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.

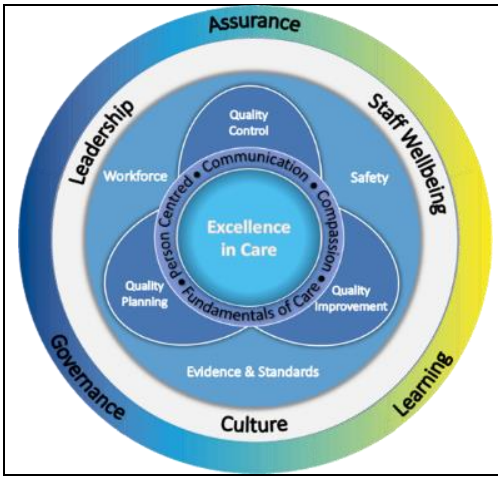
Care Assurance Visit (CAV)

Date:	9/04/2025	**Lead Reviewer:**	Head of Nursing
Clinical Area/Service:	Community Nursing	**Other Participants, for example Peer, AHPs:**	Lead Nurse Tissue Viability (TV) nurse specialist
Manager/Clinical Manager:	Operational Manager	**SCN/Charge Midwife/Team Leader:**	Team Leader
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	Recent increase of pressure ulcers reported in the community, looking to understand the impact from TV nurse education programme and establishing Link Practitioners for TV.
Governance Pathway Who is responsible for monitoring progress of any improvement plan?	Operational Manager with support from Lead Nurse

Date of previous walk round visits		**Any relevant information which should be considered during the CAV?**
Health & Safety	27/05/2024	Car maintenance/servicing flagged as a concern
IPC		
Leadership	18/10/2024	New team leader in post June 2024, team recently fully established
CAV		

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	No
Compassion	No	Communication	No
Quality Control	No	Quality Planning	No
Quality Improvement	No	Workforce	No
Safety	No	Evidence & Standards	No
Leadership	Yes	Culture	No
Staff Wellbeing	No	Assurance	Yes
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
• Increased and accurate reporting of pressure ulcers • Protected learning time for PU prevention and management leading to increased confidence of staff and accurate grading/reporting • Staff engagement with QI project on PUs • Leadership development and confidence of new Team Leader	• Ongoing support for QI journey

Patient Feedback - consider key themes from conversations during the CAV

- Patient family member commented on how useful the information leaflet was
- Patients commented on feeling supported by members of the District Nursing team who were very knowledgeable and professional, always visited when they said they would

Staff Feedback – consider key themes from conversations during the CAV

- Staff engaged and interested in the QI project about PUs
- Staff appreciating the protected learning time and feeling more confident in grading, PU prevention, factors impacting TV and having discussions with their patients

Consider next steps, for example:

- **Share good practice**
- **Overview of CAV to be written up and shared with Operational Management meeting and TV Improvement 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?**	• Good examples of risk assessment and care planning, timely and comprehensive evaluations being undertaken • Appropriate referrals to AHPs, specialist nurses when indicated (continence, TV) • Audits include documentation, data completion on Datix, use of TV policy (use of photography and wound charts), case load complexity, continence products/assessment/re-assessment • Protected learning time for education related to PU prevention and management led by Link Nurse within team
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	• Observed interactions between 3 patients and District Nursing team, interactions were person centred and considered the holistic view of patient and family – avoided task focus • Discussed nutritional and fluid intake and impact on integrity of skin and wound healing alongside importance of position changes and maintaining mobility as far as able, appropriate use on continence products • Patient family member commented on how useful the information leaflet was
What improvement work have you identified/progressing?	• TV nurse specialist has undertaken and developed in-house training re PU prevention, grading and management • Datix training re detail of information required, need for Red Day Review Tool, onward referral to service as appropriate • Team Link nurse providing education sessions at lunchtime which have been well supported and available for advice
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)**	Substantial 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?**	• Regular team meetings, well attended • 1:1s scheduled and prioritised by Team Leader and staff members • Clinical supervision available to all RNs – partial uptake • Annual PDRs up to date, current with identified objectives/learning needs
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.**	• Team Leader new in post since June 2024, utilising the LEiC Education and Development Framework with Operational Manager, identified 3 areas of focus including QI • Rosters one morning per week for Team Leader activities, prioritised by Team Leader and team whenever possible • One day per month protected learning time for leadership development (LEiC)
How are decisions that impact on the team made and then communicated?	• Taken to team meetings and communicated via notes of meeting, emailed to all and on staff notice board • Standing agenda for team meetings with opportunity for staff to contribute to items for discussion
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)**	Substantial Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Assurance

Example quality and safety indicators:

- Local dashboards

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
What local systems currently provide assurance - eg audits, walk rounds, scrutiny of quality information at governance meetings and who undertakes them?	• Audits include documentation, data completion on Datix, use of TV policy (use of photography and wound charts), case load complexity, continence products/assessment/re-assessment • Observed team discussion round quality board • Team Leader currently taking TV improvement work to Operational Management meeting • Organisation wide TV Improvement Group reviews data
Is the scope of local assurance processes sufficient to meet your needs? Consider the domains of care quality – patient experience, safety, effectiveness, efficiency, sustainability.	• Local assurance processes appropriate • Operational Management meeting and TV Improvement Group feed into the Service Level Clinical Care Governance meeting/dashboard
Are assurance processes available at different levels of the organisation and are there clear escalation processes and feedback to local teams?	• Assurance processes available at team, operational and strategic levels with feedback disseminated
Overall reflection of quality and safety of care delivery focussed on Assurance (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	Substantial Assurance

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance