

Monitoring and Evaluating

As a company we felt highly honoured in July 2009 to be awarded the CPAA Award for *Excellence in Monitoring and Evaluating the CPA Process*.

This award was indeed a valued credit to a relatively new company in the care sector, this unit only having been open for just over three years, and it was also a wonderful testament to not only the staff who work hard to ensure that patient centered care is a reality, but also to patients and indeed carers whose views, opinions, experiences and expertise all formed key elements to the work that has been undertaken by this unit.

Having worked in the community I had been impressed by the ethos of the company and the hard work that it was evidently undertaking not only to provide an increasingly good standard of care to the patients here in the low secure independent hospital, but also by the general ethos of listening to patients' views and of 'going the extra miles' to ensure that the services it provides are of a high and relevant standard. I was thrilled to be offered a post here and eager to get stuck into my new job.

One of my diverse roles within the unit was to undertake a CPA audit. Having never done anything like this before I was surprised to find that there was no substantiated audit tool available. The Farndon Unit has developed and retains an excellent record of treating people in a person centered; solution focused manner, working to a patient self directed recovery model. The problems highlighted within this first CPA audit (my first audit rather than the companies!) were less that the company was not meeting patient needs, they largely were, rather that there was no auditable evidence that demonstrated the excellent dynamic work that staff undertake here, supported by our strong policies and procedures.

I looked on the CPAA site to see if in fact there was one that we could use there. Although there was one that we were able to adapt sufficiently to employ as an interim audit tool, it did not fully capture the level of work being undertaken in the unit and it also proved not to be reflective of the holistic care being developed within the unit. However, we discovered the 'Refocusing the CPA' agenda advocated by the CPA Association. This was actually an exciting discovery and proved to be highly motivational. The changes being advocated by the CPAA fitted in very closely to changes that we had been contemplating as an agency. We needed to ensure that we recognised each patient as a unique individual with personal life experiences; strengths; problems; solutions; goals; achievements; social lives; hopes and dreams.

During a social work meeting we became very excited about the prospects of identifying and

developing progressive changes and drew up a document entitled 'Refocusing the CPA in the Farndon Unit', presenting this to the Hospital Director, who was very supportive of our further looking into changes that we could make.

With her support we set up a CPA Steering Group that was open to any member of staff who wished to attend and had interest from care assistants; activity co-ordinators right up to the Psychiatrists, the first meeting being held in November 2008.

During the first meeting we unanimously decided that it was imperative that we invited patients and carers to attend the Steering Group. We felt though that owing to the complexity of the task we were addressing that it may be better that the first few meetings were held by the care team then opened out to patients and carers, the aim being that we would have a clear remit of what we wanted to achieve and that this could be explained to other attendees later. At the second meeting however this decision was reversed, we realised that although we were looking at the complex end of change and reform, we were risking overlooking the needs, opinions and experiences of the patients and carers and we duly decided that it would be better if these key people were included as early as possible. To this end we invited some carers to attend and also put up posters on all the wards inviting any interested patients to attend.

The response was very pleasing, the next meeting was attended by not only staff but also a number of patients (some quite unexpectedly given that it may have been so daunting) and a carer. Their views and opinions were excellent; ideas flowed around the table at a phenomenal rate. Issues were raised that as a professional team we would never have considered, including how important certain things are to be discussed during CPA meetings: i.e. relationship issues; sexuality issues; concerns about parenting and childcare to name but a very few. It also became apparent that key areas of care within the unit were not fully understood by patients, including tool levels (risk assessments of items that patients can access); medication information (information being imparted focused too much upon possible side effects rather than on the benefits of the medication); it was also felt that the information about the unit that is given to patients at the point of initial assessment did not fully explain aspects of life within the unit to reduce anxiety about coming to a new placement.

This meeting was excellent, there was no patient/carer/professional divide, and we all came to the table as equals with the goal of making positive changes. There were no axes to be ground; no

the CPA Process

complaints, just solid discussion amongst a group of people with a shared vision. We documented all the ideas, although there were too many excellent ideas to be actioned all at once, they were too good to be put to one side and forgotten, rather we documented them and will work through them as a group into the future. One of the more exciting things though was that we all fully recognised that CPA is an ongoing live process rather than just a meeting that happens for patients/service users once every 3-6 months. It is a live and ongoing process that underpins not only the care that is provided to service users and carers, but also informs service development, staff development, progress in the mental health arena and fundamentally can be viewed as the basic building block on which empowerment; recovery and rehabilitation can all develop in a manner that not only encourages progress but also marks and measures it along the way enhancing both patients self esteem therefore sense of personal worth, but also enhancing the sense of purpose in a professionals role, thereby fostering career satisfaction.

One of the first things that needed to be done was to develop an audit tool that was capable of:

- Collating auditable information.
- Enhancing attention to holistic patient care.
- Embracing a Whole System approach to care, including not only professional opinion but also promoting full patient and carer involvement. This needed to be at every level rather than a tokenistic exercise as sadly it seems that many 'patient involvement' projects are at risk of becoming.

On comparing recommendations advocated by the CPAA in their 'Refocusing the CPA' guidelines we also identified that we needed to enhance our service by:

- Developing an holistic single assessment tool to reduce inter departmental repetition during the assessment process.
- Develop discrete treatment pathways that would enhance the structure of the care provided within the service.
- Develop/promote and enhance patient and carer involvement.

Firstly we developed a Patient Self Report document. Prior to each CPA meeting, each discipline routinely writes a report on the patients' progress, identifying work that has been undertaken and recommending what may need to be done in the future. Patients have always been given the opportunity to voice their opinions during the meetings, and each is able to access the independent advocate if they wish to for this purpose. Now however patients who wish to can complete their own self report prior to the meetings, this includes things that they are proud of;

things that they would like; their views on what is working for them; their views on what they would like to change, and their views on what they feel they need to be doing to continue to recover and their long term goals. These forms are included in the CPA packs put together before every meeting. Initially patients seemed reticent to use the forms, however those that did found them empowering and have encouraged others to use them too.

Our next task then was to develop a CPA Audit tool that would ensure that holistic care remains solidly at the centre of all that we do. To this end we developed (and through a series of refinements completed) a CPA Checklist. This is a document containing numerous sections. The first is for the 12 week after admission point where we spend time supporting new patients to settle into the unit; undertaking assessments; updating risk assessments etc. At the 12 week point (the first CPA meeting) we sit and jointly formalise the treatment pathway. The first section therefore focuses upon this initial period.

The next section focuses upon the patients and their carers' views and opinions, it also looks at areas including religion; sexuality; socialisation; physical health; past experience etc.

Other sections look at what each discipline is working on and addresses relevant areas in a patients lives; i.e. the social work section looks at benefits; housing; child contact etc; the OT section looks at activities; education etc.

There is a section on the checklist specifically aimed at addressing section 117 issues and care planning.

The final sections are for each attending person (including patient; advocate; families/friends as well as professionals) to sign to demonstrate that full agreement has been reached, with an area for disagreements and the reasons for these to be documented where necessary. At each CPA meeting a care pathway form will also be completed as part of the checklist that identifies what each discipline aims to achieve before the next CPA meeting, in this way aiming to add further structure to the care pathway.

Unmet need is also recorded; this then is collated and used for purposes of further service development.

The checklist is basically a series of tick boxes. When each subject has been discussed, if there is no identified action to be taken this then is recorded, however if any area of work is identified, this then is documented and the person responsible for seeing it through is identified on the form.



To date the form, although a little timely, is proving effective. It has been revised as new things come to the fore, for example an attending commissioner pointed out that it would be useful to document someone's MAPPA status on the CPA document, this will be done.

As an audit tool it works well as it is possible to 'count' what has been discussed and what has not. So far it was found that patient's sexuality has perhaps not been discussed routinely. We discussed this during one CPA Steering Group meeting to see if we needed to keep 'sexuality' on the checklist. This led to an open and frank discussion largely by the patient representatives in the group about the relevance of discussing sexuality during CPA meetings, identifying that there have frequently been times when medication has caused problems of a sexual nature that patients' can be too embarrassed to discuss in front of a group, having the question there on the checklist would ensure that this would be raised in a non-embarrassing manner. Although still in its early days of use within the unit, it took time to develop the tool, ratify it and promote its' use at meetings, the early signs are that it is highly effective as an audit tool and (as with the question of sexuality) we anticipate that it will have the added advantage not only of improved audits; more open discussion, but also enhanced Multi Disciplinary Team work, enhanced patient and carer inclusion in care planning and a greater care pathway structure.

Following naturally on from this enhancement to patient involvement in care planning we next looked at developing Advance Statement documentation involving the development of an Advance Statement Policy; Patient Guide to Advance Statements and a staff training session about it all. The advantage of the Advance Statements is clearly that it provides patients/service users with an opportunity of having their wishes and opinions considered at points where they may lose capacity either in the near or distant future. Advance Statements should also be highly considered during section 117 planning. We developed the formats that we now employ and a number of patients trialed completing them (supported if necessary by staff). Initially (again) the response was one of disinterest amongst some patients on the basis of completing more paperwork. Some of the patients that attend the Steering Group were amongst those that trialed the format, all those that completed an Advance Statement agreed that they found them empowering and would inspire greater confidence in their future care. The patients were aware that there would be no legal requirement for mental health services to follow their Advance Statements to the letter if it was deemed not in the patients best interests at a given point, however they uniformly stated that they felt that the fact that the statements would need to be considered offered them the opportunity of having their voices heard even at times when they may be very unwell.

The CPAA highlighted a problem of assessment suggesting that 'initial assessments should be common to all referrals and include all the elements necessary to make decisions about the CPA'.

On the back of this, and in recognition that all too many times patients are routinely asked the same questions over and over again by different disciplines involved in their care as part of departmental assessment procedures, we developed and now routinely employ an holistic assessment tool every time we assess a newly referred patient.

The tool has the advantage of holistically assessing a patients' overall experiences. It also assesses areas of work that would be relevant to each discipline, thereby making the one assessment relevant to each discipline as a starting point for working with a new patient.

The tool has been specially constructed so that it has a natural flow in documenting a patients history with specific headings that highlight problems; solutions; social background; psychiatric background; forensic/risk history; physical health; future goals; OT requirements; and family contact concerns etc. Risks are documented in such a manner that that can be transferred quickly onto the Risk Matrix document that we employ within the unit. This information is then quickly transcribed into the development of appropriate personalised care and treatment pathways that can be quickly put into place on a patient's arrival at the unit. Previously the unit used to employ a 'one size fits all 72 hour care plan' for all new admissions.

The assessment tool has been constructed in such a manner that it highlights Historical (H) elements of the HCR20 risk assessment tool that is used within the unit. With the (H) elements being assessed and identified before a patient is even admitted to the unit, these elements are transferred to HCR20 assessments forms (obviously only when a patient has been accepted to come to the unit) and the focus of the initial 12 admission period can be to assess the Current (C) elements of the HCR20.

Assessments undertaken using this tool can be transferred with the patient as they progress to a different service, thereby making the tool both ergonomically practical and ensuring that identified risks and strengths are not overlooked in the future. It also demonstrates a clear adherence to principles of a 'Whole Systems Approach'.

Almost as a bi-product of the above developmental work, we realised that we needed to develop disciplinary treatment pathways which laid out what each discipline expected to achieve for a patient, and also laid out sequences of what (given that every patient is unique) each department would strive to achieve for the patient. This was needed to develop not only the initial referral assessment tool, i.e. if a Social Worker were to undertake the assessment, they would have to have a clear idea of what the OT or Psychology departments would be seeking to achieve in the next few weeks/months and how they would structure their service. To this end, each department developed their

own Treatment/Care pathway document, thereby adding greater inter disciplinary cohesion. On the back of this work, it is now possible for patients to have clearer information about time frames for things, about what they may expect; they can see there are alternatives should a particular course of action not be suitable or effective for any reasons. This is having the positive effect of patients feeling they have more choice and that they are less 'passive recipients of care' than they once did.

Patients and Carers identified that when patients are admitted into this unit, carers, families and friends of the patient can feel disincluded in what is going on and often have no idea about what to expect; what sort of rights they may have to visit, some identified that because this is a low secure unit they felt that perhaps it would be like a prison. They did not understand about child visiting policies / procedures; what goes on within the unit, and a raft of other things.

Prior to any of our patients having escorted leave to visit family/friends or carers someone from the unit used to go to the homes to be visited first to assess and advise on risk issues. We felt that this was inadequate and that it overlooked the valued roles of family/friends or carers. To this end we developed a checklist of risks that are routinely sent out to those persons whom the patient wishes to visit, and a home assessment in undertaken. The new home assessment tool clearly looks at risks, this is an imperative area of work, but it also aims to offer the carer/family or friend the opportunity to discuss their concerns, their hopes, their fears about the patient. Prior to the home visits, the consent of the patient is always sought, and a discussion is held to ascertain what level of information a patient agrees to be shared with the person being assessed. With consent (clearly, not when no consent has been forthcoming) the home assessments are something of an information sharing session wherein (generally) information on the quality of relationships, pre-morbid presentation, periods of difficulty are discussed, the assessor is then in a position (where appropriate) to answer some of the concerns raised by the assessee. These assessments are currently proving to be invaluable not only as a tool for gathering further data, but also as a means of developing and enhancing rapport with important people involved in the patient's lives.

On the back of the work around developing the Home Assessment tool, and following discussions about a) how it feels to be a patient being admitted to an unknown unit; often in an unknown town, and b) discussions on how it feels to have an unwell person whom you care about whisked away to an unfamiliar place, the CPA Steering Group have now developed two patient/carer/staff working parties to look at developing a carer's information newsletter, that will contain information about the unit; the town; various mental illnesses and treatments and events within the unit. This has generated a real interest amongst the patients to form a 'Local area interest group' to photograph and research local areas of interest for this newsletter.

Another patient/staff/carer working group in progress is developing a 'Patient for Patient' information brochure to be given to those assessed and offered a place in the unit. This is an amazing piece of work; it was astounding how many positives were identified during the initial discussion process about this project. I suspect that no PR group would feel confident to include as many good things about something as the patients would like to have included in this brochure. Similarly no PR company would perhaps feel comfortable in revealing 'warts and all', but as the patients have said, nothing is totally perfect!

Patients have identified that they wanted a 'faith' chat group wherein those with religious beliefs of any denomination can meet up on a regular basis and discuss current affairs and issues with each other from the basis of their beliefs (wishes for the establishment of this group upon the back of conversation about whether we needed to routinely review patients' religion and faith beliefs during each CPA meeting).

The patients involved in all of the above have been absolutely amazing in their dedication to being part of the change process. Patients that had no interest in developing computer skills are spending hours on the computers writing things up as they know it will support other people in their situation in time to come.

As mentioned earlier in this article, this has been a genuinely exciting time for us all within the unit. With the encouragement and support of everyone from the Chief Executive Officer all the way through the company, we have been able to turn 'Person Centered Care' into a reality not just a buzz word; we have been able to make patient involvement a genuine reality; we have enhanced MDT working and this is just the beginning!

CPA is the structure on which care happens. I guess initially we thought it may all seem a little dry and dull when we first looked into the developments, after all, how exciting could developing an audit tool be? In fact, it has taken on a shape that is dynamic and inspiring. The ideas generated have been inspirational, questions that we probably would not even have considered have come to the table, by working together as one team; patients' staff and carers can make a difference.

As Irving Goffman so famously said: *'if something is broken, fix it; if something is working do more of it'*, our CPA Steering Group is working, we plan to do a lot more of it into the future. We still have a raft of excellent ideas to work through, and more coming to the table each meeting.

Carol Colins, Senior Social Work Manager The Farndon Unit, Raphael Healthcare

(The Farndon Unit, Raphael Healthcare received the award for the CPAA Awards 2009 category 'Excellence in Monitoring and Evaluating the CPA Process').