GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

# Review of the Quality of Care and Treatment Planning in Mental Health and Learning Disability Services

Audit Completed By Charis Jones & Marie Williams

Presented By Charis Jones & Marie Williams

Date 8th February 2021

# Background and Aims

- 2018 – NHS Wales Delivery Unit All Wales Quality Audit on Care and Treatment planning
- Audit conducted across 3 Inpatient Wards and 3 CMHT’s
- Key findings (Good Practice):
  - Person centred approach
  - Good consideration of outcomes
  - Noted use of case formulations in one team
- Key findings (areas of learning):
  - Lack of consistency with the quality
  - CTP’s not completed in timely manner
  - Lack of patient voice
  - Lack of SMART objectives
  - Inadequately incorporated risk assessment

# Methodology: Audit Standards

- 162 Case notes audited across the 3 localities during September/October 2020
- Data Capture Tool used based on the All Wales Mental Health Measure (Wales) Part 2 Audit
- Review the quality based on 4 rating scale
  - Red: no record/gaps/omissions or evidence in the case file
  - Amber/Red: info but not assured quality is sufficient
  - Amber/Green: info in date but could/should have further detail to inform care
  - Green: info current, informative and provides good and specific details

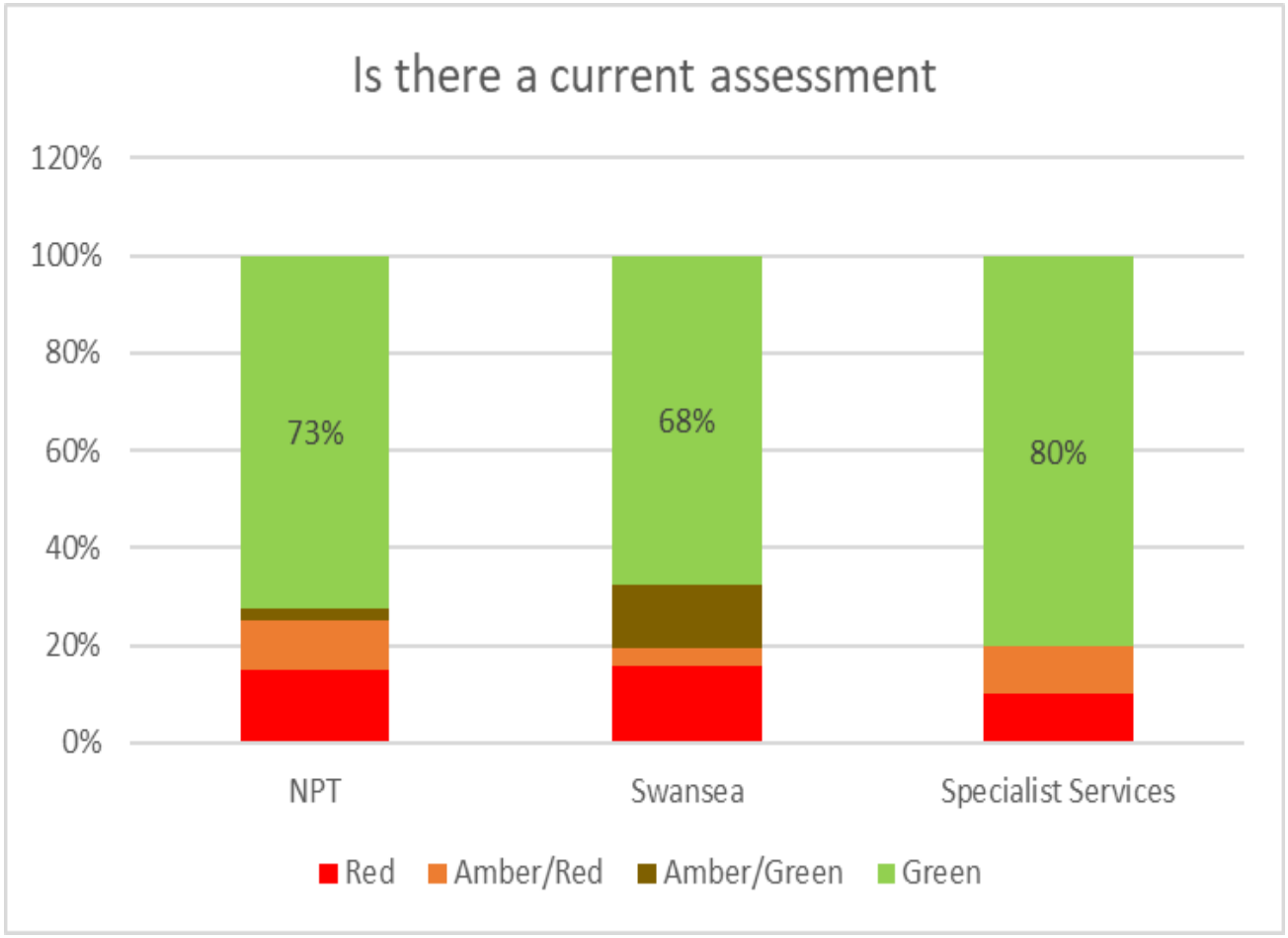
# Methodology: Sample

- The areas included were identified by Heads of Nursing/Service Managers within the Localities
- Swansea Locality
    - This was audited in its entirety to include inpatient & community, with the exception of Onnen Ward which was functioning as a SPOA
- Neath Port Talbot Locality
    - Tonna CMHT
    - Neath OPMH CMHT
    - Cardiff CLDT
    - Bridgend CLDT
- Specialist Locality
    - Rowan House
    - LLwyneryr
    - Meadow Court
    - Gwelfor
    - Cedar Ward Taith

# Finding 1- Assessment

- Average of 74% case notes contained a current assessment
- 13.6% did not have a assessment within the case notes
- Common issues for Red rating
  - No assessment
  - Out of date
  - Or filed in wrong volume

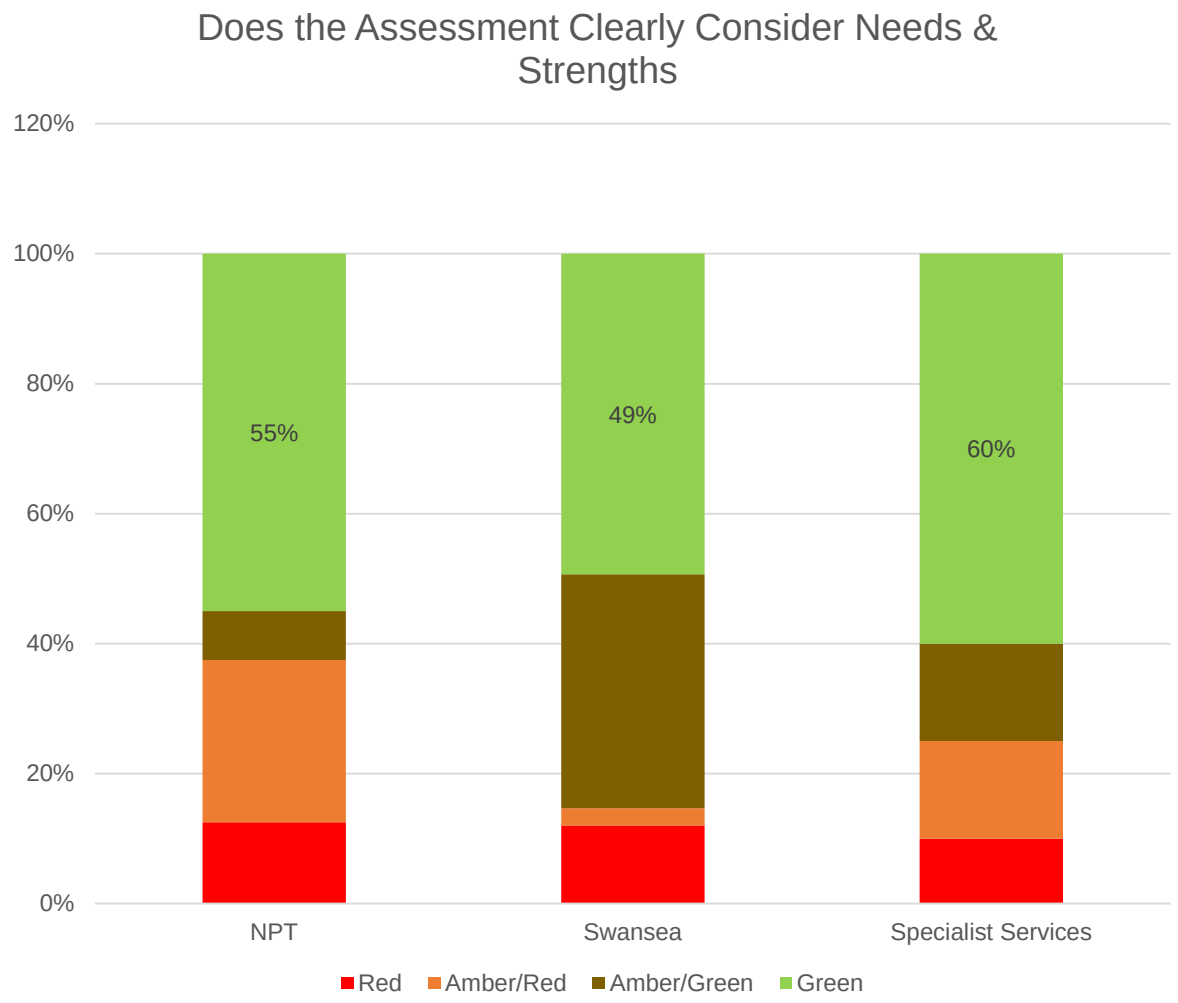
*NB. Comparatively the DU (2018) finding was 68%*



# Finding 2 – Consider Needs and Strengths

- Average of 55% clearly considered needs & strengths
- Most common issues
  - Needs had been identified but lacked information about patient strengths
  - 38% (Red & Amber/Red – NPT) incomplete, lacking detail, unclear, requiring update or out of date.

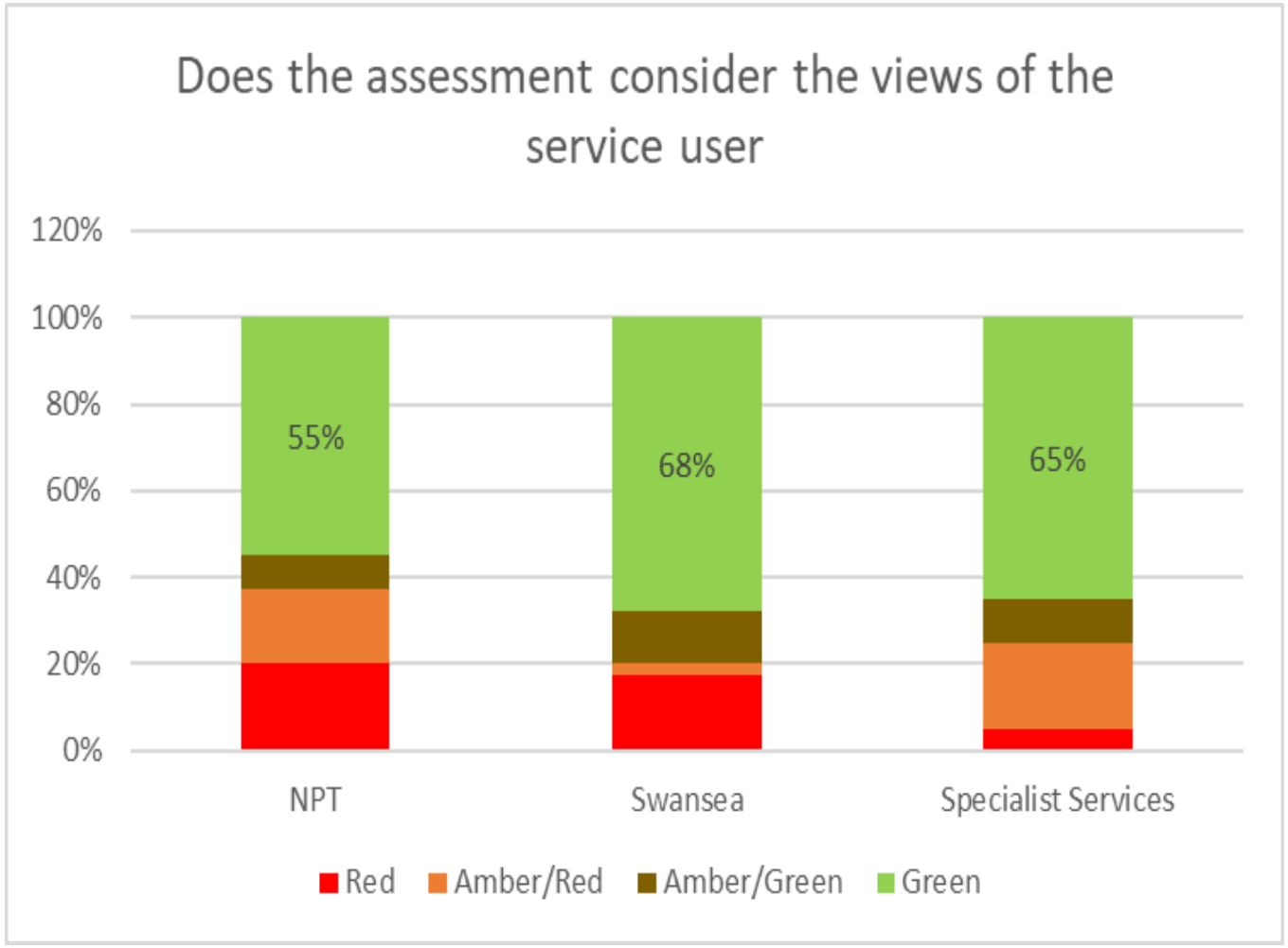
*NB. Comparatively the DU (2018) finding was Red & Amber/Red 64%*



# Finding 3 - Involvement of the Person in the Assessment Process

- Average of 63% clearly indicated the views of the service user
- Main issues:
  - Assessment out of date
  - Views not included
  - Assessment incomplete
  - View of MDT noted but not service user

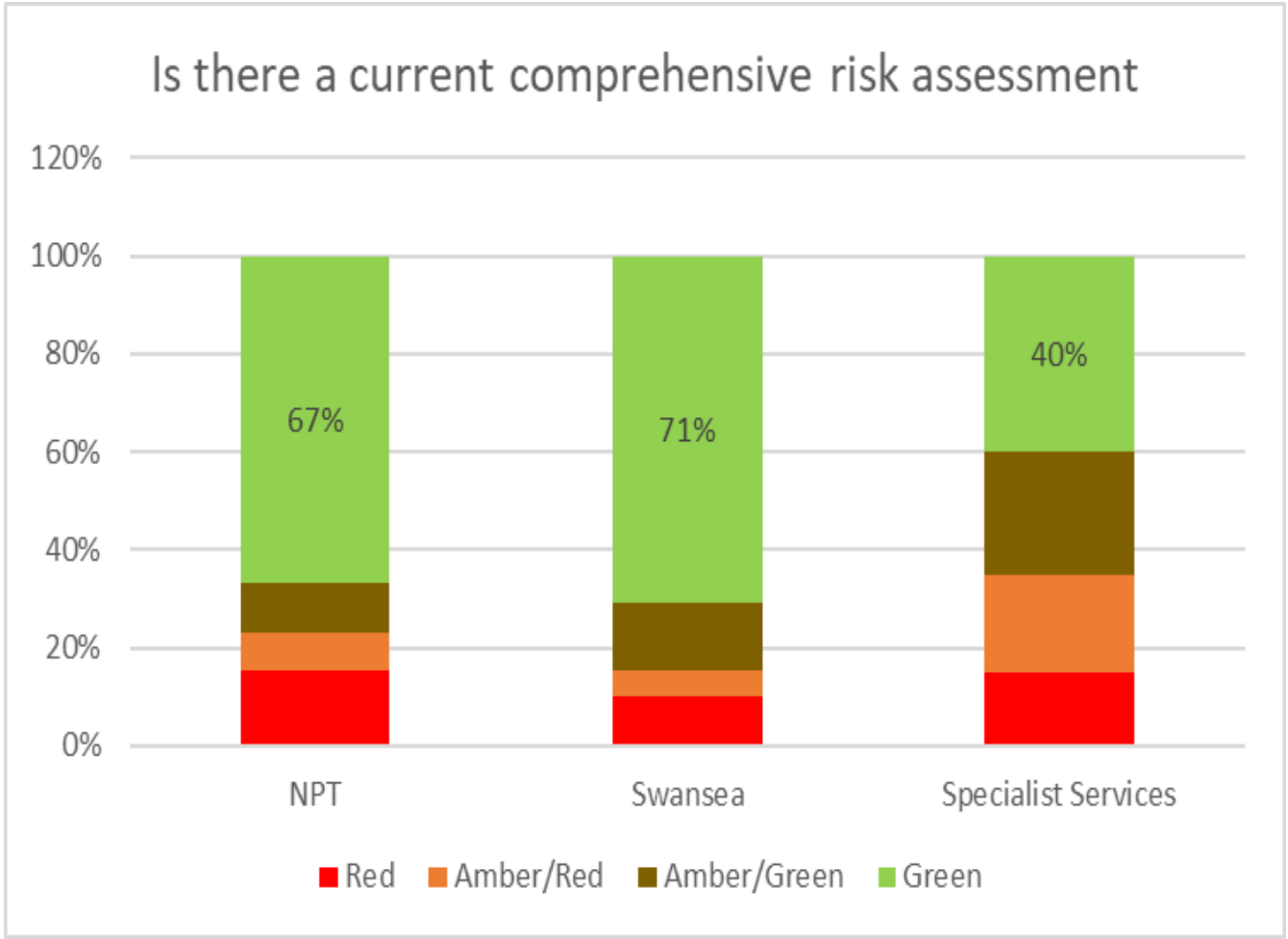
*NB. Comparatively the DU (2018) finding was Green 23%*



# Finding 4 - The Assessment and Management of Risk

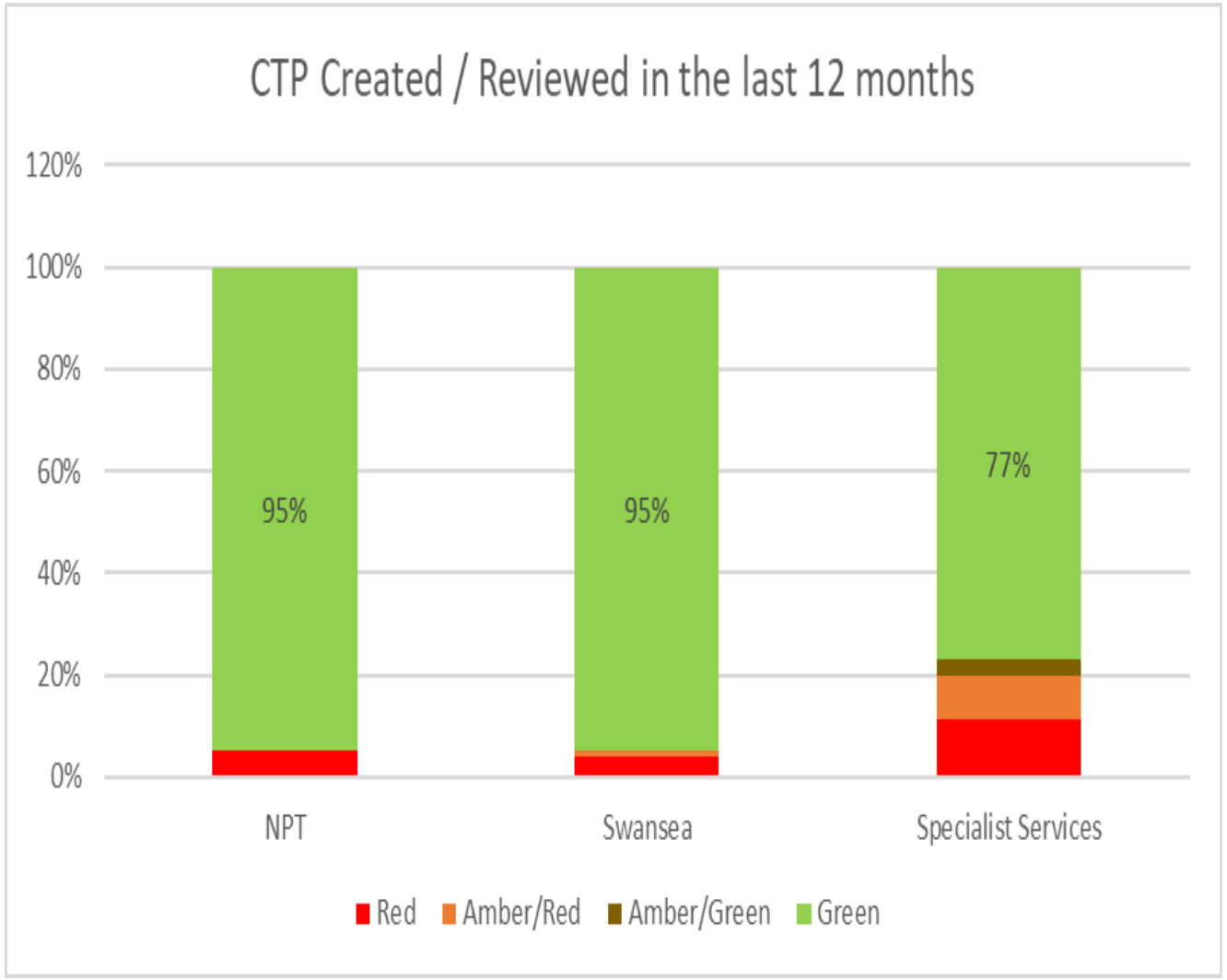
- Average of 59% audited contained a current risk assessment
- Main issues:
  - Out of date
  - Lacked action plans
  - Lacking detail
  - Lack of coping strategies
  - Not reflecting current presentation or risk

*NB. Comparatively the DU (2018) finding was Green 90%*



# Finding 5 - Care and Treatment Plan Outcomes

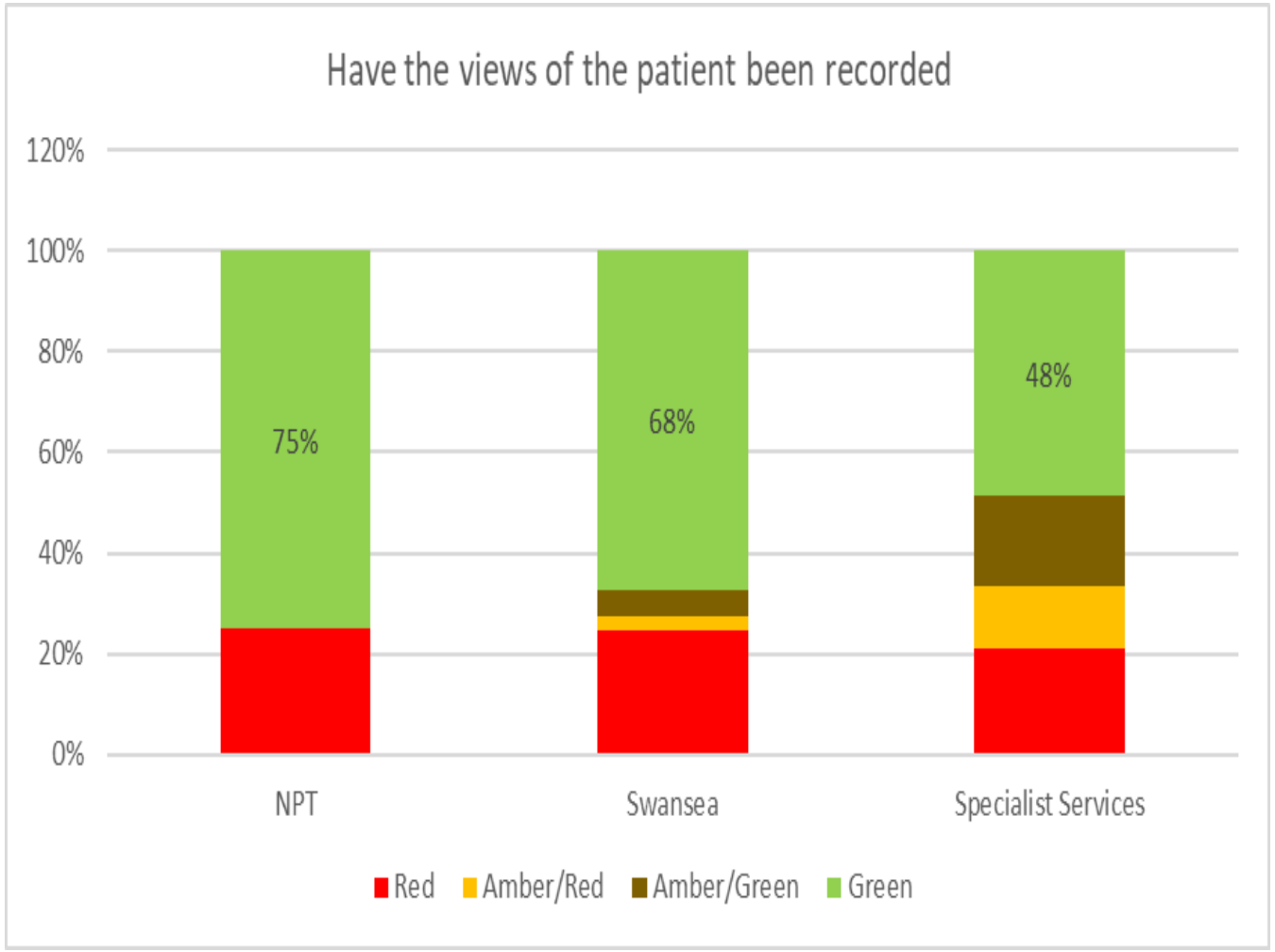
- 3 areas audited:
  - ➢ Is there a care coordinator identified
    96% green (2018: 99%)
  - ➢ Are contact details included
    93% (2018: not recorded)
  - ➢ CTP created and reviewed in last 12 months
    89% (2018: 99%)
- Disparity between inpatient and community CTP's
  - ➢ Clarity of who completed CTP while an inpatient



# Finding 6 – Views of the person been recorded

- Average of 64% showed the views of the patient
- Main issues:
  - Views not documented
  - Patient did not want to or unable to engage
  - Capacity
  - Views of MDT highlighted in this section but not the patient

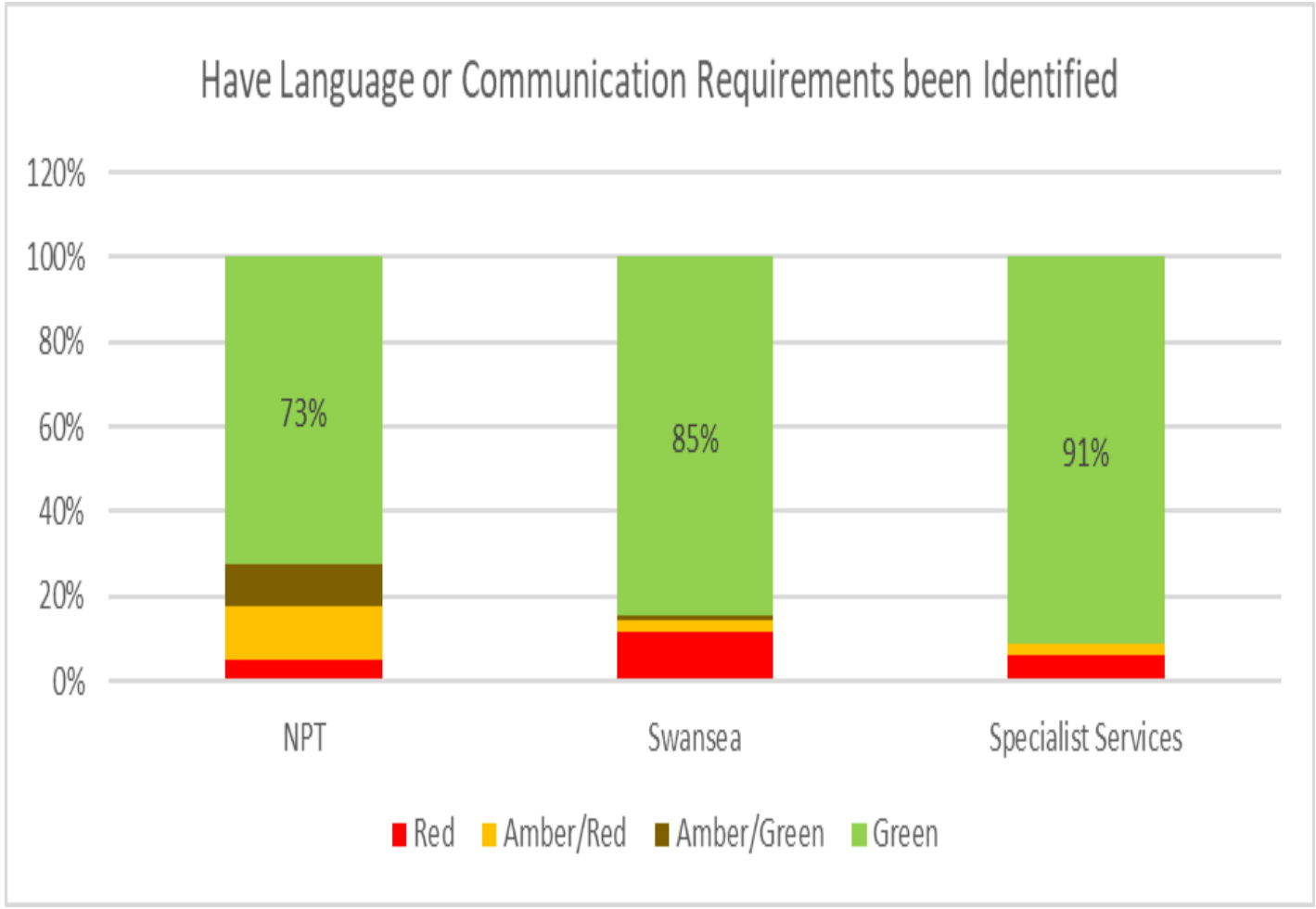
*NB. Comparatively the DU (2018) finding was 23% green*



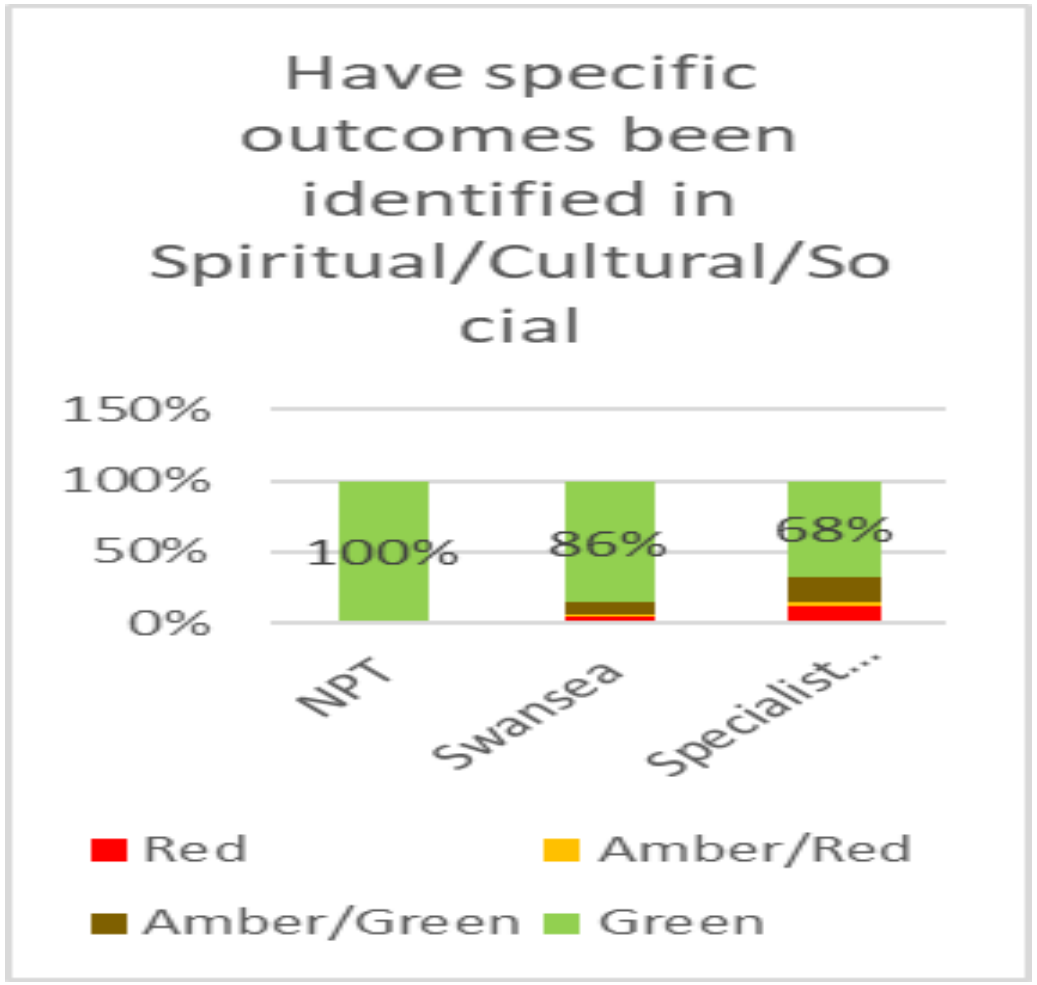
# Finding 7 – Language and Communication Needs

Analysis shows that the vast majority of Service Users had their needs and preferences identified.

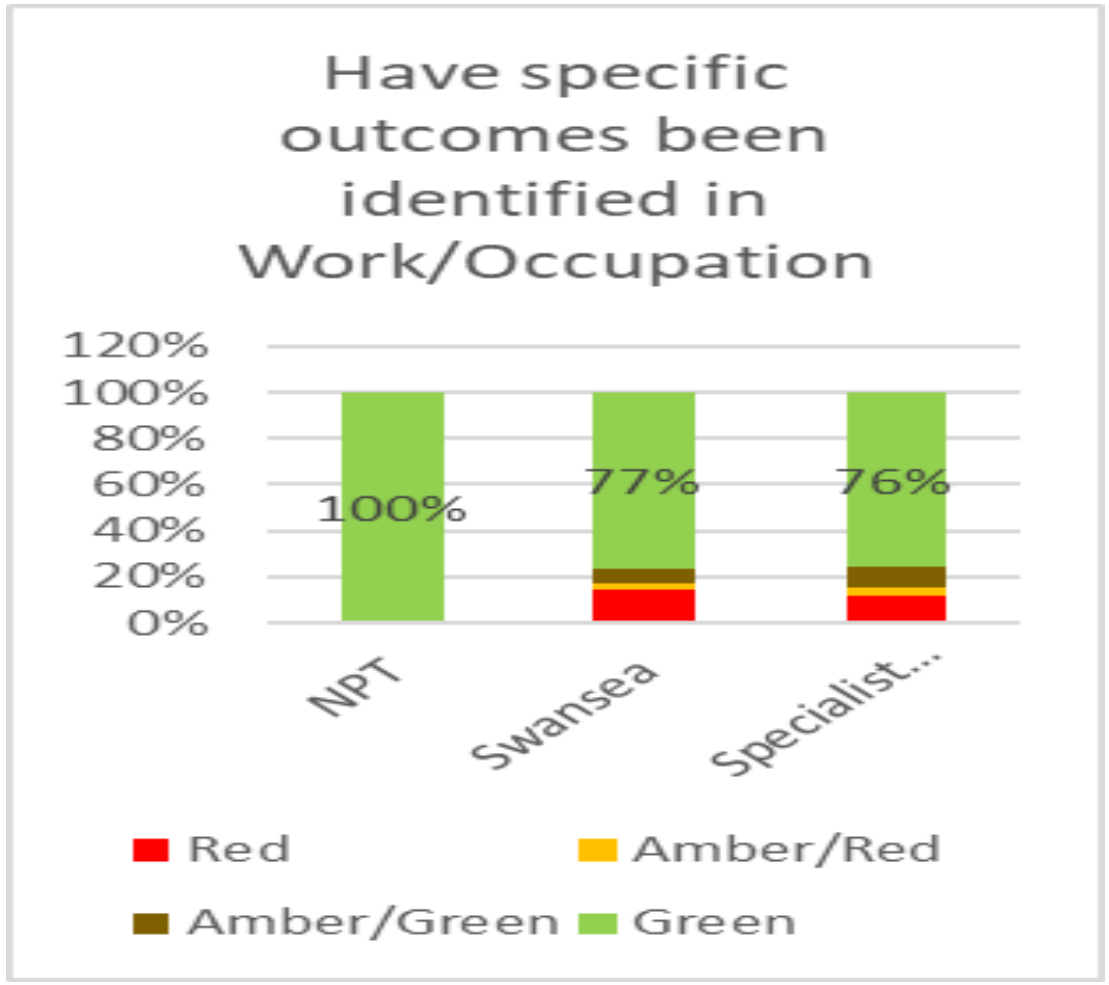
NB. Comparatively the DU(2018) review did not identify this component.



# Finding 8 – Outcomes and Care Domains

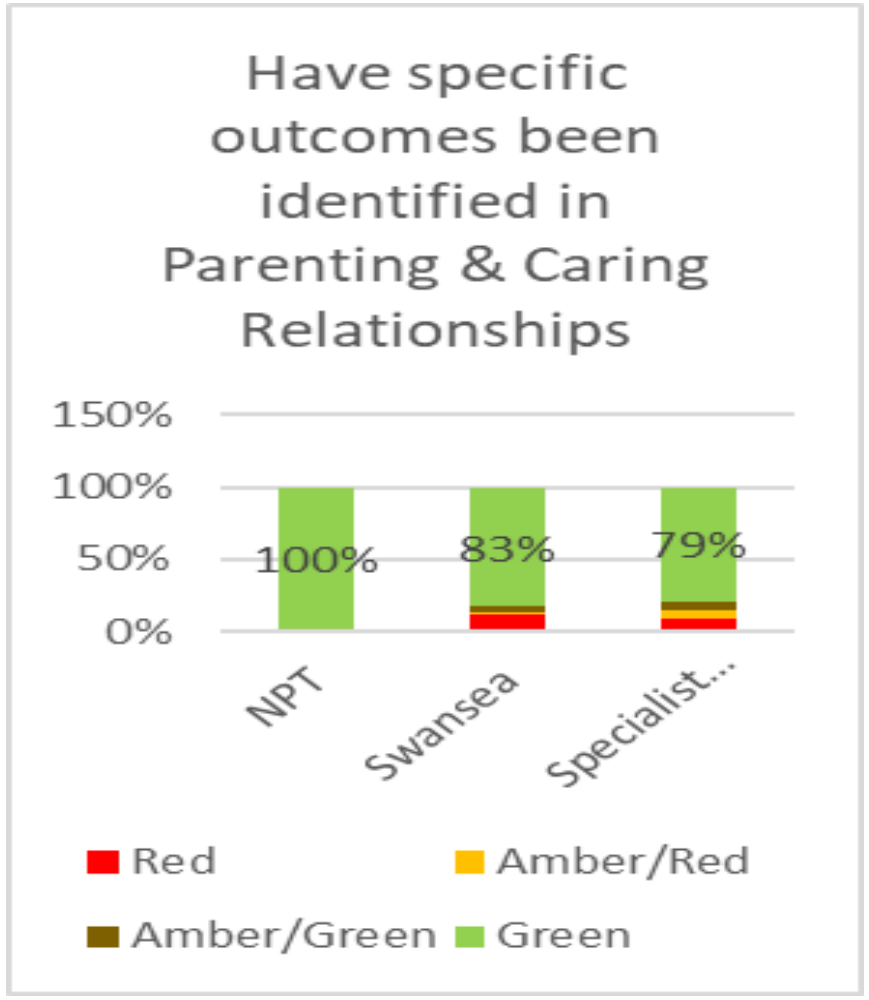



DU 2018 – 35%

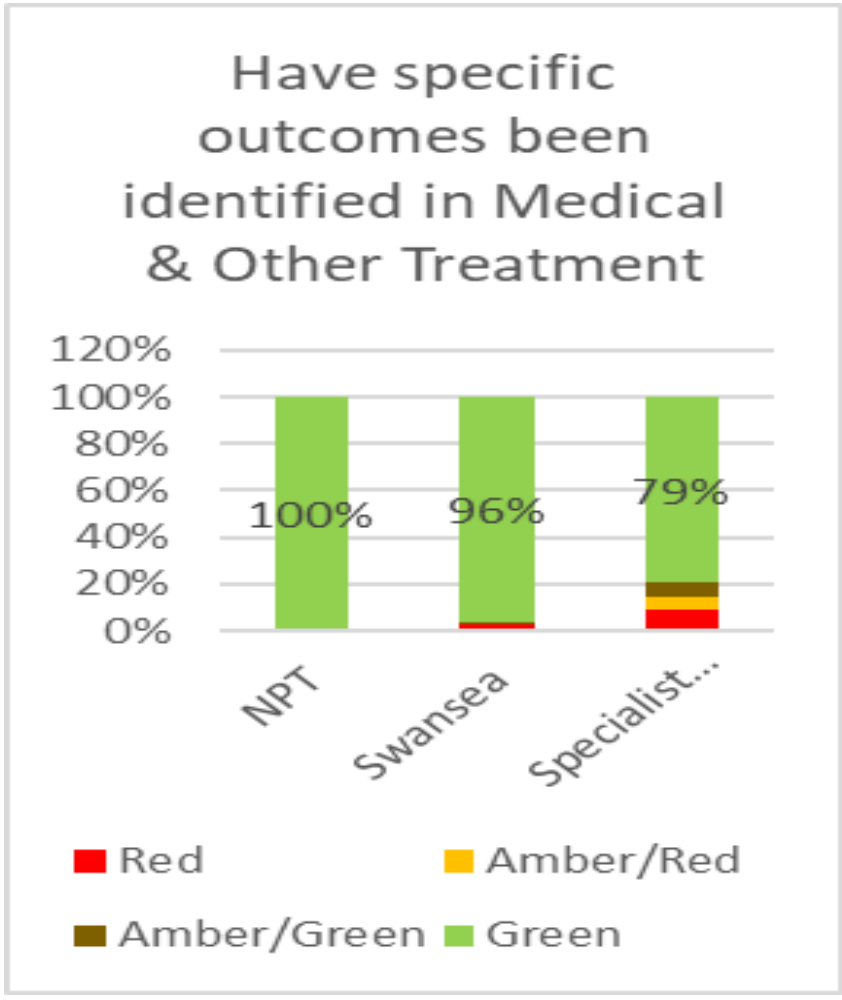



DU 2018 – 31%

# Finding 8 – Continued

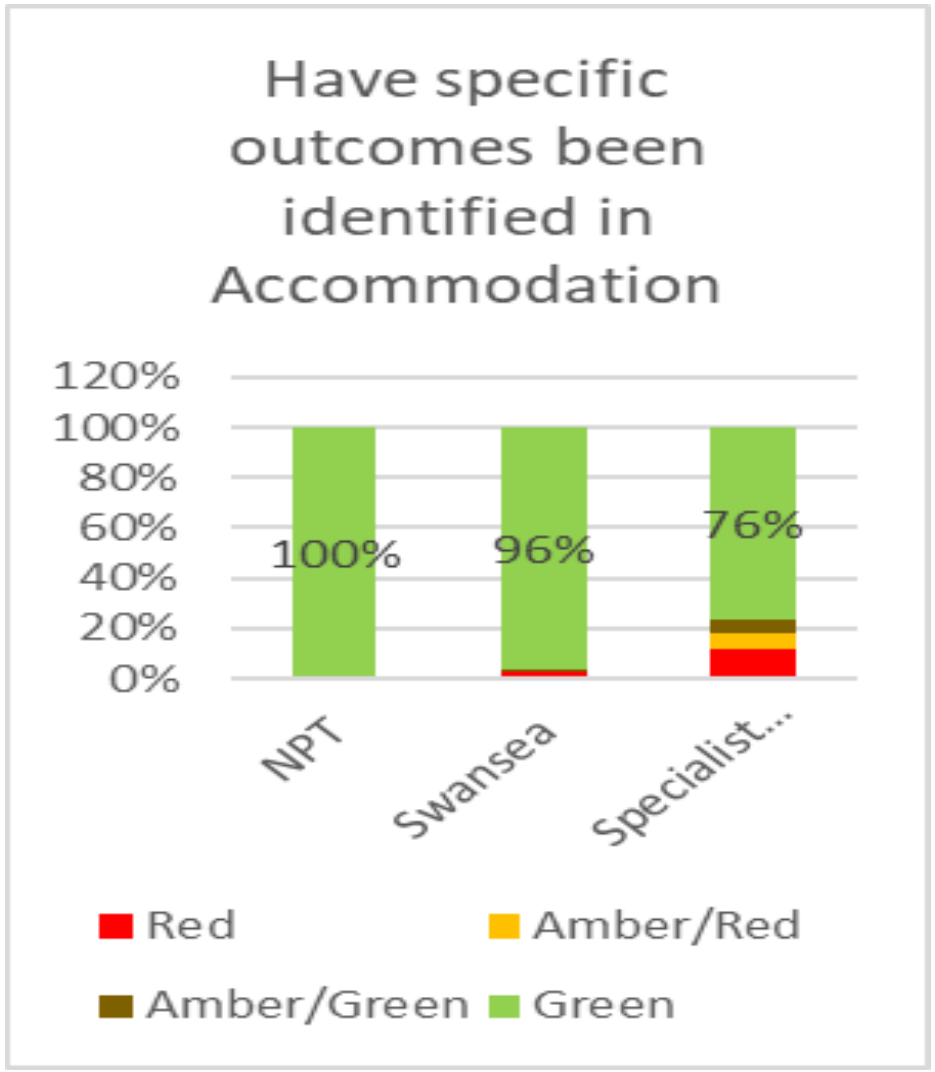



DU 2018 – 24%

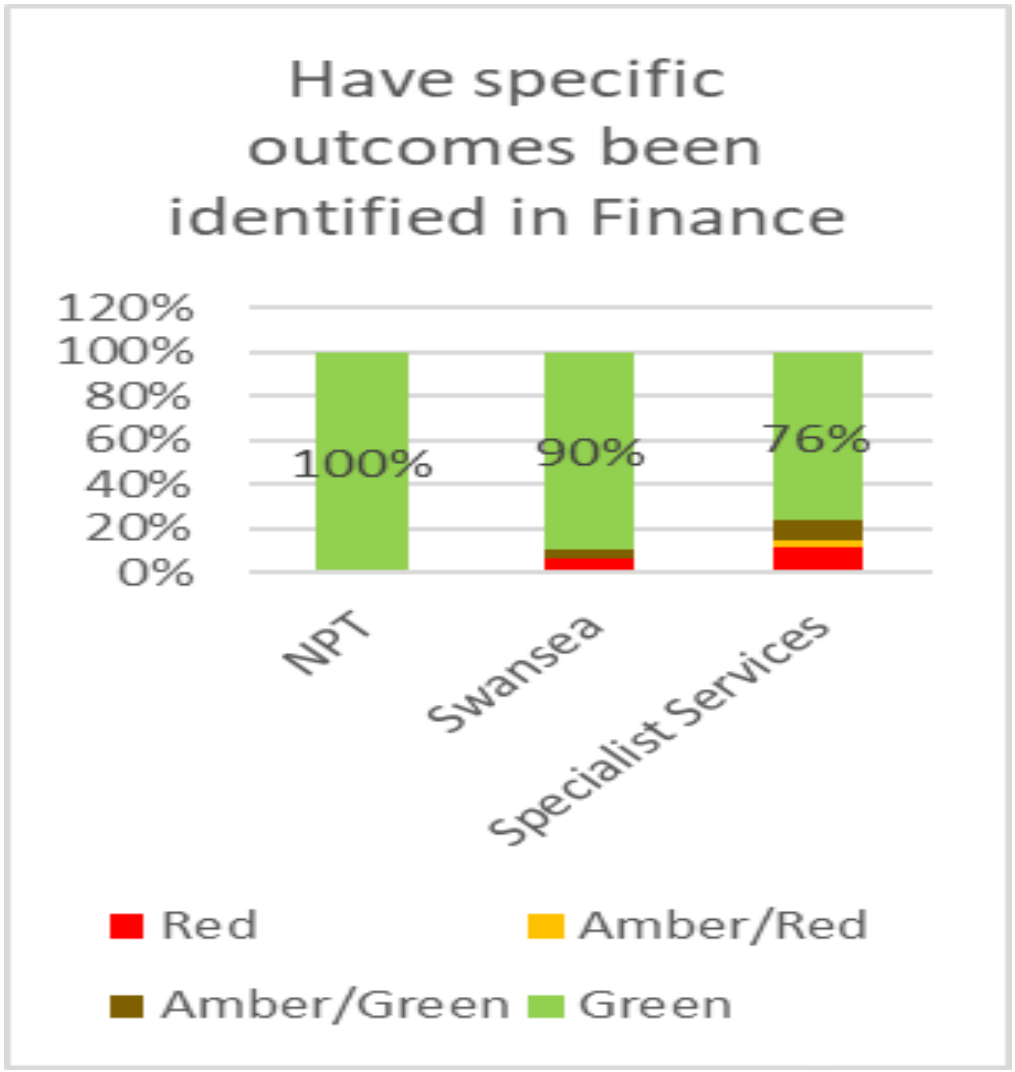



DU 2018 – 29%

# Finding 8 – Continued

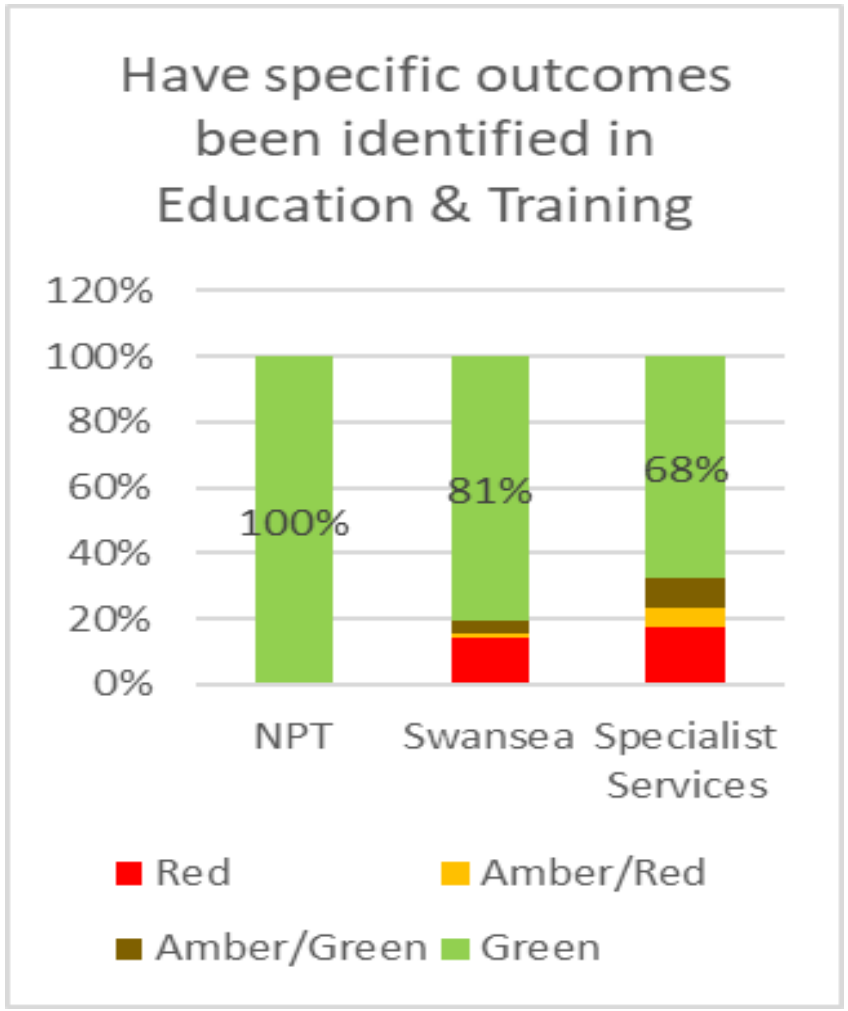



DU 2018 – 79%

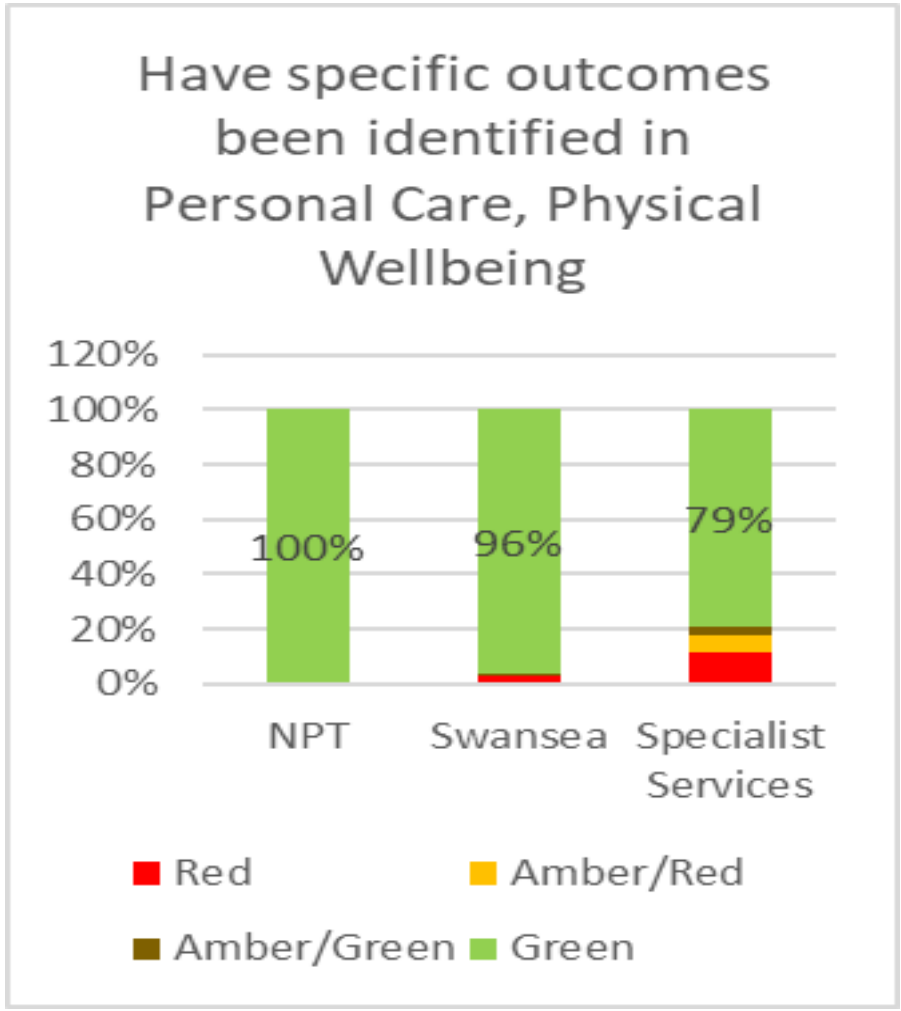



DU 2018 – 41%

# Finding 8 – Continued




DU 2018 – 29%



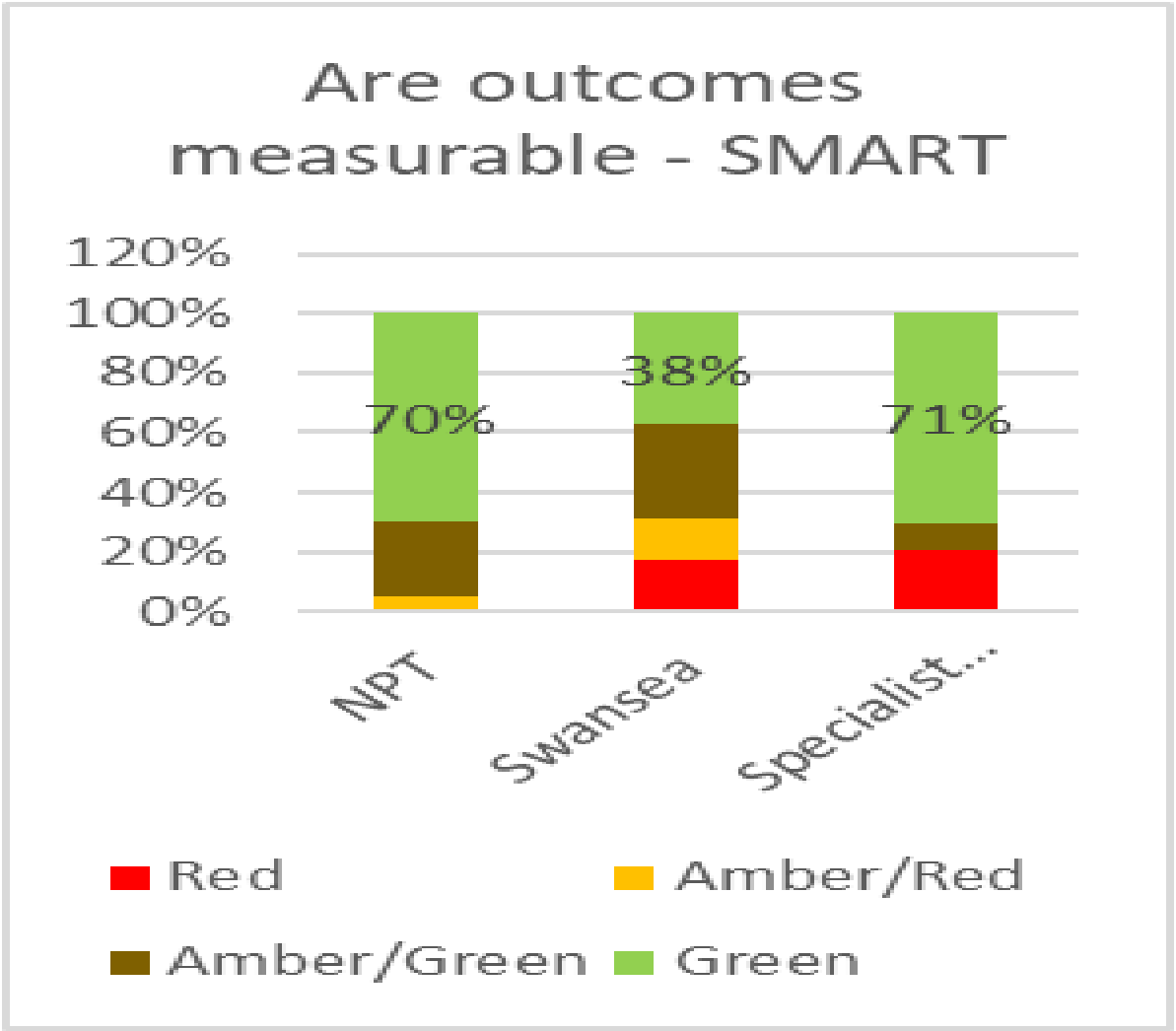

DU 2018 – 28%

# Finding 9 – SMART goals

- 3 areas audited for this finding:
  - Are outcomes measurable – 60%
  - Responsible person – 68%
  - Timescales – 54%
- Outcomes usually recorded – lack of detail re timescales and responsible person
- Use of word “on-going” or “all staff”

NB. Comparatively the DU (2018) finding was:

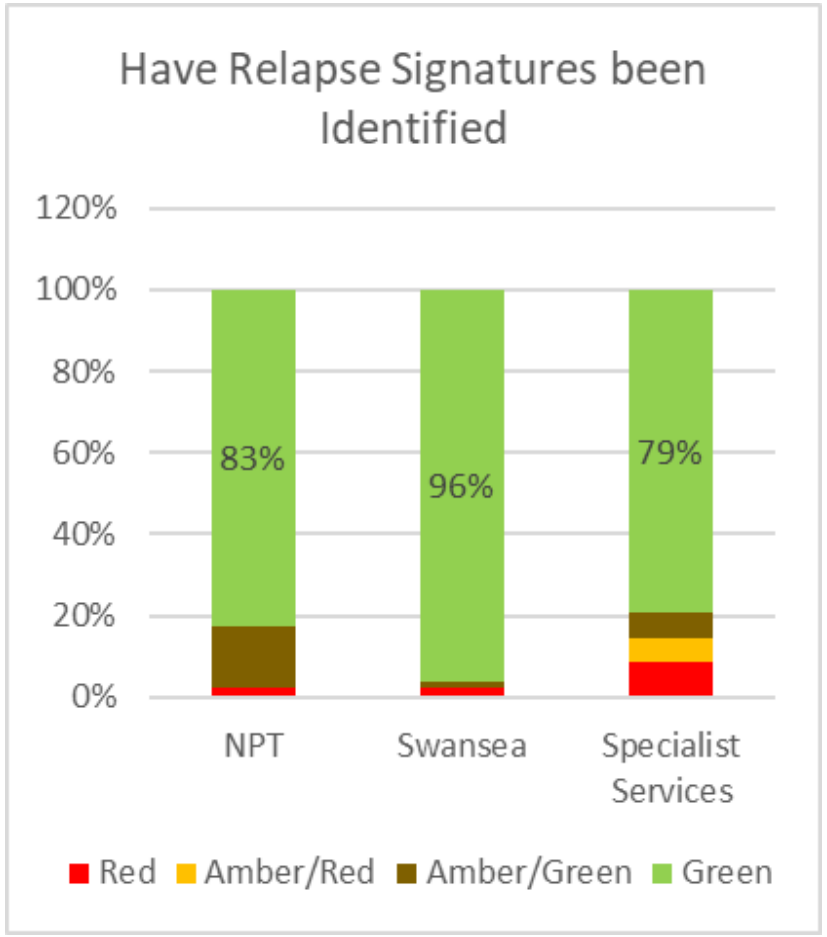
- measurable - 57% Red & Amber/Red
- Responsible person – 89% Green
- Timescales – 55% Green



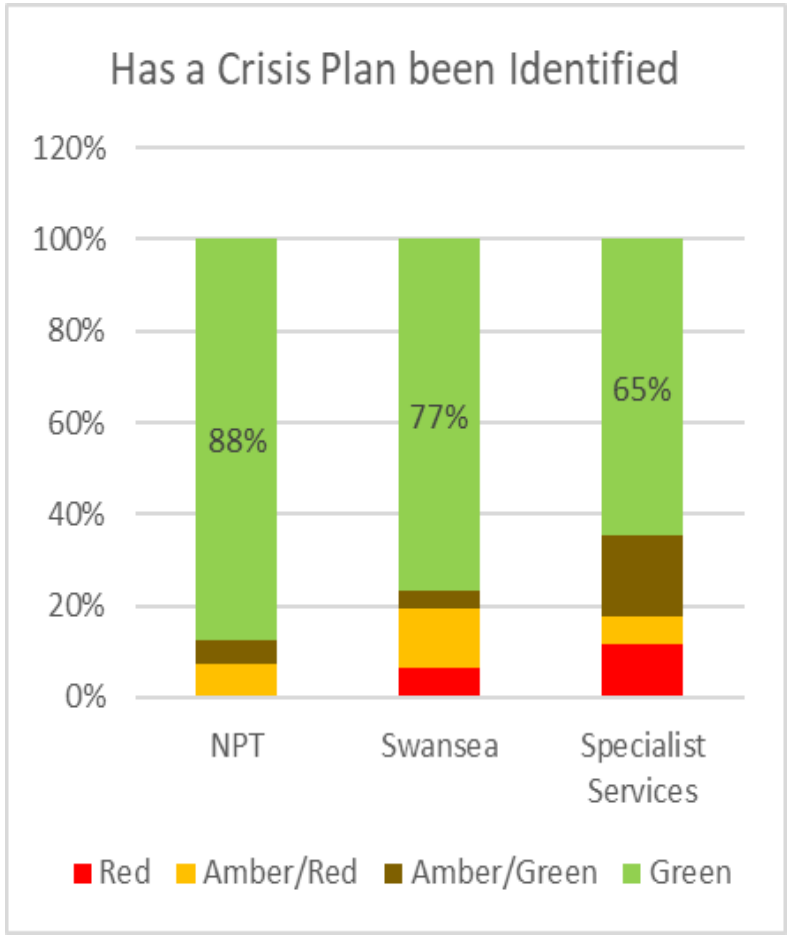
86% relapse
77% CRISIS

# Finding 10 – Relapse/Crisis planning

- Majority scored green
- Demonstrated good evidence of planning
- Red or Amber/red noted lack of meaningful detail – just a list of numbers or contacts
- Average Green - 86% relapse signatures
- Average Green - 77% Crisis plan



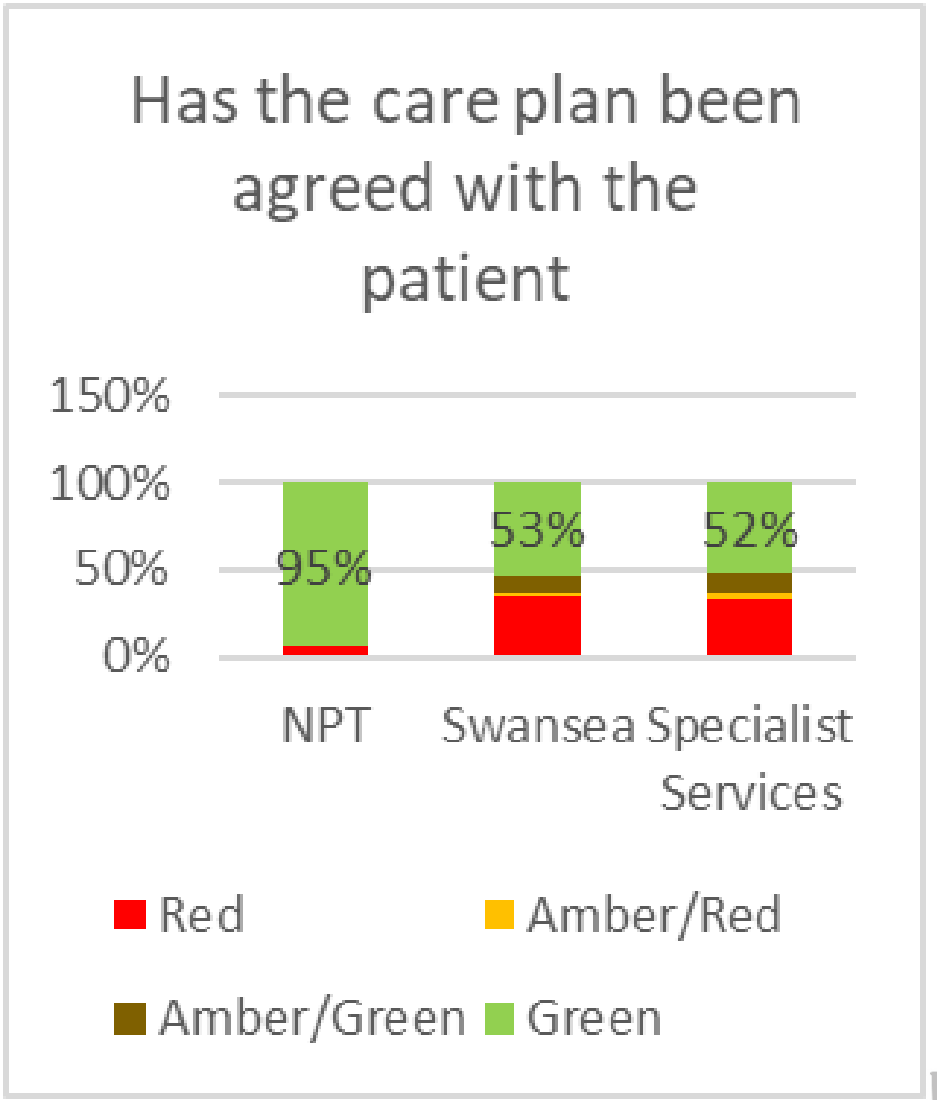

DU 2018 – 80%




DU 2018 – 34%

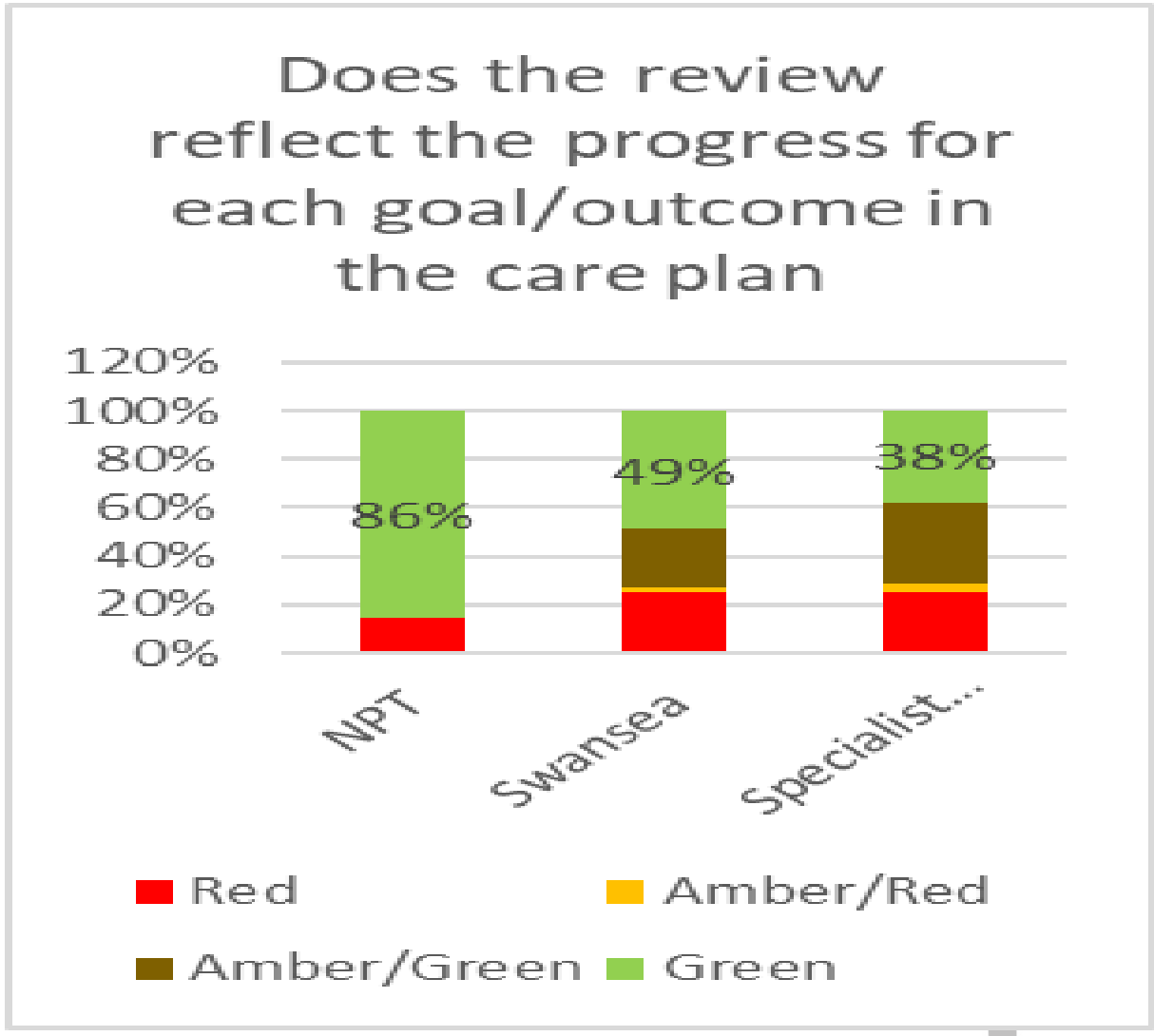
# Finding11 – Agreeing CTP with SU

- 3 areas audited:
  - Care plan agreed – 67% (2018 80%)
  - CTP signed by SU – 48% (2018 53%)
  - CTP signed by CC – 79% (2018 88%)
- Potentially erroneous Red's for signatures as some of the comments highlighted lack of capacity or refusal.
- Also noted the impact of COVID restrictions & ability to get community plans signed by Service User's.



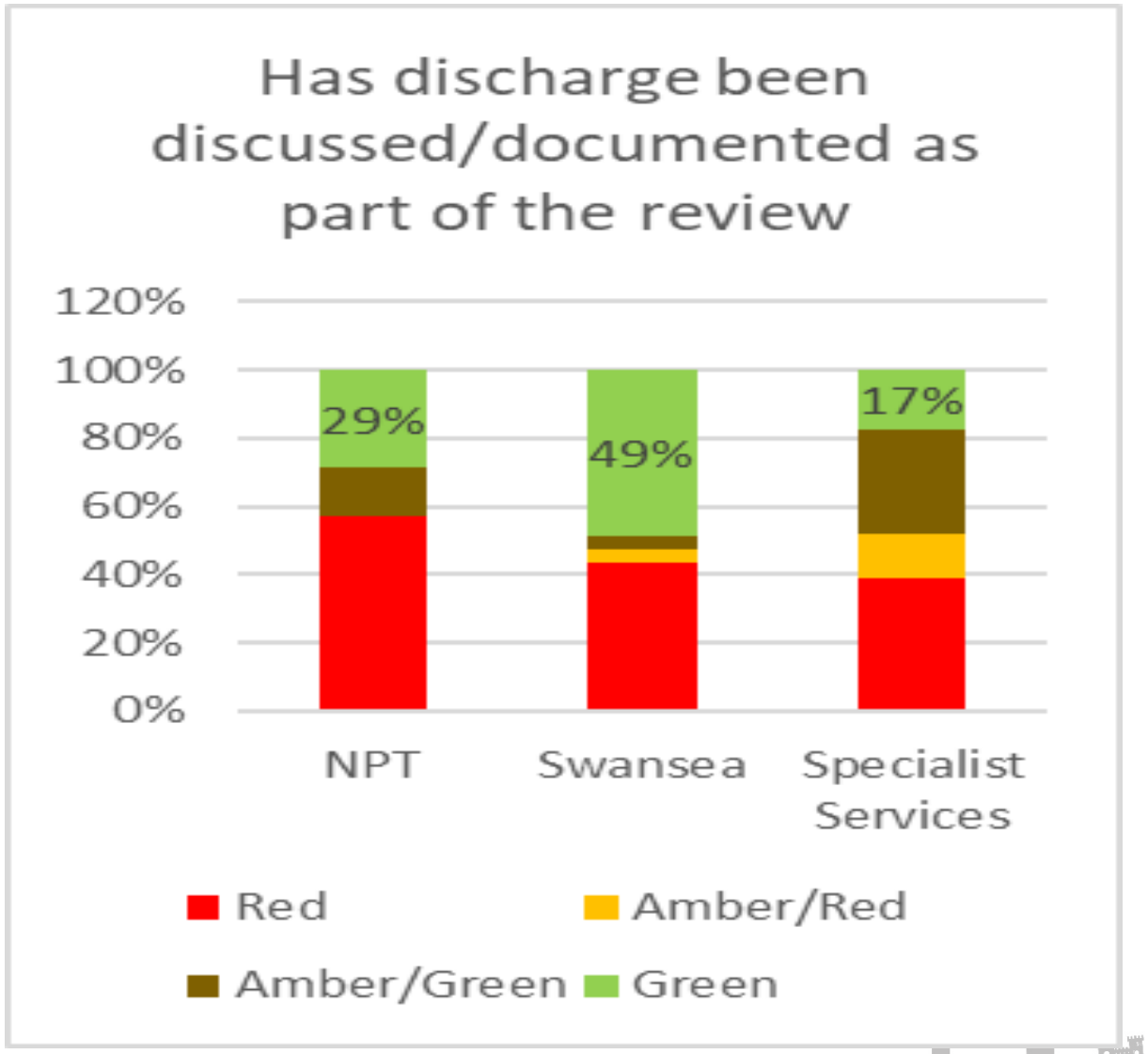
# Finding 12 – Reviewing the CTP

- 4 areas audited:
  - Date of next review – 87%
  - Views of those involved – 54% (2018 22% green)
  - Written within 2 months of review date - 68%
  - Progress for each goal/outcome – 58% (2018 10% green)
- Red or Amber/Red – did not include substantive discussion re goals and plans



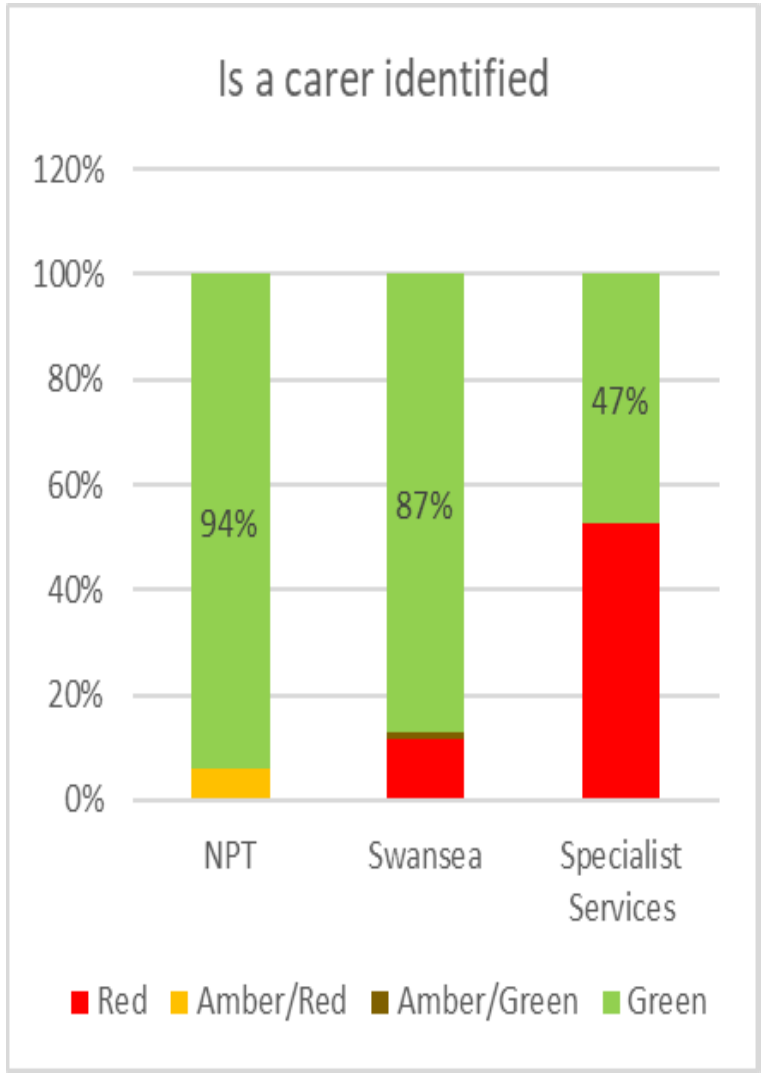
# Finding 13 – Planning Discharge

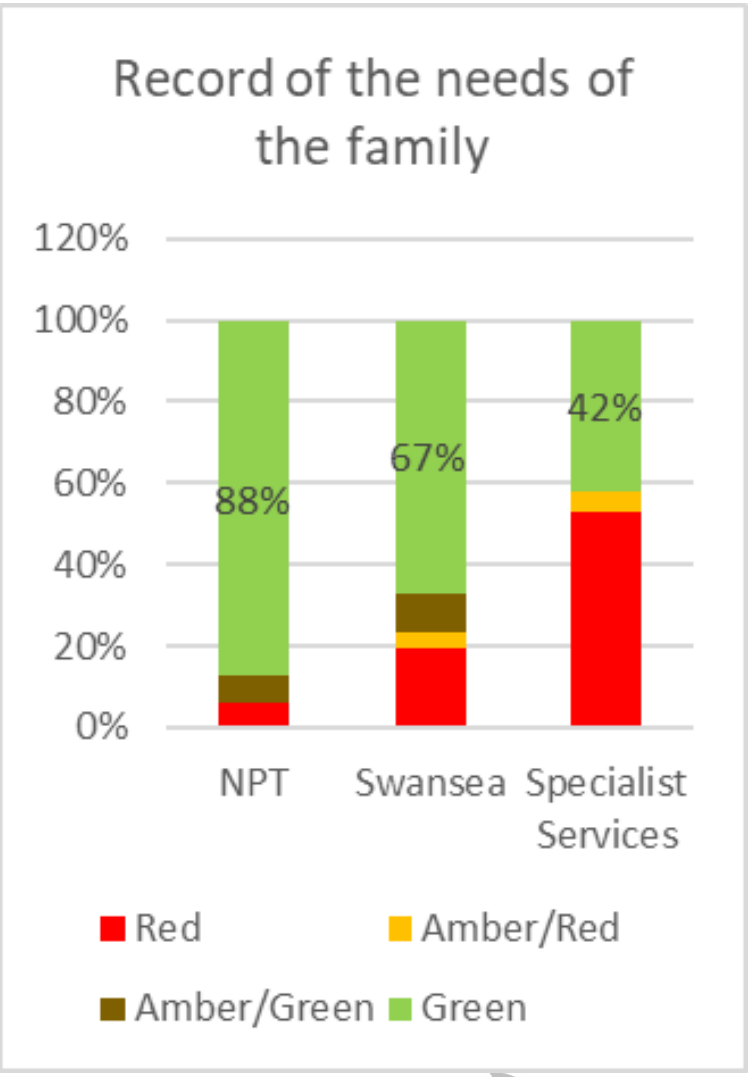
- During the reviews, there was a general lack of discharge discussion across all services – this is also relevant for CMHT's
- Some comments found about limited input re: discharge or pathways
- Green average 32%
- Red average 46% (2018 67%)



# Finding 14 – Carer/Family Needs

- Better engagement with carers and family within community services
- Data Capture shows some issues with interpretation specifically in Specialist Locality



# Summary of Findings

Areas indicating improvement:

- CTP present & in date
- Needs & strengths
- Views of the Service User included
- Care Outcomes identified
- Relapse signatures & crisis planning
- Discharge planning

# Findings continued

Areas with learning identified:

- Risk assessments
- CTPs having been completed within the last 12 months
- SMART – specific person not identified as often.
- CTP agreed by Service User
- CTP signed by Service User
- CTP signed by Care Coordinator

**Mental Health Division - ACTION PLAN: CARE AND TREATMENT PLAN REVIEW**

**Date of Action Plan: 2021**

| OBJECTIVE | ACTION(S) | PERSON RESPONSIBLE | START DATE | MONITORING ARRANGEMENTS | Progress report | |
|---|---|---|---|---|---|---|
| Ensure compliance with 90% of relevant patients having a current CTP | All teams have a data base of CTP dates and review. | Team Leads/service Managers | 2019 | To be monitored monthly Via performance dashboard | | |
| | CTP compliance is discussed as part of managerial supervision | Team Leads/ ward Managers and Directorate | July 2021 | Via Directorate Lead Nurse/Ward Manager/Team Lead in supervisions. | | |
| | Teams conduct virtual/telephone reviews as part of duty when staff are sick and unable to meet review deadlines | Lead Nurses Team leads | | Via Lead Nurse-team lead supervisions | | |
| To improve the quality of risk assessment and management plans and how they are reflected within the CTP | MDT approach to risk assessment (thorough history taking) and formulation. | All Care Co-ordinators | July 2021 | Via supervisions and via CTP audits – Nurse managers must address directly with Care Co-ordinators where CTPs do not meet these standards | | |

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| | Relapse signatures and Crisis Management plan should be mirrored in the CTP and Risk Assessment. | All Care co-ordinators. | | | | |
| | Crisis management plans should be detailed not just a list of contact numbers. They should include the names and roles person/s to contact and the intervention that the person will provide. | All care co-ordinators | | | | |
| To improve the quality of CTPS to ensure they are person centred, have SMART objectives and reflect input and evidence from service users and carers. | Ensure that Clinical Leads/CMHT/CLDT auditors have up to date skills for audit and creating SMART objectives. | L&D team, Lead Nurse QI and Directorate Lead Nurses | August 2021 | Via attendance at the practice support sessions<br>Audit tool engagement sessions prior to the next audit<br>Analysis of Service user and Carer feedback via the feedback team on involvement and choices around care | | |
| | Practice support sessions to be provided for Clinical Lead/Care Coordinator intended to enhance skills and share knowledge base in writing SMART Objectives. | L&D team, Lead Nurse QI and Directorate Lead Nurses | | | | |
| | Clinical Leads/CMHT/CLDT auditors cascade their knowledge and skills to the Care Coordinators in their area of responsibility. | Clinical Leads/CMHT/CLDT auditors | | | | |
| | Strategies for collating service user and carers evidence to be well developed in skill set for clinical lead. | All Clinical Leads and CTP auditors. | | | | |

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| | Practice Support sessions to focus on service users and carers evidence concurrently with SMART objectives. | L&D team | | | | |

**Learning Disabilities Division - ACTION PLAN: CARE AND TREATMENT PLAN REVIEW**

**Date of Action Plan: 2021**

| OBJECTIVE | ACTION(S) | PERSON RESPONSIBLE | START DATE | MONITORING ARRANGEMENTS | Progress report | | |
|---|---|---|---|---|---|---|---|
| Audit Cycle and Process | Agree regular audit cycle within the division. | Lead Nurses & Directorate Managers/QI lead nurse | September 2021 | Audit cycle | | | |
| | Auditors to be identified in advance and planning session to be arranged to address possible issues. | Lead Nurses & Directorate Managers/QI lead nurse | November 2021 | Attendance at session | | | |
| Improve skills and confidence of clinicians involved in audit | Auditors to complete audit alongside clinicians in practice. | Lead Nurses/Heads of professions | November 2021 | Audit cycle/PADR | | | |
| | Use the audit tool informally in supervision and peer to peer support sessions. | Lead Nurses/Heads of professions | November 2021 | Supervision, PADR | | | |
| Increase opportunity for learning from audit | Use CTP audit tool with non-relevant patients to provide comparisons/increase confidence in process | Lead Nurses/Heads of professions | November 2021 | Audit cycle | | | |

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| | Arrange feedback on audit within three months of audit taking place. | Head of Nursing and Lead Nurse QI | January 2022 | SMT/Team meetings | | |
| CTP PROCESS<br><br>To improve the MDT input into the CTP process | Share audit results and cycle with the MDT. | Lead Nurses/Heads of professions/ Directorate Managers | September 2021 | Directorate SMT/Team meetings | | |
| | Give key messages to clinical leaders and team managers about their role in CTP. | Lead Nurses/Heads of professions/ Directorate Managers | September 2021 | Directorate SMT/team meetings | | |
| | Ensure teams are clear that CTP is central to care planning and reinforce this as the overarching plan of care. | Lead Nurses/Heads of professions/ Directorate Managers | September 2021 | Minutes of meetings<br>Audit cycle | | |
| | All members of the MDT to be aware of training available from L&D team. | Lead Nurse L&D | July 2021 | Intranet/flyers/e-mails from L&D team. Increased awareness and attendance at training. | | |
| ASSESSMENT, CARE PLANNING AND SMART GOALS<br><br>Develop skills and confidence in using outcome measures e.g. SMART goals. | Utilise HEF works Heads of professions to make links between assessed needs and setting goals. | Jo John (Lead nurses) | December 2021 | Attendance records/ minutes of meetings<br>Improvement in audit outcomes | | |
| | The LD Division will be clear about the expectation of the use of outcome measures. | Jo John (Lead nurses) | March 2022 | Record keeping audits, CTP audits, feedback from service users, families and staff | | |

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| | Share good practice examples from audits across the service group. | Lead Nurse QI | September 2021 | Attendance at feedback sessions, notes from meetings, lunch and learn event | | |
| | Learning and development peer support sessions to be facilitated by L&D team. Supporting development of SMART goals and increased awareness of CTP issues in LD. | Lead Nurse L&D & Head of Nursing/Lead Nurse QI | December 2021 | Attendance at feedback sessions, notes from meetings, lunch and learn event | | |
| All Relevant Patients will have a current assessment of their needs. | Joint working from CLDT & inpatient areas on CTP's on developing goals and focus on clarity of (relapse indicators & early indicators) | Lead Nurses | March 2022 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |
| | Teams will identify relevant assessment tools which will enable them to formulate an individual's care. | Lead Nurses/Heads of professions | December 2021 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |
| | Review forms to be used in all reviews with signatures and dates complete. | Lead Nurses/Heads of professions | Review forms circulated 9.7.21 December 2021 | Audit process/reviews | | |
| | Joint working from CLDT & inpatient areas on CTP's on developing goals and focus on clarity of (relapse indicators & early indicators) | Lead Nurses | March 2022 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |
| RISK ASSESSMENT AND RISK MANAGEMENT PLANS | Ensure that all staff are able to access appropriate training regarding risk assessment and risk management. | Lead Nurse L&D & divisional managers/ lead nurses/heads of profession | Training will be available in autumn 2021. | There are have been 3 nominations for WARRN TTT from Learning Disabilities, they | | |

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| Ensure risks are identified via the use of recognised risk assessment tools. | | | | are all band 7 nurses. | | |
| | Increase percentage of staff who have undergone WARRN training to 75%. | Lead Nurse L&D & divisional managers/ lead nurses/heads of profession | Training will be available in autumn 2021. | | | |
| Ensure robust risk management plans are devised following assessment. | Review risk assessments and CTPs at the same time to ensure consistency in detail and flow of information | Lead Nurses & heads of profession | December 2021 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |
| Increase service user voice in CTP/care planning/risk assessment | Plans will demonstrate engagement with the person and inclusion of their wants needs and wishes as well as their family members where appropriate. | Lead Nurses & heads of profession | December 2021 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |
| | Plans will be signed by the individual, if not possible a statement will be included explaining the reason and level of involvement the person has had. | Lead Nurses & heads of profession | December 2021 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |
| | Accessible information will be used to engage the person in a way they understand with the plan | Lead Nurses & heads of profession | December 2021 | Evidence in reviews/notes/audit cycle. Improvements in audit outcomes. | | |

**Forensic Division - ACTION PLAN: CARE AND TREATMENT PLAN REVIEW**

**Date of Action Plan: July 2021**

| OBJECTIVE | ACTION(S) | PERSON RESPONSIBLE | START DATE | MONITORING ARRANGEMENTS | Progress report | | | |
|---|---|---|---|---|---|---|---|---|
| Ensure compliance with 90% of relevant patients having a current CTP | All wards and teams have a data base of CTP dates and review. | Ward Managers | **2021** | To be monitored monthly Via performance dashboard | Databases in situ & operational to be reviewed and updated re level of information | | | |
| | CTP compliance is to be discussed and monitored as part of ward managers meetings and Clinical Team Meeting | Ward Managers and Clinical Teams - DHo Nursing | July 2021 | Via weekly ward Manager meetings and CTM's. | In place – to be formalised | | | |
| | Ward managers and the clinical teams will ensure that where there is staff sickness and compliance deadlines are imminent appropriate cover is agreed and provided to ensure that this does not impact upon a timely review and update of any patients CTP | Ward Managers and Clinical Teams - DHo Nursing | July 2021 | Via weekly ward Manager meetings and CTM's | To be embedded | | | |
| | Potential barriers to achieving compliance will be identified at the earliest opportunity and action will be identified and taken to overcome them in a timely manner | Ward managers and Clinical Teams | July 2021 | Via weekly ward Manager meetings, CTM's and supervision with primary nurses | To be reconfirmed | | | |
| To ensure that all CTP's are live documents which are reflective of the individual patients | Ward managers, Clinical teams and Primary Nurses to ensure that the CTP is the primary document that informs the current episode of care | Ward managers Clinical Teams and primary nurses | July 2021 | Via weekly ward Manager meetings, CTM's and supervision with primary nurses | To review current position | | | |

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| current episode of care – whether that be as an inpatient or supported within the community by the aftercare team | | | | | | |
| To ensure that all CTP's reflect MDT input and is assured to be high quality, incorporating detailed risk assessments, relapse indicators and robust management planning which are reflected appropriately throughout. | To ensure that an MDT approach to risk assessment and formulation is implemented consistently. | All Care Co-ordinators, ward managers and Clinical Teams | July 2021 | Via ward CTM's and via CTP audits – Nurse/ward managers must address any circumstances whereby CTPs do not meet the required standards via discussion with the Care Coordinator in the first instance and escalate any continued non-compliance appropriately | In place – to review | |
| | Relapse signatures and Crisis Management plan should be mirrored in the CTP and Risk Assessment. | As above | | | | |
| | Crisis management plans should be detailed including the names and roles person/s to contact and the intervention that each person named will provide. | As above | | | | |
| To ensure that all CTP's are person centred, have SMART objectives and are reflective of the individual patient | Ensure that auditors - Clinical Leaders across inpatient and the after care service have up to date skills for audit and creating SMART objectives. | L&D team, Lead Nurse QI Deputy Head of Nursing | August 2021 | Via attendance at development/ enhancement sessions. | To review | |

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| with evidence of patient and carer involvement. | Skill development/skill enhancement sessions to be provided around skills and knowledge of writing SMART Objectives, patient carer engagement and involvement and quality assuring CTP's. | L&D team, Lead Nurse QI and Deputy Head of Nursing | | Audit outcomes.<br><br>Analysis of Service user and Carer feedback via the feedback team | | |
| | Clinical Leaders - auditors to share their knowledge and skills to the Care Coordinators and co-authors – primary nurses/clinical team in their area of responsibility. | All Clinical Leads and CTP auditors. | | | | |

# All Wales MHM PART 2 Audit Tool

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|---|---|---|---|---|---|
| Client code: | | | Team: | | |
| Name of Auditor: | | | Date of Audit: | | |
| Date of CTP: | | Date of Assessment: | | Date of Risk Assessment: | |

| **ASSESSMENTS** | | | | | |
|---|---|---|---|---|---|
| **Standards** | **Red** | **Amber /Red** | **Amber/ green** | **Green** | **Comments** |
| Consent to share information obtained ***(4.24)*** | | | | | |
| Is there a current assessment ***(3.36)*** | | | | | |
| Does the assessment clearly consider needs & strengths ***(2.12)*** | | | | | |
| Does the assessment considered the views of the service user ***(2.16)*** | | | | | |
| Is there a current comprehensive risk assessment ***(2.21)*** | | | | | |
| Is there a Risk Management plan/Risk management arrangements ***(2.20)*** | | | | | |
| Does the risk management plan address the risks identified ***(2.20)*** | | | | | |

| **CARE AND TREATMENT PLAN** | | | | | |
|---|---|---|---|---|---|
| **Standards** | **Red** | **Amber /Red** | **Amber/ Green** | **Green** | **Comments** |
| CTP created/reviewed within last 12 months ***(6.11)*** | | | | | |
| Is a Care Coordinator identified ***(3.1)*** | | | | | |
| Care Coordinators contact details ***(CTP)*** | | | | | |
| Have outcomes been identified that meet the needs /risks identified in the assessment ***(4.34)*** | | | | | |
| Is the date of the next review | | | | | |

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| recorded ***(CTP)*** | | | | | |
| Are outcomes measurable – SMART | | | | | |
| Are outcomes relating to management of risk incorporated within the CTP ***(2.18)*** | | | | | |
| Does the CTP reflect the involvement of the Carer ***(4.18)*** | | | | | |
| *Have specific outcomes been identified in the following areas* ***(4.36)*** | | | | | |
| Accommodation | | | | | |
| Finance | | | | | |
| Spiritual / Cultural / Social | | | | | |
| Work and occupation | | | | | |
| Medical and other treatment | | | | | |
| Parenting and caring relationships | | | | | |
| Education and training | | | | | |
| Personal care, physical wellbeing | | | | | |
| | | | | | |
| Responsible person identified for each action (***CTP)*** | | | | | |
| Are timescales specified ***(CTP)*** | | | | | |
| Have relapse signatures been identified ***(4.81-5)*** | | | | | |
| Has a crisis plan been identified ***(4.81-5)*** | | | | | |
| Have language or communication requirements been identified ***(4.4*** | | | | | |

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| Have the views of the patients been recorded ***(4.15)*** | | | | | |
| Has the care plan been agreed with the patient ***(4.16)*** | | | | | |
| Has the CTP been signed by the service user ***(CTP)*** | | | | | |
| Has the CTP been signed by the Care Coordinator ***(CTP)*** | | | | | |
| **REVIEW** | | | | | |
| **Standards** | **Red** | **Amber/ Red** | **Amber/ Green** | **Green** | **Comments** |
| Does the review demonstrate that the views of those involved have been sought ***(4.18)*** | | | | | |
| Does the Review reflect the progress for each goal/outcome in the care plan **(6.4) (6.9)** | | | | | |
| Has discharge been discussed / documented as part of the Review | | | | | |
| Has the care plan been updated / written within 2 weeks of the Review date **(6.16)** | | | | | |
| **Need of the family** | | | | | |
| **Standards** | **Red** | **Amber/ Red** | **Amber/ Green** | **Green** | **Comments** |
| Record of the needs of the family | | | | | |
| Appropriate referral for children at risk | | | | | |
| Name of children's services worker recorded | | | | | |
| **Carers Assessment** | | | | | |
| Is a Carer identified | | | | | |
| Has a Carers Assessment been offered? | | | | | |

**Areas for discussion:**

Unmet needs

This is the Audit Key that will be used in line with the All Wales Audit tool, in order for this to be more of a quality review rather than a tick box exercise

It is anticipated that the quality and standard of information will be considerably varied. Therefore the following key will be used to by the reviewer to indicate the quality of the evidence.

Red

- Red will indicate that there is no recorded evidence within the case file e.g. there is no CTP in place, the document is not complete, or there significant gaps or omissions between stages of the process.

Amber Red

- Amber Red will indicate that there is information recorded however the reviewer is not assured that the quality of information is sufficient e.g. the recorded statement is vague or brief, the statement is out of date or not congruent with current care (such as a risk assessment identifies suicide but the risk management plan does not reference this)

Amber Green

- Amber Green will indicate that there is evidence of information, the information is in date but the information could / should provide further detail to inform care e.g. '*encourage Dave to engage with community activities*'

Green

- Green will indicate that the information is current, informative and provides good detail to inform care and provides specific detail on outcomes and service provision e.g. SMART
- Green may also indicate a first person narrative – although this cannot be exclusive