Essex Partnership University NHS Foundation Trust

Assurance Review of Consent for Oxevision

October 2025

Final

EPUT020913_0001

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

There was no strategic risk in relation to consent for Oxevision.

SCOPE

The overall objective was to provide assurance on the effectiveness of the consent processes in place within the Trust. This review focused on the arrangements for consent for Oxevision.

KEY STRATEGIC FINDINGS

The Trust has in place an Oxevision Standard Operating Procedure (SOP), which clearly outlines the processes in place for obtaining consent for the use of Oxevision, training requirements and roles and responsibilities clearly identified as part of the process.

Audit testing identified that for four of 10 staff, the competency checklist was not evidenced as no response was received from the relevant Ward Manager within the timeframe of the audit.

Testing of a sample of 17 patients across five wards, in June and July, where Oxevision is in use, identified significant exceptions such as lack of evidence of completed admissions checklist within six hours of patient's admission for 21 patients.

It was confirmed that as at the time of audit fieldwork, there were no oversight arrangements for senior management/committee to regularly review data in relation to consent for Oxevision. The implementation plan for Oxevision did include steps to 'agree audit and assurance plan', and to align tendable audit to new SOP).

GOOD PRACTICE IDENTIFIED

Review of the Oxevision and Oxevision Observations training slides showed that the training material covered all expected elements identified from the Oxevision SOP. The implementation plan runs from April to December 2025 with dissemination, briefing and training over April/May 2025, and continued embedding with further training and comms to December 2025.

ACTION POINTS

Urgent	Important	Routine	Operational
1	4	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	Testing of a sample of 17 patients admitted in June and July 2025 for whom Oxevision was used revealed the following exceptions: • For 9 cases, there was no admissions checklist. Hence, no evidence of informed consent. • In 4 cases evidence of informed consent was seen on the admissions checklist however this was were completed within 6 hours of admission (completion was 5 days, 7 days, 1 day, 8 hours after admission). • For 10 cases, there was no evidence that consent was documented on the patient's clinical case notes. Although in some cases conversations about Oxevision and Oxevision Observations were recorded in the patient's clinical record. • For 11 cases, the patients' views relating to Oxevision and Oxevision Observations were not recorded.	Satisfactory documentation be maintained, including: • Ensuring that an admission checklist is consistently completed for all patients where Oxevision is used. • Documenting consent discussions and outcomes in the patient's clinical case notes. • Recording patience views and preferences relating to Oxevision and Oxevision Observations to ensure these are not overlooked.	1	• *Quality matron and trust audit lead to create audit template on tendable for weekly ward matron completion and oversight.* • *Tendable Audit reports are pulled into a PowerBI report. Matron will present compliance and actions to mitigate non- compliance to the Inpatient Quality and Safety meeting which occurs.* • *Highlight Compliance and actions reports to form part of the AF quality slides this will ensure Executive oversight on a monthly basis.*	*01/11/25*	*Matron responsible for completion of consent audit.* *Ward managers responsible for overseeing the implementation of new working processes as detailed in the SOP* *DDQS and DMD DMD/DDQS- present Executive Director Chair of AF meeting.*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	All staff need to complete a competency checklist. This is a document which demonstrates competency for Oxevision and Oxevision Observations. The document needs to be signed by an Assessor and the staff member including a date of when competency was achieved, outlining that training was completed and fully understood. Testing of a sample of ten employees who were required to have undertaken Oxevision training identified that a competency checklist was not evidenced for four cases due to non-response from the Manager within the timeframe of the audit. It should be noted that there was evidence of completion training in all these cases.	(Christopher Unit and Harlow) Evidence of completion of the competency checklist be retained and readily accessible to the Quality Matron.	2	• *Quality matron will load the induction checklist to the SOPHIA application. (Currently a paper document) This will enable digital signature and accountability.* ○ *Ward based compliance list report can be pulled from SOPHIA. This will mitigate the risk of paper competency checklists being mislaid or not available.* • *Quality matron will add Question to the Ward manager tenable audit to check SOPHIA Oxevision induction checklist report to ensure all staff fit to practice.*	*03/11/25*	*Ward Manager* *Ward Manger* *Quality Matron*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	Testing of a sample of 17 patients admitted in June and July for whom Oxevision was used identified two cases where the patients lacked mental capacity to consent. When a patient lacks mental capacity to make the decision and give consent best interest decisions by the Nurse in Charge (NIC) are made on behalf of the patient regarding whether the use of the Oxevision system is in the patient's best interests and must be recorded on the patients clinical record. However, this was not clearly documented for one of these cases. In addition, for the two cases where the patients lacked mental capacity to consent, a Multi-Disciplinary Team (MDT) meeting was not evidenced to have taken place. The Standard Operating Procedure states that where there is reason to believe a patient lacks mental capacity, an MDT meeting should then be arranged to specifically review this decision as soon as is reasonably possible.	Where a patient lacks mental capacity to consent, best interest decisions be clearly documented with rationale and a Multidisciplinary Team meeting be convened, and decision taken recorded, as stipulated by the Oxevision Standard Operating Procedure.	2	*3 new Oxevision audits to be placed on the tendable audit platform.* 1. *Patient record audit: admission checklist, clinical case note, care plan & ward review) – for up to x25 patient records.* 2. *Staff based audit to include training, for up to x30 staff.* 3. *Policy & Governance audit. This will specifically address consent and mental capacity. It has also been agreed that this will be applicable for all inpatient areas including Specialist Services.*	*01/12/25*	*Quality matron to make amendments to audit* *Inpatient Matrons to ensure Compliance* *DMD/DDQS- present to AF for Executive Director Chair of AF meeting*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Directed	Testing of 17 patients for whom Oxevision was used identified that in all cases, whilst there was evidence that regular ward review meetings took place, there was no record that discussions on the use of Oxevision and Oxevision Observations took place at the meetings.	Records of discussions on the use of Oxevision and Oxevision Observations at the ward review meetings be maintained for audit purposes.	2	*As above in item 3. This is highlighted in the SoP linked to the competency checklist and audited through Tendable.* *Tendable Audit reports are pulled into a PowerBI report. Matron will present compliance and actions to mitigate non-compliance to the Inpatient Quality and Safety meeting which occurs.* *Highlight Compliance and actions reports to form part of the AF quality slides*	*01/12/25*	*Ward Manager* *Matron* *DMD/DDQS present to AF for Executive Director Chair of AF meeting*
5	Delivery	As at time of audit fieldwork, there were no oversight arrangements for senior management/committee to regularly review data in relation to consent for Oxevision. There should be arrangements in place for reporting and monitoring of consent/use of Oxevision at local and senior level including internal audits as appropriate. It was also noted that the internal audit methodology needed reviewing to ensure samples were selected appropriately and reviewed at local levels.	Establish local and corporate monitoring/oversight arrangements including regularly monitoring of performance data on consent and use of Oxevision as appropriate; and outcomes from internal audits.	2	*Governed by Inpatient Quality and Safety Meetings and Specialist Inpatient Quality and Safety Meetings.* *Highlight Compliance and actions reports to form part of the AF quality slides- Chaired by Executive directors.*	*01/12/25*	*DmD/DDQS* *DMD/DDQS- present Executive Director Chair of AF meeting.*

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Operational Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No operational effectiveness matter was identified as part of this review.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	Governance Framework	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	Risk Mitigation	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	Compliance	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1, 2, 3, & 4	-

Other Findings
As at the time of audit fieldwork, there were 11 sites across the Trust where Oxevision had been deployed. Testing was undertaken across five wards, namely: Beech ward; Grangewaters ward; Chelmer ward; Christopher Unit; and St Aubyn Child and Adolescent Mental Health Services (CAMHS).
The Trust has in place a Standard Operating Procedure (SOP) for the use of the Oxehealth Oxevision and Oxevision Observations. It was confirmed that the document was last approved in April 2025 by the Oxehealth Project Board, with the next review date being October 2025. Review of the SOP showed that the document clearly outlines the processes in place for gaining consent for the use of Oxevision, the training requirements, and the relevant roles and responsibilities.
All staff who work in an inpatient ward must be trained using the Oxevision system. The mandatory training consists of the completion of the Oxevision and Oxevision Observations courses on Oxehealth Academy, which is an external provider, and the Oxevision OLM (Online Learning Management). When staff have completed their mandatory training the completion status is displayed on their Mandatory Training Tracker List on the Trust's intranet. All mandatory training components require a 100% pass mark and need to be completed annually.
It was confirmed from a review of the Oxevision and Oxevision Observations training slides that the training material covered all of the outlined elements from the Oxevision SOP.

Other Findings

Oxevision (Oxehealth) is a medical device that uses an infrared-sensitive camera to measure patient pulse and breathing rate. Oxevision categorised as a class IIa (medical devices categorised as medium risk devices that require regulatory approval to ensure safe usage) vital signs medical device software that supports the observations of a patient and is compatible with all skin types. Class IIa are devices that are categorised as medium risk that require regulatory approval to ensure safe usage. Oxevision falls under this category as it monitors vital signs.

Through discussion with the Quality Matron the following process was confirmed for consent for Oxevision:

- Staff share information about Oxevision and Oxevision Observations at the time of admission, with the admitting nurse completing an admissions checklist, which evidences that an Oxevision and Oxevision Observations conversation has been completed with the patient within 6 hours of admission and informed consent has been gained or withdrawn for the use of Oxevision.
- Staff are required to also complete a full care plan within 72 hours of the patient's admission, which should be recorded on the patient's clinical record. The patient's consent and views relating to Oxevision must be recorded in the full care plan.
- If the patient has capacity to consent, this should be documented within the full care plan. Where the patient does not, best interest decision is taken for the patient, and this should be documented within the patient's clinical records.
- Oxevision and Oxevision Observations should form part of the standing agenda during ward community meetings to allow patients and members of the Multi-Disciplinary Team (MDT) to have open discussions.
- Patient discussions during ward review meetings regarding the use of Oxevision and Oxevision Observations should routinely take place and be recorded in the patient records.
- A patient has the right to withdraw consent for the use Oxevision at any time. However, if the patient consent is not given on admission, or is withdrawn during the admission process, the Oxevision system can be individually isolated by the Nurse in Charge (NIC) using the monitor to select 'Camera off' for the patient's bedroom. A decision to turn the camera off should only occur if the NIC deems the action clinically safe prior to an MDT decision meeting. If not, the Oxevision system will remain on and the rationale will be explained to the patient and this is to be documented in the patient clinical record.

Testing of a sample of ten employees who are all required to have undertaken Oxevision training, selected from the wards / units rotas for a day in July 2025 across the five wards visited revealed that:

- in all cases the staff had appropriately completed Oxevision and Oxevision observations training and scored 100%.
- in all cases, the staff training was displayed as completed with an appropriate completion date on the Mandatory Training Tracker.
- in all cases the training in the use of the Oxevision system is included in the staff local induction to an inpatient ward.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	5	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of Scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of Scope	-	-

Other Findings

None.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of Arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report:

Stage	Issued	Response Received
Audit Planning Memorandum:	23rd June 2025	23rd June 2025
Draft Report:	10th September 2025	
Revised Draft Report:	23rd October 2025	27th October 2025
Final Report:	28th October 2025	