The King's Fund

ORGANISATIONAL *Audit*

HOSPITAL ACCREDITATION PROGRAMME

Organisational Standards & Criteria

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FOREWORD

Four years have passed since the publication of the second edition of the Organisational Audit manual in 1990. Since that time, we have revised several individual sections of the manual, in order to ensure that the standards remain at the forefront of good practice, as well as to reflect the significant changes which have taken place in the organisational structure of hospitals. The republication of the management standards in response to the many demands placed upon the management of hospitals by the NHS and Community Care Act of 1990 is one example of this. The pace and scale of changes since 1990 have been enormous - both in the services provided and in the management structures which have developed to support them. While a healthy diversity exists, clear organisational patterns are emerging, for example in the form of clinical directorates, which the revised structure of the manual itself is designed to reflect.

The 1990 legislation has impacted in a number of ways. Hospitals, operating in an increasingly competitive environment, have become acutely aware of the link between organisational capability and the capacity to deliver high quality clinical care, and of the importance of demonstrating this capacity to consumers and purchasers alike. This has emphasised the relevance of an external evaluation in monitoring performance in this area, and the contribution organisations such as the King's Fund can make to this process.

Following extensive consultations with clients and its own multiprofessional governing body, King's Fund Organisational Audit (KFOA) will offer formal accreditation to acute hospitals from 1995. A key factor in the acceptability and ultimate success of this initiative will be the strength of the standards themselves, the foundation upon which the Organisational Audit approach is built. In order to ensure that these standards provide an objective framework within which hospitals can work and against which they can be measured, we have undertaken the significant revision which this manual embodies. We have reformatted the standards to make clear the distinction between the criteria to be measured and the guidance which supports them. In time we shall provide this guidance separately, as well as further documentation to support surveyors and hospitals in their use of the manual. In addition, and central to the process of revision, we have attributed 'weightings' to the standards upon which our decisions concerning accreditation will be made.

This work has taken place in consultation with experts in each area of the standards. Our debt to them in enormous. We are already planning the next edition of the manual, which will result from the feedback which we shall receive during its use in the year ahead. We look to our users to continue to provide us with the constructive criticism which is the surest safeguard that our standards and our process will remain true to the founding purpose of Organisational Audit: that of supporting healthcare organisations in the pursuit of continuing organisational development.

We would like to acknowledge the enormous support we have received from all those who have been involved in the revision and restructuring of this manual.

Our thanks go to:

The King's Fund, which continues to support us in all the work that we do.

The Gatsby Foundation, one of the Sainsbury family's charitable trusts, without whose generosity the acute hospital programme would never have been possible.

The professionals in the field who have contributed to the development, revision and

'weighting' of the criteria and the professional and consumer organisations who have commented on the draft edition of this manual (pages XI - XVI).

Lee Braithwaite and Roger Meeks for designing and typesetting this publication.

The support staff at KFOA who have helped in the typing of this manual, its numerous rewrites and the 'weighting' exercise, particularly Ann Patrick.

And finally:

Special thanks must go to Karen Wright, Standards Development Manager, whose indefatigable efforts have made the publication of this document possible. Her focus and patience, in the face of so daunting a task, have been a source of admiration to all who have endeavoured to make that task ever more complicated.

Tessa Brooks
Director
King's Fund Organisational Audit
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INTRODUCTION

This third edition of the Organisational Audit manual marks the beginning of a new phase within the King's Fund Organisational Audit (KFOA) - that of accreditation.

Over the last four years, KFOA has developed a national approach to improving the organisation and delivery of healthcare through the setting and monitoring of standards. Since its inception, the programme has grown to such an extent that, by the end of 1994, 180 units, from both the NHS and the independent sector, will have participated in the process.

The standards contained within this manual underpin the KFOA programme. They provide a hospital/trust with a means to question practice and to stimulate development work. They provide a real opportunity for staff to question 'what they do', 'why they do it' and 'whether it could be done better'. However, for these standards to remain authoritative they must be subject to continual scrutiny and regular update. Standards are not meant to be static - they need to be modified and shaped to reflect changing needs and circumstances. Certainly, in the last four years the healthcare sector has seen many changes and the Organisational Audit manual, published in 1990, is no longer able to meet these changing needs successfully.

As a direct result of these changes and as a result of the feedback that our most valued critics, the participating units, have given us, we have embarked upon a total revision of this manual. The revision, which has taken place over the last 15 months in liaison with many professionals from the field, has resulted in a number of changes to the structure and content of the 1990 edition.

REVISED AND UPDATED SECTIONS

In this edition of the manual the following chapters are new or have been fully revised: accident and emergency service; chiropody service; dietetic service; estates management; health and safety; hospital based social work; infection control; medical physics and biomedical engineering service; medical service; midwifery service; nursing service; occupational health; occupational therapy service; orthoptic service; physiotherapy service; radiotherapy service; risk management; security service; speech and language therapy service and telecommunications service.

Much of the development and revision work has been undertaken by specialist working parties, the members of which have been drawn from the field and from professional organisations.

All members of the working parties were asked to either revise or develop the criteria in light of the following:

* measurability - the criteria should be measurable, both by the staff implementing the criteria and by the surveyors measuring compliance against them.
* achievability - whilst it is acknowledged that some hospitals will find it more difficult to achieve the criteria than others, it is also recognised that there is little point in including criteria that are not achievable.
* flexibility - the criteria should be flexible enough to be used by large and small, public and private healthcare facilities.
* acceptability - the criteria should represent a consensus on currently accepted professional practice.

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In February of this year, senior professionals from the healthcare field were invited to participate in a large scale 'weighting' exercise. They were asked to 'weight' the criteria according to the following classifications:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met*

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

*This manual is not a legal textbook. For guidance as to the precise law and its applicability in specific circumstances, legal advice should always be sought. KFOA cannot accept any responsibility for any inaccuracies in individual references to legal and professional requirements.

CROSS-REFERENCING

It is recognised that services/departments in a hospital/trust do not operate as discrete entities. Indeed, one of the benefits of participating in the Organisational Audit process is that it encourages multidisciplinary working across departmental boundaries. For this reason many of the criteria, which can only be met with the input of other disciplines, have been cross-referenced to criteria relevant to other disciplines.

GLOSSARY

A glossary has been inserted at the back of the volume 1. This glossary contains general terms from the following sections: The Patient's Rights and Special Needs, Corporate Management, Core Standards for Non-Clinical Services and Core Standards for Clinical Services. For future editions, the glossary will be expanded to include a definition of those terms contained in the service specific chapters.

SOURCE OF PUBLICATIONS

Details of how to obtain the publications referred to in this manual are given on Pages IX - X.

FURTHER REVISIONS

The process of revision is, by its very nature, a lengthy one and it has not been possible to revise the content of all of the sections within this manual in the last twelve months. However, a revision of the outstanding sections will be addressed throughout 1995. In addition, standards and criteria will be developed for key areas in the hospital/trust which have not, as yet, been tackled - for example, the mortuary, the business office, the transport department.

further encourage staff to work with the criteria on a multidisciplinary basis.

Each core section of the manual contains the following sub-sections:

Aims and Objectives

Management and Staffing

Staff Development and Education

Policies and Procedures

Facilities and Equipment

Quality Management and Evaluation

In addition, a patient care sub-section appears between 'facilities and equipment' and 'quality management and evaluation' in the Core Standards for Clinical Services chapter.

The sub-sections follow a logical sequence:

* the aims of the service and the objectives that need to be in place to achieve those aims;
* the staffing structures that are needed to achieve the aims;
* the training that is necessary to equip staff with the skills they need to achieve the aims;
* policies and procedures needed to guide staff in their activities;
* facilities and equipment needed to deliver the service;
* the evaluation of the service to ensure that the aims set are being met.

INTERPRETATION

Guidance information is now shown in italics beneath a number of the criteria in the manual. The aims of the guidance are threefold: first, to help staff interpret the criteria; secondly, to provide guidelines for meeting the criteria; and, thirdly, to provide an indication of the areas that the surveyors will be assessing during the survey.

WEIGHTING CLASSIFICATIONS

Over the last four years, it has become clear that the sheer volume of standards contained within the 1990 edition of the manual presents a daunting prospect to any unit first embarking on the Organisational Audit process. Whilst participating units understand that KFOA does not expect all of the standards to be implemented in the year long preparatory period, there is clearly a need to help units manage their workload by focusing on the more fundamental criteria and by helping them to prioritise workload and plan action timetables. To address this issue, KFOA has decided to allocate a priority 'weighting' to all criteria contained within this edition of the manual. The need for such an undertaking has since been strengthened by the decision to offer accreditation to hospitals/trusts from 1995.

* adaptability - the criteria should be non-prescriptive. They state what should be in place and not how something should be put in place. The criteria can then be implemented in accordance with local needs.
* national applicability - the Organisational Audit process offers a common framework of standards and criteria against which all hospitals within the UK can be assessed. It is therefore important to ensure that the criteria reflect national needs and are not tailored to meet the requirements of any one country, region, or district.

The standards and criteria developed by the working parties have been circulated to the professional bodies for comment before their incorporation into this edition of the Organisational Audit manual.

There have also been numerous minor changes and additions made to the remaining chapters of the manual where discrepancies have been identified and improvements suggested as a result of the 'weighting exercise' (see 'weighting classifications').

STANDARDS AND CRITERIA

In order to add greater clarity, we have now made a distinction between standards and criteria as follows:

Standard: the overall goal.

Criterion: the mechanism that needs to be in place in order to achieve the overall goal.

By taking such an approach, participating units and KFOA surveyors are able to clearly measure whether or not a standard has been achieved.

STRUCTURE OF THE MANUAL

The manual is divided into seven sections:

* The Patient's Rights and Special Needs
* Corporate Management
* Core Standards for Non-Clinical Services
* Service Specific Criteria for Non-Clinical Services (see Contents for services covered)
* Core Standards for Clinical Services
* Service Specific Criteria for Clinical Services (see Contents for services covered)
* Health Record Content.

Core sets of standards to be used by non-clinical and clinical services have been developed to (a) take into account the changing organisational face of the NHS - namely the introduction of 'clinical directorate' type structures - and (b) remove the repetition of standards from section to section. We hope that this change will facilitate distribution of the standards and criteria and

THE FUTURE

It is clear that, whilst the third edition of the Organisational Audit manual marks a significant move forward, there is still work to be done to refine and improve its content and to provide additional information to facilitate the Organisational Audit process. In the coming months we will be publishing the following material to accompany the manual:

* a reference booklet containing lists of references which relate to the 'A' category criteria.
* an interpretation booklet containing expanded guidance on how to interpret and implement the criteria.
* a coordinator booklet to help guide hospital/trust coordinators through the Organisational Audit process.
* a software package for self-assessment and monitoring of performance against the standards.

Updating the standards and criteria is an on-going process. We are committed to ensuring that the contents of this manual remain as current as possible and will continue to draw on the expertise of professionals in the field to strengthen and improve our existing revision mechanisms.

Karen Wright
Standards Development Manager
King's Fund Organisational Audit
September 1994

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HOW TO USE THE MANUAL

For Hospitals/Trusts Participating in the Organisational Audit Process

WORKING WITH THE STANDARDS AND CRITERIA

Staff at all levels should be involved in working with the criteria relevant to their area of work. This will encourage ownership of the process and group discussion. It will also facilitate the identification of weak and problem areas, bringing out into the open different staff members' perceptions of how well their service is complying with the criteria. There is limited value in the manager completing the self-assessment of the service against the criteria, based only on their own perception of the situation.

At the end of the preparatory period, all departments/services should complete and return to KFOA a self-assessment of the progress that has been made towards meeting the criteria. These self-assessments will then be used (a) by the surveyors to build up a picture of the hospital/trust before the survey begins and (b) by KFOA to feed any comments on the criteria into the on-going revision process.

DISTRIBUTION AND COMPLETION OF THE STANDARDS AND CRITERIA

The responsibility for assessing the hospital/trust against the Corporate Management standards and criteria rests with the executive management team/trust board. Only one self-assessment return per hospital/trust should be made.

The issues which need addressing in The Patient's Rights and Special Needs chapter should be looked at throughout the hospital/trust but only one corporate return should be made. However, it is important for service staff to contribute to the assessment and it is therefore suggested that a copy of this section is distributed to each directorate/service.

The Core Standards for Non-Clinical Services and the Core Standards for Clinical Services should be distributed to all non-clinical and clinical services respectively, together with the relevant service specific criteria. In independent hospitals, each department should complete and return an assessment against either the Core Standards for Non-Clinical Services or the Core Standards for Clinical Services, as well as the service specific criteria. In NHS hospitals/trusts, the core standards should be applied across all of the services within a directorate, but only one return per directorate should be made. In addition to this, each individual service should complete and return the relevant service specific criteria. One return per directorate should be made for the nursing and medical service specific criteria.

The Health Record Content chapter is relevant to all staff contributing to the patient's health record and, as such, these staff should be aware of, and work towards meeting, the requirements of KFOA. However, only one corporate return is expected.

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HOW TO OBTAIN PUBLICATIONS MENTIONED IN THE MANUAL

Many of the publications are likely to be available from your library or information service. If not, copies can be obtained from the following sources.

Department of Health and NHS publications

Priced publications are usually available from HMSO (see below).

Letters and Health Service Guidelines are sent to all Chief Executives and General Managers. If you are unable to obtain a copy within your own organisation you should write to:

Letters:

Public Enquiry Office
Department of Health
Room 444
Richmond House
79 Whitehall
LONDON
SW1A 2NS

Health Service Guidelines:

BAPS
Health Publication Unit
DSS Distribution Centre
Heywood Stores
Manchester Road
Heywood
LANCASHIRE
OL10 2PZ

Useful numbers:

General enquiries
(Department of Health): 071 210 4850

NHS Executive: 0532 545000

NHS Estates: 0532 547000

Legislation and other official publications

Available from:

HMSO Publication Centre
P.O. Box 276
LONDON
SW8 5DT
071 873 0011 (enquiries)
071 873 9090 (orders)
071 873 8200 (fax orders)

They can also be obtained from HMSO agencies (see Yellow Pages) or ordered from good booksellers.

Health and Safety Executive publications

Available from:

HSE Books
P.O. Box 1999
Sudbury
SUFFOLK
CO10 6FS
0787 881165
0787 313995 (fax)

Priced publications are also available from Dillons Bookstores, and may be ordered from branches of Ryman.

British Standards

Available from:

BSI Standards
Linford Wood
Milton Keynes
BUCKINGHAMSHIRE
MK14 6LE
0908 226888 (enquiries)
0908 221166 (orders)
0908 322484 (fax orders)

Other publications

Most may be ordered from good booksellers.

In case of difficulty, please contact King's Fund Organisational Audit for additional advice.

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THE PATIENT'S RIGHTS AND SPECIAL NEEDS

This document contains a set of organisational standards and criteria specific to the rights and special needs of patients. By working with these, your hospital/trust will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help prioritise workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

This set of standards and criteria should be addressed at corporate level. However, to achieve an accurate self-assessment of the whole organisation, the standards and criteria will need to be widely distributed.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA), a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME 1

THE PATIENT'S RIGHTS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 1

The rights of all patients regardless of age, disability, race, gender and sexual orientation are recognised, respected and complied with by all staff involved in their care or treatment.

Criteria		*Comments*	*please tick* Yes	No	
1.1	The patient is aware of his or her right to:				
1.1.1	be referred to a consultant whom they consider acceptable				**A**
1.1.2	seek a second opinion				**A**
1.1.3	be given a clear explanation of their medical condition and any treatment, investigation or procedure proposed, including risks and alternatives, before agreeing on the course of action to be taken				**A**
1.1.4	have access to their own health record (subject to the restrictions of the Data Protection Act 1984, the Access to Health Records Act 1990 and the Access to Health Records (Northern Ireland) Order 1993) and to be sure that the information recorded in the health record will remain confidential				**A**
1.1.5	a full investigation of clinical and non-clinical complaints completed within a timescale specified in a written complaints procedure				**A**
1.1.6	choose whether or not to take part in medical research or medical student training.				**A**
1.2	There is evidence that the hospital/trust recognises and responds to the following:				
1.2.1	respecting the personal dignity of patients at all times				**A**
1.2.2	protecting the personal privacy of the patient within the constraints of the individual treatment plan				**A**
1.2.3	the special emotional and physical needs of groups such as children, the confused, the elderly, the mentally ill and people with learning difficulties				**A**
1.2.4	the requirements of those with sensory or physical impairments				**A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

		Comments	please tick Yes	No	
1.2.5	maintaining confidentiality between staff and patients (particularly with regard to information given to relatives and carers)				A
1.2.6	respecting the culture and traditions of ethnic groups within the population served.				A
	(See also Core Standards for Clinical Services chapter, criterion 5.4.)				
1.3	The following information is provided to the patient:				
1.3.1	waiting time for first outpatient appointment				A
1.3.2	waiting time in the accident and emergency department after initial assessment				A
1.3.3	services provided within the hospital/trust (for example, hospital booklet)				B
1.3.4	treatment/procedure leaflets.				B
	Interpretation				
	* *all written information is assessed according to an agreed policy on quality which includes the following:*				
	content				
	graphics and style				
	readability ie plain English				
	suitability for target audience				
	cultural appropriateness				
	* *written information for patients is kept up to date and reviewed on a systematic basis*				
	* *information leaflets for patients are translated into other languages where appropriate*				
	* *health promotion literature is available in all wards and departments*				
	* *copies of The Patient s Charter are displayed throughout the hospital/trust (NHS only)*				

THE PATIENT'S RIGHTS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

* *the needs of patients with visual/reading difficulties are considered (for example, braille or tape).*

1.4 Patients with communication difficulties have access to an advocacy/link worker service. ☐☐ **B**

1.5 There is evidence that mechanisms are in place to ensure that those who take decisions on behalf of mentally incapacitated patients have the authority to do so. ☐☐ **B**

1.6 An interpreter service is available to reflect the needs of local ethnic populations. ☐☐ **A**

Interpretation

* *in cases of emergency (or after hours), when an interpreter is not available, a telephone interpreter service is used and the interpreter called in as soon as possible.*

1.7 There is evidence that all statutory safety requirements in relation to the hospital/trust s environment and procedures are enforced (see also Corporate Management chapter, Facilities and Equipment standard, criterion 9.6). ☐☐ **A**

1.8 There are written policies and procedures for obtaining informed consent. ☐☐ **A**

Interpretation

These policies and procedures include obtaining consent for:

* *anaesthesia*

* *electro-convulsive therapy*

* *hazardous assessment procedures*

* *participation in research projects*

* *participation in teaching exercises*

* *photographic and audiovisual recording*

* *surgical procedures*

* *unusual medications*

* *other procedures where consent is required by law.*

(See also Health Record Content chapter, criterion 1.1.12.)

VOLUME 1

THE PATIENT'S SPECIAL NEEDS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 2

Staff are aware of, and respond to, the requirements of patients with special needs.

Criteria	*Comments*	*please tick* Yes	No	
Care of the Terminally Ill Patient				
2.1 Care is managed on an individual basis to ensure that the patient s and family s physical, emotional, spiritual and social needs are assessed and necessary measures to meet them are planned, implemented and evaluated.				**A**
2.2 There is a written philosophy of care.				**A**
2.3 Staff are trained to meet the special needs of patients and their families.				**B**
2.4 Provision is made for relatives/carers to stay overnight with the patient.				**B**
2.5 Visiting is unrestricted.				**B**
2.6 There is a policy for dealing with advance directives completed by terminally ill patients.				**B**
2.7 Support and information is provided to families after the death of a patient (for example, help with the arrangement of burial/cremation arrangements, bereavement counselling).				**B**
Chaplaincy and Spiritual Care				
2.8 If requested, patients, carers and staff have access to the pastoral and/or spiritual support of their choice.				**B**
2.9 There is a mechanism to ensure that patients and carers are aware of the pastoral and/or spiritual support available within the hospital/trust.				**B**
2.10 A quiet area is set aside for prayer and meditation.				**B**
2.11 Chaplains, visiting clergy, pastoral workers and religious leaders of non-Christian faiths have access to office space and telephones.				**B**
Children				
2.12 The Department of Health guidelines The Welfare of Children and Young People in Hospital (1991) are used to inform the way in which care is organised and delivered.				**A**
2.13 There is a written philosophy of care for children which is understood by all staff in contact with children.				**A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.14 In a unit dedicated to the care of children, there are two trained members of the nursing staff on duty at all times (registered sick children s nurse or a nurse trained in the child branch of Project 2000). ☐☐ **A**

2.15 There is a senior registered sick children s nurse available at all times to provide help and advice when it is not possible to nurse a child in a dedicated children s unit (for example, independent sector). ☐☐ **A**

2.16 There is a registered sick children s nurse or a nurse trained in the child branch of Project 2000 available on a 24 hour basis to provide advice and support to other departments responsible for nursing children. ☐☐ **A**

Interpretation

These departments include:

* *accident and emergency department (see also Accident and Emergency Service chapter, criterion 2.10.9)*
* *intensive care unit (see also Special Care Service chapter, criterion 2.9.2)*
* *outpatient department (see also Outpatient Service chapter, criterion 2.5)*
* *theatres (see also Operating Theatre Service/Anaesthetic Service chapter, criterion 2.6.4).*

2.17 Where nursery nurses are employed, their roles and responsibilities are clearly defined (this may be in a job description). ☐☐ **B**

2.18 There is a designated children s physician or surgeon responsible for supervising the child s care while in hospital (where children are admitted to departments other than a children s department, a named paediatric consultant is designated responsible for providing advice on the child s care and treatment to the consultant concerned). ☐☐ **A**

2.19 There are written policies and procedures which meet the specific needs of children. ☐☐ **A**

Interpretation

These include:

* *routine admission (see also Corporate Management chapter, Policies and Procedures standard, criterion 8.8)*

THE PATIENT'S SPECIAL NEEDS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes **No**

Comments

* *emergency admission (see also Corporate Management chapter, Policies and Procedures standard, criterion 8.8)*
* *day case admission (see also Acute Day Care Service chapter, criterion 4.1.4)*
* *intensive care unit admission*
* *isolation unit admission*
* *ward visiting*
* *discharge*
* *outpatient attendance*
* *accident and emergency attendance*
* *parents accompanying children to theatre (see also Operating Theatre Service/Anaesthetic Service chapter, criterion 4.1.11)*
* *pain management and pain relief.*

2.20 Policies and procedures are developed with multidisciplinary input. ☐☐ **B**

2.21 There are written policies and procedures to guide staff in obtaining the informed consent of a child. ☐☐ **A**

Interpretation

These include:

* *a procedure to ensure that consent to treat all children under 16 is obtained from the child and the parent/carer or guardian*
* *a procedure for dealing with parents/carers (or children where judged to be competent) refusing urgent or lifesaving treatment.*

2.22 Information is available for parents/carers on informed consent. ☐☐ **A**

2.23 There is a policy for children attending inpatient paediatric and other departments for follow-up visits (ward attenders). ☐☐ **B**

Interpretation

* *ward attendance is monitored and evaluated*
* *care is supervised by a registered sick children s nurse or a nurse trained in the child branch of Project 2000.*

THE PATIENT'S SPECIAL NEEDS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.24 There is evidence that children and parents are offered the choice of visiting the ward prior to admission. **B**

Interpretation

* *written information for parents or carers is provided during the visit (for example, what the child needs to bring with them into hospital, facilities available for parents)*

* *information for children is provided and written in an understandable form*

* *parents or carers are encouraged to remain with their child throughout the admission period.*

2.25 Children are cared for in an environment which is child centred and separate from adults. **A**

2.26 The special environmental needs of children are recognised and catered for in the following areas:

2.26.1 the accident and emergency department *(see also Accident and Emergency Service chapter, criteria 5.11.4, 5.11.5, 5.11.6)* **B**

2.26.2 the day care unit *(see also Acute Day Care Service chapter, criterion 5.1)* **B**

2.26.3 the operating theatre suite *(see also Operating Theatre Service/Anaesthetic Service chapter, criterion 5.1)* **B**

2.26.4 the outpatient department *(see also Outpatient Service chapter, criterion 5.2.5).* **B**

2.27 There is evidence that the separate accommodation needs of adolescents are addressed. **A**

Interpretation

* *where it is impractical to provide a separate adolescent unit within a children s department, a separate area should be designated*

* *adolescents up to the age of 16 (19 for those with learning difficulties) should not ordinarily be admitted to adult wards.*

THE PATIENT'S SPECIAL NEEDS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick

	Yes	No	
2.28 The special needs of adolescents are recognised and used to inform the care provided.	☐	☐	**A**
2.29 There is evidence that staff are aware of the special needs of the following:			
2.29.1 children with life-threatening illnesses	☐	☐	**A**
2.29.2 children with physical or sensory disabilities and children with learning difficulties	☐	☐	**A**
2.29.3 unaccompanied children.	☐	☐	**A**
2.30 Accommodation is provided for parents staying overnight with their children.	☐	☐	**A**
2.31 Provision is made for unrestricted parental involvement in the care of their children (unless the interests of the child preclude this).	☐	☐	**A**
2.32 There is evidence that children, adolescents and parents/carers are involved in decision making.	☐	☐	**A**
2.33 Play facilities, toys, games and books are provided for children of all ages in the areas of the hospital/trust where:			
2.33.1 they are cared for	☐	☐	**B**
2.33.2 they wait for an appointment/therapy/treatment.	☐	☐	**B**
2.34 A play specialist is designated to supervise play activities.	☐	☐	**B**
Interpretation			
* *this specialist holds the Hospital Play Specialist Examination Board Certificate (HPSEB).*			
2.35 Links are established with the Local Education Authority to ensure that education is provided to children who are admitted to hospital.	☐	☐	**A**
2.36 There is a policy for dealing with the death of a child including making arrangements for burial or cremation *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.12).*	☐	☐	**A**
2.37 Overnight facilities are available for bereaved parents.	☐	☐	**B**
2.38 All hospitals which admit children have paediatric equipment and medication available.	☐	☐	**A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick
Yes No

Interpretation

This includes:

* *anaesthetic equipment*
* *inhalation therapy equipment*
* *paediatric size needles, cannulae, infusion regulators and other intravenous equipment*
* *paediatric infusion sets*
* *resuscitation equipment.*

2.39 Staff using paediatric equipment and paediatric medication are trained in its use and regular updating is provided. ☐☐ A

2.40 In areas where children are cared for, safety precautions are taken *(see also Housekeeping Service chapter, criterion 1.4.3).* ☐☐ A

Interpretation

* *power points are fitted with safety shutters*
* *physical barriers prevent entry to hazardous areas*
* *cleaning agents and other hazardous materials are kept in correctly labelled containers with child resistant closures*
* *cupboards containing cleaning agents and other hazardous materials are kept locked.*

2.41 Written child protection procedures, formulated by the statutory authorities, are available to staff *(see also Core Standards for Clinical Services chapter, criterion 4.7.5, Hospital Based Social Work chapter, criterion 4.1).* ☐☐ A

Interpretation

* *as part of the recruitment and selection procedure, the criminal convictions of staff responsible for the care of children are checked (see also Corporate Management chapter, Human Resources standard, criterion 5.11.2)*
* *staff responsible for the care of children are trained to recognise the symptoms of child abuse and are aware of how to obtain specialist advice and support.*

THE PATIENT'S SPECIAL NEEDS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

Ethics

2.42 Mechanisms exist for:

2.42.1 the consideration of ethical issues (such as the implications of research programmes) and prevention of harm to patients — ☐☐ **A**

2.42.2 the adoption of a multidisciplinary approach to the consideration of ethical issues — ☐☐ **B**

2.42.3 the implementation of policies relating to ethical issues (clinical and non-clinical) — ☐☐ **B**

2.42.4 helping staff and families to deal with ethical dilemmas. — ☐☐ **B**

Non-English Speaking Patients

2.43 Translated health promotion material, hospital/trust information and hospital/trust forms are available and used where required. — ☐☐ **B**

2.44 There is evidence that staff are sensitive to the individual needs of patients and families from minority groups of different ethnic, religious or cultural composition *(see also Corporate Management Chapter, Policies and Procedures standard, criterion 8.12).* — ☐☐ **A**

Interpretation

Consideration is given to:

* *diet and feeding*
* *medical examinations and other interventions*
* *religious beliefs or traditions in respect of healing, medical treatment and care while dying*
* *washing and bathing.*

Patients with a Disability

2.45 There is evidence that the hospital/trust recognises and responds to internal and external access needs of patients/visitors with a visual or physical impairment *(see also Corporate Management chapter, Facilities and Equipment standard, criteria 9.5.2, 9.5.3).* — ☐☐ **A**

Seclusion, Restraint and Emergency Medication

2.46 Standards exist which comply with legislation and cover seclusion, restraint and emergency medication of a patient. — ☐☐ **A**

CORPORATE MANAGEMENT

VOLUME
1

CORPORATE MANAGEMENT

This document contains a set of corporate management organisational standards and criteria. By working with these, your hospital/trust will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help the hospital/trust prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

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B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

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Good practice which is not yet standard across the UK.

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VOLUME 1

MISSION AND OBJECTIVES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 1

The hospital/trust has a clear set of objectives which act as a guide for planning, implementing and evaluating the service offered to the local population.

Criteria	*Comments*	*please tick* Yes	No	
Mission Statement				
1.1 There is a written mission statement which is developed with input from medical, nursing and other professional staff.				**B**
1.2 The mission statement is made available to the general public, other health and related organisations and to staff within the hospital/trust.				**B**
Objectives and Business Planning				
1.3 There is a written strategic direction document for the hospital/trust.				**A**
1.4 There is an annual business plan for the hospital/trust which is reviewed and updated annually.				**A**
1.5 The business plan and strategic direction document are developed with input from medical, nursing and other clinical and non-clinical staff *(see also Core Standards for Non-Clinical Services chapter, criterion 2.1.3 and Core Standards for Clinical Services chapter, criterion 2.1.3).*				**B**
1.6 The business plan and strategic direction document are publicised widely (NHS only).				**A**

VOLUME 1

CONTRACT SERVICES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 2

There are written, signed agreements for all services provided or purchased by the hospital/trust.

please tick
Yes No

Criteria

Comments

2.1 There is a structured and systematic approach to developing and negotiating contracts. ☐☐ **A**

Interpretation

These agreements include the following dimensions:

* *price*
* *quality (clinical and non-clinical)*
* *volume/activity.*

2.2 Where the hospital/trust is the provider, medical, nursing and other clinical and non-clinical staff responsible for delivering the service are involved in contract negotiation, determination of activity targets and determination of quality indicators *(see also Core Standards for Non-Clinical Services chapter, criterion 2.1.4 and Core Standards for Clinical Services chapter, criterion 2.1.4).* ☐☐ **B**

2.3 There is a procedure in place for managing extracontractual referrals. ☐☐ **B**

2.4 Contract specifications are drawn up for services provided or purchased by the hospital/trust. ☐☐ **A**

Interpretation

When drawing up specifications the following aspects are considered:

* *a specification of the formal lines of communication and responsibility between the service provider/ purchaser and the hospital or trust*
* *a requirement for the provision of services by trained and qualified staff*
* *mechanisms for identifying and remedying the problems in service delivery*
* *planned reviews of each specialty involving consultants/managers and general practitioner users (provided services only)*

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick

Yes No

Comments

* *progress towards achieving outcomes identified by Health of the Nation (provided services only)*
* *the frequency and content of reporting requirements (provided services only)*
* *protocols of care which indicate the different responsibilities of general practitioners, community health staff and hospital/trust staff (provided services only)*
* *tertiary referral policy and procedures (provided services only)*
* *community health council access to inspect facilities (provided services only)*
* *a mechanism for monitoring and maintaining the quality of service (purchased services only)*
* *participation of the service provider in relevant committees of the hospital/trust (purchased services only)*
* *arrangements for after hours and emergency services (purchased services only)*
* *adequacy of facilities and equipment for the service being provided both in the hospital and at the site of the external service (purchased services only).*

2.5 Compliance with contract specifications is monitored and reviewed. ☐☐ A

2.6 There is a market testing plan for the hospital/trust. ☐☐ B

VOLUME 1

MANAGEMENT ARRANGEMENTS

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard 3

There is a clear management structure in place which enables the hospital/trust to achieve its objectives.

Criteria	*Comments*	*please tick* Yes	No	
Management Structure				
3.1 There is a board of directors for the trust and/or a designated individual manager with overall responsibility for the operation and management of the hospital/trust.				A
3.2 There is a designated deputy for the hospital manager/chief executive (this may be rotated around the executive directors).				B
3.3 There are executive directors on the board with designated responsibility for non-clinical support services (for example, security, fire) and human resources.				A
3.4 There is a clear division of responsibility between the hospital manager/chief executive and the chairman.				A
3.5 There is a document(s) which states the constitutional arrangements of the hospital which is appropriate to trusts, directly managed units or independent sector hospitals, and has regard to central statute and local by-laws.				A
Interpretation				
The document includes:				
* *a description of the power and duties of the board of directors*				
* *a scheme of delegation*				
* *standing orders*				
* *standing financial instructions*				
* *policies and procedures.*				
3.6 The power and the duties of the board of directors and the standing orders are made accessible to all staff.				A
3.7 The standing orders specify those decisions which must be made by the board.				A

VOLUME 1

MANAGEMENT ARRANGEMENTS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes No

Comments

3.8 The role and functions of the chairman, non-executive members and executive members of the board are clearly set out in a document which is made available to staff and to the local community. ☐☐ **A**

3.9 The board of directors and designated individual managers ensure that:

3.9.1 the management board of the hospital/trust meets regularly and that meetings are minuted ☐☐ **A**

3.9.2 the key issues resulting from board and other meetings are communicated to staff *(see also Core Standards for Non-Clinical Services chapter, criterion 2.10.1 and Core Standards for Clinical Services chapter, criterion 2.11.1)* ☐☐ **B**

3.9.3 there are mechanisms for seeking the advice of medical, nursing, other clinical and non-clinical staff and specialist advice (for example, health promotion) in the development of hospital/trust policy ☐☐ **B**

3.9.4 there are mechanisms for seeking the views and experiences of patients and others in the community in the development of hospital/trust policy (for example, patient participation groups) ☐☐ **B**

3.9.5 there is an organisational structure, with clearly defined lines of accountability and specification of roles. ☐☐ **B**

3.10 There is a written organisational chart for the hospital/trust. ☐☐ **B**

3.11 A register of directors interests, material and relevant to NHS business, is maintained, reviewed on a systematic basis and open to public inspection. ☐☐ **A**

3.12 There is an up-to-date register of hospitality received by directors and members of staff. ☐☐ **B**

3.13 There is an audit committee with terms of reference setting out membership, limits to powers and arrangements for reporting back to the board. ☐☐ **A**

MANAGEMENT ARRANGEMENTS

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

Item	Standard	Weighting
3.14	There is a remuneration and terms of service committee with terms of reference setting out membership, limits to powers and arrangements for reporting back to the board.	A
3.15	There is a designated secretary to the board.	A
3.16	The responsibilities of the secretary are clearly defined.	B

Interpretation

These include:

- * *maintaining standing orders*
- * *maintaining standing financial instructions in liaison with the director of finance*
- * *retaining the corporate seal and its applications*
- * *keeping a register of directors interests.*

Item	Standard	Weighting
3.17	The board publishes an annual report and annual accounts.	A
3.18	The annual report and annual accounts are made available to the public.	A
3.19	There is a widely publicised procedure enabling staff to raise their concerns about maladministration, breaches of codes of conduct and accountability and other concerns of an ethical nature.	A

VOLUME
1

COMMUNICATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 4

There is effective communication with patients, carers, staff, external organisations and the local community.

Criteria		*Comments*	*please tick* Yes	No	
4.1	There are mechanisms for communication with:				
	4.1.1 the local community				**A**
	4.1.2 staff throughout the hospital/trust				**A**
	4.1.3 external organisations (for example, community health councils, community services, general practitioners)				**A**
	4.1.4 the media.				**B**
4.2	There are mechanisms for systematically auditing the effectiveness of communication systems.				**B**
4.3	There is a written communication strategy for the hospital/trust.				**B**
4.4	The effectiveness of the communication strategy is reviewed on a systematic basis.				**B**
4.5	There is a clear channel of communication for patients complaints/suggestions/expressions of satisfaction *(see also Policies and Procedures standard, criterion 8.4.1).*				**A**
4.6	Opportunities are available for staff to train in communication skills and customer care.				**C**

VOLUME 1

HUMAN RESOURCES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 5

There is a human resource strategy and human resource policies and procedures which enable staff to be deployed effectively and efficiently.

please tick
Yes No

Criteria

Comments

Human Resource Strategy

5.1 There is an individual at senior management level who has overall responsibility for developing, implementing and evaluating the human resource strategy. ☐☐ **A**

5.2 There is a written human resource strategy for the hospital/trust which is in evidence at operational level. ☐☐ **A**

Interpretation

When developing the human resource strategy the following are taken into consideration:

- *there are trained and qualified staff available to meet service requirements and maintain high quality patient care*
- *staffing levels are systematically assessed and monitored against workload*
- *the additional requirements of research, local and national committee work, mentoring, teaching, assessment and supervision are reflected in staffing levels*
- *the skill-mix/grading and competence profile of staff are regularly reviewed to ensure their effective deployment*
- *details about the hospital s/trust s workforce are recorded, in order to provide manpower information for management purposes (for example, sickness rates, absence rates, numbers and grades of staff).*

5.3 The human resource strategy is reviewed on a systematic basis. ☐☐ **A**

5.4 There are documented human resource policies and procedures. ☐☐ **A**

5.5 Terms and conditions of service of staff are:

5.5.1 written and available to all employees ☐☐ **A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick Yes No

5.5.2 reviewed periodically and revised as necessary — A

5.5.3 incorporated into individual staff contracts/letters of engagement — A

5.5.4 dated and signed. — B

5.6 There is a mechanism for informing staff of changes in their terms and conditions of service. — A

5.7 Job descriptions are issued for all posts *(see also Core Standards for Non-Clinical Services chapter, criterion 2.22 and Core Standards for Clinical Services chapter, criterion 2.23).* — B

5.8 There is evidence that human resource policies and procedures ensure compliance with anti-discriminatory legislation. — A

5.9 There is a mechanism to ensure that staff are aware of, and understand, the human resource policies and procedures which relate to their jobs and responsibilities. — A

Recruitment and Selection

5.10 There is a documented procedure for the recruitment and selection of all staff. — B

Interpretation

The procedure includes:

* *job definition*
* *selection criteria*
* *obtaining references*
* *health screening*
* *issuing a letter of appointment within one week of the job offer.*

5.11 As part of the recruitment and selection procedure:

5.11.1 qualifications are checked — A

5.11.2 criminal convictions are checked *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.41)* — A

5.11.3 equal opportunities are monitored. — A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

5.12 All staff receive written contracts of employment within 13 weeks of appointment *(see also Core Standards for Non-Clinical Services chapter, criterion 2.24 and Core Standards for Clinical Services chapter, criterion 2.26).*

5.13 Personnel records are maintained.

Interpretation

These records include:

* *application form/curriculum vitae*
* *references*
* *the contract of employment and any amendments issued*
* *an up-to-date job description*
* *details of qualifications held*
* *records of leave and sickness*
* *appraisal details.*

Orientation and Induction

5.14 There is a system to ensure that on appointment hospital/trust staff receive induction in the following areas:

5.14.1 fire

5.14.2 health and safety

5.14.3 patient confidentiality

5.14.4 accident and/or untoward incident reporting

5.14.5 security

5.14.6 pay arrangements.

(See also Health and Safety Management standard, criterion 11.13, Core Standards for Non-Clinical Services chapter, criterion 3.1, Core Standards for Clinical Services chapter, criterion 3.1.)

Training and Development

5.15 There is a written training and development strategy for the hospital/trust.

Interpretation

The strategy addresses:

* *the needs of the individual as identified within the appraisal system*

A
A
A
A
A
A
A
A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

* *the needs which arise as the result of changes in practice, the law and the introduction of new technology*
* *business plan objectives.*

5.16 There are written organisation and management development strategies for the hospital/trust. ☐☐ **B**

5.17 Educational and developmental opportunities for staff are publicised. ☐☐ **B**

Interpretation

These include:

* *occupational standards*
* *vocational qualifications.*

5.18 There is access to programmes of continuing education which are arranged in conjunction with, and meet the requirements of, professional bodies and institutions. ☐☐ **B**

5.19 Staff have access to local library services and are given time to update their knowledge (access to national library services may also be required) *(see also Core Standards for Non-Clinical Services chapter, criterion 3.10, Core Standards for Clinical Services chapter, criterion 3.13 and the Library Service chapter of this manual).* ☐☐ **B**

5.20 Current reference manuals, pamphlets, journals and textbooks are readily available within individual departments/service areas *(see also Core Standards for Non-Clinical Services criterion 3.11 and Core Standards for Clinical Services criterion 3.14).* ☐☐ **C**

5.21 Records of study leave are maintained. ☐☐ **B**

5.22 Where the hospital/trust provides clinical experience for students, there is a written agreement between the hospital/trust and the educational establishment detailing the responsibility for their induction, teaching, supervision and assessment. ☐☐ **B**

Performance Review

5.23 There is a documented staff appraisal system for all staff. ☐☐ **B**

Interpretation

The staff appraisal system identifies:

* *objectives, strengths and weaknesses in performance*

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

* *areas for personal development and training.*

(See also Core Standards for Non-Clinical Services chapter, criterion 2.23 and Core Standards for Clinical Services chapter, criterion 2.25.)

5.24 The following objectives are included in all management performance review activities:

5.24.1 health and safety *(see also Health and Safety Management standard, criterion 11.5)* ☐☐ A

5.24.2 quality. ☐☐ B

Employee Relations

5.25 There are written policies and procedures for the conduct of industrial relations activities. ☐☐ A

Interpretation

The policies and procedures:

* *are agreed, and subject to consultation with, the staff side locally*
* *include:*

disciplinary procedure

grievance procedure

disputes procedure

appeals procedure

recognition arrangements for trade unions and professional organisations

arrangements for consultation and negotiation within the hospital/trust

the maintenance of records concerning protected and new terms and conditions of service

job evaluation.

5.26 Systems exist for the collection, storage and aggregation of manpower information to meet Korner manpower return requirements (NHS only). ☐☐ A

VOLUME 1

FINANCIAL RESOURCES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 6

The financial resources of the hospital/trust are efficiently and effectively managed.

please tick
Yes No

Criteria

Finance

6.1 The hospital/trust maintains an internal audit system which meets the audit requirements of the Secretary of State. ☐☐ **A**

Interpretation

* *the internal audit section carries out appraisals and makes recommendations to management for operations under its control*
* *internal audit is sufficiently independent to allow the auditors to perform their duties in a manner which enables professional judgements and recommendations to be effective and impartial*
* *internal auditors exercise due professional care in carrying out their duties*
* *the internal audit section is appropriately staffed in terms of numbers, grades, qualifications and experience, having regard to its responsibilities and objectives*
* *staff are trained to fulfil their responsibilities*
* *the internal auditor seeks to foster constructive working relationships and mutual understanding with management, external auditors, any other review agencies and the audit committee*
* *internal audit work is adequately planned, controlled and recorded in order to achieve the agreed objectives of the internal audit department, to establish audit priorities and to ensure the effective use of audit resources*

Comments

VOLUME 1

FINANCIAL RESOURCES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes No

Comments

* *internal auditors use a systems based approach to identify and evaluate the soundness, adequacy and application of financial and other management controls*
* *internal auditors obtain sufficient, relevant and reliable evidence on which to base conclusions and recommendations*
* *internal auditors ensure that findings, conclusions and recommendations arising from each individual internal audit assignment are communicated promptly to the appropriate level of management and actively seek a response*
* *internal auditors ensure that arrangements are made to follow up audit recommendations*
* *the internal auditors report to the audit committee.*

6.2 There is a written financial strategy which covers forecast pay/price inflation and future uncertainty. **A**

6.3 There is a mechanism for developing budgets (as part of the business plan) with the participation of appropriate staff *(see also Core Standards for Non-Clinical Services chapter, criterion 2.1.2 and Core Standards for Clinical Services chapter, criterion 2.1.2).* **B**

6.4 Budget holders receive financial training/ guidance *(see also Core Standards for Non-Clinical Services chapter, criterion 2.7 and Core Standards for Clinical Services chapter, criterion 2.8).* **B**

6.5 Budget holders are held accountable for their financial performance. **B**

6.6 User-friendly extracts from standing orders and standing financial instructions are issued to all budget holders. **C**

6.7 Budget statements are distributed to all managers and budget holders no later than 21 days after the accounting period *(see also Core Standards for Non-Clinical Services chapter, criterion 2.5 and Core Standards for Clinical Services chapter, criterion 2.6).* **B**

VOLUME 1

FINANCIAL RESOURCES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

	Yes	No	*Comments*

6.8 The budget statement provides information relevant to the management of the ward/service/department *(see also Information Services standard, criterion 7.7, Core Standards for Non-Clinical Services chapter, criterion 2.6 and Core Standards for Clinical Services chapter criterion 2.7).* ☐ ☐ **B**

6.9 A report is produced monthly for the executive management team and the board which sets out the financial position to date and identifies areas requiring action. ☐ ☐ **B**

6.10 The report is in a format approved by the board. ☐ ☐ **B**

6.11 There is a mechanism for establishing the reasons for budget variation in either income or expenditure. ☐ ☐ **B**

6.12 Annual accounts are produced within three months of the year end. ☐ ☐ **A**

6.13 There is a capital asset register which is routinely maintained. ☐ ☐ **A**

6.14 There is a capital asset replacement programme. ☐ ☐ **B**

6.15 There is a system for managing the level of debtors and creditors within specified targets. ☐ ☐ **B**

Interpretation

* *an analysis of the duration of the debt is routinely produced to the executive management team/trust board*
* *there are written procedures for debt recovery, which are instigated routinely*
* *bad debts are reviewed at least six monthly*
* *there are written procedures for the payment of creditors which are regularly monitored.*

6.16 There are mechanisms which ensure that charitable or endowment funds held by the hospital/trust are properly accounted for. ☐ ☐ **A**

6.17 Any surplus charitable or endowment funds are invested in accordance with the Trustee Investment Act (1961) and the investment strategy of the trustees. ☐ ☐ **A**

VOLUME 1

FINANCIAL RESOURCES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	*Comments*
6.18	In the case of NHS trusts, the investment of surplus funds is in accordance with relevant guidelines.			**A**
6.19	There is a system for managing the level and security of stock.			**B**
6.20	There is an up-to-date inventory of attractive items costing less than £5,000 per item (for example, computers, calculators, mobile telephones, slide projectors).			**B**
6.21	There are written and up-to-date policies and procedures for all accounting functions.			**B**

VOLUME 1

INFORMATION SERVICES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard 7

The hospital/trust collects, stores and uses accurate computerised information which enables informed decisions to be made.

Criteria	*Comments*	*please tick* Yes	No	
7.1 There is a written information management/technology strategy for the hospital/trust.				A
7.2 Information systems enable the minimum data standards to be met *(see also Health Record Service chapter, criterion 4.5).*				A
Interpretation				
These information systems:				
* *identify the purchasing authority for each patient seen*				
* *identify the registered general practitioner for each patient*				
* *assign contract numbers to each patient episode*				
* *assign clinical codes at discharge or within 14 days, using a current version of the international classification of diseases and OPCS procedure codes (or other approved classifications)*				
* *group patients using a current grouping system.*				
7.3 The effectiveness of information systems is reviewed on a systematic basis.				B
Interpretation				
* *accuracy and timeliness of coding is monitored*				
* *information for management decision making is systematically reviewed.*				
7.4 Confidentiality is maintained in accordance with the Data Protection Act 1984 and unauthorised access to the information systems is prevented.				A
7.5 Coding systems are in place to:				
7.5.1 supply information for the national Patient s Charter league table				A

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick

Yes	No	Comments	Weighting
		7.5.2 achieve targets for recording completed patient/consultant episodes within specified timescales	B
		7.5.3 supply data that monitors progress towards Health of the Nation targets.	B
		7.6 Information is produced which shows:	
		7.6.1 patient workload per individual consultant per ICD code	B
		7.6.2 theatre utilisation and overall workload per consultant per OPCS/BUPA classification.	B
		7.7 Monthly monitoring information integrates activity with finance and manpower information *(see also Financial Resources standard, criterion 6.8).*	B
		7.8 There are written procedures for computing and network services disaster recovery *(see also Risk Management standard, criterion 10.9).*	A
		7.9 There are information systems in place to support the needs of clinical (uniprofessional and multidisciplinary) audit.	B
		Interpretation	
		These systems:	
		* *are able to access demographic and clinical data held on other operational systems*	
		* *are flexible enough to hold various types of clinical data for routine audit and audit projects*	
		* *are able to collate and aggregate data flexibly for audit purposes.*	

VOLUME 1

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 8

There are written policies and procedures which support activities and guide staff, patients and visitors in the functions and responsibilities of the hospital/trust.

Criteria		*Comments*	*please tick* Yes	No	
8.1	Corporate policies and procedures are:				
8.1.1	in accordance with statutory requirements				**A**
8.1.2	centrally indexed/compiled into a policy manual				**B**
8.1.3	dated				**B**
8.1.4	subject to a systematic review process.				**B**
8.2	Mechanisms exist to ensure that corporate policies and procedures are widely communicated throughout the hospital/trust.				**A**
8.3	The activities of the hospital/trust are monitored to ensure that they are consistent with corporate policies.				**B**
	Complaints and Untoward Incidents				
8.4	Policies and procedures are developed for:				
8.4.1	patient and staff complaints *(see also Communication standard, criterion 4.5)*				**A**
8.4.2	patient and staff accidents, errors (for example, medications) and incidents *(see also Risk Management standard, criterion 10.5).*				**A**
8.5	Corporate records are kept of complaints, accidents, errors and incidents and include details of the action taken (see also Core Standards for Non-Clinical Services chapter, criterion 4.8 and Core Standards for Clinical Services chapter, criterion 4.8).				**A**
	Admission				
8.6	There are written policies and procedures for admission to the hospital/trust which cover at least the following:				
8.6.1	routine admission				**A**
8.6.2	emergency admission				**A**
8.6.3	conditions for refusing admission				**A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick

		Yes	No	
8.6.4	arrangements when admission is refused	☐	☐	A
8.6.5	cancellation of routine admission	☐	☐	A
8.6.6	information to be given to the patient pre-admission and on admission.	☐	☐	B
8.7	There is a system in place to ensure that staff are aware of the admissions policies and procedures.	☐	☐	A
8.8	The special needs of children are taken into consideration when developing admissions policies *(see also The Patient s Rights and Special Needs chapter, Special Needs standard, criterion 2.19).*	☐	☐	A
8.9	There is an individual with designated responsibility for admissions.	☐	☐	B

Discharge

8.10	There is a written policy for the safe discharge of the patient.	☐	☐	A

Interpretation

The policy covers the following:

* *period of notice required by a patient in order to prepare for discharge*
* *liaison with the patient s general practitioner*
* *liaison with, and organisation of, any community/social service support a patient may require (for example, home help, district nurse, health visitor)*
* *information given to the patient concerning future management of their medical condition*
* *information given to the patient concerning the management of their condition at home*
* *information given to the patient concerning any advised changes in lifestyle*
* *information given to the patient s general practitioner (see also Health Record Content chapter, criteria 1.1.16, 1.1.17)*
* *issues relating to supervised discharge of patients*
* *transport arrangements*

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

* *the special requirements of the patient who has no social support*
* *ensuring that no NHS patient is discharged to a nursing/residential home against his/her wishes if he/she or a relative is personally responsible for paying the home s fees*
* *information concerning funding if long-term nursing care is required.*

8.11 There is documented evidence that discharge planning begins on the day of admission or prior to admission where possible. ☐☐ B

Dealing with the Deceased

8.12 There is a policy for dealing with the deceased (including babies and children) *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.36).* ☐☐ A

Interpretation

Procedures include:

* *referral to the coroner*
* *dealing with personal effects*
* *observing the religious beliefs and traditions of minority ethnic groups (see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.44)*
* *arranging burial/cremation if necessary.*

Health Promotion

8.13 Policies are developed which encourage the general health of patients and staff (for example, a policy on smoking within the hospital/trust) and take into consideration Health of the Nation targets *(see also Core Standards for Non-Clinical Services chapter, criterion 5.1 and Core Standards for Clinical Services chapter, criterion 5.1).* ☐☐ A

8.14 The following counselling services are provided:

8.14.1 stress counselling *(see also Core Standards for Clinical Services chapter, criterion 2.37.2)* ☐☐ B

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick Yes No

Comments

8.14.2 how to stop smoking *(see also Core Standards for Non-Clinical Services chapter, criterion 5.2 and Core Standards for Clinical Services chapter, criterion 5.2).* ☐☐ C

Major Incident Plans (External and Internal)

8.15 The hospital/trust has an external major incident, all-hazards plan (it is recognised that not all units will have a role in external major incident response) *(see also Accident and Emergency Service chapter, criterion 2.13).* ☐☐ A

8.16 The external major incident plan is developed in consultation with:

8.16.1 emergency services ☐☐ A

8.16.2 local authorities. ☐☐ A

8.17 All departments/services having a role in an external major incident prepare an action plan *(see also Core Standards for Non-Clinical Services chapter, criterion 4.9 and Core Standards for Clinical Services chapter, criterion 4.9).* ☐☐ A

Interpretation

* *the action plan ensures that all staff are aware of their individual responsibilities in the event of a major incident.*

8.18 There is evidence that the hospital/trust rehearses the external major incident plan. ☐☐ B

Interpretation

* *rehearsals are part of a coordinated practice in which other emergency services participate*
* *rehearsals involve medical, nursing, managerial and other staff as appropriate*
* *rehearsals are evaluated and a written report produced.*

8.19 All external major incidents are evaluated and a written report produced. ☐☐ B

8.20 The hospital/trust develops internal incident plans. ☐☐ A

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No

Comments

Interpretation

* *these incidents include:*

bomb threats

explosion

fire

loss of vital services (for example, electricity, water) (see also Estates Management chapter, criterion 1.19)

* *the plans include evacuation procedures*

* *the plans are developed with the assistance of qualified fire, safety and other appropriate experts*

* *staff are made aware of incident plans.*

8.21 Internal incident plans are reviewed annually and revised as necessary. ☐☐ **B**

8.22 Practices for all internal incidents are held at least annually for day and night staff and under varied conditions. ☐☐ **C**

Interpretation

* *there is a mechanism to ensure that all staff attend internal incident practices*

* *a record of attendance at practices is maintained.*

8.23 Any internal incidents are evaluated and a written report produced. ☐☐ **B**

Waiting List Management

8.24 There is a policy for the management of waiting lists. ☐☐ **B**

8.25 A senior manager is designated responsible for the development, implementation and monitoring of the waiting list management policy. ☐☐ **B**

8.26 Waiting lists are reviewed on a systematic basis. ☐☐ **B**

Interpretation

This review ensures that:

* *all patients on the list are still in need of treatment*

* *personal details are up to date.*

VOLUME 1

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 9

The environment, facilities and equipment ensure safe, efficient and effective care of patients, staff and visitors and enable the overall objectives of the hospital/trust to be achieved.

please tick
Yes No

Criteria

(Reference should also be made to the Estates Management chapter.)

Comments

9.1 There is a written estates strategy which is consistent with the strategic direction and the business plan of the hospital/trust. ☐☐ **A**

Interpretation

Consideration is given to:

* *service level agreements*
* *lines of accountability*
* *estate investment programme*
* *asset value*
* *functional suitability and space utilisation*
* *performance targets for improving asset utilisation*
* *building, plant and equipment maintenance programme.*

9.2 There is a documented estate control plan for the hospital/trust site. ☐☐ **A**

Interpretation

This covers at least the following:

* *a development control plan to cover all developments on the site*
* *a condition survey of all buildings*
* *identification of any listed buildings or conservation areas*
* *dates of recent site additions and/or deletions.*

9.3 The estate control plan is systematically reviewed and updated. ☐☐ **A**

9.4 There are designated individuals at senior management level responsible for the maintenance of all facilities and equipment. ☐☐ **A**

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

9.5 There is evidence that provision is made for:

9.5.1 the special needs of children — **A**

9.5.2 wheelchair access inside and outside the hospital/trust buildings — **A**

9.5.3 patients, visitors or staff with sensory or physical impairments — **A**

(See also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criteria 1.2.3, 1.2.4 and The Patient s Special Needs standard, criterion 2.45.)

9.6 There is a system in place to ensure that all equipment and facilities conform to existing statutory health and safety requirements *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 1.7).* — **A**

9.7 There is evidence that patient safety devices are installed across the hospital/trust. — **A**

Interpretation

- *patient safety devices may include:*

  handrails in passageways

  grab rails and emergency call systems in patient toilets, showers and bathrooms

  safety straps on wheelchairs

  trolleys with side rails

  variable height beds fitted with adjustable side rails

- *there is provision for emergency entry to toilets, showers and bathrooms.*

9.8 There is clear internal and external signposting. — **A**

Interpretation

Consideration is given to:

- *the needs of ethnic minority populations*
- *the needs of the visually impaired.*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

9.9 Car parking requirements are reviewed on a systematic basis. ☐☐ **B**

Interpretation

The review includes:

* *arrangements for the disabled*
* *arrangements for emergency vehicles (including staff attending emergencies).*

VOLUME 1

RISK MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 10

There is a structured approach to the management of risk in the hospital/trust which results in safer systems of work, safer practices, safer premises and a greater staff awareness of danger and liability.

Criteria	*Comments*	*please tick* Yes	No	
10.1 There is an individual at senior management level who has overall responsibility for the management of risk within the hospital/trust.				**A**
10.2 There is a risk management strategy which is endorsed by the hospital manager/trust board and details aims, objectives and individual responsibilities.				**A**
10.3 This strategy is made available to all staff and close liaison with the health and safety committee is maintained.				**B**
10.4 There is a structure in place to ensure that risks are identified, control measures prioritised and necessary action taken *(see also Health and Safety Management standard, criterion 11.18).*				**A**
10.5 There is a standardised incident reporting system *(see also Policies and Procedures standard, criterion 8.4.2, Core Standards for Non-Clinical Services chapter, criterion 4.7.1, Core Standards for Clinical Services chapter, criterion 4.7.1).*				**A**
10.6 Information on untoward incidents is collected, monitored and evaluated. Reports are produced on a systematic basis and issued to the relevant department/service area.				**B**
10.7 Untoward incidents are individually investigated.				**A**
10.8 There is a designated individual responsible for liaising with legal professionals, insurance companies and claimants and for processing claims.				**A**
10.9 Potential categories of disaster (for example, environmental, accidental systems failure, fraud, strikes) are assessed and contingency plans drawn up if necessary *(see also Information Services standard, criterion 7.8).*				**A**

VOLUME 1

HEALTH AND SAFETY MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 11

There is a managed approach to health and safety which creates a safe and healthy environment for patients, staff and visitors.

please tick

Criteria	*Comments*	Yes	No	
Policy Development				
11.1 There is a written hospital/trust-wide health and safety policy which conforms to the requirements of Section 2(3) of the Health and Safety at Work etc Act 1974, is considered in all business practice and decision making and is signed and dated by the hospital manager/chief executive.				**A**
11.2 Written departmental health and safety policies and procedures are developed and implemented and are consistent with the hospital/trust health and safety policy.				**A**
11.3 Health and safety policies are subject to continuous review.				**A**
Organisational Development				
11.4 There is a qualified individual at senior management level who has overall responsibility for formulating, implementing and developing health and safety policy.				**A**
11.5 Health and safety responsibilities of line managers are clearly defined within their job descriptions.				**A**
Interpretation * *these managers have the necessary authority and competence to carry out their duties effectively and are held accountable for their actions* * *health and safety objectives are set and reviewed annually as part of the performance review process (see also Human Resources standard, criterion 5.24.1).*				
11.6 Suitable arrangements are in place for obtaining competent safety advice. *Interpretation* * *the authority and accountability of the advisor (however named) are clearly defined and a direct reporting line to the executive management team/trust board is established.*				**A**

VOLUME 1

HEALTH AND SAFETY MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes **No**

Comments

11.7 There is a hospital/trust multidisciplinary safety committee (or committees). ☐☐ **A**

Interpretation

This:

* *meets a minimum of six times per annum*
* *includes senior management, staff and trade union representation and is consulted on the development, implementation and monitoring of the health and safety policy*
* *is actively involved in the setting and monitoring of performance standards for health and safety.*

11.8 The committee reports to the executive management team/trust board on a systematic basis. ☐☐ **B**

11.9 An annual health and safety report is produced. ☐☐ **A**

Interpretation

This is:

* *presented to the executive management team/trust board*
* *made available to all staff within the hospital/trust.*

11.10 Safety representatives are appointed within each service area and are provided with the training necessary to make an informed contribution to health and safety issues *(see also Core Standards for Non-Clinical Services chapter, criterion 2.30.3 and Core Standards for Clinical Services chapter, criterion 2.36.3).* ☐☐ **A**

11.11 First aid arrangements are in place and are in accordance with the Health and Safety (First Aid) Regulations 1981. ☐☐ **A**

11.12 Mechanisms are in place within the hospital/trust to promote the awareness of health and safety policy and health and safety issues (for example, notice boards, newsletters, suggestion schemes). ☐☐ **B**

HEALTH AND SAFETY MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

11.13 There is a documented hospital/trust-wide safety education programme. ☐☐ **A**

Interpretation

This:

* *includes orientation of new employees to safety practices within the hospital/trust (for example, emergency procedures, reporting procedures, work risks and precautions needed) (see also Human Resources standard, criterion 5.14)*
* *is reviewed at least annually to determine its effectiveness.*

11.14 All local orientation and induction programmes include an introduction to the hospital/trust health and safety policy and any necessary health and safety instruction *(see also Human Resources standard, criterion 5.14, Core Standards for Non-Clinical Services chapter, criterion 3.4.4 and Core Standards for Clinical Services chapter, criterion 3.4.4).* ☐☐ **A**

11.15 Arrangements are in place for identifying and providing on-going health and safety instruction and training (for example, when changes in staff or working practices occur). All instruction and training are recorded. ☐☐ **A**

11.16 Temporary workers on fixed or short-term contracts (for example, bank staff, agency staff and contractors on site) are provided with information concerning health and safety issues which may be encountered in their work on hospital/trust property or in connection with their work on behalf of the hospital/trust. ☐☐ **A**

Planning and Implementation

11.17 There is an up-to-date management plan which identifies health and safety objectives, targets and timescales and is developed in consultation with staff. ☐☐ **A**

11.18 Hazards are identified and a full risk assessment of the hospital/trust is carried out in accordance with the Management of Health and Safety at Work Regulations 1992 *(see also Risk Management standard, criterion 10.4).* ☐☐ **A**

VOLUME 1

HEALTH AND SAFETY MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

Interpretation

The assessment takes into consideration the following:

* *the Control of Substances Hazardous to Health Regulations 1988*
* *the Electricity at Work Regulations 1989*
* *the Genetically Modified Organisms (Contained Use) Regulations 1992*
* *the Health and Safety (Display Screen Equipment) Regulations 1992*
* *the Manual Handling Operations Regulations 1992*
* *the Noise at Work Regulations 1989*
* *the Personal Protective Equipment at Work Regulations 1992*
* *the Pressure Systems and Transportable Gas Containers Regulations 1989*
* *the Provision and Use of Work Equipment Regulations 1992*
* *the Workplace (Health, Safety and Welfare) Regulations 1992.*

11.19 Significant risk assessment findings are documented. **A**

11.20 Where necessary, preventive and protective measures (control measures) are implemented. **A**

11.21 Following assessment, all identified control measures are recorded to ensure consistent implementation across the hospital/trust site. **A**

11.22 Risk assessments are reviewed and updated on a systematic basis or when circumstances change. **A**

Performance Measures

11.23 Regular departmental/service inspections are carried out in hazardous areas *(see also Core Standards for Non-Clinical Services chapter, criterion 2.14 and Core Standards for Clinical Services chapter, criterion 2.15).* **A**

11.24 There is a clear reporting procedure in place throughout the hospital/trust for recording, investigating, reporting and taking action on accidents, incidents, hazards and defects. **A**

HEALTH AND SAFETY MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

11.25 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1985 (RIDDOR) are complied with. ☐☐ **A**

11.26 There is a system in place for disseminating safety action bulletins and hazard notices. ☐☐ **A**

11.27 The objectives and effectiveness of the safety committee are evaluated annually and modified as required. ☐☐ **B**

Audit and Review

11.28 Audit and review systems are established, operated and maintained. ☐☐ **A**

Interpretation

These are designed to assess the following elements of the health and safety management system:

* *policy*
* *organisation*
* *planning and policy implementation*
* *measuring systems*
* *reviewing systems.*

VOLUME 1

FIRE SAFETY

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard 12

The hospital/trust is constructed, equipped, operated and maintained in a manner which ensures the safety of its patients, visitors and staff and protects the property from fire and the products of combustion.

Criteria	*Comments*	*please tick* Yes	No	
Policy Development				
12.1 There is a written hospital/trust-wide fire safety policy which conforms to the requirements of the Firecode Policy and Principles document and is signed and dated by the hospital manager/chief executive.				A
Management Responsibilities				
12.2 The chief executive/hospital manager is responsible for ensuring the implementation of Firecode guidance in all premises owned or occupied by the trust.				A
12.3 There is a system in place to ensure that all line managers and staff are aware of their responsibility under duty of care to comply with the guidance.				A
12.4 An appropriately qualified and experienced fire safety advisor is designated responsible for fire safety.				A
12.5 The responsibilities of the fire safety advisor are in accordance with the requirements of Firecode.				A
12.6 In each hospital there is a member of staff designated as the nominated officer (fire).				A
12.7 The responsibilities of the nominated officer (fire) are in accordance with the requirements of Firecode.				A
12.8 There is written evidence of the extent to which buildings comply with legislation relating to fire safety (for example, the Fire Precautions Act 1971, Firecode, Health and Safety at Work etc Act 1974, Building Regulations, EC directives and the proposed Fire Precautions (Places of Work) Regulations).				A
12.9 Fire standards for existing buildings conform to the requirements of HTM 85.				A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes **No**

Comments

12.10 For designated areas (as defined by the Fire Precautions Act 1971) there is written evidence that a fire inspection by the local fire authority has taken place within the last three years. Similarly, all major building developments and alterations are inspected in accordance with the building regulations and Firecode.

A

12.11 There is a documented response to recommendations made by the local fire authority.

A

Interpretation

- *this sets out the action already taken or proposed by the hospital/trust, the rationale on which it is based and the planned timetable of compliance*
- *the timetable shows evidence of priority being given to:*

  achieving certification for the relevant parts of the estate

  recommendations which have a direct bearing on issues of patient safety

  eradication of gross fire hazards

  early compliance with recommendations that are readily achievable.

12.12 Comprehensive assessments of fire risk are regularly conducted and recorded in accordance with Firecode (this includes carrying out safety checks in unused buildings).

A

12.13 There is written evidence of approval from the local fire authority in relation to all new buildings, major works and/or alterations.

A

Fire Systems and Equipment

12.14 Fire fighting equipment (for example, fire extinguishers, hydrants, hose reels, fire blankets) is provided as appropriate and conforms to relevant British Standards.

A

12.15 All fire systems and equipment are appropriate to the type of fire most likely to occur in the area in which they are located.

A

VOLUME 1

FIRE SAFETY

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No

Comments

Interpretation

Attention is given to the following hazardous areas:

- * *designated smoking areas*
- * *engineering plant rooms/boiler rooms*
- * *electrical rooms including special systems for high voltage installations*
- * *fuel and gas storage compounds*
- * *health records storage areas*
- * *incinerators*
- * *kitchens*
- * *laboratories*
- * *laundry storage areas and linen rooms*
- * *maintenance workshops*
- * *pharmacies*
- * *refuse collection and storage areas*
- * *rooms or spaces used for permanent or temporary storage of combustible supplies and equipment*
- * *shops and other retail outlets*
- * *treatment rooms and patient bed areas where oxygen and other potentially hazardous gases are used.*

12.16 There is recorded evidence that the testing and maintenance of fire systems and equipment is performed on a systematic basis by a qualified person. **A**

12.17 There is a written programme in place to ensure that all fire alarm, fire detection and emergency lighting systems which do not conform to HTM 82 are upgraded. **A**

12.18 All electrical equipment brought into the hospital/trust is subject to a safety inspection. **A**

12.19 Access for fire engines is maintained at all times. **A**

12.20 Dry risers are clearly sign-posted. **A**

Evacuation

12.21 There is adequate protected means of escape from all parts of the building in compliance with the requirements of local fire authorities, building regulations and guidance notes. **A**

FIRE SAFETY

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

12.22 Formal means of escape are:

12.22.1 accessible at all times **A**

12.22.2 wide enough for the evacuation of non-ambulant patients and staff **A**

12.22.3 not used to store combustible materials. **A**

12.23 Fire exit signs are clearly displayed. **A**

12.24 Patient rooms and exit doors are kept unlocked at all times. **A**

12.25 In areas where doors must be locked (for example, some psychiatric units) there are written instructions detailing the means of escape during a fire. **A**

12.26 Fire procedures are prominently displayed throughout the hospital/trust (these take into consideration the disruption that may be caused by construction, redevelopment or upgrading work). **A**

12.27 Procedures detailing action to be taken in the event of patients having to be moved are displayed in patient areas. **A**

Training

12.28 Where clinically acceptable, managers arrange regular fire drills for day and night staff under varied conditions (for example, smoke filled rooms). **A**

12.29 Fire exercises are conducted in liaison with the local fire authority. **B**

12.30 When drills and exercises are carried out:

12.30.1 they are evaluated **B**

12.30.2 a written report is produced **B**

12.30.3 staff attendance is documented. **B**

12.31 All staff are:

12.31.1 trained annually in fire procedures, including fire alarm notification and the operation of fire fighting equipment *(see also Core Standards for Non-Clinical Services chapter, criteria 2.17, 2.20 and Core Standards for Clinical Services chapter, criteria 2.18, 2.21)* **A**

12.31.2 familiar with the method and route of evacuation from their area and understand when and how evacuation will be authorised **A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

12.31.3 trained to evacuate patients (where appropriate).

Policies

12.32 There is a system in place to ensure that all incidents of fire are reported and investigated by the fire safety officer. **A**

12.33 The purchasing of new textiles and furniture is in accordance with the guidance contained in HTM 87. **A**

Interpretation

- *there is a policy in place to ensure that all textiles and furniture not complying with HTM 87 are programmed for replacement*
- *all items donated or purchased with donations from voluntary organisations meet the requirements of HTM 87.*

12.34 Old furniture stocks are reduced to a minimum level and stored in a designated area. **A**

12.35 When improvements in security are proposed, the security advisor (however named) consults with the fire safety officer prior to implementation *(see also Security Service chapter, criterion 1.12).* **B**

VOLUME 1

MANAGEMENT OF WASTE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 13

All waste is disposed of in a manner which ensures that patients, staff, visitors and the environment are protected from harm.

please tick
Yes No

Criteria

Comments

13.1 Waste disposal is carried out in accordance with the Environmental Protection Act 1990 duty of care and official guidelines (for example, Health Services Advisory Committee Safe Disposal of Clinical Waste). **A**

Interpretation

Policies and procedures include:

* *segregating general and contaminated waste at the sight of generation (including colour coding and labelling the place and the date of origin)*
* *disposing of sharp objects in suitable containers*
* *dealing with needlestick injuries*
* *labelling and disposing of cytotoxic and radioactive waste*
* *safe handling of contaminated waste including the use of approved contaminated waste bags, protective clothing, and appropriate storage facility prior to incineration or removal from the site*
* *disposing of special waste (for example, prescription returns).*

(See also Infection Control standard, criterion 14.10.)

13.2 Waste disposal policies and procedures are documented *(see also Estates Management chapter, criterion 1.14.3).* **A**

13.3 Suitable and adequate containers are provided to wards and departments. **A**

13.4 Storage of waste is kept to a minimum and secured at all times. **A**

13.5 Hospital owned vehicles used to transport waste are cleaned:

13.5.1 at least weekly **A**

13.5.2 when leakage or spillage has occurred. **A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

13.6 When the same vehicles are used to transport waste and non-waste items, they are cleaned prior to each usage. ☐ ☐ **A**

13.7 All staff involved in handling clinical waste receive training *(see also Housekeeping Service chapter, criterion 1.1.1 and Portering Service chapter, criterion 1.1.2).* ☐ ☐ **A**

13.8 There is a procedure in place to ensure that the incinerator operator has a valid licence. ☐ ☐ **A**

VOLUME 1

INFECTION CONTROL

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 14

There is an effective hospital/trust-wide programme for prevention, detection and control of infection.

Criteria	*Comments*	*please tick* Yes	No	
Structure and Responsibilities				
14.1 The hospital manager/chief executive is responsible for establishing and maintaining infection control arrangements across the hospital/trust.				**A**
14.2 There is an infection control team which comprises an infection control doctor, an infection control nurse and, if the infection control doctor is from another specialty, a consultant medical microbiologist.				**A**
14.3 The infection control doctor is responsible to the hospital manager/chief executive for the provision of infection control advice and the formulation and promulgation of infection control policy.				**A**
14.4 The infection control doctor has direct access to the hospital manager/chief executive.				**B**
14.5 There is evidence that the number of infection control nurses is appropriate to the number of beds, the number of hospitals and area over which they are covered and the patient case mix.				**B**
14.6 The responsibilities of the infection control team include:				
14.6.1 dealing with incidents or outbreaks of infection				**A**
14.6.2 developing infection control policies and procedures				**A**
14.6.3 educating staff				**A**
14.6.4 organising 24 hour emergency cover				**A**
14.6.5 establishing action groups during significant outbreaks				**A**
14.6.6 liaising with the Consultant in Communicable Disease Control (CCDC)				**A**
14.6.7 carrying out surveillance and audit of hospital acquired infection				**A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick

Yes No

Comments

14.6.8 giving advice on proposed building constructions to ensure that they are designed in line with infection control requirements ☐☐ B

14.6.9 giving advice on equipment and consumable items intended for patient use to ensure that they conform with infection control standards ☐☐ B

14.6.10 giving advice on tenders for other services when infection control input is necessary ☐☐ B

14.6.11 liaising with other hospitals and external bodies (for example, the local environmental health department, the Public Health Laboratory Service, the Department of Health where necessary). ☐☐ B

14.7 There is a multidisciplinary infection control committee which advises and supports the infection control team. ☐☐ A

Interpretation

The committee:

* *reviews the annual infection control programme*
* *reviews recent outbreaks*
* *reviews all procedures in relation to infection control*
* *discusses specific areas of concern from the infection control team*
* *agrees guidelines for the surveillance of infections and infection potential*
* *reviews anonymised results of infection control audits.*

14.8 The committee membership consists of:

14.8.1 the infection control team ☐☐ A

14.8.2 the CCDC ☐☐ B

14.8.3 representation from medical and nursing staff and hospital management ☐☐ B

14.8.4 paramedical and support services as appropriate (for example, pharmacy, sterile services, engineering). ☐☐ B

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Comments	Yes	No	
14.9 The committee meets regularly (as a minimum twice a year) and meetings are minuted.			**B**
Policies and Procedures			
14.10 There are written infection control policies.			**A**
Interpretation			
These cover:			
* *clinical procedures (medical, surgical, nursing and paramedical)*			
* *the disposal of waste (see also Management of Waste standard, criteria 13.1, 13.2)*			
* *outbreaks*			
* *high risk patients (for example, immunosuppressed) and communicable diseases*			
* *sterilisation and disinfection*			
* *engineering and building services*			
* *hotel services (housekeeping, laundry/linen and catering) (see also Housekeeping Service chapter, criterion 1.4)*			
* *mortuary and last office guidance.*			
14.11 These policies and procedures are:			
14.11.1 subject to a systematic review			**B**
14.11.2 dated			**B**
14.11.3 referenced to appropriate legislation or published professional guidance			**B**
14.11.4 contained within a manual.			**B**
14.12 The infection control manual is distributed to each ward and department (relevant policies only) *(see also Core Standards for Non-Clinical Services chapter, criterion 4.7.8 and Core Standards for Clinical Services chapter, criterion 4.7.11).*			**A**
14.13 Policies and procedures are reviewed through regular infection control audits.			**B**
Education			
14.14 There is an on-going, coordinated programme of education for all staff within the hospital/trust.			**A**
14.15 Courses are tailored to meet the needs of individual groups of staff.			**B**

INFECTION CONTROL

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

14.16 The infection control team is involved in:

14.16.1 the hospital/trust orientation and induction programme — ☐☐ B

14.16.2 junior doctors orientation and induction programme — ☐☐ B

14.16.3 basic level training of other healthcare personnel (for example, nursing students, medical students). — ☐☐ B

14.17 Resources are available to purchase educational material. — ☐☐ C

Communication

14.18 Communication links are established between the infection control team and:

14.18.1 the CCDC — ☐☐ A

14.18.2 the hospital/trust laboratory service *(see also Pathology Service chapter, criterion 2.2)* — ☐☐ A

14.18.3 external services (for example, local authority, community health staff, general practitioners, the Public Health Laboratory Service) — ☐☐ B

14.18.4 occupational health *(see also Occupational Health standard, criterion 15.12).* — ☐☐ B

14.19 Minutes and reports from the infection control committee are distributed to:

14.19.1 the executive management team/trust board — ☐☐ B

14.19.2 individual directorates or equivalent (where in place). — ☐☐ B

Isolation

14.20 Facilities for infectious patients and those requiring isolation are available. — ☐☐ A

Surveillance

14.21 There is a programme in place for the surveillance of infection within the hospital/trust which includes the collection, analysis and dissemination of data. — ☐☐ A

Outbreaks

14.22 Arrangements are in place for the control of outbreaks of infection. — ☐☐ A

14.23 There are mechanisms for liaising with the CCDC. — ☐☐ A

VOLUME 1

INFECTION CONTROL

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No
☐	☐

Comments

14.24 Reports are prepared by the infection control team following each outbreak.

☐ ☐ **B**

VOLUME 1

OCCUPATIONAL HEALTH

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard 15

The hospital/trust ensures a safe and healthy environment for staff.

please tick

Criteria	*Comments*	Yes	No	
15.1 Staff have access to an occupational health service which is confidential to those using it.				A
Where the service is provided internally:				
Operational Policy				
15.2 There is an operational policy for the service.				A
Interpretation				
* *the operational policy details:*				
aims				
functions				
organisation				
reporting lines to senior management				
* *the operational policy is developed by occupational health staff in liaison with employer and worker representatives*				
* *the operational policy is endorsed by the executive management team/trust board*				
* *the operational policy is reviewed systematically.*				
Functions				
15.3 There are policies on health assessment.				A
Interpretation				
These include:				
* *pre-placement assessment*				
* *health screening and surveillance*				
* *immunisation against, for example, rubella, tuberculosis, hepatitis B*				
* *post-sickness absence*				
* *referrals to the occupational health department*				
* *communicating results of assessment to the referrer.*				

VOLUME 1

OCCUPATIONAL HEALTH

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes **No**

Comments

15.4 In areas where potential or actual hazards are identified, the needs for appropriate health surveillance are assessed and programmes implemented (for example, personal health checks). **A**

Interpretation

Examples include:

* *gluteraldehyde plus other respiratory sensitisers*
* *noise*
* *display screen units*
* *employees with high levels of sickness absence*
* *employees sustaining certain work accidents or health related problems*
* *exposure to chemicals identified in COSHH assessments.*

15.5 There is a hospital/trust programme which ensures that employees undertaking exposure prone procedures are immune or are non-carriers of hepatitis B. **A**

15.6 The service is involved in the development of programmes to coordinate Health Workplace Initiatives. **B**

15.7 Union appointed safety representatives are informed of trends in ill-health and accident data. **B**

15.8 Ill-health and accident data are presented to the health and safety committee. **B**

15.9 Effective and appropriate data systems are maintained which facilitate epidemiology and research. **B**

Interpretation

Data systems include:

* *attendance records*
* *clinical information such as immunisation details and surveillance results*
* *environmental reports*
* *ill-health retirement.*

15.10 The service participates in the hospital/trust orientation and induction programme. **B**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick Yes No

Interpretation

* *this programme addresses the hazards that will be encountered by the employees concerned.*

15.11 The service participates in manual handling and lifting training. ☐☐ B

Internal and External Communication

15.12 Lines of communication are established and maintained between the occupational health service and other departments/personnel. ☐☐ B

Interpretation

The departments/personnel include:

* *health and safety officer (however named)*
* *infection control (see also Infection Control standard, criterion 14.8.4)*
* *occupational hygiene*
* *pathology service (see also Pathology Service chapter, criterion 2.2)*
* *radiation protection*
* *human resources.*

15.13 Reports on the work of the service are presented to the executive management team/trust board and the health and safety committee. ☐☐ B

15.14 The service is represented on the following committees:

15.14.1 health and safety ☐☐ A

15.14.2 infection control *(see also Infection Control standard, criterion 14.8.3).* ☐☐ B

15.15 Communication links are established with external organisations (for example, environmental health, the Health Education Authority, the Health and Safety Executive s medical division (EMAS)). ☐☐ B

Staffing

15.16 The head of the service is trained in occupational health. ☐☐ A

15.17 All staff are encouraged to acquire specialist qualifications and opportunities for refresher training are provided. ☐☐ B

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick

Yes No

Comments

15.18 The service is supported in its work by administrative and clerical staff. ☐☐ B

Records

15.19 Occupational health records are maintained by the service. ☐☐ A

Interpretation

These include:

* *transferable information (for example, personal identification, employment details, types and dates of immunisation, diagnostic dates, accidents at work)*
* *a confidential clinical record.*

15.20 Occupational health records are stored securely. ☐☐ A

15.21 Occupational health records are retained for a minimum of 40 years after the date of the last entry or longer if required by law. ☐☐ A

15.22 Occupational health staff are aware of, and understand, the Access to Medical Reports Act 1988. ☐☐ A

15.23 Sufficient storage space for occupational records is available. ☐☐ B

Facilities

15.24 The service is delivered within close proximity to the hospital/trust. ☐☐ B

VOLUME 1

QUALITY IMPROVEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 16

There is a quality improvement strategy for the hospital/trust which supports its business plan.

Criteria	*Comments*	*please tick* Yes	No	
16.1 There is a designated individual at board level responsible for the quality improvement strategy of the hospital/trust.				**A**
16.1 There is a written quality improvement strategy for the hospital/trust.				**A**
Interpretation *The quality improvement strategy details:* * *definition of quality applied* * *objectives of the programme* * *methods to achieve these objectives* * *implementation timetable* * *management responsibility for, and the organisational structure to support, the commitment to quality management* * *a mechanism for providing the necessary resources to support the quality management and evaluation activities.*				
16.3 Quality management and evaluation activities include:				
16.3.1 the development of locally based standards which are consistent with the content of national charters and (where applicable) Health of the Nation				**B**
16.3.2 clinical audit (uniprofessional and multidisciplinary)				**B**
Interpretation * *clinical audit meetings and other peer review activities are supported by the hospital manager/chief executive as part of the quality improvement strategy* * *clinical audit meetings are undertaken regularly and outcomes recorded*				

VOLUME 1

QUALITY IMPROVEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes No

Comments

* *there is evidence of management action as a result of audit findings*

16.3.3 the routine and systematic review of quality indicators — ☐☐ **B**

Interpretation

The routine and systematic review of quality indicators may include:

* *cancelled operations*

* *complaints and unresolved or unsatisfactory resolutions (patient s perspective)*

* *drug errors*

* *incidence of hospital acquired infections*

* *patients not arriving for admission/treatment*

* *mortality and morbidity including at least the following:*

avoidable complications

unexpected death

untoward occurrences

* *staff grievances*

* *staff sickness*

16.3.4 a systematic approach to patient and service user satisfaction including the documentation of action taken and the recording of results — ☐☐ **B**

16.3.5 training staff in the development, implementation and review of quality activities on a regular and systematic basis — ☐☐ **B**

16.3.6 evaluating the impact of the programme and establishing reporting mechanisms (including frequency). — ☐☐ **B**

(See also Core Standards for Non-Clinical Services chapter, criterion 6.2 and Core Standards for Clinical Services chapter, criterion 7.2.)

CORE STANDARDS FOR NON-CLINICAL SERVICES

VOLUME 1

CORE STANDARDS FOR NON-CLINICAL SERVICES

This document contains a set of organisational standards and criteria specific to any non-clinical service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the United Kingdom.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion is achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA) programme, a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

These Core Standards for Non-Clinical Services are not 'stand alone' standards and are designed to be used in conjunction with the relevant service specific criteria contained within this manual. It will therefore be necessary for each service to complete a self-assessment of progress against the core standards and the service specific criteria. If, however, the service forms part of a larger unit of management (for example, a facilities directorate), the core standards should be applied across the unit of management as a whole with each constituent service feeding into one overall assessment.

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VOLUME
1

AIMS AND OBJECTIVES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 1

The service has clear aims and objectives which are consistent with those of the hospital/trust and are reflected in policy and business planning documentation.

please tick
Yes No

Criteria

Comments

1.1 Written aims are developed which are consistent with the overall mission of the hospital/trust. ☐☐ **B**

Interpretation

When developing aims the following are taken into consideration:

* *providing a service based on professional standards set by the relevant professional organisation*
* *ensuring patient and staff safety*
* *maintaining and improving a high standard of service through audit activities (monitoring, assessing, taking action, reviewing, feeding back)*
* *maintaining communication with other members of the healthcare team to:*

  meet the needs of the patient

  meet the needs of staff

  coordinate services
* *ensuring that staff have the necessary competencies to deliver the service required.*

1.2 There is a written philosophy statement which reflects the values of the service. ☐☐ **B**

Interpretation

The following values are reflected in the delivery of the service:

* *being courteous and considerate to patients, carers and staff at all times*
* *respecting the privacy, dignity and rights of patients, carers and staff*
* *respecting and responding to cultural differences*
* *responding to the individual needs of patients, carers and staff.*

VOLUME 1

AIMS AND OBJECTIVES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

			please tick Yes	No	*Comments*	
1.3	The philosophy statement is:					
	1.3.1	developed and endorsed by staff				B
	1.3.2	clearly displayed within the department/service area.				B
1.4	Measurable objectives are developed which are consistent with the overall objectives of the hospital/trust.					B
1.5	The objectives are:					
	1.5.1	developed and endorsed by staff				B
	1.5.2	reviewed annually in line with the business plan and/or service contract				B
	1.5.3	reviewed when:				
		(a) the role of the hospital/trust changes				B
		(b) there is a change in the provision or pattern of service delivery				B
		(c) there is a change in the nature and scope of professional practice				B
		(d) significant feedback from users is received.				B

VOLUME 1

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

Criteria		*Comments*	*please tick* Yes	No	
Management Arrangements					
2.1	The responsibilities of the head of each service include:				
2.1.1	management arrangements				**B**
2.1.2	budgetary accountability				**B**
2.1.3	business planning development *(see also Corporate Management chapter, Mission and Objectives standard, criterion 1.6)*				**B**
2.1.4	development and delivery of contracts/internal service agreements *(see also Corporate Management chapter, Contract Services standard, criterion 2.2)*				**B**
2.1.5	development and training of staff				**B**
2.1.6	involvement in the appointment and deployment of staff				**B**
2.1.7	involvement in grievance and disciplinary procedures				**B**
2.1.8	involvement in the preparation and setting of the budget *(see also Corporate Management chapter, Financial Resources standard, criterion 6.3)*				**B**
2.1.9	liaising with other services				**B**
2.1.10	skill-mix reviews				**B**
2.1.11	staff appraisal.				**B**
2.2	There is a designated individual to take responsibility for the service in the absence of the manager.				**B**
2.3	The organisational structure is clearly understood by staff in terms of managerial accountability and is supplemented by an up-to-date written chart.				**B**
2.4	The organisational structure is revised:				
2.4.1	annually				**B**
2.4.2	when staffing changes take place				**B**
2.4.3	when the service is restructured.				**B**

VOLUME 1

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

Finance and Information

2.5 Reports of income and expenditure are received by the budget holder(s) at monthly intervals throughout the year and are representative of the previous month s activity *(see also Corporate Management chapter, Financial Resources standard, criterion 6.7).* ☐☐ **B**

2.6 Income and expenditure reports are:

2.6.1 timely ☐☐ **B**

2.6.2 accurate ☐☐ **B**

2.6.3 clear. ☐☐ **B**

(See also Corporate Management chapter, Financial Resources standard, criterion 6.8.)

2.7 Access to financial advice is available *(see also Corporate Management chapter, Financial Resources standard, criterion 6.4).* ☐☐ **B**

2.8 Records and statistics are available on:

2.8.1 staff absenteeism (unauthorised) ☐☐ **B**

2.8.2 staff sickness ☐☐ **B**

2.8.3 staff turnover ☐☐ **B**

2.8.4 special leave (for example, maternity/paternity leave). ☐☐ **B**

(See also Corporate Management chapter, Human Resources standard, criterion 5.2.)

2.9 These statistics are monitored against agreed targets. ☐☐ **C**

Communication

2.10 Regular service meetings are held to:

2.10.1 brief staff on hospital/trust matters *(see also Corporate Management chapter, Management Arrangements standard, criterion 3.8.2)* ☐☐ **B**

2.10.2 discuss issues related to the provision of the service. ☐☐ **B**

2.11 All staff are aware of the dates of these meetings. ☐☐ **B**

2.12 Minutes of these meetings are kept and made available to staff. ☐☐ **B**

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

Health and Safety

(See also Corporate Management chapter, Health and Safety Management and Fire Safety standards.)

2.13 Risk assessments are carried out in accordance with hospital/trust strategy, the findings are documented and preventive and protective measures are implemented (for example, protective clothing, lifting training). ☐☐ A

2.14 Health and safety inspections are carried out on a systematic basis. ☐☐ A

2.15 The health and safety responsibilities of staff are clearly defined. ☐☐ A

2.16 Copies of health and safety regulations are readily available to staff. ☐☐ B

2.17 Fire drills are carried out on a systematic basis and records are kept for inspection. ☐☐ A

2.18 Corridors and doorways are kept free of obstruction. ☐☐ A

2.19 Fire fighting equipment is available in the service area and is clearly marked. ☐☐ A

2.20 All staff attend annual fire lectures. ☐☐ A

2.21 There is ready access to a first aid box. ☐☐ A

Human Resources

2.22 Written and dated job descriptions are available for all posts *(see also Corporate Management chapter, Human Resources standard, criterion 5.7).* ☐☐ B

Interpretation

* *job descriptions are reviewed:*

  annually

  on vacation of the post

* *the postholder is informed of any changes to the job description.*

2.23 There is a documented staff appraisal system for all staff *(see also Corporate Management chapter, Human Resources standard, criterion 5.23).* ☐☐ B

Interpretation

The staff appraisal system:

* *is based on the job description and work objectives*

VOLUME 1

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

* *identifies strengths in performance, areas for development and educational needs.*

2.24 All staff receive a contract of employment within 13 weeks of appointment which clearly states terms and conditions of service *(see also Corporate Management chapter, Human Resources standard, criterion 5.12).* ☐☐ **A**

2.25 Access to personnel advice is available. ☐☐ **B**

Staffing

2.26 There is a mechanism to systematically assess and monitor staffing levels against workload *(see also Corporate Management chapter, Human Resources standard, criterion 5.2).* ☐☐ **A**

2.27 The additional requirements of teaching, supervising and assessing are reflected in staff establishment, numbers of staff on duty and qualifications of staff on duty. ☐☐ **C**

2.28 Provision is made for out-of-hours or emergency cover where required. ☐☐ **A**

2.29 Up-to-date duty rosters are clearly displayed and made available to staff where appropriate. ☐☐ **A**

2.30 There are nominated and trained individuals responsible for the following:

2.30.1 COSHH assessment ☐☐ **A**

2.30.2 first aid ☐☐ **A**

2.30.3 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.10).* ☐☐ **A**

2.31 Staff have access to an occupational health service *(see also Corporate Management chapter, Occupational Health standard).* ☐☐ **A**

VOLUME 1

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

Criteria	*Comments*	*please tick* Yes	No	
Orientation and Induction				
3.1 All staff receive induction at a corporate level on the following areas:				
3.1.1 fire				**A**
3.1.2 health and safety				**A**
3.1.3 patient confidentiality				**A**
3.1.4 accident and/or untoward incident reporting				**A**
3.1.5 security				**A**
3.1.6 pay arrangements.				**A**
(See also Corporate Management chapter, Human Resources standard, criterion 5.14.)				
3.2 The head of the service is responsible for ensuring that a record of attendance at the hospital/trust orientation and induction programme is maintained, signed and dated.				**B**
3.3 All staff appointed are subject to local orientation and induction arrangements.				**A**
3.4 As a minimum the local arrangements:				
3.4.1 prepare staff for their role and responsibilities				**A**
3.4.2 introduce staff to the policies and procedures of the service and the hospital/trust				**A**
3.4.3 explain emergency procedures (for example, fire)				**A**
3.4.4 introduce staff to the hospital/trust health and safety policy and current health and safety legislation, explain its impact on the service and highlight the responsibilities of the employee to their employer *(see also Corporate Management chapter, Health and Safety Management standard criterion 11.14)*				**A**
3.5 Local orientation and induction arrangements are documented.				**B**

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

Continuing Education

3.6 All staff involved in the moving and handling of patients, equipment or other heavy loads receive training/updating in lifting and handling. **A**

3.7 Attendance at lifting and handling training sessions is documented. **A**

3.8 The continuing education programme is linked to performance development, appraisal and the objectives of the hospital/trust *(see also Management and Staffing standard, criterion 2.23).* **B**

3.9 As part of on-going education and professional updating the following are made available:

3.9.1 training when changes in practice take place, the law changes, new technology or equipment is introduced or new responsibilities are assumed (for example, management development) *(see also Facilities and Equipment standard, criterion 5.7)* **A**

3.9.2 information on advances in practice **B**

3.9.3 information on, and support for taking advantage of, educational opportunities arranged by other institutions. **C**

3.10 Staff have access to local information and library services (access to national library services may also be required) *(see also Library Service chapter, criterion 2.2 and Corporate Management chapter, Human Resources standard, criterion 5.19).* **B**

3.11 Current reference manuals, pamphlets, journals and relevant textbooks are readily available within the department/service area for reference and guidance *(see also Corporate Management chapter, Human Resources standard, criterion 5.20).* **C**

3.12 Records of attendance at conferences, seminars and meetings are kept and reviewed annually. **B**

3.13 The benefits of educational activities are evaluated. **C**

VOLUME 1

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 4

There are written policies and procedures which reflect current knowledge, are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

Criteria	*Comments*	*please tick* Yes	No	
Service Policies				
4.1 Service policies and procedures are consistent with national or local guidelines.				**A**
4.2 Where necessary, service policies and procedures are developed in consultation with representatives from other relevant professions (for example, infection control).				**A**
4.3 Staff are involved in the development of service policies and procedures.				**B**
4.4 Service policies and procedures are:				
4.4.1 reviewed and systematically updated				**B**
4.4.2 accessible within the department/service area				**B**
4.4.3 contained within a manual.				**B**
4.5 There is a system in place for informing staff when changes to policies and procedures occur.				**A**
Hospital/Trust Policies				
4.6 Senior staff are involved in the development of hospital/trust policies and procedures where these impact on their service.				**B**
4.7 Staff have access to hospital/trust policies and procedures, which include as a minimum:				
4.7.1 accidents, errors and incidents				**A**
4.7.2 all relevant personnel policies (for example, grievance, disciplinary)				**A**
4.7.3 complaints from patients, carers and staff				**A**
4.7.4 COSHH				**A**
4.7.5 emergency/evacuation procedures				**A**
4.7.6 fire				**A**
4.7.7 health and safety				**A**
4.7.8 infection control				**A**
4.7.9 management of waste.				**A**

VOLUME 1

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No
☐	☐

(See also Corporate Management chapter, Management Arrangements standard, criterion 3.19, Human Resources standard, criterion 5.5, Policies and Procedures standard, criterion 8.4, Risk Management standard, criterion 10.5, Health and Safety Management standard, criterion 11.1, Management of Waste standard, criteria 13.1, 13.2 and Infection Control standard, criterion 14.12.)

Comments

4.8 Records are kept of accidents, errors, incidents and complaints in line with the hospital/trust policy *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.5).*

☐ ☐ **A**

4.9 The role of the service in fire/disaster plans of the hospital/trust is documented and staff are made aware of it *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.17).*

☐ ☐ **A**

VOLUME 1

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 5

The environment, facilities and equipment ensure safe, efficient and effective operation of the service.

please tick
Yes No

Criteria

Comments

General Facilities

5.1 There is evidence that staff are aware of, and adhere to, the hospital/trust smoking and alcohol policies *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.13).* **A**

5.2 Counselling is available to help staff stop smoking *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.14.2).* **C**

5.3 Storage space is available to meet service needs. **B**

Staff Facilities

5.4 Access to the following staff facilities is available:

5.4.1 office space for the designated manager **B**

5.4.2 office space for staff providing the service **B**

5.4.3 a rest room **B**

5.4.4 wash and changing rooms. **B**

5.5 Catering arrangements are in place for all staff working day and night shifts *(see also Catering Service chapter, criterion 2.4.1).* **A**

Equipment

5.6 There is evidence that materials and equipment are available to enable staff to carry out their duties. **A**

5.7 Specialised equipment is used only by staff trained and competent in its operation *(see also Staff Development and Education standard, criterion 3.9.1).* **A**

5.8 Where necessary, the following are provided:

5.8.1 lifting aids **A**

5.8.2 personal protective equipment. **A**

5.9 The service has access to emergency support in the event of equipment failure. **A**

VOLUME 1

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No

Comments

5.10 The head of the service is involved in the process of equipment procurement. ☐ ☐ **B**

5.11 There is a system of preventative maintenance and replacement in place which is clearly understood by staff *(see also Estates Management chapter, criterion 1.9).* ☐ ☐ **A**

VOLUME 1

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 6

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

Criteria	*Comments*	*please tick* Yes	No	
6.1 There is a written quality management and evaluation programme for the service (this may form part of business planning documentation).				**B**
Interpretation				
The quality management programme details:				
* *objectives of the programme*				
* *methods to achieve the objectives*				
* *implementation timetable.*				
6.2 The quality management and evaluation programme includes:				
6.2.1 the development of local standards consistent with national charters and purchaser contract requirements				**B**
6.2.2 the assessment of patient/visitor satisfaction				**B**
6.2.3 the use of resources (for example, type of stock, amount, facilities)				**B**
6.2.4 the assessment of service user satisfaction (including staff)				**B**
6.2.5 the assessment of the service against organisational standards				**B**
6.2.6 the systematic review of quality indicators on a service-wide basis				**B**
6.2.7 the training of staff in the development, implementation and review of quality activities.				**B**
(See also Corporate Management chapter, Quality Improvement standard, criterion 16.3.)				
6.3 Evaluation activities include the following elements:				
6.3.1 monitoring: the routine collection of information/statistics about important aspects of service delivery				**B**
6.3.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery				**B**

QUALITY MANAGEMENT AND EVALUATION

Weighting

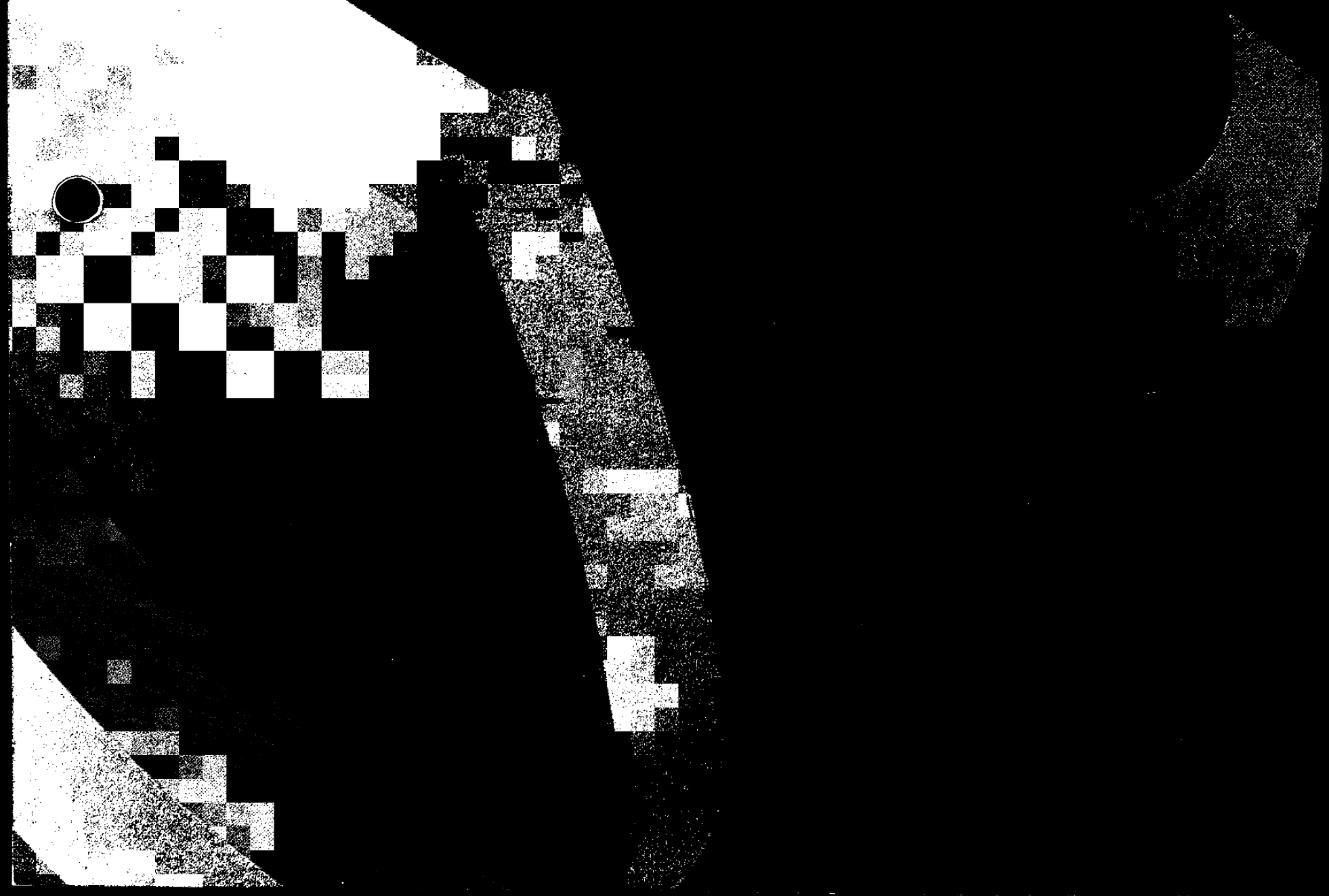
Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		Comments	*please tick* Yes	No	
6.3.3	action: when important problems or opportunities to improve service delivery are identified, action is taken and documented		☐	☐	**B**
6.3.4	review: the effectiveness of action taken is evaluated to ensure long-term improvements		☐	☐	**B**
6.3.5	feedback: the results of activities are regularly communicated to staff.		☐	☐	**B**

NON-CLINICAL SERVICE SPECIFIC CRITERIA



VOLUME 1

CATERING SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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VOLUME 1

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick
Yes No

Comments

2.1 Where food services are provided under contract, or where foodstuffs are purchased from outside sources, the hospital/trust ensures that services and foods conform to current food legislative requirements *(see also Corporate Management chapter, Contract Services standard, criterion 2.4).* **A**

2.2 There is a system in place to ensure that a close working relationship is established with the chief environmental health officer. **A**

2.3 Lines of communication between the catering service and the dietetic service are established *(see also Dietetic Service chapter, criterion 2.4).* **B**

2.4 The head of the service is responsible for ensuring that:

2.4.1 catering arrangements are available for all staff working day and night shifts *(see also Core Standards for Clinical Services chapter, criterion 5.7 and Medical Service chapter, criterion 5.4)* **A**

2.4.2 catering arrangements are available for relatives staying in the hospital/trust (for example, parents of children, families/carers of critically or terminally ill patients) **B**

2.4.3 there are food outlets within the hospital/trust (for example, kiosks, vending machines, trolleys). **B**

2.5 Catering staff are supported in the delivery of the service by:

2.5.1 administrative and clerical staff **B**

2.5.2 portering staff. **B**

VOLUME 1

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:		*please tick* Yes	No	***Comments***
3.1	All staff, including trainees and agency staff, receive:			
3.1.1	training in food handling	☐	☐ A	
3.1.2	training in hygiene practices.	☐	☐ A	
3.2	There is a system in place to ensure that all training (initial, refresher and updates):			
3.2.1	takes place on a systematic basis	☐	☐ A	
3.2.2	is recorded.	☐	☐ A	

VOLUME 1

POLICIES AND PROCEDURES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current knowledge, are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick
Yes No

In addition to the core standard criteria:

Comments

4.1 Service policies and procedures:

4.1.1 reflect the requirements of the Food Safety Act 1990 — A

4.1.2 comply with HSG(92)34 Management of Food Services and Food Hygiene in the NHS — A

4.1.3 are agreed by the dietitian and the catering manager *(see also Dietetic Service chapter, criterion 2.4).* — B

4.2 There are documented operational policies for the safe storage, preparation, handling and distribution of food. — A

Interpretation

These cover:

* *the selection of raw ingredients*
* *the selection of suppliers*
* *the carriage of foodstuffs in internal and external delivery vehicles*
* *checking the quality and quantity of food supplies on arrival and at regular intervals thereafter*
* *ensuring that the temperature is appropriate to food being stored and complies with current legislation*
* *ensuring that foods which may contaminate each other are stored separately (for example, cooked and uncooked meats, washed and unwashed salad, Kosher and Halal meals)*
* *keeping storage facilities clean, hygienic and odour free*
* *ensuring that the storage of food in dry storage, refrigerators and freezers complies with food hygiene regulations*
* *rotating stock under the first in, first out system*

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments	please tick Yes	No	Weighting
* *preparing and handling food in accordance with food hygiene regulations*			
* *minimising the holding times of prepared foods to preserve nutritional value and food acceptability*			
* *disposing of waste safely*			
* *the care and cleaning of all areas and equipment*			
* *machine washing and washing dishes by hand (including refernce to scraping and pre-soaking, water temperature, rinsing and sanitising and quick drying of items)*			
* *the safe serving of meals to infectious patients and patients who are immunocompromised*			
* *the collection and clearing of trays and dishes after the meal which ensure noise is minimised for patients.*			
4.3 There are procedures for:			
4.3.1 health screening food handlers prior to appointment			A
4.3.2 food handlers to report if they are suffering from certain infections and action to be taken			A
4.3.3 the training of supervisors and food handlers.			A
4.4 The bulk preparation of food for long-term holding (for example, chilling or freezing) is carried out only if equipment and qualified staff are available to establish and supervise standards of handling, preparation and processing.			A
4.5 Menus are planned, in discussion with the dietetic service, to provide meals which meet the needs of patients and staff *(see also Dietetic Service chapter, criterion 2.4).*			B
Interpretation			
Attention is drawn to the following:			
* *attractive presentation of food*			
* *a flexible menu ordering system*			
* *portion size*			

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes **No**

Comments

* *variety and texture*
* *cultural preferences*
* *requirements of special patient populations (for example, children)*
* *menu cycles (taking into account the length of patient stay as well as food availability)*
* *the needs of patients and staff on either restricted or therapeutic diets.*

4.6 There are documented polices for:

4.6.1 dealing with a major catering emergency ☐☐ **A**

4.6.2 fire ☐☐ **A**

4.6.3 safety. ☐☐ **A**

4.7 There is a continuing programme of pest and vermin control. ☐☐ **A**

4.8 There is a stock control system. ☐☐ **B**

4.9 The stock control system deters pilfering. ☐☐ **B**

VOLUME 1

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective operation of the service.

In addition to the core standard criteria:

Comments

please tick

Yes	No	
		5.1 Food premises are registered with the local authority. **A**
		5.2 There are separate areas within the department for the following:
		5.2.1 handwashing **A**
		5.2.2 food delivery (receiving area) including facilities for checking the quality and the quantity of the food received and enabling food to be transferred rapidly to the appropriate storage area **A**
		5.2.3 food storage **A**
		5.2.4 food preparation (including an area to prepare therapeutic diets, special diets, infant feeds and parenteral and supplementary feeding) **A**
		5.2.5 cooking and reheating/regeneration **A**
		5.2.6 holding prepared food **A**
		5.2.7 washing dishes **B**
		5.2.8 equipment storage **B**
		5.2.9 waste disposal. **A**
		5.3 The layout of the department is designed to allow an efficient and hygienic flow of work. **B**
		5.4 Facilities comply with the requirements of relevant building regulations and statutory requirements. **A**

Interpretation

Attention is drawn to the following:

* *the cleaning of floors, walls and ceilings and the maintenance of sanitary conditions in all food rooms*
* *satisfactory lighting for working conditions and monitoring standards of cleanliness*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes **No**

Comments

* *ventilation, temperature and humidity control to provide satisfactory working conditions and to promote cleanliness*

* *fire safety requirements*

* *health and safety regulations.*

5.5 Equipment is purchased from an approved supplier. ☐ ☐ **B**

5.6 There is evidence that equipment complies with relevant safety standards. ☐ ☐ **A**

Interpretation

Particular attention is given to:

* *safety systems or alarms in walk-in refrigerators and freezers*

* *electrical, gas and pressure equipment*

* *fish fryers.*

5.7 Special eating utensils are available to meet the needs of particular patient groups (such equipment may include modified eating and drinking utensils for patients with special feeding needs, for example, paediatric patients or those with physical impairments). ☐ ☐ **B**

VOLUME 1

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 6

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

Comments

please tick
Yes No

6.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐ ☐ **B**

Interpretation

The quality indicators may include the following:

* *special diets*
* *unit cost*
* *waste.*

6.2 Arrangements are in place for patients to consult with catering staff and give feedback on the meals provided (for example, a patient comment card system). ☐ ☐ **B**

6.3 A written response to the recommendations of the environmental health officer is produced. ☐ ☐ **B**

6.4 Recommendations made by the environmental health officer are complied with. ☐ ☐ **A**

VOLUME
1

ESTATES MANAGEMENT

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 1

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard

The hospital/trust is constructed, equipped, operated and maintained in a manner which supports the safety and comfort of patients, staff and visitors.

please tick

Criteria	Comments	Yes	No	
(Reference should also be made to the Facilities and Equipment standard within the Corporate Management chapter.)				
Plans and Policies				
1.1 There is an estates operational plan in line with the guidance detailed in ESTATECODE which is reviewed and updated at least annually.				A
1.2 Where maintenance backlog exists, necessary work is identified, costed and prioritised and a programme for elimination drawn up in accordance with the hospital s/trust s development control plan.				A
1.3 An up-to-date asset register is maintained which is an integral part of the hospital s/trust s management information system.				A
1.4 The asset register is readily available.				B
1.5 There is an asset management strategy which is based on investment appraisal techniques and life cycle costing.				B
1.6 Up-to-date drawings are maintained which detail:				
1.6.1 fire zones and escape routes				A
1.6.2 hospital floor plans				B
1.6.3 internal routeing and location of building services				B
1.6.4 roads and traffic direction				B
1.6.5 site distribution of services and utilities				B
1.6.6 site layout.				B
1.7 A fully operational building management system is installed.				B
1.8 There is a comprehensive maintenance and replacement programme in place in line with the recommendations of ESTATECODE *(see also Core Standards for Clinical Services chapter, criterion 5.15).*				A

VOLUME 1

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Interpretation

The maintenance programme is designed to reduce the incidence of failure and to control risks associated with:

- *building fabric*
- *equipment*
- *footpaths, roadways and external lighting*
- *plant.*

		please tick Yes	No	Comments
1.9	The maintenance programme includes:			
1.9.1	redecorating		B	
1.9.2	upgrading.		B	
1.10	A procedure is in place for reporting defects inside and outside working hours.		B	
1.11	Safe hot water and heating surface temperatures are maintained and monitored.		A	
1.12	There is a system in place for the management of electrical safety which, in addition to the Electricity at Work Regulations 1989, takes into account HTM 2011, HTM 2014, HTM 2020 and HTM 2021.		A	
1.13	Lighting complies with CIBSE Lighting Guide No 2. Hospitals and Healthcare Buildings. 1989.		A	
1.14	The following are in place:			
1.14.1	an environmental policy which covers emissions to air, land and water and takes into consideration the general environmental conditions set out in BS7750		A	
1.14.2	preventative measures against the growth of *Legionella pneumophila* in service plant		A	
1.14.3	a waste management policy which covers the duty of care responsibilities for all waste production (household, clinical and special) *(see also Corporate Management chapter, Management of Waste standard, criterion 13.2)*		A	
1.14.4	an energy policy which sets targets for consumption reductions and ensures optimum procurement prices		B	

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick

		Yes	No	
1.14.5	a disposal of surplus land and buildings policy			B
1.14.6	a procurement policy which deals with waste minimisation			C
1.14.7	a building management system and maintenance programme linked through the use of a computer based asset management and accounting system.			C

Operational Requirements

1.15	A project manager is appointed for all capital projects.			B
1.16	A cost control system is in place for all capital schemes.			B
1.17	Communication systems are designed for the management of routine and emergency services, and maintained in good working order. Communication systems include:			
1.17.1	alarm systems			A
1.17.2	emergency systems (for example, crash , fire)			A
1.17.3	internal and external staff paging			A
1.17.4	internal routes (for example, walkways, stairways)			A
1.17.5	nurse call systems			A
1.17.6	telephones with direct lines for certain services (for example, admissions)			A
1.17.7	vertical transportation (for example, lifts, escalators, paternosters, dumb waiters, air tube systems)			A
1.17.8	facsimile machines.			B
1.18	Natural and mechanical ventilation systems are installed.			A

Interpretation

These:

* *ensure that airborne infections are controlled where appropriate*
* *meet service needs*
* *remove dangerous gases.*

(See also Laundry and Linen Services chapter, criterion 1.18 and Sterile Services Department chapter, criterion 1.7.)

VOLUME 1

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

1.19 Emergency back-up systems are in place for essential services and life support systems *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.20).* ☐☐ **A**

Interpretation

These include at least the following:

* *blood refrigerators, frozen food stores*
* *boiler plant*
* *electrical systems*
* *medical gases*
* *water storage.*

1.20 All estates staff are provided with training which allows them to carry out their duties in a safe and efficient manner (for example, competent or authorised persons, project management, major disposals). ☐☐ **A**

1.21 Korner statistics are collected and returned to the Department of Health. (NHS only). ☐☐ **A**

1.22 Information is collected, monitored and evaluated on the following:

1.22.1 minor adaptations response times ☐☐ **C**

1.22.2 routine repair work response times. ☐☐ **C**

VOLUME
1

HEALTH RECORD SERVICE

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(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick

Yes	No	Comments

2.1 In a hospital/trust where the employment of a health records manager on a full-time or part-time basis is not justified, there is evidence that the hospital/trust receives on-going consultative advice from a qualified person. ☐ ☐ **B**

2.2 There is a health record committee or equivalent (in independent hospitals this function may be carried out by the medical advisory committee/management team). ☐ ☐ **B**

Interpretation

* *the membership of the health record committee includes the manager of the health record service, medical and nursing staff representatives, and other professional staff who contribute substantially to the patient s health record*

* *the health record committee:*

meets regularly

keeps minutes

reports regularly to the executive management team/trust board

has members who attend a majority of meetings

reviews its membership at an agreed interval

* *the responsibilities of the health record committee include the following:*

determining standards and policies for the format of the patient s health record

introducing new record forms or introducing alterations to existing forms

agreeing policies and procedures for the health record service

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick

Yes No

Comments

recommending action to be taken when problems arise with health records (for example, when records are not returned to the storage area)

analysing the content of the health record on a systematic basis to ensure that the recorded clinical information facilitates the provision and evaluation of patient care

analysing records to determine the identity of those making entries in the record

regularly reporting the findings of the analysis to the executive management team/trust board.

2.3 Statistical data is collected which is accurate, timely and meets the hospital/trust/Department of Health requirements (this may be collected by an information department). ☐☐ A

Interpretation

The type of information collected includes the following:

* *births and deaths*
* *complications*
* *diagnoses/conditions*
* *length of stay*
* *number of admissions and discharges*
* *procedures performed*
* *re-admissions.*

2.4 Health record staff are involved in hospital/trust evaluation activities. ☐☐ B

Interpretation

Involvement includes:

* *compiling requested patient care statistical data for utilisation review and clinical audit (uniprofessional and multidisciplinary) programmes*
* *supervising and/or advising in relation to data collection by other hospital/trust staff*
* *reviewing health records to determine compliance with established standards*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

* *suggesting methods to improve health record information systems.*

2.5 The department is supported in the delivery of the service by the following:

2.5.1 administrative and clerical staff ☐☐ **B**

2.5.2 portering staff. ☐☐ **B**

Weighting

Essential practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current knowledge, are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:

Comments

please tick
Yes No

4.1 A health record is maintained for every patient. **A**

4.2 There is a documented system of identification, a patient master index and a filing system which enable rapid record retrieval. **A**

4.3 There is provision for 24 hour access to records. **A**

4.4 There are documented policies for the following:

4.4.1 safeguarding the information in the record against loss, damage, or use by unauthorised persons **A**

4.4.2 where computerised records are maintained, taking measures to ensure confidentiality in accordance with the Data Protection Act 1984, Department of Health guidance and the professional code of ethics **A**

4.4.3 confidentiality and release of information which takes into account the Data Protection Act 1984, Access to Medical Reports Act 1988, Access to Health Records Act 1990 and Access to Health Records (Northern Ireland) Order 1993 **A**

4.4.4 retention, destruction and microfilming of records **A**

4.4.5 storage of records held separately from the main record (for example, accident and emergency) **A**

4.4.6 compilation of Korner returns (NHS only). **A**

4.5 All records are coded at discharge or within 14 days using a current version of the international classification of diseases and OPCS procedure codes or other approved classifications *(see also Corporate Management chapter, Information Services standard, criterion 7.2).* **A**

4.6 Records removed from storage are tracked. **B**

VOLUME
1

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective operation of the service.

In addition to the core standard criteria:

please tick
Yes No

Comments

5.1 The location of the department enables records to be retrieved and distributed rapidly. **B**

5.2 There is space available for other staff to read and work with records, including records on microfilm or other storage retrieval systems. **B**

5.3 There is space to meet future record storage needs. **C**

5.4 The active storage area includes all records currently in use within the hospital/trust. **B**

5.5 The active and inactive records are:

5.5.1 stored in accordance with statutory requirements **A**

5.5.2 secured to protect records against loss, damage, or use by unauthorised persons. **A**

5.6 The department is fitted with smoke alarms. **A**

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 6

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick

Yes **No**

Comments

6.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

* *missing notes*
* *time taken to retrieve notes.*

VOLUME
1

HOUSEKEEPING SERVICE

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(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 1

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard

The housekeeping service ensures and maintains a high standard of cleanliness and hygiene throughout the hospital/trust.

Criteria	*Comments*	*please tick* Yes	No	
1.1 Staff are given in-service training on the following:				
1.1.1 disposal of waste *(see also Corporate Management chapter, Management of Waste standard, criteria 13.1, 13.7)*				A
1.1.2 food handling (if involved in the serving of drinks, meals)				A
1.1.3 safety measures in hazardous areas such as the sterile services department, kitchens, workshops, laundry, laboratories and radiology areas				A
1.1.4 the control of infection and the role of the employee in this control (for example, type and storage of mop heads).				A
1.2 Staff who are assigned tasks in specialist areas such as the operating theatres, labour suite, accident and emergency departments, special care units and isolation rooms receive additional training in the execution of procedures unique to these departments *(see also Special Care Service chapter, criterion 2.11).*				A
1.3 There are documented policies and procedures for the following:				
1.3.1 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)*				A
1.3.2 health screening				B
1.3.3 stock control.				B
1.4 Policies and procedures for housekeeping reflect the hospital/trust control of infection policy and include:				
1.4.1 cleaning of specialised areas (for example, laboratories, mortuaries, operating theatres, special care units)				A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

1.4.2 disposal of general and contaminated waste *(see also Corporate Management chapter, Management of Waste standard, criterion 13.1)* — ☐☐ **A**

1.4.3 measurement, labelling, storage and proper use of housekeeping and cleaning supplies *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.40)* — ☐☐ **A**

1.4.4 use, cleaning, storage and care of cleaning equipment — ☐☐ **A**

1.4.5 evaluation of cleaning effectiveness — ☐☐ **B**

1.4.6 routine and special-purpose cleaning. — ☐☐ **B**

1.5 There are documented procedures for pest control and evidence that the hospital/trust is free from infestation. — ☐☐ **A**

1.6 Domestic storage areas are kept uncluttered. — ☐☐ **B**

VOLUME
1

LAUNDRY AND LINEN SERVICES

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B **Good Practice**

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C **Desirable Practice**

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VOLUME 1

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard

The laundry and linen services provide clean linen throughout the hospital/trust on a daily basis.

Criteria		*Comments*	*please tick* Yes	No	
1.1	Staff are given in-service training on the following:				
	1.1.1 the control of infection and the role of the employee in this control		☐	☐	**A**
	1.1.2 safety measures to be employed.		☐	☐	**A**
1.2	There are documented policies for the following:				
	1.2.1 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)*		☐	☐	**A**
	1.2.2 handling and storage of linen		☐	☐	**A**
	1.2.3 health screening.		☐	☐	**B**
1.3	Linen is available to the following on a daily basis:				
	1.3.1 wards and departments		☐	☐	**A**
	1.3.2 on-call rooms *(see also Medical Service chapter, criterion 5.5).*		☐	☐	**A**
1.4	The amount of clean linen supplied is based on calculated need.		☐	☐	**B**
1.5	There is a system in place for supplying clean linen out of hours and in emergencies *(see also Accident and Emergency Service chapter, criterion 2.10.5).*		☐	☐	**A**
1.6	There is a stock control system.		☐	☐	**B**
1.7	The stock control system deters pilfering.		☐	☐	**B**
1.8	Clean linen is handled and stored in such a way as to:				
	1.8.1 avoid undue reabsorption of moisture		☐	☐	**A**
	1.8.2 avoid contamination from surface contact or airborne deposition.		☐	☐	**A**
1.9	Stocks are rotated on a first-in, first-out basis.		☐	☐	**B**
1.10	A linen inventory is kept.		☐	☐	**B**
1.11	There are written procedures for handling linen.		☐	☐	**A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Interpretation

These include:

- * *physical appearance and condition of linen*
- * *processing techniques*
- * *wash formula (for example, time, temperature, use of bleach, final pH).*

		please tick Yes	No	Comments
1.12	Soiled linen is collected to avoid spread of infection and is placed in bags or containers at the site of contamination (for example, by the bedside at the time of changing).	☐	☐ **A**	
1.13	Clean linen and soiled linen are transported and stored separately.	☐	☐ **A**	
1.14	The following are cleaned on a systematic basis:			
	1.14.1 containers transporting soiled linen bags	☐	☐ **A**	
	1.14.2 storage areas for soiled linen.	☐	☐ **A**	
1.15	Infectious linen is clearly identified and suitable precautions are taken in its processing.	☐	☐ **A**	
1.16	In-house laundering facilities are separated from:			
	1.16.1 the clean linen processing area	☐	☐ **A**	
	1.16.2 patient rooms	☐	☐ **A**	
	1.16.3 areas of food preparation and storage	☐	☐ **A**	
	1.16.4 areas in which clean material and equipment are stored.	☐	☐ **A**	
1.17	The laundry area is planned and equipped to prevent the dissemination of contaminants.	☐	☐ **A**	
1.18	There is an exhaust ventilation system which ensures that air flows from clean to soiled areas *(see also Estates Management chapter, criterion 1.18).*	☐	☐ **A**	
1.19	Surfaces and overhead areas in the laundry are cleaned on a systematic basis.	☐	☐ **A**	
1.20	To minimise the risk of cross-infection:			
	1.20.1 handwashing facilities are readily available	☐	☐ **A**	
	1.20.2 staff working with infectious linen change into clean uniforms at the start of each shift or working day.	☐	☐ **A**	

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

1.21 In linen-handling/laundry areas staff do not:

1.21.1 smoke

1.21.2 eat.

☐☐ **A**

☐☐ **B**

VOLUME 1

LIBRARY SERVICE

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Activities for the library service may include:

**** providing an enquiry and information service***

**** offering a document supply service in the form of loans from stock, interlibrary loans, copies for retention within the copyright law***

**** encouraging users in the use of information through publicising services, providing introductory talks to new staff and offering courses and workshops on literature searching and information management techniques***

**** providing an up-to-date collection in the form of primary documents, secondary sources and slides, audiotapes, videotapes, computer readable databases and computer assisted learning programmes***

**** providing a cataloguing, classification and index system***

**** encouraging interaction and cooperation with the regional network of healthcare librarians, with other libraries and with other information providers in the hospital, trust, district or region.***

MANAGEMENT AND STAFFING

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

Comments

please tick
Yes No

2.1 There is a mechanism for consultation with all categories of user (this may be through a library committee). ☐ ☐ **B**

2.2 The library opening hours meet the requirements of users *(see also Core Standards for Clinical Services chapter, criterion 3.13).* ☐ ☐ **B**

2.3 The service is supported by administrative and clerical staff. ☐ ☐ **B**

VOLUME 1

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:

please tick

	Yes	No		Comments
3.1 Professional librarians are encouraged to participate in continuing professional development (for example, the Library Association s Framework for Continuing Professional Development (CPD)).	☐	☐	B	
3.2 Library assistants are encouraged to acquire appropriate technical qualifications (for example, the City and Guilds certificate) and/or to qualify professionally.	☐	☐	B	

VOLUME 1

POLICIES AND PROCEDURES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current knowledge, are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
4.1 There are documented policies and procedures for the following:				
4.1.1 patients requesting access to the library				B
4.1.2 stock selection				B
4.1.3 stock acquisition				B
4.1.4 stock withdrawal				B
4.1.5 relationships with other information providers within the hospital, trust, district or region				B
4.1.6 relationships with other libraries.				B
4.2 Library staff are aware of:				
4.2.1 copyright law				A
4.2.2 the Data Protection Act 1984.				A

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective operation of the service.

In addition to the core standard criteria:

please tick

Comments **Yes** **No**

5.1 Collections within the library are accessible to users and library staff and take into consideration the special needs of the disabled. **B**

5.2 There is a readily identifiable service point for users (for example, an enquiry desk). **B**

5.3 There are areas within the library for:

5.3.1 reading current periodicals **B**

5.3.2 reference and literature searching **B**

5.3.3 research and private study **B**

5.3.4 using audiovisual and electronic information. **C**

5.4 The library s collections are:

5.4.1 classified in line with a recognised system **B**

5.4.2 arranged in classified order and clearly displayed. **B**

5.5 Secure arrangements are in place to protect the library s collections and equipment. **B**

5.6 The library facilities include:

5.6.1 computers **B**

Interpretation

Computer based services include:

* *databases and other locally held information*
* *on-line information retrieval*
* *computer aided learning programmes*

5.6.2 photocopiers **B**

5.6.3 working space for library staff to receive and process incoming materials and interlibrary loans **B**

5.6.4 access to a seminar room **C**

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

5.6.5 microform reading **C**

5.6.6 a facsimile machine. **C**

5.7 There is a list of periodicals held in the library. **B**

5.8 The library is linked to the district/hospital/ trust local area network (LAN), which it uses to distribute and to receive information. **C**

VOLUME 1

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 6

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick
Yes No

Comments

6.1 The quality of the information and documents supplied by the library is periodically reviewed. ☐☐ **B**

Interpretation

The review looks at:

* *accuracy*
* *relevance*
* *timeliness*
* *long-term significance.*

6.2 Statistical information is monitored and evaluated (see minimum data set established by NHS Regional Librarians Group). ☐☐ **B**

Interpretation

This includes:

* *numbers of enquiries received*
* *numbers of interlibrary loans (outgoing and incoming)*
* *numbers of photocopied book/report extracts and journal articles made by library staff.*

VOLUME 1

PORTERING SERVICE

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(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

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VOLUME 1

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard

The portering service is organised to provide safe, effective and efficient movement of patients and goods through the hospital/trust.

Criteria	*Comments*	*please tick* Yes	No	
1.1 Staff are given in-service training on the following:				
1.1.1 control of infection and the role of the employee in this control (for example, portering of specimens)				**A**
1.1.2 dealing with clinical waste *(see also Corporate Management chapter, Management of Waste standard, criteria 13.1, 13.7)*				**A**
1.1.3 food handling (for staff involved in the handling of food)				**A**
1.1.4 moving and handling of patients, equipment or other heavy loads				**A**
1.1.5 safety measures in hazardous areas such as the central sterilising service, kitchens, workshops, laundry, laboratories and radiology areas				**A**
1.1.6 handling physical and verbal violence.				**B**
1.2 Staff who are assigned tasks in specialist areas receive additional training in the execution of procedures unique to these departments.				**A**
1.3 There are documented policies for the following:				
1.3.1 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)*				**A**
1.3.2 the moving and handling of patients, equipment or other heavy loads				**A**
1.3.3 transporting of specimens *(see also Pathology Service chapter, criterion 4.3)*				**A**
1.3.4 storage of medical gas cylinders				**A**
1.3.5 changing of nitrous oxide cylinders				**A**
1.3.6 handling physical and verbal violence				**B**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

1.3.7 health screening — ☐ ☐ **B**

1.3.8 mortuary duties. — ☐ ☐ **B**

1.4 Information on response times to requests is collected, monitored and evaluated. — ☐ ☐ **C**

VOLUME
1

SECURITY SERVICE

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(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 1

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard

There are comprehensive internal and external security arrangements in place to protect the property and to ensure that the safety of patients, staff and visitors is maintained at all times.

Criteria		Comments	please tick Yes	No	Weighting
1.1	There is a staff identification system in place.				A
1.2	All staff wear name badges.				A
1.3	All external doors (with the exception of entrances to the accident and emergency department and fire doors) are locked after a nominated hour at night.				A
1.4	There is evidence that the security of unoccupied offices/departmental areas is maintained at all times.				A
1.5	Pathways to residential accommodation and other on-call facilities are well-lit *(see also Medical Service chapter, criterion 5.1).*				A
1.6	Internal and external security inspection tours of the hospital/trust buildings are conducted at night.				B
1.7	There is evidence that arrangements are made to minimise risk in high risk/vulnerable areas. *Interpretation* * *there is access to mechanical security aids (for example, personal attack alarms, panic buttons)* * *shatterproof glass and coded door locks are installed.* *(See also Pharmaceutical Service chapter, criterion 5.2.2 and Special Care Service chapter, criterion 5.16.)*				B
1.8	There is a policy on handling physical and verbal violence.				B
1.9	Training in handling physical and verbal violence is provided.				B
1.10	There is a key-holding and key issue policy in place across the hospital/trust.				B
1.11	There is a structure in place to ensure that security issues are discussed, action plans are developed and reports are produced for the executive management team/trust board.				B

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

1.12 The security advisor consults with the fire safety officer prior to the implementation of security improvements *(see also Corporate Management chapter, Fire Safety standard, criterion 12.35).*

☐ ☐ **B**

VOLUME
1

STERILE SERVICES DEPARTMENT

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B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 1

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard

The department is organised to provide an efficient and effective sterile service to all users within the hospital/trust.

please tick
Yes No

Criteria

Comments

1.1 Staff are given in-service training on the following:

1.1.1 the control of infection and the role of the employee in this control — **A**

1.1.2 safety measures in hazardous areas — **A**

1.1.3 the moving and handling of equipment or other heavy loads. — **A**

1.2 There is evidence of a system designed in accordance with the Institute of Sterile Services Management Guide to Good Manufacturing Practice for NHS Sterile Services Departments. This system is an integral part of the hospital s/trust s infection control procedure. — **A**

1.3 There are written instructions for the cleaning and sterilisation of equipment and there is evidence that these processes are regularly monitored. — **A**

1.4 Storage and bench space is available for equipment, surgical supplies, linen and housekeeping materials. — **B**

1.5 Soiled, clean, unsterile and sterile items are held separately. — **B**

1.6 The department is planned and equipped to prevent the dissemination of contaminants. — **A**

1.7 There is an exhaust ventilation system which ensures that air flows from clean to soiled areas *(see also Estates Management chapter, criterion 1.18).* — **A**

1.8 Surfaces and overhead areas in the department are cleaned on a systematic basis. — **B**

1.9 To minimise the risk of cross-infection, handwashing facilities are available. — **A**

1.10 Temperature and humidity are environmentally controlled and checked on a systematic basis by maintenance staff. — **B**

1.11 Special equipment for the cleaning, drying and sterilisation of hospital equipment is available. — **A**

VOLUME
1

TELECOMMUNICATIONS SERVICE

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(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 1

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard

An efficient and effective telecommunications service is provided both internally and externally on a 24 hour basis.

Criteria	*Comments*	*please tick* Yes	No	*Weighting*
1.1 There are documented policies for the following:				
1.1.1 bleep system failure				A
1.1.2 board system failure				A
1.1.3 bomb threats				A
1.1.4 crash calls				A
1.1.5 fire in the switchboard area				A
1.1.6 fire elsewhere in the hospital/trust				A
1.1.7 major incidents				A
1.1.8 making calls outside of the hospital/trust (hospital staff)				B
1.1.9 telephone complaints.				B
1.2 The role of the service during a major incident is tested at least annually.				B
1.3 The following equipment is subject to a planned programme of testing:				
1.3.1 alarms				A
1.3.2 crash bleeps				A
1.3.3 incident pagers				A
1.3.4 emergency back-up/bypass system.				A
1.4 Records of these tests are maintained.				B
1.5 Staff receive training in the use of the emergency back-up/bypass system.				B
1.6 If the bleep system is located within the switchboard area, a stock of spare batteries for bleepers and pagers is held.				B
1.7 All crash calls are recorded.				B
1.8 An up-to-date list of personnel on call within the hospital/trust is available.				A
1.9 All staff are aware of the action to be taken in the event of attack alarms being sounded in the switchboard area (for example, pharmacy).				A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	*Comments*	
1.10	There is a system in place to ensure that staff are kept fully informed of the following:				
	1.10.1 extension number changes	☐	☐		**B**
	1.10.2 direct line changes	☐	☐		**B**
	1.10.3 changes in personnel.	☐	☐		**B**
1.11	Arrangements are in place for dealing with out-of-hours admissions and queries.	☐	☐		**A**
1.12	Staff receive training in customer care .	☐	☐		**C**
1.13	Access to the switchboard area is controlled.	☐	☐		**B**
1.14	Information is collected, monitored and evaluated on the following:				
	1.14.1 internal call response times	☐	☐		**C**
	1.14.2 external call response times	☐	☐		**C**
	1.14.3 usage and cost of lines and calls.	☐	☐		**C**

VOLUME 1

GLOSSARY

ABSENTEEISM Absence from work not authorised through the appropriate channels.

ACCIDENT Any unexpected or unforeseen occurrence, especially one that results in injury or damage.

ACCIDENT REPORT A written report of an accident. The format of the report is laid down in health and safety legislation.

ADOLESCENTS Young people in the process of moving from childhood to adulthood. Adolescents may have special needs as patients because of their age.

ADVANCE DIRECTIVE A document which sets out the wishes of a patient if they are later unable to give or withhold consent for a particular treatment. This is particularly important when the patient's wishes may conflict with clinical judgement.

ADVOCACY SERVICE A service which provides individuals to act on behalf of, and in the interests of, patients/clients who may feel unable to represent themselves in their contacts with a healthcare facility.

AIMS Overall purpose of a department or service.

APPRAISAL SYSTEM A system aimed at improving individuals' performance against their job description and work objectives, by identifying strengths, areas for development and educational needs.

BUSINESS PLAN A plan which sets out how the strategic aims of an organisation, or part of an organisation, are to be achieved.

CAPITAL ASSET Land, property, plant or equipment owned by a trust or used by a hospital whose value exceeds £5,000.

CAPITAL ASSET REGISTER A list of all the capital assets of an organisation. This contains information required to administer a capital asset replacement programme such as the purchase price, acquisition and replacement date of assets.

CAPITAL ASSET REPLACEMENT PROGRAMME A programme which uses depreciation accounting techniques to even out the cost of the replacement of capital assets.

CARER A person who regularly and in an unpaid capacity helps a relative or friend with domestic, physical or personal care as a result of illness or disability.

CHILDREN Young people aged between 0 and 16 who have special needs in hospital because of their age.

CLINICAL AUDIT A systematic review of the activities of staff providing clinical care.

CLINICAL RESPONSIBILITIES Range of activities for which a clinician is accountable.

COMMUNICATION STRATEGY A written statement of objectives for effective communication and a plan for meeting those objectives. The strategy should be consistent with the business plan.

CONTINUING EDUCATION Activities which provide education and training to staff. These may be used to prepare for specialisation or career development as well as facilitating personal development.

CONTROL MEASURES Ways in which risk can be controlled. These include physical controls such as locking away drugs and valuable items and system controls such as restricting access to hazardous areas to specific staff groups.

CORPORATE Relating to the whole of an organisation, for example the management of a trust.

CORPORATE SEAL A seal used by trusts to certify documents used in legal transactions, such as the sale of land, to fulfil legal requirements.

CULTURE AND TRADITIONS OF ETHNIC GROUPS National, religious, linguistic or ethnic backgrounds that affect people's health and social needs, experience of health services and access to healthcare.

DISASTER RECOVERY (COMPUTER SERVICES) Mechanisms for recovering information and/or vital computer services.

ERRORS Mistakes made by staff in the performance of their duties.

ESTATES STRATEGY A written statement of objectives relating to estates management and a plan for meeting those objectives. The strategy should be consistent with the business plan.

FINANCIAL STRATEGY A written statement of objectives relating to financial management and a plan for meeting those objectives. The strategy should be consistent with the business plan.

HAZARD The potential to cause harm, including ill-health and injury, damage to property, plant, products or the environment, production losses or increased liabilities.

HAZARD ASSESSMENT PROCEDURE The process by which the origins, frequencies, costs and effects of hazards are identified and strategies adopted to avoid or minimise their effects.

HEALTH AND SAFETY POLICY A plan of action for the health, safety and well-being of staff, patients, clients, residents and visitors of a healthcare facility.

HOSPITAL ACQUIRED INFECTION An infection acquired by a patient during their stay in hospital which is unconnected with their reason for admission.

HUMAN RESOURCE STRATEGY A written statement of human resource objectives and a plan for meeting those objectives. The strategy should be consistent with the business plan.

INCIDENT An event or occurrence, especially one which leads to trouble. An example of this could be an attack on a member of staff by a patient.

INCOME AND EXPENDITURE REPORTS An accountancy tool which describes and analyses the flow of funds into and out of an organisation to assess liquidity. Sometimes known as "source and application of funds statements" or commonly "cash flow statements".

INFORMED CONSENT The legal principle by which a patient must agree to any treatment proposed, having been informed of its nature, purpose and likely effects.

INTERNAL SERVICE AGREEMENTS Contracts between departments to provide particular goods or services under specific terms and conditions for a given period of time. In an acute setting, they are often known as 'Service Level Agreements'.

INTERPRETER SERVICE A service providing trained interpreters for patients/clients whose first language is not English.

KORNER RETURNS A minimum data set which is collected in all districts for management purposes. The name derives from the review of NHS information requirements by the NHS/DHSS steering group on health services information, chaired by Dame Edith Korner.

LOCAL AREA NETWORK (LAN) A local area network provides a system for intercommunication between computer terminals, PCs and related equipment operating within the same geographical area.

MAJOR INCIDENT (EXTERNAL) A serious external incident which requires the hospital/trust to implement contingency plans or change or suspend some normal functions. An example would be the aftermath of a rail crash.

MAJOR INCIDENT (INTERNAL) A serious incident occurring within the healthcare facility which results in the changing or suspension of some normal functions or threatens the organisation. This requires the drawing up of contingency plans. Examples of this would include the loss of electricity or telecommunications services or bomb threats.

MINIMUM DATA SETS A group of statistics or other information that together compromise the minimum amount of information required to inform any management process, for example for contract monitoring.

MISSION STATEMENT Statement of purpose of an organisation.

MORBIDITY The incidence of a particular disease or group of diseases in a given population during a specified period of time.

MORTALITY The number of deaths in a given population during a specified period of time.

MULTIDISCIPLINARY A combination of several disciplines working towards a common aim.

NATURE OF PROFESSIONAL PRACTICE The essential qualities of the responsibilities which fall to individual health practitioners/professionals.

OBJECTIVES Specific and measurable statements which set out how overall aims are to be achieved.

ORGANISATION AND MANAGEMENT DEVELOPMENT STRATEGY A written document which sets out the strategy for developing the management skills needed by an organisation.

ORGANISATIONAL CHART A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.

ORIENTATION AND INDUCTION PROGRAMME An introduction to an organisation designed to enable newly appointed staff to function effectively in a new position.

OUTCOME The end result of treatment, which can be used to measure the effectiveness of care.

PATIENT EPISODE A series of events which comprises all clinical contacts experienced by a patient in the course of their treatment for a particular condition.

PATIENT SATISFACTION/SERVICE USER SATISFACTION The degree of satisfaction or dissatisfaction with a service that a patient or service user expresses.

PATTERN OF DELIVERY The way in which services are delivered, their structure and relationship to each other. This does not relate to the content of services.

PHILOSOPHY The values of a service or department. A philosophy is characterised by statements such as 'We believe...' and 'Our values are...'.

POLICY An operational statement of intent in a given situation.

PREVENTATIVE MAINTENANCE AND REPLACEMENT PROGRAMME A plan for the maintenance of machines to minimise the amount of time lost through breakdown by anticipating and preventing likely problems.

PROCEDURE The steps taken to fulfil a policy.

PROFESSIONAL STANDARDS Professionally agreed levels of performance.

PROJECT 2000 The system of nurse education which places increased emphasis on student centred and research based learning.

QUALITY IMPROVEMENT STRATEGY A written statement of objectives relating to quality improvement and a plan for meeting those objectives. The strategy should be consistent with the business plan.

QUALITY INDICATOR A standard of service which acts as a measurement of quality. Examples could include the incidence of infection as a likely indicator of the quality of care, or re-admission rates as an indicator of the quality of discharge planning and preparation.

RECORD/PATIENT NUMBER See 'Unique Hospital Unit Number System'.

RISK MANAGEMENT A systematic approach to the management of risk, to reduce loss of life, financial loss, loss of staff availability, loss of availability of buildings or equipment, or loss of reputation.

RISK MANAGEMENT STRATEGY A written statement of objectives for the management of risk and a plan for meeting those objectives. The strategy should be consistent with the business plan.

SAFE DISCHARGE OF PATIENTS A procedure for the discharge of patients who require care in the community which complies with Department of Health guidelines.

SERVICE CONTRACT A legally binding contract between an organisation and an external supplier of goods or services. The contract sets out the agreed cost and quality for a given period.

SKILL-MIX The balance of skill, qualifications and experience of nursing and other clinical staff employed in a particular area.

STAFFING INCIDENT REPORTING SYSTEM
A standardised system for reporting incidents and near misses. The NHS Executive recommends that no more than two forms are used for this.

STANDING FINANCIAL INSTRUCTIONS Specific instructions issued by the board of a hospital or trust to regulate conduct of the hospital/trust, its directors, managers and agents in relation to all financial matters.

STANDING ORDERS A series of established instructions governing the manner in which business will be conducted.

STRATEGY A written statement of objectives and a plan for meeting those objectives. Strategies should be consistent with the business plan.

TRAINING AND DEVELOPMENT STRATEGY
A written statement and objectives for the training and development of staff and a plan for meeting these objectives. The strategy should be consistent with the business plan.

UNIQUE HOSPITAL UNIT NUMBER SYSTEM
A combination of numbers and/or letters that identifies a patient's health record as unique.

UNUSUAL MEDICATIONS Unusual medications are those which are currently unlicensed, or being used for an unlicensed indication. Patients must be informed before they receive such medications.

VITAL SERVICES These services are essential to the normal operation of the organisation. Examples include electricity, water, medical gases and telecommunications.

The King's Fund

ORGANISATIONAL *Audit*

HOSPITAL ACCREDITATION PROGRAMME

Organisational
Standards & Criteria

VOLUME
2

VOLUME 2

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VOLUME 2

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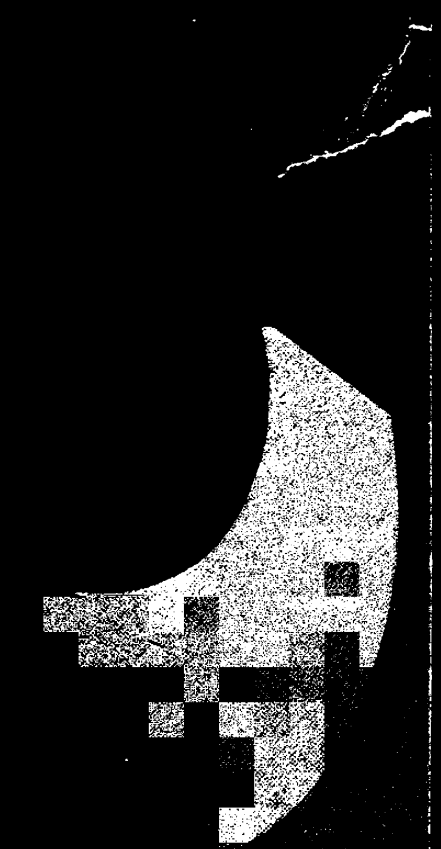

CLINICAL SERVICE SPECIFIC CRITERIA

CORE STANDARDS FOR CLINICAL SERVICES

VOLUME
2

CORE STANDARDS FOR CLINICAL SERVICES

This document contains a set of organisational standards and criteria specific to any clinical service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion is achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA) programme, a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

These Core Standards for Clinical Services are not 'stand alone' standards and are designed to be used in conjunction with the relevant service specific criteria contained within this manual. It will therefore be necessary for each service to complete a self-assessment of progress against the core standards and the service specific criteria. If, however, the service forms part of a larger unit of management (for example, a clinical directorate), the core standards should be applied across the unit of management as a whole with each constituent service feeding into one overall assessment.

To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME
2

AIMS AND OBJECTIVES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard 1

The service has clear aims and objectives which are consistent with those of the hospital/trust and are reflected in policy and business planning documentation.

please tick
Yes No

Criteria

Comments

1.1 Written aims are developed which are consistent with the overall mission of the hospital/trust. ☐ ☐ **B**

Interpretation

When developing aims the following are taken into consideration:

* *providing a service based on an assessment of the individual patient s needs*
* *providing a routine, regular and, where appropriate, emergency service*
* *providing a service based on professional standards set by relevant professional organisations*
* *ensuring patient and staff safety*
* *maintaining and improving the service through evaluation activities (monitoring, assessing, taking action, reviewing, feeding back)*
* *maintaining effective communication with patients and carers (subject to the patient s wishes) with respect to the nature and management of clinical conditions and their outcomes*
* *maintaining communication with other members of the healthcare team to:*

  meet the needs of the patient

  meet the needs of staff

  coordinate services
* *complying with national charters, national standards and purchaser contract requirements*
* *ensuring that staff have the necessary competencies to deliver the care required*

VOLUME 2

AIMS AND OBJECTIVES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No
☐	☐

Comments

* *consulting, collaborating and teaching within the hospital/trust and with other health, local authority and voluntary services.*

1.2 There is a written philosophy statement which reflects the values of the service. ☐☐ **B**

Interpretation

The following values are reflected in the delivery of the service:

* *being courteous and considerate to patients, carers and staff*

* *respecting the privacy, dignity and rights of the patient and their carers*

* *respecting and responding to cultural differences*

* *responding to the individual needs of patients, carers and staff.*

1.3 The philosophy statement is:

1.3.1 developed and endorsed by staff ☐☐ **B**

1.3.2 clearly displayed within the service area ☐☐ **B**

1.3.3 adapted to meet the needs of local client groups. ☐☐ **B**

1.4 Measurable objectives are developed which are consistent with the overall objectives of the hospital/trust. ☐☐ **B**

1.5 The objectives are:

1.5.1 developed and endorsed by staff ☐☐ **B**

1.5.2 reviewed annually in line with the business plan and/or service contract ☐☐ **B**

1.5.3 reviewed when:

(a) the role of the hospital/trust changes ☐☐ **B**

(b) there is a change in the provision or pattern of service delivery ☐☐ **B**

(c) there is a change in the nature and scope of professional practice ☐☐ **B**

(d) significant feedback from users of the service is received. ☐☐ **B**

VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

Criteria	*Comments*	*please tick* Yes	No	
Management Structure				
2.1 The responsibilities of the director (however named) and/or the head of each service include:				
2.1.1 management arrangements				**B**
2.1.2 budgetary accountability				**B**
2.1.3 business planning development *(see also Corporate Management chapter, Mission and Objectives standard, criterion 1.6)*				**B**
2.1.4 development and delivery of contracts/internal service agreements *(see also Corporate Management chapter, Contract Services standard, criterion 2.2)*				**B**
2.1.5 development and training of staff				**B**
2.1.6 ensuring that the quality and appropriateness of clinical care provided is monitored and evaluated				**B**
2.1.7 involvement in the appointment and deployment of staff				**B**
2.1.8 involvement in grievance and disciplinary procedures				**B**
2.1.9 involvement in the preparation and setting of the budget *(see also Corporate Management chapter, Financial Resources standard, criterion 6.3)*				**B**
2.1.10 liaising with other services				**B**
2.1.11 promoting the health of patients, staff and visitors				**B**
2.1.12 skill-mix reviews				**B**
2.1.13 staff appraisal.				**B**
2.2 There is a designated individual to take responsibility for each individual service in the absence of its manager.				**B**

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.3 The organisational structure is clearly understood by staff in terms of professional and managerial accountability and is supplemented by an up-to-date written chart. ☐☐ **B**

2.4 The organisational chart is revised:

2.4.1 annually ☐☐ **B**

2.4.2 when staffing changes ☐☐ **B**

2.4.3 when the service is restructured.

Finance and Information

2.5 The budget holder(s) is responsible for the management of the budget. ☐☐ **B**

2.6 Reports of income and expenditure are received by the budget holder(s) at monthly intervals *(see also Corporate Management chapter, Financial Resources standard, criterion 6.7).* ☐☐ **B**

2.7 Income and expenditure reports are:

2.7.1 timely ☐☐ **B**

2.7.2 accurate ☐☐ **B**

2.7.3 clear. ☐☐ **B**

(See also Corporate Management chapter, Financial Resources standard, criterion 6.8.)

2.8 Access to financial advice is available *(see also Corporate Management chapter, Financial Resources standard, criterion 6.4).* ☐☐ **B**

2.9 Records and statistics are available on:

2.9.1 staff absenteeism (unauthorised) ☐☐ **B**

2.9.2 staff sickness ☐☐ **B**

2.9.3 staff turnover ☐☐ **B**

2.9.4 special leave (for example, maternity/paternity leave). ☐☐ **B**

(See also Corporate Management chapter, Human Resources standard, criterion 5.2.)

2.10 These statistics are monitored against agreed targets. ☐☐ **C**

Communication

2.11 Regular multidisciplinary service meetings are held to:

2.11.1 brief staff on hospital/trust matters *(see also Corporate Management chapter, Management Arrangements standard, criterion 3.9.2)* ☐☐ **B**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick

	Yes	No	
2.11.2 discuss issues related to the provision of the service.	☐	☐	B
2.12 All staff are aware of the dates of these meetings.	☐	☐	B
2.13 Minutes are kept and made available to staff.	☐	☐	B

Health and Safety

(See also Corporate Management chapter, Health and Safety Management and Fire Safety standards.)

2.14 Risk assessments are carried out in accordance with hospital/trust strategy, the findings are documented and preventive and protective measures are implemented.	☐	☐	A
2.15 Health and safety inspections are carried out on a planned, systematic basis.	☐	☐	A
2.16 The health and safety responsibilities of staff are clearly defined.	☐	☐	A
2.17 Copies of health and safety regulations are readily available to staff.	☐	☐	B
2.18 Fire drills are carried out on a planned, systematic basis and records are kept for inspection.	☐	☐	A
2.19 Corridors and doorways are kept free of obstruction.	☐	☐	A
2.20 Fire fighting equipment is available in the service area and is clearly marked.	☐	☐	A
2.21 All staff attend annual fire lectures.	☐	☐	A
2.22 There is ready access to a first aid box.	☐	☐	A

Human Resources

2.23 Written and dated job descriptions are available for all posts *(see also Corporate Management chapter, Human Resources standard, criterion 5.7).*	☐	☐	B

Interpretation

* *job descriptions are reviewed:*

  annually

  on vacation of the post

* *the post holder is informed of any changes to the job description.*

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.24 There is evidence that clinical responsibilities and activities of staff, including trainees, are clearly defined. ☐☐ **A**

2.25 There is a documented staff appraisal system for all staff *(see also Corporate Management chapter, Human Resources standard, criterion 5.23).* ☐☐ **B**

Interpretation

The staff appraisal system:

* *is based on the job description and work objectives and the professional portfolio (where applicable)*
* *identifies strengths in performance, areas for development and educational needs.*

2.26 All staff receive a contract of employment within 13 weeks of appointment which clearly states terms and conditions of service *(see also Corporate Management chapter, Human Resources standard, criterion 5.12).* ☐☐ **A**

2.27 Access to personnel advice is available. ☐☐ **B**

Staffing

2.28 There is evidence that staff act in accordance with legislation affecting professional practice and professional guidelines. ☐☐ **A**

2.29 There is a mechanism to systematically assess and monitor staffing levels against workload (clinical and non-clinical) *(see also Corporate Management chapter, Human Resources standard, criterion 5.2).* ☐☐ **A**

2.30 The additional requirements of research, local and national committee work, teaching, supervising, mentoring and assessing are reflected in staff establishment, numbers of staff on duty and qualifications of staff on duty. ☐☐ **C**

2.31 Provision is made for out-of-hours and emergency cover where required. ☐☐ **A**

2.32 The following are clearly displayed and made available to staff:

2.32.1 up-to-date on-call rotas ☐☐ **A**

2.32.2 up-to-date duty rosters. ☐☐ **A**

2.33 All unqualified staff/students working within the service are supervised. ☐☐ **A**

VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.34 Where appropriate, the service is supported in the delivery of care by the following:

2.34.1 other professional and technical staff **B**

2.34.2 administrative and clerical staff (for example, receptionists, secretaries, ward clerks) **B**

2.34.3 hotel services staff (for example, porters, housekeepers). **B**

2.35 There is a system in place to ensure that all temporary staff employed by the service are appropriately qualified. **A**

2.36 There are nominated and trained individuals responsible for the following:

2.36.1 COSHH assessment **A**

2.36.2 first aid **A**

2.36.3 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.10)* **A**

2.36.4 manual handling and lifting. **A**

2.37 Staff have access to:

2.37.1 an occupational health service *(see also Corporate Management chapter, Occupational Health standard)* **A**

2.37.2 a stress counselling service *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.14.1).* **B**

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

Criteria	*Comments*	*please tick* Yes	No	
Orientation and Induction				
3.1 All staff receive induction at a corporate level on the following areas:				
3.1.1 fire				**A**
3.1.2 health and safety				**A**
3.1.3 patient confidentiality				**A**
3.1.4 accident and/or untoward incident reporting				**A**
3.1.5 security				**A**
3.1.6 pay arrangements.				**A**
(See also Corporate Management chapter, Human Resources standard, criterion 5.14.)				
3.2 The head of the service is responsible for ensuring that a record of attendance at the hospital/trust orientation and induction programme is maintained, signed and dated.				**B**
3.3 All staff appointed are subject to local orientation and induction arrangements (this includes locum staff/bank staff).				**A**
3.4 As a minimum the local arrangements:				
3.4.1 prepare staff for their role and responsibilities				**A**
3.4.2 introduce staff to the policies and procedures of the service and the hospital/trust				**A**
3.4.3 explain emergency procedures (for example, fire, patient collapse)				**A**
3.4.4 introduce staff to the hospital/trust health and safety policy and current health and safety legislation, explain its impact on the service and highlight the responsibilities of the employee to their employer *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.14).*				**A**
3.5 Local orientation and induction arrangements are documented.				**B**

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No

Continuing Education

		Comments	Yes	No	
3.6	All staff in direct contact with the patient are trained in basic resuscitation techniques.				**A**
3.7	Staff are given in-service instruction on:				
3.7.1	control of infection procedures				**A**
3.7.2	COSHH regulations				**A**
3.7.3	food handling (for staff involved in the handling of food)				**A**
3.7.4	health and safety responsibilities.				**A**
3.8	All staff involved in the moving and handling of patients, equipment or other heavy loads receive training/updating in lifting and handling.				**A**
3.9	Attendance at training sessions is recorded.				**A**
3.10	The training provided to students working within the service is monitored and reviewed.				**B**
3.11	The continuing education programme is linked to performance development, appraisal and the objectives of the hospital/trust *(see also Management and Staffing standard, criterion 2.25).*				**B**
3.12	As part of on-going education and professional updating the following are made available:				
3.12.1	training when changes in practice take place, the law changes, new technology or equipment is introduced or new responsibilities are assumed (for example, management development) *(see also Facilities and Equipment standard, criterion 5.11)*				**A**
3.12.2	professional and other resource material				**B**
3.12.3	support for undertaking research, introducing innovations and applying them to the service				**B**
3.12.4	information on advances in practice				**B**
3.12.5	information on, and support for taking advantage of, educational opportunities arranged by other institutions, academic and vocational qualifications and other sources of training and development.				**C**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

3.13 Staff have access to local information and library services (access to national library services may also be required) *(see also Library Service chapter, criterion 2.2 and Corporate Management chapter, Human Resources standard, criterion 5.19).*

☐ ☐ **B**

3.14 Current reference manuals, pamphlets, journals and relevant textbooks are available within the service area *(see also Corporate Management chapter, Human Resources standard, criterion 5.20).*

☐ ☐ **C**

3.15 Records of attendance at conferences, seminars and meetings are kept and reviewed annually.

☐ ☐ **B**

3.16 The benefits of educational activities are evaluated.

☐ ☐ **C**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

Criteria	*Comments*	*please tick* Yes	No	
Service Policies				
4.1 Service policies and procedures are consistent with national or local guidelines.				A
4.2 Where necessary, service policies and procedures are developed in consultation with representatives from other relevant professions (for example, infection control, health record keeping, social care, health promotion).				A
4.3 Staff are involved in the development of service policies and procedures.				B
4.4 Service policies and procedures are:				
4.4.1 reviewed and systematically updated				B
4.4.2 readily accessible within the service area				B
4.4.3 contained within a manual.				B
4.5 There is a system in place for informing staff when changes in policies and procedures occur.				A
Hospital/Trust Policies				
4.6 Senior staff are involved in the development of hospital/trust policies and procedures where these impact on their service.				B
4.7 Staff have access to hospital/trust policies and procedures, which include as a minimum:				
4.7.1 access to health records				A
4.7.2 accidents (patient and staff), errors and incidents				A
4.7.3 admission				A
4.7.4 all relevant personnel policies (for example, grievance, disciplinary)				A
4.7.5 child protection				A
4.7.6 complaints from patients, carers or staff				A
4.7.7 confidentiality of information				A
4.7.8 COSHH				A
4.7.9 discharge				A

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

4.7.10 health and safety — **A**

4.7.11 infection control — **A**

4.7.12 informed consent to treatment (including consent for children) — **A**

4.7.13 management of waste. — **A**

(See also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criteria 2.21, 2.41, Corporate Management chapter, Management Arrangements standard, criterion 3.19, Human Resources standard, criterion 5.5, Policies and Procedures standard, criteria 8.4-8.23, Risk Management standard, criterion 10.5, Health and Safety Management standard, criterion 11.1, Management of Waste standard, criteria 13.1, 13.2 and Infection Control standard, criteria 14.10, 14.12.)

4.8 Records are kept of accidents, errors, incidents and complaints in line with the hospital/trust policy *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.5).* — **A**

4.9 The role of the service in fire/disaster plans of the hospital/trust is documented and staff are made aware of it *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.17).* — **A**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

please tick

Criteria	*Comments*	Yes	No	
General Facilities				
5.1 There is evidence that staff are aware of, and adhere to, the hospital/trust smoking and alcohol policies *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.13).*				**A**
5.2 Counselling is available to help staff stop smoking *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.14.2).*				**C**
5.3 Storage space is available to meet service needs (for example, equipment, stationery, disposable items, drugs, flammable materials).				**B**
Patient Facilities				
5.4 Where patients are examined/treated/consulted with, there is evidence that the following are recognised and responded to:				
5.4.1 visual privacy				**A**
5.4.2 auditory privacy				**A**
5.4.3 mobility problems (for example, wheelchair access)				**A**
5.4.4 visual impairments				**A**
5.4.5 auditory impairments				**A**
5.4.6 children.				**A**
(See also The Patient s Rights and Special Needs chapter of this manual.)				
5.5 There are facilities available for:				
5.5.1 confidential consultations				**A**
5.5.2 bereaved/distressed relatives and carers (where appropriate).				**A**
Staff Facilities				
5.6 Access to the following staff facilities is available:				
5.6.1 office space for the designated manager and other senior staff as appropriate				**B**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

		please tick Yes	No	Weighting
5.6.2	office space for staff providing the service			B
5.6.3	a rest room			B
5.6.4	wash and changing rooms			B
5.6.5	equipped teaching/seminar rooms.			B
5.7	Catering arrangements are in place for all staff working day and night shifts *(see also Catering Service chapter, criterion 2.4.1).*			A
	Equipment			
5.8	There is evidence that materials and equipment are available to enable staff to carry out their duties.			A
5.9	Emergency resuscitation equipment is readily accessible.			A
5.10	Resuscitation equipment (for example, defibrillators) is checked and recorded at least daily (unless otherwise recommended by the manufacturer).			A
5.11	Specialised equipment is only used by staff trained and competent in its operation *(see also Staff Development and Education standard, criterion 3.12.1).*			A
5.12	Where necessary, the following are provided:			
	5.12.1 lifting aids			A
	5.12.2 personal protective equipment.			A
5.13	The service has access to emergency support in the event of equipment failure.			A
5.14	The head of the service is involved in the process of equipment procurement.			B
5.15	There is a system of preventative maintenance and replacement in place which is clearly understood by staff *(see also Estates Management chapter, criterion 1.8).*			A

VOLUME
2

PATIENT CARE

The following standard is only applicable to those services involved in direct patient care.

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

Criteria		*Comments*	*please tick* Yes	No	
6.1	There is evidence that:				
6.1.1	the delivery of care is in accordance with the agreed standards of practice within the individual profession				**A**
6.1.2	care is centred on the patient and their relatives or carers				**A**
6.1.3	staff maintain the individual patient s right to confidentiality and the right to be kept fully informed at all times				**A**
6.1.4	staff are aware of the legislation that enables patients to access their own health records				**A**
6.1.5	where research is undertaken, staff protect the individual patient s rights *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.1.6).*				**A**

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

Criteria	*Comments*	*please tick* Yes	No	
7.1 There is a written quality management and evaluation programme for the service (this may form part of business planning documentation).				**B**
Interpretation				
The quality management and evaluation programme details:				
* *objectives of the programme*				
* *methods to achieve the objectives*				
* *implementation timetable.*				
7.2 The quality management and evaluation programme includes:				
7.2.1 the development of local standards consistent with national charters, national standards and purchaser contract requirements				**B**
7.2.2 the assessment of patient/visitor satisfaction				**B**
7.2.3 the evaluation of practice against professional standards				**B**
7.2.4 the evaluation of patient care through regular uniprofessional and multidisciplinary audit				**B**
7.2.5 the use of resources (for example, type of stock, amount, facilities)				**B**
7.2.6 the assessment of service user satisfaction (including staff)				**B**
7.2.7 the assessment of the service against organisational standards				**B**
7.2.8 the systematic review of quality indicators on a service-wide basis				**B**
7.2.9 the training of staff in the development, implementation and review of quality activities.				**B**
(See also Corporate Management chapter, Quality Improvement standard, criterion 16.3).				

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

7.3 Evaluation activities include the following elements:

7.3.1 monitoring: the routine collection of information/statistics about important aspects of service delivery — ☐☐ B

7.3.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery — ☐☐ B

7.3.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented — ☐☐ B

7.3.4 review: the effectiveness of action taken is evaluated to ensure long-term improvements — ☐☐ B

7.3.5 feedback: the results of activities are regularly communicated to staff. — ☐☐ B

7.4 Korner statistics are collected and returned to the Department of Health (NHS only). — ☐☐ A

VOLUME
2

ACCIDENT AND EMERGENCY SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA), a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick
Yes No

Comments

2.1 There is at least one designated accident and emergency consultant based in the department who directs the service. ☐☐ **A**

2.2 There is a deputy(ies) designated to act in the absence of the director (however named). ☐☐ **A**

2.3 There is a designated, senior and experienced registered nurse, who manages the nursing staff. ☐☐ **A**

2.4 The consultant and senior nurse are involved in:

2.4.1 business plan preparation ☐☐ **B**

2.4.2 the preparation and setting of the budget for the accident and emergency service. ☐☐ **B**

2.5 There is at least one doctor employed by the accident and emergency department on duty at all times in the department. ☐☐ **A**

Interpretation

* *this doctor is sufficiently experienced to deal effectively with the majority of emergencies that present in the department.*

2.6 Consultant staff or equivalent deputies are available via a 24 hour on-call system and if required, specialists are available immediately (for example, paediatricians, neurosurgeons). ☐☐ **A**

2.7 There is a senior nurse in charge of each shift. ☐☐ **A**

Interpretation

* *this nurse is sufficiently experienced to deal effectively with the majority of emergencies that present in the department.*

2.8 First level registered nurses with post-registration education and/or experience of accident and emergency services are present on all shifts. ☐☐ **A**

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		Comments	*please tick* Yes	No	
2.9	Nursing staff rotate around the department and onto night duty.				**B**
2.10	The following are available on a 24 hour basis:				
2.10.1	a cardiac arrest team				**A**
2.10.2	a member of staff certified as proficient in advanced cardiac life support techniques.				**A**
2.10.3	a member of staff certified as proficient in advanced trauma life support techniques				**A**
2.10.4	a radiological service *(see also Diagnostic Imaging Service chapter, criterion 2.7)*				**A**
2.10.5	arrangements for the provision of pharmaceutical supplies, IV fluids including plasma expanders, sterile items, disposable items and linen *(see also Pharmaceutical Service chapter, criterion 4.2.1, Sterile Services Department chapter, criterion 1.16 and Laundry and Linen Services chapter, criterion 1.5)*				**A**
2.10.6	intensive therapy and high dependency services				**A**
2.10.7	facilities for the supply and cross-matching of blood				**A**
2.10.8	laboratory services for all routine studies and standard analysis of blood, urine and other body fluids *(see also Pathology Service chapter, criteria 2.2, 4.10)*				**A**
2.10.9	a registered sick children s nurse or nurse trained in the child branch of Project 2000 *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.16)*				**A**
2.10.10	emergency theatre facilities and emergency theatre staff (anaesthetists, surgical specialists, operating theatre practitioners) *(see also Operating Theatre Service/Anaesthetic Service chapter, criterion 2.10)*				**A**
2.10.11	a trauma team.				**B**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	*Comments*	
2.11	Plaster and ECG technicians are available during office hours.	☐	☐		**B**
2.12	Lines of communication between the accident and emergency service and the following external services are established:				
	2.12.1 ambulance service	☐	☐		**A**
	2.12.2 local general practitioners	☐	☐		**A**
	2.12.3 police service	☐	☐		**A**
	2.12.4 social services	☐	☐		**A**
	2.12.5 coastguard service (dependent on location)	☐	☐		**B**
	2.12.6 community health services	☐	☐		**B**
	2.12.7 fire and rescue service	☐	☐		**B**
	2.12.8 industry.	☐	☐		**B**
2.13	The service is involved in developing plans for:				
	2.13.1 internal emergencies	☐	☐		**A**
	2.13.2 major incidents.	☐	☐		**A**

(See also Corporate Management chapter, Policies and Procedures standard, criteria 8.15-8.23.)

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick

Yes	No	

In addition to the core standard criteria:

Comments

3.1 As part of on-going education and professional updating the following are provided:

3.1.1	bereavement training and training in how to deal with sudden death		**C**
3.1.2	health promotion training.		**C**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:		*please tick* Yes	No	*Comments*
4.1	There are documented policies and procedures for the following:			
4.1.1	access to poisons information service			**A**
4.1.2	admission, discharge, transfer and referral of patients			**A**
4.1.3	assessment of patients priorities (triage)			**A**
4.1.4	handling cardiac arrests			**A**
4.1.5	management of children in accident and emergency departments			**A**
4.1.6	patients refusing treatment			**A**
4.1.7	patients without identification			**A**
4.1.8	dealing with patients belongings			**B**
4.1.9	dealing with the police (for example, requests for blood specimens, blood alcohol estimations, evidence, statements, disclosure of information, suspected victims of crime, requests for examination in rape or other violent cases)			**B**
4.1.10	handling physical and verbal violence			**B**
4.1.11	patients recalled for examination or treatment			**B**
4.1.12	psychiatric referral procedures			**B**
4.1.13	requests for reports for legal purposes and provision of evidence in court			**B**
4.1.14	sudden death (for example, deaths on arrival, patients brought in dead)			**B**
4.1.15	utilisation of observation beds.			**B**
4.2	When developing policies and procedures, the special needs of children are considered.			**A**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
5.1 The location is clearly signposted within the grounds of the hospital/trust.		☐	☐	**A**
5.2 There is access and space for ambulances.		☐	☐	**A**
5.3 The location of the emergency access is clearly visible.		☐	☐	**A**
5.4 The ambulance access is under cover.		☐	☐	**B**
5.5 There are separate entrances for ambulant and stretcher arrivals.		☐	☐	**B**
5.6 The ambulance bay is close, and has easy access, to the resuscitation area.		☐	☐	**A**
5.7 Cleansing facilities are available for ambulances/ambulance personnel.		☐	☐	**C**
5.8 There is space and privacy to undertake:				
5.8.1 initial assessment		☐	☐	**A**
5.8.2 resuscitation		☐	☐	**A**
5.8.3 suturing		☐	☐	**A**
5.8.4 plastering		☐	☐	**A**
5.8.5 other forms of medical treatment		☐	☐	**A**
5.8.6 observation of patients.		☐	☐	**A**
5.9 Resuscitation bays have full resuscitation and treatment equipment.		☐	☐	**A**
5.10 A range of equipment and instruments is available for:				
5.10.1 adults		☐	☐	**A**
5.10.2 children where applicable (for example, child size resuscitation equipment).		☐	☐	**A**
5.11 The following are present in the department:				
5.11.1 information on waiting time post initial assessment		☐	☐	**A**
5.11.2 sufficient seating facilities to cater for the number and type of patients expected to attend the department		☐	☐	**B**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

		Comments	please tick Yes	No	Weighting
5.11.3	patient information leaflets (for example, how to use the accident and emergency service, prevention of accidents in the home, general practitioner services available) *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3)*				B
5.11.4	a designated area for the examination or treatment of children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.26.1)*				B
5.11.5	play facilities for children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.33)*				B
5.11.6	separate waiting area for children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.26.1)*				B
5.11.7	clean toilet and washroom facilities with access for wheelchairs				B
5.11.8	a room designated for use by grieving or distressed relatives/carers/staff				B
5.11.9	access to public telephones				B
5.11.10	facilities for nursing mothers				C
5.11.11	public transport information				C
5.11.12	refreshments (for example, vending machine)				C
5.11.13	reading material.				C
5.12	There are storage facilities for major incident equipment.				B
5.13	There is access to a visiting room in which relatives can spend time with the deceased.				C

VOLUME 2

PATIENT CARE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:	*Comments*	*please tick* Yes	No	
6.1 On arrival all patients are subject to assessment (this may take place before registration).				**A**
Interpretation				
* *procedures are in place to prioritise waiting children and to ensure that they are seen promptly.*				
6.2 Assessment is:				
6.2.1 performed by an appropriately experienced nurse or doctor				**A**
6.2.2 documented and signed.				**A**
6.3 There is a named, qualified nurse responsible for the care of each patient.				**A**
6.4 On arrival all patients are correctly identified, and a record created which uses a unique hospital unit number system.				**A**
6.5 An accident and emergency record is maintained.				**A**
Interpretation				
* *the accident and emergency record contains:*				
the approved Korner minimum data set				
details of medical interventions				
details of nursing interventions				
a description of clinical, laboratory and radiological findings				
details of information given to patients and/or their carers on discharge				
the printed name and signature of the attending clinician and the time the patient was attended				
the printed name and signature of the attending nurse and the time the patient was attended				

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

* *the accident and emergency record is available on a 24 hour basis in accordance with local policy.*

6.6 A copy of the accident and emergency record of attendance and treatment in the department is included in the patient s health record if the patient is either admitted to the hospital/trust or referred to the outpatient department *(see also Health Record Content chapter, criterion 1.1.9).*

6.7 The record system is computerised. B

6.8 Immediate access to the child at risk register is available. C

6.9 Seriously ill patients are observed and monitored at all times. A

6.10 When seriously ill patients are transferred to other areas of the hospital or to other hospitals/trusts they are accompanied by an escort capable of managing likely complications. A

6.11 There are clear arrangements for the handover of patients and the transfer of documentation. A

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

Comments

please tick

Yes	No	

7.1 Patient waiting times within the department for initial assessment are monitored. ☐☐ **A**

7.2 There is evidence that quality indicators are reviewed on a service-wide basis. ☐☐ **B**

Interpretation

The quality indicators may include the following:

- *time spent in department*
- *scheduled and unscheduled return visits*
- *referral (admissions and outpatient)*
- *use of investigations.*

7.3 The department participates in national audit projects (for example, Major Trauma Outcome Study). ☐☐ **C**

VOLUME
2

ACUTE DAY CARE SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

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VOLUME 2

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Day surgery may be provided in the following areas:

Day Surgery Unit - a self-contained day surgery unit with its own admission suite, wards, theatre and recovery area and administrative facilities.

Day Case Ward - a day case ward with patients going to the main operating theatre where lists may be made up entirely of day cases. With a smaller workload, planned day case operations may be incorporated in the routine list.

MANAGEMENT AND STAFFING

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick

	Yes	No	
2.1 The day care service is directed by a clinician who has overall responsibility for coordinating the activities of the unit.	☐	☐	A
2.2 A qualified, senior registered nurse manages the nursing staff.	☐	☐	A
2.3 There is an acute day care users committee.	☐	☐	B

Interpretation

This committee:

- *includes representation from surgeons, physicians, anaesthetists, general practitioners and nursing staff*
- *meets regularly*
- *keeps minutes of meetings*
- *develops and promotes policies including an operational policy for the day care service*
- *monitors utilisation*
- *participates in planning structural alterations and/or additions*
- *coordinates quality assurance activities.*

Comments

VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.4 The day care service is represented on any committees where the management of the operating suite is discussed (for example, theatre users committee). ☐☐ **C**

2.5 The following services are readily available:

2.5.1 blood bank ☐☐ **A**

2.5.2 the pathology service *(see also Pathology Service chapter, criterion 2.2)* ☐☐ **A**

2.5.3 the diagnostic imaging service. ☐☐ **A**

2.6 There is evidence that the day care service communicates regularly with:

2.6.1 general practitioners ☐☐ **B**

2.6.2 community services. ☐☐ **B**

2.7 Clinical procedures are directed by appropriately qualified members of the medical staff. ☐☐ **A**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
3.1 Senior staff are available within the unit to provide guidance and support to the following where they are present:				
3.1.1 house officers				**A**
3.1.2 medical students				**A**
3.1.3 nursing students				**A**
3.1.4 operating department assistants.				**A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick

Yes	No

In addition to the core standard criteria:

Comments

4.1 There is a written admission policy which includes reference to at least the following:

4.1.1 clinical procedures performed on a day basis — A

4.1.2 medical fitness — A

4.1.3 social fitness — A

Interpretation

When selecting patients for day surgery:

* *housing conditions must allow patients to recover from their operation in comfort*
* *there must be an inside lavatory and access to a telephone*
* *an adult must be available to provide care after discharge*
* *the patient s home must be within a reasonable distance of the hospital*

4.1.4 admission of children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.19)* — A

4.1.5 period of notice for admission. — B

4.2 There is a booking system in place which ensures that patients are given adequate notice of their admission. — B

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

		please tick Yes	No	Weighting
4.3	There is a system to ensure that the general medical and domestic status of the patient are assessed at the initial outpatient visit. *Interpretation* *This may be carried out:* * *by surgical outpatient staff* * *in an anaesthetic screening clinic* * *by nursing staff on the day unit.*			A
4.4	Written and verbal information is given to the patient during the initial visit. This includes:			
4.4.1	the patient s pre-admission responsibilities and preparation (for example, requirements for fasting, shaving, time of arrival)			A
4.4.2	post-anaesthetic effects (for example, drowsiness, nausea, dizziness, vomiting and headaches)			A
4.4.3	provision for after hours contact and emergency care/admission			A
4.4.4	the patient s discharge responsibilities.			A
4.5	There are procedures in place which ensure that:			
4.5.1	case notes and investigation reports are assembled pre-operatively			A
4.5.2	patient identity bracelets are prepared			A
4.5.3	outpatient follow-up appointments are made.			B
4.6	There is a written discharge policy.			A
4.7	The discharge policy ensures that:			
4.7.1	the patient is discharged into the care of an adult and is accompanied home			A
4.7.2	clear, written post-operative instructions are given to the patient and relative/carer on discharge *Interpretation* *These include:* * *constraints of activity following an anaesthetic (for example, no driving, no cooking)*			A

Comments

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

* *instructions regarding attendance at the general practitioner s surgery/outpatient department*

4.7.3 the patient is provided with a contact number to ring in the event of medical problems arising ☐☐ **B**

4.7.4 the address and telephone number of the person into whose care the patient is discharged are recorded in the patient s health record. ☐☐ **C**

4.8 A copy of the discharge summary is despatched to the patient s general practitioner on the day of discharge. ☐☐ **B**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

please tick
Yes No

5.1 The design of the service provides space for the reception, anaesthesia, surgery, recovery and observation of patients and is in line with Health Building Note 52 *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.26.2).*

B

Interpretation

- * *suitably equipped accommodation separate from the operating room and access corridors is provided for the patient awaiting surgery and takes into consideration the special needs of children*
- * *the area for receiving the patient into the operating theatre is close to the junction of clean and public zones*
- * *the demarcation of clean and public zones is clearly marked*
- * *there is an equipped and staffed area for patients recovering from anaesthesia which complies with guidelines issued by the Association of Anaesthetists and/or Royal College of Anaesthetists and takes into consideration the special needs of children*
- * *the day surgical ward is equipped with adjustable trolleys and beds*
- * *there are areas for the collection of used equipment and waste*
- * *storage space is provided for:*

  equipment

  linen

  pharmaceutical supplies

  controlled drugs

  surgical supplies
- * *doorways, corridors, ramps and stairwells enable non-ambulatory patients to be evacuated as quickly as possible.*

Comments

VOLUME
2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	*Comments*
5.2	The following patient facilities are available:			
5.2.1	a patient reception area adjacent to the ward in which the patient and escort can wait on arrival and prior to departure	☐	☐	**B**
5.2.2	changing rooms with secure cupboards for clothes and valuables	☐	☐	**B**
5.2.3	toilets with grab rails, safety locks and wash basin.	☐	☐	**B**
5.3	Fire detection, alarm and suppression systems are installed.	☐	☐	**A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

please tick Yes No

In addition to the core standard criteria:

Comments

6.1 A named, qualified nurse is responsible for the nursing care of each patient. ☐☐ A

6.2 Day care service records are maintained which satisfy medico-legal requirements. ☐☐ A

Interpretation

In addition, the day care service record:

* *meets the needs of clinical care*
* *is signed and dated*
* *meets the needs of audit.*

6.3 Details of the procedure are written into the patient s health record. ☐☐ A

Interpretation

The record of the procedure includes:

* *signed consent to the procedure*
* *admission diagnosis or reason for admission*
* *anaesthesia/sedation administered*
* *personnel involved in the procedure*
* *dressings and drainage systems used*
* *nursing care given, signed and dated by the nurse responsible*
* *written and oral instructions given to the patient:*

  discharge instructions

  follow-up instructions.

6.4 A register of operations/procedures performed is maintained within the day care unit. ☐☐ A

6.5 Nursing staff telephone the patient the day after discharge to improve the continuity of care. ☐☐ C

6.6 Staff participate in multidisciplinary patient reviews. ☐☐ B

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

Comments

please tick

Yes | No

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐ ☐ **B**

Interpretation

The quality indicators may include the following:

* *degree of involvement of community personnel*
* *follow-up arrangements*
* *inappropriate referrals*
* *non-attendance rates*
* *overnight stays or transfers*
* *re-admissions*
* *use of investigations.*

VOLUME 2

CHIROPODY/PODIATRY SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA), a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

please tick

	Yes	No
In addition to the core standard criteria:		
2.1 The service is managed and staffed by members of the profession who are currently registered under the Professions Supplementary to Medicine Act 1960.	☐	☐ **A**
2.2 There is an up-to-date record of staff with registration, together with a list of names, designations and signatures.	☐	☐ **A**
2.3 All unqualified clinical staff, trainees or assistants working within the service practise under the supervision of a member of staff registered under the Professions Supplementary to Medicine Act 1960.	☐	☐ **A**

Comments

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
3.1 Staff maintain personal professional development update diaries.				**B**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:		***Comments***	*please tick* Yes	No	
4.1	There are documented policies and procedures for the following:				
4.1.1	patient safety		☐	☐	**A**
4.1.2	recording of care given, batch numbers and other information relating to drugs, particularly anaesthetics		☐	☐	**A**
4.1.3	referral to, and discharge from, the service		☐	☐	**A**
4.1.4	reporting back to the referrer		☐	☐	**A**
4.1.5	staff safety		☐	☐	**A**
4.1.6	storage and handling of equipment		☐	☐	**A**
4.1.7	information issued to patients		☐	☐	**B**
4.1.8	on-going care (for example, referral systems inside and outside the hospital/trust).		☐	☐	**B**

VOLUME 2

PATIENT CARE

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

please tick
Yes No

Comments

6.1 A named, registered member of staff is accountable for each patient referred to their care. ☐☐ A

6.2 There is a written care programme for each patient. ☐☐ A

Interpretation

- * *the care programme is developed:*
  - *after an assessment of the patient*
  - *in consultation with, and taking into account the wishes of, the patient, carer or advocate*
  - *in collaboration with other staff when necessary*
- * *the care programme details at least the following:*
  - *the patient/carer s informed consent where appropriate*
  - *a statement of the patient s needs and expectations*
  - *details of specific care given*
  - *education/advice*
  - *continuing assessment and evaluation of needs*
  - *communication with other members of the clinical team*
  - *follow-up arrangements*
  - *preparation for discharge*
  - *referral/discharge details.*

6.3 A written record (which may be a summary) is filed in the patient s health record *(see also Health Record Content chapter, criterion 1.1.9).* ☐☐ A

6.4 The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact. ☐☐ A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

6.5 All records are held in a secure storage area and retained for the legally required period after discharge. **A**

6.6 A copy of the discharge summary is sent to the source of referral and to the relevant agencies or organisations involved with the patient on discharge. **A**

6.7 Staff participate in reviews of patients in their care. **B**

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐ ☐ **B**

Interpretation

The quality indicators may include the following:

* *patients not arriving for treatment/appointment and the reasons why*
* *inappropriate referrals*
* *pre- and post-appointment waiting times*
* *patient time spent in the department*
* *discharge (planned, appropriate and coordinated)*
* *follow-up.*

VOLUME
2

DIAGNOSTIC IMAGING SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

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To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
2.1 The service is clinically directed by a qualified radiologist.				**A**
Interpretation				
* *the radiologist may be full- or part-time depending on the size and complexity of the department.*				
2.2 The following are on duty or available at all times:				
2.2.1 a qualified radiologist				**A**
2.2.2 state registered radiographers				**A**
2.2.3 a qualified and experienced medical radiation physicist				**A**
2.2.4 registered nurses.				**B**
2.3 Radiographers are accountable to, and supervised by, a designated senior radiographer.				**B**
2.4 There is a radiation protection supervisor for the department.				**A**
2.5 The role of the radiation protection supervisor is clearly defined.				**A**
2.6 There is a radiation protection advisor for the hospital/trust.				**A**
2.7 Arrangements are in place for dealing with out of hours or emergency requests *(see also Accident and Emergency Service chapter, criterion 2.10.4, Operating Theatre Service/Anaesthetic Service chapter, criterion 2.6.1 and Special Care Service chapter, criterion 2.9.8).*				**A**
2.8 All radiographic procedures are conducted by an appropriately qualified person or by students under the guidance of an appropriately qualified person.				**A**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
3.1 A library of instructive radiographs is maintained for educational and teaching purposes.				**C**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:

please tick

Comments | **Yes** | **No**

4.1 There is evidence that practice conforms to the Ionising Radiations Regulations 1985. — **A**

4.2 When developing ionising radiation policies and procedures, the radiation protection supervisor and radiation protection advisor are involved. — **A**

4.3 Diagnostic imaging and interventional procedures are performed only upon written request by an approved referral source or an approved health screening scheme. — **A**

4.4 The clinical justification for requests is assessed in accordance with national or locally approved guidelines. — **A**

4.5 All images are interpreted and reported on by an appropriately trained and qualified person. — **A**

4.6 Reporting is prioritised according to local need. — **B**

4.7 When there are critical or unexpected findings, the radiologist, or in their absence, the state registered radiographer, consults with the referring doctor immediately. — **A**

4.8 A duplicate report is kept on file in the department or in some other accessible storage system. — **B**

4.9 A film or other hard copy image is produced after an investigation. — **B**

4.10 There is a local policy for the length of time that films and reports are stored. — **A**

4.11 Films and reports are stored using a coding (hospital/departmental) system. — **B**

4.12 There are documented policies and procedures for the following:

4.12.1 care of patients with special needs, including those who are critically ill and those needing isolation precautions — **A**

4.12.2 conditions which require immediate notification of the referring doctor — **A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

4.12.3 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)* — A

4.12.4 imaging examinations in areas other than the diagnostic imaging department — A

4.12.5 treatment of medical emergencies — A

4.12.6 appointment/open access system — B

4.12.7 information issued to patients and relatives or carers. — B

4.13 Radiation safety measures are developed in consultation with all professional staff involved in delivering the service and in consultation with the radiation protection supervisor and radiation protection advisor. — A

4.14 The implementation of radiation safety measures is supervised by the radiation protection supervisor. — A

4.15 As a minimum safety measures include precautions against:

4.15.1 chemical hazards — A

4.15.2 contamination/infection risks — A

4.15.3 electrical hazards — A

4.15.4 fire and explosion — A

4.15.5 mechanical hazards. — A

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:

Comments

please tick

	Yes	No

5.1 There are prominently displayed signs warning pregnant women of radiation dangers to the foetus (where appropriate, these signs are multilingual). ☐ ☐ **A**

5.2 The department has:

5.2.1 sufficient seating facilities to cater for the number and type of patients expected to attend the clinic ☐ ☐ **B**

5.2.2 space for wheelchairs/beds ☐ ☐ **B**

5.2.3 toilet and washroom facilities located within easy reach of the department ☐ ☐ **B**

5.2.4 patient information leaflets (for example, health promotion, making/cancelling appointments) *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3)* ☐ ☐ **B**

5.2.5 information on patient waiting time ☐ ☐ **B**

5.2.6 play facilities/area for children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.33.2)* ☐ ☐ **B**

5.2.7 public transport information ☐ ☐ **C**

5.2.8 access to facilities suitable for nursing mothers ☐ ☐ **C**

5.2.9 reading material. ☐ ☐ **C**

5.3 There is a safe and secure store for pharmaceutical products *(see also Pharmaceutical Service chapter, criteria 2.1, 5.3).* ☐ ☐ **A**

5.4 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the Ionising Radiations Regulations 1985. ☐ ☐ **A**

5.5 Staff working with radiological equipment wear radiation monitoring devices. ☐ ☐ **A**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

5.6 The radiation monitoring devices are assessed periodically in accordance with statutory regulations. **A**

5.7 Results are reported to the radiation protection supervisor. **A**

5.8 Continuous records of these results are kept for the working lifetime of staff employed by the service. **A**

5.9 All rooms and equipment are assessed for safety at acceptable intervals by suitably qualified radiation experts. **A**

5.10 Records of safety assessment are kept. **A**

5.11 All equipment is calibrated in accordance with regulations. **A**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

* *inappropriate referrals*
* *referral patterns*
* *appropriateness of investigations*
* *waiting time for appointments*
* *time spent by patients in the department*
* *patient radiation doses arising from common procedures*
* *reject film rates*
* *time taken to return reports to referring doctors.*

VOLUME 2

DIETETIC SERVICE

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To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick
Yes No

Comments

2.1 The service is managed and staffed by members of the profession who are currently registered under the Professions Supplementary to Medicine Act 1960. ☐☐ A

2.2 There is an up-to-date record of staff with registration, together with a list of names, designations and signatures. ☐☐ A

2.3 All students working within the service practise under the supervision of a registered member of staff. ☐☐ A

2.4 Regular meetings are held with the catering department/contract caterers. ☐☐ B

Interpretation

The meetings provide an opportunity to discuss:

* *development of catering policies and procedures*
* *provision of special diets*
* *provision of supplementary foods*
* *food choice*
* *menu planning*
* *monitoring.*

(See also Catering Service chapter, criteria 2.3, 4.1.3, 4.5.)

2.5 Staff liaise with the pharmacy service to discuss the provision of nutritional supplements *(see also Pharmaceutical Service chapter, criterion 2.6).* ☐☐ B

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:		*please tick* Yes	No	***Comments***
3.1	Staff are aware of the Food Safety Act 1990 and are trained in food handling where appropriate.	☐	☐ **A**	
3.2	Staff maintain personal professional development update diaries.	☐	☐ **B**	
3.3	The training material used by dietitians is up to date and subject to a planned, systematic review.	☐	☐ **B**	
3.4	The service trains other hospital/trust staff, particularly nursing, medical and catering staff, on aspects of nutrition and therapeutic diets.	☐	☐ **B**	

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick
Yes No

In addition to the core standard criteria:

Comments

4.1 There are documented policies and procedures for the following:

4.1.1	patient safety		**A**
4.1.2	recording of care given		**A**
4.1.3	referral to, and discharge from, the service		**A**
4.1.4	reporting back to the referrer		**A**
4.1.5	staff safety		**A**
4.1.6	storage and handling of equipment		**A**
4.1.7	evaluation of nutritional care		**B**
4.1.8	information issued to patients		**B**
4.1.9	inpatients on special diets		**B**
4.1.10	nutritional assessment of all clients		**B**
4.1.11	on-going care (for example, referral systems inside and outside the hospital/trust)		**B**
4.1.12	outpatient clinics		**B**
4.1.13	provision of diet sheets (for example, ward manual).		**B**

4.2 The service is involved in the formulation of policies to promote healthy food choices for patients and staff (for example, children, ethnic groups, elderly people). **B**

4.3 The service is involved in the formulation of policies relating to nutrition and special diets (for example, nutritional support, supplementary foods/feeding, food service, food provision and supplies). **B**

VOLUME 2

PATIENT CARE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

please tick
Yes No

Comments

6.1 A named, registered member of staff is accountable for each patient referred to their care. ☐☐ **A**

6.2 There is a written care programme for each patient. ☐☐ **A**

Interpretation

- *the care programme is developed:*
  - *after an assessment of the patient*
  - *in consultation with, and taking into account the wishes of, the patient, carer or advocate*
  - *in collaboration with other staff when necessary*
- *the dietetic care management of individually referred patients includes the following:*
  - *overall assessment*
  - *teaching on normal nutrition/specific diet*
  - *on-going review and support*
  - *liaison with carers*
  - *discharge planning.*

6.3 Care programmes developed by students are countersigned by a registered member of staff. ☐☐ **A**

6.4 A written record (which may be a summary) is filed in the patient s health record *(see also Health Record Content chapter, criterion 1.1.9).* ☐☐ **A**

6.5 The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact. ☐☐ **A**

6.6 All records are held in a secure store area and retained for the legally required period after discharge. ☐☐ **A**

VOLUME
2

PATIENT CARE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	*Comments*	
6.7	A copy of the discharge summary is sent to the source of referral and to the agencies or organisations involved with the patient on discharge.	☐	☐		**A**
6.8	Staff participate in reviews of patients in their care.	☐	☐		**A**
6.9	Written information produced by the department (for example, health promotion material, diets) reflects current practice and knowledge and is subject to regular review.	☐	☐		**B**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick

Yes	No
☐	☐

In addition to the core standard criteria:

Comments

7.1 Staff set and monitor nutritional standards for food in the hospital/trust. ☐ ☐ **C**

VOLUME
2

HOSPITAL BASED SOCIAL WORK

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick

Yes **No**

Comments

2.1 There is a written agreement between the employing authority and the hospital/trust which clearly defines the service to be offered to hospital patients, relatives and carers and is in accordance with LAC(91)14 Health-Related Social Work. ☐ ☐ **A**

2.2 There is a written agreement between the employing authority and the hospital/trust which clearly defines the level of administrative staff, equipment and accommodation to be provided in order to support the hospital based social work service. ☐ ☐ **A**

2.3 Arrangements for professional supervision are in place for qualified and unqualified staff. ☐ ☐ **A**

2.4 Designated staff participate in service development and influence decision making both within the hospital/trust and the employing authority. ☐ ☐ **B**

Interpretation

* *there is evidence that staff views on policy and service development are sought and fed into the decision making process*
* *results of decision making are communicated to staff.*

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the employing authority.

please tick

Yes	No

In addition to the core standard criteria:

Comments

3.1 There are locally agreed policies between the employing authority and the hospital/trust on the contribution of hospital social workers to:

3.1.1 the hospital/trust orientation and induction programme ☐☐ **C**

3.1.2 pre-qualification courses ☐☐ **C**

3.1.3 post-qualification courses. ☐☐ **C**

3.2 There is an agreed policy between the employing authority and the hospital/trust on the placement of students (this complies with the Central Council for Education and Training in Social Work (CCETSW) regulations - Improving Standards in Practice Learning August 1989). ☐☐ **C**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick
Yes No

In addition to the core standard criteria:

Comments

4.1 There are local policies in place which detail the roles and responsibilities of staff in relation to the implementation of the Mental Health Act 1983, the Children Act 1989 and the NHS and Community Care Act 1990. **A**

Interpretation

* *clear arrangements are in place to cover:*

a written Section 136 policy

a written Section 117 policy

ready access to an approved social worker (ASW)

child protection (see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.41)

children in need

children receiving inpatient treatment for longer than three months

simple and complex assessments

nursing home placements

care management

discharge in line with LAC(89)7 and HC(89)5

* *details of these arrangements are made known to other professional staff.*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

4.2 Locally agreed policies and procedures are developed for the following:

4.2.1 referral

Interpretation

- * *the policy details:*
  - *when referrals are to be made to the hospital based social work department*
  - *when referrals are to be made directly to service providers (for example, home care services, meals on wheels)*
- * *details of the referral policy are made available to patients and other professional staff within the hospital/trust*

A

4.2.2 recording in the patient s health record

Interpretation

This policy:

- * *maintains confidentiality in line with the Data Protection Act 1984 and the Access to Personal Files for Social Services Act 1987*
- * *facilitates communication (for example, reports, letters)*
- * *ensures that the employing authority of the hospital based social work department is recorded*
- * *ensures that social work contributions to decisions affecting patient welfare are recorded*

A

4.2.3 dealing with non-residents of the local authority

B

4.2.4 transfer of responsibility for cases to local community based social work staff

B

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick
Yes No

4.2.5 transfer of responsibility to other statutory agencies (for example, probation and voluntary agencies).

4.3 Written information is available to patients and their carers and to other professional staff within the hospital/trust. B

Interpretation

This details:

* *the service offered*
* *the location of the service*
* *how to access the service*
* *how to contact the service out of hours.* B

VOLUME
2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:		*please tick* Yes	No	***Comments***
5.1	On-site departments are clearly signposted.			**B**
5.2	Facilities are available for interviewing patients.			**B**

VOLUME 2

PATIENT CARE

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

please tick

Yes	No

In addition to the core standard criteria:

Comments

6.1 There is evidence that staff act in accordance with all the employing authority s policies including equal opportunities, complaints and customer care. ☐☐ A

6.2 A designated member of staff is accountable for each patient referred to their care. ☐☐ A

6.3 There is a written assessment and care plan for each patient. ☐☐ A

Interpretation

* *the assessment and care plan is developed:*

  after an assessment of the patient

  in consultation with, and taking into account the wishes of, the patient, carer or advocate

  in collaboration with other staff when necessary

* *the assessment and care plan details at least the following:*

  key worker/key point of contact

  the patient/carer s informed consent where appropriate

  a statement of the patient s needs

  details of specific care given

  education/advice

  continuing assessment and evaluation of needs

  communication with other members of the clinical team

  follow-up arrangements

  preparation for discharge

  referral/discharge details.

6.4 Assessment and care plans developed by unqualified staff are countersigned by a senior member of staff. ☐☐ A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes **No**

Comments

6.5 The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact. ☐☐ **A**

6.6 All records are held in a secure storage area and retained for the legally required period after discharge. ☐☐ **A**

6.7 Staff participate in reviews of patients in their care. ☐☐ **B**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 A policy is agreed between the employing authority and the hospital/trust on the implementation of a quality improvement strategy consistent with that of the hospital/trust. ☐ ☐ **B**

VOLUME
2

MEDICAL PHYSICS AND BIOMEDICAL ENGINEERING SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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VOLUME 2

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

These criteria are equally applicable to a whole Medical Physics and Biomedical Engineering Service or to an individual speciality division within it:

Please circle the division to which this section applies.

Clinical Instrumentation

Radiation Protection (ionising and non-ionising radiation)

Computing and Informatics

Radiopharmacy

Diagnostic Radiology Physics

Radiotherapy Physics

Equipment Management

Rehabilitation Engineering

Nuclear Medicine

Ultrasound

Physiological Measurement

(The King's Fund Organisational Audit has additional criteria for all of the above services. They are available for use but will not form part of the audit visit.)

MANAGEMENT AND STAFFING

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

Comments

please tick Yes No

2.1 There is a clinical scientist with relevant experience available at all times during normal working hours. ☐ ☐ A

2.2 Each clinical scientist holds a category of registration recognised by the professional bodies as appropriate to the activities undertaken. ☐ ☐ A

Weighting

Essential Practice

Good Practice

Desirable Practice

please tick
Yes No

Comments

2.3 Senior medical physics technicians hold an appropriate BTEC, City and Guilds or other suitable technical qualification in a relevant discipline. ☐☐ **A**

2.4 Lines of communication between departmental staff and other hospital/trust staff are established and, where appropriate, the limits of their responsibilities are clearly defined. ☐☐ **A**

2.5 Responsibility for the operation of satellite services is clearly defined and documented. ☐☐ **B**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick

	Yes	No	
In addition to the core standard criteria:			***Comments***
3.1 Information and scientific data from manufacturers concerning their products is available within the department.	☐	☐	**A**
3.2 Where trainee clinical scientists are in post, training is structured in accordance with IPSM/BES guidelines and under the supervision of a recognised training coordinator.	☐	☐	**B**
3.3 Where technician training is carried out it is done in accordance with requirements of the national training manual.	☐	☐	**B**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick

Yes	No	
		In addition to the core standard criteria:
		4.1 Safety policies and procedures are maintained in accordance with regulatory guidelines (for example, the Ionising Radiations Regulations 1985). **A**
		4.2 There are documented policies and procedures for the following:
		4.2.1 care of patients having special needs, including those who are critically ill and those needing isolation **A**
		4.2.2 conditions which require immediate notification to the referring clinician or on-take team **A**
		4.2.3 COSHH regulations **A**
		4.2.4 health and safety **A**
		4.2.5 information issued to patients and/or carers **A**
		4.2.6 information required for referral to the clinical physics service (for example, details of approved referral sources, adequate clinical information to justify the examination) **A**
		4.2.7 maintenance of confidential records **A**
		4.2.8 occupational health (for example, lifting procedures) **A**
		4.2.9 patient safety **A**
		4.2.10 procedures performed in areas other than the specified department **A**
		4.2.11 reporting back to the referrer **A**
		4.2.12 reporting procedures employed for each investigation **A**
		4.2.13 scheduling **A**
		4.2.14 stock control **A**
		4.2.15 storage and handling of equipment. **A**
		4.3 As a minimum, safety measures include precautions against:
		4.3.1 electrical hazards **A**

Comments

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick

		Yes	No	
		☐	☐	
4.3.2	fire and explosion	☐	☐	**A**
4.3.3	mechanical hazards	☐	☐	**A**
4.3.4	radiation hazards	☐	☐	**A**
4.3.5	biological hazards	☐	☐	**A**
4.3.6	chemical hazards.	☐	☐	**A**
4.4	When developing ionising radiation policies and procedures, the radiation protection advisor is involved.	☐	☐	**A**

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
5.1 Secure storage facilities are available in the department to ensure that all dangerous substances and, in particular, radioactive substances are held under conditions which conform to statutory and manufacturers requirements.				**A**
5.2 Refrigerated storage facilities are available for the safe storage of materials.				**A**
5.3 Specialised facilities are available for the safe handling of hazardous materials.				**A**
5.4 There is provision for the comfort of patients attending the department which includes:				
5.4.1 sufficient seating facilities to cater for the type and number of patients expected to attend the department				**B**
5.4.2 toilet and washroom facilities within easy reach of the department				**B**
5.4.3 patient information leaflets which describe the procedures to be undertaken *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3).*				**B**
5.4.4 reading material.				**C**
5.5 Specialised equipment has documented levels of operation and performance, allowing traceability to national standards.				**A**
5.6 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the requirements of the Ionising Radiations Regulations 1985.				**A**
5.7 Equipment is calibrated according to defined protocol.				**A**
5.8 All portable electrical equipment (as defined by the Electricity at Work Regulations 1989) is tested to at least the minimum described in this standard (PAT).				**A**

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick

Yes	No
☐	☐

In addition to the core standard criteria:

Comments

7.1 The quality management and evaluation programme includes a list of standards and statutory requirements to be met. ☐☐ **B**

7.2 Standards used are traceable to national standards. ☐☐ **B**

7.3 The service participates in data gathering for required hospital/trust returns and national audit programmes. ☐☐ **B**

7.4 There is evidence that quality indicators are reviewed on a service-wide basis. ☐☐ **B**

Interpretation

The quality indicators may include the following:

* *response time*
* *turn-around time for results*
* *precision and accuracy*
* *appropriateness*
* *use of clinical investigations.*

VOLUME 2

MEDICAL SERVICE

This document contains a set of organisational standards and criteria specific to the medical service. By working with these, you will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

please tick

Comments | **Yes** | **No**

2.1 Medical staff meet regularly with other professionals within the local management structure to maintain good communications. B

2.2 There is a medical committee which is responsible for representing the professional needs and views of these staff. B

Interpretation

This is a formally constituted committee which:

- *meets at least quarterly*
- *keeps formal minutes*
- *communicates both with the executive management team/trust board and with all medical staff*
- *is responsible for acting in an advisory role and making recommendations to the executive management team/trust board on medical matters.*

2.3 There is an association of junior staff which is responsible for safeguarding the interest and welfare of its members. B

2.4 The scope and limitations (duties, responsibilities and activities) of medical staff, including consultants, are clearly defined in job descriptions and contracts of employment. A

2.5 The scope and limitations of medical students are clearly defined. A

2.6 There is evidence that job plans are reviewed annually. A

2.7 Supervision is available for all doctors in training. A

2.8 When pre-registration house officers (PRHOs) are on duty, a more senior member of staff in an appropriate specialty is available on site to provide cover and help. A

2.9 All doctors in training work rotas which comply with the regulations detailed in Junior Doctors - The New Deal . A

VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	
		Comments		
2.10	There is evidence that the range of duties undertaken by doctors in training is assessed to ensure that they are not overburdened by inappropriate responsibilities.			**A**
2.11	There are arrangements in place to ensure, prior to their arrival, that locum staff are suitably qualified.			**A**
2.12	A consultant is responsible for arranging the handover between the outgoing staff and the incoming locum.			**A**
2.13	All locum staff participate in a short induction programme on arrival.			**C**
2.14	All junior locum staff are supervised.			**A**
2.15	The performance of each junior locum is assessed and the findings documented.			**C**

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:

please tick
Yes No

Comments

3.1 All doctors in training attend an orientation and induction programme on appointment. ☐☐ **A**

3.2 The training provided to doctors in training is monitored and reviewed by a designated clinical tutor. ☐☐ **B**

3.3 Each PRHO is allocated an educational supervisor who is a named consultant. ☐☐ **A**

3.4 The training provided to medical students is monitored and reviewed by a designated clinical tutor. ☐☐ **B**

3.5 Arrangements are made to ensure that all consultant and equivalent staff meet the respective Royal College requirements for Continuing Medical Education. ☐☐ **B**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

please tick

Yes	No

In addition to the core standard criteria:

Comments

5.1 Accommodation is provided for resident staff in line with Junior Doctors - The New Deal . A

Interpretation

- * *this accommodation is sited within easy reach of the resident s place of work*
- * *all corridors, paths and roads in the hospital grounds are well lit and measures are taken to ensure the safety of residents called to the hospital during the hours of darkness (see also Security Service chapter, criterion 1.5)*
- * *all residents rooms:*

  are fitted with security locks

  are free from leaks or damp

  are regularly maintained

  are provided with fast and efficient heating

  are adequately furnished

  contain a telephone by each bed which is connected to the internal telephone system

  contain a wash basin with hot and cold running water
- * *the residential accommodation includes access to adequate, clean and well maintained:*

  bathroom and shower facilities

  kitchen facilities

  common room facilities

  personal laundry facilities.

5.2 Adherence to the requirements of Junior Doctors - The New Deal is monitored on a systematic basis. A

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

5.3 On-call staff are provided with accommodation which is of an equivalent standard to that of resident staff. ☐☐ **A**

5.4 Catering arrangements are available at night, during the weekends and during bank holidays *(see also Catering Service chapter, criterion 2.4.1).* ☐☐ **A**

5.5 On-call rooms are supplied with clean linen on a daily basis *(see also Laundry and Linen Services chapter, criterion 1.3.2).* ☐☐ **A**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

Comments

please tick
Yes No

6.1 A named consultant directs and is accountable for the clinical care of each patient. ☐☐ A

6.2 The patient s health record contains a clearly written treatment/care plan. ☐☐ A

Interpretation

- *the treatment/care plan is developed:*
  - *after an assessment of the patient*
  - *in consultation with, and taking into account the wishes of, the patient and their carers*
  - *in collaboration with other staff involved directly in the patient s care*
- *the treatment/care plan includes:*
  - *a provisional diagnosis*
  - *a statement of the patient s needs*
  - *details of specific clinical care to be given*
  - *health education needs*
  - *discharge plan*
  - *legible name and status of the clinician responsible.*

6.3 Each entry in the patient s health record is:

6.3.1 accompanied by the doctor s printed name ☐☐ A

6.3.2 dated ☐☐ A

6.3.3 timed where applicable. ☐☐ A

6.4 Medical staff participate in multidisciplinary patient reviews. ☐☐ B

(See also Health Record Content chapter.)

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick

Comments | **Yes** | **No**

7.1 All staff participate in a regular programme of audit which includes:

7.1.1 uniprofessional audit (medical audit) — **A**

7.1.2 multidisciplinary audit (clinical audit). — **B**

7.2 There is a nominated consultant within each department responsible for organising and developing audit programmes. — **B**

7.3 Audit meetings are held on a regular basis. — **A**

7.4 Records of audit meetings are kept. — **A**

Interpretation

These include:

* *a list of those attending*
* *broad topics discussed*
* *conclusions or recommendations reached.*

7.5 Patient anonymity is maintained throughout the audit proceedings. — **A**

7.6 The following facilities are available to support the audit process:

7.6.1 clerical assistance — **B**

7.6.2 computer facilities. — **B**

7.7 Maternal deaths are referred to the Confidential Enquiry into Maternal Deaths. — **B**

7.8 Peri-operative deaths are referred to the National Confidential Enquiry into Peri-Operative Deaths. — **B**

7.9 Stillbirths and deaths in infancy are referred to the Confidential Enquiry into Stillbirths and Deaths in Infancy. — **B**

VOLUME 2

MIDWIFERY SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA), a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	*Comments*	*please tick* Yes	No	
2.1 A nominated senior midwife has 24 hour responsibility and accountability for the midwifery service.				A
2.2 All midwives have 24 hour local access to professional midwifery advice from a supervisor of midwives.				A
2.3 There is a system in place for any practising midwife to refer to a consultant when needed.				A
Interpretation				
The following are available:				
* *24 hour access to a consultant obstetrician*				
* *consultant anaesthetic advice during pregnancy and after delivery*				
* *access to other professionals as required (for example, consultant physicians, consultant cardiologists).*				
2.4 Intensive therapy services are available on a 24 hour basis.				A
2.5 The nominated senior midwife is involved in:				
2.5.1 the development of a local midwifery strategy which reflects national targets (for example, Health of the Nation) and takes into consideration current policy				B
2.5.2 the preparation of the business plan				B
2.5.3 the preparation and setting of the budget				B
2.5.4 the recruitment, allocation, promotion and termination of all staff in their employ				B
2.5.5 disciplinary and grievance procedures.				B
Interpretation				
* *in cases of alleged professional misconduct, the supervisor of midwives is involved.*				

VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

2.6 Midwifery teams/committees with clearly stated terms of reference meet to develop strategies for the implementation of the objectives of the midwifery service in line with the recommendations detailed in Changing Childbirth. ☐☐ B

2.7 There is a maternity liaison committee with professional and lay representation. ☐☐ A

2.8 All midwives hold current registration with the UKCC to practise midwifery. ☐☐ A

2.9 There is a system in place to: ☐☐ A

2.9.1 confirm registration at appointment ☐☐ A

2.9.2 check the periodic registration of existing staff ☐☐ A

2.9.3 take action if registration is found to have lapsed ☐☐ A

2.9.4 annually submit a notification to practice. ☐☐ A

2.10 All non-registered staff employed within the midwifery service work under the supervision of, and have access to, a registered midwife on a 24 hour basis. ☐☐ A

2.11 There is a named supervisor of midwives allocated to each midwife. ☐☐ A

2.12 All newly qualified midwives and those returning to practice after five years:

2.12.1 complete an approved return to practice course ☐☐ A

2.12.2 have a named preceptor. ☐☐ B

2.13 At least one registered midwife is present on all shifts in all areas. ☐☐ A

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

3.1 As part of the on-going education and professional updating programme the following are provided:

3.1.1 professional learning and study leave days in accordance with the Post-Registration Education and Practice Project recommendations ☐☐ **A**

3.1.2 additional training to support midwives in developing their scope of professional practice ☐☐ **B**

3.1.3 bereavement training ☐☐ **C**

3.1.4 health promotion training. ☐☐ **C**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick Yes No

In addition to the core standard criteria:

Comments

4.1 Local policies for the service are developed. A

Interpretation

These include:

* *ante-natal screening*
* *domino deliveries*
* *home births*
* *infant feeding*
* *information given to parents of babies born with undiagnosed congenital malformations (for example, Down s syndrome)*
* *neonatal death*
* *paediatric screening*
* *relatives and friends are able to visit mother and baby at any reasonable time as long as others are not disturbed*
* *stillbirth/miscarriage/ termination of pregnancy for abnormality*
* *the woman s choice regarding place and mode of birth*
* *visiting times*
* *water births.*

4.2 Midwifery policies and procedures are developed with medical input and agreed by a professional midwifery committee. B

Interpretation

Policies and procedures:

* *are research based*
* *contain a bibliography and relevant references*
* *are agreed by the client wherever appropriate.*

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

4.3 Responsibilities and activities of midwifery staff, including learners, are clearly defined in at least the following areas and are supported by the relevant UKCC guidelines:

4.3.1 administration of drugs — A

4.3.2 information issued to women, their partners and their families (including all aspects of the birth) — A

4.3.3 maintenance of records and reports — A

4.3.4 provision of information to media and police and the maintenance of confidentiality — A

4.3.5 scope of professional practice. — A

4.4 There is a procedure in place for identifying the baby while in hospital. — A

Interpretation

* *the baby is identified by two labels put on immediately after birth (one label on the arm, one on the leg)*
* *the labels are checked by the mother as soon as possible.*

4.5 Security procedures are in place to guard against abduction. — A

4.6 The following information is made available to the woman:

4.6.1 type of care on offer — A

4.6.2 where she can have the baby — A

4.6.3 options for pain relief — A

4.6.4 what tests will be used and why — A

4.6.5 advice on looking after herself, including healthy diet and not smoking — A

4.6.6 advice about feeding the baby, including the benefits of breastfeeding. — A

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

	In addition to the core standard criteria:	*Comments*	*please tick* Yes	No	Weighting
5.1	Overnight facilities are available for:				
	5.1.1 bereaved parents				C
	5.1.2 parents who need to develop confidence in handling and managing babies who have been ill and who require special care at home (for example, oxygen therapy for babies with broncho-pulmonary dysplasia).				C
5.2	There are office facilities for the midwife in charge of the ward or department.				B
5.3	Within the ante-natal clinic waiting area the following are provided:				
	5.3.1 information on clinic waiting time				A
	5.3.2 sufficient seating facilities to cater for the number and type of women expected to attend the clinic				B
	5.3.3 information leaflets in the appropriate language (for example, health promotion) *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3)*				B
	5.3.4 toilet and washroom facilities located within easy reach of the clinic				B
	5.3.5 play facilities/area for children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.33.2)*				B
	5.3.6 space for wheelchairs/prams				B
	5.3.7 public transport information				C
	5.3.8 reading material.				C

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

Comments

please tick
Yes No

6.1 A named, registered midwife is responsible for the midwifery care of each woman. ☐☐ A

6.2 There is evidence that:

6.2.1 the information given to the woman on where she can have her baby enables an informed choice to be made ☐☐ A

6.2.2 women are given the choice of carrying their records or leaving them with the hospital, GP or midwife ☐☐ A

6.2.3 a flexible approach to the provision of parent education is taken ☐☐ B

6.2.4 the woman is given information on helping her choose which method of feeding to use ☐☐ A

6.2.5 the woman is given the choice of having her partner or other friend or relative with her during the birth ☐☐ A

6.2.6 the mother is given the choice of either keeping her baby with her in hospital or putting the baby in the nursery. ☐☐ A

6.3 During the ante-natal period a written care plan is developed. ☐☐ A

Interpretation

The care plan is developed:

* *after an assessment of the woman*
* *in consultation with, and taking into account the wishes of, the woman and her family*
* *in collaboration with other staff involved directly in the woman s care.*

6.4 Care plans are reviewed, and revised if necessary, during the ante-natal, intrapartum and postnatal periods. ☐☐ A

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

		please tick Yes	No	*Comments*	
6.5	Care plans developed by student midwives are supervised and countersigned by a registered midwife.				A
6.6	A midwifery record, which conforms to UKCC guidelines, is maintained for each woman and is signed, timed and dated by the midwife responsible.				A
6.7	On discharge from midwifery care, the midwifery record is incorporated into the woman s health record.				A
6.8	A copy of the transfer summary is sent to the appropriate professionals (for example, the general practitioner, health visitor).				A
6.9	All women s maternity records are retained for a minimum of 25 years. *Interpretation* * *this includes records of episodes of maternity care that end in stillbirth or neonatal death* * *a local policy is developed which determines which elements are to be regarded as a permanent constituent of the record.*				A
6.10	Midwives participate in multidisciplinary patient reviews.				B

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick

		Comments	Yes	No	
7.1	There is evidence that quality indicators are reviewed on a service-wide basis.				**B**
	Interpretation				
	The quality indicators may include the following:				
	* *induction, caesarean and forceps deliveries rates*				
	* *infection rates*				
	* *peri-natal and maternal mortality rates*				
	* *re-admission rates.*				
7.2	Local infant feeding standards are developed.				**B**
7.3	Infant feeding statistics are maintained and audited.				**C**
7.4	There is a system in place which facilitates the evaluation of:				
	7.4.1 midwifery activities				**B**
	7.4.2 midwifery practice				**B**
	7.4.3 record keeping.				**B**

VOLUME
2

NURSING SERVICE

This document contains a set of organisational standards and criteria specific to the nursing service. By working with these, you will be able to evaluate your organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help prioritise workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service/ward feeding into one overall assessment.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	*Weighting*
2.1 There is a nominated senior nurse at ward or departmental level with 24 hour responsibility and accountability.				A
2.2 All nurses have 24 hour access to professional nursing advice.				A
2.3 There is nursing input into the:				
2.3.1 development of a local strategy for nursing which reflects national targets (for example, Health of the Nation) and takes into consideration current policy				B
2.3.2 preparation of the business plan				B
2.3.3 preparation and setting of the nursing service budget.				B
2.4 Nursing teams/committees with clearly stated terms of reference meet to develop strategies for the implementation of the aims and objectives of the nursing service.				B
2.5 The nominated senior nurse at ward or departmental level is involved in:				
2.5.1 the recruitment, allocation, promotion and termination of all nursing staff in their employ				B
2.5.2 disciplinary and grievance procedures.				B
2.6 All nurses hold current registration with the UKCC to practise nursing in their current specialty.				A
2.7 All nurses hold appropriate qualifications for the post held.				A
2.8 There is a system in place to:				
2.8.1 confirm registration at appointment				A
2.8.2 check the periodic registration of existing staff				A
2.8.3 take action if registration is found to have lapsed				A
2.8.4 annually submit a notification to practice.				A

VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

2.9 All non-registered staff working within the nursing service practise under the supervision of, and have access to, a registered nurse on a 24 hour basis. ☐☐ **A**

2.10 All newly qualified staff and those returning to practice after five years:

2.10.1 complete an approved return to practice course ☐☐ **A**

2.10.2 have a named preceptor. ☐☐ **B**

2.11 First level registered nurses with the relevant qualifications and/experience are present on all shifts where specialised nursing care is required. ☐☐ **A**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

3.1 As part of the on-going education and professional updating programme the following are provided:

3.1.1 professional learning and study leave days in accordance with the Post-Registration Education and Practice Project recommendations ☐☐ **A**

3.1.2 additional training to support nurses in developing their scope of professional practice ☐☐ **B**

3.1.3 bereavement training (where appropriate) ☐☐ **C**

3.1.4 health promotion training. ☐☐ **C**

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:

Comments

please tick
Yes No

4.1 Nursing policies and procedures are agreed by an appropriate professional nursing committee. **B**

Interpretation

Policies and procedures:

* *are research based*
* *contain a bibliography and relevant references.*

4.2 Responsibilities and activities of nursing staff, including pre-registration students, are clearly defined in at least the following areas and are supported by the relevant UKCC guidelines:

4.2.1 administration of drugs **A**

4.2.2 emergency situations (for example, major incidents) **A**

4.2.3 information issued to patients and carers **A**

4.2.4 maintenance of records and reports **A**

4.2.5 provision of information to media and police and the maintenance of patient confidentiality **A**

4.2.6 scope of professional practice. **A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:

please tick
Yes No

Comments

5.1 There are office facilities for the nominated senior nurse in charge of the ward or department. ☐☐ **B**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

Comments

please tick Yes No

6.1 A named, registered nurse is responsible for the nursing care of each patient. ☐☐ A

6.2 There is a written care plan for each patient. ☐☐ A

Interpretation

The care plan is developed:

* *after an assessment of the patient*
* *in consultation with, and taking into account the wishes of, the patient, carers or advocates*
* *in collaboration with other staff where appropriate.*

6.3 Care plans developed by student nurses are supervised and countersigned by a registered nurse. ☐☐ A

6.4 A nursing record, which conforms to UKCC guidelines, is maintained for each patient. ☐☐ A

Interpretation

This includes at least the following:

* *biographical data*
* *assessment data*
* *individual care plan*
* *evaluation of care.*

6.5 The nursing record is signed, timed and dated by the nurse responsible and incorporated into the patient s health record on discharge *(see also Health Record Content chapter, criterion 1.1.9).* ☐☐ A

6.6 A copy of the discharge summary is sent to the general practitioner or other source of referral. ☐☐ A

6.7 Nursing staff participate in multidisciplinary patient reviews. ☐☐ B

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐☐ **B**

Interpretation

The quality indicators may include the following:

- *length of patient stay*
- *infection rates*
- *medication errors*
- *pressure sore incidence*
- *re-admission rates.*

7.2 There is a system in place which facilitates the evaluation of:

7.2.1 nursing activities ☐☐ **B**

7.2.2 nursing practice ☐☐ **B**

7.2.3 record keeping. ☐☐ **B**

VOLUME
2

OCCUPATIONAL THERAPY SERVICE

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To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	*please tick* Yes	No	***Comments***
2.1 The service is managed and staffed by members of the profession who are currently registered under the Professions Supplementary to Medicine Act 1960.	☐	☐ **A**	
2.2 There is an up-to-date record of staff with registration, together with a list of names, designations and signatures.	☐	☐ **A**	
2.3 There are arrangements in place for the professional supervision of qualified and unqualified staff.	☐	☐ **A**	
2.4 There is regular liaison with social services to discuss equipment, adaptations, discharge and case management planning.	☐	☐ **B**	

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick

Yes	No

In addition to the core standard criteria:

Comments

3.1 Staff maintain personal professional development update diaries. **B**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:		***Comments***	*please tick* Yes	No	
4.1	There are documented policies and procedures for the following:				
4.1.1	supervision of qualified and unqualified staff				**A**
4.1.2	on-going care (for example, referral systems inside and outside the hospital/trust)				**A**
4.1.3	patient safety				**A**
4.1.4	recording of care given				**A**
4.1.5	referral to, and discharge from, the service				**A**
4.1.6	reporting back to the referrer				**A**
4.1.7	staff safety (in the clinical base and in the community)				**A**
4.1.8	storage and handling of equipment				**A**
4.1.9	assessment of the client s home				**B**
4.1.10	food hygiene				**B**
4.1.11	group activity				**B**
4.1.12	information issued to patients				**B**
4.1.13	orthotics				**B**
4.1.14	wheelchair provision.				**B**

VOLUME 2

PATIENT CARE

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

please tick
Yes No

In addition to the core standard criteria:

Comments

6.1 A named, state registered member of staff is accountable for each patient referred to their care. ☐☐ A

6.2 There is a written care programme for each patient. ☐☐ A

Interpretation

- *the care programme is developed:*
  - *after an assessment of the patient*
  - *in consultation with, and taking into account the wishes of, the patient, carer or advocate*
  - *in collaboration with other staff when necessary*
- *the care programme details at least the following:*
  - *the patient/carer s informed consent where appropriate*
  - *a statement of the patient s needs*
  - *details of specific care given*
  - *education/advice*
  - *continuing assessment and evaluation of needs*
  - *communication with other members of the clinical team*
  - *follow-up arrangements*
  - *preparation for discharge*
  - *referral/discharge details.*

6.3 Care programmes developed by unqualified staff are countersigned by a state registered member of staff. ☐☐ A

6.4 A written record (which may be a summary) is filed in the patient s health record *(see also Health Record Content chapter, criterion 1.1.9).* ☐☐ A

6.5 The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact. ☐☐ A

VOLUME 2

PATIENT CARE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

	Yes	No	Comments	
6.6 All records are held in a secure storage area and retained for the legally required period after discharge.	☐	☐		**A**
6.7 A copy of the discharge summary is sent to the source of referral and to the relevant agencies or organisations involved with the patient on discharge.	☐	☐		**A**
6.8 Staff participate in reviews of patients in their care.	☐	☐		**B**
6.9 There is information available to staff on the range and availability of disability equipment, appliances, facilities and other resources which could assist the patient living in the community.	☐	☐		**B**
6.10 Written information is available to the client which is specialty based, up to date and reflects current practice.	☐	☐		**C**
6.11 The service runs education programmes for patients and carers.	☐	☐		**C**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

QUALITY MANAGEMENT AND EVALUATION

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick

Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐ ☐ **B**

Interpretation

The quality indicators may include the following:

- *patients not arriving for treatment/ appointment and the reasons why*
- *inappropriate referrals*
- *pre- and post-appointment waiting times*
- *patient time spent in the department*
- *discharge (planned, appropriate and coordinated)*
- *follow-up.*

VOLUME
2

OPERATING THEATRE SERVICE/ ANAESTHETIC SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

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A Essential Practice

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B Good Practice

Standard good practice expected to be in place in any hospital/trust across the UK.

C Desirable Practice

Good practice which is not yet standard across the UK.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

Comments

please tick
Yes No

2.1 There is a theatre users forum or equivalent. — B

Interpretation

This forum:

* *meets regularly*
* *keeps minutes of meetings*
* *represents the interests of surgeons, anaesthetists, theatre practitioners and general management.*

2.2 There is a consultant who directs the provision of anaesthetic services. — A

2.3 A consultant anaesthetist is available at all times. — A

2.4 The doctor performing the procedure is available in the hospital/trust before the anaesthetist commences. — A

2.5 There is an anaesthetist present until the patient recovers from the anaesthetic. — A

2.6 The following services are available/accessible on a 24 hour basis:

2.6.1 diagnostic imaging *(see also Diagnostic Imaging Service chapter, criterion 2.7)* — A

2.6.2 intensive therapy and high dependency care — A

2.6.3 pathology (including blood bank) *(see also Pathology Service chapter, criterion 4.10)* — A

2.6.4 a registered sick children s nurse or nurse trained in the child branch of Project 2000 *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.16).* — A

2.7 There is a designated senior theatre practitioner to supervise the theatre practitioner staff. — A

2.8 Appropriately qualified theatre practitioners are present on all shifts. — A

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.9 Theatre practitioners qualified in operating theatre service are assigned according to their capabilities. ☐☐ **A**

2.10 Arrangements are in place to ensure that operating theatre personnel are available on a 24 hour basis to staff an emergency theatre *(see also Accident and Emergency Service chapter, criterion 2.10.10).* ☐☐ **A**

Records

2.11 Operating theatre records are maintained which satisfy medico-legal requirements. ☐☐ **A**

Interpretation

In addition, the operating theatre record:

* *meets the needs of clinical care*
* *is signed and dated*
* *meets the needs of audit.*

2.12 A record (operation note) of the surgical procedure performed is written into the patient s health record. ☐☐ **A**

Interpretation

The operation note contains details of:

* *the name and signature of the operating surgeon(s)*
* *the name of the consultant responsible*
* *description of the findings*
* *the diagnosis made and the procedure performed*
* *details of tissue removed, altered or added*
* *details and serial numbers of prosthetics used (these may be stick-on labels)*
* *details of sutures used*
* *an accurate description of any difficulties encountered and how these were overcome*
* *immediate post-operative instructions*
* *date and time.*

(See also Health Record Content chapter, criterion 1.1.14)

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

2.13 Records are kept which document the conduct of anaesthesia, in a form which enables the evaluation of the quality of care given (as recommended by the Association of Anaesthetists and/or Royal College of Anaesthetists). **A**

Interpretation

The anaesthetic record contains:

- *the pre-operative assessment by an anaesthetist, preferably by the attending anaesthetist*
- *the name of the anaesthetist and, where relevant, the name of the consultant anaesthetist responsible*
- *drugs and doses given during anaesthesia and route of administration*
- *monitoring data*
- *intravenous fluid therapy, if given*
- *the method used to secure and maintain the patient airway and any special difficulties encountered*
- *post-anaesthetic instructions where appropriate*
- *name and signature of attending anaesthetist(s)*
- *date and time.*

(See also Health Record Content chapter, criterion 1.1.15)

2.14 The anaesthetic record is filed in the patient s health record. **A**

2.15 A register of operations is maintained and signed by all participants. **A**

2.16 There are documented systems for: **A**

2.15.1 counting accountable items

2.15.2 recording tissue sent for laboratory examination.

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:

please tick

Yes	No	
		Comments

3.1 Refresher training is provided for theatre personnel who do not work regularly in the theatre suite. ☐ ☐ **A**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

3.1 Refresher training is provided for theatre personnel who do not work regularly in the theatre suite. ☐ ☐ **A**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick

Yes	No

In addition to the core standard criteria:

Comments

4.1 There are policies and procedures for the following:

4.1.1 ensuring that all information relevant to planning peri-operative care is received in the theatre — ☐☐ A

4.1.2 pre-anaesthetic assessment — ☐☐ A

Interpretation

* *the pre-anaesthetic assessment of each patient is performed by the anaesthetist who is administering the anaesthetic. Where this is not possible it is done by another anaesthetist who documents the findings and communicates them to the administering anaesthetist*

* *the assessment is timely and enables satisfactory measures to be taken to prepare the patient for anaesthesia and to perform any additional investigations which may be warranted by the patient s condition*

4.1.3 pre-operative instructions for patients (verbal and written) — ☐☐ A

4.1.4 patient identification — ☐☐ A

4.1.5 verification of the nature and site of operation — ☐☐ A

4.1.6 checking for pre-operative shaves, false teeth, crowns — ☐☐ A

4.1.7 checking of consent documents including provision of information to the patient — ☐☐ A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

4.1.8 counting procedures for accountable items and procedures to be adopted in the event of incorrect counts — **A**

4.1.9 infection control procedures, including strategies for minimising hazards from blood and body fluids *(see also Corporate Management chapter, Infection Control standard, criterion 14.10)* — **A**

4.1.10 pre-operative visiting and preparation of patients for surgery (including children) — **B**

4.1.11 parents accompanying children to theatre *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.19)* — **B**

4.1.12 scheduling of patients for listed and emergency surgical procedures — **B**

4.1.13 transporting children to theatre. — **B**

4.2 Policies and procedures ensure that the special requirements of children are taken into consideration. — **A**

4.3 There are written health and safety guidelines which meet legislative requirements. — **A**

Interpretation

The health and safety guidelines include:

* *anaesthetic equipment hazards*
* *controlled drug handling*
* *drug errors*
* *electrical hazards*
* *evaluation and testing of equipment*
* *fire and explosion*
* *instruction on use and maintenance of instruments*
* *notification of biohazards*
* *patient positioning*
* *patient transport*
* *radiation hazards*
* *sharps handling and disposal*
* *use of scavenging equipment for removal of various vapours and waste anaesthetic gases.*

FACILITIES AND EQUIPMENT

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:

please tick
Yes No

Comments

5.1 The design of the operating theatre provides space for the reception, anaesthesia, surgery, recovery and observation of patients *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.26.3).* ☐ ☐ **B**

Interpretation

- *suitably equipped accommodation separate from the operating room and access corridors is provided for the patient awaiting surgery and takes into consideration the special needs of children*
- *the area for receiving the patient into the operating theatre is close to the junction of clean and public zones*
- *the demarcation of clean and public zones is clearly marked*
- *there is an equipped and staffed area for patients recovering from anaesthesia which complies with guidelines issued by the Association of Anaesthetists and/or Royal College of Anaesthetists and takes into consideration the special needs of children*
- *there are areas for the collection and disposal of used equipment and waste*
- *there is access to facilities for the resterilisation of instruments*
- *storage space is provided for:*

  equipment

  housekeeping equipment

  linen

  pharmaceutical supplies

  controlled drugs

  surgical supplies

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

* *doorways, corridors, ramps and stairwells enable non-ambulatory patients to be evacuated as quickly as possible.*

5.2 There are emergency theatre facilities available *(see also Accident and Emergency Service chapter, criterion 2.10.10).* ☐☐ **A**

5.3 Equipment, drugs and agents are available and maintained for the following:

5.3.1 the safe administration of anaesthetics ☐☐ **A**

5.3.2 the related techniques essential to the proper care of the anaesthetised patient ☐☐ **A**

5.3.3 the safety of staff. ☐☐ **A**

5.4 Instruments and guidelines for the management of difficult intubation, tracheostomy and massive haemorrhage are available. ☐☐ **A**

5.5 Anaesthetic machines and monitoring equipment are checked before use. ☐☐ **A**

5.6 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the requirements of the Ionising Radiations Regulations 1985. ☐☐ **A**

5.7 Fire detection, alarm and suppression systems are installed. ☐☐ **A**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

* *cancelled operations*
* *infection rates*
* *morbidity*
* *mortality*
* *theatre utilisation.*

VOLUME
2

ORTHOPTIC SERVICE

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(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

please tick

Yes	No

In addition to the core standard criteria:

Comments

2.1 The service is provided and staffed by members of the profession who are currently registered under the Professions Supplementary to Medicine Act 1960. ☐ ☐ **A**

2.2 There is an up-to-date record of staff with registration, together with a list of names, designations and signatures. ☐ ☐ **A**

2.3 All unqualified staff, trainees or assistants working within the service practise under the supervision of a registered member of staff. ☐ ☐ **A**

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:

please tick

	Yes	No		
			Comments	
3.1	Staff maintain personal professional development update diaries.			**B**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:		*please tick* Yes	No	***Comments***
4.1	Service policies and procedures include at least the following:			
4.1.1	supervision of qualified and unqualified staff			**A**
4.1.2	patient safety			**A**
4.1.3	recording of care given			**A**
4.1.4	referral to, and discharge from, the service			**A**
4.1.5	reporting back to the referrer			**A**
4.1.6	staff safety			**A**
4.1.7	storage and handling of equipment			**A**
4.1.8	information issued to patients			**B**
4.1.9	on-going care (for example, referral systems inside and outside the hospital/trust).			**B**

VOLUME 2

PATIENT CARE

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

please tick
Yes No

In addition to the core standard criteria:

Comments

6.1 A named, registered member of staff is accountable for each patient referred to their care. ☐☐ **A**

6.2 There is a written care programme for each patient. ☐☐ **A**

Interpretation

- *the care programme is developed:*

  after a detailed orthoptic assessment and diagnosis of each case, using a selection of the appropriate techniques and tests available

  in consultation with, and taking into account the wishes of, the patient, carer or advocate

  in collaboration with other staff when necessary

- *the care programme details at least the following:*

  the patient/carer s informed consent where appropriate

  a statement of the patient s needs

  details of specific care given

  an assessment of the patient s ability to comply with the treatment/advice given

  education/advice

  continuing assessment and evaluation of needs

  communication with other members of the clinical team

  follow-up arrangements

  preparation for discharge

  referral/discharge details.

6.3 Care programmes developed by unqualified staff are countersigned by a registered member of staff. ☐☐ **A**

PATIENT CARE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes No	Weighting
	Comments	☐ ☐	
6.4	All treatments are carefully selected, planned and managed.	☐ ☐	**A**
6.5	A written record (which may be a summary) is filed in the patient s health record *(see also Health Record Content chapter, criterion 1.1.9).*	☐ ☐	**A**
6.6	The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact.	☐ ☐	**A**
6.7	All records are held in a secure storage area and retained for the legally required period after discharge.	☐ ☐	**A**
6.8	A copy of the discharge summary is sent to the source of referral and to the relevant agencies or organisations involved with the patient on discharge.	☐ ☐	**A**
6.9	Staff participate in reviews of patients in their care.	☐ ☐	**B**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick
Yes No

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

- *patients not arriving for treatment/ appointment and the reasons why*
- *inappropriate referrals*
- *pre- and post-appointment waiting times*
- *patient time spent in the department*
- *discharge (planned, appropriate and coordinated)*
- *follow-up.*

VOLUME 2

OUTPATIENT SERVICE

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To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	*Weighting*
2.1 Management responsibility for outpatient services is clearly defined and is made known to users of the service.		☐	☐	B
2.2 Lines of communication between the outpatient service and other departments are established.		☐	☐	B
Interpretation				
These include:				
* *the health records department*				
* *the diagnostic imaging service*				
* *the pathology service*				
* *the pharmaceutical service*				
* *the professions allied to medicine services (for example, physiotherapy, dietetics, ECG).*				
2.3 Staffing for each clinic is:				
2.3.1 determined using a skill-mix review		☐	☐	B
2.3.2 based on identified service needs.		☐	☐	B
2.4 Specialist nurses are available in specialist clinics (for example, diabetes liaison).		☐	☐	B
2.5 A registered sick children s nurse or a nurse trained in the child branch of Project 2000 is available at all times *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.16).*		☐	☐	A
2.6 Clinic rosters are available and made known to outpatient staff.		☐	☐	B
Interpretation				
The roster includes the following information:				
* *date and nature of clinic*				
* *start and finish time of clinic*				
* *name of clinic consultant*				
* *grades of medical staff conducting the clinic.*				

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

2.7 The outpatient manager is informed when clinicians take leave at least six weeks in advance. ☐ ☐ **B**

2.8 There is an individualised appointment system. ☐ ☐ **A**

2.9 There are systems for:

2.9.1 informing patients of their appointments ☐ ☐ **A**

2.9.2 reminding patients of their appointments. ☐ ☐ **C**

2.10 A list of patients and time of attendance is available before the clinic. ☐ ☐ **B**

2.11 Patients are given clear information about their appointment in advance of their first clinic attendance. ☐ ☐ **A**

Interpretation

The information includes:

* *a map of the hospital/trust*
* *date and time of appointment*
* *location and name of service and clinic*
* *procedure if not able to attend (for example, direct telephone line)*
* *transport arrangements*
* *specific instructions for any investigations such as fasting, or provision of specimens.*

2.12 A system exists for ensuring that patients attending the outpatient service are correctly identified. ☐ ☐ **A**

Records

2.13 A clinical record is assembled on or before the patient s initial visit. ☐ ☐ **A**

Interpretation

The clinical record contains the following:

* *name, address and postcode*
* *record/patient number*
* *sex*
* *next of kin*
* *source of referral*
* *history, including details of present illness and medication*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

* *complete physical examination*
* *requests for diagnostic tests*
* *progress notes, reports and consultations*
* *name and signature of doctor*
* *date and time of consultation*
* *the name and signature of the attending nurse*
* *information and advice given to patients and/or their carers.*

2.14 If the patient has previously attended the hospital, the patient s health record is available in advance of the clinic. ☐☐ **A**

VOLUME
2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick
Yes No

In addition to the core standard criteria:

Comments

4.1 There are polices and procedures for the following:

4.1.1	confidentiality of information with regard to the patient s health record	☐☐	**A**
4.1.2	prescribing of medications	☐☐	**A**
4.1.3	procedures undertaken on an outpatient basis	☐☐	**A**
4.1.4	urgent referrals	☐☐	**A**
4.1.5	use, location, care and maintenance of equipment	☐☐	**A**
4.1.6	ambulance and hospital transport arrangements	☐☐	**B**
4.1.7	discharge (for example, communication with the patient s general practitioner)	☐☐	**B**
4.1.8	information given to patients	☐☐	**B**
4.1.9	patient appointment system, including follow-up appointments	☐☐	**B**
4.1.10	patients failing to attend (did not attends)	☐☐	**B**
4.1.11	patient referral to outpatients and other departments within the hospital/trust	☐☐	**B**
4.1.12	the requesting and availability of diagnostic investigations and results.	☐☐	**B**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:

please tick
Yes No

Comments

5.1 The department has details of waiting times for first outpatient appointment. **A**

5.2 The reception area has:

5.2.1 sufficient seating facilities to cater for the number and type of patients expected to attend the clinic **B**

5.2.2 information on clinic waiting time **B**

5.2.3 patient information leaflets (for example, health promotion, making/cancelling appointments) *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3).* **B**

5.2.4 toilet and washroom facilities located within easy reach of the clinic **B**

5.2.5 play facilities/area for children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.26.4)* **B**

5.2.6 access to public telephones **B**

5.2.7 space for wheelchairs/prams **C**

5.2.8 facilities for nursing mothers **C**

5.2.9 public transport information **C**

5.2.10 reading material **C**

5.2.11 facilities for playing educational videos (for example, health promotion films). **C**

5.3 There are changing facilities for patients which maintain visual privacy. **A**

5.4 There is space and privacy to undertake minor procedures, such as changing of dressings or removal of plaster. **A**

5.5 There is a safe and secure store for pharmaceutical products used by the clinic *(see also Pharmaceutical Service chapter, criteria 2.1, 5.3).* **A**

5.6 There are separate clean and dirty utility rooms. **A**

VOLUME 2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

Comments

please tick
Yes No

7.1 Waiting times for the following are monitored:

7.1.1 first outpatient appointment ☐☐ A

7.1.2 waiting time in clinic. ☐☐ A

7.2 There is evidence that quality indicators are reviewed on a service-wide basis. ☐☐ B

Interpretation

The quality indicators may include the following:

* *clinic cancellations*
* *the number of patients failing to attend*
* *missing notes before clinic*
* *missing notes during clinic*
* *follow-up:new patient ratio.*

VOLUME
2

PATHOLOGY SERVICE

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 2

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

These criteria are equally applicable to a whole Pathology Service or to a Department of Pathology; a separate section is to be completed for each laboratory.

Please circle the department to which this section applies:

Clinical biochemistry

Haematology

Histopathology

Microbiology

Immunology

MANAGEMENT AND STAFFING

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
2.1 Each discipline is professionally directed by a consultant pathologist or a clinical scientist of equivalent standing.				**A**
2.2 Lines of communication between the pathology service and other departments are established and maintained.				**B**

Interpretation

These include:

* *accident and emergency department (see also Accident and Emergency Service chapter, criterion 2.10.8)*
* *acute day care service (see also Acute Day Care Service chapter, criterion 2.5.2)*
* *infection control (see also Corporate Management chapter, Infection Control standard, 14.18.2)*
* *occupational health (see also Corporate Management chapter, Occupational Health standard, 15.12)*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

* *operating theatre service*
* *special care units (for example, special care baby unit, intensive care unit).*

2.3 Laboratory staff are represented on multidisciplinary committees where laboratory involvement is required. ☐☐ **B**

2.4 Where satellite laboratory services are provided (for example, intensive care units, neonatal nurseries):

2.4.1 operational responsibilities are clearly defined and documented ☐☐ **A**

2.4.2 laboratory staff are involved in maintaining equipment, in quality assurance schemes and in ensuring the application of safety policies. ☐☐ **A**

(See also Special Care Service chapter, criterion 5.9.)

2.5 All off-site services provided are accredited. ☐☐ **B**

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick

Yes	No

In addition to the core standard criteria:

Comments

3.1 Training provided to medical students and postgraduates in laboratory medicine and infection control practice is monitored by a designated clinical tutor *(see also Medical Service chapter, criterion 3.4).*

☐ ☐ **B**

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick

Yes	No

In addition to the core standard criteria:

Comments

4.1 There are written procedures for the completion of test request forms and specimen labels. ☐☐ **A**

Interpretation

These procedures ensure that:

* *the request form contains all relevant clinical and patient information which:*

  is legible

  includes full name of patient, registration number, date of birth, sex, ethnic origin, occupation and details of any overseas travel

  includes name of requesting doctor and contact number

  includes source of request, consultant/general practitioner name and geographical location of the request s origin

  includes tests requested

  includes type of specimen

  details relevant clinical details

  details relevant medications

  includes date and time specimen collected

* *specimens are readily identifiable*

* *specimens requiring precautionary handling (for example, category three specimens) are clearly labelled as such.*

4.2 There are written procedures for specimen collection. ☐☐ **A**

Interpretation

The procedures include instructions for:

* *collection*

* *labelling*

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick

Yes No

Comments

* *preservation*
* *reception*
* *safety measures to be observed*
* *storage*
* *transport.*

4.3 The instructions for specimen collection are accessible to staff involved in obtaining specimens from patients or transporting specimens to the laboratory service *(see also Portering Service chapter, criterion 1.3.3).* ☐☐ A

4.4 The laboratory records:

4.4.1 all specimens received ☐☐ A

4.4.2 all specimens forwarded to other laboratories. ☐☐ A

4.5 There are written and dated test procedures. ☐☐ A

4.6 There is a written procedure for the reporting of test results. ☐☐ A

Interpretation

This ensures that:

* *results are:*

  validated before despatch

  clearly marked with patient s identity

  marked with the name and location of the requesting clinician

* *any results requiring immediate clinical attention are reported rapidly.*

4.7 There is a written procedure for transmitting results verbally. ☐☐ A

Interpretation

This ensures that:

* *only designated staff transmit and receive reports by telephone*
* *a confirmatory hard copy follows with minimum delay*
* *the following are recorded:*

  the person providing the report

  the person receiving the report

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick
Yes No

patient identity

result(s)

date and time results are telephoned

* *frozen section reports are transmitted directly to the surgeon concerned and followed up by a written report.*

4.8 Report forms are designed to fit into the patient s health record. ☐☐ B

4.9 There are written procedures for:

4.9.1 the collection, labelling, storage, preservation, transport and administration of blood and blood products ☐☐ A

4.9.2 dealing with transfusion reactions. ☐☐ A

4.10 There is a written procedure for dealing with out-of-hours test requests *(see also Accident and Emergency Service chapter, criterion 2.10.8, Operating Theatre Service/Anaesthetic Service chapter, criterion 2.6.3 and Special Care Service chapter, criterion 2.9.6).* ☐☐ A

4.11 There is a local health and safety policy. ☐☐ A

Interpretation

The policy takes into account:

* *current codes of practice*

* *health/hazard notices*

* *relevant legislation.*

(See also Corporate Management chapter, Health and Safety Management standard, criterion 11.2.)

4.12 A copy of the laboratory safety rules is given to all laboratory staff on appointment and when the rules are reviewed and revised. ☐☐ A

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	*Weighting*
5.1 Where patients attend the department, provision is made for the following:				
5.1.1 sufficient seating facilities to cater for the number and type of patients expected to attend the clinic				B
5.1.2 access to toilet and washroom facilities				B
5.1.3 patient information leaflets *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3).*				B
5.2 Within the laboratory the following are available:				
5.2.1 a designated area for receiving, despatching and handling specimens (including a separate area for dealing with high risk samples)				A
5.2.2 storage facilities for specimens, reagents and records (including a separate storage area for high risk samples)				A
5.2.3 facilities for the safe and secure storage of blood and blood products (for example, temperature monitoring, temperature alarms)				A
5.2.4 facilities for the safe disposal of cultures and potentially infectious clinical material *(see also Corporate Management chapter, Management of Waste standard, criterion 13.1).*				A
5.3 The following are provided:				
5.3.1 adequate drainage and control of effluent				A
5.3.2 adequate ventilation (for example, fume extraction)				A
5.3.3 adequate lighting				A
5.3.4 adequate heating				B

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick

	Yes	No	
5.3.5	piped gases	☐	☐	**B**
5.3.6	a deionised water supply.	☐	☐	**C**
5.4	Overnight accommodation is provided for on-call staff.	☐	☐	**A**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 Staff participate in clinical audit meetings with other specialties. ☐☐ B

7.2 There is evidence that quality indicators are reviewed on a service-wide basis. ☐☐ B

Interpretation

The quality indicators may include the following:

* *numbers of requests*
* *frequency of loss of results*
* *turn-around time for results.*

7.3 There is an internal quality control system in place. ☐☐ A

7.4 The laboratory participates in:

7.4.1 External Quality Assurance (EQA) ☐☐ A

7.4.2 a national accreditation scheme. ☐☐ C

VOLUME
2

PHARMACEUTICAL SERVICE

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If these are not in place then:

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(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

please tick
Yes No

In addition to the core standard criteria:

Comments

2.1 There is evidence that arrangements exist for the supervision of pharmaceutical products stored, prepared and/or distributed in satellite units *(see also Diagnostic Imaging Service chapter, criterion 5.3 and Outpatient Service chapter, criterion 5.5).*

2.2 An experienced pharmacist is available at all times. **A**

2.3 Each pharmacist holds current registration with the Royal Pharmaceutical Society of Great Britain (RPSGB) or the Pharmaceutical Society of Northern Ireland. **A**

2.4 Pharmacy technicians hold a BTEC, City and Guilds or other suitable technical qualification in an appropriate discipline. **B**

2.5 There is a drug and therapeutics committee, the membership of which is representative of service users. **B**

2.6 Staff liaise with the dietetic service to discuss the provision of nutritional supplements *(see also Dietetic Service chapter, criterion 2.5).* **B**

2.7 Staff liaise with medical and surgical supplies staff to ensure that all usage is in accordance with hospital/trust policy. **B**

VOLUME 2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:

please tick

		Yes	No	
3.1	Where pre-registration training is provided it is structured in accordance with RPSGB guidelines and is under the supervision of a recognised pharmaceutical tutor.	☐	☐	**A**
3.2	The continuing education needs of pharmacy support staff are identified and supported.	☐	☐	**B**
3.3	The continuing education programme provides experience in academic practice units.	☐	☐	**C**

Comments

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick

	Yes	No	
In addition to the core standard criteria:			***Comments***
4.1 The drugs and therapeutics committee is involved in the development of policies and procedures.	☐	☐	**B**
4.2 There are documented policies for all activities undertaken by the pharmaceutical service. These include:			
4.2.1 the provision of pharmaceutical services during normal working hours and out of hours *(see also Accident and Emergency Service chapter, criterion 2.10.5 and Special Care Service chapter, criterion 2.9.3)*	☐	☐	**A**
4.2.2 the manufacturing, repackaging and quality control of all medicines prepared within the hospital/trust	☐	☐	**A**
4.2.3 the distribution and supply of all medicines to wards and to individual patients	☐	☐	**A**
4.2.4 the ordering, purchase, receipt, storage and stock control of all medicines used in and supplied from the hospital/trust	☐	☐	**A**
4.2.5 the safe disposal of medicines where necessary	☐	☐	**A**
4.2.6 prescription monitoring and the provision of information and advice to hospital/trust staff, patients and other people	☐	☐	**A**
4.2.7 the safety and security of staff, medicines, facilities and equipment	☐	☐	**A**
4.2.8 the management of error and other risk (for example, drug recall, dispensing errors, drug administration errors, spillage hazards).	☐	☐	**A**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:

please tick
Yes No

Comments

5.1 There are secure storage facilities in the department which ensure that all pharmaceutical and related substances are held under conditions which conform to statutory and manufacturers requirements. **A**

5.2 Security arrangements are in place to protect the following at all times:

5.2.1 medicines storage areas (for example, alarms on controlled drugs vaults/safes) **A**

5.2.2 the department and staff (for example, door access controls, emergency alarms) *(see also Security Service chapter, criterion 1.7).* **A**

5.3 All areas where medicines are used, including wards, operating theatres and other clinical departments and areas, have adequate and properly controlled medicines storage and preparation areas in accordance with statutory requirements and any other special conditions *(see also Diagnostic Imaging Service chapter, criterion 5.3, Outpatient Service chapter, criterion 5.5 and Radiotherapy Service chapter, criterion 5.2).* **A**

5.4 Separate designated storage areas are provided for:

5.4.1 medical gases in accordance with HEI No 163 Code of Practice, Safety and Care in the Storage, Handling and Use of Medical Gas Cylinders on Health Authority Premises **A**

5.4.2 materials under quarantine **A**

5.4.3 the receipt and unpacking of incoming goods. **B**

5.5 Hazardous and/or flammable materials are stored in accordance with the relevant regulations. **A**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes	No	Comments

5.6 Controlled drugs are stored in conditions as specified in the Misuse of Drugs Act 1971, Safe Custody Regulations (not applicable to all premises). ☐ ☐ **A**

5.7 Deep freeze, refrigerator, cold room and cool area facilities are provided for safe storage of certain medicines. ☐ ☐ **A**

5.8 Where the following activities are undertaken, designated and properly equipped areas are provided:

5.8.1 regular dispensing functions including extemporaneous dispensing in accordance with the Standards of Good Professional Practice ☐ ☐ **A**

5.8.2 the manufacture and repacking of bulk non-sterile products in accordance with the requirement of the Guide to Good Pharmaceutical Manufacturing Practice ☐ ☐ **A**

5.8.3 the preparation of sterile products and intravenous additives in accordance with the requirements of the Guide to Good Pharmaceutical Manufacturing Practice and British Standards for Clean Rooms BS5295 ☐ ☐ **A**

5.8.4 the preparation of cytotoxic medicines and disposal of cytotoxic waste materials in accordance with the requirements of the Guide to Good Pharmaceutical Manufacturing Practice and the UK Cytotoxic Services Working Group Manual for Pharmacists Operating Cytotoxic Drug Services (October 1988) ☐ ☐ **A**

5.8.5 quality control procedures to be carried out on raw materials used in manufacture and products prepared in the pharmacy department ☐ ☐ **A**

5.8.6 the preparation of radio-pharmaceuticals in accordance with requirements of the Guide to Good Pharmaceutical Manufacturing Practice and Guidance Notes for Hospitals on Premises and Environment for Preparation of Radiopharmaceuticals (October 1983) ☐ ☐ **A**

5.8.7 receipt and distribution of medicines used in the hospital/trust. ☐ ☐ **A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

5.9 Equipment complies with relevant safety standards and is serviced and/or certified on a regular basis in accordance with manufacturers recommendations and/or in compliance with the Guide to Good Pharmaceutical Manufacturing Practice. ☐ ☐ **A**

5.10 There is a designated waiting area for patients using the service which provides:

5.10.1 sufficient seating facilities to cater for the number and type of patients expected to attend the clinic ☐ ☐ **B**

5.10.2 toilet and washroom facilities within easy reach of the department ☐ ☐ **B**

5.10.3 patient information leaflets *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3)* ☐ ☐ **B**

5.10.4 information on waiting time for a prescription ☐ ☐ **B**

5.10.5 reading material. ☐ ☐ **C**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

* *dispensing errors*
* *interventions initiated by the pharmacist*
* *medicines usage (for example, appropriateness of prescription, drug reactions)*
* *patient waiting time.*

VOLUME
2

PHYSIOTHERAPY SERVICE

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To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

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VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

please tick
Yes No

In addition to the core standard criteria:

Comments

2.1 The service is managed and staffed by members of the profession who are currently registered under the Professions Supplementary to Medicine Act 1960. ☐☐ **A**

2.2 There is an up-to-date record of staff with registration, together with a list of names, designations and signatures. ☐☐ **A**

2.3 All unqualified staff, trainees or assistants working within the service practise under the supervision of a registered member of staff. ☐☐ **A**

2.4 Communication links are established with medical professionals to discuss specific patient requirements. ☐☐ **B**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

3.1 Staff maintain personal professional development update diaries. ☐ ☐ **B**

VOLUME
2

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

please tick
Yes No

In addition to the core standard criteria:

Comments

4.1 There are documented policies and procedures for the following:

4.1.1	supervision of qualified and unqualified staff	☐☐	**A**
4.1.2	patient safety	☐☐	**A**
4.1.3	recording of care given	☐☐	**A**
4.1.4	referral to, and discharge from, the service	☐☐	**A**
4.1.5	reporting back to the referrer	☐☐	**A**
4.1.6	staff safety (for example, handling procedures)	☐☐	**A**
4.1.7	storage and handling of equipment	☐☐	**A**
4.1.8	information issued to patients	☐☐	**B**
4.1.9	on-going care (for example, referral systems inside and outside the hospital).	☐☐	**B**

VOLUME 2

PATIENT CARE

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

please tick
Yes No

Comments

6.1 A named, registered member of staff is accountable for each patient referred to their care. ☐☐ A

6.2 There is a written care programme for each patient. ☐☐ A

Interpretation

- * *the care programme is developed:*

  after an assessment of the patient

  in consultation with, and taking into account the wishes of, the patient, carer or advocate

  in collaboration with other staff when necessary

- * *the care programme details at least the following:*

  the patient/carer s informed consent where appropriate

  a statement of the patient s needs

  details of specific care given

  education/advice

  continuing assessment and evaluation of needs

  communication with other members of the clinical team

  follow-up arrangements

  preparation for discharge

  referral/discharge details.

6.3 Care programmes developed by unqualified staff are countersigned by a registered member of staff. ☐☐ A

6.4 A written record (which may be a summary) is filed in the patient s health record *(see also Health Record Content chapter, criterion 1.1.9).* ☐☐ A

6.5 The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact. ☐☐ A

PATIENT CARE

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

6.6 All records are held in a secure storage area and retained for the legally required period after discharge. ☐☐ **A**

6.7 A copy of the discharge summary is sent to the source of referral and to the relevant agencies or organisations involved with the patient on discharge. ☐☐ **A**

6.8 Staff participate in reviews of patients in their care. ☐☐ **B**

6.9 There is information available to staff on the range and availability of aids, appliances and facilities which could assist the patient living in the community. ☐☐ **B**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick
Yes **No**

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

* *patients not arriving for treatment/ appointment and the reasons why*
* *inappropriate referrals*
* *pre- and post-appointment waiting times*
* *discharge (planned, appropriate and coordinated)*
* *follow-up.*

VOLUME
2

RADIOTHERAPY SERVICE

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 2

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:	*please tick* Yes	No	***Comments***	*Weighting*
2.1 The service is clinically directed by a qualified clinical oncologist.				A
Interpretation				
* *the oncologist may be full- or part-time depending on the size and complexity of the department.*				
2.2 The following are on duty or contactable at all times:				
2.2.1 a qualified oncologist				A
2.2.2 state registered radiographers				A
2.2.3 a qualified and experienced medical radiation physicist				A
2.2.4 registered nurses.				B
2.3 Radiographers are accountable to, and supervised by, a designated senior radiographer.				B
2.4 There is a radiation protection supervisor for the department.				A
2.5 The role of the radiation protection supervisor is clearly defined.				A
2.6 There is a radiation protection advisor for the hospital/trust.				A
2.7 All radiotherapeutic procedures are conducted by an appropriately qualified person or by students under the guidance of an appropriately qualified person.				A

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:		*please tick* Yes	No	*Comments*
4.1	There is evidence that practice conforms to the Ionising Radiations Regulations 1985.			A
4.2	When developing ionising radiation policies and procedures, the radiation protection supervisor and radiation protection advisor are involved.			A
4.3	Simulation and planning procedures are performed and radiotherapy treatment given only upon written request by a clinical oncologist employed within the department.			A
4.4	The prescription contains sufficient clinical information to justify the treatment.			A
4.5	There is a local policy for the length of time that films, treatment plans and prescriptions are stored.			A
4.6	Films, treatment plans and prescriptions are stored using a coding (hospital/departmental) system.			B
4.7	There are documented policies and procedures for the following:			
4.7.1	care of patients with special needs, including those who are critically ill and those needing isolation precautions			A
4.7.2	health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)*			A
4.7.3	treatment of medical emergencies			A
4.7.4	appointment system			B
4.7.5	information issued to patients and relatives or carers.			B

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

4.8 Radiation safety measures are developed in consultation with all professional staff involved in delivering the service and in consultation with the radiation protection supervisor and radiation protection advisor. ☐☐ **A**

4.9 The implementation of radiation safety measures is supervised by the radiation protection supervisor. ☐☐ **A**

4.10 As a minimum safety measures include precautions against:

4.10.1 chemical hazards ☐☐ **A**

4.10.2 contamination/infection risks ☐☐ **A**

4.10.3 electrical hazards ☐☐ **A**

4.10.4 fire and explosion ☐☐ **A**

4.10.5 mechanical hazards ☐☐ **A**

4.10.6 radiation hazards. ☐☐ **A**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:

please tick

		Yes	No	*Comments*	Weighting
5.1	The department has:				
5.1.1	sufficient seating facilities to cater for the number and type of patients expected to attend the clinic				B
5.1.2	space for wheelchairs/beds				B
5.1.3	toilet and washroom facilities located within easy reach of the department				B
5.1.4	patient information leaflets (for example, health promotion, making/cancelling appointments) *(see also The Patient s Rights and Special Needs chapter, The Patient s Rights standard, criterion 1.3)*				B
5.1.5	information on patient waiting time				B
5.1.6	play facilities/area for children *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.33.2)*				B
5.1.7	public transport details				C
5.1.8	access to facilities suitable for nursing mothers				C
5.1.9	reading material.				C
5.2	There is a safe and secure store for pharmaceutical products *(see also Pharmaceutical Service chapter, criterion 5.3).*				A
5.3	Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the Ionising Radiations Regulations 1985.				A
5.4	Staff working with radiological equipment wear radiation monitoring devices.				A
5.5	The radiation monitoring devices are assessed periodically in accordance with statutory regulations.				A
5.6	Results are reported to the radiation protection supervisor.				A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		Comments	*please tick* Yes	No	
5.7	Continuous records of these results are kept for the working lifetime of staff employed by the service.				**A**
5.8	All staff are given instruction in safety precautions for patients and staff.				**A**
5.9	All rooms and equipment are assessed for safety at acceptable intervals by suitably qualified experts.				**A**
5.10	Records of safety assessment are kept.				**A**
5.11	All equipment is calibrated in accordance with regulations.				**A**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick
Yes No

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. **B**

Interpretation

The quality indicators may include the following:

- *referral patterns*
- *waiting times for appointments*
- *time spent by patients in the department.*

VOLUME
2

SPECIAL CARE SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

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A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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VOLUME 2

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Special care services are defined as discrete areas within a hospital/trust specifically organised for the management of the critically ill patient which involve the grouping of special facilities and specially trained staff.

A separate section is to be completed for each service; please indicate to which service this section applies.

Service: _____

MANAGEMENT AND STAFFING

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

In addition to the core standard criteria:

Comments

please tick

		Yes	No	
2.1	The special care unit is directed by a recognised specialist and practising clinician in the area of patient care undertaken by the unit.	☐	☐	**A**
2.2	There is a designated deputy to act in the absence of the director (however named).	☐	☐	**B**
2.3	The functions, responsibilities and authority of the director and the admitting consultants are clearly defined.	☐	☐	**B**
2.4	There is a designated resident doctor available at all times.	☐	☐	**A**

Interpretation

This doctor:

- *is experienced enough to deal with the majority of patients within the unit*
- *can deal with emergencies*
- *is within easy reach of the unit*
- *is involved in all decisions relating to the clinical care of the patient.*

2.5	A senior nurse with specialised post-registration qualification and/or experience has overall responsibility for the nursing care provided in the unit.	☐	☐	**B**
2.6	All registered nurses assigned to a special care unit have completed an in-service programme or an appropriate national board course.	☐	☐	**A**

MANAGEMENT AND STAFFING

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

please tick
Yes No

Comments

2.7 Special care service staff are represented on inter-departmental committees and involved in decision making on issues related to service provision. ☐☐ C

2.8 There is a users committee. ☐☐ B

Interpretation

The users committee:

* *comprises representatives of medical, management, nursing and paramedical staff*
* *advises the director and full-time specialists of the unit on the development, implementation and evaluation of service policies.*

2.9 The following are available at all times:

2.9.1 a cardiac arrest team ☐☐ A

2.9.2 a registered sick children s nurse or a nurse trained in the child branch of Project 2000 *(see also The Patient s Rights and Special Needs chapter, The Patient s Special Needs standard, criterion 2.16)* ☐☐ A

2.9.3 adequate supplies of medications and intravenous fluids *(see also Pharmaceutical Service chapter, criterion 4.2.1)* ☐☐ A

2.9.4 adequate, well maintained equipment for organ support ☐☐ A

2.9.5 expert advice concerning the safe use of, and preventive maintenance for, all biomedical devices and electrical installations ☐☐ A

2.9.6 pathology services (including blood bank) *(see also Pathology Service chapter, criterion 4.10)* ☐☐ A

2.9.7 a physiotherapist ☐☐ A

2.9.8 a radiographic team capable of mobile X-ray *(see also Diagnostic Imaging Service chapter, criterion 2.7)* ☐☐ A

2.9.9 technical support to ensure the safe and effective functioning of equipment. ☐☐ A

2.10 Patients, relatives and staff are aware of, and have access to, trained counsellors. ☐☐ C

VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

2.11 The housekeeping staff are aware of the special nature of the unit and dangers associated with disconnecting patients from equipment *(see also Housekeeping Service chapter, criterion 1.2).*

☐☐ **A**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
3.1 Training in handling bereavement is provided.		☐	☐	**C**

VOLUME 2

POLICIES AND PROCEDURES

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:

please tick
Yes No

Comments

4.1 There are documented policies and procedures for the following:

4.1.1 admission criteria (and contingency plans for when the unit is full) — ☐☐ A

4.1.2 do not resuscitate situations, issues of consent to treatment and research in incapacitated patients, withdrawal of care situations — ☐☐ A

4.1.3 emergency and established standard care procedures of critically ill patients — ☐☐ A

4.1.4 people who may perform special procedures, under what circumstances and under what degree of supervision — ☐☐ A

Interpretation

Special procedures in this context include for example:

* *administration of parenteral fluids and other medications*
* *cardio-pulmonary resuscitation*
* *obtaining of blood and other laboratory specimens*
* *ordering of medications*
* *controlled mechanical ventilation*
* *haemofiltration*

4.1.5 procedures to follow in the event of breakdown of essential equipment — ☐☐ A

4.1.6 requesting donor organs and the training of staff in how to approach relatives or carers — ☐☐ A

4.1.7 transfer of patients to other hospitals — ☐☐ A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		Comments	*please tick* Yes	No	
4.1.8	acquisition, maintenance, cleaning, sterilisation, preparation and location of equipment and supplies		☐	☐	**B**
4.1.9	arrangements for diagnostic imaging and laboratory investigations		☐	☐	**B**
4.1.10	arrangements for visitors		☐	☐	**B**
4.1.11	control of traffic through and within the unit including access to the unit		☐	☐	**B**
4.1.12	discharge criteria.		☐	☐	**B**

VOLUME 2

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 5

The environment, facilities and equipment ensure safe, efficient and effective care of the patient and staff.

In addition to the core standard criteria:	***Comments***	*please tick* Yes	No	
5.1 The immediate physical environment of the patient is:				
5.1.1 as unobtrusive and aesthetically pleasing as possible				**B**
5.1.2 conducive to recovery with minimum sensory deprivation and abuse				**B**
5.1.3 situated near outside windows wherever possible.				**B**
5.2 The unit is air-conditioned *(see also Estates Management chapter, criterion 1.18).*				**B**
5.3 Lighting systems are as near to natural light as possible *(see also Estates Management chapter, criterion 1.13).*				**B**
5.4 The nurses station allows effective observation of, and ready access to, all patients in the area.				**A**
5.5 Sufficient space is provided around each bed to make it accessible for routine and emergency care and to accommodate bulky equipment *(see also criterion 5.14 below).*				**A**
5.6 Patient beds:				
5.6.1 are adjustable				**A**
5.6.2 are easily moved				**A**
5.6.3 have a locking mechanism				**A**
5.6.4 have cot sides				**A**
5.6.5 have removable headboards.				**A**
5.7 Where electrically operated beds are used, staff are aware of potential electrical hazards.				**A**
5.8 There are facilities for isolation and protective isolation nursing of patients *(see also Corporate Management chapter, Infection Control standard, criterion 14.20).*				**A**
5.9 There is a laboratory room adjacent to the patient area with facilities for blood gas analysis and other tests appropriate to the work of the unit *(see also Pathology Service chapter, criterion 2.4).*				**C**

FACILITIES AND EQUIPMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

5.10 Quiet and private areas with tea and coffee making facilities and a telephone are available for waiting, grieving or otherwise distressed relatives or carers. ☐☐ **B**

5.11 Residential accommodation for relatives or carers is available and within easy reach of the unit. ☐☐ **C**

5.12 Quiet and private areas are available for staff which include tea and coffee making facilities, changing rooms and toilets. ☐☐ **B**

5.13 There is a bedroom for the resident doctor *(see also Medical Service chapter, criterion 5.1).* ☐☐ **A**

5.14 All emergency and life support equipment is readily accessible and functional *(see also criterion 5.5 above).* ☐☐ **A**

5.15 Documentation of safety testing is provided on an agreed regular basis to the unit director. ☐☐ **B**

5.16 There is an alarm system for special care unit personnel to summon additional staff in an emergency *(see also Security Service chapter, criterion 1.7).* ☐☐ **A**

5.17 Specific purpose refrigerators are available for storage. ☐☐ **A**

Interpretation

These are used to store:

* *medications*
* *blood products*
* *serum*
* *specimens.*

5.18 There are appropriate areas available for the cleaning and storage of equipment. ☐☐ **B**

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

Comments

please tick

Yes No

6.1 There is a named, qualified nurse responsible for the nursing care of each patient. ☐☐ A

6.2 There is a nursing care plan for each patient. ☐☐ A

Interpretation

The care plan is developed:

* *after an assessment of the patient*
* *in consultation with, and taking into account the wishes of, the patient, carers or advocates*
* *in collaboration with other staff where appropriate.*

6.3 Care plans developed by student nurses are countersigned by a registered nurse. ☐☐ A

6.4 A nursing record, which conforms to UKCC guidelines, is maintained for each patient. ☐☐ A

Interpretation

This includes at least the following:

* *biographical data*
* *assessment data*
* *individual care plan*
* *evaluation of care.*

6.5 The nursing record is signed, timed and dated by the nurse responsible and incorporated into the patient s health record on discharge *(see also Health Record Content chapter, criterion 1.1.9).* ☐☐ A

6.6 A copy of the discharge summary is sent to the general practitioner or other source of referral. ☐☐ A

6.7 Nursing staff participate in multidisciplinary patient reviews. ☐☐ B

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

In addition to the core standard criteria:

please tick

Yes **No**

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐ ☐ **B**

Interpretation

The quality indicators may include the following:

- *inappropriate referrals (case-mix)*
- *morbidity*
- *mortality*
- *severity and illness.*

VOLUME
2

SPEECH AND LANGUAGE THERAPY SERVICE

This document contains a set of organisational standards and criteria specific to your service. By working with these, your service will be able to evaluate its organisational effectiveness against a set of nationally developed and nationally applicable criteria.

To help your service prioritise its workload and focus on the more fundamental organisational issues, each criterion has been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standards. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

These service specific criteria are not 'stand alone' criteria and are designed to be used in conjunction with the Core Standards for Clinical Services. It will therefore be necessary to complete a self-assessment of your service's progress against the criteria specific to your service and the Core Standards for Clinical Services. If, however, your service forms part of a larger unit of management (for example, a clinical directorate) the core standards should be applied across the unit of management as a whole, with each constituent service feeding into one overall assessment.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA), a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the standards and criteria and to plan the format of each visit in advance of the survey.

To ensure that the standards and criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME
2

MANAGEMENT AND STAFFING

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 2

Each service is efficiently and effectively organised, managed and staffed to achieve its objectives.

please tick
Yes No

In addition to the core standard criteria:

Comments

2.1 Each service is managed and staffed by individuals registered by their professional body. ☐☐ **A**

2.2 There is an up-to-date record of staff with registration, together with a list of names, designations and signatures. ☐☐ **A**

2.3 All unqualified staff, trainees or assistants working within the service practise under the supervision of a registered member of staff from the appropriate profession. ☐☐ **A**

VOLUME
2

STAFF DEVELOPMENT AND EDUCATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 3

There is a development and education programme in place which facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

3.1 Staff maintain personal professional development update diaries. ☐ ☐ **B**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 4

There are written policies and procedures which reflect current professional knowledge and principles. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities.

In addition to the core standard criteria:	***Comments***	*please tick* Yes / No	Weighting
4.1 There are documented policies and procedures for the following:			
4.1.1 supervision of qualified and unqualified staff			A
4.1.2 patient safety			A
4.1.3 recording of care given			A
4.1.4 referral to, and discharge from, the service			A
4.1.5 reporting back to the referrer			A
4.1.6 staff safety			A
4.1.7 storage and handling of equipment			A
4.1.8 information issued to patients			B
4.1.9 on-going care (for example, referral systems inside and outside the hospital).			B

VOLUME 2

PATIENT CARE

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Core Standard 6

Patient care reflects the individual needs of the patient and is delivered in a systematic way.

In addition to the core standard criteria:

please tick

Comments | **Yes** | **No**

6.1 A named, registered member of staff is accountable for each patient referred to their care. — A

6.2 There is a written care programme for each patient. — A

Interpretation

- * *the care programme is developed:*
  - *after an assessment of the patient*
  - *in consultation with, and taking into account the wishes of, the patient, carer or advocate*
  - *in collaboration with other staff when necessary*
- * *the care programme details at least the following:*
  - *the patient/carer s informed consent where appropriate*
  - *a statement of the patient s needs*
  - *details of specific care given*
  - *education/advice*
  - *continuing assessment and evaluation of needs*
  - *communication with other members of the clinical team*
  - *follow-up arrangements*
  - *preparation for discharge*
  - *referral/discharge details.*

6.3 Care programmes developed by unqualified staff are countersigned by a registered member of staff. — A

6.4 A written record (which may be a summary) is filed in the patient s health record *(see also Health Record Content chapter, criterion 1.1.9).* — A

6.5 The record is signed and dated by the practitioner, and the designation (in- or outpatient) indicated for each patient contact. — A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

		please tick Yes	No	*Comments*	
6.6	All records are held in a secure storage area and retained for the legally required period after discharge.	☐	☐		**A**
6.7	A copy of the discharge summary is sent to the source of referral and to the relevant agencies or organisations involved with the patient on discharge.	☐	☐		**A**
6.8	Staff participate in reviews of patients in their care.	☐	☐		**B**

VOLUME
2

QUALITY MANAGEMENT AND EVALUATION

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Core Standard 7

Quality management and evaluation activities are undertaken by the service and are consistent with the quality improvement strategy of the hospital/trust.

please tick
Yes No

In addition to the core standard criteria:

Comments

7.1 There is evidence that quality indicators are reviewed on a service-wide basis. ☐☐ **B**

Interpretation

The quality indicators may include the following:

- *patients not arriving for treatment/ appointment and the reasons why*
- *inappropriate referrals*
- *pre- and post-appointment waiting times*
- *patient time spent in the department*
- *discharge (planned, appropriate and coordinated)*
- *follow-up.*

HEALTH RECORD CONTENT

VOLUME 2

HEALTH RECORD CONTENT

The criteria contained within this document have been classified as either essential practice, good practice or desirable practice. The definitions of these categories are as follows:

A **Essential Practice**

If these are not in place then:

(i) legal and/or professional requirements will not be met

(ii) a risk to patients or staff or visitors will be created

(iii) the patient's rights, in terms of The Patient's Charter, will be compromised.

B **Good Practice**

Standard good practice expected to be in place in any hospital/trust across the UK.

C **Desirable Practice**

Good practice which is not yet standard across the UK.

Guidance material, to help you interpret and implement the criteria, is shown in italics. A system of cross-referencing has also been introduced to highlight those criteria that relate to other services or those that can only be met with the input of other disciplines.

The self-assessment boxes and space for commenting against the criteria enable you to assess your progress towards meeting the standard. Please indicate whether or not the criterion has been complied with by ticking 'yes' or 'no' as appropriate. Where the response is 'no', please comment and indicate whether there are any plans to comply in the future. Similarly, if you wish to add information or are unsure as to whether the criterion has been achieved, please use the comments column. If the space is insufficient, please continue on a separate sheet.

This set of criteria should be addressed at corporate level. However, to achieve an accurate self-assessment of the whole organisation, the criteria will need to be widely distributed.

If your hospital/trust is participating in the King's Fund Organisational Audit (KFOA) programme, a copy of this completed document will be sent to each member of the survey team. This will enable the team to assess the hospital's/trust's overall progress towards meeting the criteria and to plan the format of each visit in advance of the survey.

To ensure that the criteria remain credible, they must be subject to continual scrutiny and update. We would therefore be extremely grateful if you could inform KFOA of any criteria which you feel are out of date, difficult to measure, ambiguous or incorrectly classified. Please use the comments column to do this or alternatively feed back your suggestions to either your Organisational Audit Coordinator (if your hospital/trust is participating in the Organisational Audit programme) or to KFOA direct. The Organisational Audit process is an evolving process which can only be improved with the help of the participating units.

VOLUME 2

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Standard

There is an accurate health record which enables the patient to receive effective continuing care, enables the healthcare team to communicate effectively, allows another doctor or professional member of staff to assume the care of the patient at any time, enables the patient to be identified without risk or error, facilitates the collection of data for research, education and audit and can be used in legal proceedings.

Criteria

(Where any part of the record is held in another form of storage, for example electronically, the following criteria still apply.)

1.1 The patient s health record contains:

Patient Identification

1.1.1 patient identification data

Interpretation

This includes as a minimum:

* *a unique record number or reference on every page*
* *name in full on every page*
* *address and postcode*
* *date of birth*
* *general practitioner*
* *name of admitting consultant*
* *telephone number*
* *sex*
* *person to notify in an emergency (next of kin)*
* *source of referral*
* *purchasing health authority (NHS only).*

Clinical Record

1.1.2 an alert notation on the front cover which is repeated on prescriptions and/or treatment sheets

1.1.3 a clinician s written diagnosis or reason for admission with the date and time of the initial consultation

please tick

Yes	No	
		A
		A
		A

Comments

Weighting

Essential Practice A

Good Practice B

Desirable Practice C

Comments

please tick
Yes No

1.1.4 an initial patient history including present and past medical history, family history, details of medication, employment history and social and environmental details if pertinent. ☐☐ A

1.1.5 a report of the initial physical examination performed by a clinician including the patient s height and weight ☐☐ A

1.1.6 progress notes, observations and consultation reports ☐☐ A

1.1.7 a note of therapeutic orders and orders for diagnostic tests ☐☐ B

1.1.8 results of investigations (for example, pathology, imaging, ECGs) ☐☐ A

1.1.9 reports by medical, nursing and allied health professionals ☐☐ A

1.1.10 drug therapy records ☐☐ A

1.1.11 details of verbal instructions/information given to patients and/or carers ☐☐ A

Patients Undergoing Surgery

1.1.12 details of consent for patients undergoing surgery ☐☐ A

Interpretation

* *there is signed evidence that consent was obtained by a doctor (if necessary, professional interpreters are used)*

* *there is signed evidence that the correct procedure was followed when obtaining informed consent for children under the age of 16 years.*

1.1.13 a pre-operative diagnosis made by a suitably qualified medical practitioner ☐☐ A

1.1.14 an operation note *(see Operating Theatre Service/Anaesthetic Service chapter, criterion 2.12 for details of content)* ☐☐ A

1.1.15 an anaesthetic record *(see Operating Theatre Service/Anaesthetic Service chapter, criterion 2.13 for details of content)* ☐☐ A

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Comments

please tick
Yes No

Discharge

1.1.16 a copy of the discharge communication which is completed on the day of the patient s discharge — ☐☐ **A**

1.1.17 a copy of the discharge summary/letter which is completed and dispatched within 14 days of the patient s discharge and sent to the general practitioner or other hospital/institution to which the patient is discharged — ☐☐ **A**

1.1.18 cause of death where death has occurred — ☐☐ **A**

Post Mortems

1.1.19 an anatomical diagnosis (provisional within 72 hours and a completed diagnosis within one month of the death) — ☐☐ **B**

1.1.20 a copy of the post mortem report — ☐☐ **A**

1.1.21 a review of the clinical diagnosis and findings of the post mortem examination. — ☐☐ **B**

1.2 There is a sheet at the front of the notes (the front sheet) which is designed to contain all the patient s demographic details and all administrative detail relevant to the admission and is completed at the time of discharge or as soon as the relevant information is available. — ☐☐ **A**

Interpretation

The front sheet includes:

* *dates of admission and discharge*
* *consultant in whose care the patient is admitted*
* *all diagnoses and procedures using the terminology of the current revision of the international classification of disease and OPCS coding for operative procedures (or other approved classifications)*
* *a list of all previous admissions, referrals or attendances together with the department attended and the consultant seen.*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

1.3 Entries into the record are made only by authorised staff and are dated and signed, with the name and designation of the signatory. ☐☐ **A**

1.4 All entries in the record, including alterations, are legible. ☐☐ **A**

1.5 Abbreviations and symbols are kept to a minimum and used in accordance with local guidelines. ☐☐ **A**

1.6 The record provides a chronological account of the patient s care. ☐☐ **A**

1.7 The contents of the health record are securely fastened within the folder. ☐☐ **B**

1.8 When a patient is transferred to another hospital, or is returning to the care of another doctor, a copy of the record is also transferred. ☐☐ **A**

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