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.

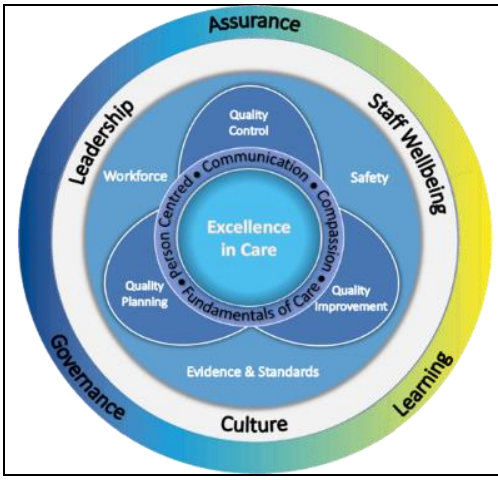
Care Assurance Visit (CAV)

Date:	12/03/2025	**Lead Reviewer:**	Lead Nurse
Clinical Area/Service:	Child Protection Team	**Other Participants, for example Peer, AHPs:**	Team Lead HON Child Protection Advisor
Manager/Clinical Manager:		**SCN/Charge Midwife/Team Leader:**	
Reason for CAV:	Options – scheduled, responsive	**Announced CAV?**	Y/N

What is the focus of the CAV? For example, specific quality and safety measures or overarching care assurance	Review the volume of Initial Referral Discussion and complexity of calls and the effect of staff wellbeing
Governance Pathway Who is responsible for monitoring progress of any improvement plan?	Lead Nurse

Date of previous walk round visits		**Any relevant information which should be considered during the CAV?**
Health & Safety		
IPC		
Leadership		
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/No	Person Centred Care	Yes/No
Compassion	Yes/No	Communication	Yes/No
Quality Control	Yes/No	Quality Planning	Yes/No
Quality Improvement	Yes/No	Workforce	Yes/No
Safety	Yes/No	Evidence & Standards	Yes/No
Leadership	Yes/No	Culture	Yes/No
Staff Wellbeing	Yes/No	Assurance	Yes/No
Governance	Yes/No	Learning	Yes/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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Assuring and Improving Nursing and Midwifery Care in Scotland

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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
Staff are very resilient and have expert level of knowledge and skills to be competent. Communication processes for workload management are in place.	Support creation of guidance for advice calls FAQ for Team leaders.

Patient Feedback - consider key themes from conversations during the CAV
Not appropriate

Staff Feedback – consider key themes from conversations during the CAV
Staff feel supported in their role, however have noticed that the workload is increased, the complexity of calls are increasing and the number of CPA's are the same. There are times that breaks are not taken and finishing on time is difficult.

Consider next steps, for example:

- **Agree improvement plan**
- **Target improvement support**
- **Share good practice**
- **Report writing and Governance Pathway (if required)**

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?**	
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	
What improvement work have you identified/progressing?	
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	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?	
Can you give examples of when you have observed patients and families being treated with dignity and respect? (or not)	
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?**	
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)**	

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Compassion

Example quality and safety indicators:

- Care Opinion feedback
- Information from the Patient Experience Team including Complaints or Adverse Events
- Trauma informed care

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
Observe how staff are interacting with people in receipt of care and families in person and on the phone	
Observe staff interactions with one another throughout the day and during huddles/handovers	
Ask person/child about interactions with staff, for example have they felt understood, treated with kindness, caring and a willingness to help	
Overall reflection of quality and safety of care delivery focussed on Compassion (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Communication

Example quality and safety indicators:

- Care Opinion feedback
- Information from the Patient Experience Team or use of Advocacy, including Complaints or Adverse Events
- Continuity of care

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
Observations of safety huddles and team handovers involving the MDT. Observation of interactions between different staff groups.	
Observe the use of escalation processes and staff feedback processes. Ask staff about how they feel they work in practice.	
Observe interactions between staff (different members of the MDT) and people in receipt of care. **Ask about the processes used to seek feedback from patients regularly and how this is used/shared.**	
Overall reflection of quality and safety of care delivery focussed on Communication (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Quality Control

Example quality and safety indicators:

- SPSP and CAIR dashboard
- Data from other sources – qualitative and quantitative

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
What data do the local team have access to - quantitative and qualitative? How frequently do teams access data about the quality of their care and what happens as a result? **How are they using the data to drive improvement? Where is the evidence?**	
Do the team know what good looks like/work towards a standard they have agreed?	
Are they working in a culture which enables them to make any required changes at a team level? Psychologically safe	
Overall reflection of quality and safety of care delivery focussed on Quality Control (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Quality Planning/Planning for Quality

Example quality and safety indicators:

- Board data for relevant Scottish Government targets such as waiting times
- SPSP, CAIR and local dashboards

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
What do people in receipt of care want from the service - how do the service know? What does the service want to deliver – is this captured in a mission statement?	
Which quality indicators are being used- what are the team working on, QI culture evident?	
Is the service set up appropriately to deliver the goals/purpose of the service- capacity, flexibility during periods of increased demand?	
Overall reflection of quality and safety of care delivery focussed on Quality Planning (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Quality Improvement

Example quality and safety indicators:

- QI qualifications within the area such as ScLIP, SiFS, ScIL or local training programmes
- QI team support
- Examples of QI testing and learning

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
What QI work is happening locally? Who in the team is involved in QI work?	
What support is available for the team?	
How is learning from tests of change communicated/shared at team level and wider?	
Overall reflection of quality and safety of care delivery focussed on Quality Improvement (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

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?	• Monthly allocation of workload to each of the CPA's • Workload spread to each CPA to meet the needs of the service, rotation of IRD's, advice, calls, supervision and delivery of training • Data base created to capture workload • If someone is off sick/unable to work - reallocation and prisonisation of work e.g. IRD's have to be covered • All staff require to have the appropriate knowledge and skills aligned to role (Band 7)
Does the person in charge identify the skill mix for safe staffing and is this being met? If not, what mitigation is in place?	• Daily Safe to start huddle – if staff are unable to meet all the needs of the service, prioritisation of work for covering IRD's is paramount. Email may be sent across relevant services to inform them of current situation. • Knowledge, skills and understanding of processes, systems and multiagency involvement • For example advice calls — can this be discussed within your own team lead? Does this need a CPA? What other information is required for this to happen, e.g. guidance, education
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?**	• Staff unable to get breaks • Large volume of work is on screen - no screen break • Workload captured on spread sheet - reviewed by lead nurse quarterly and escalated to HON if required • If IRD's are not prioritised this has a consequential effect on partner agencies, police and SW and potential escalated risk of harm to child/young person
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)**	• Workload is spread only within the team, if someone is off the immediate team must compensate • Skills are not easily transferable • This can have a detrimental effect on existing staff, impact on winder workforce, children and young people

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Evidence and Standards

Example quality and safety indicators:

- Board data for Scottish Government targets such as waiting time targets
- NICE and SIGN guidelines
- CAIR dashboard data such as QMPLE Score and QMPLE Student Feedback measures
- Annual Review, Professional Development and relevant registration (NMC, HCPC)
- GIRFEC/GIRFE/UNCRC/Pathway 4 (CfSD - Discharge without delay)

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
How are speciality specific standards used within the service?	
What are the local processes for raising awareness of updated standards/best practice? How are these then implemented?	
What planning for quality improvement work is being driven by service specific standards? What progress being made?	
Overall reflection of quality and safety of care delivery focussed on Evidence and Standards (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

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**	
What improvement work is being undertaken to address themes identified from adverse events/incidents, complaints, mortality reviews?	
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.	
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)**	

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?**	
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.**	
How are decisions that impact on the team made and then communicated?	
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	Reasonable Assurance	Limited Assurance	No Assurance

Culture

Example quality and safety indicators:

- Staff feedback such as iMatter, Joy in Work
- Board data for Scottish Government reporting such as whistleblowing
- PDWR/Appraisal and Staff professionalism
- NES Safety Culture Cards

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
Are teams encouraged to problem solve and innovate within clear boundaries? **Is psychological safety evident- do people express concerns openly?**	
How do individuals deal with differences of opinion?	
Are staff aware of how they contribute towards the vision for the service? If appropriate, are individual objectives available?	
Overall reflection of quality and safety of care delivery focussed on Culture (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	

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?	• Monthly team meetings, daily check in huddles • Restorative Supervision • 1:1's • PDP • iMatter - action plan created by team • Awareness and knowledge of polices e.g. whistleblowing
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.	• The team do not get their breaks and often spend long time sitting at the computer • Team aware of how to access staff wellbeing services • Can be difficult to discuss when team are struggling as workload is very high, the level of IRD's coming into the service in the last month is above 'normal 'calls • 2 members of the team are off work • Advice calls are not answered • Supervision does not occur • Team often work beyond contracted hours to meet the needs of the service
Do the team undertake de-brief activities after particularly challenging periods / episodes of care delivery?	• Debriefing happens within team level, discussion of workload • VBRP facilitation has also supported discussions
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)**	• Staff feel supported and understand what is required to make them feel safe at work, however this can all change if there is an increase in workload, particularly IRD's. It does mean that supervision, breaks and finishing on time does not happen. • This could have a detrimental effect of staff wellbeing

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?	
Is the scope of local assurance processes sufficient to meet your needs? Consider the domains of care quality - patient experience, safety, effectiveness, efficiency, sustainability.	
Are assurance processes available at different levels of the organisation and are there clear escalation processes and feedback to local teams?	
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	Reasonable Assurance	Limited Assurance	No Assurance

Governance

Example quality and safety indicators:

- Risk Assessment and Escalation processes
- Visible and effective governance
- Child protection/Adult support and protection

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
Are there standardised risk escalation processes and are they effective? **Is there a feedback loop for staff who have escalated risk?**	• Depending on situation, CPA would discuss peer to per then escalate to team leader and lead nurse (internal NHS process) • Multi-agency oversight if further investigation/discussion is required to seek resolution • Feedback mechanisms in place • Quality Management Assurance Group
Who reviews quality and workforce measures for this service? Who else?	• Lead Nurse, Head of Nursing, Clinical Effectiveness Coordinator
Is there a locally based system to ensure staff meet role requirements, i.e. professional registration, statutory and mandatory training.	• Robust recording and reporting system in place across organisation and Team • Administration support holds information for staff regarding registration requirements
Overall reflection of quality and safety of care delivery focussed on Governance (this can inform key areas within the Summary) **Consider level of Assurance (if using RAG)**	• Good systems in place, reasonable assurance in place

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance

Learning

Example quality and safety indicators:

- Access to Clinical Supervision and Training
- QI qualifications within the area such as ScLIP, SiFS, ScIL or local training programmes
- Hot/Cold debriefs
- Protected learning time
- TURAS learning

Potential areas to consider or questions to ask	Record areas of good practice, areas for improvement, reflections
How do the team/wider system share learning from adverse events/incidents, near misses, positive care experiences?	
What opportunities are there to access Clinical Supervision, Values Based Reflective Practice sessions, other methods of supporting reflective practice?	
What time is available to engage with Leading Excellence in Care Education and Development Framework?	
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	Reasonable Assurance	Limited Assurance	No Assurance