HQIP
Healthcare Quality Improvement Partnership

Social care audit in practice

April 2017

About us

The Healthcare Quality Improvement Partnership (HQIP) was established in 2008 to promote quality improvement. HQIP develops and promotes tools, resources, skills, methods, and guidance to support a culture of reflective practice and continuous quality improvement.

We work in partnership with both health and social care stakeholders – including people who use services and their representatives, professional staff, clinicians, and management staff – and specialise in leading and promoting data-rich or evidence-based programmes of quality improvement, where high-value qualitative or quantitative information is collected and used to drive quality improvement and better care outcomes.

The relationship between people who use services and those who deliver them is at the heart of high quality health and social care. We encourage staff to work closely with service users, to actively collaborate, listen, and share information to implement effective quality improvement initiatives.

HQIP is led by a consortium of professional bodies: the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices – the national coalition of health and social care charities that works to strengthen the voice of patients, service users, carers, their families, and voluntary organisations.

HQIP Healthcare Quality Improvement Partnership

Authors:

Sally Fereday, Healthcare Quality Improvement Partnership
Eve Riley, Healthcare Quality Improvement Partnership
Julie Fenner, Blenkin Associates

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Overview

Purpose of this guide

This guide sets out a step-by-step approach to social care audit using the quality improvement cycle, involving people who use services.

Why care audit?

The aim of social care is to improve, or maintain, the quality of people's lives, and their wellbeing, through personalisation and empowerment. To understand how successful social care practice is, and to improve upon it, we must measure outcomes using care audit, to check that services are effective for people who use them.

Who is this guide for?

This guide is written for frontline leaders who oversee the day-to-day care provided to those using their services, and the teams and individuals who work directly with them, such as volunteers, students, ancillary staff, and practitioners,[i] who may be carrying out a care audit for the first time, or who wish to develop their knowledge and skills.

Consultation process

A series of workshops and national seminars were held to ensure this guidance reflects the experiences, achievements and challenges of the many organisations, services, and disciplines within the social care sector.

Further guidance

This guide forms part of a suite of guidance developed to support social care professionals to undertake care audit, including our abridged publication, *Social care audit in practice: Summary guide (HQIP, 2017b)*, and *Social care audit for leaders (HQIP, 2017c)*, which provides an overview of the care audit process, and the role of operational and strategic leaders in implementation within their organisations.

Note on terminology

Due to the vast range of organisations, services and disciplines within the social care sector, there are some differences in terminology used. For consistency, in this document we refer to those who use social care services, whether in their own home, a care home, supported living, or other environment, as 'people who use services'. We have used the term 'manager' for the individual responsible for leading and running an organisation, whether a single home or service, or an organisation with multiple services and sites.

Case studies and case examples

Throughout this guidance, we have used case study examples from a variety of relevant organisations to help users implement practice. We have also included a 'case example' from the fictitious 'Sunnytown Care Home' which runs through each section of this document.

Acknowledgements

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i. Based on the National Skills Academy for Social Care Leadership Qualities Framework: www.skillsforcare.org.uk/documents/leadership-and-management/leadership-qualities-framework/leadership-qualities-framework.pdf

Definitions

Advocacy

Using the definition taken from the *Quality Advocacy Code of Practice (Advocacy QPM, 2014)*, 'Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.'

Care audit

Care audit is a quality improvement cycle that involves review of the effectiveness of social care and social work practice, against agreed and proven standards for high-quality care. It involves taking action to align practice with these standards to improve the quality, experience, and outcomes of care for people who use services, and their carers.

Care audit champion

A person within a team, department, or organisation, charged with supporting care audit, and encouraging and showcasing its use.

Carers

A carer is someone of any age who provides support to family or friends that could not manage without their help, for example caring for a relative, partner, or friend, who is ill, frail, disabled, or has mental health and/or substance misuse problems. For more information, please see the Carers Trust website: *www.carers.org.uk*.

Co-design

Actively involving all stakeholders (e.g. people who use services, carers, employees, partners) in a service design process to help ensure the results meet their needs and are usable.

Co-production

Actively involving all stakeholders (e.g. people who use services, carers, employees, partners) in a production process to help ensure the results meet their needs and are usable.

Empowerment

Empowerment describes the provision of information to people so that they know their rights, to support people to consider their options and make their own choices and decisions. It is also referred to as informed choice, designed to give people a voice. It is important that people feel they have been listened to and feel they have equal rights. Support can be given in many different ways. Please see examples here from POhWER, a charity providing information, advice, support and advocacy to people who experience disability, vulnerability, distress, and social exclusion: *www.pohwer.net*.

Outcome measurement

Outcome measurement, in the context of this publication, is a way of measuring the change in a person's current or future status that can be attributed to social care intervention. Outcome measurement can be used for clinical care, social care, audit, and research purposes. Outcomes can occur at different levels, i.e. national, organisational, local community, or individual user.

Personalisation

The definition of personalisation in social care used throughout this publication is provided by *SCIE (SCIE, 2010a)*: 'Personalisation means thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations. It means putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. It requires a significant transformation of adult social care so that all systems, processes, staff and services are geared up to put people first'.

National Institute for Health and Care Excellence (NICE) quality standards

NICE quality standards provide statements designed to drive and measure priority quality improvements within a particular area of care. NICE describes its quality standards as being derived from the best available evidence, such as NICE guidance, and other evidence sources accredited by NICE. They are developed independently by NICE, in collaboration with NHS and social care professionals, their partners, and service users.

Social care

The definition of social care used throughout this publication is provided by *SCIE (SCIE, 2015)*: 'All interventions provided or funded by statutory and/or independent agencies which support older people, younger adults and children in their daily lives, and provide services which they are unable to provide for themselves, or which it is not possible for family members to provide without additional support'.

Social care governance

The definition of social care governance used throughout this publication is provided by *SCIE (SCIE, 2011)* 'Social care governance focuses on the responsibility of individual workers and teams to continuously learn from and improve their practice. It encourages professionals to take real pride in their practice and enables them to introduce changes and achieve better outcomes for people who use services and their carers. Working together on governance has enabled teams to recognise, celebrate and share good practice. It has stimulated team development and learning, which has then spread across the organisation'.

Wellbeing

There is no single definition of wellbeing, as how this is interpreted will depend upon the individual, their circumstances, and their priorities. It is a broad concept, supporting: personal dignity, physical, emotional, and mental health, protection from abuse and neglect, control by the individual over their day-to-day life (including over care and support provided and the way they are provided), participation in work, education, training, or recreation, social and economic wellbeing, domestic, family and personal domains, suitability of the individual's living accommodation, and the individual's contribution to society.

Contents

Introduction

This guide provides an introduction to social care audit for frontline leaders and teams, and sets out, step-by-step:

- What care audit is and how you can use it to improve the quality of your services
- The four key stages of the care audit quality cycle
- The importance of involving and supporting the people who use your services
- Tips and guidance for conducting care audit in your organisation

As a professional working in social care services, you want to be confident that you and your team are providing high-quality care. This guide is designed to help you to work with your team, and the people who use your services, to make ongoing improvements, and to support staff to make and manage changes for efficiencies brought about as a result of care audit.

Legislative background

The *Fundamental standards of the Care Quality Commission (CQC, 2017a)* describe the care people should expect (with prompts for providers to consider), in order to meet the requirements for quality improvement and audit set out in *Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC, 2017)*:

> *"To meet this regulation, providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice."*

Many social care organisations already have a strong ethos of high-quality care, and at a national level, those such as the *Social Care Institute for Excellence (SCIE)*, and the sector-led collaboration *Think Local, Act Personal (TLAP)*, work to create a wider, sector-level approach to quality improvement. Services need to be able to demonstrate high standards of quality to improve both user and staff satisfaction, and to increase market viability. Commissioners of care need robust evidence of quality of practice, and seek to compare services across the sector, whilst a variety of care home ratings available to all via websites such as *My NHS*, part of the *NHS Choices* website, enable those who use services to make informed choices regarding care.

With the introduction of the *Health and Social Care Act 2012*, a number of changes to practice arose which focus on improving care quality:

- Establishment of local authority Health and Wellbeing Boards to integrate the local intelligence of commissioners of healthcare, social care, and public health services – those who oversee or provide social care or healthcare services are encouraged to work closely together to integrate pathways of care as far as possible for people who use services; across the social care sector there is no shared approach to quality assurance and improvement using care audit, however in the healthcare sector, clinical audit is widely used, and this guidance and suite of partner documents aim to support a unified, cross-sector approach to health and care quality improvement
- Establishment of local *HealthWatch* groups to talk with people who use services about their experiences and scrutinise how services are working; as independent consumer champions, they ensure the voices of people who use services reach decision-makers for action, and care audit can provide evidence of improvement and quality assurance where issues are identified
- Nationally, *NHS Digital* has responsibility for collecting data from across the health and social care system, which are used to drive national improvement, and shortfalls identified locally can be addressed through care audit
- Regulation of social workers transferred to the Health and Care Professions Council, where their expected *Standards of Proficiency (HCPC, 2017)* include the need to be able to assure the quality of their practice, contribute to processes designed to evaluate services, and engage in evidence-informed practice, including participation in care audit
- Responsibility of the *National Institute for Health and Care Excellence (NICE)* to develop quality standards and other guidance for social care, together with support to use these in practice, compliance with which can be checked using care audit

Furthermore, with the introduction of the *Care Act 2014*, a number of expectations arose that focus on improving specifics of care quality. Compliance with such expectations may be evaluated using care audit, including:

- The wellbeing of the individual as the over-arching principle of care, covering personal dignity, respect, and control over day-to-day life, views, wishes, feelings and beliefs, as individuals requiring personalised care
- Provision of information and support for the person-centered decisions of individuals, to overcome obstacles and challenges in managing their lives and personalised budgets
- Assessment to establish total extent of need, and the impact of need on the individual's day-to-day life, before considering eligibility
- Supported decision-making where individuals lack capacity, capacity assessments and 'best interests' decisions, providing independent advocacy, and carrying out a carer's assessment if a carer has a current or future need for support
- Managing provider failure and service interruptions for sustainability, and a duty for the largest and most difficult to replace providers to inform the Care Quality Commission of problems arising
- Protection from abuse and neglect, with the addition of Safeguarding Boards for Adults and a Safeguarding Adults Board Annual Report analysing safeguarding data
- Need prevention, including for: those who do not have any current need for care and support, adults with need for care and support whether their need is eligible or not, and carers
- Legal duty of candour when things go wrong, to openly offer an apology and take action
- Duty on local authorities to facilitate diverse, sustainable, high-quality services in their area, through measuring outcomes and providing people with meaningful choice

Personalisation of services according to the preferences and needs of those in receipt of them is essential. Individual providers of social care and social work services are committed to practice that improves self-determination, dignity, health, and wellbeing.

Why care audit?

Fundamentally, the aim of social care is to improve, or maintain, the quality of people's lives, and their wellbeing, through personalisation and empowerment.

> *"Care audits can focus attention on the little things that really matter to users – as well as big issues."*
>
> **Jill Manthorpe, Professor of Social Work and Director of the Social Care Workforce Research Unit, King's College London**

To understand how successful social care practice is, and to improve upon it, we must measure outcomes to check that services are effective for people who use them. In healthcare, the process of measuring practice against agreed and proven standards for high-quality care, and then taking action to align practice with those standards to improve service quality and outcomes for patients and their carers, is known as 'clinical audit'.

The care audit approach described in this guide follows the universal principles of audit, as per clinical audit, but takes account of the different environments in which social care exists, delivered by a wide variety of professionals, semi-professionals, and non-statutory bodies, e.g. charities. This guide offers a simple method to continually improve quality and demonstrate the effectiveness of care provided. Many examples feature care homes, and apply equally to the delivery of care at home, though the same care audit principles apply to all care settings.

Using a unified, cross-sector approach to measuring quality against common standards enables comparison of performance and highlights best practice to be shared peer to peer and through case studies. It also supports people who use services, their family members, carers, and advocates, to make meaningful choices regarding care based on clear and transparent performance data.

Benefits of care audit

Care audit identifies unmet needs and unacceptable variation in care, drives quality improvement and efficiency, and showcases excellence. Where practice meets and exceeds statutory requirements, for example, compliance with the *CQC's Fundamental standards (CQC,2017a)*, care audit is a means to confirm and demonstrate this.

As social care strives for a personalised system, approaches to quality improvement must actively support the development of services with the people who use them at their heart. Care audit benefits from the involvement of people who use services at every stage of the improvement cycle, and also contributes to meeting the requirements of the overarching domains of the *Adult Social Care Outcomes Framework (Department of Health, 2014)*:

- Ensuring quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

> *"Care audit continually improves quality of care for service users."*
>
> **Shirley Allen, Bury Council Strategic Development Unit, Department of Communities and Wellbeing**

Care audit is a simple process to help you to become better at what you do, to understand how your role helps maintain and improve the quality of services, and to identify any training and development needs you or your team may have. The care audit process facilitates team-working and collaboration to solve problems and implement change, and highlights where resources are best spent to support your professional expertise.

We hope that this guide will help you to build on your existing successes.

Care audit – an overview

> *"Evidence-based practice tells us that quality is best achieved by teams reflecting in a structured way on the service they currently provide and then on how it could be developed."*
>
> **Social care governance: a workbook based on practice in England *SCIE Guide 38* (SCIE, 2011)**

In this section:

- Different approaches to quality improvement
- Care audit and performance monitoring
- Care audit quality cycle
- Benefits of care audit
- Challenges to undertaking care audit – and solutions

Different approaches to quality improvement

Many organisations have already established systems and processes to assure and improve quality. We talked to several charities, and found that *United Response*, a national charity that supports people with learning disabilities, autism, mental health needs, and physical disabilities, have a user-led peer review process, with trained, supported service users who carry out inspections of services. *The Brandon Trust*, a UK charity working throughout Southern England to support people with learning disabilities, uses 'quality champions' across their organisation, with a whole systems management approach driven by pursuit of quality, and *Macintyre*, a national charity providing learning, support, and care for children and adults with learning disabilities, recruit to a personality profile based upon feedback from people who use their services.

Quality improvement approaches such as these must be shared, and SCIE'S *good practice framework (SCIE, 2010b)* provides a template to record and share initiatives across services.

You are probably already applying a range of methods to assure and improve quality, such as:

- Activities focused on assuring compliance with statutory frameworks – such as the *CQC's Fundamental standards (CQC, 2017a)*
- Ongoing monitoring and improvement processes – such as staff supervision, surveys of people who use services, and peer review
- Episodic activities, such as research
- One-off activities, such as Serious Case Reviews
- Activities to ensure good use of resources, focusing on service uptake and utilisation – for example, analysing use of day services, rooms and beds, length of stay, repeat use of services, and meeting financial targets

With different functions and contexts, all of these activities are valuable in assessing standards of practice as part of the overall range of activities available to assure and improve quality of care.

If you are involved in one or more of these activities you already have an understanding of quality improvement, and many of the skills to undertake care audit. Care audits move beyond measuring compliance, throughput and service use, and examine multiple cases and incidents to give a broader understanding of the quality of your services and how to improve them.

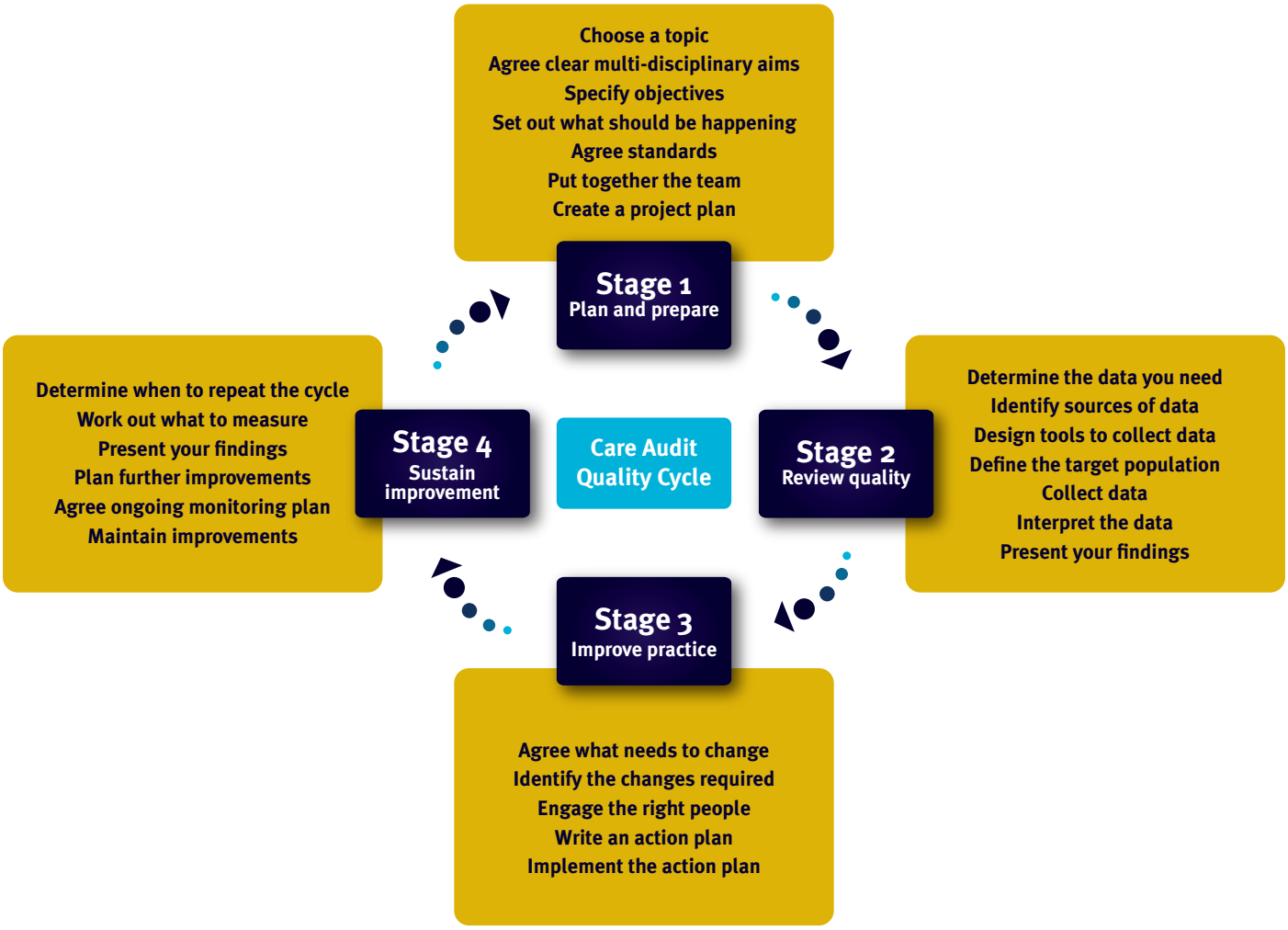
Care audit and performance monitoring

Care audit provides a system for assessing how well services meet evidence-based standards, and is therefore sometimes confused with performance monitoring. Unlike contract-monitoring and compliance activities which check performance, care audit focuses on achieving incremental, evidence-based quality improvement through an ongoing cycle that need not stop once you have hit a performance target or CQC standard.

Care audit quality cycle

The care audit quality cycle highlights how services you provide meet evidence-based standards, highlights how services might be improved, and ensures, through robust action-planning and further audit, that you implement the changes needed to improve care and outcomes for people who use your services.

The care audit quality cycle for service improvement has four stages:



The care audit quality cycle

Key stages of the care audit quality cycle

Stage 1: Plan and prepare

Preparation for a care audit as part of an ongoing quality improvement cycle:

- Determine which quality problem you will audit, e.g. a known risk to people using services, or to staff, a high cost or high volume activity, or incident or complaint trend
- Agree the criteria and standards of quality you aim to measure against
- Involve people who use services, and other interested parties, in setting your objectives, standards, and the processes you will you use

Stage 2: Review quality

Data collection to review quality may be quantitative, capturing numerical data, or qualitative, capturing people's experiences, to check whether standards are being met:

- Determine the data you need to understand whether you are meeting the standards identified, e.g. to check nutritional care, one might use the criteria 'All staff assisting people with their meals must have appropriate training to ensure people are given the time, help and encouragement they need to eat the food provided'
- Prepare appropriate data collection form or system, and pilot before use
- Collect the data
- Analyse the data, to determine whether or not you are meeting the standards set, and if not, why not

Stage 3: Improve practice

Understand where and why performance is not as good as it should be, agree how it can be improved, and develop and implement changes:

- Discuss the results with all those affected and develop a consensus on what needs to change, e.g. in the case of nutritional care, you might find that few staff have appropriate training and agree that the organisation should ensure staff are trained relevant to their role
- Agree how to address all issues identified, taking into account what is likely to be effective, feasible and affordable
- Prepare an action plan to address the issues, using a variety of methods designed to achieve better compliance – such as training, protocols, checking systems, e.g. in the case of nutrition, appetising food, provided in an environment conducive to eating well
- Identify those responsible for making sure that each required improvement action happens
- Implement agreed changes and ensure people take responsibility for the actions assigned to them in the plan

Stage 4: Sustain improvement

Everyone with responsibility must ensure the changes they make lead to improvement, by reviewing changes over time in order to sustain them:

- Integrate approaches to sustain improvements in the way the team, department or organisation works
- Agree dates for further or ongoing review or data collection, considering how long it will take for changes made to impact upon people using services
- Review performance further when changes have been made and time has elapsed, repeating the review as required and appropriate for continual improvement
- Make sure the benefits of care audit are experienced by the people who use the services, e.g. in the case of nutrition, this might mean comparing people's nutritional status after changes have been made, to that at the outset of the audit

Benefits of care audit

Care audit can bring a range of benefits to people who use services, and to staff, and can improve business performance:

Benefits of care audit for people who use services, staff, and performance

The care audit quality cycle enables providers to demonstrate whether care and treatment meet agreed standards, and where to make, and manage, changes to improve quality. Care audit is simple and flexible enough to be used in any social care environment, irrespective of organisation size, from a single home, to a large national provider organisation. It requires no external input and is most effective when carried out by existing staff as part of reflective practice.

The care audit process helps to build motivation and team-working among staff and the people who use services, as it:

1. Supports personalisation of services

- Care audit is focused on improving experience and outcomes for people using services, whether their care is delivered in a registered home, at their own home, or in other settings
- It empowers people who use services, and their carers, through involvement in every stage of the care audit process, from identifying topics to suggesting improvements, and by providing meaningful information that people who use services can use to make choices

2. Supports staff development

- Care audit empowers staff, as change is driven from the frontline, where staff are responsible for proactively driving the ongoing quality improvement process
- Staff are motivated by care audit champions who proactively identify and share best practice and improvements in quality, as opposed to the reactive focus on serious events when things go wrong, which tends to highlight failure and can lead to blame
- It supports supervision, training and development, as involvement in care audit supplements supervisory and performance management activities, and helps staff to identify their development needs

3. Supports business activity

- Care audit can boost business performance, improving the understanding of service strengths and weaknesses, enabling organisations to make more informed choices about where to target funds
- It offers credible information on the quality of services provided, which organisations can use to reassure people who use their services about the value and quality of provision, and to confidently promote their services to new audiences
- It adds commercial value, as a marker of ongoing service quality improvement, through activity undertaken by existing staff with appropriate training and support, without the need for additional external input or resources

4. Supports existing systems

- Care audit helps organisations to demonstrate how they meet regulatory requirements, with the added benefit of focus on improving quality
- It is simple and flexible enough to be used in any social care environment, and can be used irrespective of organisation size, whether across a small local organisation, multiple services within an organisation, or multiple organisations at national scale
- It emphasises incremental improvement of existing processes, driven by those closest to services – the people who use them and the staff who provide them – rather than radical, imposed service redesign

5. Supports service integration

- Care audit improves inter-professional collaboration, as the emphasis on collective team responsibility helps develop a culture of open learning, to analyse errors before harm occurs, without fear of blame
- It identifies restrictive practices requiring improvement, where people who use services, and staff from a range of teams, reflect upon how practice can be adapted to improve access, experience and outcomes

Challenges to undertaking care audit – and solutions

If your organisation is new to care audit you may meet some initial challenges, and many of these are listed below, along with potential solutions:

Challenge	Solution
Lack of expertise	Care audit can be undertaken by existing staff who already have many of the skills required. As more audits are undertaken, individuals and organisations also develop expertise. This guide provides comprehensive support to enable you to work through a care audit. We have also recommended other sources of information and guidance that will help you to build your expertise.
Lack of management support	You will be more likely to gain management support for care audit if you can demonstrate that the topic you have chosen to study is locally relevant, with clear and achievable objectives.
Lack of data	Sometimes you will be interested in an aspect of the service where data is not routinely collected. Sometimes you can use proxy measures, and sometimes you will need to design a new tool to collect data. This guide will help you to develop ideas when there is no obvious source of data.
Fear the findings will be used negatively – e.g. to blame people	Throughout this manual we emphasise the importance of care audit as a transparent process undertaken in partnership between staff and people who use services. In this way, staff should own the findings of care audit, and take responsibility for implementing solutions. Care audit is not about blaming, but about sharing responsibility to improve services before harm occurs.
Perception that it is mundane	Care audit may be perceived only as collecting data, yet it is about engaging team members across disciplines, and people who use services, to change practices for care quality improvement. We challenge anyone to find that mundane.
Perception that it will not make a difference	The difference that care audit makes is through collecting and analysing data specifically to implement changes required to improve the quality of services delivered. Improvement is fundamental to the exercise.
Problems identifying or agreeing what is best practice	Where there are no national standards of best practice from which to devise audit criteria, managers, people who use services, their carers, staff, and community groups, can work together to agree their own standards and criteria for measurement.
Concern that it is expensive to carry out	Care audit can be undertaken by existing staff, who may need to be released to undertake the work, or it can be built into day-to-day practice to minimise disruption, though those leading may initially need training and support. Continual quality improvement is essential to safe, effective, and efficient care, and with improvements made, is in the long term an investment.
Concern that it will lead to additional costs to the service	Many changes that improve services can be made at little or no cost, and may save money. However, care audit may well identify training needs or other developments required to support high-quality services. Investment in such developments is likely to be offset by improvements to service delivery, leading to better outcomes and potential cost savings with enhanced business performance.
Confusion over care audit, performance monitoring, and research	Care audit focuses purely on making specific improvements to services for and with the people who use them. Improvements might be small changes that make a big difference. Performance monitoring, however, ensures compliance with targets, often imposed by external agencies, while research sets out to test a scientific hypothesis.

Stage 1: Plan and prepare

"Frameworks for ensuring quality must be sufficiently sensitive to allow for individual variation, afford a degree of specificity so that meaningful empirical indicators of key concepts can be identified, relevant to all groups of people who receive or provide care, conceptually accessible and capable of practical application."

Quality of life in care homes: A review of the literature, My Home Life (Owen T., Meyer J. et al 2012)

This section provides guidance on how to:

- Choose a topic
- Set criteria and standards for what should be happening
- Put together an audit team
- Create a project plan

Naturally, a care audit will run more effectively if you spend time planning and preparing.

Tip

From the outset, any audit activity must be backed by senior support. An organisational lead committed to the project can share responsibility for implementing change as a result of findings, and ensure that key messages are communicated across the organisation.

1.1 Choose a topic

At a national level, the *CQC's Fundamental standards (CQC, 2017a)* describe the care people should expect, and prompts for providers to consider in terms of quality monitoring. Also nationally, NICE set a range of *guidance and quality standards (NICE, 2017)*, covering evidence-based, high-quality care to support health and social care practitioners and commissioners in optimal service provision. However, a programme of care audit should work beyond national requirements and initiatives, to address issues that relate specifically to the local population, those in receipt of care, and the services provided.

The care audit approach allows you to choose topics for review that are a priority for you. Topics can arise through feedback from people using your services, from care professionals, from emerging evidence, service objectives, risk management systems, complaints processes, incidents arising, or national strategies.

The impetus for a topic can be the perception that people who use services are not receiving an appropriate level of care and have a right to better services. Care audit is a tool to improve poor practice caused by ineffective systems and processes, and unchallenged customary behaviours.

Key points: Choosing a care audit topic

1. **Consider whether there are any factors that make a particular topic a priority; a topic might be a local priority because:**
   - It involves high cost, volume, or risk to people using the service or staff
   - There is evidence of a (serious) quality problem, for example complaints
   - You believe there is significant scope for improvement
   - There is the potential to improve outcomes for people using the service
   - There is the potential to improve efficiency
   - The topic is of key professional or stakeholder interest
   - There is NICE guidance, or a NICE quality standard, relevant to your work
   - There is associated legislation or a regulatory requirement
2. **Consider the practicalities of reviewing the topic you are proposing; it will help if you choose a topic where:**
   - There is good evidence available about the standards your services should meet, for example, the evidence underpinning a NICE quality standard
   - There are reliable sources of data readily available for data collection purposes
   - Data can be collected in a reasonable time period, which should be scheduled to ensure it is achievable
3. **Ask people using your services, and stakeholders, which topics they think you should look at:**
   A vital step in choosing a topic is consulting people who use services, their carers, professional staff, support staff, managers and those of linked services. In this way you may identify areas of concern that have not been picked up through other mechanisms, such as complaints processes, but which are worth looking into.
4. **Make sure the topic you choose is genuinely a local priority:**
   Don't just choose a topic because it looks easy to study, there are existing criteria to review against, or it's a big national issue – these factors may not make it right for you. If you are confident, for example, that an area of national interest is one in which you deliver well, but there are other issues of concern to you and the people who use your services, review those first.

Case example: Choosing a topic at Sunnytown Care Home

Staff at the Sunnytown Care Home talked informally with residents and their families about areas of care they thought might be improved. The topics they raised were:

- Provision of en-suite bathroom facilities to all rooms
- Refurbished communal areas, as these were felt to be tired
- Improved nutrition, such as availability of food between meal times and more support for those who needed help eating

The manager spoke with care coordinators at the local authority and heard they were considering asking all service providers to demonstrate the quality of their food and nutritional packages. This was because:

- There was compelling evidence from a variety of sources indicating that provision of adequate food and drink is a problem in residential care
- The national Nutrition Action Plan described the high incidence of malnutrition in the care home sector, and stated that many people using health and social care services do not feel that they are well supported when eating and drinking

Thinking about the practicalities of undertaking a care audit, staff felt that standards relating to food and nutrition could be created using a wide variety of relevant guidance, including *Meeting quality standards in nutritional care*, *British Association for Parenteral and Enteral Nutrition (BAPEN) Toolkit, 2010*, the *CQC Fundamental standard for 'Food and drink'*, Regulation 14 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Meeting nutritional and hydration needs*, and *Still Hungry to Be Heard*, (Age UK, 2010).

Taking into account the views of people using the service, their carers and the local commissioner, research about the risk of malnutrition in care home residents, and how easy it would be to develop standards to measure practice against, staff decided to undertake a care audit focusing on the nutritional care of residents.

1.2 Set explicit criteria and standards

In care audit you need to review your performance against clearly defined, measurable criteria that:

- Act as quality standards, which state what should be happening for the people who use your services
- Determine to what extent you are meeting the performance level or standard you have set

Where possible, criteria should be based upon best practice taken from the current evidence.

Key terms

There are many different definitions of the terms 'standards' and 'criteria', none of which are necessarily right or wrong. Here are some you might find helpful:

Criteria:

A **criterion** is a measurable outcome of care. **Criteria** (plural) specify required resources and activities that help to achieve a standard of care, and act as measurable statements of what should be happening.

Tip: It is important that criteria are specific, measurable, and achievable. For example:

'People who use services are fully involved in their own risk assessment, as are any other people they may want to be involved, such as a family member or independent advocate/representative', or *'People who use services receive a copy of their risk assessment report'*.

Standard/performance level/target:

An **overarching standard** might be a broad quality objective, for instance: 'NICE quality standards consist of a set of selected statements and corresponding measures that together provide markers of high-quality care'.

A **descriptive standard** might look something like the statement below, and will be supported by measurable criteria. For example: 'Feeling safe and secure: people who use services take responsibility for their own actions, secure in the knowledge that the service has proper systems in place to protect their interests'.

Explicit and quantifiable **performance levels** or **targets**, often expressed as percentages, show the degree of compliance you are expected to meet with specific criteria. For example:

Criterion:

'People who use services are told by staff about the need for insuring their personal belongings'

Performance level/target:

100%

Tip: Sometimes only the term 'standard' will be used to mean the criterion, performance level, or target, for example: '100% of people with special dietary needs will have their care plan updated within a 12-month period'.

The important point here is that the audit team agrees on the definitions of terms to be used. This will prevent confusion and increase clarity when setting criteria for the aspects of care that are going to be measured.

Standards and criteria are often described in terms of:

- Outcomes (what you expect to happen as a result of your interventions)
- Structure (what you need to have in place)
- Processes (what you do)

Outcome criteria

Care outcomes matter, because ultimately everyone using and providing care services wants to see the conditions and circumstances of individuals in receipt of care improve. However, there is sometimes only potential for limited improvement in terms of outcomes, and social care services work towards other person-centred standards, such as maintaining wellbeing, dignity, and quality of life.

Care outcomes are rarely generalised because they are different for every individual, both within, and across care groups. Often, outcomes are aspects of personal attainment set by people who use services. They might range from being able to attend a day centre once a week, to being able to keep a pet, independent living, keeping a job, maintaining a relationship, or achieving a qualification. With such personalised outcomes, a satisfactory outcome for one person using a service may well be different for another.

Sometimes we can use proxy measures for outcomes. This is when there is a strong link between an activity and the outcome you are trying to achieve:

Examples of proxy measures used to support desired outcomes

Outcome that is desired	Proxy measure
Substance user achieves stability in using alternatives to street drugs	Substance user is receiving and maintaining a methadone prescription
Person has control over their eating and has established stable eating patterns	Person is eating three balanced meals every day

Outcome criteria reflect the individual's experience of the care they receive. In settings such as residential care homes, there are standard sets of outcomes that can be measured using criteria that reflect common and shared expectations of care for anyone using such services.

A useful source of criteria is the publication *Measuring Progress: Indicators for care homes (PROGRESS, 2010)*, by PROGRESS, the EU programme for employment and social solidarity 2007-13. This contains a validated list of 94 result-oriented quality indicators, hints and support on using the indicators in practice, and how to apply them with focus on improving quality of life for residents in care homes. The handbook is relevant to all who live, visit and work in or with, care homes: management, staff, residents and their relatives, public authorities, inspection agencies and policy-makers.

Structure criteria

Criteria that concern care structure refer to physical attributes and resources needed. They may include:

- Numbers of staff
- Staff skill mix
- Organisational arrangements
- Provision of equipment and physical space
- Client records

Although an effective structure to support care does not necessarily mean quality of care is high, it increases your ability to provide the best care possible. An effective structure provides tangible evidence that factors enabling high quality are in place, and implementation of these factors is more straightforward, and can be measured.

Case example: Setting explicit structure criteria at the Sunnytown Care Home

The team at Sunnytown Care Home identified eight criteria relating to the physical attributes of the service and the resources they needed for optimal nutritional care. These were:

1. The menu is written in plain English with availability in other languages or pictorially where required.
2. Timing of meals takes into account people's normal dietary patterns.
3. Protected meal times are in operation, with an environment conducive to eating and drinking being maintained at all times.
4. People are provided with the correct tableware, including modified cutlery and any other equipment that facilitates independent eating and drinking.
5. Facilities are available to store food brought in by friends or relatives.
6. Staff are aware of people's personal food preferences.
7. Relatives and friends are encouraged to provide support at mealtimes.
8. Assistance with using toilet facilities and handwashing is offered prior to eating.

Process criteria

Process criteria focus directly on the actions and decisions taken by practitioners together with people who use services. These actions may include:

- Communication
- Assessment
- Therapeutic interventions
- Record-keeping and documentation handling

Process criteria are important as they directly influence outcomes for people using services. Using process criteria encourages teams to concentrate on the things they do that contribute directly to improved outcomes, which are necessary to maintain wellbeing, dignity, and quality of life.

Case example: Setting explicit process criteria at the Sunnytown Care Home

The team at Sunnytown Care Home identified four standards relating to the process for meal times that would help ensure optimal nutritional care. These were:

- Nutritional screening, using a specified tool such as the *Malnutrition Universal Screening Tool*, *MUST*, developed by the British Association for Parenteral and Enteral Nutrition (BAPEN, 2017), completed on admission and reviewed at predefined intervals thereafter
- All residents have a nutritional care plan that relates to the results of the nutritional screening
- People have any special dietary needs met, or dietary supplements that they require
- All people with swallowing difficulties receive advice from a suitably trained professional on the appropriate modified texture for food and drinks

Sources of possible evidence/knowledge

Where do you find criteria for current best practice? Within guidelines, research papers, national frameworks, commissioner specifications and user charters, to give a few examples. There are many ways to find current best practice to create quality criteria to be measured through care audit:

1. Evidence-based guidance

Up to date, evidence-based guidance provides objective and explicit statements of what should be happening to clients for specific service areas. There are local, national and international sources for such criteria, and standards can easily be found by searching the internet, and through organisational libraries such as that at *SCIE*.

SCIE is a useful source of best practice. In addition to the wide range of resources on the SCIE website, it also uses a *Good Practice Framework* – an online facility to help social care professionals share their examples of best practice.

The NICE libraries of *guidance and quality standards for social care* also provide criteria for a growing range of topics.

2. Up-to-date literature searches and research

Where there is no national (or local) guidance available, a literature search of specific journals or quality reviews of practice can provide up-to-date evidence to generate criteria and standards.

3. Local consensus

Where there are no national agreed criteria or best practice standards in the sector as a whole, managers, people who use services, their carers, associated local community groups, and staff, can work together to agree their own criteria and standards for measurement. The process to agree such criteria must be robust enough so that the criteria or standards created can be justified.

Setting the performance level

You will often be able to use existing agreed criteria for quality improvement, but may find that you need to set the performance level – the degree of compliance with the criteria that you wish your services to achieve. For example, you might agree a criterion that *'On every domiciliary visit, the continence management of the person receiving care is reviewed'*. Therefore, your criterion is that all people receiving domiciliary care have continence management reviewed every visit - perhaps with a performance level of 100% compliance.

However, it is not always straightforward to determine a reasonable level of compliance with criteria, and the most appropriate performance level or target. Setting the level too low may mean that you fail to identify issues in quality of care, and miss opportunities to improve. But setting the level too high can also be problematic if this is not realistic, necessary, achievable, or reflective of best practice.

For example, in a learning disabilities day centre, staff will want to support and meet the communication needs of all people who use their services. For the **criteria** 'Communication needs are regularly assessed and reviewed by an appropriately qualified professional, such as a speech and language therapist' you might set a **standard** of '100% of cases assessed each week'. If you are satisfied that evidence suggests regular checks are essential, and that all carers will be able to offer this level of service, then 100% compliance may be required. But will all cases be seen each week? Through travel difficulties, sickness, cancelled appointments, hospital admissions, holidays, and so on, you may miss this target. Therefore the standard set – the performance target aimed for in terms of compliance with the criteria – may need to be lower to take account of these challenges. You need to make sure that you set a realistic target that allows for such factors.

Another reason for setting a target of less than 100% is where an initial data collection identifies a large gap between current practice and the best practice standard of 100%. In such cases, improvement may need to be brought about incrementally, with targets introduced at a lower level and increased with each data collection round. It is important that targets are achievable, or staff morale may suffer as required improvements feel unattainable.

Targets must also take into account the safety and wellbeing of people who use services. Where a standard is essential to safety and wellbeing, for example, safe medication storage and availability, infection control processes, equipment maintenance, etc., both professional and legal duties can dictate the need for 100% compliance with standards.

Key points: Stages in setting your criteria and standards

Working with criteria and standards means goals must be set that are measurable. Of course, standardisation needs to be balanced with diversity and flexibility.

1. **Look for existing criteria:**
   You can find criteria in guidelines, research, national standards frameworks, commissioner specifications and user charters.
2. **Involve people who use your services in defining and prioritising criteria:**
   As experts by experience people who use services, and their carers play an important role in determining care audit criteria. They bring their unique perspective, which is central to the care process, present aspects of a service that are important to them, and through first hand experience describe where a service excels or needs improvement. They can identify the criteria to use, prioritise these to reflect levels of importance, and ensure that you use person-centred terminology that is meaningful to them.
3. **Ensure the criteria you create are measurable:**
   Make sure that the criteria you use enable you to measure how well you are doing.
4. **Consider factors influencing the ability to meet criteria when setting performance levels:**
   Setting performance levels means defining the degree of compliance you expect against criteria. This means quantifying a level that becomes the target degree to which your service aims to meet the criteria. You need to ensure you set the performance level or target at the right level, as setting it too high or too low can cause problems.
5. **Seek advice from those with specialist knowledge:**
   This is especially important when standards do not exist nationally, where the topic is emerging, or requires contribution from those with specific awareness or a perspective on complex issues.

Case example: Setting explicit standards at the Sunnytown Care Home

Staff undertook a literature search on the internet to discover criteria for optimal nutritional care already available, identifying 15 key publications on the subject. They reviewed each of these and found that the criteria in each of the documents could be grouped into a number of common themes. These covered:

- Organisational policies
- Training and skills
- Availability of expertise
- Assessment of individual needs
- Provision of appropriate support
- Outcomes

Staff decided the most relevant document was *Malnutrition Matters – Meeting Quality Standards in Nutritional Care: A Toolkit for Commissioners and Providers in England* (BAPEN, 2010). Using this, they developed their criteria.

1.3 Put together an audit team

As with all successful projects, every care audit needs a lead or coordinator, with knowledge of the care audit process, and the ability to motivate others. The lead ensures that team members complete their tasks by agreed deadlines, and enables a seamless flow from one stage of the care audit to the next, using SMART objectives, e.g. those that are Specific, Measurable, Achievable, Relevant and Time-bound. Typically, this will be a team leader or manager role, but it need not be. In teams with a number of experienced practitioners or staff, leading a quality improvement project can be a useful development opportunity, or marker of seniority.

Equally important is the working group or team who will be carrying out the care audit. This could well be the whole organisation, or a specific care team.

SMART objectives will help you to write your care audit project plan:

Specific: clearly define care audit aims and objectives in terms of who?, what?, where?, why?, when? and how?

Measurable: aspects of care audited should be measurable, so you know when goals have been achieved

Achievable: make sure your plan is achievable given the resources, knowledge and time available

Relevant: ensure the audit is aligned with organisational priorities and any actions arising are appropriate

Time-bound: define when each audit phase will be completed and allow time to complete the project

Key points: Developing a care audit team

1. **Keep the team as small as possible:**
   Small teams – of those who are 'on the ground' providing the service – make the best teams for carrying out care audit. By keeping the team small you minimise the amount of organisation and coordination required, minimise disruption, and are more likely to achieve consistency in audit approach.

2. **However, ensure you have the stakeholders you need on the team:**
   Particularly in a larger organisation, team members should be representative of all key relevant and associated groups. They can help you plan the care audit, collect information, communicate your findings and make improvements. They might include:
   - People who use services
   - Professional staff
   - Support staff such as receptionists and administrators
   - Managers
   - Commissioners

   If you work in a care environment with nurses or other healthcare professionals, they should be familiar with the audit processes we describe here, especially where your review covers matters of healthcare within the services you provide – for example, covering medication, or wound management. Involving them in a care audit is therefore useful and will bring additional expertise.

3. **Consider the support that team members will need:**
   Team members need training to help them understand how to carry out care audit. This might comprise training sessions of different types, including basic training, practical workshops, and small group or team sessions, possibly built into team meetings. Training need not be onerous – care audit is a simple process, but staff must understand the process in advance of taking part, which may require careful scheduling over a period of time.

4. **Include and support people who use services, and their carers, on the team:**
   People who use services are valuable members of the care audit team, providing a unique user perspective on the care audit. You need to ensure that people who use services are supported and enabled to fully participate. This includes setting out clear roles and expectations, providing any necessary training, and enabling their involvement – for example, through paying expenses – and providing support as required.

1.4 Create a project plan

Key headings for the project plan:

As with all project plans, the plan for a care audit needs to include:

- **Who is involved in completing each task:**
  Allocate roles to individual members of the team to share work fairly and ensure clarity of responsibility
- **What the key tasks are:**
  Break down and clarify each step of the care audit, and associated tasks
- **When each task is due to start and finish:**
  Timetable steps to ensure that all team members know what is expected of them, and help them to schedule tasks into their routine

Key points: Creating a care audit project plan

1. **Availability of staff:**
   It is often a challenge for social care professionals to find sufficient time for care audit, and managers have a responsibility to ensure that time is provided in both large and small organisations.
2. **Predicted costs and savings:**
   You will need to analyse costings, which may include staff time, training, and equipment, and you should also try to identify costs associated with implementing changes to improve practice, and potential savings, for example, returns on investment through increased efficiency.
3. **Time for reviewing performance:**
   Remember to include time for reviewing performance after the team has implemented changes, to ensure sustained improvement.

Case study: Learning from case records audit, Halton Borough Council

Objectives:

Halton Borough Council's quarterly 'audit of practice days' illustrates how care audit is a powerful driver for improving the quality of front line practice and management. A team of auditors, drawn from a cross section of front line staff and senior managers, meets for two days to analyse a random selection of children's cases. The process is sharply focused on learning and includes meetings with social workers and families, as well as analysis of recording. Recommendations from the audit are carefully tracked and outcomes are reported to senior managers and the Halton Safeguarding Children Board.

Method:

Four dates are set over a calendar year, and cases are randomly selected across all areas of work, including family support, child in need, child protection, looked after children, and care leavers. The random selection may be supplemented by audit of specific issues arising from inspections, local or national serious case reviews, research, or emerging practice issues. A recent audit included children in need experiencing domestic abuse. Another audit tested the impact of changes in arrangements for strategy meetings that precede child protection investigations.

All staff have the opportunity to join an audit team, including front line staff, residential staff, managers, and senior managers. Front line staff highly value working alongside senior managers; they describe how it builds mutual respect and trust as 'everybody's equal' and they 'don't feel intimidated'.

The context and focus of the days are explained clearly, and the boundaries of confidentiality and processes to be followed are made clear. During the morning, pairs of auditors use a structured audit proforma to reach and record judgements about the quality of practice over the previous six months. They also agree areas to explore with the relevant social worker during afternoon meetings and, where necessary, fostering and residential staff.

Results:

The audit process has evolved to focus on the child's lived experience, along with the quality and impact of practice. Auditors consider how far the findings of assessments are reflected in actions taken, and whether there is evidence of positive outcomes for children. Recommendations for improvement are made, learning is shared, and implementation of change is ensured by managers.

Conclusion:

Care audit promotes quality amongst staff and ensures reflective practice leads to improvement for people who use services.

1.5 Find out more

The Healthcare Quality Improvement Partnership (HQIP)
The HQIP website has a wealth of guidance and material to support clinical audit in the NHS. Although written for a healthcare audience, it is equally relevant to social care: *www.hqip.org.uk*

The Social Care Institute for Excellence (SCIE)
SCIE's core mission is to identify and spread knowledge about best practice to help improve and transform social care services: *www.scie.org.uk*

The National Institute for Health and Care Excellence (NICE)
The Health and Social Care Act 2012 set out the responsibility for NICE to develop quality standards and other guidance for social care in England. As part of their preparation for taking on this role in April 2013, the Department of Health asked NICE to develop social care guidance and quality standards, together with support for using these in practice: *www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp*

Measuring Progress: Indicators for Care Homes
This publication contains a validated list of 94 result-oriented quality indicators, hints, and support on using the indicators in practice, with focus on improving quality of life for residents in care homes. The handbook is relevant to all who live, visit, work in, and with, care homes: management, staff, residents and their relatives, public authorities, inspection agencies and policy-makers: *www.euro.centre.org/data/progress/PROGRESS_ENGLISH.pdf*

Stage 2: Review quality

"Debates about quality of life may be complex but at their core each person defines quality of life for themselves as individuals. Integral to quality of life is what makes life meaningful, enjoyable and worth living. Any process seeking to enhance it therefore begins with discussion of individual ideas about quality of life, what contributes to this, ways in which it could be supported and the individual's priorities within these."

Quality of life in care homes: A review of the literature, My Home Life (Owen T., Meyer J. et al 2012)

This section provides guidance on how to:

- Determine the data you need
- Identify data sources
- Design tools to collect data
- Define the group whose care will be reviewed
- Collect data
- Interpret your findings
- Present your findings

Reviewing practice as part of care audit involves collecting data that is quantitative, and sometimes qualitative, capturing people's experiences to determine whether criteria are being met.

Tip

Development of carefully produced, clearly written and thoroughly tested data collection tools, such as audit forms, surveys, and questionnaires, leads to more robust information from which to draw conclusions regarding care delivered.

2.1 Determine the data you need

In the planning stage you will have identified clear audit criteria and standards that focus on particular aspects of care. This preparation should help you to define the data you need to collect, to check whether you are achieving the standards you have set.

Key points: Determining the data to collect

1. **Collect only the data you need:**
   It is tempting to gather data the team finds interesting or informative, but which do not relate directly to the standards set, making data collection more laborious, and findings harder to analyse to identify the improvements to practice required. Collecting only the data you need is more efficient and effective.
2. **Collect the demographic data of people who use services only if you really need it:**
   Teams often collect extra data on demographics, such as age and gender, to provide a profile of the population who use the service. However, unless you need this information, e.g. to ensure there are no differences between any particular service-user groups, this is unnecessary.

2.2 Identify data sources

It is worth spending time considering whether the data you need are already collected, and if so, how best to access this. It could be that the data is held on several databases, on paper, or electronically, in different departments, or not collected at all.

In an ideal world, if an aspect of care is important enough to be reviewed, then associated data would be routinely collected and readily accessible. Where this is the case, you can review existing records to see if you are compliant with standards. However, where data is not collected, you will need to create data collection forms.

Potential data sources

- Care/case notes
- Direct interviews
- Surveys/questionnaires
- Admission records
- Unscheduled visits by professionals (e.g. social worker, GP, district nurse)
- Nutrition records
- Medication records
- Discharge records
- Direct observation
- Meeting notes
- Shift/staffing records
- Incident reports – falls, etc
- Cleaning schedules
- Training records
- Visit logs and diaries
- Equipment maintenance records
- Representative interviews
- Emergency admissions

2.3 Design tools to collect data

If the data you need are not routinely collected, you will need to develop a data collection system as part of your care audit.

Key points: Designing effective data collection tools

1. **Look online for existing surveys or questionnaires before developing new tools:**
   Audit tools related to aspects of care you want to review may already be available online to download. Whilst there are some generally agreed criteria for quality of care and quality of life, it is possible that suitable instruments to audit these criteria have already been produced, or can be easily constructed. There are a number of resources available on the HQIP website that can be adapted for use in different care settings: *www.hqip.org.uk*.

2. **Make sure any tools or data collection forms you develop are clear and easy to use:**
   If you are designing data collection tools, remember they need to be clear and easy to use for consistency in implementation. This means thinking about:
   - Layout, so the tool is simple to follow and flows well
   - Font size, so it is easy to read
   - Terminology, so it is clear and readily understood
   - Length, so people are not deterred from completing it once they have started

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3. **Comply with local and national data protection requirements:**
   When designing data collection tools, ensure you anonymise data and do not collect any information about people using your service that enables a particular individual to be identified, such as:
   - Name
   - Date of birth
   - Address
   - Postcode (although the first part of a postcode is acceptable as it allows some analysis of socio-economic grouping)

   HQIP's guide, *Information governance in local quality improvement (HQIP, 2017d)*, is available on the HQIP website: *www.hqip.org.uk*.

4. **Pilot test any data collection forms, surveys, or questionnaires, before use:**
   The best way to find out if people can understand your data collection form, survey, or questionnaire, and whether they are likely to complete it, is by pilot testing it, requesting feedback on wording, layout, and length, and reviewing data collected for consistency.

Case example: Designing a data collection tool at Sunnytown Care Home

The team planned to audit whether people were being provided with appropriate support to eat. As one measure of the support provided, it was important to ensure that the residents themselves felt well supported to eat. One of the audit criteria was therefore 'Residents feel they receive the support they need to eat'.

The team developed a survey for residents, including a question to help them assess this. They pilot-tested the question 'How well supported do you feel to eat?', but found that not all residents understood the question, and that responses were extremely varied and did not generate the information that would enable them to express how well they were doing in this area.

As a result of the pilot test, they revised the question to become: 'Do you have enough support to eat, yes or no?' The team agreed that the standard they wanted to achieve was for 100% of residents to feel supported.

2.4 Define the group whose care will be reviewed

You may find that the large number of people who use your services precludes the audit of everyone's records. Sampling is a useful way to reduce the amount of data collection you need to do, using a representative sample of units (such as care homes, people who use services, or records) from the services you provide, to generalise your results back to the wider group from which they were taken.

Key points: Working out your sample for care audit

1. **Ensure sample size is manageable but representative:** If you decide to use a sampling technique, you need to strike a balance between the amount of time and energy it will take to collect the data, and ensure your sample size is sufficient to accurately reflect your entire target population.
2. **Avoid a sample that may skew results:** There is of course no such thing as a perfect sample, so a practical approach is required, for example, if your 'most difficult' or 'least busy' day is a Thursday, it's probably unrepresentative to choose that day alone to audit your practice. Similarly, days after Bank holidays, Friday afternoons, weekends, and records of only women, or only men, can skew a sample. Query whether a sample seems right from your service, team, and user perspectives.

HQIP's guide, *An introduction to statistics for local clinical audit and quality improvement (HQIP, 2015a)* covers techniques for sample size selection, and is available on the HQIP website: *www.hqip.org.uk*.

Case example: Deciding whose care to review at Sunnytown Care Home

Choosing residents to review care

The team considered whether the care audit should focus on all residents, or whether to take a random sample of residents. Since the aim was to identify aspects of care that could be improved, they agreed that the sample should be weighted towards residents for whom nutritional care presents greater challenges. This included those at higher risk due to other factors, for example, physical ill-health, or those 80-plus years of age.

Choosing staff to review care

The team agreed the selection of employees to complete staff questionnaires should be based on 'quota sampling' (i.e. self-selected quotas for staff at different grades). Although random sampling would give a less biased outcome, the team felt it would be difficult to administer, and likely to achieve a low return rate. While the responses from a self-selected quota were likely to be biased towards staff with an interest in nutritional care, the team felt at this initial stage of the audit cycle that would have advantages in identifying areas of potential weakness for improvement.

2.5 Collect data

Key points: Supporting your data collection

1. **Brief the team:**
   It is helpful to hold a meeting with everyone involved in collecting data to explain why they will be collecting it, what will be involved and how they will complete the task. You may have identified some pitfalls or discovered useful techniques from the pilot that can be shared with the team. Please see the example briefing and instruction sheet overleaf.
2. **Ensure appropriate confidentiality:**
   You will need to ensure your processes adhere to legal and organisational requirements relating to data protection, confidentiality and consent. There should be no issue if you don't share the data outside of your care setting, and if data is not identifiable to an individual person. Any other releases will need checking carefully, and HQIP's guide, *Information governance in local quality improvement (HQIP, 2017d)*, is available on the HQIP website: *www.hqip.org.uk*.
3. **Make sure you get consent:**
   You should ensure that people give informed consent before completing any surveys or questionnaires. Because social care services are often provided to vulnerable people, they may have limited capacity to give informed consent. HQIP's *Guide to managing ethical issues in quality improvement or clinical audit projects (HQIP, 2017e)* is available on the HQIP website: *www.hqip.org.uk*.
4. **Remember interviewer bias:**
   Where surveys or interviews are used, avoid leading questions that might skew responses.

Case example: Briefing for staff collecting data at Sunnytown Care Home

As a number of staff needed to be involved in collecting data, the service manager arranged a meeting for them all. She also attended a series of meetings held on different days to give all staff the opportunity to hear about and take part in the care audit. At the meetings she handed out a briefing sheet, which was also pinned to the notice board in the staff room, and the resident's board for information.

Briefing sheet for staff collecting data for care audit

Collection methods:

We will use four different approaches to collect data around whether people who use our services are being provided with optimal nutrition and appropriate support to eat:

1. **Review of policies, processes, and resources:**
   This will look at the policies we have in place, the processes we use, and the resources available to us; the manager will undertake this review.
2. **Resident records audit:**
   We will take a random sample of residents' records to review the information we hold about their weight, nutritional needs and food preferences; as this is a lot of work, the manager and senior care assistants will complete it.
3. **Resident questionnaire:**
   This is a short questionnaire to be completed by residents individually, developed in discussion with two residents who are working with us on the care audit; it asks whether they feel they get the food they like, and the help they need to eat it; where residents are not able to complete the questionnaire without help, senior care assistants and resident representatives working with us will help them.
4. **Staff questionnaire:**
   This will look at relevant nutrition-related training that staff have received; we would like as many staff of each grade as possible to complete the questionnaire.

Ethics:

- **Awareness of the care audit:**
  We want staff, residents, and their families, to know that we are undertaking a care audit, and have developed a simple poster for staff and residents, to share information about what we are doing
- **Consent for the resident records audit:**
  We will let residents and their families know that a sample of residents' records will be audited; none of their information will be used in a way that enables the individual to be identified, but we will give them the option for their records to be excluded
- **Confidentiality and consent for resident and staff questionnaires:**
  We have prepared a briefing sheet for staff, and residents, who are all invited to participate, and they will have an opportunity to review the briefing sheet and ask any questions; staff and residents must provide informed consent before questionnaires are completed; if they are willing to complete a questionnaire, they should tick the consent box on the first page of the questionnaire; a member of staff or a relative may assist the resident in completing the questionnaire; resident and staff responses to questionnaires will be confidential

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Data collection process:

Resident records audit:
Residents have been selected randomly using their room number. We have developed a 'tracker form', to make sure we keep track of whose records have been reviewed. Please make sure you fill out the tracker form each time you carry out a review of a resident's records.

Resident questionnaire:
Residents have been selected randomly using their room number. We have developed a 'tracker form', to make sure we keep track of who has completed a questionnaire. Please make sure you fill out the tracker form each time you receive a completed questionnaire. We will not use the information on the tracker form, it is only for the purpose of identifying residents who may wish to meet with the team to discuss the questionnaire further.

Staff questionnaire:
Please ask staff to complete the 'tracker form'. They should tick the sheet to indicate they have completed the questionnaire, and insert their name if they are willing to meet with the team to discuss it.

Collection of identifiable data:
Please note that all information collected on the tools should be anonymous. Important: Please do not record names, dates of birth, or any other information that may identify individuals.

Returning the completed audit tools:
Please ensure all questionnaires are put into the individual envelopes provided, in order to maintain confidentiality. We have put a box in the communal lounge for residents and staff to 'post' their completed questionnaires.

Please ensure all the forms are completed and returned by Friday 10th May.

2.6 Interpret your findings

Once all data have been collected, you need to review it to:

- Determine how close you are to achieving the standard for each of the criteria you set
- Identify where you are not doing well, and decide why this might be

Your analysis will determine if practice needs to change, and if so, how. Analysis can range from a simple calculation of percentages – for example, the percentage of records in which a particular criteria has been met – through to the use of relatively sophisticated statistical techniques. In most cases, it is better to use simple methods to analyse and present your findings so that everyone involved in the care audit process can understand, including those who use services. HQIP's, *An introduction to statistics for local clinical audit and quality improvement (HQIP, 2015a)* covers techniques for local data analysis and presentation, and is available on the HQIP website: *www.hqip.org.uk*.

Key points: 'Reality check' your data

Sometimes results may look odd or fall below the standard you expect; reasons for this include:

1. The sample was in some way unrepresentative.
2. The way the audit standard was written led to the wrong data being collected.
3. Care is being undertaken as it should be, but it is not being recorded properly.

Review of results requires a 'reality check' on reliability. Once you think, objectively, that the results present a true picture of actual adherence to standards, or otherwise, you can make plans to address any shortfalls in care identified to improve the quality of your services.

2.7 Present your findings

To keep momentum you should communicate care audit findings as soon as possible after you have finished collecting data.

You will probably have a broad mix of people interested in the results – including people who use your services and their families, as well as managers and possibly your commissioners – so your findings need to be presented clearly and effectively and in the best format for the audience, to ensure they are accessible to everyone. This will develop a collective understanding of challenges identified, and highlight the changes you need to make (covered in the next section of this guide).

Your audience is likely to include:

- People who use services and their carers
- Care staff within your organisation
- Support staff such as receptionists and administrators
- Managers
- Staff from associated linked services
- Commissioners

Tip

Although circulating and publishing your care audit findings is important, even if this is no more than sending a summary to all teams, you must keep improvement cycle momentum by immediately moving on to the next, most vital stage of care audit – acting upon your findings by implementing change to improve quality of care.

Key points: Presenting your findings

1. **Use different formats to present the findings to different audiences:**
   Different ways of presenting your findings include developing a full written report, giving presentations at meetings, and providing posters that can be displayed in staff and client areas.

   It will help your audience if you present the data clearly, using graphs and charts, backed up with tables using percentages to summarise raw data.

2. **Include stories from people who use services, and from staff:**
   Individual accounts from people who use services and staff are fundamental to understanding experiences and engaging people in improvement action.

3. **Check proposed feedback materials with people who use services on your team:**
   People who use your services, and their carers, can help ensure that your feedback on audit findings is easy to understand. For example, by reviewing written materials they can advise whether these are written clearly, with data and conclusions presented so that they are easy to understand.

4. **Make it clear that your findings are only the starting point for improvement:**
   State that your findings provide the information and context required to plan the changes needed to make improvements to services, e.g. 'this is what we found, and this is how we are going to improve things'.

Case example: Care audit findings at the Sunnytown Care Home

One of the key audit criteria that Sunnytown Care Home used was that: 'the food meets people's nutritional needs and preferences'. The team checked this using four methods:

1. Through a review of policies, processes, and resources, the team found that:
   - There is a policy setting out standards on food services and the assessment of food preferences on admission of each resident to the home
   - Care plans require staff to ask each resident about their food preferences, and record these
2. Through a record-keeping audit, the team found that:
   - Almost all resident records (96%) had the sections in the initial care admission assessment for personal dietary preferences completed
   - 90% of residents have their food preferences recorded in their care plans (although this sometimes read 'no preference given')
3. Through a resident survey, the team found that:
   - Nearly all residents (97%) indicated they were able to choose the food they liked; however, 37% of residents thought they did not always receive the food that they had ordered, and 4% of residents did not feel supported to eat
4. Through a staff questionnaire, the team found that:
   - Most staff (86%) felt that all residents were asked about their food and drink preferences on admission
   - 81% felt that these preferences were recorded and communicated to all relevant staff for all residents
   - 75% felt that all food and drink preferences were reviewed
   - 100% felt that residents were given a choice of food at each mealtime
   - 97% felt that residents receive the dishes they ask for at each mealtime

These results show:

- How people who use services can have different perceptions to staff around the same service; and
- How audit is useful to review what we think we are doing, and whether or not we are actually doing it, to identify improvements required

Case study: *360 Forward*,[ii] Care audit – residents' feedback

Standard:

The resident has a choice of culturally-acceptable food and drinks that meet nutritional requirements:

- Able to agree nutritional needs as a partner in the care planning process as far as capable
- Able to influence variety and quantity of food, and choose meals from a varying menu
- Receives person-centred help with eating and drinking in accordance with needs and abilities

Strengths:

- Most residents are satisfied with the food and like the choice and quality, portion size and assistance provided
- *"There is always a choice, we have a menu at the start of the week. Every day you are asked if you would like what is on the menu or an alternative"*
- Documentation – residents had been consulted about menus on at least one occasion
- Residents appreciate the support of staff in the dining room at mealtimes

Areas for improvement:

- Some residents would like more consultation about menu choices and more notice taken of suggestions
- Some residents would like to see improvements such as more variety in main meals, fewer sausages and stews, and more vegetables
- Some residents receive person-centred help with eating, but at the expense of sitting where they'd prefer: *"I would like to choose who to sit with"*
- One resident is concerned at the inadequate level of assistance in eating and drinking given to dependent residents, and poor food presentation
- Six of nine residents said staff did not ask whether they required their food to be prepared in a particular way *'I would like apples and cucumbers peeled...skin is difficult to digest'*
- *'Night staff...served me a drink lukewarm'*

ii. With thanks to 360 Forward who provided this example of feedback given following an assessment of services against their 360 Standard Framework: www.360fwd.com

2.8 Find out more

Guide to managing ethical issues in quality improvement or clinical audit projects (HQIP, 2017e)

This guide sets out when issues of ethics might arise and how to manage these. Although written for a healthcare audience, it is equally relevant to social care, and available on the HQIP website: *www.hqip.org.uk*

Information governance in local quality improvement (HQIP, 2017d)

Information governance is a framework for handling personal information in a confidential and secure manner, to appropriate legal, ethical, and quality standards. This guide is designed to explain the legislation regarding confidentiality, to ensure you are working within it, to inform you of your information governance responsibilities at each stage of the audit process, to provide best practice guidelines and simple 'do's and don'ts' and to give guidance on advising service users about how their information may be used for audit purposes. Although written for a healthcare audience, it is equally relevant to social care, and available on the HQIP website: *www.hqip.org.uk*

An introduction to statistics for local clinical audit and improvement (HQIP, 2015a)

This introductory guide has been designed for individuals who are new to audit. It aims to explain how descriptive statistics are used to present and analyse audit data, and to provide general principles on how to present statistics clearly and concisely. Although written for a healthcare audience, it is equally relevant to social care, available on the HQIP website: *www.hqip.org.uk*

How to develop a patient-friendly clinical audit report (HQIP, 2012)

This guide is about producing audit reports that can be easily read and interpreted by service users and others who are interested in the audits that organisations are carrying out. Although written for a healthcare audience, it is equally relevant to social care, available on the HQIP website: *www.hqip.org.uk*

Stage 3: Improve practice

Alongside the regulatory structures that ensure that the appropriate environment is in place, processes for continuous quality improvement internal to care homes offer an approach to move standards beyond the bare minimum while tailoring the environment to the needs and preferences of those living in it."

Quality of life in care homes: A review of the literature, My Home Life (Owen T., Meyer J. et al 2012)

This section provides guidance on how to:

- Develop a consensus on what needs to change
- Identify specific improvements required
- Engage the right people in making changes
- Write an action plan for improvement
- Implement the action plan

Service improvement requires that we understand where and why practice is not as good as it should be, agree how it can be improved, and develop and implement changes designed to address shortfalls in care.

Tip

Change management for improvement does not necessarily require extensive project planning – even small scale, simple changes introduced across an organisation in response to care audit findings can impact positively upon care delivery, quality, and efficiency.

3.1 Develop a consensus on what needs to change

Through discussion with people who use services, their carers, your team, and others, based on the findings of the care audit review you need to agree which shortfalls are to be addressed, and how. Identifying areas for improvement from the audit findings should be fairly easy – the real challenge comes in identifying why the problems exist, in order to introduce measures to prevent them.

Key points: Possible reasons for not meeting a standard

1. Staff do not have a consistent, shared understanding of agreed processes, or how service values – such as promoting equality – should be put into practice
2. Staff are not aware of the care that should have been offered
3. Failure in training, induction or supervision
4. Structural or physical issues with your building or organisation
5. Lack of time or resources
6. Reduced performance by specific staff
7. Inappropriate or restrictive value systems

Wherever possible, you should identify care and service delivery problems collaboratively, rather than simply imposing management judgement. Teams need to collectively 'own' problems and feel accountable for developing and implementing solutions, leading to a greater sense of what needs to be improved in terms of processes and systems, as opposed to blaming individuals. Staff can also find it hard to let go of current and often long-standing customary practices, though this can be encouraged by ensuring they are involved in identifying which practices need to change, why, and how.

When care audit findings are complicated and a team is struggling to understand the cause of a care or service delivery problem, more sophisticated approaches such as root cause analysis, e.g. using a fishbone diagram, and asking the 'five whys' (see below), are often helpful to enable you to direct your improvement activities to the root causes of problems.

Key points: Root cause analysis – the fishbone diagram and the 'five whys'

When using a team approach to problem solving there are often many opinions as to a problem's root cause. One way to capture different ideas and stimulate discussion about root causes is to use the cause and effect diagram, commonly called a 'fishbone diagram' (see illustration overleaf). The fishbone diagram helps to visually display the many potential causes for a specific care or service delivery problem, and their effect.

The fishbone diagram also supports a team to determine what to do about a problem. Working as a team to create the fishbone diagram can help bring out a more thorough exploration of the issues behind a problem – which will lead to a more robust solution.

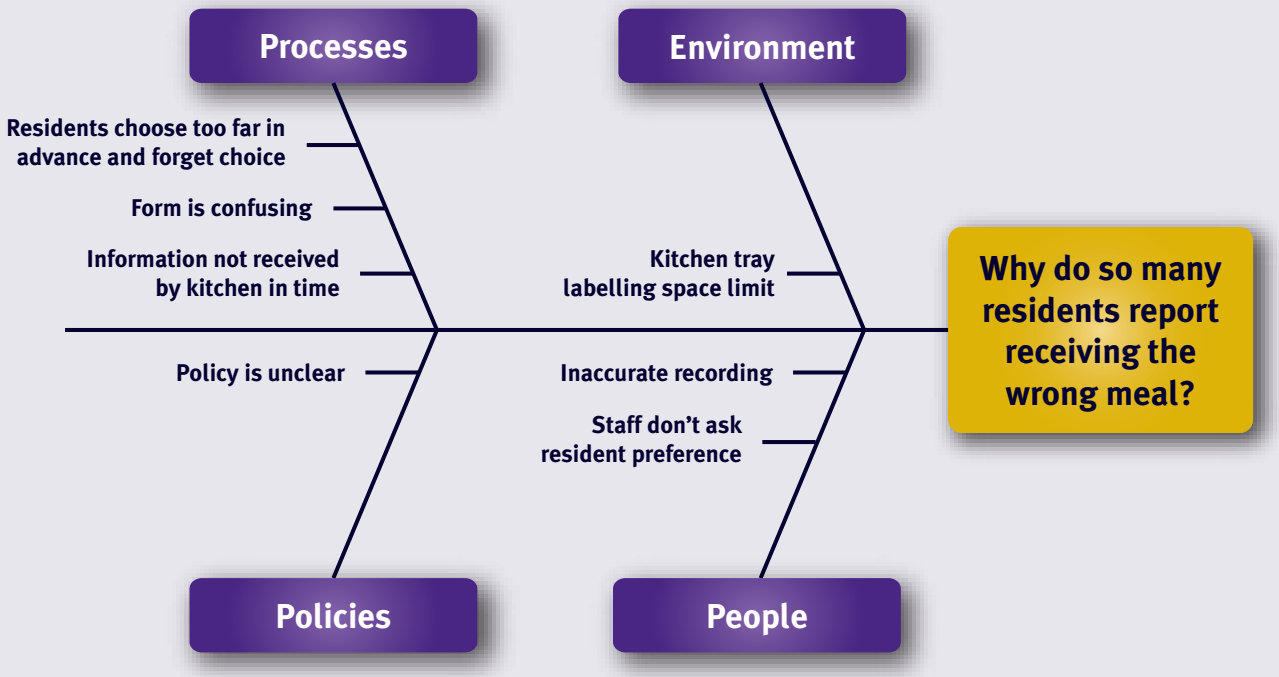
To construct a fishbone diagram, start by stating the problem in the form of a question, such as 'Why do so many residents report not receiving the food they ordered?'.

Framing the problem as a question will help in discussing possible solutions, as each time we ask 'Why?' we get closer to potential root causes, answering questions towards changes required for improvement. Asking 'Why?' five times for each line of enquiry, ('the five whys') can be helpful, e.g.:

1. *'Why do so many residents report not receiving the food they ordered?'*
   Answer: because the food they ordered is not always documented.
2. *'Why is the food residents ordered not always documented?'*
   Answer: because menu cards aren't always available.
3. *'Why aren't menu cards always available?'*
   Answer: because we sometimes run out of stock.
4. *'Why do we run out of menu card stock?'*
   Answer: because no checking system is in place and no-one monitors stock.
5. *'Why is there no system or monitor to check menu card stock?'*
   Answer: because no-one has been asked to design a process or nominated to monitor cards.

Using a whiteboard or similar, the team should agree a statement of the care or service delivery problem and then place this as a question at the 'head' of the fishbone diagram. The rest of the fishbone diagram consists of a line drawn across the page from the head, which acts as a 'spine', and several lines, or 'fish bones', branching from this, labelled with potential contributory factor categories for consideration. Contributory factors are then added to the diagram throughout discussions, until root causes become clear (see case example overleaf).

Case example: fishbone diagram at the Sunnytown Care Home



Once you have a consensus on what needs to change, you can collaboratively set clear objectives for improvement, so that everyone within the team works to achieve the same outcomes.

3.2 Identify specific improvements required

It is incredibly frustrating for staff and others involved in care audit when they identify care or service delivery problems and potential solutions, but nothing is done to bring about improvements. Therefore, identifying changes required and implementing them is important not only to improve the quality of care you provide, but also to show staff that their review was worthwhile, to keep them engaged with the quality improvement agenda, and lift morale with positive transformation for everyone as a result of their care audit work. There is a clear role for management and leadership here, and research has shown that changes are more likely to be successful when they are:

- Non-threatening
- Perceived as being beneficial
- Compatible with current beliefs and practices
- Implemented incrementally

Key points: Changes often made through care audit

Often the required changes identified through care audit fall into the following categories:

1. A new or revised protocol
2. A new or revised checklist
3. Changes to care plan and assessment forms
4. Introduction of stickers or labels
5. Further training, mentoring or supervision
6. Changed shift patterns and team skill mix
7. Clearer service access points
8. Physical changes – layout, design alteration

Although solutions often fall into the categories above, try to think of others to specifically address the issues arising. Sometimes issues lie with a lack of staff confidence or morale, which can lead to team members feeling unable to make suggestions for improvement. For example, staff may need more opportunities to share ideas and agree supportive ways to work together, therefore changes to team meetings may be required.

Not all quality issues are straightforward when searching for solutions – sometimes problems are more deep-rooted and part of a wider organisational culture – for example, failure to show enough empathy or warmth to people who use services. This is a typical finding from surveys of people using services and their relatives, but it cannot be solved by a checklist, and may be the result of entrenched issues for some staff who need more support, supervision and mentoring. Long term solutions might be associated with recruitment and development packages, improved working hours and shift patterns, remuneration and bonuses, organisational structural change, and supportive management processes.

Key points: Identifying the changes required

1. **Involve everyone who will be affected in identifying changes you need to make:**
   Clinical, administrative, and managerial staff experience different stages of a process and are able to offer their individual insights. People who use services and their carers bring another perspective. Involving a wide range of people will help you to identify a broad selection of possible solutions, and will also increase ownership of changes agreed and the likelihood of support to implement them.
2. **Consider how changes proposed might affect people differently:**
   Some changes may affect specific groups of people differently, for example, because of their age, health, disability, gender, race, religious beliefs, or sexual orientation. If this is the case, involve those groups to consider how you can mitigate such effects, and find practical and feasible solution.
3. **Combine long-term, strategic changes with 'quick wins' to build momentum:**
   Sometimes you will identify long-term, more strategic changes that you and your team need to make.
   In this case, it is useful to have some quick wins you can implement easily in the short-term, to get the improvement process started. These help to build momentum and demonstrate that the care audit process is worthwhile. Even modest changes implemented regularly can have a significant impact on care quality improvement.
4. **Don't only propose changes that are obvious and easy:**
   Sometimes problems are complex and deep-rooted, and the real solutions are long-term, such as how you recruit staff, or whole-system deficits in organisational culture. Addressing such problems can be as or more important than making simpler, small-scale changes, requiring realistic goals and timeframes.
5. **Design changes that are 'built in' not 'bolt on':**
   Your changes are more likely to stick if they are 'built in' to or replace current systems and processes, rather than 'bolt on' changes that work outside of, or in addition to, current processes.

Case example: Identifying changes required at the Sunnytown Care Home

The manager ran a series of meetings over a two-week period to give all staff the opportunity to hear about the care audit findings and consider what needed to change. She also invited residents and a number of carers to a small focus group to hear what they thought about the findings, and what would improve things from their perspective. A briefing sheet describing the key findings and requesting feedback was pinned to boards in both common areas and staff areas.

While all issues identified were dealt with as far as possible, staff and residents met to agree the key priority improvements required. These were:

- Reduce the number of residents reporting that they did not always receive the food they had ordered
- Reduce the number of residents reporting feeling hungry between mealtimes
- Increase the number of residents and staff who feel that residents are given portion sizes that reflect their needs and preferences
- Increase staff awareness and uptake of training in nutritional care

Case example: Taking action for improvement at the Sunnytown Care Home

Problem	37% of residents reported that they did not always receive the food they had ordered
Causes identified	• The form for recording people's choices was unclear, so choices were not always accurately documented • Residents were being asked too far in advance of the meal, so sometimes forgot what they had ordered • The kitchen was receiving menu choices for some residents too late
Target	100% of residents to receive the food they ordered
Actions	• Inform the organisation and staff of the findings • Redesign the forms for recording people's food choices • Set clear guidelines for when and how the forms are to be completed • Prepare staff to use the new forms with training • Monitor the use of the new forms and provide feedback routinely

3.3 Engage the right people in making changes

In order to implement changes proposed through care audit, you need to make sure you have the right senior support for the process, a coordinating project lead, and people to actually make change happen.

Roles that need to be performed:

- **Senior sponsor:**
  You need a senior sponsor with both the authority and the enthusiasm to lead change; he or she is not necessarily responsible for the day-to-day management of the process, but will be accountable for the successful implementation of the changes and will ensure that the work is supported at all levels; this person must be able to ensure that the resources you need are available, and must give those implementing change the power to act
- **Change manager:**
  This is the person who manages the improvement process, planning and coordinating the work and monitoring and reporting on progress
- **Change team:**
  This is the group of staff responsible for implementing change; you need to ensure that this team has the confidence of both management and other members of staff and that it has the optimum skill mix; there may be a need to work with external advisors to achieve this, for example, in relation to advocacy for specific user groups, to ensure commitment to changes in practice that may challenge deep-rooted values

3.4 Write an action plan for improvement

Once you have agreed the changes to be made, you will need to develop an action plan to achieve them.

Key points: Effective action plans

Many action plan templates exist, but to be effective they must comprise:

1. **A live document:**
   That can be updated as tasks are completed, or altered when unexpected issues arise so that these can be incorporated into the plan.
2. **SMART objectives:**
   Those which are **S**pecific, **M**easurable, **A**greed, **R**ealistic and **T**ime-bound.
3. **Details:**
   The more detail the action plan contains, the better chance of success in achieving and sustaining change.

Your action plan should include the following:

- **Recommendations:**
  The requirements for change that were identified following analysis of the data collected
- **Objectives:**
  Definite statements that describe what the change project is trying to achieve – written in a way that can be evaluated at the conclusion of the project to check whether objectives were met
- **Constraints/barriers:**
  These need to be identified clearly so that they may be mitigated; your data analysis will have highlighted some of these, but areas of concern such as bottlenecks in the system should be addressed before and during the implementation of changes required
- **Likely cost implications:**
  Include both positive and negative costs
- **Actions required:**
  The activities the team will undertake to make improvements
- **Timescales:**
  Timeframe in which each action will be undertaken
- **Responsible individuals:**
  Names and job titles of key individuals responsible for each action
- **Outcome measures:**
  Need to refer directly to objectives and recommendations, and describe the desired end result, or target, to evaluate how effectively the change has been implemented
- **Monitoring:**
  Identifies who will monitor each specific action; in most cases this will be done either during change team meetings, or by the change manager

An example of a summary care audit action plan can be found overleaf.

Project Number:

KEY (Change status)

1. Recommendation agreed but not yet actioned
2. Action in progress
3. Recommendation fully implemented
4. Recommendation never actioned (please state reasons)
5. Other (please provide supporting information)

EXAMPLE: Care audit action plan

Project title:	

Action plan lead*:	Name:	Title:	Contact No:

*This column identifies who will monitor each specific action. In most cases this will be done in the change team meetings, by the change manager.

Ensure that the recommendations detailed in the action plan mirror those recorded in the recommendations section of the audit report. 'Actions required' should specifically state what needs to be done to achieve the recommendations. All updates to the action plan should be included in the 'Action status' section.

Recommendation	**Actions required** (Specify 'None', if none required)	**Action by date**	**Person responsible** (Name and title)	**Action status** (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendations have not been addressed, costs, etc.)	**Change stage** (See Key above)
The requirements for change identified following the analysis of the original data collection, SMART objectives, and any outcome measures.	*The activities the team will undertake, and any constraints, barriers, or costs.*	*The timeframe in which each action will be undertaken.*	*The names and job titles of key individuals responsible for each action.*	*Include constraints/barriers to improvement to be addressed or circumnavigated.* *Also include the likely cost implications – positive and negative.*	

3.5 Implement the action plan

Implementing change is a challenge – reshuffling resources to achieve improvements, introducing new ideas to increase quality, and ensuring people stick to agreed plans. Some might feel they lack the specific skills to implement major change, and consider using outside consultants, however the simplicity of care audit as an improvement method means that external support is rarely required. If you are a confident senior practitioner or manager, you will already have the skills you need to implement change as part of care audit. Change management requires leadership and engagement, devising improvement strategies, providing space for people who use services, and staff, to agree improvements required – and supporting teams to share the task of implementing them.

Key points: Approaches to implementing improvements

1. **Involve people who use services:**
   People who use services are often keen to help develop improvement strategies if you invite them to. Their stories and perspective are powerful in convincing people of the need for change.
2. **Ensure continuous two-way communication with those implementing the action plan:**
   You need to keep the team briefed as the change process is rolled out, and to be readily available to answer queries and provide advice to staff as they adapt to any changes.
3. **Give the responsibility to change things to all members of staff:**
   Ask your entire team to identify issues, devise solutions, and consider how to implement them. When people buy into the need for change, and potential solutions, they happen, so giving ownership is important – new responsibilities feel lighter to individuals who have helped to create them, and such responsibility builds confidence, developing individuals as well as teams.
4. **Involve managers from other teams in designing and implementing change:**
   In larger organisations, where improvements from one setting are often applied to others, teams may feel that changes are imposed and not reflective of the care they provide. Here, the care audit sample you use is important to demonstrate the validity of your findings to a range of services, and all staff should be involved in designing solutions to share ownership of required change. Involving people from other organisations, for example, advocacy groups, user groups, or resident associations, can also assist.
5. **Keep track of the impact of the changes beyond your team:**
   In larger organisations, changing practice in one team or department may impact upon other teams and departments, and even partner organisations. It is possible that the improvements you make have unexpected effects that are beneficial, but you also need to know if they are causing problems.
6. **Monitor progress to ensure things are getting done:**
   It's crucial that the care audit action plan is monitored, to check that people complete the actions assigned to them to the deadlines given.
7. **Run a forum for staff affected by changes:**
   This can be a regular session where staff can comment on how changes are progressing, share any concerns, and identify ways to improve systems and processes.

Case study: *Voice of the child and young person audit, Bedford Borough Council*

Background:

The audit was launched to explore whether the voice of the child is heard by Bedford Borough agencies during their work with children and families.

Objectives:

The focus of this ongoing audit is to ensure that children are seen alone (when appropriate) by professional staff working with them, and that their wishes and feelings are recorded.

Methods:

Local agency auditors are guided by their own agency's policies and standards, as well as the Bedford Borough Safeguarding Children Board Procedures, and asked to review individual cases selected at random, drawing out key themes for improvement, and providing examples of good practice that can be shared across the agencies. The questions considered in reviewing these documents were:

- Did the young person attend their child protection conference?
- Did an advocate attend with or on behalf of the young person?
- Is there evidence that a discussion was held with the young person (over 12 years) regarding their attendance at the conference?
- For children between 4 and 12 years – were their wishes and views obtained as set out in the Local Safeguarding Children Board interagency procedures?

Results:

Using a rating system, all of the cases were judged as being 'satisfactory' to 'excellent' with none being considered as 'poor'. However, among others, the following areas for improvement were identified:

- Case records need to include analysis of the information obtained via assessment processes which are child focused and reflect the wishes and feelings of the child
- Health professionals need to have age appropriate communications with the child and include these in their assessments
- Acknowledgement that young children can give accounts of their likes and dislikes at a young age, and professionals should engage in direct communications with the child
- All professionals to be fully aware of Gillick competence when assessing children, rather than assuming parents/carers must be present or involved

Conclusion:

The audit has improved the quality of care for children and young persons as it has led to a number of improvements, including the revision of tools available for communication with children and young people, the requirement that assessments that do not have the child's views included should not be signed off, and the need for agencies to consider implementing 'Voice of the Child Champions'.

3.6 Find out more

Guide to using quality improvement tools to drive clinical audit (HQIP, 2011a)

This guide describes how quality improvement approaches can be applied to audit, and specific quality improvement tools that can contribute to the audit process. Although written for a healthcare audience it is equally relevant to social care, and available on the HQIP website:
www.hqip.org.uk

Transforming clinical audit data into quality improvements (HQIP, 2011b)

This practical guide sets out how to check and report on findings, analyse variations in practice and shortcomings in care, and how to plan for improvement. Although written for a healthcare audience it is equally relevant to social care, and available on the HQIP website:
www.hqip.org.uk

A guide to quality improvement methods (HQIP, 2015)

This guide brings together 12 quality improvement (QI) methods, providing an overview of each, and practical advice on how and when to implement them, with illustrative case examples. QI methods covered include clinical audit, 'Plan, Do, Study, Act', model for improvement, LEAN/Six Sigma, performance benchmarking, process mapping, and statistical process control, and it is aimed at all professionals with an interest in QI. Although written for a healthcare audience, it is equally relevant to social care, and available on the HQIP website:
www.hqip.org.uk

Stage 4: Sustain improvement

> *"All of these studies, however, found difficulties in maintaining improvement beyond the period of the project and there is a need for sustainable interventions that become part of the culture of the care home."*
>
> **Quality of life in care homes: A review of the literature, My Home Life (Owen T., Meyer J. et al 2012)**

This section provides guidance on how to:

- Determine when to repeat the care audit cycle
- Work out what to re-measure
- Present your findings
- Plan further improvements
- Agree ongoing monitoring arrangements
- Maintain the improvement cycle

Practitioners, managers, teams and services need to ensure the changes they make through care audit lead to sustainable improvements in the quality of care they provide.

Tip

Improvements are most sustainable when they are built into systems, processes, and care records, turning required change into unavoidable action, automating changes as far as possible, to ensure they are embedded in day-to-day practice.

4.1 Determine when to repeat the care audit cycle

A complete care audit cycle involves collecting data on compliance, implementing changes to address shortfalls identified, and reviewing changes over time to see whether improvements have been made. However, re-measurement, or collecting data on an ongoing basis, is not necessarily the same as repeating Stage 2 of the care audit cycle in its entirety to review quality of practice.

Re-measurement might simply entail monitoring to ensure that changes implemented and revised expectations are adhered to, and that previous practices do not inadvertently recur. To keep practice on track further basic changes may be made, for example, amended shift patterns, extra training, reminders about new protocols, etc. For clarity of communication, you should only re-emphasise necessary adjustments.

However, a large and complex organisation with a number of teams, care homes, or services, might prefer the reassurance associated with repeating Stage 2 of the care audit cycle in its entirety.

Key points: Planning a repeat data collection

1. **How long will it take for the changes you have made to impact upon people using the service?**
   Where the changes you make will immediately affect every person using the service on a daily basis, it may be reasonable to measure their impact after one month; where the changes take effect more gradually, you may prefer to wait between three and six months. However, it can be important not to wait too long, and lose momentum. When results show that changes made are fully embedded and effective on an ongoing basis, after several episodes of data collection, your action plan may be signed off as complete.
2. **How many people have been affected by the changes you have made?**
   When changes have been implemented, you need to plan to collect enough data from across the population to identify how many people, from whichever groups may be relevant, have been affected, and measure the true effect of those changes.
3. **What are the other pressures and demands within the service?**
   It can be helpful to avoid holiday periods that may affect staffing levels, and other times of demand on a service such as annual appraisals, collating year-end statistics, etc., to ensure data collection findings are relevant. However, it can be useful or indeed important to a particular study to ensure services are reviewed at times of pressure, to ensure relevancy, for example, when testing staffing rota efficacy, or the impact of annual appraisals on care provided.
4. **Have the circumstances that led to the initial review process changed completely?**
   At the time of planned repeated data collection the aim of the original review process may have changed, or the processes under review may have stopped for reasons outside of the control of the audit. Therefore, the circumstances that led to the initial review process should be checked to ensure they are still relevant, with adjustments made where required.
5. **Is there enough concern about practice to plan a repeat of the whole care audit cycle?**
   For example, have the triggers for the first audit cycle gone away, such as complaints, or feedback from people who use services, or have they continued?

4.2 Work out what to re-measure

Care audit supports repeated testing and evaluation of small scale changes.

- You should re-measure all criteria where your original analysis showed standards not met to the level set, and where you implemented change or improvement mechanisms
- If new issues or challenges have emerged since your initial review, these can be reviewed alongside the original criteria

For true repeat data collection as part of a care audit cycle, you should use the same processes for sample selection, data collection and analysis as were used originally. In this way, the second or subsequent data sets you collect can be compared with those collected originally, to determine how much things have improved, or otherwise. Although you can't immediately compare data with any new criteria added, you can at least do so in your next cycle.

4.3 Present your findings

Present results to enable comparison of repeated data collections against the standards you have set. The way you present your findings should enable your audience to have a robust discussion about improvements made, or any decline in compliance with standards set, over time, and to make recommendations around what should happen from this point onwards. Discussion of findings as part of a team-building exercise ensures all stakeholders are engaged in the process of making changes for improvement, rather than feeling subject to changes made by others.

4.4 Plan further improvements

If you are exceeding the performance levels you set, you may consider raising them to ensure your performance improves year-on-year. Setting such challenges ensures continual practice development – as long as expectations are realistic, and supported by true cultural engagement.

However, you may not achieve the level you set, and this requires further evaluation and adjustment to practice, as part of the improvement cycle, until desired levels are reached. Benchmarking practice with other organisations or services can help to determine what might be a reasonable performance level to aim for, and what is achievable, while sharing best practice through a variety of local and national forums can also foster improvement on a wider scale.

Key points: Performance levels

1. **Benchmark with other organisations or services:**
   This will help you to determine whether the level you have set is reasonable and achievable.
2. **Identify and implement further changes:**
   If you are confident that the performance level you have set is appropriate, implement further changes to help you achieve it.
3. **Revise the performance level:**
   If it is agreed that no further change can be implemented, or if you feel that the performance level originally set is not achievable, you may agree revised performance levels (unless these have been set at a statutory or mandatory level).

4.5 Agree ongoing monitoring arrangements

Once your team is satisfied with the performance levels achieved against standards set, agree monitoring arrangements to ensure that improvements made are maintained. Arrangements might, for example, comprise an annual review, or ongoing snapshot checks. Routine care data collections, or the care records themselves, can be adapted to ensure continuous monitoring systems are in place.

4.6 Maintain the improvement cycle

You want to ensure that hard-won improvements are maintained and reinforced successfully over time, and there are a number of ways to do this:

1. **User-friendly systems and processes:**
   Ensure changes implemented fit with preferred practices, and complement effective procedures and processes already in place.

2. **Incorporate routine review into meeting agendas:**
   Change is more likely to be sustained where care and services delivered are subject to audit and discussed and revisited at regular intervals, such as through follow up as standing meeting agenda items. Regular review provides the opportunity for staff and other stakeholders to raise issues, and to share positive feedback, motivating staff, and acknowledging efforts to improve care.

3. **Make changes visible:**
   Change often involves updating or re-writing documentation such as policies, procedures, and protocols that support the delivery of care. However, these important aids to effective practice often sit on a shelf without routine use, so ensure they are visible during care delivery, and turn them into action with reminders throughout routine care recording to help ensure change is sustained over time.

4. **Induction of new staff:**
   Ensure that new staff, or those returning to work, are trained to use new or updated policies, procedures, and protocols, and make sure documentation that supports the delivery of care is visible, accessible and in routine use.

5. **Fine-tune changes made:**
   Initially, changes might appear successful, but after a while, issues can become apparent. It is all too easy to revert back to previous ways of working when problems arise. Staff affected by changes are ideally placed to suggest adjustments, and should be encouraged to report issues and propose solutions to iron out teething problems.

6. **Lead by example:**
   Much of the responsibility for sustaining change lies with managers and leaders who can oversee that change and observe daily practice to ensure that lapses into previous ways of working do not happen. This involves reminding staff of revised practices and the reasons for these, and motivating them to adhere to changes agreed as a result of quality improvement work.

7. **Showcase care audit:**
   Throughout the year, running events at which teams showcase their care audit work, both locally and nationally, promotes an improvement culture, acknowledges successes and reinforces changes made.

Case study: *Dignity in care, Warrington Borough Council*

Background:

There was a general consensus within Warrington Adult Social Care services that residential services provided people with dignity in care, but there was no actual proof to back this up.

Aim:

A working group was formed to look at how dignity in care could be better evidenced, which included service users, staff, and managers.

Design:

National guidance around dignity in care was used to provide standards for an audit, along with comments and complaints made about residential services, which were reviewed for any trends. This led to eight core themes to be included as part of an audit tool: Environment, Privacy, Respect, Personal Care: Bathing, Personal Care: Toileting, Personal Care: Grooming, Communication, and Meal Times. The audit involved a range of evidence collection methods, including written documentation review, observation, witness testimonies, and service user and carer feedback.

Results:

To begin with, staff were shown the audit tool and standards, and all felt that they provided dignity in care. However, when asked to formally evidence this there were areas for improvement. For example, there was no set protocol for mealtimes, so this has now been introduced, whereby service users are asked whether they would like the table laid for dinner, as some people prefer a formal occasion, whereas others favour a more informal style; this new protocol is compliant with person-centred planning, and does not assume a 'one-size fits all' approach. Furthermore, the service user Dignity Champion suggested picture menus, which have been well received by people with dementia. Also, it became apparent that in some instances there was a routine of toileting, and a new protocol was introduced so that all staff understand that people have a choice regarding toileting, and not to make assumptions about timing.

Conclusions:

A dignity toolkit created through the care audit ensures that, going forward, staff tasks are led by service user wishes, and that this can be evidenced. Once the audit was completed, there was a need for further monitoring to ensure that all practice is continually evaluated, so an action plan workbook was developed to support routine ongoing care audit. The workbook was also adapted for day service settings, with plans to roll out the approach to the independent sector via the Residential and Domiciliary Care Forum.

4.7 Find out more

Transforming clinical audit data into quality improvements (HQIP, 2011b)
This practical guide sets out how to check and report on findings, analyse variations in practice and shortcomings in care, and how to plan for improvement. Although written for a healthcare audience it is equally relevant to social care, and available on the HQIP website:
www.hqip.org.uk

Overcoming challenges to improving quality (the Health Foundation, 2012)
This report explores challenges to improving quality that emerged from a synthesis of 14 Healthcare Foundation improvement programmes and evaluations, and suggests ways to overcome them. Although written for a healthcare audience it is equally relevant to social care:
www.health.org.uk

Achieving better outcomes: Involving people who use services, their carers, external advisory groups, and advocates

> *"Involving people who use services and their carers in the decision-making process is fundamental to good practice and acknowledges them as experts in their own lives. They also have expertise of value to others, which should inform policy-making, practice, service review and development, and the setting and monitoring of standards."*
>
> **Social care governance: a workbook based on practice in England (*SCIE Guide 38 (SCIE, 2011)*)**

In this section:

- When to involve people who use services
- Tools and techniques for involving people
- Supporting and enabling people who use services to be involved

Throughout this guidance we have emphasised that you should involve those who use services in care audit processes, and this section provides more detail on how to do this.

Involving the people who use your services to improve them is essential: they are your partners, as those receiving care. Person-centred care planning, self-directed support, and individualised budgets are examples of leadership by people who use services, as they themselves choose and manage their own packages of care in partnership with professionals.

Care audit involves people who use services, and their carers, at every stage, to make real differences to the quality of care for specific individuals, or groups, through co-design and co-production to meet their personal and cultural needs. This drives up standards of practice, challenges norms, and tackles complacent practice that is restrictive of self-determination, or oppressive to people who use services, supporting the development of personalised services for those who use them, and for their carers.

However, the key reason for involving people who use services and their carers in care audit is that it leads to better outcomes for them. Their knowledge, experience, and perspective are important, and can contribute to all aspects of a care audit.

When people who use services are involved in:

- **Defining what quality looks like:**
  Services are measured against dimensions that really matter to the people who use them
- **Assessing how well services are doing:**
  Findings are often broader and more credible
- **Planning how services can be improved:**
  Changes are more likely to have an impact on how people experience care

Most importantly, though, those who use services often feel they benefit personally from involvement in care audit, through being listened to, social interaction, and influencing their processes of care.

Case study: *Changing Our Lives – Quality of Life Audits*

Changing Our Lives is an organisation that supports people of all ages with learning disabilities to speak up for their rights and take control of their lives. It has a team of quality auditors, all of whom have learning disabilities and experience of using care services, who receive regular training around confidentiality, safeguarding, observation skills, and audit. They lead person-centred Quality of Life Audits in a range of services, including residential homes, supported living centres, domiciliary care, and day services.

The auditors judge services against a set of Quality of Life Standards that were written by people with learning disabilities. All of the auditors receive support from an officer from Changing Our Lives to carry out audits, but each audit is always led by people with learning disabilities. A report is produced at the end of the audit with recommendations about what the service can do to improve. The audit team will then re-audit the service to make sure the recommendations have been implemented.

At Sandwell Metropolitan Borough Council, the standards have been written into service provider contracts, meaning that providers are not compliant if they do not meet the standards set by people with learning disabilities.

"The quality auditors provide a clear message to our providers of the importance of going beyond the minimum expectations and advancing the choice and independence of the people they support."

Sandwell's principal contracts officer

When to involve people who use services

Setting the strategic direction of the organisation's programme of care audit

People who use your services, their carers, and potential users of services, can and should be involved from the outset. Any programme of care audit should reflect the latest requirements and directives of regulation and government, but should also reflect local needs and issues from the perspective of people who use services. Organisations such as the *Dementia Engagement and Empowerment Project (DEEP)*, who involve people with dementia in influencing services and policies that affect them, provide useful *guidance (DEEP, 2016)* to make involvement as easy as possible for everyone (with or without dementia).

"It's important to have choice because it's your home, and it's right to have a proper say in who comes in and helps you. It has to be user led – so it's about the person, rather than being management-led."

Pam Newman, Service Manager,
Queen's Park Housing Scheme

Stage 1: Plan and prepare

Key activities in which people might be involved:

- **Deciding which aspect of a service to audit:**
  People who use services and their carers understand which aspects of services work well and which do not, from their first-hand experience and perspective
- **Defining clear objectives:**
  People who use services and their carers can help you to define clear objectives to improve their experience of care
- **Agreeing standards:**
  People who use services and their carers play an important role in determining standards, for example, they can be invited to prioritise a list of possible audit standards to reflect the level of importance to them

Stage 2: Review quality

People who use services are particularly valuable in providing qualitative data around the lived experience of a service, from two perspectives: getting involved in gathering the data and as consultees providing the data.

Key activities in which people might be involved:

- **Designing data collection tools:**
  People using services can help with the design of data collection tools, by, for example, reviewing the design of surveys to ensure that they are easy for service users to understand and to complete
- **Providing qualitative feedback:**
  It is essential you seek the views of people who actually use the service under review as part of any care audit, for example, through surveys, one-to-one interviews or focus groups
- **Collecting qualitative data:**
  As experts by experience, people who use services can help collect qualitative information, carrying out interviews and engaging with others who use your services; people who use your services are sometimes able to talk more openly to an expert by experience, whose background knowledge enables them to explore themes a staff member might not

Stage 3: Improve practice

Key activities in which people might be involved:

- **Helping to develop feedback:**
  People who use your services and their carers can ensure your verbal and written feedback on findings is accessible, with clear conclusions and data that all stakeholders can understand
- **Identifying how practice can be improved:**
  People's direct experience of care gives them a unique point of view about ways to improve the quality of a service, and changes needed
- **Hearing the feedback:**
  It is important that people who use your services, their family, and carers, have an opportunity to receive feedback from the care audit process, to provide reassurance through material evidence that you are continually checking and improving the quality of your services

Stage 4: Sustain improvement

Key activities in which people might be involved:

- **Plan further improvements:**
  People who use your services and their carers can provide a check and balance regarding whether or not changes implemented are effective, or further improvement is required
- **Agree ongoing monitoring arrangements:**
  People's direct experience of care gives them a unique point of view about ways to test the quality of a service, which is useful in developing monitoring arrangements

Tools and techniques for involving people

Existing sources of information

Most services already have a range of information from people who use services, and their carers, that can be used to identify topics for a care audit. Information often relates to users' concerns and may include:

- Emails or letters describing concerns or complaints
- Individual stories or feedback from focus groups
- Direct observations of care
- Direct conversations
- Critical incident reports
- Satisfaction surveys

Community support and advocacy groups

Finding people who use services willing to get involved in care service development can be a challenge. Local community groups provide connections with interested and enthusiastic service users who may want to be involved, with experience of the local landscape, sometimes from 'seldom heard' groups. National organisations can also provide such connections.

Examples include:

- Voluntary and community organisations at a local or national level
- Local and national disease or condition-specific interest groups
- Hard-to-reach individuals, groups or communities
- Overview and scrutiny committees
- Other social care providers
- Advocacy and support agencies and organisations
- Independent organisations

> *"Involvement increases my confidence in the transparency, relevance and rigour of the audit."*
>
> **Dr Sarah Markham, HQIP Service User Network member**

There are a variety of local, condition-specific groups in most areas, for example, for those living with stroke or diabetes. Local authorities have also established *HealthWatch* groups, to talk with people who use services about their experiences and scrutinise how care homes are working.

Advocacy groups work with a wide variety of people who experience difficulty in articulating their views or being listened to. Often, advocacy groups work with a particular group of people, for example, by age, disability, or sexual orientation. Sometimes you may need to involve advocacy groups or advocates to support one or more people using your services to become involved in a care audit, or to share their views. Advocacy groups can also represent the views of people using services where they may find it threatening to challenge practice.

Focus groups

Focus groups are comprised of a small number of people who roughly represent the stakeholders whose views need to be considered for any project. These groups can provide a useful way to gather views at several stages in a care audit, for example:

- When identifying possible topics, by asking people who use services to identify what works for them, and what does not, in accessing and using services
- By meeting routinely during the care audit cycle, to discuss topics, standards, results, monitoring arrangements, and changes required

Supporting and enabling people who use services to be involved

It is just as important that people who use services are properly supported and enabled to participate in care audit, as in other activities. People who use services involved in the process of carrying out a care audit need particular support beyond that provided to those involved only as consultees. Without the appropriate support their involvement will be tokenistic and may lack focus, they won't feel valued, and their skills and experience won't be utilised effectively.

Key points: Supporting and enabling people who use services to be involved

1. **Set clear roles and expectations:**
   People who use services and their carers who are involved in care audit need to know what their role is and what they are being asked to do, including what is expected from them in terms of participation, commitment, and workload, which needs to be widely understood by and agreed with other care audit team members.

2. **Provide training:**
   People who use services who are members of the care audit team should receive any training required to enable them to contribute effectively to the process. Training might include:
   - Assertiveness and 'speaking up' courses
   - Disability equality training
   - Equal opportunities training
   - Confidence-building courses run by service-user trainers
   - Information governance training covering data protection and confidentiality
   - Guidance on purchaser and provider decision-making structures
   - Training in committee procedures and negotiating skills
   - Information about what has and hasn't worked in other care audits
   - Legal issues and rights training in community care and other legislation

3. **Enable people to be involved:**
   There are a number of ways in which you may need to support people to be involved, including:
   - Practical support to get involved: you may wish to provide refreshments, and remunerate people in recognition of the time and work they give to care audit, covering their costs and expenses, including travel
   - Support to play an active role: you may need to provide support to enable people to play an active role, for example, avoiding the use of jargon, or providing other communications support; often, people feel more confident participating when there is more than one person who uses services in their group
   - Working together in different ways: you might involve people in a variety of ways, such as setting up online forums, or giving people the opportunity to participate remotely via email or video-conferencing, rather than only by attending focus groups
   - Support through advocacy groups where appropriate: to assist people who use services to actualise their voice and ensure their views are listened to

Continued on the next page >

4. **Protect client confidentiality:**
   By law you have a duty to keep client information confidential. Where people who use services are involved, you need to ensure processes are in place so there are no breaches of your legal duties to protect confidentiality, or of your own internal guidelines. Access to data about other people who use services must be restricted, and HQIP's guide, *Information governance in local quality improvement (HQIP, 2017d)*, provides useful information on this.
   Information governance training is required, and signed confidentiality agreements should be retained to protect personal identifiable data.
5. **Ensure sensitivity:**
   You need to be sensitive to, and open about, the differences between the values, incentives, and perceptions of people who use services, staff, and other stakeholders.

Helpful organisational policies, protocols, and guidance that may support you in enabling people who use services to be involved in care audit include:

- A volunteer policy (see case example below)
- A confidentiality/data protection policy and protocols
- A serious untoward incidents policy
- An expenses/reimbursement policy

Case study: Swindon People First – volunteer policy

Swindon People First, an organisation for people with learning difficulties, developed a contract setting out clear expectations for other organisations wishing them to take part in their committees:

Swindon People First Contract

If you want People First to be on your committee, you must agree these things to make it OK for us:

- We should have a voice to say what we want
- You need to listen to us and give us time to talk
- We won't come to your committee just so it looks good
- You need to let us know why you want us on the committee
- You need to tell us what we will get out of being on your committee
- You have got to make minutes and agendas available on tape if we want them
- The committee should pay for a supporter
- Everyone on the committee needs to be trained to know how to involve us
- The committee has to use words we understand
- We must be able to stop meetings if we need you to say something again or explain
- Everyone should have their expenses paid – if the rest of the committee get paid then we should too

Find out more

Healthcare Quality Improvement Partnership (HQIP) – patient and public involvement case studies
HQIP has developed a wide range of resources for professionals and people who use services, to support the involvement of service users in audit and quality improvement, including a number of case studies. Although written for a healthcare audience, these are equally relevant to social care:
www.hqip.org.uk/involving-patients/

Changing Our Lives
Changing Our Lives supports people with learning disabilities of all ages to speak up for their rights and take control of their lives. One of their activities is undertaking Quality of Life Audits for individuals and services, using an experienced team of people with learning and physical disabilities, people with mental health needs, and older people, based on a set of Whole Life Standards developed by young people and adults with learning disabilities, physical disabilities, and Autistic Spectrum Condition:
www.changingourlives.org

Social Care Institute for Excellence (SCIE) – dedicated participation pages
SCIE has developed a wide range of resources to support involvement and participation of people who use services and their carers in service development, which can be downloaded from:
www.scie.org.uk/publications/guides/guide17/participation/index.asp

Dementia Engagement and Empowerment Project (DEEP)
DEEP involve people with dementia in influencing services and policies that affect them, and provide useful guidance to make involvement as easy as possible for everyone (with or without dementia), which can be downloaded from:
www.dementiavoices.org.uk

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Care Act 2014: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Carers Trust: www.carers.org.uk

Changing Our Lives: www.changingourlives.org

Dementia Engagement and Empowerment Project (DEEP): www.dementiavoices.org.uk

Health and Social Care Act 2012: www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Healthwatch England: the consumer champion for health and social care: www.healthwatch.co.uk

HQIP dedicated patient and public involvement pages: www.hqip.org.uk/involving-patients/

Macintyre: www.macintyrecharity.org

My NHS: www.nhs.uk/service-search/performance/search

NHS Choices: www.nhs.uk/pages/home.aspx

NHS Digital: collecting data from across the health and social care system: www.digital.nhs.uk

National Institute for Health and Care Excellence (NICE) – Social care guidelines and quality standards: www.nice.org.uk/about/nice-communities/social-care

NICE Library for social care guidance: www.nice.org.uk/guidance/published?tpe=sc

NICE Library for social care quality standards: www.nice.org.uk/standards-and-indicators/quality-standards-topic-library

POhWER: www.pohwer.net

SCIE: www.scie.org.uk

Think Local, Act Personal: www.thinklocalactpersonal.org.uk/

United Response: www.unitedresponse.org.uk

Further information is available at: www.hqip.org.uk

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6th Floor, 45 Moorfields, London, EC2Y 9AE

T 020 7997 7370 F 020 7997 7398
E communications@hqip.org.uk

www.hqip.org.uk

Registered Office: 70 Wimpole Street, London W1G 8AX
Registration No. 6498947
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