Coordinate my care (CMC) Clinical Quality Audit Framework

A CMC Clinical Quality Audit is an important exercise to improve and maintain the high quality of care plans that improve outcomes for our most vulnerable patients.

When preparing to audit CMC care plans in your locality (a GP practice; Primary Care Network; Hospital; CCG; STP) we recommend submitting to the CMC Clinical Quality Manager a **Clinical Audit proposal** using the following format:

- ✓ Introduction (max 250 words):
- ✓ Proposal (max 250 words):
- ✓ Aims of clinical quality audit:
- ✓ Objectives:
- ✓ Proposed methodology:
- ✓ Timelines:
- ✓ Expected outcomes:

If you require any support with the proposal, we recommend setting up an introductory meeting with CMC Clinical Quality Manager.

When conducting audit of CMC care plans, please consider:

- Accessibility: Can the plan be seen by other people who need to act on its instruction (i.e. is it a published care plan)?
- Currency: Is the information in the plan current enough to respond to the person's urgent or emergency care needs? When it was last updated?
- Communication: Does the plan communicate the most relevant information to those providing urgent or emergency care?
- Comprehensive: Does the plan communicate adequate background information to support clinicians to support the person holistically?

It is vital to provide as much qualitative feedback as possible, as every care plan is unique for each patient. Sometimes however it might be helpful to use standardised approach to reviewing areas of CMC care plans which are particularly useful to urgent care services.

We encourage providing feedback from audits to individual clinicians (where appropriate), as well as teams and the wider health and social care community is the form of a Final Report.

Standardised CMC audit template:

<u>Proposed Scoring (this can be changed in the context of each audit:</u>

Not completed = 0: left blank, no information recorded
Limited = 1: very limited information recorded
Satisfactory = 2: appropriate level of information recorded to help inform decisions
Extensive = 3: additional detail and information which helps to inform decisions.

Key Information	**Assessment criteria**	**Score**	**Notes (additional comments from assessor)**
Is the care plan in draft or published?		0-in draft 3-published	

Last approval date	If the care plan was last approved year or more ago, urgent care providers confidence in any information provided will be jeopardised	0- Review overdue 3 – review up to date	
Symptom management	Information related to each diagnosis	0 – Not completed 1 – limited 2 – satisfactory 3 – extensive	
Cardiopulmonary Resuscitation (CPR) Discussion			This needs to be assessed in the context of each patient. Sometimes there is a discussion recorded and evidence that the CPR will not be successful but on the summery 'discussion not yet made' Providing conflicting information on the care plan may lead to avoidable incidents. One might find that the DNARCPR is attached as a document, but not reflected in the care plan.
Emergency treatment plan	Additional information to compliment ceiling of treatment (free text box)	0 – Not completed 1 – limited 2 – satisfactory 3 – extensive	
Medication including anticipatory medication	Key medication listed	0 – Not completed 1 – limited 2 – satisfactory 3 – extensive	
Advanced Decision to Refuse Treatment/Lasting Power of Attorney	Where these are located and how to find/contact	0 – Not completed 1 – limited 2 – satisfactory	

		3 – extensive	
Communication and functional abilities	How the person communicates and the need for an interpreter (if appropriate Baseline functional ability, pain, bladder and bowel function etc	0 – Not completed 1 – limited 2 – satisfactory 3 – extensive	
What matters to me	Record of information which gives a sense of the person and their wishes, including religious/cultural needs and preferences.	0 – Not completed 1 – limited 2 – satisfactory 3 – extensive	
Key contacts	Record of key personal and relevant **health and care** contacts (excluding GP) e.g hospice, mental health team, community palliative care team Clearly recorded if no personal contact available.	0 – Not completed 1 – limited 2 – satisfactory 3 – extensive	
Any attached documents?	LPA for health etc.?		
Urgent care updates			Understanding of the level of urgent care engagement with the care plan, gives a very indication around its quality.

Feedback

It is essential to share findings of your audit as wide as possible to change practice and improve quality. Please share your Final Report with CMC for onwards sharing with Pan-London health and social care community.