Care Assurance Visit (CAV) Template

This template has been completed to provide a practical example of using the tool/template in practice.

The information used within the template is based on a theoretical scenario. All data provided is mock data, no patient or Board identifiable information has been used. It has been created in collaboration with subject matter experts.

You may also wish to view the QoC review guidance videos created to help get the most out of the Guidance, tools and templates.

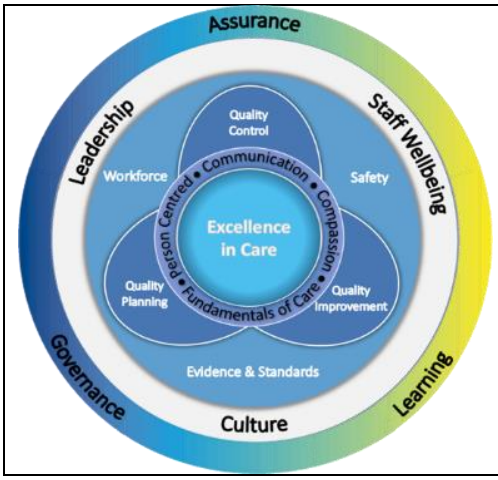
Care Assurance Visit (CAV)

Date:	9/4/25	**Lead Reviewer:**	Head of Nursing
Clinical Area/Service:	Specialist Dementia Ward	**Other Participants, for example Peer, AHPs:**	Consultant psychiatrist, Lead AHP
Manager/Clinical Manager:	CNM	**SCN/Charge Midwife/Team Leader:**	SCN
Reason for CAV:	Responsive	**Announced CAV?**	Y

What is the focus of the CAV? For example, specific quality and safety measures or overarching care assurance	Talking to patients about their experience, discussions with staff and observations about the ward environment
Governance Pathway Who is responsible for monitoring progress of any improvement plan?	• Governance – Clinical and Care Governance Committee • Oversight of implementation/recommendations – Operational Service Group

Date of previous walk round visits		**Any relevant information which should be considered during the CAV?**
Health & Safety	16/08/2024	Ligature risks identified
IPC	14/12/2024	No issues
Leadership	23/02/2023	Prioritisation of V&A training
CAV	N/A	

Use the Preparing for and undertaking Care Assurance Visit Tool to identify the elements of the EiC Framework which will inform this CAV. Not all elements of the EiC Framework will be relevant for each Care Assurance Visit, you can select the number of relevant elements to use on the visit.



EiC Element	Focus of CAV?	EiC Element	Focus of CAV?
Fundamentals of Care	Yes	Person Centred Care	Yes
Compassion	No	Communication	No
Quality Control	No	Quality Planning	No
Quality Improvement	No	Workforce	Yes
Safety	Yes	Evidence & Standards	No
Leadership	Yes	Culture	No
Staff Wellbeing	Yes	Assurance	No
Governance	No	Learning	No

The Care Assurance Visit Summary below can be used to record reflections from the visit. This can be used to identify and agree with local team the areas to celebrate/share, the priority areas requiring support and improvement planning.

Assurance Levels Based on Scope of Review and Information Considered*

Level of Assurance		Description	Rationale
Substantial Assurance		A robust framework of standards and indicators ensure high quality, safe and effective person centred care is likely to be achieved	Standards and indicators are applied continuously or with only minor lapses so that the desired outcomes are achieved
Reasonable Assurance		Adequate framework of standards and indicators with minor weaknesses present	Standards and indicators are applied frequently but with evidence of non-compliance so that the desired outcomes are achieved inconsistently
Limited Assurance		Satisfactory framework of standards and indicators but with significant weaknesses evident which are likely to undermine the achievement of high quality, safe and effective person centred care	Standards and indicators are applied but with some significant lapses so that the desired outcomes are only achieved occasionally
No Assurance		High risk of high quality, safe and effective person centred care not being achieved due to the absence of key standards and indicators	Significant breakdown in the application of standards and indicators so that the desired outcomes are never achieved

*Not essential to use RAG rating unless agreed at scoping stage

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Post Care Assurance Visit (CAV) Summary

3 key areas of success to celebrate and/or share	3 key areas for improvement
• Care plans demonstrate person centred care delivery • We noticed staff demonstrating empathy, kindness and compassion to other staff, with patients and their families	• Creating induction/orientation pack for new staff • Ensuring staff on duty are aware of policies and procedures, for example what assessments are required to be completed • Improved communication with relatives

Patient Feedback - consider key themes from conversations during the CAV

- One patient said they felt well cared for, although they noted the nurses were all really busy.
- Lots of feedback was shared from family members, they noted staff were busy and they felt unaware of future plans for their family member

Staff Feedback – consider key themes from conversations during the CAV

- Spoke with domestic who was positive about the ward, they did highlight issues occurring when certain staff “cliques” were on duty
- One substantive member of staff noted it was challenging with the large number of temporary staff that are within the area and at times felt stressed as was the only member of staff familiar with the area and patients on the ward

Consider next steps:

- Agree improvement plan – and target improvement support
- Share good practice
- Report writing – share with the Clinical Care Governance Group

Fundamentals of Care

Example quality and safety indicators:

- SPSP and CAIR dashboard data such as Inpatient Falls rate, Food Fluid & Nutrition measures, Early Warning Scores and Pressure Ulcer rates
- Waiting times – inpatient and out patient services
- Length of stay, number of delayed discharges
- Caseload size and complexity GIRFEC assessments

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
Review documentation related to risk assessment, care planning and care delivery recorded by the multi-disciplinary team **What audits do you currently undertake, how have you responded to results?**	• Stress and distress assessments not completed within 14d timescale • FFN – whilst CAIR does not show completion looking at the case notes we can see these are complete and result in comprehensive nutritional care plans, timeframe is an area for improvement • Falls assessments incomplete, potential to implement the falls change package • Frailty assessments incomplete • 4AT completed but lack of substantive staff has seen poor compliance with reassessment and implementation of care plan
Observe the person in receipt of care within the clinical area/community setting noting their needs, have these been met? For example hydration, nutrition, safety, communication, child development, inactivity and deconditioning, comfort and analgesia	• Good communication between staff and patients were observed • We noted water jugs were filled and available at bed side • Interactions between domestic and patients were positive, demonstrating kindness • We observed no patients within the communal space, this area lacked engaging activities • Ward was noisy due to buzzers, alarms and patient voices
What improvement work have you identified/progressing?	• QI Board was visible on ward however, data displayed was several months out of date • Interested staff member was undertaking improvement work around FFN
Overall reflection of quality and safety of care delivery focussed on Fundamentals of Care (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Limited Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Person Centred Care

Example quality and safety indicators:

- Care plan and bundle audits (SPSP)
- Waiting times – inpatient and outpatient services
- Length of stay, number of delayed discharges
- Trauma informed care
- Anticipatory care planning
- Therapeutic indicators

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
Review examples of care planning (for example birth plan) and "Getting to Know Me"/"My World Assessment" documents to see how care is individualised. Does this match with what you observe?	• GTKM were observed empty, incomplete and left at bed sides
Can you give examples of when you have observed patients and families being treated with dignity and respect? (or not)	• Good interactions between domestic and patient, displaying compassion and kindness
Speak to people in receipt of care about their experience. Ask about the person's/child's experience and how it feels being cared for in this area. Consider questions such as: - **Do you feel safe?** - **Do you feel listened to with understanding and compassion?** • **Are services working well together to support you to achieve your goals?** • **Has clear and understandable information been provided, helping you to make the right decisions?** • **Is care supporting you to achieve the goals that are important to you?**	• Families noted nursing staff were very busy, happy to provide information for GTKM document but nurses but they didn't have time to complete with patients and families • One relative also commented that the ward was noisy on more than one occasion when visiting however, they commented that their relative was well cared for • Families felt unaware of future plans • Spoke with domestic who was positive about the ward, they did highlight issues occurring when certain staff "cliques" were on duty
Overall reflection of quality and safety of care delivery focussed on Person Centred Care (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Limited Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Workforce

Example quality and safety indicators:

- CAIR dashboard such as Establishment Variance, Predictable Absence Allowance and Supplementary Staffing Use (Bank and Agency/Overtime and Excess)
- Staffing level (workload) tool run

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
How are recurring staffing risks captured and triangulated with quality and patient outcomes / staff well-being?	• Twice daily recording on RTS TURAS platform • Triangulation of workforce and quality and safety indicators are not routinely happening in the ward
Does the person in charge identify the skill mix for safe staffing and is this being met? If not, what mitigation is in place?	• Recent run of staffing workload tool shows they have the correct ratio of staff and skill mix to provide safe care however, vacancies are creating patient quality and safety risks and potential impact on staff wellbeing • Regular use of Bank/Agency nursing staff, and locums, to ensure safe staffing numbers while acknowledging staff not familiar with ward environment, paperwork or patient group • Orientation and induction for agency staff very limited
Are there documented and well understood processes for how to deal with surge capacity / additional beds/complexity within caseload and caseload size? **What is observed regarding patient placement, maintenance of dignity, potential harm?**	• Single room ward, with en-suite facilities • Limited observation of patients due to the position of the nurse station and the horseshoe footprint of the ward
Overall reflection of quality and safety of care delivery focussed on Workforce (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Limited Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Safety

Example quality and safety indicators:

- SPSP, CAIR and/or local dashboard
- Use of Mental Health Act – restraint, covert medication, capacity
- Incident reporting systems
- Feedback from Care Opinion, Patient Experience Team and Complaints
- Real Time Staffing and Escalation

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
What is the safety culture in this clinical area? **- Infection Prevention and Control Procedures – what audits are undertaken (any themes), are improvement plans fully implemented?** **- Medicines safety and storage processes, omissions/errors**	• Twice daily safety huddles • Staff are aware of escalation process and using appropriately • RTS information accurate, up to date and no gaps • Observed correct use of covert medicine procedure and policy
What improvement work is being undertaken to address themes identified from adverse events/incidents, complaints, mortality reviews?	• No evidence of improvement projects however, staff did share information about interest in FFN improvement work • Adverse event reviews are undertaken however, no evidence of action plans to take forward learning
Consider staffing data – Real Time Staffing recording and escalation, establishment variance, supplementary staffing use, skill mix, compliance with the guiding principles of HCSA (to provide safe and high-quality services, and to ensure the best health care or care outcomes for service users), how much time the Team Leader has to lead.	• With gaps in establishment SCN is working clinically to ensure safe staffing levels, limited opportunity to lead
Overall reflection of quality and safety of care delivery focussed on Safety (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Limited Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Leadership

Example quality and safety indicators:

- Time to Lead
- TURAS – training and appraisal (local records keeping)

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
How often do the team get a one to one/supervision opportunity to discuss current workload and any support requirements? **What is the system for annual appraisal and is it effective?**	• Supervision is currently limited but SCN is making every effort to see staff members on a regular basis to check in individually • Appraisals are up to date but staffing levels have hampered efforts to support study time/development opportunities • SCN making efforts to support protected learning time, see above
Consider duration/experience of Team Leader in a leadership role and their preparation/training and support available within the role. **What protected leadership/management time is available (agreed as per local governance arrangements) and how is it utilised? If unable to protect the agreed leadership time, then risk and mitigations should be recorded.**	• SCN is very experienced they have written an SBAR to capture recurring risk and identify potential solutions for their CNM • Staff report feeling supported and recognise the challenges within the area
How are decisions that impact on the team made and then communicated?	• Regular team meetings, staff bulletin board well utilised, good communication of information and staff feel involved in key decisions • Substantive staff feel part of a good team and acknowledge difficulties with the number of temporary staff coming into the ward
Overall reflection of quality and safety of care delivery focussed on Leadership (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Reasonable Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Staff Wellbeing

Example quality and safety indicators:

- CAIR dashboard such as Predictable Absence Allowance, Establish Variance measures
- iMatter, Joy in Work
- TURAS – Appraisal and Training

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
How supported do staff feel by their immediate team and wider leadership? Do staff know where to go for support on both clinical and operational issues? Are there clear lines of delegation for decision making with clear lines of escalation for issues?	• Staff feel supported by SCN, by each other and appreciate input of chaplaincy and CNM • We asked staff where they would go for support and there was good recognition of resources that are available and in some cases currently being accessed • Staff felt supported to report and record incidents of V&A, they recognise the number of incidents and number of 1:1 episodes, they mentioned feeling upset and concerned at not being able to provide the level of care required
Do staff get their breaks? What are their break facilities like? What wellbeing activities are readily available for staff? Consider application of NHS Scotland Workforce Policies.	• This is one area staff felt could be improved due to staffing issues, they are often unable to leave the ward for breaks and are frequently interrupted
Do the team undertake de-brief activities after particularly challenging periods / episodes of care delivery?	• Evidence of de-briefs were available • Staff mentioned that they felt supported by SCN, members of the team, chaplaincy and CNM
Overall reflection of quality and safety of care delivery focussed on Staff Wellbeing (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Reasonable Assurance – around processes are insitu however, recognising the potential for a number of staff to burn out if staffing situation does not improve

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance