factor 7

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. screening takes place on admission to hospital and care homes, on registration at GP surgeries, at their first clinic appointment or on a first visit to *People's* homes. Screening is repeated for *people* when there is clinical concern, or a risk of malnutrition or morbid obesity and/or repeated weekly for *people* in hospital
- c. screening should be undertaken using a validated evidence-based tool such as the Malnutrition Universal Screening Tool (MUST). Screening should include body mass index (BMI), percentage unintentional weight loss or gain, time over which nutrient intake has been unintentionally reduced or increased, and/or the likelihood of future impaired or increased nutrient intake

- d. a full assessment using a validated evidence-based tool and appropriate referral is undertaken for *people* who are identified initially as at risk of malnutrition or as morbidly obese
- e. screening and assessment is undertaken in partnership with *people* (where possible)
- f. nutritional support should be considered for those *people* who are identified initially as at risk of malnutrition or who are malnourished
- g. *add your local indicators here*

Factor 8

Planning, implementation, evaluation and revision of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have a plan of care

BEST PRACTICE

People's care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink

Indicators of best practice for factor 8

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *planning, implementing, evaluating and revising care involves people and their carers, as well as all relevant members of staff*
- c. *care plans or care pathways designed to meet people's nutritional needs are used and outcomes measured. The results are used to improve care*
- d. *evaluation leads to changes designed to meet nutritional requirements*

- e. user-friendly information concerning nutrition management is available for *people*, carers and staff
- f. audit is undertaken and the results disseminated and used to inform practice development
- g. *add your local indicators here*

Factor 9

Assistance

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not receive assistance to eat

BEST PRACTICE

People receive the care and assistance they require with eating and drinking

Indicators of best practice for factor 9

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a system is in place to ensure those *people* requiring assistance to eat and drink receive it
- c. the level of assistance required is assessed on every occasion that food and drink is served
- d. assistance to eat and drink is provided according to *people's* needs. This may include the positioning of *people* requiring care, providing appropriate utensils, feeding *people* or supporting them to buy and make their own meals at home or in the community
- e. carers are involved in assisting *people* to eat and drink (where appropriate)

- f. education programmes are in place to teach *people* with specific needs to feed themselves
- g. independence to eat and drink is promoted. Food and drink are placed in easy reach of *people* to facilitate this.
- h. *people's* dignity is maintained while eating and drinking
- i. relevant staff are involved in providing advise and/or assistance, for example, dieticians, nutritionists, catering staff, speech and language therapists, occupational therapists and physiotherapists
- j. *add your local indicators here*

Factor 10

Monitoring

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



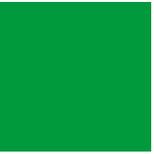
Indicators of best practice for factor 10

The following indicators support best practice for eating and drinking needs and preferences:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a system is in place to use information on food and drink intake to identify those at risk of malnutrition or morbid obesity and to amend care to meet *people's* needs
- c. food and drink intake is monitored and documented by *people*, carers and staff (as appropriate)
- d. *people* who are vulnerable and/or are designated temporarily 'nil by mouth' are monitored to identify those at risk of malnutrition and/or dehydration

- e. food is served, and food containers are collected, by a person who is able to accurately report *people's* food and drink intake to the relevant person
- f. *add your local indicators here*

Notes



Essence of Care 2010

Benchmarks for the Prevention
and Management of Pain



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Best Practice – General Indicators

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These are:

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- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for the Prevention and Management of Pain

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

Definitions

For the purpose of these benchmarks, **pain** is:

whatever the person experiencing pain says it is, existing whenever the person communicates or demonstrates (voluntarily or involuntarily) it does (adapted from McCaffrey M. 1968)⁵

and

an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (Merskey and Bogduk 1994.)⁶

The above definitions incorporate the concept of pain as a subjective and complex experience and include acute, chronic, intermittent, temporary, long term, acute on chronic etc pain and pain experienced at the end of life.

For the purpose of these benchmarks, **acute pain** is:

pain of less than 12 weeks duration or pain that occurs during the expected period of healing

For the purpose of these benchmarks, **chronic pain** is:

pain of more than 12 weeks duration or pain that continues after the expected period of healing

5 McCaffrey M (1968) Nursing Practice Theories Related to Cognition, Bodily Pain and Man-Environment Interactions University of California at Los Angeles Students' Store; Los Angeles

6 Merskey H and Bogduk N (eds) (1994) Classification of Chronic Pain (2nd Edn) p210 International Association for the Study of Pain Task Force on Taxonomy. ISAP Press; Seattle WA

For the purpose of these benchmarks, **pain** management is:

any intervention designed to prevent or alleviate pain and/or its impact, such that quality of life and ability to function are optimised

Since pain is complex, managing pain requires a holistic approach. Therefore, physical (including function), social, psychological, and spiritual aspects of pain need to be considered as part of assessment, care planning, implementation, evaluation and revision of practice and care.

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (Carers UK, 2002). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *people* aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

Factor	Best practice
1. Access	<i>People</i> experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate access to services to manage pain
2. <i>People</i> and carer participation	<i>People</i> (where able), carers and staff are active partners in the decisions involving pain management
3. Assessment	<i>People</i> have an ongoing, comprehensive assessment of their pain
4. Care planning, intervention, evaluation, review and prevention	<i>People's</i> individualised care concerning pain is planned, implemented, continuously evaluated and revised in partnership with <i>people</i> , staff and carers
5. Knowledge and skills	<i>People</i> , carers and staff have the knowledge and skills to understand how best to manage pain
6. Self-management	<i>People</i> are enabled to manage their pain when they wish to, and as appropriate
7. Partnership working	<i>People</i> , carers and appropriate agencies work collaboratively to enable <i>people</i> to meet their pain management needs
8. Service evaluation and audit	Services are regularly reviewed and evaluated by <i>people</i> , carers, providers and commissioners for effect, breadth and equity

Factor 1

Access

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers do not have access to timely and appropriate pain management

BEST PRACTICE

People experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate access to services to manage pain

Indicators of best practice for factor 1

The following indicators support best practice for the prevention and management of pain:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. up-to-date information about pain management and services, and how to access them, is readily available in all care environments and (where applicable) given in advance of care. Information is provided in a suitable format and in plain language
- c. appropriate and timely pain management and services are accessible for *people* with pain or anticipated pain (such as pain following surgery), and their carers. This includes interventions, resources, equipment, personnel and space to provide care, as well as urgent pain management when required
- d. *people* and carers are enabled to access pain management services when managing further episodes of pain

- e. commissioning organisations ensure that *people* have access to a full range of pain management services
- f. a single point of access leads to appropriate pain management services that are co-ordinated
- g. information concerning access to complementary therapies and services, and the evidence base for their use and possible effects, are available to *people*
- h. there is equality of access to services for all *people* with pain or anticipated pain. This includes interventions, resources, equipment, personnel and space to provide care
- i. *add your local indicators here*

Factor 2

People and carer participation

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 2

The following indicators support best practice for the prevention and management of pain:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people* are facilitated and supported to be partners in decisions involving their pain management. This includes *people* with special needs, specific cultural needs and/or those who are vulnerable. Advocates are used where appropriate⁷
- c. *people's* and carers' decisions about managing pain are based on an understanding of choices and opportunities

⁷ National Institute for Mental Health in England (2008) Independent Mental Health Advocacy. Guidance for Commissioners. National Institute for Mental Health England: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_097681.pdf
Department of Health (2002) National Standards for the Provision of Children's Advocacy Services Department of Health: London accessed 06 September 2010 at http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4017049

- d. *people* and carers are listened to, treated with respect and can discuss their concerns openly with staff. Where appropriate, *people* and carers are consulted separately
- e. *people's* and carers' needs, views and preferences are sought actively (where possible) and incorporated into a realistic, appropriate pain management plan
- f. *people*, carers and staff develop and agree a realistic, appropriate pain management plan
- g. *people*, carers and staff understand the pain management plan
- h. *people* and carers are involved in evaluation of their pain management plan
- i. *add your local indicators here*

Factor 3

Assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 3

The following indicators support best practice for the prevention and management of pain:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. any health or social services encounter includes an enquiry about pain that leads to an appropriate referral as required
- c. *people's* pain management needs are identified on initial contact and as required
- d. staff are competent to recognise when a person is experiencing pain, whether or not that person is able to describe the pain and/or its severity⁸

⁸ For example, with reference to guidance such as RCN (2009) **The Recognition and Assessment of Acute Pain in Children Update of Full Guideline** RCN: London accessed 21 June 2010 at http://www.rcn.org.uk/__data/assets/pdf_file/0004/269185/003542.pdf

- e. staff are competent to assess pain and ascertain (where possible) the underlying cause of pain, or are able to refer onwards as appropriate
- f. an evidence-based tool appropriate to the needs of *people* and their condition(s) is used to assess pain (including severity). This includes the use of, for example, standard and/or self-report data collection tools (where possible) and observation scales. Observation of behavioural expression or a report from a carer or advocate may be used where there are communication difficulties or to accommodate different cognitive levels
- g. evidence-based information concerning pain assessment and management is accessible to *people* and carers in a suitable format and in plain language
- h. physical (including function), social, psychological and spiritual aspects of *people's* pain and health profile are assessed (where possible) using evidence-based tools
- i. the assessment process recognises *people's* and carers' perspectives, opinions and expectations of pain and its management
- j. *people's* pain experiences and (where appropriate) previous treatment are included in the assessment, for example, whether the pain is acute, chronic, intermittent, temporary, long term and/or whether the pain has been treated palliatively etc
- k. assessment includes consideration of the use, interactions and side effects etc of medications
- l. the impact of strategies to manage pain are assessed. For example, on other treatments, or existing or long terms conditions
- m. assessment of pain and management strategies by *people*, carers and staff is ongoing and is collaborative, and reviewed as appropriate. For example, pain is observed regularly along with other vital physiological measurements (that is, pain is one of the 'vital signs')
- n. *add your local indicators here*

Factor 4

Care planning, implementation, evaluation, review and prevention

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 4

The following indicators support best practice for the prevention and management of pain:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *planning, implementing, evaluating and revising care is a collaborative process that involves people and their carers or advocates (as appropriate), as well as all relevant members of staff*

- c. pain management plans are evidence-based⁹ and reflect all the components of *people's* care including recognising the individual's experience of pain and expectations of pain relief, the agreed level of pain relief and function to be achieved, and/or the coping strategies required
- d. a documented rationale for the pain management plan is in place
- e. interventions, such as medication to prevent, reduce or remove pain, are provided promptly and the results evaluated. This includes the need to employ distraction methods for *people* and/or prescribe in anticipation of pain
- f. access to a range of pain management interventions and services, such as psychological care and care at the end of life, is facilitated as appropriate
- g. *people* and carers can initiate a review of pain management strategies as they require
- h. *people* hold their own pain management records where appropriate
- i. safety issues in relation to pain management, including the use of medication, risk of self-harm, increased risk of suicide, are addressed
- j. staff are competent and plan, implement, evaluate and revise care and demonstrate a professional attitude to *people* who require their pain to be managed
- k. *add your local indicators here*

9 For example, using guidance developed by the National Institute for Clinical Excellence such as NICE (2010) **Neuropathic Pain. The Pharmacological Management of Neuropathic Pain in Adults in Non-Specialist Settings** accessed 13 July 2010 at <http://www.nice.org.uk/nicemedia/live/12948/47949/47949.pdf>
Marie Curie Palliative Care Institute Liverpool (2009) **The Liverpool Care Pathway for the Dying Patient (LCP) Core Documentation. LCP generic document version 12, Supporting documentation** accessed 27 April 2010 at <http://www.mcpcil.org.uk/pdfs/LCP%20V12%20Core%20Documentation.pdf>

Factor 5

Knowledge and Skills

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 5

The following indicators support best practice for the prevention and management of pain:

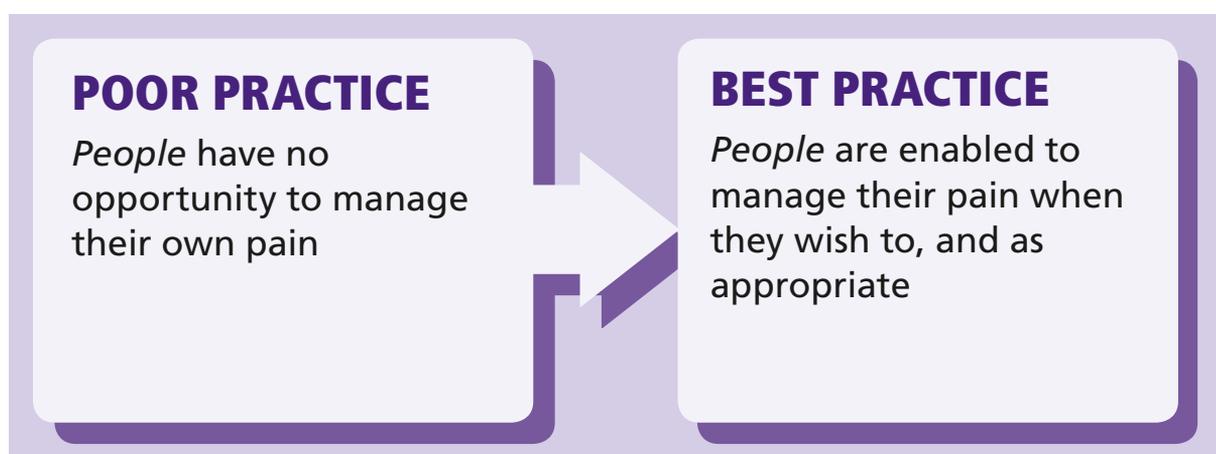
- a. *general indicators (see page 4) are considered in relation to this factor*
- b. timely, individualised, correct and evidence-based information about *people's* pain and pain management and coping strategies, is provided, where appropriate, to enable *people* and/or carers to participate equally in decisions about the most appropriate package for managing pain
- c. information concerning management strategies for pain, including complementary therapies, pain relieving injections and medicines etc, is available, together with a summary of the evidence base and an indication in which clinical conditions the treatments are effective.
- d. information concerning assistance available when *people* cannot care for themselves (or carers cannot provide care), or in an emergency, is provided to *people* and carers

- e. education and training needs of *people* and carers are assessed and learning outcomes are identified and met
- f. *people* and carers are provided with ongoing, individualised evidence-based education and training to meet their pain management needs and preferences
- g. the views and expectations of *people* and carers are used to inform the education and training programmes of *people*, carers and staff. This includes the use of *people's* testimonies such as in the Expert Patient Programme (DH 2008)
- h. staff education includes the prevention of pain as well as the complexity and impact of pain on the social, physical, spiritual, emotional, psychological and economic well-being of *people* and carers
- i. staff attitudes to *people* in pain and pain management are assessed and education put in place to ensure understanding of *people's* perspectives
- j. commissioners have the knowledge and skills to commission a clinically and cost effective service for *people* with pain and their carers
- k. *add your local indicators here*

Factor 6

Self-management

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 6

The following indicators support best practice for the prevention and management of pain:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. all means are explored to enable *people* to manage their pain if they wish to do so, including consideration and support of *people's* and carers' capacity and capability
- c. *people* are offered the opportunity to manage their pain, and/or its impact on their lives, to an acceptable level
- d. *people* and carers have the opportunity to attend education programmes or sessions to enable them to manage pain
- e. self-management plans are developed in partnership with *people*, carers and staff
- f. ongoing assessment and review of self-management plans is evident

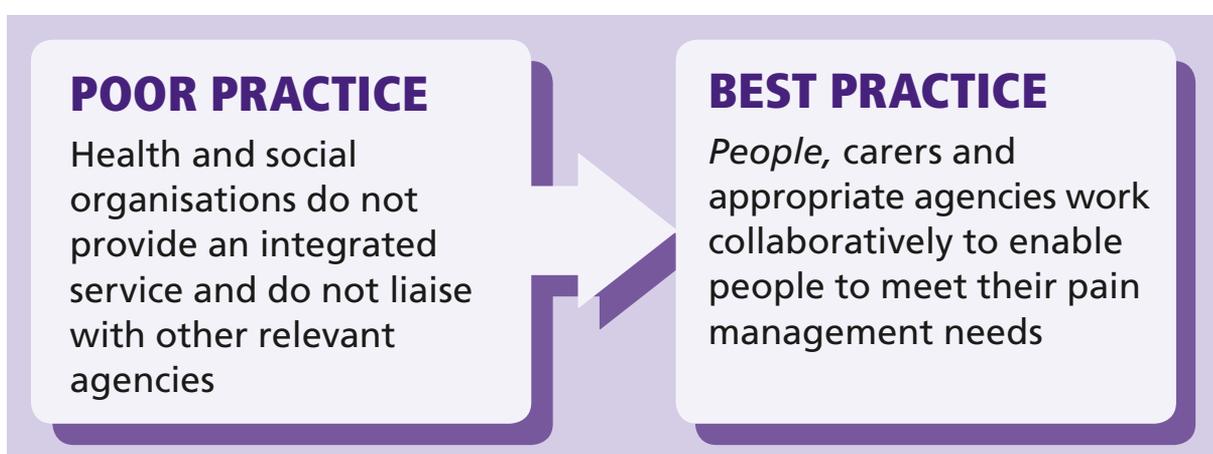
- g. the organisation identifies and removes barriers to *people* managing their pain
- h. *people* and carers are provided with up-to-date information about external resources, such as peer support groups and networks, Royal Colleges, the British Pain Society and web based services¹⁰
- i. up-to-date evidence-based information is provided on a range of resources and how to access them. This includes information about, for example, medication and technological, mechanical and electronic methods of pain management, or complementary therapies (as appropriate)
- j. *people* and carers are enabled to use methods of pain control (where appropriate)
- k. staff support is provided when requested for *people* and carers to manage pain
- l. monitoring and assessment takes place for *people* who are administering medicines to themselves
- m. the risk of harm to *people* and carers who are managing pain is assessed and revised to meet individuals' needs, including the need for good management of medicines
- n. *add your local indicators here*

10 Web services such as <http://www.healthtalkonline.org>; <http://www.patientopinion.org.uk/> or NHS Choices at <http://www.nhs.uk/aboutnhschoices/aboutnhschoices/termsandconditions/pages/patientfeedback.aspx>

Factor 7

Partnership working

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 7

The following indicators support best practice for the prevention and management of pain:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. co-ordinated, continuous, consistent, multidisciplinary, multidimensional and accessible services exist between health and social care organisations within different environments that work in partnership with, for example, employers, voluntary organisations and schools, Royal Colleges, the British Pain Society, as appropriate and as agreed. A key worker co-ordinates continuing management and care
- c. joint planning to facilitate *people's* desired outcomes is evident
- d. opportunities exist for *people* and carers to participate in joint planning across agency boundaries, for example, as in the case of rehabilitation or end of life care

- e. there is prompt and accurate information sharing between all involved in the management of care whilst meeting *people's* needs and ensuring confidentiality is demonstrated
- f. an assessment and joint care review are undertaken by all relevant staff prior to *people* moving to another service and/or environment
- g. joint documentation is utilised in the management of pain across agency boundaries (where appropriate)
- h. *add your local indicators here*

Factor 8

Service evaluation and audit

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

No service evaluation is carried out

BEST PRACTICE

Services are regularly reviewed and evaluated by people, carers, providers, and commissioners for effect, breadth and equity

Indicators of best practice for factor 8

The following indicators support best practice for the prevention and management of pain:

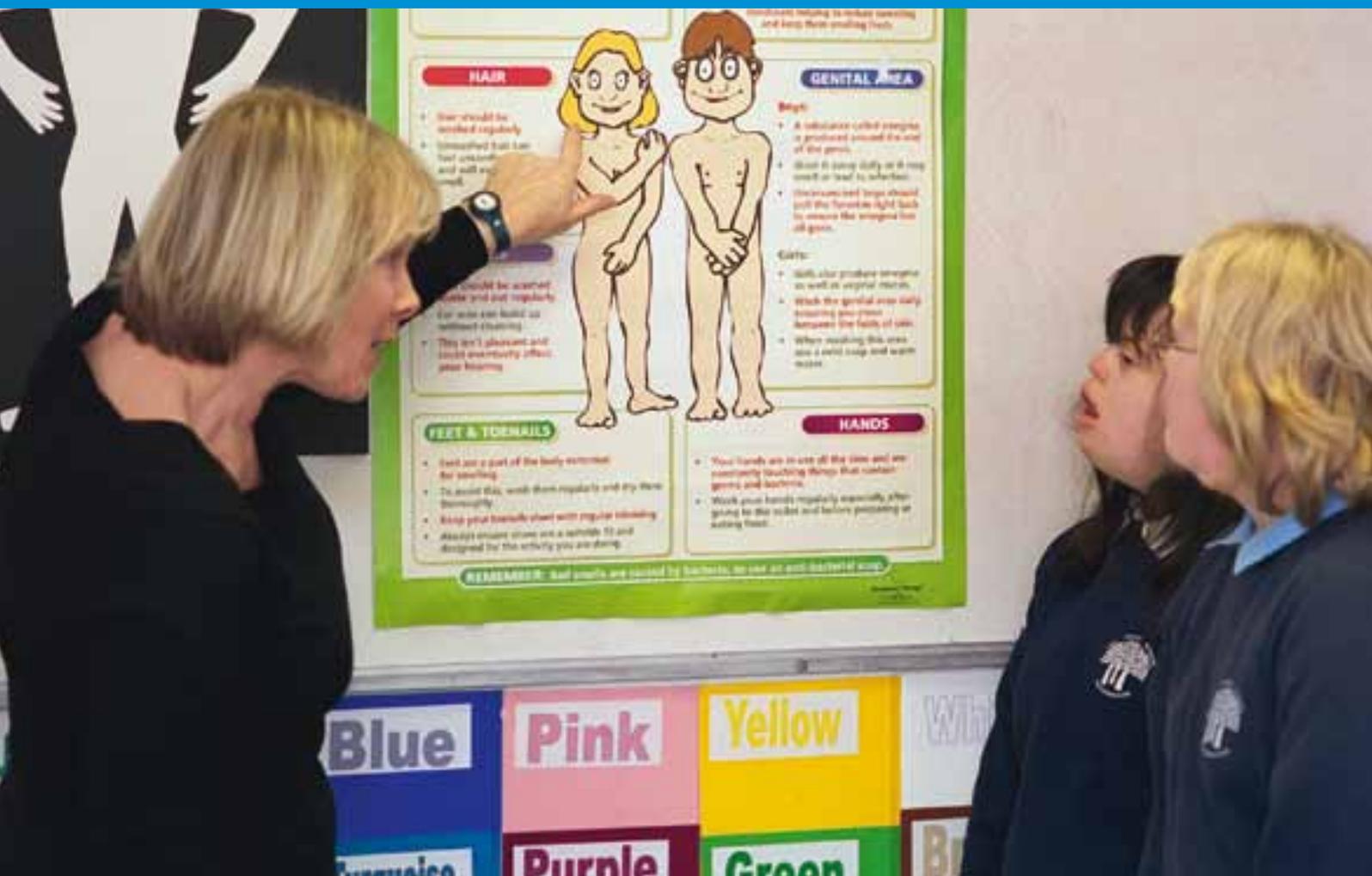
- a. *general indicators (see page 4) are considered in relation to this factor*
- b. services that support *people* with pain and their carers are systematically reviewed and published at least annually and as required. Service review should include availability, access, quality, timeliness, and continuity of services; appropriateness of services for local health care needs; recorded pain scores; cost effectiveness and clinical effectiveness; staff attitudes; and an analysis of information obtained from complaints, letters, *people's* interviews, the national Patient Satisfaction Survey and Patient Advice and Liaison Services
- c. risk is assessed and reassessed within an appropriate time frame

- d. risks, incidents, complaints and concerns are recorded, monitored, analysed and the information used to improve care
- e. a written evaluation of pain services is provided annually by staff and commissioners
- f. *add your local indicators here*

Notes

Essence of Care 2010

Benchmarks for Personal Hygiene



Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 14641
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Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for Personal Hygiene





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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon*
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Personal Hygiene

Agreed person-focused outcome

People's personal hygiene needs and preferences are met according to their individual and clinical needs

Definitions

For the purpose of these benchmarks, **personal hygiene care** is:

the physical act of cleansing the body to ensure that the hair, nails, ears, eyes, nose and skin are maintained in an optimum condition. It also includes mouth hygiene which is the effective removal of plaque and debris to ensure the structures and tissues of the mouth are kept in a healthy condition. In addition, personal hygiene includes ensuring the appropriate length of nails and hair.

For simplicity, **people requiring care** is shortened to people or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People's personal hygiene needs and preferences are met according to their individual and clinical needs

Factor	Best practice
1. Assessment	<i>People</i> are assessed to identify the advice and/or care required to maintain and promote their personal hygiene
2. Planning, implementation, evaluation and revision of care	<i>People's</i> care is planned, implemented, continuously evaluated and revised to meet needs and preferences
3. Environment	All personal hygiene care and advice is given in an environment that is safe and appropriate to <i>People's</i> needs and preferences
4. Toiletries	<i>People</i> have toiletries to meet their needs and preferences
5. Assistance	<i>People</i> receive the care and assistance they require to meet personal hygiene needs and preferences
6. Knowledge and skills	<i>People</i> and carers are provided with the knowledge and skills to meet personal hygiene needs and preferences

Factor 1

Assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's personal hygiene needs are not assessed

BEST PRACTICE

People are assessed to identify the advice and/or care required to maintain and promote their personal hygiene

Indicators of best practice for factor 1

The following indicators support best practice for personal hygiene:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. there are documented rationale for undertaking an assessment of the need for hair, nails, mouth, ears, eyes, nose and skin personal hygiene advice and care
- c. the assessment undertaken incorporates identification of individual needs and preferences, and identification of those at risk of not being able to maintain their personal hygiene
- d. the assessment and reassessment is performed in a timely manner in partnership with *people* and carers (as appropriate)
- e. the assessment tool used is evidence-based

- f. assessed needs are communicated to the multi-professional team, for example, the dentist, dental hygienist, podiatrist, dietician, infection control team and the occupational therapist (where appropriate)
- g. education and training in assessment of personal hygiene is provided for *people, carers and staff*
- h. *add your local indicators here*

Factor 2

Planning, implementation, evaluation and revision of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have a plan of care

BEST PRACTICE

People's care is planned, implemented, continuously evaluated and revised to meet needs and preferences

Indicators of best practice for factor 2

The following indicators support best practice for personal hygiene:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. the evidence base that underpins advice and care is apparent, reviewed and kept up-to-date
- c. the care provided and the delivery of care is agreed with *people* and carers
- d. condition and cleanliness of hair, nails, mouth, ears, eyes, nose and skin are monitored and care provided as required and (where possible) as preferred
- e. care is evaluated and revised as required
- f. the length of hair and nails is monitored and care provided as required

- g. care is delivered in a manner that is compassionate and respectful.
People are moved gently as appropriate
- h. *people's* responses to an offer of (assistance with) personal hygiene care is taken into account when care is negotiated and facilitated
- i. staff competencies in planning, implementing, evaluating and revising advice and care are maintained and monitored
- j. documentation and tools used in planning, implementing, evaluating and revising care are appropriate and evidence-based
- k. *add your local indicators here*

Factor 3

Environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Personal hygiene care and advice is given in an unsafe and inappropriate environment

BEST PRACTICE

All personal hygiene care and advice is given in an environment that is safe and appropriate to people's needs and preferences

Indicators of best practice for factor 3

The following indicators support best practice for personal hygiene:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. adaptations have been made to the environment to maintain privacy and dignity
- c. the environment meets *people's* individual requirements, for example, there is sufficient space for moving a wheelchair in a toilet with the door closed
- d. all risk factors are taken into account to ensure a safe environment, for example, avoiding a too high water temperature and wet floors
- e. information is provided on the location of facilities

- f. privacy and dignity is assured
- g. infection control arrangements ensure the safety of *people*, carers and staff
- h. *add your local indicators here*

Factor 4

Toiletries

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have toiletries for their personal use

BEST PRACTICE

People have toiletries to meet their needs and preferences

Indicators of best practice for factor 4

The following indicators support best practice for personal hygiene:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. toiletries are made available to *people* if they do not have their own
- c. *people* are encouraged to provide their own toiletries
- d. personal use of toiletries is assured and items are not shared
- e. *people* and carers are made aware of which toiletries are required
- f. *add your local indicators here*

Factor 5

Assistance

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are not offered assistance to meet personal hygiene needs

BEST PRACTICE

People receive the care and assistance they require to meet personal hygiene needs and preferences

Indicators of best practice for factor 5

The following indicators support best practice for personal hygiene:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a trained and/or experienced member of staff is available to provide care and assistance to meet hair, nails, mouth, ears, nose and skin personal hygiene needs
- c. supervision of unregistered and/or inexperienced staff is undertaken at an appropriate level
- d. care and assistance with personal hygiene is provided according to *people's* needs
- e. the level of assistance to be provided by staff is discussed with *people* and carers
- f. *add your local indicators here*

Factor 6

Knowledge and skills

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers are not provided with knowledge and skills to meet personal hygiene needs

BEST PRACTICE

People and carers are provided with knowledge and skills to meet personal hygiene needs and preferences

Indicators of best practice for factor 6

The following indicators support best practice for personal hygiene:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. the range, evidence base and format of information used is accessible and understandable to *people* and carers
- c. information is available to ensure *people* and carers are aware of special hygiene needs that may occur as a result of specific treatments, for example, chemotherapy or surgery
- d. *people's* and carers' understanding of assessment, planning, implementing and revising care for personal hygiene is evaluated
- e. promotion of hair, nails, mouth, ears, nose and skin personal hygiene is supported by staff working in partnership with *people* and carers
- f. add your local indicators here

Notes

Essence of Care 2010

Benchmarks for Prevention and
Management of Pressure Ulcers



Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 14641
Title	ESSENCE OF CARE 2010
Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
Target Audience	PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs , Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations
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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff
Cross Ref	Essence of Care 2001, Communication, Promoting Health and Care Environment
Superseded Docs	Essence of Care 2001 Gateway No. 4656 and 8489
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

**Benchmarks for Prevention and
Management of Pressure Ulcers**





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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Prevention and Management of Pressure Ulcers

Agreed person-focused outcome

People experience care that maintains or improves the condition of their skin and underlying tissues

Definitions

For the purpose of these benchmarks, a **pressure ulcer** is:

an area of localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (European Pressure Ulcer Advisory Panel)⁵

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

5 European Pressure Ulcer Advisory Panel (2010) **Pressure Ulcer Prevention Quick Reference Guide** European Pressure Ulcer Advisory Panel website accessed 26 August 2010 at <http://www.epuap.org/guidelines.html>

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People experience care that maintains or improves the condition of their skin and underlying tissues

Factor	Best practice
1. Screening and assessment	<i>People</i> who are screened on initial contact and identified at risk of developing pressure ulcers receive a full assessment of their risk
2. Information	<i>People</i> and carers have ongoing access to evidence-based information concerning pressure ulcer prevention and management
3. Planning, implementation, evaluation and revision of care	<i>People's</i> care is planned, implemented, continuously evaluated and revised to meet their individual needs and preferences concerning pressure ulcer prevention and management
4. Prevention – repositioning	<i>People</i> are repositioned to reduce the risk, and manage the care, of pressure ulcers
5. Prevention – pressure redistribution	<i>People</i> are cared for on pressure redistributing support surfaces to reduce the risk, and manage the care, of pressure ulcers
6. Prevention – resources and equipment	<i>People</i> have the resources and equipment required to reduce the risk, and manage the care, of pressure ulcers

Factor 1

Screening and assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's existing pressure ulcers, or their risk of developing pressure ulcers, are not identified

BEST PRACTICE

People who are screened on initial contact and identified at risk of developing pressure ulcers receive a full assessment of their risk

Indicators of best practice for factor 1

The following indicators support best practice for pressure ulcer prevention and management:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people* are screened on admission to hospital, care homes or other care environments or situations
- c. screening is repeated for *people* when there is a concern about risk. This is done at least weekly for *people* in hospital and for those who are at risk of developing pressure ulcers
- d. *people* who are identified initially as having pressure ulcers or who are vulnerable to the development of pressure ulcers should receive a full assessment using an evidence-based tool
- e. the screening and assessment tools are evidence-based and adequate and include a manual handling assessment and nutritional assessment

- f. screening, assessment and reassessment is carried out within an acceptable time frame according to national guidance
- g. staff conducting screening and assessment must be competent
- h. assessment by someone with specialist training, experience and knowledge is available and can be readily accessed if required
- i. *add your local indicators here*

Factor 2

Information

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers have no access to information

BEST PRACTICE

People and carers have ongoing access to evidence-based information concerning pressure ulcer prevention and management

Indicators of best practice for factor 2

The following indicators support best practice for pressure ulcer prevention and management:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. a range of information is available in a format that meets the needs of *people* and carers
- c. information is evidence-based
- d. *people* and carers have the opportunity to discuss information and its relevance to their needs with a competent member of staff
- e. *people's* and carers understanding of information is assessed and choices and preferences are documented
- f. *add your local indicators here*

Factor 3

Planning, implementation, evaluation and revision of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 3

The following indicators support best practice for pressure ulcer prevention and management:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people* and carers (as appropriate) are involved in planning, implementation, evaluation and revision of advice and care
- c. all relevant staff are involved in planning, implementation, evaluation and revision of advice and care, for example, dietician, nurse, doctor, occupational therapist, physiotherapist, tissue viability nurse etc
- d. responsibilities of *people*, carers and staff members with regard to treatments, interventions, milestones and targets are negotiated and agreed
- e. all care plans are underpinned by best evidence

- f. mechanisms are in place to ensure the review of plans and evaluation
- g. variance to implementation of care and progress is evaluated and recorded
- h. education and training in the prevention and management of pressure ulcers is provided for *people* and carers
- i. documentation reflects accurate and timely evaluation, for example audit of records
- j. guidelines and policies are in use that support prevention and management of pressure ulcers
- k. *add your local indicators here*

Factor 4

Prevention – repositioning

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 4

The following indicators support best practice for pressure ulcer prevention and management:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people's need for repositioning is assessed, documented, met and evaluated with evidence of ongoing reassessment*
- c. *equipment is available to enable correct moving, handling and positioning of people*
- d. *people are positioned in a manner that is comfortable for them*
- e. *information for re-positioning is available for people and/or carers*
- f. *policies or guidelines are in use, for example, health and safety, manual handling and use of equipment*
- g. *add your local indicators here*

Factor 5

Prevention – pressure redistribution

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have access to pressure redistribution support surface devices

BEST PRACTICE

People are cared for on pressure redistributing support surfaces to reduce the risk, and manage the care, of pressure ulcers

Indicators of best practice for factor 5

The following indicators support best practice for pressure ulcer prevention and management:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people's* need for pressure redistribution is assessed, documented, met and evaluated with evidence of ongoing reassessment
- c. *people* are offered and/or receive the appropriate pressure redistribution for their level of need such as seating, mattresses, specialist beds, bed frames, electric profiling bed frames, moving and handling hoists, footwear and insoles etc
- d. *people's* comfort is assessed and maintained

- e. information on how to access and use the pressure redistribution surfaces is provided to *people*, carers and staff
- f. audits are conducted to assess the appropriateness of the use of pressure redistribution surfaces
- g. *add your local indicators here*

Factor 6

Prevention – resources and equipment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are not provided with any resources or equipment

BEST PRACTICE

People have the resources and equipment required to reduce the risk, and manage the care, of pressure ulcers

Indicators of best practice for factor 6

The following indicators support best practice for pressure ulcer prevention and management:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a range of resources and equipment appropriate to the area of practice is available, for example, pressure redistribution of support surface devices such as seating, mattresses, specialist beds, bed frames, electric profiling bed frames, moving and handling hoists, footwear and insoles etc
- c. arrangements for the cleaning, maintenance and storage of equipment are in place
- d. ordering, delivery and monitoring systems are in place for resources and equipment

- e. *people*, carers and staff are made aware of the equipment available and how to use it safely
- f. where *people's* need for resources and equipment is identified there is a system in place to ensure these are made available in a timely manner
- g. *add your local indicators here*

Essence of Care 2010

Benchmarks for Promoting
Health and Well-being



Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 14641
Title	ESSENCE OF CARE 2010
Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

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- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

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- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

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4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for promoting health and well-being

Agreed person-focused outcome

People will be supported to make healthier choices for themselves and others

Definitions

For the purpose of these benchmarks:

health is:

a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity⁵

well-being is:

a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment⁶

lifestyle is:

a way of life or style of life that reflects the attitudes and values of a person or group⁷

5 World Health Organisation (1948) Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22nd July 1946 by the representatives of 61 states (Official Records of the World Health Organisation, no.2,p.100) and entered into force on 7 April 1948. The definition has not been amended since 1945. accessed 11 July 2010 at <http://www.who.int/about/definition/en/print.html>

6 Department of Health (2010) New Horizons. Working Together for Better Mental Health. Confident Communities, Brighter Futures. A Framework for Developing Well-being accessed 11 July 2010 at <http://www.nmhdu.org.uk/silo/files/confident-communities-brighter-futures.pdf>

7 The American Heritage® Dictionary of the English Language (4th edn) (2008), accessed 27 November 2008 at <http://dictionary.reference.com/browse/lifestyle>

For the purpose of these benchmarks, **communities** are:

a group of people living or working in a geographical area or a group of people who have common characteristics, interests, need or experiences

For simplicity, **people requiring care, and/or promotion of their health and well-being** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes children, young *people* under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those 'who look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *people* aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People will be supported to make healthier choices for themselves and others

Factor	Best practice
1. Empowerment	<i>People</i> , carers and communities are enabled to find ways to maintain or improve their health and well-being via every appropriate contact
2. Assessment	<i>People</i> , carers and communities are enabled to identify their health and well-being promotion needs
3. Engagement	<i>People</i> , carers and communities are involved in planning and actions concerning promotion of health and well-being
4. Partnership	Promotion of health and well-being is undertaken in partnership with others using a variety of expertise and experiences
5. Access	<i>People</i> , carers and communities have access to information, services and support that meets their health and well-being needs and circumstances
6. Environment	<i>People</i> , carers, communities and agencies influence and create environments that promote <i>people's</i> health and well-being
7. Outcomes of promoting health and well-being	<i>People</i> , carers and communities have an improved, sustainable and good quality of health and well-being

Factor 1

Empowerment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People, carers and communities are not able to make decisions on their health and well-being

BEST PRACTICE

People, carers and communities are enabled to find ways to maintain or improve their health and well-being via every appropriate contact

Indicators of best practice for factor 1

The following indicators support best practice for promoting health and well-being:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people, carers and communities are supported to gain the knowledge, skills and opportunities to maintain and improve their own, and others', health*
- c. a person-focused approach exists
- d. advocacy services are accessible
- e. a comprehensive directory of local health-promoting services for local and national, health and social, statutory and voluntary organisations is available
- f. *people are guided to information and services*
- g. *people's decisions are based on informed choices and opportunities*

- h. opportunities to participate in relevant programmes, for example, the Expert Patients Programme or 'stop smoking' programme, are available
- i. directed and self-referral to health promoting services can be demonstrated
- j. every opportunity is taken to identify ways to provide equal access to promotion of health and well-being
- k. a range of approaches are used to make the most of every contact
- l. the culture of workplaces promotes the health and well-being of the workforce
- m. systems are in place to measure whether opportunities are taken by *people, carers, staff, communities, and statutory and voluntary organisations* to promote health and well-being, for example, by auditing of the use of services
- n. *add your local indicators here*

Factor 2

Assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 2

The following indicators support best practice for promoting health and well-being:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. all assessments, processes and outcomes have been identified
- c. assessed needs are recorded and acted upon
- d. the views of *people*, carers and communities inform the assessment process
- e. priority areas are identified and addressed
- f. national and international evidence is used to inform the assessment process
- g. evidence-based assessment tools are used, where available
- h. staff are competent to assess and promote health and well-being
- i. *add your local indicators here*

Factor 3

Engagement

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Those responsible for promoting health and well-being are not responsive to the needs of people, carers or communities

BEST PRACTICE

People, carers and communities are involved in planning and actions concerning the promotion of health and well-being

Indicators of best practice for factor 3

The following indicators support best practice for promoting health and well-being:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *effective partnership working and collaboration between people, carers, staff, communities, and statutory and voluntary organisations enables the identification of health and well-being needs that should be addressed*
- c. *people-focused plans that address needs and include goals, actions and outcomes are developed in partnership and are in place*
- d. *care pathways include aspects of improving health and well-being*
- e. *add your local indicators here*

Factor 4

Partnership

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Promotion of health and well-being is undertaken in isolation

BEST PRACTICE

Promotion of health and well-being is undertaken in partnership with others using a variety of expertise and experiences

Indicators of best practice for factor 4

The following indicators support best practice for promoting health and well-being:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. all opportunities to work in partnership are identified and used
- c. the use and development of networks is demonstrated
- d. sustainable partnership working is evident
- e. *people, carers, staff, communities, and the contributions of statutory and voluntary organisations are recognised and valued*
- f. there is guidance to partner organisations that provide services to promote health and well-being
- g. policies for the protection of health and well-being, and disease prevention and education are in place and continuously practised
- h. *add your local indicators here*

Factor 5

Access

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People have no access to health or well-being promoting information, services or support

BEST PRACTICE

People, carers and communities have access to information, services and support that meets their health and well-being needs and circumstances

Indicators of best practice for factor 5

The following indicators support best practice for promoting health and well-being:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people* and carers can access the services they need
- c. barriers to accessing information, services and support have been identified and are being addressed
- d. services are provided in settings that are appropriate and accessible
- e. information is available in a way that meets *people's* needs
- f. *people* are aware of available information and support
- g. *people* are directed to specialist services, such as smoking cessation and 'exercise by prescription' services

- h. audits are conducted to assess whether *people*, carers and communities have access to, and are able to use, the services they require (where appropriate)
- i. *add your local indicators here*

Factor 6

Environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People, carers, communities and agencies do not influence and create an environment that promotes health and well-being

BEST PRACTICE

People, carers, communities and agencies influence and create environments that promote people's health and well-being

Indicators of best practice for factor 6

The following indicators support best practice for promoting health and well-being:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people's confidentiality is respected*
- c. *environmental risk assessments include health and well-being promotion perspectives and action is taken as necessary*
- d. *issues that have an impact on health and well-being are considered, for example lifestyle, culture, transport and housing*
- e. *the culture supports the promotion of a healthy lifestyle, for example, provision of healthy eating options or advice*
- f. *opportunities are used to influence and engage other agencies, for example, schools, social services and voluntary organisations*

- g. policies are in place in workplace environments to promote and support health and well-being
- h. the impact of new projects and service development on health and well-being is assessed in partnership with *people*, carers, staff, communities, and statutory and voluntary organisations and the results used to improve practice
- i. *add your local indicators here*

Factor 7

Outcomes of promoting health and well-being

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

There is no sustainable change and public health information does not inform the agenda

BEST PRACTICE

People, carers, communities and agencies influence and create environments that promote people's health and well being

Indicators of best practice for factor 7

The following indicators support best practice for promoting health and well-being:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. examples of health and well-being improvements are recognised, celebrated and used to inform the ongoing public health agenda
- c. structures are in place to support local health promoting networks and methods of sharing good practice and information are implemented
- d. outcomes are shared to inform practice and future service delivery
- e. a range of information is gathered and reported on, to demonstrate health and well-being outcomes are being achieved

- f. audit programmes, which can demonstrate health and well-being improvement, are in place
- g. sustainable *people*, carers and community involvement can be demonstrated
- h. progress is being made towards meeting key health and well-being promotion targets
- i. a dedicated specialist with a health and well-being promotion function within each area is evident
- j. work is evaluated in partnership with *people*, carers, staff, communities, and statutory and voluntary organisations to identify effectiveness and benefits. The results are used to improve practice
- k. *add your local indicators here*

Essence of Care 2010

Benchmarks for Record Keeping



Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 14641
Title	ESSENCE OF CARE 2010
Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
Target Audience	PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs , Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations
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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for Record Keeping





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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Record Keeping

Agreed person-focused outcome

People benefit from records that promote communication and high quality care

Definitions

For the purpose of these benchmarks, a **care record** is:

any paper or electronic-based record which contains information or personal data pertaining to people's care.

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid'. (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People benefit from records that promote communication and high quality care

Factor	Best practice
1. Access to care records	<i>People</i> are able to access their care records in a format that meets their needs
2. Single records	<i>People</i> have a single, lifelong, multi-professional and multi-agency (where appropriate) care record which supports integrated care
3. Practice and evidence	<i>People's</i> care records demonstrate that their care is evidence-based
4. Security	<i>People's</i> care records are safeguarded

Factor 1

Access to care records

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are unable to access their care records

BEST PRACTICE

People are able to access their care records in a format that meets their needs

Indicators of best practice for factor 1

The following indicators underpin best practice:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people* have access to their care records
- c. *people's* and the public's awareness of accessibility of care records is promoted
- d. *people* are aware that there are circumstances in which part of their care record may not be accessible, for example, if a professional considers it likely to cause serious harm to *people* or others
- e. *people* have a copy of their care plan (where appropriate)
- f. information about care records is provided in a format that is accessible to *people*
- g. systems are in place for the efficient retrieval of care records
- h. *add your local indicators here*

Factor 2

Single records

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

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

BEST PRACTICE

People have a single, lifelong, multi-professional and multi-agency (where appropriate) care record which supports integrated care

Indicators of best practice for factor 2

The following indicators underpin best practice:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. a single electronic care record is utilised amongst all relevant staff and services (where possible and appropriate) to provide consistency and continuity of care
- c. care records that are held by *people* are user friendly and meet any special needs
- d. staff discuss and agree with *people* what they are going to write in the care records
- e. care records are comprehensive, accurate, clear and free from unauthorised abbreviation

- f. care records are audited against regulatory and professional standards, and local and national guidance⁵ for record keeping, such as the NHS Care Records Guarantee,⁶ Records Management Code of Practice,⁷ and Information Governance guidance⁸
- g. staff are competent to create, use and maintain care records, including the ability to keep accurate, comprehensive, care records
- h. care records are shared by staff according to Caldicott principles⁹ and information sharing protocols
- i. *add your local indicators here*

5 DH (2007) **Social Care Information Governance** accessed 28 November 2008 at http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Informationforsocialcare/DH_4075306

6 Department of Health (2009) **The Care Record Guarantee. Our Guarantee for NHS Care Records in England** accessed 25 July 2010 at <http://www.nigb.nhs.uk/guarantee/2009-nhs-crg.pdf>

7 Department of Health (2006) **The Records Management: NHS Code of Practice** accessed 28 November 2008 at <http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Recordsmanagement/index.htm>

8 Department of Health (2007) **NHS Information Governance – Guidance on Legal and Professional Obligations** accessed 28 November 2008 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616

9 Department of Health (1997) **Report on the Review of Patient-Identifiable Information** accessed 25 July 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4068404.pdf

Factor 3

Practice and evidence

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 3

The following indicators underpin best practice:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people's care records demonstrate that their care follows evidence-based guidance and any variance from this is explained*
- c. *recorded variance is analysed and used to inform changes in people's care*
- d. *agreement is reached between staff on evidence-based documentation*
- e. *people's involvement in the development of evidence-based documentation is facilitated and supported*
- f. *audits are undertaken of care records, the results are used to improve practice and care*
- g. *review of quality and content of documentation is evident*
- h. *add your local indicators here*

Factor 4

Security

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's care records are not safeguarded

BEST PRACTICE

People's care records are safeguarded

Indicators of best practice for factor 4

The following indicators underpin best practice:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people's confidentiality is respected*
- c. *people are aware that there are circumstances in which confidential information about them may be used or disclosed, for example, reporting infectious diseases, births of children or where there is a court order*
- d. *people are aware of the choice they have to decide whether their information can be disclosed or used in particular ways*
- e. *people's confidentiality is respected according to Caldicott principles*
- f. *arrangements are in place to send and receive confidential information in a secure setting, such as when sending faxes of information concerning care*

- g. paper and electronic records can only be accessed by specified individuals using a secure system
- h. *people's* care records on removable media (such as tapes, disks, laptop and handheld computers, optical discs (DVD and CD-ROM), solid state memory cards, memory sticks and pen drives) is encrypted to the appropriate standards
- i. care records and information concerning *people* are not left accessible or in public places, for example, there is a 'clear desk' policy in place that is adhered to and staff 'log out' of electronic record systems when not in use
- j. care records are stored and transported securely and there is a record tracking system in place
- k. there is a system to dispose of care records appropriately that includes their destruction
- l. *add your local indicators here*

Essence of Care 2010

Benchmarks for Respect and Dignity



Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 14641
Title	ESSENCE OF CARE 2010
Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
Target Audience	PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs , Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations
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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for Respect and Dignity





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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon*
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Respect and Dignity

Agreed person-focused outcome

People experience care that is focused upon respect

Definitions

For the purpose of these benchmarks:

respect is:

regard for the feelings and rights of others.

dignity is:

quality of being worthy of respect.

privacy is:

freedom from unauthorised intrusion.

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *people* aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People experience care that is focused upon respect

Factor	Best practice
1. Attitudes and behaviours	<i>People</i> and carers feel that they matter all of the time
2. Personal world and personal identity	<i>People</i> experience care in an environment that encompasses their values, beliefs and personal relationships
3. Personal boundaries and space	<i>People's</i> personal space is protected by staff
4. Communication	<i>People</i> and carers experience effective communication with staff, which respects their individuality
5. Privacy – confidentiality	<i>People</i> experience care that maintains their confidentiality
6. Privacy, dignity and modesty	<i>People's</i> care ensures their privacy and dignity, and protects their modesty
7. Privacy – private area	<i>People</i> and carers can access an area that safely provides privacy

Factor 1

Attitudes and behaviours

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers experience deliberate, negative and offensive attitude and behaviour

BEST PRACTICE

People and carers feel that they matter all of the time

Indicators of best practice for factor 1

The following indicators support best practice for respect and dignity:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. good attitudes and behaviour are promoted and monitored including consideration of non-verbal behaviour and body language
- c. issues about attitude and behaviour are addressed with appropriate staff
- d. partnerships exist between *people*, carers and staff that promote good attitudes and behaviours
- e. *add your local indicators here*

Factor 2

Personal world and personal identity

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's individual values, beliefs and personal relationships are never explored

BEST PRACTICE

People experience care in an environment that encompasses their values, beliefs and personal relationships

Indicators of best practice for factor 2

The following indicators support best practice for respect and dignity:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *stereotypical views are challenged*
- c. *diversity is valued and specific and special needs are accommodated*
- d. *people's needs and preferences are ascertained and continuously reviewed*
- e. *people's personal relationships are respected*
- f. *add your local indicators here*

Factor 3

Personal boundaries and space

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's personal boundaries are deliberately invaded

BEST PRACTICE

People's personal space is protected by staff

Indicators of best practice for factor 3

The following indicators support best practice for respect and dignity:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. personal boundaries are identified and communicated to staff, for example, by using *people's* own language
- c. personal boundaries are assessed using psychological, physical, emotional and spiritual parameters
- d. *people's* personal space is respected and protected
- e. strategies are in place to prevent disturbing or interrupting *people*, for example, requesting and awaiting an invitation to enter before entering their personal area
- f. privacy is maintained effectively, for example, using curtains, screens, walls, rooms, blankets, appropriate clothing and appropriate positioning of *people*

- g. the acceptability of touch is identified with *people*
- h. clinical risk is managed with consideration of privacy, dignity and modesty
- i. privacy is achieved when the presence of others is required
- j. *add your local indicators here*

Factor 4

Communication

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers are 'communicated at'

BEST PRACTICE

People and carers experience effective communication with staff, which respects their individuality

Indicators of best practice for factor 4

The following indicators support best practice for respect and dignity:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people* are addressed as they wish and are spoken to using their preferred name. This information is documented
- c. staff listen actively to *people* and carers
- d. *people's* individual needs and views are taken into account
- e. *people* are respected as individuals
- f. *people* and carers are enabled to communicate effectively, for example, by the use of communication aids, or by the use of a competent translation and interpretation service which is available and accessible when required
- g. *add your local indicators here*

Factor 5

Privacy – confidentiality

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document



Indicators of best practice for factor 5

The following indicators support best practice for respect and dignity:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. precautions are taken to prevent information being shared inappropriately, such as, by telephone conversations being overheard, computer screens being viewed, staff discussing personal details in public places, and white boards being read
- c. procedures are in place for communicating *people's* personal information in a confidential manner, for example, during handover procedures, consultant and/or teaching rounds, admission procedures and telephone calls, and when calling *people* in outpatients and breaking bad news

- d. explicit or expressed valid consent is sought from *people* when special measures are required to overcome communication difficulties, for example, when using competent interpreters
- e. *add your local indicators here*

Factor 6

Privacy, dignity and modesty

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's privacy, dignity and modesty are not considered

BEST PRACTICE

People's care ensures their privacy and dignity, and protects their modesty

Indicators of best practice for factor 6

The following indicators support best practice for respect and dignity:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. staff are proactive in maintaining *people's* privacy, dignity and modesty, for example, by using signage to indicate when *people* are engaged in private activity
- c. *people* are protected from unwanted public view, for example, by using curtains, screens, walls, clothes and covers
- d. appropriate clothing is available for *people* who cannot wear their own clothes
- e. policies are in place to support *people* to have access to their own clothes
- f. *people* can have a private telephone conversation

- g. modesty is achieved for those moving between differing care environments
- h. the organisation has a designated person whose aim is to work in partnership with staff to ensure they care with dignity
- i. *add your local indicators here*

Factor 7

Privacy – private area

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers are denied access to any area that offers privacy

BEST PRACTICE

People and carers can access an area that safely provides privacy

Indicators of best practice for factor 7

The following indicators support best practice for respect and dignity:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a private area is created where care is delivered when required
- c. quiet areas are available at all times and *people* and carers are aware of how to access them
- d. clinical risk is managed with consideration of privacy
- e. *add your local indicators here*

Essence of Care 2010

Benchmarks for Safety



Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 14641
Title	ESSENCE OF CARE 2010
Author	DEPARTMENT OF HEALTH
Publication Date	1ST OCTOBER 2010
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BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for Safety



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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Safety

Agreed person-focused outcome

People, their carers, visitors and staff feel safe, secure and supported

Definitions

For the purpose of these benchmarks:

safety is:

protection or freedom from physical, mental, verbal abuse, and/or injury

secure is:

certain to remain safe from physical, mental, verbal abuse, and/or injury

For simplicity, **people requiring care** is shortened to *people (in italics)* or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People, their carers, visitors and staff feel safe, secure and supported

Factor	Best practice
1. Orientation	<i>People are fully oriented to the care environment, to help them feel safe</i>
2. Assessment – risk of injury	<i>People have a comprehensive, ongoing assessment of their risk of injury</i>
3. Assessment – risk to others	<i>People have a comprehensive, ongoing assessment of risk to harm others</i>
4. Observation and pPrivacy	<i>People experience care in an environment that allows safe observation and privacy</i>
5. Planning, implementation, evaluation and revision of care	<i>People’s care is planned, implemented, continuously evaluated and revised to meet their safety needs and preferences</i>
6. Positive culture	<i>People experience care in a culture that constantly reviews practice and uses learning to improve care</i>

Factor 1

Orientation

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are not oriented to their care environment and do not feel safe

BEST PRACTICE

People are fully oriented to the care environment, to help them feel safe

Indicators of best practice for factor 1

The following indicators support best practice for safety:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. people are oriented to the care environment taking into account their feelings, concerns, abilities, skills and cognitive level
- c. orienting each person to a care area is the responsibility of a specified person, this can include staff and other people requiring care (where appropriate)
- d. the care environment is adapted (where possible) to help people feel safe and to reduce risk, for example, of slips, trips or falls
- e. specific action is taken to make people at risk of feeling vulnerable, feel safe and secure

- f. appropriate resource materials, such as information booklets, CDs and DVDs, are used to promote orientation prior to, or on, admission
- g. people experience continuity of care and staff (where possible)
- h. key workers are identified
- i. *add your local indicators here*

Factor 2

Assessment – risk of injury

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have an assessment made of their risk of injury

BEST PRACTICE

People have a comprehensive, ongoing assessment of their risk of injury

Indicators of best practice for factor 2

The following indicators support best practice for safety:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. an evidence-based risk assessment tool is used, which incorporates all key risk indicators, such as those for *people* at risk of falling or who are confused and which takes into account, for example, mental health needs, physical and cognitive ability, feelings, concerns etc
- c. subsequent assessments and joint care reviews are undertaken by all relevant staff in partnership with *people* and carers (where appropriate) prior to *people* moving to another environment

- d. *people* and carers are involved in educating staff, to ensure that assessment and management are appropriate and sensitive to specific needs, including those in relation to the Mental Capacity Act, Deprivation of Liberty, human rights, adult and child protection and previous life events, and to specific treatments such as medication and electro-convulsive therapy
- e. knowledge of *people's* and their family's history, social context and significant events prior to, and since, admission and/or treatment, are ascertained, recorded and shared as appropriate, for example, with colleagues and police (as appropriate)
- f. procedures are in place to ascertain presence, and to identify misuse, of alcohol and drugs
- g. *add your local indicators here*

Factor 3

Assessment – risk to others

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have an assessment made of their risk of harm to others

BEST PRACTICE

People have a comprehensive, ongoing assessment of risk to harm others

Indicators of best practice for factor 3

The following indicators support best practice for safety:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. an evidence-based risk assessment tool is used which incorporates all key risk indicators, such as those for *people* at risk of falling or who are confused or the risk to *people* safety posed by visitors or resident carers, and which takes into account, for example, mental health needs, physical and cognitive ability, feelings, concerns etc
- c. subsequent assessments and joint care reviews are undertaken by all relevant staff in partnership with *people* and carers (where appropriate), prior to *people* moving to another environment and prior to visitor or family access

- d. *people* and carers are involved in educating staff, to ensure that assessment and management are appropriate and sensitive to specific needs, including those in relation to the Mental Capacity Act, human rights, adult and child protection and previous life events, and to specific treatments such as medication and electro-convulsive therapy
- e. knowledge of *people's* and their family's history, social context and significant events prior to, and since, admission and/or treatment, are ascertained, recorded and shared as appropriate, for example, with colleagues or police (as appropriate)
- f. procedures are in place to ascertain presence, and to identify misuse, of alcohol and drugs
- g. *add your local indicators here*

Factor 4

Observation and privacy

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have privacy and are not cared for in an environment that allows safe observation

BEST PRACTICE

People experience care in an environment that allows safe observation and privacy

Indicators of best practice for factor 4

The following indicators support best practice for safety:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. an up-to-date policy concerning observation and privacy is in place and this is adhered to. This includes, for instance, the specification of staff who have the role of observing *people*, and ensuring that observations are supportive, therapeutic and non-judgemental
- c. resources allow the appropriate level of observation and monitoring throughout the day, in the evening, at night and prior to discharge
- d. all opportunities are taken for maintaining privacy and dignity during observation and monitoring
- e. the reasons for observation and monitoring and how this will be carried out is explained to *people*

- f. the satisfaction of *people* and carers with the observation and monitoring process is ascertained and relevant changes made to maintain safety and optimise care
- g. assessment is made of environmental safety including any obstructions to observation, access to means of suicide (for example, opening windows, non-safety glass, structures that be used for hanging) and the availability of harmful products
- h. administration of medication should be conducted in a manner to prevent the risk of *people* stockpiling
- i. *add your local indicators here*

Factor 5

Planning, implementation, evaluation and revision of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's ongoing safety needs are not considered

BEST PRACTICE

People's care is planned, implemented, continuously evaluated and revised to meet their safety needs and preferences

Indicators of best practice for factor 5

The following indicators support best practice for safety:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people* are regularly and actively involved in identifying care that meets their own, and others, safety needs, including negotiating, for example, their choice of staff
- c. the safety needs of *people* and others are addressed in care planning and delivery of care. This is continuously evaluated and regularly considered in care reviews
- d. *people* and carers are encouraged to express any safety and security concerns
- e. the quality of documentation is assessed and audited

- f. *people* have, or have access to, a copy of the care plan in a format that they understand
- g. plans to enable *people's* understanding are implemented and care reviewed
- h. well *people* with recurrent mental health issues are enabled to develop personal plans and preferences for care for when they are in a crisis
- i. the attitudes of staff to *people* who deliberately harm themselves and/or others are assessed and education put in place to ensure understanding of *people's* perspectives
- j. support or information for *people* who deliberately harm themselves or others, such as the National Self harm Network, SHOUT (Self Harm Overcome by Understanding and Tolerance) magazine, Rape Crisis, Childhood Incest Survivors, Samaritans, YoungMinds, National Society for the Prevention of Cruelty to Children and other voluntary organisations, is made available and accessible
- k. procedures are in place to ascertain presence, and to identify misuse, of alcohol and drugs
- l. adequate competent staff are available to supervise *people* who may harm or injure themselves and/or others in order to keep *people* safe
- m. *add your local indicators here*

Factor 6

Positive culture

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not feel able to report adverse incidents and complaints

BEST PRACTICE

People experience care in a culture which constantly reviews practice and uses learning to improve care

Indicators of best practice for factor 6

The following indicators support best practice for safety:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. complaint procedures are user friendly, confidential (where appropriate) and accessible, including for groups of *people* at risk of harm
- c. systems are in place for *people*, carers and staff to report staff who are insensitive, abusive, harmful or incompetent
- d. incidents, such as acts of violence, aggression and seclusion, are reviewed and evaluated and the knowledge is used to improve care
- e. incident debriefing arrangements are in place and the information is used to improve care
- f. audits are undertaken and results are disseminated and used to inform practice development

- g. information concerning risk and *people's* and carers' views, is collected and used to determine resources, monitor performance and inform education
- h. *people*, carers, outside agencies, advocates or user groups are involved in audit of complaints, incidents and the evaluation of services
- i. *add your local indicators here*

Essence of Care 2010

Benchmarks for Self Care



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Author	DEPARTMENT OF HEALTH
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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff
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Benchmarks for Self Care



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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues¹ that must be considered with every factor.

These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

1 Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People's* best interests are maintained where they lack the capacity to make particular decisions.²
- Confidentiality is maintained by all staff members

People, carer and community members' participation

- *People*, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people's* and carers' individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

2 Mental Capacity Act 2005 accessed 25 November 2008 at <http://www.legislation.gov.uk/ukpga/2005/9/contents>

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people's* welfare are minimised.⁴

3 Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

4 Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for Self Care

Agreed person-focused outcome

People have control over their care

Definitions

For the purpose of these benchmarks, '**self care**' (or **people caring for themselves**) is:

the choices people make and the actions people take on their own behalf in the interest of maintaining their health and well-being.

People can care for themselves in various ways including managing their:

- health (lifestyle)
- health status information (monitoring and diagnosis)
- care choices (decisions)
- illness (treatment, care and rehabilitation).

For simplicity, **people requiring care** is shortened to *people* (in italics) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People have control over their care

Factor	Best practice
1. Choice	<i>People</i> are enabled to make informed choices about caring for themselves and those choices are respected
2. Assessment, planning, implementation, evaluation and revision of care	<i>People's</i> ability to care for themselves is continuously assessed, planned, implemented, evaluated and reviewed to meet their needs
3. Risk	<i>People's</i> care is continuously assessed for risk of harm to themselves and their carers, and is revised to meet their needs
4. Knowledge and skills	<i>People</i> and carers have the knowledge and skills to manage relevant aspects of <i>people's</i> care
5. Partnership	<i>People</i> , carers, staff and/organisations work in partnership to meet care needs
6. Access to services and resources	<i>People</i> and carers can access services and resources to enable them to manage relevant aspects of care
7. Environment	<i>People's</i> environment promotes their ability to care responsibly for themselves

Factor 1

Choice

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People are not given a choice on how their care is delivered

BEST PRACTICE

People are enabled to make informed choices about caring for themselves and those choices are respected

Indicators of best practice for factor 1

The following indicators support best practice for caring for themselves:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people* are informed of all options of how care can be delivered, including what care can be provided and what care they can undertake themselves
- c. *people's* options of care delivery are discussed and their choices and preferences obtained, respected and met (where appropriate)
- d. options of care delivery are discussed with carers as appropriate, and their choices and preferences obtained, respected and met (where appropriate)
- e. consistent information is provided by staff
- f. evaluation and revision of care continues to reflect *people's* choices
- g. *add your local indicators here*

Factor 2

Assessment, planning, implementation, evaluation and revision of care

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People's ability to care for themselves is not assessed and there is no care plan

BEST PRACTICE

People's ability to care for themselves is continuously assessed, planned, implemented, evaluated and reviewed to meet their needs

Indicators of best practice for factor 2

The following indicators support best practice for caring for themselves:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *assessment is undertaken which includes ongoing review and documentation of people's ability to care for themselves*
- c. *assessment is undertaken which includes ongoing review and documentation of the carers' ability to support people caring for themselves*
- d. *staff are competent to assess people's ability and confidence to care for themselves and the carers' ability and confidence to support people*
- e. *assessment informs, and is reflected, in care*

- f. *people's* views are sought and used to inform self-care assessment, planning, implementation and evaluation
- g. care plans are agreed with *people* and carers, and these are used and evaluated
- h. *people* and carers participate as partners in planning and evaluating services
- i. relevant staff, services and agencies are involved in assessing, planning and delivering and evaluating care
- j. *people's* satisfaction is assessed and any complaints or problems addressed in a timely manner
- k. *add your local indicators here*

Factor 3

Risk

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

There is no assessment of the risk of harm to people caring for themselves, and their carers

BEST PRACTICE

People's care is continuously assessed for risk of harm to themselves and their carers, and is revised to meet their needs

Indicators of best practice for factor 3

The following indicators support best practice for caring for themselves:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. a current evidence-based tool that incorporates all key risk factors is utilised to assess risk of harm
- c. risk is assessed and reassessed within an appropriate time frame
- d. *people's* and carers' acceptance of risk of harm is documented
- e. education and training concerning risk assessment and acceptability, and special care needs is provided to *people*, carers and staff
- f. risks, incidents, complaints and concerns are recorded, monitored, analysed and results are shared and used to improve care
- g. risk assessment data is used to inform care plans
- h. *add your local indicators here*

Factor 4

Knowledge and skills

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers do not have the knowledge and skills to manage self-care

BEST PRACTICE

People and carers have the knowledge and skills to manage relevant aspects of *people's* care

Indicators of best practice for factor 4

The following indicators support best practice for caring for themselves:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. *people's* and carers knowledge and skills are assessed
- c. education and training needs of *people* and carers are assessed and learning outcomes are identified, agreed and met
- d. education and training are available for *people* and carers to enable them to manage and deliver relevant aspects of self care
- e. the views and expectations of *people* and carers are used to inform education and training programmes
- f. information concerning assistance available when *people* cannot care for themselves or in an emergency, is provided to *people* and carers

- g. information is provided in a format that meets *people's* and carers' individual needs
- h. expert resources are available to enable *people* to develop knowledge and skills, such as the Expert Patients Programme
- i. add your local indicators here

Factor 5

Partnership

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People, carers, staff and/ organisations do not work in partnership

BEST PRACTICE

People, carers, staff and/ organisations work in partnership to meet care needs

Indicators of best practice for factor 5

The following indicators support best practice for caring for themselves:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *staff and/organisations work and communicate effectively with each other, people and carers*
- c. *documentation enables joint and comprehensive assessment and promotes partnership with people and carers, for example, by having shared contracts*
- d. *opportunities exist for people and carers to engage in partnership meetings*
- e. *efficiency and effectiveness of partnership arrangements are continuously monitored and evaluated*
- f. *people's and carers' views are used in staff education programmes*
- g. *add your local indicators here*

Factor 6

Access to services and resources

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers do not know about services that would meet their needs

BEST PRACTICE

People and carers can access services and resources to enable them to manage relevant aspects of care

Indicators of best practice for factor 6

The following indicators support best practice for caring for themselves:

- a. *general indicators* (see page 4) are considered in relation to this factor
- b. a list of local and national services and resources to meet needs within a geographical area or community is available and accessible, this includes, for example, health and social services, voluntary services and/ organisations, trades people and complementary therapies
- c. *people* and carers know how to access services and resources, for example, by using the Citizen's Advice Bureau, NHS Direct etc
- d. *people's* and carers awareness and uptake of service and resources is monitored and evaluated
- e. information of services and resources is evidence-based, up-to-date and available in a language and format that *people* and carers can understand. This includes, for example, large print

- f. arrangements for immediate access to services and resources are in place to enable, for example, an earlier discharge
- g. add your local indicators here

Factor 7

Environment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

The environment fails to support *people* in caring for themselves

BEST PRACTICE

People's environment promotes their ability to care responsibly for themselves

Indicators of best practice for factor 7

The following indicators support best practice for caring for themselves:

- a. *general indicators (see page 4) are considered in relation to this factor*
- b. *people, carers and staff work together to identify risk factors, and adaptations required, to enable and encourage people to care for themselves independently (where possible)*
- c. *adaptations are made to the environment (or are offered to people) to enable people to care for themselves*
- d. *infection control arrangements ensure the safety of people and carers*
- e. *add your local indicators here*

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