Peer Audit
Protocol

- **One case will be audited every three months at the PSDM meeting.**
- **Cases to be audited at the nominated PSDM will be agreed at the beginning of the year or at midway point.**
- **The audit will be documented using the agreed peer audit review form and feedback form.**
- **1:1 or group intervention can be brought to peer audit.**
- **Areas requiring further discussion in individual clinical supervision to be logged in review summary form.**
- **Person delivering peer audit will complete OT process form and provide hand out before audit.**
- **Peer audit summary to be documented in client record and communicated to key worker /named nurse.**
- **Peer audit documentation to be included in CPD portfolio.**

PEER AUDIT GUIDELINES

Assessment Process

1. Comprehensive history and initial assessment available.
2. Assessment of:-

- client's major work/leisure roles.
- client's routine, structure, occupational balance, rest and sleep
- P.A.D.L./ D.A.D.L.
- client's social functioning.
- risk.
- client's psychosexual functioning.
- client's emotional/mental state and motivation.

3. Takes into consideration clients cultural and spiritual values.
4. Identifies problem areas, strengths and personal goals with client where possible.
5. Offers specific specialist assessment in line with personal training.

Intervention Planning

1. Negotiates and prioritises goals in consultation with client and/or carer/significant other.
2. Intervention planning documentation completed.
3. Demonstrates evidence of liaising and working with M.D.T. and/or external agencies as required.
4. Considers unmet needs.
5. Uses risk assessment to inform risk management.

Intervention and Liaison Process

1. Provides and/or offers:-
   - Intervention directed at functional life skills.
   - Intervention directed at psycho-social functioning.
   - Intervention directed at work, productivity and leisure.
   - Intervention directed at offering a therapeutic environment.
   - Intervention directed at cognitive/problem solving function.
   - Support to family and/or carer/significant others.
2. Demonstrates evidence of consideration of social inclusion.

Evaluation Process

1. Client given opportunity to express opinion of intervention offered and/or received and aspects of this feedback noted where applicable, actioned.
2. Reason for end of contract identified and explored (as appropriate).
3. Recommendation for any changes in practice and highlighting of good practice noted and actioned.
4. Was the plan of intervention completed and was the outcome recorded?
5. Did the intervention end by mutual agreement with the client?
6. Was necessary communication with other agencies made?

Evidence of Clinical Reasoning

1. Consideration of the impact of assessment process on client.
2. Evidence of establishing therapeutic relationship.
3. Ensures clients implicit and/or explicit consent to all aspects of Occupational Therapy process.
4. Demonstrates and shows evidence of client centred practice.
5. Shows consideration of models and approaches to Occupational Therapy practice.
6. Demonstrates consideration of client's personal and occupational history and cultural experiences.

Communication (liaison with other professionals)

1. Meets professional record keeping and presentation standards.
2. Statutory documentation completed.
3. Case discussed in supervision where necessary and documented.
4. Serious concerns reported to appropriate person.
5. Contact made with other involved agents.
6. Plans formulated for on-going follow-up on discharge, including statutory requirements such as C.P.A. Sec 117 M.H.A. and child protection.
7. Referral made to other agencies (as related to identified goals).
8. Lack of appropriate resources noted and reported.
9. Shows consideration of section 17 leave