KING
FUN
CENTR

ORGANISATIONAL AUDIT

(Accreditation UK)



STANDARDS FOR AN ACUTE HOSPITAL

Quality
Improvem
Programm

FOREWORD

The publication of the second edition of this manual represents a significant landmark in the development of the King's Fund organisational audit (accreditation) project. It marks the culmination of a year spent testing the standards themselves, and the applicability of the organisational audit approach to the UK health care system, as well as signalling the extension of the programme into a further 50 acute hospitals over the next two years.

In the Foreword to the last edition I stressed that the document was a first attempt to frame standards for the organisation of an acute hospital and that these standards would need to evolve over time. We hope that this process is evident in the revised manual. The reader will notice changes in the section headings listed in the document as well as alterations to both their internal format and to a number of standards. These changes have taken place as a result of extensive field testing and consultation with professional and consumer organisations; we are confident that they represent a considerable improvement. The standards will continue to be subject to amendment and the ring binder presentation will enable changes to individual sections to be integrated with a minimum of difficulty. The observant reader will also notice a subtle change in the title of the document to organisational audit (accreditation), reflecting our view that the developmental nature of the work is more accurately represented by this phase.

Acknowledgements

Once again we would like to acknowledge the enormous support which we have received in developing the standards and piloting the survey approach. Our thanks go to:

The Gatsby Foundation, one of the Sainsbury Family's *many* charitable trusts, the generosity of which has made this work possible.

The pilot sites — Brighton, East Dorset, North Derbyshire, North West Hertfordshire, Nottingham and West Dorset Health Authorities, The Hospital of St John and St Elizabeth and AMI Chiltern Hospital: all the staff in these organisations who have given their support and advice, and in particular the local survey co-ordinators.

The many professional and consumer organisations for their comments and suggestions on the first draft of the manual, which have been incorporated into this edition.

The surveyors — Mr David Bowden, Dr David Burnett, Dr Richard Burwood, Mr Ian Carruthers, Mrs Elizabeth Davies, Dr Steven McDonald, Mr John Newton, Mr Philip Nye, Mrs Diana Sale and Mr Hugh Thelwall-Jones, all of whom contributed in large part to the success of the first phase of the project.

The publications unit at the King's Fund Centre, and special thanks to Johanna Gurney for typing the manual.

Tessa Brooks
Director
Quality Improvement Programme

August 1990

INTRODUCTION

In late 1988 the King's Fund Quality Improvement Programme hosted a workshop for an invited audience of senior health service personnel and representatives of professional bodies, to consider the possibility of developing a national approach to setting and monitoring standards for the organisation of health care. The timing was opportune. The conference caught the growing mood of concern about the variation which exists, not only in the standard of clinical care, but also in the organisational capability of acute hospitals to sustain that care. Support for an experiment to explore the applicability of an "accreditation" type model to the UK health care system was such that a number of districts volunteered to take part in a pilot, if the King's Fund was prepared to organise the necessary work. The challenge was accepted.

The subsequent publication of the White Paper *Working for Patients*, which laid out a scenario for the management of health care in which commissioners and providers would negotiate agreements within a quasi internal market, highlighted the relevance of a process which could demonstrate that the necessary systems and procedures were in place to maintain a quality organisation as well as offer a robust monitoring tool for this purpose.

ORGANISATIONAL AUDIT (ACCREDITATION) PROGRAMME
Phase I: Spring 1989 – Spring 1990

By Spring 1989 the Quality Improvement Programme project had been set up. The aims were twofold:

1. To develop a comprehensive framework of organisational standards for an acute hospital which could be applied nationally
2. To examine the process of assessing a hospital's progress towards meeting those standards

Six NHS acute units had agreed to take part in the exercise. They were:

- Bournemouth General (East Dorset Health Authority)
- Chesterfield and Derbyshire Royal (North Derbyshire HA)
- Hemel Hempstead (North West Herefordshire HA)
- Queens Medical Centre (Nottingham HA)
- Royal Sussex County (Brighton HA)
- West Dorset (West Dorset HA)

In addition two independent hospitals (AMI Chiltern and St John and St Elizabeth) also agreed to take part, presenting an opportunity to develop standards which would be applicable to both the public and independent sectors.

The Quality Improvement Programme together with representatives from these units (consultants, DGM's, senior nurses and UGM's) formed a project steering group. This group took an early decision to build upon the experience of other countries in monitoring and developing standards and to adapt this experience to reflect the health care needs of this country. It examined the North

American and Australian models of accreditation and considered that the Australian system provided the most appropriate base on which to build its own work. The model which subsequently evolved is termed "organisational audit".

Accreditation

Accreditation is a system which comprises three main stages:

1. The development of organisational standards concerned with the systems and process of delivery of health care — standards are developed in consultation with the relevant professional organisations and are revised annually to ensure that they reflect current health trends
2. Implementation of standards — the various accreditation agencies provide support material and guidance on interpretation of standards
3. Evaluation of compliance with standards — by means of a survey, conducted by a team comprising a senior consultant, manager and a nurse

Participation in the accreditation process is voluntary.

For further details on the various accreditation models see *Health Service Accreditation: An International Overview* (Ingrid Sketris, 1988. London: King's Fund Centre, Paper no 88/69).

Developing Standards

The first draft manual of standards covering a range of services offered by an acute unit was produced in September 1989. While using the Australian accreditation document as its basis, the manual included references to guidelines issued by the various professional organisations, Department of Health, as well as detailed organisational guidelines already developed in a separate King's Fund project. The draft was subject to significant revision by a multidisciplinary editorial panel and went out for consultation to professional and consumer organisations in Autumn 1989.

The staff of pilot sites were also involved in a practical evaluation of the document, to determine which standards could be implemented and the impact which these would have on the service provided to the patient and the working environment for staff.

Preparing for Survey

The assessment of a hospital's progress towards meeting the standard is termed the "survey". By the autumn of 1989 each of the participating authorities had established a local steering group comprising the DGM, UGM, consultants, senior nurses and professions allied to medicine, which was responsible for the dissemination of information, for ensuring that all staff understood the survey process and that the applicable standards were met. The King's Fund worked closely with these groups.

Pre-Survey Documentation

One of the key tasks for the group was to distribute and co-ordinate the completion of the pre-survey documentation. This consisted of:

(a) A hospital profile form — providing information on the hospital: the range and size of services, number of beds, population served, staffing levels and organisation.

(b) Self assessment forms — consisting of the manual divided into individual service sections, adapted to allow compliance with standards to be indicated and comments to be made. This enabled staff to assess their own progress towards meeting standards, and expand or explain their responses and to comment on the validity of the standards themselves. The completed forms were returned to the King's Fund, checked and circulated to the survey team. These forms have now been included in the main body of this manual.

The Surveyors

The key to the success of the survey process is the calibre of the surveyors chosen. Each of the participating authorities was invited to nominate senior members of staff to act as surveyors. From these nominations three teams comprising a consultant, a senior nurse and a district general manager were selected. All were volunteers who gave their services free of charge and devoted approximately fifteen days to the task. This included a three day training programme.

The surveys, lasting between three and four days, were conducted between February and April 1990. This was followed by an extensive evaluation of the process and the standards. The experience of testing the standards in "the field" was invaluable and has been incorporated into this draft of the manual.

For further details on the first phase of the project, see *The Quality Question* (a King's Fund Centre publication, 1990).

THE NEXT STEP

More acute units than could realistically be assessed wished to participate in the programme and the number of volunteers continues to increase. Eighteen hospitals have been selected for survey in the next phase of the programme, planned for 1991, and these hospitals are currently in the preparatory phase. They will obviously benefit from experience gained in the first phase of the project but will also assist in the development of the process and standards. A further twenty five hospitals have been scheduled for survey in 1992.

To support this increasing level of activity, an advisory council comprising membership from the major professional bodies and consumer interests has been established to guide the future work of the programme. This body will also give serious consideration to the long-term management of the programme.

THE MANUAL

The purpose of this manual is to provide a comprehensive set of organisational standards covering the major aspects of an acute general hospital. This will form the basis of a professional peer review (the survey) the aim of which is to support the staff of hospitals in the provision of high quality patient care. The principle underlying this approach is that by voluntarily submitting to survey, those hospitals participating in the process are seeking to demonstrate the capability of their organisations to provide such care.

The guide is intended for use by all staff in hospitals to be surveyed in order to prepare for survey. It is envisaged that the standards will be appropriate to an average acute general hospital of a size to support all major services including an Accident and Emergency department. Where this is not the case, reference should be made to other available guidance, for example *Towards Good Practices in Small Hospitals: Some suggested guidelines* (Charles Shaw, Margaret Hurst and Simon Stone, 1988. Birmingham: National Association of Health Authorities). While every attempt has been made to provide comprehensive coverage of services in such a hospital, it is acknowledged that at this stage this is not always the case. Further standards will develop over time including those for community and long term care facilities.

The standards developed apply to both the NHS and the independent sectors. It is recognised however, that certain references, for example, those relating to medical services, education and training, may be inappropriate to the independent sector. These differences in organisation will be taken into account during the survey process and reflected in subsequent redrafting of the manual. Indeed it is well understood that no one organisation will meet all the standards in any one section. However, the survey team will look for clear evidence that hospitals conform to the majority of standards and will give particular weight to those standards relating to patient safety. The guiding principles informing the standards are that they should:

- support the patient's expectations of quality care and personal dignity
- be desirable and measurable
- relate as directly as possible to the quality of care and to the quality of the environment in which care is provided
- emphasise an efficient and effective use of available resources
- represent a consensus on currently accepted professional practice
- state objectives rather than mechanisms for meeting objectives

Much work has yet to be done to refine and polish the standards, indeed the process of improvement must be continual. The production of the document in ring binder form will make future amendments more practical, as well as allowing for easier use by units and surveyors. It will also enable the inclusion of new sections, such as that on patient care, and supporting documentation as this is developed.

Content

The manual has three main divisions and nineteen sections.

1. Management and Support Services

Hospital Management
Catering Service
Hotel Services
Infection Control
Health and Safety
Library Service
Medical Record Service
Medical Record Content

2. Professional Management

Medical
Nursing
Professions Allied to Medicine

3. Departmental Management

Accident and Emergency Service
Acute Day Care Service
Laboratory Service
Operating Theatre Service
Out-Patient Service
Pharmaceutical Service
Radiology Service
Special Care Service

Format of Sections

Each section of the manual contains the following sub-sections.

1. Philosophy and objectives
2. Management and staffing
3. Staff development and education
4. Policies and procedures
5. Facilities and equipment
6. Evaluation and quality assurance

A patient care sub-section has been added to most of the services covered within this manual. The subsections follow a logical sequence, beginning with the service philosophy and the objectives which need to be in place in order to achieve that philosophy. This is followed by the support structures required to achieve the objectives, and concludes with evaluation and quality assurance activities.

There is some overlap of standards between sub-sections, but as far as possible, this has been minimised by clear cross-referencing. The repetition of the sub-sections for all nineteen services adds to the volume of the manual but does enable each chapter to be read as a free standing document.

The standards within each section seek to establish that there is clear evidence of:

- a patient centred service
- the efficient and effective overall management of resources
- the efficient and effective management of human resources
- continuous evaluation

Self-Assessment Forms

As explained in the introduction to this manual, the self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES / NO answers and space for comments. Each hospital is asked:

(a) to indicate whether each standard is being complied with

(b) if the standard is *not* being met then to state the reason in the comments column, together with any comments on the standards in general

The other half of the page is to be completed by the survey team member.

Completion of this document serves two purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

Supporting Documentation

It is envisaged that supporting documentation will be developed over time which will offer detailed guidance in respect of certain standards. Reference is made to current guidance and regulations.

Christine Pitt
Organisational Audit Project Manager

August 1990

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HOSPITAL MANAGEMENT

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

HOSPITAL MANAGEMENT

1. PHILOSOPHY AND OBJECTIVES

The hospital management provides the leadership and direction to enable the effective treatment of patients, the efficient use of resources and the provision of a high quality service for the people served.

Standards

Mission Statement

1.1 There is a clearly worded statement which outlines the mission of the hospital.

1.2 The statement is developed with input from the medical, nursing and other senior professional staff.

1.3 The statement shows the hospital's responsibility for ensuring that the rights and dignity of patients and their carers are respected.

1.4 The statement shows the hospital's role and responsibility to the local community and people served.

1.5 The statement demonstrates the hospital management's responsibility for the well-being of all staff in its employ.

1.6 The statement demonstrates the hospital's commitment to quality.

1.7 The mission statement is made available to the general public and to staff within the hospital.

Planning

1.8 The hospital management develops short and long term objectives for the hospital to achieve the hospital mission. These objectives are reviewed regularly and revised to reflect changes which have occurred.

1.9 There is a business plan for the implementation of the objectives of the hospital.

1.10 The plan incorporates contributions from the medical, nursing and other senior staff.

1.11 There is provision for the implementation and evaluation of the business plan.

1.12 The plan is subject to regular review and update to ensure that objectives are being met. Each review is dated.

1.13 Patient/customer satisfaction is integral to the evaluation of the business plan.

HOSPITAL MANAGEMENT

1. PHILOSOPHY AND OBJECTIVES

The hospital management provides the leadership and direction to enable the effective treatment of patients, the efficient use of resources and the provision of a high quality service for the people served.

Standards	Comment		Comment
Mission Statement			
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4 ☐ Y ☐ N		☐ Y ☐ N	
1.5 ☐ Y ☐ N		☐ Y ☐ N	
1.6 ☐ Y ☐ N		☐ Y ☐ N	
1.7 ☐ Y ☐ N		☐ Y ☐ N	
Planning			
1.8 ☐ Y ☐ N		☐ Y ☐ N	
1.9 ☐ Y ☐ N		☐ Y ☐ N	
1.10 ☐ Y ☐ N		☐ Y ☐ N	
1.11 ☐ Y ☐ N		☐ Y ☐ N	
1.12 ☐ Y ☐ N		☐ Y ☐ N	
1.13 ☐ Y ☐ N		☐ Y ☐ N	

1.14 The hospital management takes the steps necessary to ensure that the hospital conforms to statute and local government regulations.

2. MANAGEMENT AND STAFFING

There is a clear structure for the management of the hospital. This may be a board of directors or a designated individual, having overall responsibility for the operation and management of the hospital in accordance with its stated mission and objectives.

Standards

Management

2.1 There is a document of standing orders which states the constitutional arrangements of the hospital, having regard to central statute and local bye-laws.

2.2 The standing orders include:

- 2.2.1 mechanism for appointment of board members where appropriate
- 2.2.2 qualifications and/or experience required of board members
- 2.2.3 terms and conditions of office
- 2.2.4 power and duties of the hospital management
- 2.2.5 relationship with any senior authorities if such exist
- 2.2.6 relationship with the hospital manager and other senior management staff (medical, nursing and other senior professionals)
- 2.2.7 authority delegated to the hospital manager and other senior medical, nursing or other professional staff and conditions under which such authority is withdrawn
- 2.2.8 mechanism for purchasing goods and handling financial transactions

2.3 There is a mechanism to ensure that any changes in statutory requirements are incorporated into the standing orders.

2.4 The standing orders are accessible to hospital staff, patients and the general public.

Hospital Manager

2.5 There is a hospital manager (however named) whose authority and duties are defined in a written statement by the appropriate authority (for example, Board of Trustees, District Health Authority, Management Board).

2.6 The hospital manager is appointed by this authority.

2.7 The hospital manager is qualified by education and experience appropriate to the responsibilities of the position.

1.14 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

There is a clear structure for the management of the hospital. This may be a board of directors or a designated individual, having overall responsibility for the operation and management of the hospital in accordance with its stated mission and objectives.

Standards	Comment	Comment
Management		
2.1 ☐ Y ☐ N		☐ Y ☐ N
2.2		
2.2.1 ☐ Y ☐ N		☐ Y ☐ N
2.2.2 ☐ Y ☐ N		☐ Y ☐ N
2.2.3 ☐ Y ☐ N		☐ Y ☐ N
2.2.4 ☐ Y ☐ N		☐ Y ☐ N
2.2.5 ☐ Y ☐ N		☐ Y ☐ N
2.2.6 ☐ Y ☐ N		☐ Y ☐ N
2.2.7 ☐ Y ☐ N		☐ Y ☐ N
2.2.8 ☐ Y ☐ N		☐ Y ☐ N
2.3 ☐ Y ☐ N		☐ Y ☐ N
2.4 ☐ Y ☐ N		☐ Y ☐ N
Hospital Manager		
2.5 ☐ Y ☐ N		☐ Y ☐ N
2.6 ☐ Y ☐ N		☐ Y ☐ N
2.7 ☐ Y ☐ N		☐ Y ☐ N

2.8 There is a designated individual to act in the absence of the hospital manager, to provide the hospital with direction at all times.

2.9 The hospital manager is responsible for:

2.9.1 the application and implementation of operational policies for the hospital

2.9.2 the establishment of an organisational structure

2.9.3 the organisation of the administrative functions of the hospital, the delegation of duties and the establishment of formal lines of responsibility and accountability on the part of other managers and staff

2.9.4 facilitating departmental and inter-departmental meetings

2.9.5 the recommendation of policies to the board on the overall activities of the hospital, and working relationships with other community services which affect health care in the hospital

2.10 The hospital manager or designated deputy attends meetings of the board as appropriate.

2.11 The performance of the hospital manager is regularly reviewed by the appropriate authority.

2.12 There is a written organisational chart for the hospital management which clearly delineates current responsibilities and authority.

2.13 There is a mechanism for effective communication between the hospital management and staff of the hospital.

2.14 Regular staff meetings are held to maintain good communications and to review service practices.

2.15 The hospital management team meets at stated intervals (which are of sufficient regularity to ensure the effective management of the hospital).

2.16 There are recorded minutes of these meetings which are signed and dated.

2.17 There is a mechanism to ensure that minutes are circulated to the relevant members of staff.

2.18 These minutes are circulated within a specified period of time.

2.19 There is a mechanism for seeking the advice/recommendations of senior medical, nursing and other staff in the development of hospital policy or any policy relating to patient care.

2.20 There is evidence of a mechanism for communication and consultation with appropriate external organisations (community health councils, general practitioners, patient advisory groups).

1.14 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

There is a clear structure for the management of the hospital. This may be a board of directors or a designated individual, having overall responsibility for the operation and management of the hospital in accordance with its stated mission and objectives.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2			
2.2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.2.7 ☐ Y ☐ N		☐ Y ☐ N	
2.2.8 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
Hospital Manager			
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7 ☐ Y ☐ N		☐ Y ☐ N	

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9

2.9.1 ☐ Y ☐ N ☐ Y ☐ N

2.9.2 ☐ Y ☐ N ☐ Y ☐ N

2.9.3 ☐ Y ☐ N ☐ Y ☐ N

2.9.4 ☐ Y ☐ N ☐ Y ☐ N

2.9.5 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.21 The hospital management establishes and maintains personnel policies and practices to support good patient care. These policies are:

2.21.1 written and available to all employees and discussed with each new employee

2.21.2 reviewed periodically and revised as necessary and dated accordingly

2.22 A procedure is established for notifying employees of changes in the established personnel policies.

2.23 Accurate and complete personnel records are maintained which are confidential and available to the employee. These include at least:

2.23.1 records of leave and sickness

2.23.2 record of date and source of references received and given

2.23.3 results of recent staff appraisal

2.23.4 qualifications held/experience

2.23.5 evidence of current registration and management

2.23.6 records of clinical placements

2.23.7 amendments to the employment contract

2.24 There is a form of staff identification.

2.25 Written and dated job descriptions are available for all posts, which specify at least the following:

2.25.1 job title and grade

2.25.2 qualifications and/or experience required for the post

2.25.3 functions, responsibilities and accountability

2.25.4 frequency and type of staff appraisal

2.25.5 review date

2.26 A documented staff appraisal system exists for all staff.

2.27 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.28 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.29 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Personnel

2.21	☐ Y ☐ N	☐ Y ☐ N
2.21.1	☐ Y ☐ N	☐ Y ☐ N
2.21.2	☐ Y ☐ N	☐ Y ☐ N
2.22	☐ Y ☐ N	☐ Y ☐ N
2.23	☐ Y ☐ N	☐ Y ☐ N
2.23.1	☐ Y ☐ N	☐ Y ☐ N
2.23.2	☐ Y ☐ N	☐ Y ☐ N
2.23.3	☐ Y ☐ N	☐ Y ☐ N
2.23.4	☐ Y ☐ N	☐ Y ☐ N
2.23.5	☐ Y ☐ N	☐ Y ☐ N
2.23.6	☐ Y ☐ N	☐ Y ☐ N
2.23.7	☐ Y ☐ N	☐ Y ☐ N
2.24	☐ Y ☐ N	☐ Y ☐ N
2.25		
2.25.1	☐ Y ☐ N	☐ Y ☐ N
2.25.2	☐ Y ☐ N	☐ Y ☐ N
2.25.3	☐ Y ☐ N	☐ Y ☐ N
2.25.4	☐ Y ☐ N	☐ Y ☐ N
2.25.5	☐ Y ☐ N	☐ Y ☐ N
2.26	☐ Y ☐ N	☐ Y ☐ N
2.27	☐ Y ☐ N	☐ Y ☐ N
2.28	☐ Y ☐ N	☐ Y ☐ N
2.29	☐ Y ☐ N	☐ Y ☐ N

Staffing

2.30 The hospital management ensures that there are appropriately qualified personnel available to meet service requirements and high quality patient care.

2.31 Staffing is calculated and allocated on the basis of workload and a recognised dependency system where applicable.

2.32 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.33 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.34 The organisational chart is reviewed annually, revised and dated.

Industrial Relations

2.35 There is a documented policy for the satisfactory conduct of industrial relations activities.

2.36 There is a documented grievance procedure.

2.37 There is a mechanism to ensure that all staff are aware of industrial relations policies and procedures.

Finance

2.38 The hospital management is responsible for the efficient and effective use of the financial resources of the hospital.

2.39 There is a mechanism for developing budgets with the participation of appropriate staff.

2.40 Budgets exist at departmental or service level, as appropriate. These relate to the objectives of the department or service and to the overall budgetary programme of the hospital.

2.41 There is an internal accounting system which provides information on the current financial position of the hospital.

2.42 There are written policies and procedures for all accounting functions.

2.43 There is a mechanism for producing monthly budget statements to all designated budget holders.

2.44 The budget statement includes information to facilitate effective management of the ward/ service/department.

2.45 Each budget holder provides financial management reports to the hospital management.

2.46 These financial management reports are subject to periodic review to ensure their accuracy

Staffing

2.30 ☐ Y ☐ N ☐ Y ☐ N

2.31 ☐ Y ☐ N ☐ Y ☐ N

2.32 ☐ Y ☐ N ☐ Y ☐ N

2.33 ☐ Y ☐ N ☐ Y ☐ N

2.34 ☐ Y ☐ N ☐ Y ☐ N

Industrial Relations

2.35 ☐ Y ☐ N ☐ Y ☐ N

2.36 ☐ Y ☐ N ☐ Y ☐ N

2.37 ☐ Y ☐ N ☐ Y ☐ N

Finance

2.38 ☐ Y ☐ N ☐ Y ☐ N

2.39 ☐ Y ☐ N ☐ Y ☐ N

2.40 ☐ Y ☐ N ☐ Y ☐ N

2.41 ☐ Y ☐ N ☐ Y ☐ N

2.42 ☐ Y ☐ N ☐ Y ☐ N

2.43 ☐ Y ☐ N ☐ Y ☐ N

2.44 ☐ Y ☐ N ☐ Y ☐ N

2.45 ☐ Y ☐ N ☐ Y ☐ N

2.46 ☐ Y ☐ N ☐ Y ☐ N

Contract Services

2.47 There are written agreements covering the purchase and provision of services from external agencies to the hospital.

2.48 These services meet the appropriate standards in this manual.

2.49 There is documentation on contract services which ensures:

- 2.49.1 specification of formal lines of communication and responsibility between the service provider and the hospital
- 2.49.2 mechanisms for monitoring the quality of service
- 2.49.3 provision of services by people appropriately qualified to perform their duties
- 2.49.4 adequate pick up and delivery arrangements
- 2.49.5 participation of the provider in relevant committees of the hospital
- 2.49.6 arrangements for after hours and emergency services
- 2.49.7 mechanisms for dealing with problems in service delivery
- 2.49.8 adequacy of facilities and equipment for the service being provided both at the hospital and at the site of the external service
- 2.49.9 contract staff are made aware of local hospital policies, in particular emergency procedures

3. STAFF DEVELOPMENT AND EDUCATION

The hospital management is responsible for ensuring continuing education, orientation and in-service programmes for all levels of staff to maintain and develop their knowledge and skills, to meet the needs of the individual and the objectives of the hospital.

Standards

3.1 There is a planned orientation and induction programme for all categories of newly appointed staff and for staff transferring to a new department or role.

3.2 This programme is appropriate to the size of the hospital and includes:

- 3.2.1 information about the philosophy and objectives of the hospital
- 3.2.2 information about the relationship between the service and the total organisation of the hospital
- 3.2.3 preparation of staff for their role and responsibilities
- 3.2.4 explanation of lines of authority both within the service and within the hospital
- 3.2.5 explanation of the method used to evaluate staff performance
- 3.2.6 introduction of staff to the policies and procedures of the service and the hospital

Contract Services

2.47 ☐ Y ☐ N ☐ Y ☐ N

2.48 ☐ Y ☐ N ☐ Y ☐ N

2.49

2.49.1 ☐ Y ☐ N ☐ Y ☐ N

2.49.2 ☐ Y ☐ N ☐ Y ☐ N

2.49.3 ☐ Y ☐ N ☐ Y ☐ N

2.49.4 ☐ Y ☐ N ☐ Y ☐ N

2.49.5 ☐ Y ☐ N ☐ Y ☐ N

2.49.6 ☐ Y ☐ N ☐ Y ☐ N

2.49.7 ☐ Y ☐ N ☐ Y ☐ N

2.49.8 ☐ Y ☐ N ☐ Y ☐ N

2.49.9 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The hospital management is responsible for ensuring continuing education, orientation and in-service programmes for all levels of staff to maintain and develop their knowledge and skills, to meet the needs of the individual and the objectives of the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.2.4 ☐ Y ☐ N		☐ Y ☐ N	
3.2.5 ☐ Y ☐ N		☐ Y ☐ N	
3.2.6 ☐ Y ☐ N		☐ Y ☐ N	

3.2.7 explanation of emergency procedures (for example, fire drill)

3.2.8 provision of information on the occupational health service offered to staff

3.3 As a minimum the continuing education programme:

3.3.1 utilises professional and other resource material

3.3.2 supports and encourages relevant research

3.3.3 provides information on educational opportunities arranged by other institutions

3.3.4 provides orientation to new areas

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.7 There are mechanisms to inform staff of programmes being offered within the hospital.

4. POLICIES AND PROCEDURES

The hospital management ensures that dated, written, signed policies and procedures are available to support activities and to guide all staff, patients and visitors on the functions and responsibilities of the hospital.

Standards

4.1 There is evidence that in determining policies and procedures the hospital management considers the relevant influences both internal and external to the hospital.

4.2 Policies and procedures are:

4.2.1 written in a clear and intelligible style

4.2.2 determined on the basis of sound information and consultation

4.2.3 recorded in relevant minutes

4.2.4 able to guide those making decisions

4.2.5 capable of implementation

4.2.6 not in conflict with any statutory requirements

4.2.7 compiled into a comprehensive policy manual

3.2.7 ☐ Y ☐ N ☐ Y ☐ N

3.2.8 ☐ Y ☐ N ☐ Y ☐ N

3.3

3.3.1 ☐ Y ☐ N ☐ Y ☐ N

3.3.2 ☐ Y ☐ N ☐ Y ☐ N

3.3.3 ☐ Y ☐ N ☐ Y ☐ N

3.3.4 ☐ Y ☐ N ☐ Y ☐ N

3.4 ☐ Y ☐ N ☐ Y ☐ N

3.5 ☐ Y ☐ N ☐ Y ☐ N

3.6 ☐ Y ☐ N ☐ Y ☐ N

3.7 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

The hospital management ensures that dated, written, signed policies and procedures are available to support activities and to guide all staff, patients and visitors on the functions and responsibilities of the hospital.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2			
4.2.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2.2 ☐ Y ☐ N		☐ Y ☐ N	
4.2.3 ☐ Y ☐ N		☐ Y ☐ N	
4.2.4 ☐ Y ☐ N		☐ Y ☐ N	
4.2.5 ☐ Y ☐ N		☐ Y ☐ N	
4.2.6 ☐ Y ☐ N		☐ Y ☐ N	
4.2.7 ☐ Y ☐ N		☐ Y ☐ N	

4.3 Policies and procedures are developed for at least the following:

- 4.3.1 allocation of resources
- 4.3.2 complaints (for patients and staff) in accordance with HC(88)37, Hospital Complaints Procedures
- 4.3.3 confidentiality of information
- 4.3.4 information systems
- 4.3.5 personnel and conditions of service
- 4.3.6 purchasing
- 4.3.7 review of organisation and structures
- 4.3.8 review of use of resources

Admissions / Discharge

4.4 There is a policy for admission procedures which covers:

- 4.4.1 information given to patients pre-admission and on admission
- 4.4.2 routine admissions
- 4.4.3 emergency admissions
- 4.4.4 conditions for refusing admissions
- 4.4.5 arrangements when admissions are refused
- 4.4.6 cancellation of routine admissions

4.5 There is a mechanism to ensure that all staff are aware of admissions policy and procedure.

4.6 All admissions are authorised by a member of the medical staff.

4.7 There is a mechanism for monitoring admissions and cancellations.

4.8 There is an admissions manager, or a person designated to act as admissions manager.

4.9 There is a designated deputy to act in the absence of the admissions manager.

4.10 There is a policy for the safe discharge of patients which covers:

- 4.10.1 information given to patients and/or carers
- 4.10.2 liaison with community services
- 4.10.3 transport

4.3

4.3.1 ☐ Y ☐ N ☐ Y ☐ N

4.3.2 ☐ Y ☐ N ☐ Y ☐ N

4.3.3 ☐ Y ☐ N ☐ Y ☐ N

4.3.4 ☐ Y ☐ N ☐ Y ☐ N

4.3.5 ☐ Y ☐ N ☐ Y ☐ N

4.3.6 ☐ Y ☐ N ☐ Y ☐ N

4.3.7 ☐ Y ☐ N ☐ Y ☐ N

4.3.8 ☐ Y ☐ N ☐ Y ☐ N

Admissions / Discharge

4.4

4.4.1 ☐ Y ☐ N ☐ Y ☐ N

4.4.2 ☐ Y ☐ N ☐ Y ☐ N

4.4.3 ☐ Y ☐ N ☐ Y ☐ N

4.4.4 ☐ Y ☐ N ☐ Y ☐ N

4.4.5 ☐ Y ☐ N ☐ Y ☐ N

4.4.6 ☐ Y ☐ N ☐ Y ☐ N

4.5 ☐ Y ☐ N ☐ Y ☐ N

4.6 ☐ Y ☐ N ☐ Y ☐ N

4.7 ☐ Y ☐ N ☐ Y ☐ N

4.8 ☐ Y ☐ N ☐ Y ☐ N

4.9 ☐ Y ☐ N ☐ Y ☐ N

4.10

4.10.1 ☐ Y ☐ N ☐ Y ☐ N

4.10.2 ☐ Y ☐ N ☐ Y ☐ N

4.10.3 ☐ Y ☐ N ☐ Y ☐ N

Major Incident Plans

The hospital has written plans to deal with internal and, where applicable, external incidents and accidents. Plans are co-ordinated with other local emergency and voluntary services as appropriate.

(External)

4.11 The hospital has an external major incident, all hazards plan based on its capabilities. It is recognised that not all hospitals will have a role in external major incident response.

4.12 The incident plan is developed in consultation with:

- 4.12.1 emergency services
- 4.12.2 representatives of other health service agencies
- 4.12.3 local authorities
- 4.12.4 voluntary agencies

4.13 The scope of the hospital's role and resources is made known to:

- 4.13.1 local police
- 4.13.2 fire brigade
- 4.13.3 ambulance teams
- 4.13.4 local authority
- 4.13.5 voluntary agencies

4.14 The major incident plan provides for:

- 4.14.1 consideration of the type of incidents likely to occur
- 4.14.2 defined authority and control
- 4.14.3 an efficient system of notifying staff
- 4.14.4 availability of essential medical and support materials
- 4.14.5 assignment of staff to specific tasks and responsibilities
- 4.14.6 visual identification for staff involved in the plan
- 4.14.7 conversion of all appropriate space into clearly defined areas for efficient triage, for patient observation and for immediate care
- 4.14.8 clear signposting of emergency areas
- 4.14.9 maintaining security in order to keep unauthorised persons from the triage area
- 4.14.10 arrangements for the prompt discharge or transfer of current in-patients who can be moved without harm
- 4.14.11 making available a list of casualties

Major Incident Plans

The hospital has written plans to deal with internal and, where applicable, external incidents and accidents. Plans are co-ordinated with other local emergency and voluntary services as appropriate.

(External)

4.11 ☐ Y ☐ N ☐ Y ☐ N

4.12

4.12.1 ☐ Y ☐ N ☐ Y ☐ N
4.12.2 ☐ Y ☐ N ☐ Y ☐ N
4.12.3 ☐ Y ☐ N ☐ Y ☐ N
4.12.4 ☐ Y ☐ N ☐ Y ☐ N

4.13

4.13.1 ☐ Y ☐ N ☐ Y ☐ N
4.13.2 ☐ Y ☐ N ☐ Y ☐ N
4.13.3 ☐ Y ☐ N ☐ Y ☐ N
4.13.4 ☐ Y ☐ N ☐ Y ☐ N
4.13.5 ☐ Y ☐ N ☐ Y ☐ N

4.14

4.14.1 ☐ Y ☐ N ☐ Y ☐ N
4.14.2 ☐ Y ☐ N ☐ Y ☐ N
4.14.3 ☐ Y ☐ N ☐ Y ☐ N
4.14.4 ☐ Y ☐ N ☐ Y ☐ N
4.14.5 ☐ Y ☐ N ☐ Y ☐ N
4.14.6 ☐ Y ☐ N ☐ Y ☐ N
4.14.7 ☐ Y ☐ N ☐ Y ☐ N

4.14.8 ☐ Y ☐ N ☐ Y ☐ N
4.14.9 ☐ Y ☐ N ☐ Y ☐ N
4.14.10 ☐ Y ☐ N ☐ Y ☐ N

4.14.11 ☐ Y ☐ N ☐ Y ☐ N

4.14.12 appropriately designed tags to accompany each casualty

4.14.13 transportation arrangements for prompt transfer of casualties when necessary to the appropriate hospital, after emergency medical or surgical care has been given

4.14.14 facilities for viewing and identifying those brought in dead

4.14.15 mortuary facilities

4.14.16 availability of basic utilities and supplies including gas, water, electricity, food

4.14.17 effective communication systems within and outside the hospital

4.14.18 the establishment of a public information centre

4.14.19 assignment of public relations duties to a suitable person

4.14.20 a media communications plan to provide organised dissemination of information

4.14.21 de-briefing and review of major incident plan procedures

4.15 All staff are aware of their role in the event of a major incident.

4.16 All staff are issued with written details of their role in the event of a major incident.

4.17 The external major incident plan is rehearsed in some form at least once a year.

4.18 The rehearsal is part of a co-ordinated practice in which other emergency services participate. However, if this is not practicable, at least the local aspects of the plan are rehearsed.

4.19 Practices must involve the medical, nursing, management and other staff as appropriate.

4.20 There is a written report and evaluation of each practice.

4.21 There is a written report and evaluation of any major incident.

4.22 Plans are reviewed annually and revised as necessary.

4.23 Each department in the hospital is made aware of its function and prepares an action plan.

(Internal)

4.24 Plans for fire, internal incidents and emergency situations include evacuation procedures and are developed with the assistance of qualified fire, safety and other appropriate experts. Emergency situations may include:

4.24.1 bomb threats

4.24.2 drug demands

4.24.3 provision of medical services in areas other than wards (for example, kitchens, laundry, workshops)

4.24.4 explosion

4.24.5 loss of vital services

4.14.12 ☐ Y ☐ N ☐ Y ☐ N

4.14.13 ☐ Y ☐ N ☐ Y ☐ N

4.14.14 ☐ Y ☐ N ☐ Y ☐ N

4.14.15 ☐ Y ☐ N ☐ Y ☐ N

4.14.16 ☐ Y ☐ N ☐ Y ☐ N

4.14.17 ☐ Y ☐ N ☐ Y ☐ N

4.14.18 ☐ Y ☐ N ☐ Y ☐ N

4.14.19 ☐ Y ☐ N ☐ Y ☐ N

4.14.20 ☐ Y ☐ N ☐ Y ☐ N

4.14.21 ☐ Y ☐ N ☐ Y ☐ N

4.15 ☐ Y ☐ N ☐ Y ☐ N

4.16 ☐ Y ☐ N ☐ Y ☐ N

4.17 ☐ Y ☐ N ☐ Y ☐ N

4.18 ☐ Y ☐ N ☐ Y ☐ N

4.19 ☐ Y ☐ N ☐ Y ☐ N

4.20 ☐ Y ☐ N ☐ Y ☐ N

4.21 ☐ Y ☐ N ☐ Y ☐ N

4.22 ☐ Y ☐ N ☐ Y ☐ N

4.23 ☐ Y ☐ N ☐ Y ☐ N

(Internal)

4.24 ☐ Y ☐ N ☐ Y ☐ N

4.24.1 ☐ Y ☐ N ☐ Y ☐ N

4.24.2 ☐ Y ☐ N ☐ Y ☐ N

4.24.3 ☐ Y ☐ N ☐ Y ☐ N

4.24.4 ☐ Y ☐ N ☐ Y ☐ N

4.25 Plans include:

4.25.1 the assignment of personnel to specific tasks and responsibilities

4.25.2 instructions for the use of alarm systems and signals

4.25.3 information concerning methods of fire containment

4.25.4 information concerning the location of fire fighting equipment

4.25.5 systems for notification of appropriate persons

4.25.6 specification of evacuation routes and procedures

4.25.7 other provisions as the local situation dictates

4.26 Plans are reviewed annually and revised as necessary.

4.27 Staff are familiar with incident plans which are readily available and displayed throughout the hospital.

4.28 Practices for all internal incidents are held at least annually for day and night staff and under varied conditions in order to:

4.28.1 ensure that all staff are provided with training to enable performance of assigned tasks

4.28.2 evaluate the effectiveness of the plan

4.29 There is a mechanism to ensure that all staff attend internal incident practices.

4.30 A record of attendance at practices is maintained.

4.31 There is a written report and evaluation of all practices.

4.32 There is a written report and evaluation of all incidents.

4.33 Policies and procedures are contained within a manual which as a minimum is:

4.33.1 regularly reviewed (annually) and updated

4.33.2 readily accessible for reference

4.34 Mechanisms exist to ensure that policies and procedures are widely communicated throughout the hospital.

4.35 The hospital management regularly monitors the activities of the hospital to ensure that they are consistent with written policies.

4.25

4.25.1 ☐ Y ☐ N ☐ Y ☐ N

4.25.2 ☐ Y ☐ N ☐ Y ☐ N

4.25.3 ☐ Y ☐ N ☐ Y ☐ N

4.25.4 ☐ Y ☐ N ☐ Y ☐ N

4.25.5 ☐ Y ☐ N ☐ Y ☐ N

4.25.6 ☐ Y ☐ N ☐ Y ☐ N

4.25.7 ☐ Y ☐ N ☐ Y ☐ N

4.26 ☐ Y ☐ N ☐ Y ☐ N

4.27 ☐ Y ☐ N ☐ Y ☐ N

4.28 ☐ Y ☐ N ☐ Y ☐ N

4.28.1 ☐ Y ☐ N ☐ Y ☐ N

4.28.2 ☐ Y ☐ N ☐ Y ☐ N

4.29 ☐ Y ☐ N ☐ Y ☐ N

4.30 ☐ Y ☐ N ☐ Y ☐ N

4.31 ☐ Y ☐ N ☐ Y ☐ N

4.32 ☐ Y ☐ N ☐ Y ☐ N

4.33 ☐ Y ☐ N ☐ Y ☐ N

4.33.1 ☐ Y ☐ N ☐ Y ☐ N

4.33.2 ☐ Y ☐ N ☐ Y ☐ N

4.34 ☐ Y ☐ N ☐ Y ☐ N

4.35 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The hospital management has overall responsibility for the provision of facilities and equipment to enable the achievement of the hospital objectives, in keeping with its business plan and to support patient care.

Standards

5.1 The hospital management is responsible for the maintenance of the facilities and equipment of the hospital.

5.2 The facilities and equipment available enable both clinical and diagnostic services to carry out their duties.

5.3 There is provision for access to facilities for wheelchairs.

5.4 There is provision for those with visual or hearing impairment.

5.5 There is a planned preventative maintenance programme for all facilities and equipment, in accordance with HEI(98) 1982, Management of Equipment.

5.6 There is a planned up-grading and replacement programme for all facilities and equipment.

5.7 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. PATIENTS' RIGHTS AND SPECIAL NEEDS

Standards

Care of the Terminally Ill Patient

6.1 The physical, emotional, spiritual and social needs of terminally ill patients and their relatives are recognised and catered for.

6.2 Families and carers are encouraged to participate in the care of patients.

6.3 Consideration is given to the special needs of family and staff caring for the terminally ill patient.

6.4 Educational opportunities are provided for staff and volunteers.

6.5 Facilities for overnight stays are made available to relatives and carers.

5. FACILITIES AND EQUIPMENT

The hospital management has overall responsibility for the provision of facilities and equipment to enable the achievement of the hospital objectives, in keeping with its business plan and to support patient care.

Standards		Comment		Comment
5.1	☐ Y ☐ N		☐ Y ☐ N	
5.2	☐ Y ☐ N		☐ Y ☐ N	
5.3	☐ Y ☐ N		☐ Y ☐ N.	
5.4	☐ Y ☐ N		☐ Y ☐ N	
5.5	☐ Y ☐ N		☐ Y ☐ N	
5.6	☐ Y ☐ N		☐ Y ☐ N	
5.7	☐ Y ☐ N		☐ Y ☐ N	

6. PATIENTS' RIGHTS AND SPECIAL NEEDS

Standards		Comment		Comment
Care of the Terminally Ill Patient				
6.1	☐ Y ☐ N		☐ Y ☐ N	
6.2	☐ Y ☐ N		☐ Y ☐ N	
6.3	☐ Y ☐ N		☐ Y ☐ N	
6.4	☐ Y ☐ N		☐ Y ☐ N	
6.5	☐ Y ☐ N		☐ Y ☐ N	

Chaplaincy and Pastoral Care

6.6 All patients, relatives and staff in the hospital have access to pastoral care and the minister of religion of their choice for personal attention, spiritual ministration and counselling.

6.7 Pastoral services are provided by authorised chaplains, visiting clergy and pastoral workers.

6.8 There is a written hospital plan which details and authorises chaplains, visiting clergy and pastoral workers to have access to patients, relatives and staff.

6.9 The plan describes their organisational relationship with the hospital.

6.10 Provision of pastoral care is facilitated by making the following available to chaplains, visiting clergy and pastoral workers:

- 6.10.1 access to in-service education programmes as appropriate
- 6.10.2 involvement, where appropriate, in clinical discussion and the therapeutic programme
- 6.10.3 a quiet area set aside for worship and meditation
- 6.10.4 access to normal staff facilities

Children

6.11 There is recognition of the special emotional needs of children in hospital, in line with guidelines issued by NAWCH.

6.12 When presenting to a hospital children are protected from sights and sounds which may be distressing to them. *(See Accident and Emergency section of this manual.)*

6.13 Where children are treated in hospitals which are not designated paediatric hospitals, a separate area is assigned to them.

6.14 A registered sick children's nurse is available to care for children admitted to the hospital.

6.15 Parental participation in the care of their child is positively encouraged, including open visiting hours and provision for parents or parent-substitutes to stay with the child.

6.16 There are arrangements for the preparation of parents and their child prior to non-urgent admissions.

6.17 There are arrangements for the education of children who are admitted for long periods.

6.18 A suitably experienced or qualified staff member is designated for play activities. The person may have this responsibility in addition to other duties, or a staff member may be employed specifically for this purpose.

6.19 The special needs of the unaccompanied child are recognised and catered for.

Chaplaincy and Pastoral Care

6.6 ☐ Y ☐ N ☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10

6.10.1 ☐ Y ☐ N ☐ Y ☐ N

6.10.2 ☐ Y ☐ N ☐ Y ☐ N

6.10.3 ☐ Y ☐ N ☐ Y ☐ N

6.10.4 ☐ Y ☐ N ☐ Y ☐ N

Children

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

6.15 ☐ Y ☐ N ☐ Y ☐ N

6.16 ☐ Y ☐ N ☐ Y ☐ N

6.17 ☐ Y ☐ N ☐ Y ☐ N

6.18 ☐ Y ☐ N ☐ Y ☐ N

6.19 ☐ Y ☐ N ☐ Y ☐ N

6.20 All hospitals which admit children ensure that appropriate equipment and medication are available. Special attention is drawn to:

6.20.1 anaesthetic equipment

6.20.2 inhalation therapy equipment

6.20.3 paediatric size needles, cannulae and other intravenous equipment

6.20.4 paediatric infusion sets

6.20.5 resuscitation equipment

6.21 Policies are established regarding performance of anaesthesia and surgery on young children, which cover accompaniment by parents.

Ethics

6.22 A mechanism exists for the consideration of ethical issues, prevention of harm to patients and the implementation of resulting policies.

6.23 There is a multi-disciplinary approach to the consideration of ethical issues.

6.24 A mechanism exists to assist staff and families dealing with ethical dilemmas.

Care for Cultural Groups

6.25 Interpreter services are available and made known to patients and staff.

6.26 The language used by the patient (if it is other than English) is prominently recorded on the patient's record.

6.27 Translated health promotion material, hospital information and hospital forms, for example, consent forms, are available and used where required.

6.28 In cases of emergency or after hours, where a professional interpreter is not available, a telephone interpreter service is used and the interpreter called in as soon as possible to communicate with the patient.

6.29 Staff members who may act as non-professional interpreters are assessed and trained.

Rights and Privacy

6.30 There are written standards which describe the rights of patients which are made known to patients and staff.

6.31 Such standards address the following issues:

6.31.1 respect of personal dignity in the provision of care and treatment

6.31.2 protection of personal privacy within the constraints of the individual treatment plan

6.20 ☐ Y ☐ N ☐ Y ☐ N

6.20.1 ☐ Y ☐ N ☐ Y ☐ N

6.20.2 ☐ Y ☐ N ☐ Y ☐ N

6.20.3 ☐ Y ☐ N ☐ Y ☐ N

6.20.4 ☐ Y ☐ N ☐ Y ☐ N

6.20.5 ☐ Y ☐ N ☐ Y ☐ N

6.21 ☐ Y ☐ N ☐ Y ☐ N

Ethics

6.22 ☐ Y ☐ N ☐ Y ☐ N

6.23 ☐ Y ☐ N ☐ Y ☐ N

6.24 ☐ Y ☐ N ☐ Y ☐ N

Care for Cultural Groups

6.25 ☐ Y ☐ N ☐ Y ☐ N

6.26 ☐ Y ☐ N ☐ Y ☐ N

6.27 ☐ Y ☐ N ☐ Y ☐ N

6.28 ☐ Y ☐ N ☐ Y ☐ N

6.29 ☐ Y ☐ N ☐ Y ☐ N

Rights and Privacy

6.30 ☐ Y ☐ N ☐ Y ☐ N

6.31

6.31.1 ☐ Y ☐ N ☐ Y ☐ N

6.31.2 ☐ Y ☐ N ☐ Y ☐ N

6.31.3 confidentiality of all information recorded in patients' medical records, including information communicated to patients' friends/relatives or to other staff

6.31.4 confidentiality between staff and patients

6.31.5 right to refuse service or treatment

6.31.6 right to seek a second opinion

6.31.7 complaints procedure in accordance with HC(88)37, Hospital Complaints Procedures

6.31.8 speedy and full investigation of patient complaints

6.31.9 special emotional and physical needs of various patient groups such as children, the elderly and mentally ill people

6.31.10 requirements of those with hearing or visual impairment

6.31.11 information given to patients concerning the nature of their medical condition and any treatment, investigation or procedure

6.31.12 patient access to and communication with people outside the hospital

6.31.13 special attention to patients who have no social support

6.32 There are policies and procedures on obtaining informed consent for:

6.32.1 anaesthesia

6.32.2 surgical procedures

6.32.3 electro-convulsive therapy

6.32.4 unusual medications

6.32.5 hazardous assessment procedures

6.32.6 participation in teaching exercises

6.32.7 participation in any research project

6.32.8 photographic and audiovisual recording

6.32.9 other procedures where consent is required by law

6.33 Patients have the right to expect that all safety requirements are enforced in relation to the hospital's environment and procedures.

Seclusion and Restraint

6.34 Standards exist which comply with relevant legislation and cover seclusion or restraint of a patient.

6.35 A review of all uses of restraint or seclusion is carried out.

6.36 No undue physical discomfort is to be caused to the patient.

6.37 All restraints are authorised by the attendant doctor and recorded in the medical record.

6.31.3 ☐ Y ☐ N ☐ Y ☐ N

6.31.4 ☐ Y ☐ N ☐ Y ☐ N

6.31.5 ☐ Y ☐ N ☐ Y ☐ N

6.31.6 ☐ Y ☐ N ☐ Y ☐ N

6.31.7 ☐ Y ☐ N ☐ Y ☐ N

6.31.8 ☐ Y ☐ N ☐ Y ☐ N

6.31.9 ☐ Y ☐ N ☐ Y ☐ N

6.31.10 ☐ Y ☐ N ☐ Y ☐ N

6.31.11 ☐ Y ☐ N ☐ Y ☐ N

6.31.12 ☐ Y ☐ N ☐ Y ☐ N

6.31.13 ☐ Y ☐ N ☐ Y ☐ N

6.32

6.32.1 ☐ Y ☐ N ☐ Y ☐ N

6.32.2 ☐ Y ☐ N ☐ Y ☐ N

6.32.3 ☐ Y ☐ N ☐ Y ☐ N

6.32.4 ☐ Y ☐ N ☐ Y ☐ N

6.32.5 ☐ Y ☐ N ☐ Y ☐ N

6.32.6 ☐ Y ☐ N ☐ Y ☐ N

6.32.7 ☐ Y ☐ N ☐ Y ☐ N

6.32.8 ☐ Y ☐ N ☐ Y ☐ N

6.32.9 ☐ Y ☐ N ☐ Y ☐ N

6.33 ☐ Y ☐ N ☐ Y ☐ N

Seclusion and Restraint

6.34 ☐ Y ☐ N ☐ Y ☐ N

6.35 ☐ Y ☐ N ☐ Y ☐ N

6.36 ☐ Y ☐ N ☐ Y ☐ N

6.37 ☐ Y ☐ N ☐ Y ☐ N

7. EVALUATION AND QUALITY ASSURANCE

The hospital management has overall responsibility for ensuring the development and implementation of an effective evaluation and quality assurance programme throughout the hospital.

Standards

7.1 There is a written quality assurance plan for the whole hospital.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The quality assurance plan is developed in consultation with representatives of the medical, nursing, paramedical and other hospital staff.

7.4 The hospital management is responsible for and provides the necessary resources to support the evaluation and quality assurance programme for the hospital.

7.5 The quality assurance plan details:

- 7.5.1 objectives of the plan
- 7.5.2 methods to achieve these objectives
- 7.5.3 individuals or team/committee responsible for conducting activities
- 7.5.4 implementation plan
- 7.5.5 evaluation of the impact of the programme

7.6 The evaluation activities include the following elements:

- 7.6.1 monitoring: the routine collection of information about important aspects of delivery of services
- 7.6.2 assessment: the periodic assessment of this information in order to identify problems and to improve service delivery
- 7.6.3 action: when problems or opportunities to improve service delivery are identified, action is taken and documented
- 7.6.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 7.6.5 feedback: the results of activities are communicated to the staff

7.7 Evaluation meetings are held on a regular basis.

7.8 Records of attendance and minutes of evaluation meetings are kept which accurately reflect the conclusions recommendations, action taken and results of action taken.

7.9 Clinical audit meetings are encouraged and supported by hospital management.

7. EVALUATION AND QUALITY ASSURANCE

The hospital management has overall responsibility for ensuring the development and implementation of an effective evaluation and quality assurance programme throughout the hospital.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4 ☐ Y ☐ N		☐ Y ☐ N	
7.5			
7.5.1 ☐ Y ☐ N		☐ Y ☐ N	
7.5.2 ☐ Y ☐ N		☐ Y ☐ N	
7.5.3 ☐ Y ☐ N		☐ Y ☐ N	
7.5.4 ☐ Y ☐ N		☐ Y ☐ N	
7.5.5 ☐ Y ☐ N		☐ Y ☐ N	
7.6			
7.6.1 ☐ Y ☐ N		☐ Y ☐ N	
7.6.2 ☐ Y ☐ N		☐ Y ☐ N	
7.6.3 ☐ Y ☐ N		☐ Y ☐ N	
7.6.4 ☐ Y ☐ N		☐ Y ☐ N	
7.6.5 ☐ Y ☐ N		☐ Y ☐ N	
7.7 ☐ Y ☐ N		☐ Y ☐ N	
7.8 ☐ Y ☐ N		☐ Y ☐ N	
7.9 ☐ Y ☐ N		☐ Y ☐ N	

7.10 The hospital management is responsible for ensuring the timely completion of Korner returns.

7.11 Statistics collected are used to effect management/practice change.

7.12 The hospital management receives feedback on the evaluation and quality assurance programmes throughout the hospital and acts on recommendations.

7.10 ☐ Y ☐ N

7.11 ☐ Y ☐ N

7.12 ☐ Y ☐ N

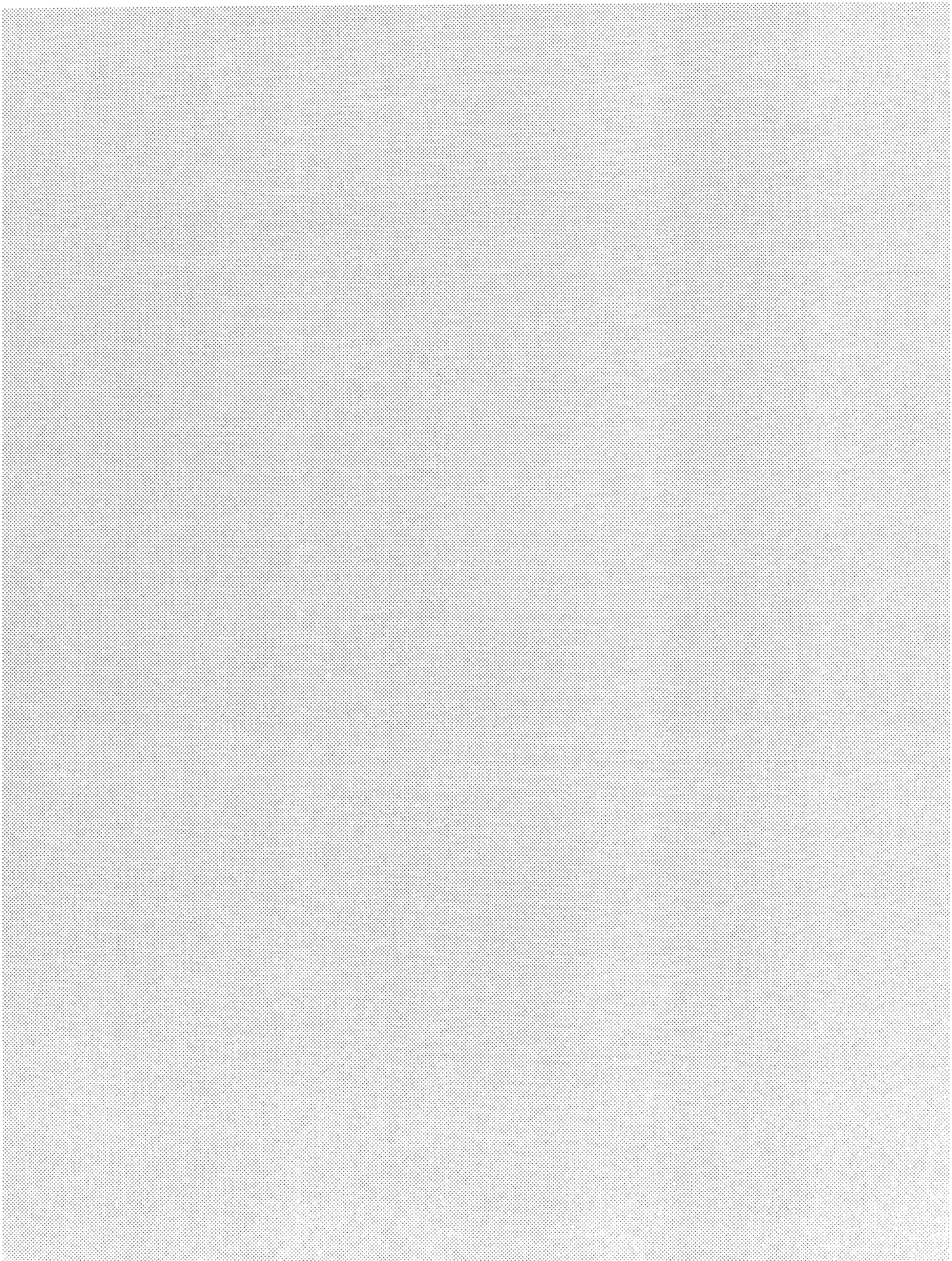
☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

HOSPITAL MANAGEMENT

Surveyor's General Comments



HOSPITAL MANAGEMENT

Surveyor's Comments

Standard Number	Recommendation

CATERING SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

CATERING SERVICE

PREAMBLE

This chapter refers to the catering service provided for patients, their relatives and hospital staff. This service may be provided by one or more departments. If it is provided by an external agency the contract includes compliance with these standards.

1. PHILOSOPHY AND OBJECTIVES

The catering department is responsible for providing a high quality service to patients, staff and visitors and for the ethical and professional practices of its staff.

Standards

1.1 Staff within the catering department develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the catering department develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the catering service.

1.3 The objectives for the service include at least the following:

- 1.3.1 providing patients and staff with a quality service
- 1.3.2 providing patients and staff with a quality service based on established professional standards
- 1.3.3 providing and maintaining a high quality service through analysis, review and evaluation of activities
- 1.3.4 ensuring patient and staff safety
- 1.3.5 maintaining effective communication with other members of the healthcare team to:
  - (a) meet patient needs
  - (b) enable co-ordination of services
- 1.3.6 health promotion

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

- 1.4.1 be courteous and considerate to patients and their carers at all times
- 1.4.2 respect patients' privacy and dignity and that of their carers
- 1.4.3 respect and cater for cultural and religious dietary requirements
- 1.4.4 respond to communication difficulties

CATERING SERVICE

PREAMBLE

This chapter refers to the catering service provided for patients, their relatives and hospital staff. This service may be provided by one or more departments. If it is provided by an external agency the contract includes compliance with these standards.

1. PHILOSOPHY AND OBJECTIVES

The catering department is responsible for providing a high quality service to patients, staff and visitors and for the ethical and professional practices of its staff.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.3.6 ☐ Y ☐ N		☐ Y ☐ N	
1.4 ☐ Y ☐ N		☐ Y ☐ N	
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4.4 ☐ Y ☐ N		☐ Y ☐ N	

1.5 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.5.1 the role of the hospital

1.5.2 the provision of services

1.5.3 the pattern of delivery of service

1.5.4 staffing patterns

1.5.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The catering service is organised, managed and staffed to provide a high quality service for patients and staff, in accordance with the objectives of the hospital and the needs of the people served.

Standards

2.1 The service is managed by an appropriately qualified person.

2.2 There is a close working relationship and co-operation with the dietetic service.

2.3 The manager of the service is involved in the preparation of the service's budget.

2.4 The manager is responsible for the efficient and effective management of the service's budget.

2.5 Reports of budget expenditure are communicated to budget holders at set intervals throughout the year.

2.6 The budget reports are accurate.

2.7 Records and statistics are available for the effective management of the service which as a minimum include:

2.7.1 ratio of staff to workload

2.7.2 staff absentee rate

2.7.3 staff sickness rate

2.7.4 staff turnover rate

2.8 Regular staff meetings are held to:

2.8.1 maintain good communications

2.8.2 review service practices

2.9 Minutes of these meetings are kept.

1.5

1.5.1 ☐ Y ☐ N ☐ Y ☐ N
1.5.2 ☐ Y ☐ N ☐ Y ☐ N
1.5.3 ☐ Y ☐ N ☐ Y ☐ N
1.5.4 ☐ Y ☐ N ☐ Y ☐ N
1.5.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The catering service is organised, managed and staffed to provide a high quality service for patients and staff, in accordance with the objectives of the hospital and the needs of the people served.

Standards	Comment		Comment
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7			
2.7.1 ☐ Y ☐ N		☐ Y ☐ N	
2.7.2 ☐ Y ☐ N		☐ Y ☐ N	
2.7.3 ☐ Y ☐ N		☐ Y ☐ N	
2.7.4 ☐ Y ☐ N		☐ Y ☐ N	
2.8			
2.8.1 ☐ Y ☐ N		☐ Y ☐ N	
2.8.2 ☐ Y ☐ N		☐ Y ☐ N	
2.9 ☐ Y ☐ N		☐ Y ☐ N	

2.10 Staff are informed of the outcomes of these meetings.

2.11 The catering service is involved in the development of hospital policies and procedures, where appropriate.

2.12 The manager is responsible for ensuring that catering arrangements exist for all staff working shifts (day and night).

2.13 Catering services are available for relatives detained in the hospital, for example, parents of children, relatives/carers of critically or terminally ill patients.

Personnel

2.14 Written and dated job descriptions are available for all posts, which specify at least the following:

- 2.14.1 job title and grade
- 2.14.2 qualifications and/or experience required for the post
- 2.14.3 functions, responsibilities and accountability
- 2.14.4 frequency and type of staff appraisal
- 2.14.5 review date

2.15 A documented staff appraisal system exists for all staff.

2.16 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.17 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.18 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.19 Staffing is calculated and allocated on the basis of workload.

2.20 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.21 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.22 The organisational chart is reviewed annually, revised and dated.

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.14

- 2.14.1 ☐ Y ☐ N ☐ Y ☐ N
- 2.14.2 ☐ Y ☐ N ☐ Y ☐ N
- 2.14.3 ☐ Y ☐ N ☐ Y ☐ N
- 2.14.4 ☐ Y ☐ N ☐ Y ☐ N
- 2.14.5 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 Staff are supported in the delivery of care by the following personnel:

2.23.1 administrative

2.23.2 ancillary

2.23.3 secretarial

2.24 Work schedules provide guidance to employees in the performance of their duties.

3. STAFF DEVELOPMENT AND EDUCATION

The catering service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the service

3.1.3 explains relationships within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 explains the method used to evaluate staff performance

3.1.7 introduces staff to the policies and procedures of the service and the hospital

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.2 As a minimum the continuing education programme:

3.2.1 utilises professional and other resource material

3.2.2 supports and encourages relevant research

3.2.3 provides information on advances in practice related to the service

3.2.4 provides information on educational opportunities arranged by other institutions

3.2.5 provides orientation to new service areas

3.3 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.4 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

2.23		
2.23.1	☐ Y ☐ N	☐ Y ☐ N
2.23.2	☐ Y ☐ N	☐ Y ☐ N
2.23.3	☐ Y ☐ N	☐ Y ☐ N
2.24	☐ Y ☐ N	☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The catering service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.2	☐ Y ☐ N	☐ Y ☐ N	
3.1.3	☐ Y ☐ N	☐ Y ☐ N	
3.1.4	☐ Y ☐ N	☐ Y ☐ N	
3.1.5	☐ Y ☐ N	☐ Y ☐ N	
3.1.6	☐ Y ☐ N	☐ Y ☐ N	
3.1.7	☐ Y ☐ N	☐ Y ☐ N	
3.1.8	☐ Y ☐ N	☐ Y ☐ N	
3.1.9	☐ Y ☐ N	☐ Y ☐ N	
3.2			
3.2.1	☐ Y ☐ N	☐ Y ☐ N	
3.2.2	☐ Y ☐ N	☐ Y ☐ N	
3.2.3	☐ Y ☐ N	☐ Y ☐ N	
3.2.4	☐ Y ☐ N	☐ Y ☐ N	
3.2.5	☐ Y ☐ N	☐ Y ☐ N	
3.3	☐ Y ☐ N	☐ Y ☐ N	
3.4	☐ Y ☐ N	☐ Y ☐ N	

3.5 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

4. POLICIES AND PROCEDURES

Written and updated policies and procedures are developed to guide the service and support staff which are consistent with relevant regulations and reflect current knowledge and principles for a catering department.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the catering service.

4.2 Policies and procedures are agreed by the hospital management, dietitian and the catering manager, which reflect the requirements of the Food Bill.

4.3 Policies and procedures comply with the Department of Health Publications, "Hygiene" for managers, and "Clean Food" for staff (HC(84)14).

4.4 Staff are actively involved in the formulation of policies and procedures.

4.5 When policies and procedures are developed, attention is drawn to practice in other fields, for example, dietetics, infection control, and occupational health.

4.6 Policies and procedures are consistent with those of the hospital.

4.7 There are policies, which are documented and followed, for:

- 4.7.1 fire precautions
- 4.7.2 procedure in the case of a major catering emergency
- 4.7.3 safety

4.8 Fire drills are held at regular and frequent intervals.

4.9 A stock control system facilitates ordering and stocktaking and deters pilfering.

4.10 There are documented policies for the storage and handling of food. Attention is drawn to the following:

- 4.10.1 quality and quantity of food supplies are checked
- 4.10.2 temperature is appropriate to food being stored
- 4.10.3 storage facilities are clean, hygienic and odour free
- 4.10.4 rotation of stock ensures use within "use-by" date
- 4.10.5 preparation and handling of food is carried out in accordance with food hygiene regulations

3.5 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

Written and updated policies and procedures are developed to guide the service and support staff which are consistent with relevant regulations and reflect current knowledge and principles for a catering department.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6 ☐ Y ☐ N		☐ Y ☐ N	
4.7			
4.7.1 ☐ Y ☐ N		☐ Y ☐ N	
4.7.2 ☐ Y ☐ N		☐ Y ☐ N	
4.7.3 ☐ Y ☐ N		☐ Y ☐ N	
4.8 ☐ Y ☐ N		☐ Y ☐ N	
4.9 ☐ Y ☐ N		☐ Y ☐ N	
4.10 ☐ Y ☐ N		☐ Y ☐ N	
4.10.1 ☐ Y ☐ N		☐ Y ☐ N	
4.10.2 ☐ Y ☐ N		☐ Y ☐ N	
4.10.3 ☐ Y ☐ N		☐ Y ☐ N	
4.10.4 ☐ Y ☐ N		☐ Y ☐ N	
4.10.5 ☐ Y ☐ N		☐ Y ☐ N	

4.10.6 holding times of prepared foods are minimised to preserve nutritional value and food acceptability

4.10.7 the handling and distribution of prepared food is carried out only if adequate equipment and qualified staff are available to establish and supervise standards of handling, preparation and processing

4.10.8 disposal of waste

4.11 Foods which may contaminate each other are stored separately (for example, cooked and uncooked meats, washed and unwashed salad).

4.12 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 (ref. Department of Health Guidelines for Cook–Chill/Cook).

4.13 Written procedures include the care and cleaning of all areas and equipment.

4.14 Procedures for machine and for hand dishwashing include reference to:

4.14.1 scraping and presoaking

4.14.2 water temperature

4.14.3 rinsing and sanitising

4.14.4 quick drying of items

4.15 Menus are planned, in discussion with the dietetic service, to provide meals which meet the needs of patients and staff on either restricted or therapeutic diets. Attention is drawn to the following:

4.15.1 attractive presentation of food

4.15.2 appropriate portion size

4.15.3 menus allow for a variety of food and food textures

4.15.4 cultural preferences

4.15.5 requirements of special patient populations (for example, children)

4.15.6 menu cycles, taking into account the length of patient stay as well as food availability

4.16 There is a continuing programme of pest and vermin control.

4.17 There are procedures for the safe provision of meals to infectious patients and patients whose immune system is compromised, which include use of disposable plates and utensils.

4.18 Other food outlets within the hospital (for example, kiosks, vending machines, trolleys) provide food items which allow for a choice of food.

4.10.6	☐ Y ☐ N	☐ Y ☐ N
4.10.7	☐ Y ☐ N	☐ Y ☐ N
4.10.8	☐ Y ☐ N	☐ Y ☐ N
4.11	☐ Y ☐ N	☐ Y ☐ N
4.12	☐ Y ☐ N	☐ Y ☐ N
4.13	☐ Y ☐ N	☐ Y ☐ N
4.14		
4.14.1	☐ Y ☐ N	☐ Y ☐ N
4.14.2	☐ Y ☐ N	☐ Y ☐ N
4.14.3	☐ Y ☐ N	☐ Y ☐ N
4.14.4	☐ Y ☐ N	☐ Y ☐ N
4.15	☐ Y ☐ N	☐ Y ☐ N
4.15.1	☐ Y ☐ N	☐ Y ☐ N
4.15.2	☐ Y ☐ N	☐ Y ☐ N
4.15.3	☐ Y ☐ N	☐ Y ☐ N
4.15.4	☐ Y ☐ N	☐ Y ☐ N
4.15.5	☐ Y ☐ N	☐ Y ☐ N
4.15.6	☐ Y ☐ N	☐ Y ☐ N
4.16	☐ Y ☐ N	☐ Y ☐ N
4.17	☐ Y ☐ N	☐ Y ☐ N
4.18	☐ Y ☐ N	☐ Y ☐ N

4.19 There is a policy for dealing with:

4.19.1 accidents

4.19.2 errors

4.19.3 incidents

4.19.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.20 Records are kept which indicate to whom items listed in 4.19 have been referred and the action which has been taken.

4.21 Policies and procedures are dated and contained within a manual which as a minimum is:

4.21.1 regularly reviewed (annually) and updated

4.21.2 readily accessible for reference in the department

4.22 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The physical facilities and equipment ensure the efficient, hygienic and safe operation of the catering service.

Standards

5.1 There is an office for the catering manager.

5.2 There are toilet, changing, locker and showering facilities for staff, which comply with statutory health and safety regulations.

5.3 There is a rest room for staff.

5.4 Facilities are available for patients to consult catering staff.

5.5 The layout provides for the efficient, hygienic and safe work flow of the food service and allows for the following:

5.5.1 receiving of food stores

5.5.2 storage of food

5.5.3 food preparation

5.5.4 cooking and reheating/regeneration

5.5.5 holding of prepared food

5.5.6 distribution of food and meals

5.5.7 service of meals

4.10.6	☐ Y ☐ N	☐ Y ☐ N
4.10.7	☐ Y ☐ N	☐ Y ☐ N
4.10.8	☐ Y ☐ N	☐ Y ☐ N
4.11	☐ Y ☐ N	☐ Y ☐ N
4.12	☐ Y ☐ N	☐ Y ☐ N
4.13	☐ Y ☐ N	☐ Y ☐ N
4.14		
4.14.1	☐ Y ☐ N	☐ Y ☐ N
4.14.2	☐ Y ☐ N	☐ Y ☐ N
4.14.3	☐ Y ☐ N	☐ Y ☐ N
4.14.4	☐ Y ☐ N	☐ Y ☐ N
4.15	☐ Y ☐ N	☐ Y ☐ N
4.15.1	☐ Y ☐ N	☐ Y ☐ N
4.15.2	☐ Y ☐ N	☐ Y ☐ N
4.15.3	☐ Y ☐ N	☐ Y ☐ N
4.15.4	☐ Y ☐ N	☐ Y ☐ N
4.15.5	☐ Y ☐ N	☐ Y ☐ N
4.15.6	☐ Y ☐ N	☐ Y ☐ N
4.16	☐ Y ☐ N	☐ Y ☐ N
4.17	☐ Y ☐ N	☐ Y ☐ N
4.18	☐ Y ☐ N	☐ Y ☐ N

4.19

4.19.1 ☐ Y ☐ N ☐ Y ☐ N

4.19.2 ☐ Y ☐ N ☐ Y ☐ N

4.19.3 ☐ Y ☐ N ☐ Y ☐ N

4.19.4 ☐ Y ☐ N ☐ Y ☐ N

4.20 ☐ Y ☐ N ☐ Y ☐ N

4.21 ☐ Y ☐ N ☐ Y ☐ N

4.21.1 ☐ Y ☐ N ☐ Y ☐ N

4.21.2 ☐ Y ☐ N ☐ Y ☐ N

4.22 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The physical facilities and equipment ensure the efficient, hygienic and safe operation of the catering service.

Standards	Comment		Comment
5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.5.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.5.6 ☐ Y ☐ N		☐ Y ☐ N	
5.5.7 ☐ Y ☐ N		☐ Y ☐ N	

5.5.8 clearing after meals

5.5.9 dishwashing

5.5.10 storage of equipment

5.5.11 waste disposal

5.6 Facilities comply with requirements of relevant building regulations and statutory requirements. Attention is drawn to the following:

5.6.1 floors, walls and ceilings are easily cleaned

5.6.2 lighting meets the food hygiene regulations "Lighting Standards for Kitchens", and is satisfactory for working conditions and monitoring standards of cleanliness

5.6.3 control of ventilation, temperature and humidity provides satisfactory working conditions and promotes cleanliness

5.6.4 compliance with the fire safety requirements

5.6.5 compliance with health and safety regulations

5.7 There is a receiving area with facilities for checking the quality and quantity of the food and which allows for the rapid transfer of food to appropriate storage.

5.8 Storage of food in dry storage, refrigerators and freezers complies with the food hygiene regulations.

5.9 Equipment complies with relevant safety standards. Particular attention is given to a safety system or alarm in walk-in refrigerators and freezers, and to electrical, gas and pressure equipment and fish fryers.

5.10 Facilities are available for preparation of therapeutic diets, special diets, infant feeds and enteral and supplementary feeding.

5.11 There are procedures for the collection and cleaning of trays and dishes after the meal which ensure noise is minimised for patients.

5.12 Facilities are available within the kitchen for handwashing.

5.13 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.

5.14 Equipment is purchased from an approved supplier.

5.15 Where specialised equipment is used, it is operated only by staff trained to do so.

5.16 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.17 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

5.5.8 ☐ Y ☐ N ☐ Y ☐ N

5.5.9 ☐ Y ☐ N ☐ Y ☐ N

5.5.10 ☐ Y ☐ N ☐ Y ☐ N

5.5.11 ☐ Y ☐ N ☐ Y ☐ N

5.6 ☐ Y ☐ N ☐ Y ☐ N

5.6.1 ☐ Y ☐ N ☐ Y ☐ N

5.6.2 ☐ Y ☐ N ☐ Y ☐ N

5.6.3 ☐ Y ☐ N ☐ Y ☐ N

5.6.4 ☐ Y ☐ N ☐ Y ☐ N

5.6.5 ☐ Y ☐ N ☐ Y ☐ N

5.7 ☐ Y ☐ N ☐ Y ☐ N

5.8 ☐ Y ☐ N ☐ Y ☐ N

5.9 ☐ Y ☐ N ☐ Y ☐ N

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

5.14 ☐ Y ☐ N ☐ Y ☐ N

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16 ☐ Y ☐ N ☐ Y ☐ N

5.17 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

The catering department ensures the provision of a high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the catering service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme of the service includes the review of at least the following:

- 6.3.1 service users' satisfaction
- 6.3.2 the catering service in comparison with standards set out in this chapter
- 6.3.3 the performance of all catering staff
  (see Management and Staffing within this section)
- 6.3.4 the use of resources (for example, monitoring wastage)

6.4 The evaluation activities include the following elements:

- 6.4.1 monitoring: the routine collection of information/statistics about important aspects of delivery of services
- 6.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery
- 6.4.3 action: when important problems or opportunities to improve service delivery are identified, actions are taken and documented
- 6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Service evaluation meetings are held on a regular basis.

6.6 Records of attendance and minutes of evaluation meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.7 The staff within the service receive a report of results obtained through evaluation of the service.

6.8 The staff within the service participate in the formulation of plans for improvement.

6.9 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff which is known to all.

6. EVALUATION AND QUALITY ASSURANCE

The catering department ensures the provision of a high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3.3 ☐ Y ☐ N		☐ Y ☐ N	
6.3.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4.5 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6 ☐ Y ☐ N		☐ Y ☐ N	
6.7 ☐ Y ☐ N		☐ Y ☐ N	
6.8 ☐ Y ☐ N		☐ Y ☐ N	
6.9 ☐ Y ☐ N		☐ Y ☐ N	

6.10 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.11 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

6.12 Statistics are kept and used for the efficient management of the services.

6.13 Statistics collected are used to effect management/practice change.

6.14 There are local policies for the collection of information on key areas such as:

- 6.14.1 number of meals provided
- 6.14.2 special diets
- 6.14.3 unit cost
- 6.14.4 waste

6.15 There is compliance with the environmental health officer's requirements.

6.16 There is a written response to the recommendations of the environmental health officer.

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14

6.14.1 ☐ Y ☐ N ☐ Y ☐ N

6.14.2 ☐ Y ☐ N ☐ Y ☐ N

6.14.3 ☐ Y ☐ N ☐ Y ☐ N

6.14.4 ☐ Y ☐ N ☐ Y ☐ N

6.15 ☐ Y ☐ N ☐ Y ☐ N

6.16 ☐ Y ☐ N ☐ Y ☐ N

CATERING SERVICE

Surveyor's General Comments

CATERING SERVICE
Surveyor's Comments

Standard Number	Recommendation

HOTEL SERVICES

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

HOTEL SERVICES

PREAMBLE

This chapter contains standards which apply to a range of hotel services. Each service completes the "core" section, standards 1–6, and the section specific to them. For the 'core' standards, please indicate which service has completed the section by ticking the appropriate box.

Domestic ☐

Estates / Works ☐

Linen / Laundry ☐

Porters ☐

Security ☐

1. PHILOSOPHY AND OBJECTIVES

Each service is responsible for providing a high standard of service to the patient and to hospital staff and for the ethical and professional practices of its own staff.

Standards

1.1 Staff within each service develop a written philosophy which is consistent with that of the hospital.

1.2 Staff within each service develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the service.

1.3 The objectives for each service include at least the following:

1.3.1 ensuring patient and staff safety

1.3.2 providing and maintaining a high standard of service through analysis, review and evaluation of activities

1.3.3 maintaining effective communication with other members of the hospital staff to:

(a) meet patient needs

(b) enable co-ordination of services

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

HOTEL SERVICES

PREAMBLE

This chapter contains standards which apply to a range of hotel services. Each service completes the "core" section, standards 1–6, and the section specific to them. For the 'core' standards, please indicate which service has completed the section by ticking the appropriate box.

Domestic ☐

Estates / Works ☐

Linen / Laundry ☐

Porters ☐

Security ☐

1. PHILOSOPHY AND OBJECTIVES

Each service is responsible for providing a high standard of service to the patient and to hospital staff and for the ethical and professional practices of its own staff.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.4			
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	

1.4.3 respect and cater for cultural differences

1.4.4 respond to communication difficulties

1.5 The objectives for each service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.5.1 the role of the hospital

1.5.2 the provision of services

1.5.3 the pattern of delivery of service

1.5.4 staffing patterns

1.5.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

Each service is organised, managed and staffed to meet the stated objectives and anticipated needs of that service. The service is organised and staffed to supply, maintain and encourage an efficient, effective and safe service to patients, carers and visitors and to support the activities of medical, nursing and allied services.

Standards

Management

2.1 Each service is managed by a person appropriately qualified by education, training and/or experience.

2.2 The head of each service is involved in the preparation of the budget for the service.

2.3 The head of each service is responsible for the efficient and effective management of the service's budget.

2.4 Reports of budget expenditure are communicated to budget holders at set intervals throughout the financial year.

2.5 The budget reports are accurate.

2.6 Records and statistics are available for the effective management of the service which as a minimum include:

2.6.1 ratio of staff to workload

2.6.2 staff absentee rate

2.6.3 staff sickness rate

2.6.4 staff turnover rate

1.4.3 ☐ Y ☐ N ☐ Y ☐ N

1.4.4 ☐ Y ☐ N ☐ Y ☐ N

1.5

1.5.1 ☐ Y ☐ N ☐ Y ☐ N

1.5.2 ☐ Y ☐ N ☐ Y ☐ N

1.5.3 ☐ Y ☐ N ☐ Y ☐ N

1.5.4 ☐ Y ☐ N ☐ Y ☐ N

1.5.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

Each service is organised, managed and staffed to meet the stated objectives and anticipated needs of that service. The service is organised and staffed to supply, maintain and encourage an efficient, effective and safe service to patients, carers and visitors and to support the activities of medical, nursing and allied services.

Standards	Comment	Comment
Management		
2.1 ☐ Y ☐ N		☐ Y ☐ N
2.2 ☐ Y ☐ N		☐ Y ☐ N
2.3 ☐ Y ☐ N		☐ Y ☐ N
2.4 ☐ Y ☐ N		☐ Y ☐ N
2.5 ☐ Y ☐ N		☐ Y ☐ N
2.6		
2.6.1 ☐ Y ☐ N		☐ Y ☐ N
2.6.2 ☐ Y ☐ N		☐ Y ☐ N
2.6.3 ☐ Y ☐ N		☐ Y ☐ N
2.6.4 ☐ Y ☐ N		☐ Y ☐ N

2.7 Each service meets at regular intervals to:

2.7.1 maintain good communications

2.7.2 review service practices

2.8 Minutes of these meetings are kept.

2.9 Staff are informed of the outcomes of these meetings.

2.10 Senior staff from each service are involved in the development of hospital policies and procedures, where appropriate.

2.11 Where more than one committee has an interest in a hotel service issue, there is co-ordination of action taken or proposed by the committees.

2.12 Where services are provided on a contract basis, there is a written agreement stating the requirements for service delivery which include at least the following:

2.12.1 formal lines of communication and responsibility between the person/service and the hospital are specified

2.12.2 those providing the service are qualified to perform their duties

2.12.3 pick up and delivery arrangements are made where required

2.12.4 there is appropriate participation in committees of the hospital

2.12.5 arrangements exist for out of hours and emergency services

2.12.6 the quality of external service is monitored and is involved with quality assurance programmes of the hospital

2.12.7 mechanisms exist for dealing with problems in service delivery

2.12.8 facilities and equipment ensure the provision of a safe, effective and efficient service at the hospital and at the site of the external service

2.13 There is a mechanism to ensure that contract services meet the appropriate standards within this manual.

Personnel

2.14 Written and dated job descriptions are available for all posts, which specify at least the following:

2.14.1 job title and grade

2.14.2 qualifications and/or experience required for the post

2.14.3 functions, responsibilities and accountability

2.14.4 frequency and type of staff appraisal

2.14.5 review date

2.7

2.7.1 ☐ Y ☐ N ☐ Y ☐ N

2.7.2 ☐ Y ☐ N ☐ Y ☐ N

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.12.1 ☐ Y ☐ N ☐ Y ☐ N

2.12.2 ☐ Y ☐ N ☐ Y ☐ N

2.12.3 ☐ Y ☐ N ☐ Y ☐ N

2.12.4 ☐ Y ☐ N ☐ Y ☐ N

2.12.5 ☐ Y ☐ N ☐ Y ☐ N

2.12.6 ☐ Y ☐ N ☐ Y ☐ N

2.12.7 ☐ Y ☐ N ☐ Y ☐ N

2.12.8 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.14.1 ☐ Y ☐ N ☐ Y ☐ N

2.14.2 ☐ Y ☐ N ☐ Y ☐ N

2.14.3 ☐ Y ☐ N ☐ Y ☐ N

2.14.4 ☐ Y ☐ N ☐ Y ☐ N

2.14.5 ☐ Y ☐ N ☐ Y ☐ N

2.15 A documented staff appraisal system exists for all staff.

2.16 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.17 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.18 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.19 Staffing is calculated and allocated on the basis of workload.

2.20 Provision is made for out of hours and emergency cover where required.

2.21 The additional requirements of training and supervision are reflected in the numbers of staff on duty.

2.22 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.23 The organisational chart is reviewed annually, revised and dated.

2.24 Duty rosters are clearly displayed and available to staff within the department.

3. STAFF DEVELOPMENT AND EDUCATION

Each service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to each service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the service

3.1.3 explains the relationship within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 explains the method used to evaluate staff performance

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

Each service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.2 Staff are given in-service training which includes instruction on:

3.2.1 the control of infection and the role of the employee in this control (for example, portering of specimens, type and storage of mop heads, disposal of contaminated material)

3.2.2 safety measures in hazardous areas such as the central sterilising service, kitchens, workshops, laundry, laboratories and radiology areas

3.3 Staff who are assigned tasks in special 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.

3.4 As a minimum the continuing education programme:

3.4.1 utilises professional and other resource material

3.4.2 supports and encourages relevant research

3.4.3 provides information on advances in practice related to the service

3.4.4 provides information on educational opportunities arranged by other institutions

3.4.5 provides orientation to new service areas

3.5 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.6 Current reference manuals, pamphlets, journals and text books, as well as information and scientific data from manufacturers concerning their products, are available for reference and guidance.

3.7 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

4. POLICIES AND PROCEDURES

There are current, written policies and procedures for each service which reflect current technical knowledge and are consistent with relevant regulations and the objectives of each service.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of each service.

4.2 Policies and procedures are developed by each service in collaboration with other relevant services and management.

3.1.8 ☐ Y ☐ N		☐ Y ☐ N
3.1.9 ☐ Y ☐ N		☐ Y ☐ N
3.2		
3.2.1 ☐ Y ☐ N		☐ Y ☐ N
3.2.2 ☐ Y ☐ N		☐ Y ☐ N
3.3 ☐ Y ☐ N		☐ Y ☐ N
3.4		
3.4.1 ☐ Y ☐ N		☐ Y ☐ N
3.4.2 ☐ Y ☐ N		☐ Y ☐ N
3.4.3 ☐ Y ☐ N		☐ Y ☐ N
3.4.4 ☐ Y ☐ N		☐ Y ☐ N
3.4.5 ☐ Y ☐ N		☐ Y ☐ N
3.5 ☐ Y ☐ N		☐ Y ☐ N
3.6 ☐ Y ☐ N		☐ Y ☐ N
3.7 ☐ Y ☐ N		☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are current, written policies and procedures for each service which reflect current technical knowledge and are consistent with relevant regulations and the objectives of each service.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies and procedures are developed, attention is drawn to practice in other fields, for example, infection control and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Policies and procedures cover at least:

- 4.6.1 health and safety
- 4.6.2 occupational health
- 4.6.3 stock control

4.7 There is a policy for dealing with:

- 4.7.1 accidents
- 4.7.2 errors
- 4.7.3 incidents
- 4.7.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.8 Records are kept which indicate to whom items listed in 4.7 have been referred and the action which has been taken.

4.9 Policies and procedures are dated and contained within a manual which as a minimum is:

- 4.9.1 regularly reviewed (annually) and updated
- 4.9.2 readily accessible for reference in the department

4.10 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

Facilities and equipment are available for the safe, effective and efficient operation of each service.

Standards

5.1 There is space, materials and equipment to enable staff to carry out their duties.

5.2 There are office facilities for the head of each service.

5.3 There is a rest room available for staff.

5.4 Washrooms and changing facilities are available.

4.3	☐ Y ☐ N	☐ Y ☐ N
4.4	☐ Y ☐ N	☐ Y ☐ N
4.5	☐ Y ☐ N	☐ Y ☐ N
4.6		
4.6.1	☐ Y ☐ N	☐ Y ☐ N
4.6.2	☐ Y ☐ N	☐ Y ☐ N
4.6.3	☐ Y ☐ N	☐ Y ☐ N
4.7		
4.7.1	☐ Y ☐ N	☐ Y ☐ N
4.7.2	☐ Y ☐ N	☐ Y ☐ N
4.7.3	☐ Y ☐ N	☐ Y ☐ N
4.7.4	☐ Y ☐ N	☐ Y ☐ N
4.8	☐ Y ☐ N	☐ Y ☐ N
4.9	☐ Y ☐ N	☐ Y ☐ N
4.9.1	☐ Y ☐ N	☐ Y ☐ N
4.9.2	☐ Y ☐ N	☐ Y ☐ N
4.10	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

Facilities and equipment are available for the safe, effective and efficient operation of each service.

Standards	Comment		Comment
5.1	☐ Y ☐ N	☐ Y ☐ N	
5.2	☐ Y ☐ N	☐ Y ☐ N	
5.3	☐ Y ☐ N	☐ Y ☐ N	
5.4	☐ Y ☐ N	☐ Y ☐ N	

5.5 Where specialised equipment is used, it is operated only by staff trained to do so.

5.6 Equipment is subject to a planned, preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.7 All equipment and facilities conform to existing health and safety regulations (HE(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. EVALUATION AND QUALITY ASSURANCE

Each service ensures the provision of high quality service by its involvement in the evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for each service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme for each service includes the review of at least the following:

6.3.1 service users' satisfaction

6.3.2 the service in comparison with standards set out in this chapter

6.3.3 the performance of all staff in each department
(see Management and Staffing within this section)

6.3.4 the use of resources (identification of losses, type and amount of stock etc.)

6.4 The evaluation activities include the following elements:

6.4.1 monitoring: the routine collection of information statistics about important aspects of delivery of services

6.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery

6.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Service evaluation meetings are held on a regular basis.

6.6 Records of attendance and minutes of evaluation meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

5.5 ☐ Y ☐ N ☐ Y ☐ N

5.6 ☐ Y ☐ N ☐ Y ☐ N

5.7 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

Each service ensures the provision of high quality service by its involvement in the evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3.3 ☐ Y ☐ N		☐ Y ☐ N	
6.3.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4.5 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6 ☐ Y ☐ N		☐ Y ☐ N	

6.7 The staff within the service receive a report of results obtained through evaluation of the service.

6.8 The staff within the service participate in the formulation of plans for improvement.

6.9 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

6.10 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.11 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

6.12 Statistics are collected on service performance (for example, response times to requisitions).

6.13 Statistics collected are used to effect management/practice change.

7. ESTATES MANAGEMENT

The hospital is constructed, equipped, operated and maintained in a manner which supports the patient care objectives and the physical safety and comfort of patients, staff and visitors.

Please also refer to core standards for hotel services.

Standards

7.1 Where there is a system of energy management, it does not compromise the safety and welfare of patients and staff.

7.2 New electrical equipment is checked for compliance with established standards prior to use (for example, British Standards, Institute of Electrical Engineers Regulations for Electrical Installations).

7.3 A register of plans of building services, plant and equipment is maintained and is readily available.

7.4 Operational manuals for plant and equipment are maintained and are readily available.

7.5 There is a comprehensive planned maintenance programme in line with relevant statutory standards and the recommendations of the DHSS Estmancode and Estatecode which includes:

7.5.1 assets register

7.5.2 schedules and records of maintenance inspections

7.5.3 supervision of service contracts

7.5.4 work schedule system

5.5	☐ Y ☐ N	☐ Y ☐ N
5.6	☐ Y ☐ N	☐ Y ☐ N
5.7	☐ Y ☐ N	☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

Each service ensures the provision of high quality service by its involvement in the evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment	Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N
6.2 ☐ Y ☐ N		☐ Y ☐ N
6.3		
6.3.1 ☐ Y ☐ N		☐ Y ☐ N
6.3.2 ☐ Y ☐ N		☐ Y ☐ N
6.3.3 ☐ Y ☐ N		☐ Y ☐ N
6.3.4 ☐ Y ☐ N		☐ Y ☐ N
6.4		
6.4.1 ☐ Y ☐ N		☐ Y ☐ N
6.4.2 ☐ Y ☐ N		☐ Y ☐ N
6.4.3 ☐ Y ☐ N		☐ Y ☐ N
6.4.4 ☐ Y ☐ N		☐ Y ☐ N
6.4.5 ☐ Y ☐ N		☐ Y ☐ N
6.5 ☐ Y ☐ N		☐ Y ☐ N
6.6 ☐ Y ☐ N		☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

7. ESTATES MANAGEMENT

The hospital is constructed, equipped, operated and maintained in a manner which supports the patient care objectives and the physical safety and comfort of patients, staff and visitors.

Please also refer to core standards for hotel services.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4 ☐ Y ☐ N		☐ Y ☐ N	
7.5 ☐ Y ☐ N		☐ Y ☐ N	
7.5.1 ☐ Y ☐ N		☐ Y ☐ N	
7.5.2 ☐ Y ☐ N		☐ Y ☐ N	
7.5.3 ☐ Y ☐ N		☐ Y ☐ N	

7.6 Life cycle costs and utilisation of buildings, plant and equipment are reviewed and recommendations made regarding upgrading and replacement in accordance with relevant statutory regulations and HEI(98) 1982, Management of Equipment.

7.7 Communication systems are designed for the management of routine and emergency services, and maintained in good working order. Communication systems include:

7.7.1 telephones with direct lines for certain services such as out-patients and admissions

7.7.2 internal and external paging

7.7.3 nurse call systems

Ventilation and Air-Conditioning

7.8 Air-conditioning and ventilation systems are installed for the purpose of safety and comfort of patients and staff.

7.9 When air-conditioning and ventilation systems are installed, there is regard for the control of airborne infections.

7.10 Installations comply with the codes of practice produced by the Chartered Institute of Building Services.

7.11 Operating theatres, nurseries, special care units, isolation rooms and laboratories are air-conditioned/ventilated in accordance with the relevant standards and specifications recommended by the British Standards Codes of Practice.

7.12 There is documented evidence that water towers associated with air-conditioning systems are inspected regularly to ensure they are clean and free of algae, and that the plant and the water is treated to maintain it at a microbiologically accepted standard.

Water Supply

7.13 When water is obtained from a source other than a public water supply, it is microbiologically tested periodically and treated as necessary (ref. Department of Health Code of Practice: The Control of Legionellae in Health Care Premises).

7.14 The water is approved as safe by the authority having such jurisdiction.

7.15 The hospital's water supply system is not connected with other piping systems or with a fixture which could allow contamination of the water supply.

7.16 There is documented evidence that where water is stored at warm temperature (for example, 35 to 45°C), storage tanks are checked and treated regularly to ensure the water is clean and maintained at a microbiologically accepted standard (ref. Department of Health HM90(12), Health Service Management: The Control of Legionellae and Safe Hot Water Temperatures).

7.6 ☐ Y ☐ N ☐ Y ☐ N

7.7 ☐ Y ☐ N ☐ Y ☐ N

7.7.1 ☐ Y ☐ N ☐ Y ☐ N

7.7.2 ☐ Y ☐ N ☐ Y ☐ N

7.7.3 ☐ Y ☐ N ☐ Y ☐ N

Ventilation and Air-Conditioning

7.8 ☐ Y ☐ N ☐ Y ☐ N

7.9 ☐ Y ☐ N ☐ Y ☐ N

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

Water Supply

7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15 ☐ Y ☐ N ☐ Y ☐ N

7.16 ☐ Y ☐ N ☐ Y ☐ N

8. DOMESTIC SERVICE

The domestic service ensures and maintains a high standard of cleanliness and hygiene in all wards and departments.

Please also refer to core standards for hotel services.

Standards

8.1 Policies and procedures for housekeeping reflect the hospital control of infection policy and include:

8.1.1 cleaning of specialised areas (for example, laboratories, mortuaries, operating theatres, special care units)

8.1.2 disposal of general and contaminated waste

8.1.3 evaluation of cleaning effectiveness

8.1.4 measurement, labelling, storage and proper use of housekeeping and cleaning supplies

8.1.5 routine and special-purpose cleaning

8.1.6 use, cleaning, storage and care of cleaning equipment

8.2 Storage areas are kept uncluttered.

8.3 The entire hospital, including storage areas, is kept free of infestation and vermin, and there is a documented procedure for pest control.

8.4 Where housekeeping services are provided to the hospital on a contract basis, the hospital ensures that the standards outlined above are written into the specification and maintained.

9. LAUNDRY / LINEN SERVICE

There is a daily supply of clean linen to wards and departments which is based on calculated need.

Please also refer to core standards for hotel services.

Standards

9.1 There is provision for supplies out of hours and for emergencies.

9.2 There is a system of stock control which deters pilfering.

9.3 There is a supply of clean linen, handled and stored in such a way as to avoid reabsorption of moisture and contamination from surface contact or airborne deposition.

9.4 Stocks are rotated on a first-in, first-out basis and a linen inventory is kept.

8. DOMESTIC SERVICE

The domestic service ensures and maintains a high standard of cleanliness and hygiene in all wards and departments.

Please also refer to core standards for hotel services.

Standards	Comment		Comment
8.1 ☐ Y ☐ N		☐ Y ☐ N	
8.1.1 ☐ Y ☐ N		☐ Y ☐ N	
8.1.2 ☐ Y ☐ N		☐ Y ☐ N	
8.1.3 ☐ Y ☐ N		☐ Y ☐ N	
8.1.4 ☐ Y ☐ N		☐ Y ☐ N	
8.1.5 ☐ Y ☐ N		☐ Y ☐ N	
8.1.6 ☐ Y ☐ N		☐ Y ☐ N	
8.2 ☐ Y ☐ N		☐ Y ☐ N	
8.3 ☐ Y ☐ N		☐ Y ☐ N	
8.4 ☐ Y ☐ N		☐ Y ☐ N	

9. LAUNDRY / LINEN SERVICE

There is a daily supply of clean linen to wards and departments which is based on calculated need.

Please also refer to core standards for hotel services.

Standards	Comment		Comment
9.1 ☐ Y ☐ N		☐ Y ☐ N	
9.2 ☐ Y ☐ N		☐ Y ☐ N	
9.3 ☐ Y ☐ N		☐ Y ☐ N	
9.4 ☐ Y ☐ N		☐ Y ☐ N	

9.5 Written procedures for handling linen are in accordance with HC(87)30, Hospital Laundry Arrangements for Used and Infected Linen, and refer to:

9.5.1 physical appearance and condition of linen

9.5.2 processing techniques

9.5.3 wash formula (for example, time, temperature, use of bleach, final pH)

9.6 Soiled linen is collected in such a manner as to avoid spread of infection and is placed in bags or containers at the site of contamination, i.e. by the bedside at time of changing, etc.

9.7 Clean linen and soiled linen are transported and stored separately.

9.8 Containers transporting soiled linen bags and storage areas for soiled linen are cleaned regularly.

9.9 Soiled linen from infectious patients is clearly identified and suitable precautions are taken in its processing.

9.10 In-house laundering facilities are separated from the clean linen processing area, patient rooms, areas of food preparation and storage and areas in which clean material and equipment are stored.

9.11 The laundry area is planned and equipped to prevent the dissemination of contaminants and there is good exhaust ventilation with air-flow from clean to soiled areas.

9.12 Surfaces and overhead areas in the laundry are cleaned regularly.

9.13 To minimise the risk of cross infection, hand washing facilities are readily available, and staff change into clean uniforms at the start of each shift or working day.

9.14 Staff do not smoke in linen-handling areas.

9.15 Where linen services are provided to the hospital on a contract basis, the hospital ensures that the standards outlined above are written into the specification and maintained.

9.5 ☐ Y ☐ N ☐ Y ☐ N

9.5.1 ☐ Y ☐ N ☐ Y ☐ N

9.5.2 ☐ Y ☐ N ☐ Y ☐ N

9.5.3 ☐ Y ☐ N ☐ Y ☐ N

9.6 ☐ Y ☐ N ☐ Y ☐ N

9.7 ☐ Y ☐ N ☐ Y ☐ N

9.8 ☐ Y ☐ N ☐ Y ☐ N

9.9 ☐ Y ☐ N ☐ Y ☐ N

9.10 ☐ Y ☐ N ☐ Y ☐ N

9.11 ☐ Y ☐ N ☐ Y ☐ N

9.12 ☐ Y ☐ N ☐ Y ☐ N

9.13 ☐ Y ☐ N ☐ Y ☐ N

9.14 ☐ Y ☐ N ☐ Y ☐ N

9.15 ☐ Y ☐ N ☐ Y ☐ N

10. PORTERING SERVICE

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

Please also refer to core standards for hotel services.

Standards

Waste Disposal

10.1 Waste disposal is carried out in accordance with statutory regulations and official guidelines, for example, Health and Safety Commission's "Safe Disposal of Clinical Waste". There are documented policies and/or procedures which provide for:

10.1.1 definition of contaminated waste

10.1.2 disposal of sharp objects in accordance with the relevant regulations (sharp objects are placed in suitable containers for disposal in a safe manner)

10.1.3 labelling and disposal of cytotoxic and radio-active waste in accordance with the appropriate statutory requirements

10.1.4 segregation by colour coding of general and contaminated waste at the point of origin

10.1.5 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 and a mechanism for monitoring such handling — (These procedures include the sterilisation, where applicable, of contaminated waste prior to removal from the site, and the removal of waste from the site in accordance with the relevant regulations.)

Security

10.2 There are comprehensive arrangements for the internal security of the hospital.

10.3 There are comprehensive arrangements for the external security of the hospital.

10. PORTERING SERVICE

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

Please also refer to core standards for hotel services.

Standards	Comment		Comment
Waste Disposal			
10.1 ☐ Y ☐ N		☐ Y ☐ N	
10.1.1 ☐ Y ☐ N		☐ Y ☐ N	
10.1.2 ☐ Y ☐ N		☐ Y ☐ N	
10.1.3 ☐ Y ☐ N		☐ Y ☐ N	
10.1.4 ☐ Y ☐ N		☐ Y ☐ N	
10.1.5 ☐ Y ☐ N		☐ Y ☐ N	
Security			
10.2 ☐ Y ☐ N		☐ Y ☐ N	
10.3 ☐ Y ☐ N		☐ Y ☐ N	

HOTEL SERVICES

Surveyor's General Comments

HOTEL SERVICES
Surveyor's Comments

Standard Number	Recommendation

INFECTION CONTROL

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

INFECTION CONTROL

1. INFECTION CONTROL

There is an effective hospital-wide infection control policy.

Standards

1.1 Responsibility for the control of infection is instituted, directed, reviewed and modified by a multidisciplinary infection control committee.

1.2 The committee is chaired by a doctor with a knowledge of, and special interest in, infection control.

1.3 The committee includes representation from medical, nursing, paramedical, support services and management, as appropriate. In smaller hospitals infection control matters may be dealt with as part of a larger committee whose terms of reference encompass various aspects of safety and patient care.

1.4 The infection control committee develops written policies and procedures for continuing review and evaluation of all aseptic, isolation and sanitation techniques.

1.5 Preventive and control procedures are subject to continual review and are amended as required.

1.6 These procedures include practices which relate to:

- 1.6.1 all waste disposal
- 1.6.2 central sterilising service
- 1.6.3 cross-infection and isolation
- 1.6.4 engineering
- 1.6.5 food handling
- 1.6.6 food storage
- 1.6.7 housekeeping
- 1.6.8 laundry
- 1.6.9 pathology
- 1.6.10 pharmacy
- 1.6.11 sterilization and disinfection
- 1.6.12 surgical and nursing procedures
- 1.6.13 ventilation
- 1.6.14 water storage

INFECTION CONTROL

1. INFECTION CONTROL

There is an effective hospital-wide infection control policy.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4 ☐ Y ☐ N		☐ Y ☐ N	
1.5 ☐ Y ☐ N		☐ Y ☐ N	
1.6			
1.6.1 ☐ Y ☐ N		☐ Y ☐ N	
1.6.2 ☐ Y ☐ N		☐ Y ☐ N	
1.6.3 ☐ Y ☐ N		☐ Y ☐ N	
1.6.4 ☐ Y ☐ N		☐ Y ☐ N	
1.6.5 ☐ Y ☐ N		☐ Y ☐ N	
1.6.6 ☐ Y ☐ N		☐ Y ☐ N	
1.6.7 ☐ Y ☐ N		☐ Y ☐ N	
1.6.8 ☐ Y ☐ N		☐ Y ☐ N	
1.6.9 ☐ Y ☐ N		☐ Y ☐ N	
1.6.10 ☐ Y ☐ N		☐ Y ☐ N	
1.6.11 ☐ Y ☐ N		☐ Y ☐ N	
1.6.12 ☐ Y ☐ N		☐ Y ☐ N	
1.6.13 ☐ Y ☐ N		☐ Y ☐ N	
1.6.14 ☐ Y ☐ N		☐ Y ☐ N	

1.7 Copies of the policies and procedures are distributed to each ward and department.

1.8 The committee is consulted in order to ensure that:

1.8.1 proposed building constructions are designed in line with accepted infection control requirements

1.8.2 proposed new equipment intended for patient care conforms with accepted infection control standards

1.9 The committee reviews reports of:

1.9.1 incidence of hospital acquired infection

1.9.2 implementation of infection control policies

1.9.3 deviation from infection control policies

1.9.4 specific surveillance studies of infections and infection potential

1.10 Environmental inspections are conducted throughout the hospital for the purpose of reviewing policies and procedures related to infection control. The results of these inspections are documented.

1.11 An appropriately qualified person is designated to co-ordinate infection control practices. This person may be employed full-time or have responsibilities in addition to infection control.

1.12 An infection control officer has delegated authority for the supervision and effective implementation of recommended infection control policies and is responsible for surveillance of hospital acquired and communicable infections on a systematic and current basis.

1.13 There are policies and procedures for dealing with infectious patients and those requiring isolation, including:

1.13.1 accommodation for isolated patients enables them to receive care of the same quality as is provided throughout the hospital

1.13.2 there are work areas and equipment to assist in the control of the disease

1.13.3 facilities for hand washing and for implementing effective isolation techniques are available

1.13.4 isolation facilities are available for all clinical services. These include, for example, adequate provision for patients with compromised immune systems or who are infectious, including the newborn

1.14 The infection control co-ordinator is involved with induction and in-service training courses for all staff members.

1.7 ☐ Y ☐ N ☐ Y ☐ N

1.8

1.8.1 ☐ Y ☐ N ☐ Y ☐ N

1.8.2 ☐ Y ☐ N ☐ Y ☐ N

1.9

1.9.1 ☐ Y ☐ N ☐ Y ☐ N

1.9.2 ☐ Y ☐ N ☐ Y ☐ N

1.9.3 ☐ Y ☐ N ☐ Y ☐ N

1.9.4 ☐ Y ☐ N ☐ Y ☐ N

1.10 ☐ Y ☐ N ☐ Y ☐ N

1.11 ☐ Y ☐ N ☐ Y ☐ N

1.12 ☐ Y ☐ N ☐ Y ☐ N

1.13

1.13.1 ☐ Y ☐ N ☐ Y ☐ N

1.13.2 ☐ Y ☐ N ☐ Y ☐ N

1.13.3 ☐ Y ☐ N ☐ Y ☐ N

1.13.4 ☐ Y ☐ N ☐ Y ☐ N

1.14 ☐ Y ☐ N ☐ Y ☐ N

1.15 Education and training aims to reduce risks to staff and patients and includes:

1.15.1 basic and applied microbiology

1.15.2 health requirements

1.15.3 housekeeping

1.15.4 personal hygiene

1.15.5 safety

1.15.6 sterile-supply processing and handling techniques

1.15.7 work clothing

1.16 A procedure exists for dealing with the control of outbreaks of infection which involves other hospitals/emergency services as appropriate and includes a procedure for dealing with the media interest in the event of such an occurrence.

2. STERILISATION AND DISINFECTION SERVICES

The central sterilising service provides sterilising services for all areas within the hospital which use sterile instruments, dressings, linen and other items, and, where applicable, provides the decontamination and disinfection of medical and surgical equipment.

Please also refer to core standards for hotel services.

Standards

2.1 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, to reduce the risk of infection to both patients and staff. This system is an integral part of the hospital's infection control procedure.

2.2 There are detailed written instructions for the cleaning and sterilisation of equipment and evidence of regular monitoring of these processes.

2.3 The service is under the management of an appropriately qualified person.

2.4 The design of the central sterilising service is in accordance with the current Health Building Note and allows for:

2.4.1 storage and bench space for equipment, surgical supplies, linen and housekeeping materials

2.4.2 separation of soiled, clean, unsterile and sterile items with clear demarcation of the areas

2.5 The central sterilising service is planned and equipped to prevent the dissemination of contaminants and there is good exhaust ventilation with air flow from clean to soiled areas.

1.15

1.15.1	☐ Y ☐ N	☐ Y ☐ N
1.15.2	☐ Y ☐ N	☐ Y ☐ N
1.15.3	☐ Y ☐ N	☐ Y ☐ N
1.15.4	☐ Y ☐ N	☐ Y ☐ N
1.15.5	☐ Y ☐ N	☐ Y ☐ N
1.15.6	☐ Y ☐ N	☐ Y ☐ N
1.15.7	☐ Y ☐ N	☐ Y ☐ N
1.16	☐ Y ☐ N	☐ Y ☐ N

2. STERILISATION AND DISINFECTION SERVICES

The central sterilising service provides sterilising services for all areas within the hospital which use sterile instruments, dressings, linen and other items, and, where applicable, provides the decontamination and disinfection of medical and surgical equipment.

Please also refer to core standards for hotel services.

Standards	Comment		Comment
2.1	☐ Y ☐ N	☐ Y ☐ N	
2.2	☐ Y ☐ N	☐ Y ☐ N	
2.3	☐ Y ☐ N	☐ Y ☐ N	
2.4	☐ Y ☐ N	☐ Y ☐ N	
2.4.1	☐ Y ☐ N	☐ Y ☐ N	
2.4.2	☐ Y ☐ N	☐ Y ☐ N	
2.5	☐ Y ☐ N	☐ Y ☐ N	

2.6 Surfaces and overhead areas in the central sterilising service are cleaned regularly.

2.7 To minimise the risk of cross infection, hand washing facilities are readily available.

2.8 There is environmental control of temperature and humidity which is checked regularly by maintenance staff.

2.9 Special equipment appropriate to the central sterilising service for the cleaning, drying and sterilisation of hospital equipment is available and complies with current regulations, for example, HTM(10) 1980 Performance and Recording of Tests on all Autoclave Systems, British Standard Specifications relating to materials and equipment.

2.10 Sterilisers, including ethylene oxide, are checked in accordance with statutory regulations.

2.11 Potentiometer and/or microbiological tests are conducted and results recorded following repair and/or maintenance of sterilisers.

2.12 A policy is developed for the use of items designated as single use by the manufacturer.

2.13 Linen to be sterilised is inspected, folded and/or assembled into packs in an area set aside for this purpose and separate from the main sterilising area where instruments and dressings are packed and sterilising performed.

2.14 Arrangements are made for supplies required out of hours.

See also Domestic, Linen, Estates and Portering Services.

2.6 ☐ Y ☐ N ☐ Y ☐ N

2.7 ☐ Y ☐ N ☐ Y ☐ N

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

INFECTION CONTROL

Surveyor's General Comments

INFECTION CONTROL

Surveyor's Comments

Standard Number	Recommendation

HEALTH AND SAFETY

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

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The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

HEALTH AND SAFETY

1. FIRE SAFETY

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

Standards

1.1 An appropriately qualified person is designated responsible for fire safety.

1.2 All buildings comply with legislation relating to fire safety, for example, the Fire Precaution Act 1971, FIRECODE and the Health and Safety at Work Act 1974.

1.3 There is written evidence of a recent fire inspection from the appropriate fire authority within the last three years, and in the event of a major building alteration, development or service alteration, as required by the FIRECODE.

1.4 There is a documented response to any recommendations made by the fire authority setting out the action already taken or proposed by the hospital, the rationale on which it is based and the planned timetable of compliance. The timetable shows evidence of priority being given to:

1.4.1 achieving certification for the relevant parts of the estate

1.4.2 recommendations which have a direct bearing on issues of patient safety

1.4.3 eradication of gross fire hazards

1.4.4 early compliance with recommendations that are readily achievable

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

1.6 The design and construction of new buildings minimises the risk of spread of fire and smoke (for example, satisfactory ventilation systems, compartmentation).

1.7 Approved fire detection and alarm systems (such as smoke detectors or manual fire alarms) exist throughout the hospital and are prominently displayed. An audible alarm system produces signals louder than the level of operational noise in the area and distinctive from other signals/alarms used in the area.

1.8 Fire fighting equipment (for example, fire extinguishers, hydrants, hose reels, fire blankets) is provided which conforms to British Standard Specification 5423: 1977.

HEALTH AND SAFETY

1. FIRE SAFETY

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

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4 ☐ Y ☐ N		☐ Y ☐ N	
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4.4 ☐ Y ☐ N		☐ Y ☐ N	
1.5 ☐ Y ☐ N		☐ Y ☐ N	
1.6 ☐ Y ☐ N		☐ Y ☐ N	
1.7 ☐ Y ☐ N		☐ Y ☐ N	
1.8 ☐ Y ☐ N		☐ Y ☐ N	

1.9 All fire systems and equipment are appropriate to the type of fire most likely to occur in the area in which they are located and there is written evidence that regular testing and maintenance is performed (at least annually). Particular attention is given to hazardous areas which include, but are not restricted to, the following:

1.9.1 designated smoking areas

1.9.2 electrical rooms

1.9.3 incinerators

1.9.4 kitchens

1.9.5 laboratories

1.9.6 laundry storage areas and linen rooms

1.9.7 maintenance workshops

1.9.8 plant rooms

1.9.9 refuse collection and storage areas

1.9.10 rooms or spaces used for permanent or temporary storage of combustible supplies and equipment

1.10 Placement of signposting for fire equipment allows for ready identification of equipment, and exit signs are in accordance with BS 5378.

1.11 There is adequate means of escape from all parts of the building in compliance with requirements of local fire authorities and building regulations.

1.12 Doorways, corridors, ramps and stairways designated as means of escape in case of fire are kept free of obstruction at all times and are wide enough for the evacuation of non-ambulant patients and staff.

1.13 Fire and smoke doors can be opened and closed manually. Except where otherwise prescribed, fire and smoke doors may be held open by electric hold-open devices arranged to release upon activation of the fire alarm system.

1.14 Doors to patient rooms and exit doors are not locked except where specifically required to be so (for example, some psychiatric units). In such cases there are documented policies and procedures for the means of escape.

1.15 There are written policies concerning smoking within the hospital. Policies should include at least:

1.15.1 smoking is prohibited in any room, ward or department where flammable liquids, combustible gases or oxygen are being used or stored, and in any other hazardous area of the hospital. In such areas, "No Smoking" signs or symbols are displayed

1.15.2 smoking by patients classified as mentally or physically responsible for their actions is permitted only under supervision

1.15.3 smoking by patients, staff and visitors is discouraged and only permitted in

1.9 ☐ Y ☐ N ☐ Y ☐ N

1.9.1 ☐ Y ☐ N ☐ Y ☐ N
1.9.2 ☐ Y ☐ N ☐ Y ☐ N
1.9.3 ☐ Y ☐ N ☐ Y ☐ N
1.9.4 ☐ Y ☐ N ☐ Y ☐ N
1.9.5 ☐ Y ☐ N ☐ Y ☐ N
1.9.6 ☐ Y ☐ N ☐ Y ☐ N
1.9.7 ☐ Y ☐ N ☐ Y ☐ N
1.9.8 ☐ Y ☐ N ☐ Y ☐ N
1.9.9 ☐ Y ☐ N ☐ Y ☐ N
1.9.10 ☐ Y ☐ N ☐ Y ☐ N

1.10 ☐ Y ☐ N ☐ Y ☐ N

1.11 ☐ Y ☐ N ☐ Y ☐ N

1.12 ☐ Y ☐ N ☐ Y ☐ N

1.13 ☐ Y ☐ N ☐ Y ☐ N

1.14 ☐ Y ☐ N ☐ Y ☐ N

1.15 ☐ Y ☐ N ☐ Y ☐ N

1.15.1 ☐ Y ☐ N ☐ Y ☐ N

1.15.2 ☐ Y ☐ N ☐ Y ☐ N

1.15.3 ☐ Y ☐ N ☐ Y ☐ N

1.16 Fire emergency plans and procedures are developed according to details given in the section on major incident plans. *(See Hospital Management section of this manual.)*

1.17 Fire emergency plans and procedures are made known to all staff members and are readily available and prominently displayed throughout the hospital.

1.18 Fire drills are held regularly for day and night staff, under varied conditions.

1.19 All staff are trained in fire procedures including fire alarm/notification procedures and are familiar with the use and operation of the fire fighting equipment available.

1.20 All staff are aware of the method and route of evacuation from their area of work and staff residences.

1.21 Staff are trained to physically evacuate patients from wards or other locations (for example, clinics, departments, dining areas, chapels).

1.22 There is a written plan available throughout the hospital detailing action to be taken in the event of patients having to be moved; details of evacuation drills appear in the section on major incident plans. *(See Hospital Management section of this manual.)*

1.23 There is a written report and evaluation of all drills, and documentation of staff attendance.

1.24 There is a person designated as the nominated officer (fire). This person represents fire safety issues on the safety committee (however named). This role may be part-time or combined with other duties.

1.25 Where installed, automatic fire extinguishing systems are appropriate for the area to be protected and do not cause a situation which in itself could endanger the lives or safety of patients, staff or visitors.

1.26 There is a system for at least annual inspection and/or testing as appropriate of the automatic fire extinguishing systems.

1.27 All incidents of fire are reported and investigated.

2. HEALTH AND SAFETY PROGRAMMES

The management of the hospital promotes occupational health and safety programmes which ensure a safe and healthy environment for patients, staff and visitors.

Standards

2.1 There is a full occupational health service for all staff.

2.2 There is a written hospital-wide safety policy and written departmental safety policies and procedures.

1.16	☐ Y ☐ N	☐ Y ☐ N
1.17	☐ Y ☐ N	☐ Y ☐ N
1.18	☐ Y ☐ N	☐ Y ☐ N
1.19	☐ Y ☐ N	☐ Y ☐ N
1.20	☐ Y ☐ N	☐ Y ☐ N
1.21	☐ Y ☐ N	☐ Y ☐ N
1.22	☐ Y ☐ N	☐ Y ☐ N
1.23	☐ Y ☐ N	☐ Y ☐ N
1.24	☐ Y ☐ N	☐ Y ☐ N
1.25	☐ Y ☐ N	☐ Y ☐ N
1.26	☐ Y ☐ N	☐ Y ☐ N
1.27	☐ Y ☐ N	☐ Y ☐ N

2. HEALTH AND SAFETY PROGRAMMES

The management of the hospital promotes occupational health and safety programmes which ensure a safe and healthy environment for patients, staff and visitors.

Standards	Comment		Comment
2.1	☐ Y ☐ N	☐ Y ☐ N	
2.2	☐ Y ☐ N	☐ Y ☐ N	

2.3 There is a multidisciplinary health and safety committee (or committees), which includes trade union representation, for the purpose of implementing and maintaining a comprehensive safety policy for patients, staff and visitors, as well as monitoring and reporting on occupational health matters.

2.4 The chairman of the committee is appointed by the general manager.

2.5 The committee must meet a minimum of six times per annum.

2.6 A report from the health and safety committee is presented to the hospital's management board at least twice per annum.

2.7 In hospitals where these matters are dealt with by more than one committee, there is evidence of effective communication between the committees.

2.8 Occupational health and safety programmes are carried out in accordance with statutory regulations.

2.9 There is a designated safety officer whose authority and accountability for safety related activities is clearly defined. In some hospitals this role may be part-time or combined with other duties.

2.10 There are members of staff, where appropriate, trained and designated to act as first aid officers.

2.11 There are written safety procedures specific to hazardous areas and work systems. For example:

2.11.1 central sterilising service

2.11.2 food preparation and service areas

2.11.3 handling disinfectants

2.11.4 handling antibiotics

2.11.5 laundries

2.11.6 laboratories

2.11.7 operating theatres

2.11.8 radiological areas

2.11.9 special care units

2.11.10 workshops

2.12 Special safety measures in the form of facilities and equipment, policies and procedures are provided for hazardous areas in accordance with statutory requirements. Attention is paid to:

2.12.1 COSHH regulations

2.12.2 facilities for rapid flushing of caustic or toxic chemicals

1.16	☐ Y ☐ N	☐ Y ☐ N
1.17	☐ Y ☐ N	☐ Y ☐ N
1.18	☐ Y ☐ N	☐ Y ☐ N
1.19	☐ Y ☐ N	☐ Y ☐ N
1.20	☐ Y ☐ N	☐ Y ☐ N
1.21	☐ Y ☐ N	☐ Y ☐ N
1.22	☐ Y ☐ N	☐ Y ☐ N
1.23	☐ Y ☐ N	☐ Y ☐ N
1.24	☐ Y ☐ N	☐ Y ☐ N
1.25	☐ Y ☐ N	☐ Y ☐ N
1.26	☐ Y ☐ N	☐ Y ☐ N
1.27	☐ Y ☐ N	☐ Y ☐ N

2. HEALTH AND SAFETY PROGRAMMES

The management of the hospital promotes occupational health and safety programmes which ensure a safe and healthy environment for patients, staff and visitors.

Standards	Comment		Comment
2.1	☐ Y ☐ N	☐ Y ☐ N	
2.2	☐ Y ☐ N	☐ Y ☐ N	

2.3 ☐ Y ☐ N ☐ Y ☐ N

2.4 ☐ Y ☐ N ☐ Y ☐ N

2.5 ☐ Y ☐ N ☐ Y ☐ N

2.6 ☐ Y ☐ N ☐ Y ☐ N

2.7 ☐ Y ☐ N ☐ Y ☐ N

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.11.1 ☐ Y ☐ N ☐ Y ☐ N
2.11.2 ☐ Y ☐ N ☐ Y ☐ N
2.11.3 ☐ Y ☐ N ☐ Y ☐ N
2.11.4 ☐ Y ☐ N ☐ Y ☐ N
2.11.5 ☐ Y ☐ N ☐ Y ☐ N
2.11.6 ☐ Y ☐ N ☐ Y ☐ N
2.11.7 ☐ Y ☐ N ☐ Y ☐ N
2.11.8 ☐ Y ☐ N ☐ Y ☐ N
2.11.9 ☐ Y ☐ N ☐ Y ☐ N
2.11.10 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.12.1 ☐ Y ☐ N ☐ Y ☐ N
2.12.2 ☐ Y ☐ N ☐ Y ☐ N

2.12.3 procedures to be followed in the event of spillage and/or staff contamination (for example, by cytotoxic and radio-active materials)

2.12.4 storage and licensing of radio-active materials in accordance with the Radiation Protection Act and Regulations

2.12.5 storage of flammable liquids

2.12.6 storage of volatile flammable materials

2.13 Protective clothing and equipment is provided where necessary and their usage monitored.

2.14 Accident reporting procedures within the hospital comply with RIDDOR regulations.

2.15 All portable gas cylinders are appropriately stored, restrained and secured (ref. HTM no 22):

2.15.1 Oxygen and flammable gases are stored separately

2.15.2 Storage areas are ventilated, of non-combustible construction and secured as appropriate

2.15.3 Gas cylinders are restrained and large cylinders are stored in an upright position

2.15.4 Flammable anaesthetic gases are not used in piped systems

2.15.5 Storage areas are appropriately signposted and include "No Smoking" in accordance with statutory requirements

2.16 There is provision for an alternative light and/or power supply which meets the needs of the hospital in the event of a failure of the local supply, in accordance with HTM(11) 1974, Emergency Electrical Services, and the BSI Code of Practice "The Emergency Lighting of Premises".

2.17 There is provision for emergency suction and medical gas supplies in key areas such as operating theatres, special care hospitals, accident and emergency departments (ref. HTM no 22).

2.18 Patient safety devices are installed and include:

2.18.1 hand rails in passage ways

2.18.2 nurse call system to which the patient has access

2.18.3 patient toilets, showers and bathrooms equipped with grab rails and emergency call systems

2.18.4 provision for emergency entry to toilets, showers and bathrooms

2.18.5 provision of variable height beds fitted with adjustable side rails where possible

2.18.6 safety straps on wheelchairs and trolleys which are not fitted with side rails

2.18.7 side rails in accordance with criteria established to ensure patient safety

2.12.3 ☐ Y ☐ N ☐ Y ☐ N

2.12.4 ☐ Y ☐ N ☐ Y ☐ N

2.12.5 ☐ Y ☐ N ☐ Y ☐ N

2.12.6 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15

2.15.1 ☐ Y ☐ N ☐ Y ☐ N

2.15.2 ☐ Y ☐ N ☐ Y ☐ N

2.15.3 ☐ Y ☐ N ☐ Y ☐ N

2.15.4 ☐ Y ☐ N ☐ Y ☐ N

2.15.5 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18

2.18.1 ☐ Y ☐ N ☐ Y ☐ N

2.18.2 ☐ Y ☐ N ☐ Y ☐ N

2.18.3 ☐ Y ☐ N ☐ Y ☐ N

2.18.4 ☐ Y ☐ N ☐ Y ☐ N

2.18.5 ☐ Y ☐ N ☐ Y ☐ N

2.18.6 ☐ Y ☐ N ☐ Y ☐ N

2.18.7 ☐ Y ☐ N ☐ Y ☐ N

2.19 In areas where there may be children, special precautions are taken, including:

2.19.1 power points have safety shutters

2.19.2 physical barriers prevent entry to hazardous areas

2.19.3 cleaning agents and other hazardous materials are kept in properly labelled containers with child-resistant closures

2.20 The hot water supply in patient areas is automatically controlled to prevent accidental scalding.

2.21 Buildings which accommodate non-ambulant patients on floors other than ground level should have at least one lift which can hold at least one adult-size bed. The installation and maintenance of lifts and dumb waiters complies with all applicable regulations and have insurance certificates.

2.22 Shafts (for example, linen chutes) are equipped with doors having self-closing devices and appropriate safety latches.

2.23 Signs throughout the hospital are clearly displayed and easy to follow (for example, directional and safety signs, exits and smoking restrictions).

2.24 Regular safety inspections of all areas are carried out and the findings documented for the safety committee.

2.25 A system exists for the reporting and follow up of ad hoc hazards.

2.26 All staff are familiar with safety procedures.

2.27 There is a safety education programme that includes orientation of new employees to the hospital safety practices, as well as orientation and continuing education regarding safety practices specific to individual departments/services.

2.28 Orientation and in-service training programmes utilise findings of the quality assurance teams, the safety committee, the infection control committee and other appropriate committees.

2.29 Orientation and in-service training programmes are documented and a record of attendance is maintained.

2.30 There is evidence that the training programmes are reviewed at least annually to determine their effectiveness.

2.31 Policies refer to the operation of motor vehicles provided for staff use, and include maintenance and proof that a current driver's licence is held by the driver, or an internal driving ability test for non-road-going vehicles.

2.19

2.19.1 ☐ Y ☐ N ☐ Y ☐ N

2.19.2 ☐ Y ☐ N ☐ Y ☐ N

2.19.3 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27 ☐ Y ☐ N ☐ Y ☐ N

2.28 ☐ Y ☐ N ☐ Y ☐ N

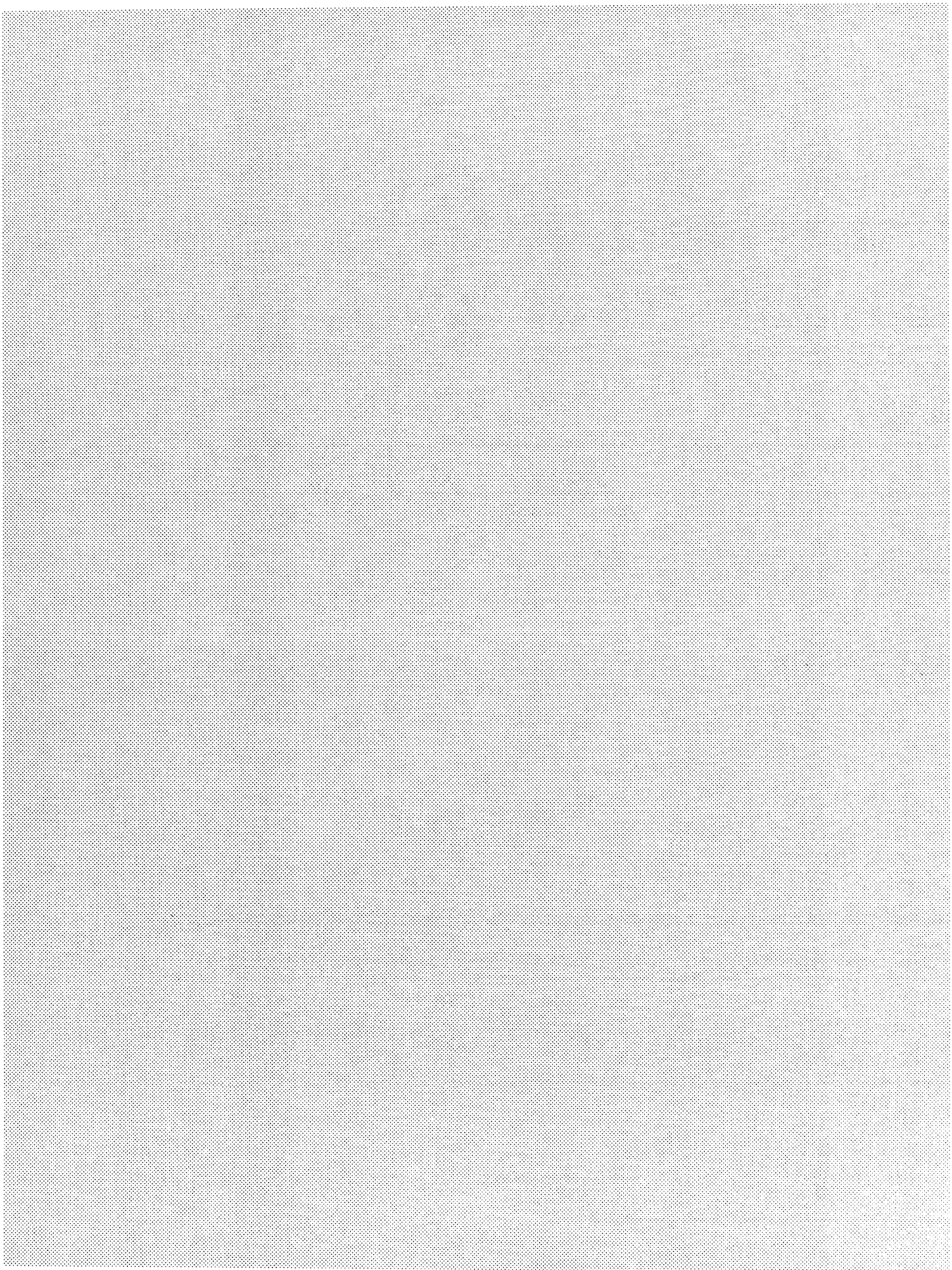
2.29 ☐ Y ☐ N ☐ Y ☐ N

2.30 ☐ Y ☐ N ☐ Y ☐ N

2.31 ☐ Y ☐ N ☐ Y ☐ N

HEALTH AND SAFETY

Surveyor's General Comments



HEALTH AND SAFETY

Surveyor's Comments

Standard Number	Recommendation

LIBRARY SERVICE

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LIBRARY SERVICE

The library service may be organised as one of the following:

(a) A department of the hospital

(b) A branch or access point of a district managed service

(c) A contract with a university medical library service or other appropriate educational institution

. PHILOSOPHY AND OBJECTIVES

The library provides a service to meet the informational needs of the hospital and ncourages the effective use of information by all staff engaged in health care. All staff of the ospital have ready access to the service.

Standards

1.1 Staff within the library develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the library develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the library service.

1.3 The objectives for the service include at least the following:

1.3.1 providing an enquiry and information service in the form of:

(a) enquiry answering service

(b) computer searching of on-line and locally held databases

(c) current awareness and literature alerting services

1.3.2 offering a document supply service in the form of:

(a) loans from stock

(b) interlibrary loans

(c) copies for retention within the terms of the copyright law

1.3.3 encouraging users in the use of information by:

(a) publicising services

(b) providing introductory talks to all staff on appointment

(c) offering courses and workshops on literature searching and information management techniques

LIBRARY SERVICE

The library service may be organised as one of the following:

(a) **A department of the hospital**

(b) **A branch or access point of a district managed service**

(c) **A contract with a university medical library service or other appropriate educational institution**

1. PHILOSOPHY AND OBJECTIVES

The library provides a service to meet the informational needs of the hospital and encourages the effective use of information by all staff engaged in health care. All staff of the hospital have ready access to the service.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
(c) ☐ Y ☐ N		☐ Y ☐ N	
1.3.2			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
(c) ☐ Y ☐ N		☐ Y ☐ N	
1.3.3			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
(c) ☐ Y ☐ N		☐ Y ☐ N	

1.3.4 providing an up-to-date collection which meets the information needs of the hospital and users. This is in the form of:

(a) primary documents such as books, journals and reports

(b) secondary sources such as directories, indexes and abstracts

(c) material in a variety of media such as slides, audiotapes, videotapes, computer readable databases and computer assisted learning programs

1.3.5 providing a cataloguing, classification and index system which facilitates retrieval by users and library staff

2. MANAGEMENT AND STAFFING

The library service is organised, managed and staffed to meet the needs of the hospital and users and to achieve service objectives.

Standards

Management

2.1 The service is managed by a qualified librarian.

2.2 The management structure encourages interaction and co-operation with the regional library service, with other libraries, and with other information providers in the hospital.

2.3 The library manager is involved in the preparation of the library's budget.

2.4 The library manager is responsible for the efficient and effective management of the library's budget.

2.5 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.6 The budget reports are accurate.

2.7 Records and statistics are available for the effective management of the library which as a minimum include:

2.7.1 ratio of staff to workload

2.7.2 staff absentee rate

2.7.3 staff sickness rate

2.7.4 staff turnover rate

2.8 Regular staff meetings are held to:

2.8.1 maintain good communications

1.3.4

(a) ☐ Y ☐ N ☐ Y ☐ N

(b) ☐ Y ☐ N ☐ Y ☐ N

(c) ☐ Y ☐ N ☐ Y ☐ N

1.3.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The library service is organised, managed and staffed to meet the needs of the hospital and users and to achieve service objectives.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7			
2.7.1 ☐ Y ☐ N		☐ Y ☐ N	
2.7.2 ☐ Y ☐ N		☐ Y ☐ N	
2.7.3 ☐ Y ☐ N		☐ Y ☐ N	
2.7.4 ☐ Y ☐ N		☐ Y ☐ N	
2.8			
2.8.1 ☐ Y ☐ N		☐ Y ☐ N	
2.8.2 ☐ Y ☐ N		☐ Y ☐ N	

2.9 Minutes of meetings are kept.

2.10 Staff are informed of the outcomes of these meetings.

2.11 The library service is involved in the development of hospital policies and procedures, where appropriate.

2.12 There are established working relationships between the library service and relevant hospital staff to co-ordinate the support required for educational courses.

2.13 There is an effective mechanism for consultation with all categories of user.

2.14 The library opening hours meet the requirements of the users.

Personnel

2.15 Written and dated job descriptions are available for all posts, which specify at least the following:

- 2.15.1 job title and grade
- 2.15.2 qualifications and/or experience required for the post
- 2.15.3 functions, responsibilities and accountability
- 2.15.4 frequency and type of staff appraisal
- 2.15.5 review date

2.16 A documented staff appraisal system exists for all staff.

2.17 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.18 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.19 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.20 Staffing is calculated and allocated on the basis of workload.

2.21 The additional requirements of training and supervising are reflected in the numbers of staff on duty.

2.22 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.15

2.15.1 ☐ Y ☐ N ☐ Y ☐ N

2.15.2 ☐ Y ☐ N ☐ Y ☐ N

2.15.3 ☐ Y ☐ N ☐ Y ☐ N

2.15.4 ☐ Y ☐ N ☐ Y ☐ N

2.15.5 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 The organisational chart is reviewed annually, revised and dated.

2.24 Staff are supported in the delivery of a library service by the following personnel:

2.24.1 administrative

2.24.2 secretarial

3. STAFF DEVELOPMENT AND EDUCATION

The library service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the library service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the library service

3.1.3 explains the relationships within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 introduces staff to the regional and national healthcare library networks

3.1.7 explains the method used to evaluate staff performance

3.1.8 introduces staff to the policies and procedures of the service and the hospital

3.1.9 explains emergency procedures (for example, fire drill)

3.1.10 provides information on the occupational health service offered to staff

3.2 As a minimum the continuing education programme:

3.2.1 utilises professional and other resource material

3.2.2 supports and encourages relevant research

3.2.3 provides information on advances in practice related to the library service

3.2.4 provides information on educational opportunities arranged by other institutions

3.2.5 provides orientation to new areas such as computer technology for libraries

3.3 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.4 Library assistants are encouraged to acquire appropriate technical qualifications (such as the City and Guilds certificate) and/or to qualify professionally.

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24

2.24.1 ☐ Y ☐ N ☐ Y ☐ N

2.24.2 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The library service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.1.10 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.2.4 ☐ Y ☐ N		☐ Y ☐ N	
3.2.5 ☐ Y ☐ N		☐ Y ☐ N	
3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.4 ☐ Y ☐ N		☐ Y ☐ N	

4. POLICIES AND PROCEDURES

There are current, written policies, procedures and standards which reflect current knowledge and practice.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the library service.

4.2 Staff are actively involved in the formulation of policies and procedures.

4.3 When policies and procedures are developed attention is drawn to practice in other fields, for example occupational health.

4.4 Policies and procedures are consistent with those of the hospital.

4.5 Policies and procedures cover at least the following topics:

- 4.5.1 stock selection
- 4.5.2 stock acquisition
- 4.5.3 relationships with other libraries
- 4.5.4 relationships with other information providers within the hospital or district

4.6 There is a policy for dealing with:

- 4.6.1 accidents
- 4.6.2 complaints

4.7 Records are kept which indicate to whom items listed in 4.6 have been referred and the action which has been taken.

4.8 Policies and procedures are dated and contained within a manual which as a minimum is:

- 4.8.1 regularly reviewed (annually) and updated
- 4.8.2 readily accessible for reference in the department

4.9 Staff are informed of current policies and procedures and follow them in all activities.

4. POLICIES AND PROCEDURES

There are current, written policies, procedures and standards which reflect current knowledge and practice.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5			
4.5.1 ☐ Y ☐ N		☐ Y ☐ N	
4.5.2 ☐ Y ☐ N		☐ Y ☐ N	
4.5.3 ☐ Y ☐ N		☐ Y ☐ N	
4.5.4 ☐ Y ☐ N		☐ Y ☐ N	
4.6			
4.6.1 ☐ Y ☐ N		☐ Y ☐ N	
4.6.2 ☐ Y ☐ N		☐ Y ☐ N	
4.7 ☐ Y ☐ N		☐ Y ☐ N	
4.8 ☐ Y ☐ N		☐ Y ☐ N	
4.8.1 ☐ Y ☐ N		☐ Y ☐ N	
4.8.2 ☐ Y ☐ N		☐ Y ☐ N	
4.9 ☐ Y ☐ N		☐ Y ☐ N	

5. FACILITIES AND EQUIPMENT

The facilities and equipment meet the immediate and foreseeable needs of the library service. The library accommodation facilitates safe, effective and efficient working arrangements and provides an environment which is conducive for study.

Standards

5.1 The library accommodation meets the space criteria laid down by the Department of Health in Health Building Note 42: "Accommodation for Education and Training".

5.2 The location of the library is:

- 5.5.1 accessible
- 5.5.2 central
- 5.5.3 close to parking facilities

5.3 There is access for disabled readers and staff.

5.4 There are areas within the library for the full range of readers' activities:

- 5.4.1 reading current periodicals
- 5.4.2 reference and literature searching
- 5.4.3 research and private study
- 5.4.4 use of audiovisual and electronic information

5.5 There is space and shelving to store and display the library's holdings of books, journals and other media.

5.6 The library's collections are clearly displayed and guided.

5.7 There is consideration for the security of the collections.

5.8 The library facilities include:

- 5.8.1 computers for:
  - (a) computer aided learning programmes
  - (b) databases and other locally held information
  - (c) on-line information retrieval
- 5.8.2 microform reading and printing
- 5.8.3 photocopiers

5.9 There is working space for library staff, not within the main library area, which provides for the receipt and processing of incoming materials, interlibrary loans etc.

5. FACILITIES AND EQUIPMENT

The facilities and equipment meet the immediate and foreseeable needs of the library service. The library accommodation facilitates safe, effective and efficient working arrangements and provides an environment which is conducive for study.

Standards	Comment		Comment
5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.2			
5.5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4			
5.4.1 ☐ Y ☐ N		☐ Y ☐ N	
5.4.2 ☐ Y ☐ N		☐ Y ☐ N	
5.4.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.6 ☐ Y ☐ N		☐ Y ☐ N	
5.7 ☐ Y ☐ N		☐ Y ☐ N	
5.8			
5.8.1			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
(c) ☐ Y ☐ N		☐ Y ☐ N	
5.8.2 ☐ Y ☐ N		☐ Y ☐ N	
5.8.3 ☐ Y ☐ N		☐ Y ☐ N	
5.9 ☐ Y ☐ N		☐ Y ☐ N	

5.10 There is a separate office for the library manager.

5.11 The library is linked to the district/hospital Local Area Network, which it uses both to distribute and to receive information.

5.12 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.13 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. EVALUATION AND QUALITY ASSURANCE

The library service ensures the provision of a high quality service by its involvement in the evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the library service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance plan for the library service includes the review of at least the following:

6.3.1 service users' satisfaction

6.3.2 the library service in comparison with standards set out in this chapter

6.3.3 the performance of all library staff
(see Management and Staffing in this section)

6.3.4 the use of resources

6.4 The quality of the information and documents supplied by the library are periodically reviewed in terms of their:

6.4.1 accuracy

6.4.2 relevance

6.4.3 timeliness

6.5 The evaluation activities include the following elements:

6.5.1 monitoring: the routine collection of information/statistics about important aspects of delivery of services

6.5.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

The library service ensures the provision of a high quality service by its involvement in the evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3.3 ☐ Y ☐ N		☐ Y ☐ N	
6.3.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	
6.5			
6.5.1 ☐ Y ☐ N		☐ Y ☐ N	
6.5.2 ☐ Y ☐ N		☐ Y ☐ N	

6.5.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

6.5.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

6.5.5 feedback: the results of activities are regularly communicated to the staff

6.6 Service evaluation meetings are held on a regular basis.

6.7 Records of attendance and minutes of evaluation meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.8 The staff within the service receive a report of results obtained through evaluation of service.

6.9 The staff within the service participate in the formulation of plans for improvement.

6.10 There is a mechanism for making and dealing with complaints/suggestions from users and staff, which is known to all.

6.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.12 There is a mechanism for the systematic testing of users' views and implementation of change as a result.

6.13 Statistics are collected and used to effect management/practice change, for example:

6.13.1 records of enquiries received and the answers provided

6.13.2 interlibrary loans (outgoing and incoming)

6.13.3 all photocopies made by library staff

(ref. minimum data set established by NHS Regional Librarians Group)

6.14 There are local policies for collection of information on key areas such as request response times.

6.5.3 ☐ Y ☐ N ☐ Y ☐ N

6.5.4 ☐ Y ☐ N ☐ Y ☐ N

6.5.5 ☐ Y ☐ N ☐ Y ☐ N

6.6 ☐ Y ☐ N ☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.13.1 ☐ Y ☐ N ☐ Y ☐ N

6.13.2 ☐ Y ☐ N ☐ Y ☐ N

6.13.3 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

LIBRARY SERVICE

Surveyor's General Comments

LIBRARY SERVICE
Surveyor's Comments

Standard Number	Recommendation

MEDICAL RECORD SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

MEDICAL RECORD SERVICE

1. PHILOSOPHY AND OBJECTIVES

The medical record service provides a safe, efficient and effective system for the storage and retrieval of the patient's medical record.

Standards

1.1 Staff within the medical record department develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the medical record department develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the medical record service.

1.3 The objectives for the service include at least the following:

- 1.3.1 maintaining confidentiality in accordance with the Data Protection Act 1984
- 1.3.2 providing services on a routine, regular and emergency basis
- 1.3.3 providing and maintaining a high quality service through organisational audit and service evaluation activities
- 1.3.4 maintaining communication with medical, nursing staff and other professional staff concerning storage and retrieval of medical records
- 1.3.5 conducting professional activities in accordance with standards set by the relevant professional organisation (for example, the Association of Medical Records Officers)

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

- 1.4.1 be courteous and considerate to patients and their carers at all times
- 1.4.2 respect patients' privacy and dignity and that of their carers
- 1.4.3 respect and cater for cultural differences
- 1.4.4 respond to communication difficulties

1.5 The objectives for the service are reviewed annually, discussed and endorsed by staff, as a minimum when there is a change in:

- 1.5.1 the role of the hospital
- 1.5.2 the provision of services
- 1.5.3 the pattern of delivery of services
- 1.5.4 staffing patterns
- 1.5.5 the nature of professional practice

MEDICAL RECORD SERVICE

1. PHILOSOPHY AND OBJECTIVES

The medical record service provides a safe, efficient and effective system for the storage and retrieval of the patient's medical record.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.4			
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4.4 ☐ Y ☐ N		☐ Y ☐ N	
1.5			
1.5.1 ☐ Y ☐ N		☐ Y ☐ N	
1.5.2 ☐ Y ☐ N		☐ Y ☐ N	
1.5.3 ☐ Y ☐ N		☐ Y ☐ N	
1.5.4 ☐ Y ☐ N		☐ Y ☐ N	
1.5.5 ☐ Y ☐ N		☐ Y ☐ N	

2. MANAGEMENT AND STAFFING

The medical record service is organised, managed and staffed to enable the provision of medical records which are pertinent to the treatment given in the hospital and its associated services.

Standards

Management

2.1 The service is managed by a qualified or experienced person.

2.2 There is a designated deputy to act in the absence of the manager.

2.3 In a hospital where the employment of a medical records manager on a full-time or part-time basis is not justified, documented evidence shows that the hospital is receiving ongoing consultative advice from a qualified person.

2.4 The manager (however named) is involved in the preparation of the budget for the medical record service.

2.5 The manager (however named) is responsible for the efficient and effective management of the service's budget.

2.6 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.7 The budget reports are accurate.

2.8 Records and statistics are available for the effective management of the service which as a minimum include:

- 2.8.1 ratio of staff to workload
- 2.8.2 staff absentee rate
- 2.8.3 staff sickness rate
- 2.8.4 staff turnover rate

2.9 Regular staff meetings are held to:

- 2.9.1 maintain good communications
- 2.9.2 review service practices

2.10 Minutes of these meetings are kept.

2.11 Staff are informed of the outcomes of these meetings.

2. MANAGEMENT AND STAFFING

The medical record service is organised, managed and staffed to enable the provision of medical records which are pertinent to the treatment given in the hospital and its associated services.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7 ☐ Y ☐ N		☐ Y ☐ N	
2.8			
2.8.1 ☐ Y ☐ N		☐ Y ☐ N	
2.8.2 ☐ Y ☐ N		☐ Y ☐ N	
2.8.3 ☐ Y ☐ N		☐ Y ☐ N	
2.8.4 ☐ Y ☐ N		☐ Y ☐ N	
2.9			
2.9.1 ☐ Y ☐ N		☐ Y ☐ N	
2.9.2 ☐ Y ☐ N		☐ Y ☐ N	
2.10 ☐ Y ☐ N		☐ Y ☐ N	
2.11 ☐ Y ☐ N		☐ Y ☐ N	

2.12 There is a medical record committee whose membership includes the manager of the medical record service, medical and nursing staff representatives, and other professional staff who contribute substantially to the medical record.

2.13 The medical record committee:

2.13.1 meets regularly

2.13.2 keeps minutes

2.13.3 reports regularly to the hospital management

2.13.4 has members who attend a majority of meetings

2.13.5 reviews its membership at an agreed interval

2.14 The issues considered by the medical record committee include at least the following:

2.14.1 to determine standards and policies for the medical record format

2.14.2 to introduce new medical record forms or alteration to existing forms

2.14.3 to recommend action to be taken when problems arise in relation to medical records and medical record services (for example, when records are not returned to the storage area)

2.14.4 to analyse the content of the medical record on a systematic basis to ensure that the recorded clinical information enables the provision and evaluation of patient care

2.15 Statistical information is provided by the medical record service or elsewhere as determined by the requirements of the hospital and is distributed to appropriate committees and members of staff.

2.16 The type and amount of information maintained includes the following:

2.16.1 births and deaths

2.16.2 complications

2.16.3 diagnoses/conditions

2.16.4 length of stay

2.16.5 number of admissions and discharges

2.16.6 procedures performed

2.17 Medical record staff may act as a resource for evaluation activities of the hospital and associated services. Involvement includes:

2.17.1 compiling requested patient care statistical data for utilisation review and clinical audit programmes

2.17.2 supervising and/or advising in relation to data collection by other hospital staff

2. MANAGEMENT AND STAFFING

The medical record service is organised, managed and staffed to enable the provision of medical records which are pertinent to the treatment given in the hospital and its associated services.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7 ☐ Y ☐ N		☐ Y ☐ N	
2.8			
2.8.1 ☐ Y ☐ N		☐ Y ☐ N	
2.8.2 ☐ Y ☐ N		☐ Y ☐ N	
2.8.3 ☐ Y ☐ N		☐ Y ☐ N	
2.8.4 ☐ Y ☐ N		☐ Y ☐ N	
2.9			
2.9.1 ☐ Y ☐ N		☐ Y ☐ N	
2.9.2 ☐ Y ☐ N		☐ Y ☐ N	
2.10 ☐ Y ☐ N		☐ Y ☐ N	
2.11 ☐ Y ☐ N		☐ Y ☐ N	

2.12 There is a medical record committee whose membership includes the manager of the medical record service, medical and nursing staff representatives, and other professional staff who contribute substantially to the medical record.

2.13 The medical record committee:

2.13.1 meets regularly

2.13.2 keeps minutes

2.13.3 reports regularly to the hospital management

2.13.4 has members who attend a majority of meetings

2.13.5 reviews its membership at an agreed interval

2.14 The issues considered by the medical record committee include at least the following:

2.14.1 to determine standards and policies for the medical record format

2.14.2 to introduce new medical record forms or alteration to existing forms

2.14.3 to recommend action to be taken when problems arise in relation to medical records and medical record services (for example, when records are not returned to the storage area)

2.14.4 to analyse the content of the medical record on a systematic basis to ensure that the recorded clinical information enables the provision and evaluation of patient care

2.15 Statistical information is provided by the medical record service or elsewhere as determined by the requirements of the hospital and is distributed to appropriate committees and members of staff.

2.16 The type and amount of information maintained includes the following:

2.16.1 births and deaths

2.16.2 complications

2.16.3 diagnoses/conditions

2.16.4 length of stay

2.16.5 number of admissions and discharges

2.16.6 procedures performed

2.17 Medical record staff may act as a resource for evaluation activities of the hospital and associated services. Involvement includes:

2.17.1 compiling requested patient care statistical data for utilisation review and clinical audit programmes

2.17.2 supervising and/or advising in relation to data collection by other hospital staff

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13

2.13.1 ☐ Y ☐ N ☐ Y ☐ N

2.13.2 ☐ Y ☐ N ☐ Y ☐ N

2.13.3 ☐ Y ☐ N ☐ Y ☐ N

2.13.4 ☐ Y ☐ N ☐ Y ☐ N

2.13.5 ☐ Y ☐ N ☐ Y ☐ N

2.14

2.14.1 ☐ Y ☐ N ☐ Y ☐ N

2.14.2 ☐ Y ☐ N ☐ Y ☐ N

2.14.3 ☐ Y ☐ N ☐ Y ☐ N

2.14.4 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16

2.16.1 ☐ Y ☐ N ☐ Y ☐ N

2.16.2 ☐ Y ☐ N ☐ Y ☐ N

2.16.3 ☐ Y ☐ N ☐ Y ☐ N

2.16.4 ☐ Y ☐ N ☐ Y ☐ N

2.16.5 ☐ Y ☐ N ☐ Y ☐ N

2.16.6 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.17.1 ☐ Y ☐ N ☐ Y ☐ N

2.17.2 ☐ Y ☐ N ☐ Y ☐ N

2.17.3 reviewing medical records to determine compliance with established standards for an adequate medical record

2.17.4 suggesting methods to improve medical record information systems

Personnel

2.18 Written and dated job descriptions are available for all posts, which specify at least the following:

2.18.1 job title and grade

2.18.2 qualifications and/or experience required for the post

2.18.3 functions, responsibilities and accountability

2.18.4 frequency and type of staff appraisal

2.18.5 review date

2.19 A documented staff appraisal system exists for all staff.

2.20 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.21 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.22 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.23 Staffing is calculated and allocated on the basis of workload.

2.24 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.25 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.26 The organisational chart is reviewed annually, revised and dated.

2.27 Staff are supported in the delivery of care by the following personnel:

2.27.1 administrative

2.27.2 ancillary

2.27.3 secretarial

2.17.3 ☐ Y ☐ N ☐ Y ☐ N

2.17.4 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.18

2.18.1 ☐ Y ☐ N ☐ Y ☐ N

2.18.2 ☐ Y ☐ N ☐ Y ☐ N

2.18.3 ☐ Y ☐ N ☐ Y ☐ N

2.18.4 ☐ Y ☐ N ☐ Y ☐ N

2.18.5 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27

2.27.1 ☐ Y ☐ N ☐ Y ☐ N

2.27.2 ☐ Y ☐ N ☐ Y ☐ N

2.27.3 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The medical record service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 explains the relationships within the department and with the hospital
- 3.1.3 prepares staff for their role and responsibilities
- 3.1.4 explains lines of authority both within the service and with the hospital
- 3.1.5 explains the method used to evaluate staff performance
- 3.1.6 introduces staff to the policies and procedures of the service and the hospital
- 3.1.7 explains emergency procedures (for example, fire drill)
- 3.1.8 provides information on the occupational health service offered to staff

3.2 As a minimum the continuing education programme:

- 3.2.1 utilises professional and other resource material
- 3.2.2 supports and encourages relevant research
- 3.2.3 provides information on advances in practice related to the medical record service and the particular speciality
- 3.2.4 provides information on educational opportunities arranged by other institutions
- 3.2.5 provides orientation to areas such as computer systems
- 3.2.6 covers health and safety at work

3.3 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.4 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.5 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.6 Where hospitals have responsibilities relative to teaching and research, medical record service staff co-operate with these programmes as required.

3. STAFF DEVELOPMENT AND EDUCATION

The medical record service provides in-service and continuing education programmes for al levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.2.4 ☐ Y ☐ N		☐ Y ☐ N	
3.2.5 ☐ Y ☐ N		☐ Y ☐ N	
3.2.6 ☐ Y ☐ N		☐ Y ☐ N	
3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.6 ☐ Y ☐ N		☐ Y ☐ N	

4. POLICIES AND PROCEDURES

Written policies and procedures reflect current standards of medical record management and guide the staff responsible for maintaining medical records.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the medical record service.

4.2 Policies and procedures are agreed by the medical records committee.

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies and procedures are developed, attention is drawn to practice in other fields, for example occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 A hospital record is maintained for every patient.

4.7 There is a documented system of identification, a patient master index and a filing system which allows for rapid retrieval of records.

4.8 There is provision for twenty four hour access to hospital records.

4.9 There are policies for at least the following:

- 4.9.1 safeguarding the information in the record against loss, damage, or use by unauthorised persons
- 4.9.2 where computerised records are maintained specific measures are taken to ensure confidentiality in accordance with the Data Protection Act 1984, Department of Health Guidance and the professional code of ethics
- 4.9.3 confidentiality and release of information which takes into account the Data Protection Act and Access to Medical Record Act, 1988
- 4.9.4 retention, destruction and microfilming of medical records (in accordance with British Standards Guidelines B56498 1984 and Health Circular (89/20) and guidelines to the appropriate storage of active and inactive records)
- 4.9.5 storage of records held separately from the main record (for example, accident and emergency)
- 4.9.6 compilation of statistical returns

4.10 All records are coded and indexed (where applicable) within three months of the patient's discharge.

4.11 There is a system for recording and monitoring medical records which are absent from the hospital and associated services.

4. POLICIES AND PROCEDURES

Written policies and procedures reflect current standards of medical record management and guide the staff responsible for maintaining medical records.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6 ☐ Y ☐ N		☐ Y ☐ N	
4.7 ☐ Y ☐ N		☐ Y ☐ N	
4.8 ☐ Y ☐ N		☐ Y ☐ N	
4.9			
4.9.1 ☐ Y ☐ N		☐ Y ☐ N	
4.9.2 ☐ Y ☐ N		☐ Y ☐ N	
4.9.3 ☐ Y ☐ N		☐ Y ☐ N	
4.9.4 ☐ Y ☐ N		☐ Y ☐ N	
4.9.5 ☐ Y ☐ N		☐ Y ☐ N	
4.9.6 ☐ Y ☐ N		☐ Y ☐ N	
4.10 ☐ Y ☐ N		☐ Y ☐ N	
4.11 ☐ Y ☐ N		☐ Y ☐ N	

4.12 There is a policy for dealing with:

4.12.1 accidents

4.12.2 errors

4.12.3 incidents

4.12.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.13 Records are kept which indicate to whom the matter has been referred and the action which has been taken.

4.14 Policies and procedures are contained in a manual which is:

4.14.1 regularly reviewed (annually) and updated

4.14.2 readily accessible for reference in the department

4.15 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

Facilities and equipment are available for the safe, efficient and effective operation of the service and are in accordance with Health Building Note 4.

Standards

5.1 The space available is consistent with Health Building Note 4.

5.2 The location of the medical record department facilitates the rapid retrieval and distribution of medical records.

5.3 There are office facilities for the manager of the service.

5.4 There is space available for other personnel to read and work with medical records, including records on microfilm.

5.5 There is storage space for medical records which allows for future storage needs.

5.6 The active storage area includes all records currently in use by staff at the hospital.

5.7 The active and inactive records are stored in accordance with statutory requirements.

5.8 The active and inactive medical record store is secure to protect records against loss, damage, or use by unauthorised persons.

5.9 Where specialised equipment is used, it is operated only by staff trained to do so.

4.12		
4.12.1	☐ Y ☐ N	☐ Y ☐ N
4.12.2	☐ Y ☐ N	☐ Y ☐ N
4.12.3	☐ Y ☐ N	☐ Y ☐ N
4.12.4	☐ Y ☐ N	☐ Y ☐ N
4.13	☐ Y ☐ N	☐ Y ☐ N
4.14	☐ Y ☐ N	☐ Y ☐ N
4.14.1	☐ Y ☐ N	☐ Y ☐ N
4.14.2	☐ Y ☐ N	☐ Y ☐ N
4.15	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

Facilities and equipment are available for the safe, efficient and effective operation of the service and are in accordance with Health Building Note 4.

Standards	Comment		Comment
5.1	☐ Y ☐ N	☐ Y ☐ N	
5.2	☐ Y ☐ N	☐ Y ☐ N	
5.3	☐ Y ☐ N	☐ Y ☐ N	
5.4	☐ Y ☐ N	☐ Y ☐ N	
5.5	☐ Y ☐ N	☐ Y ☐ N	
5.6	☐ Y ☐ N	☐ Y ☐ N	
5.7	☐ Y ☐ N	☐ Y ☐ N	
5.8	☐ Y ☐ N	☐ Y ☐ N	
5.9	☐ Y ☐ N	☐ Y ☐ N	

5.10 There is a planned preventative maintenance and replacement programme for all equipment in accordance with HEI(98) 1982, Management of Equipment.

5.11 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. EVALUATION AND QUALITY

The medical record service ensures the provision of a high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the medical record service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme includes the review of at least the following:

6.3.1 service users' satisfaction

6.3.2 the medical record service in comparison with standards set out in this chapter

6.3.3 the performance of all medical record staff
(see Management and Staffing in this section)

6.3.4 the evaluation of service performance through multidisciplinary audit

6.3.5 use of resources

6.4 The evaluation activities include the following elements:

6.4.1 monitoring: the routine collection of information/statistics about significant aspects of delivery of services

6.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery

6.4.3 action: when significant problems or opportunities to improve service delivery are identified, action is taken and documented

6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Service evaluation meetings are held on a regular basis.

6.6 Records of attendance and minutes of evaluation meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY

The medical record service ensures the provision of a high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3.3 ☐ Y ☐ N		☐ Y ☐ N	
6.3.4 ☐ Y ☐ N		☐ Y ☐ N	
6.3.5 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4.5 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6 ☐ Y ☐ N		☐ Y ☐ N	

6.7 The staff within the service receive a report of results obtained through evaluation of the service.

6.8 The staff within the service participate in the formulation of plans for improvement.

6.9 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

6.10 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.11 There is a mechanism for the systematic testing of users' views and implementation of change as a result.

6.12 Statistics are collected for Korner returns.

6.13 Statistics collected are used to effect management/practice change.

6.14 There are local policies for collection of information on key areas such as missing notes, time taken to retrieve notes.

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

MEDICAL RECORD SERVICE
Surveyor's General Comments

MEDICAL RECORD SERVICE
Surveyor's Comments

Standard Number	Recommendation

MEDICAL RECORD CONTENT

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

MEDICAL RECORD CONTENT

An accurate medical record is maintained which facilitates a high standard of patient care and allows for evaluation of the care provided. A medical record is a composite of all data on a given patient whether as an in-patient, out-patient or emergency patient. The entire medical record is contained in one folder with a unique identification number for each individual patient.

Standards

1.1 The record enables:

- 1.1.1 the patient to receive effective continuing care
- 1.1.2 effective communication within the health care team
- 1.1.3 another doctor or other professional staff to assume the care of the patient at any time
- 1.1.4 the carrying out of concurrent or retrospective evaluation of patient care
- 1.1.5 identification of the patient without risk or error
- 1.1.6 data collection for research and education
- 1.1.7 use in legal interest of patient or professional staff

1.2 Entries into the records are made only by authorised staff and are dated and signed, with the name and designation of the signatory.

1.3 All entries in the record, including alterations to the record, are legible.

1.4 Abbreviations and symbols are kept to a minimum and limited to those approved by the medical records committee.

1.5 The notes provide a relevant, chronological account of the patient's care and justify clinical decisions.

1.6 Where possible, originals of all reports by medical, nursing and allied health professionals are filed in the records.

1.7 Each record contains at least the following identification data:

- 1.7.1 a unique medical record number or reference on every page
- 1.7.2 name in full on every page
- 1.7.3 address and postcode
- 1.7.4 telephone number
- 1.7.5 date of birth
- 1.7.6 sex

MEDICAL RECORD CONTENT

An accurate medical record is maintained which facilitates a high standard of patient care and allows for evaluation of the care provided. A medical record is a composite of all data on a given patient whether as an in-patient, out-patient or emergency patient. The entire medical record is contained in one folder with a unique identification number for each individual patient.

Standards	Comment		Comment
1.1			
1.1.1	☐ Y ☐ N	☐ Y ☐ N	
1.1.2	☐ Y ☐ N	☐ Y ☐ N	
1.1.3	☐ Y ☐ N	☐ Y ☐ N	
1.1.4	☐ Y ☐ N	☐ Y ☐ N	
1.1.5	☐ Y ☐ N	☐ Y ☐ N	
1.1.6	☐ Y ☐ N	☐ Y ☐ N	
1.1.7	☐ Y ☐ N	☐ Y ☐ N	
1.2	☐ Y ☐ N	☐ Y ☐ N	
1.3	☐ Y ☐ N	☐ Y ☐ N	
1.4	☐ Y ☐ N	☐ Y ☐ N	
1.5	☐ Y ☐ N	☐ Y ☐ N	
1.6	☐ Y ☐ N	☐ Y ☐ N	
1.7			
1.7.1	☐ Y ☐ N	☐ Y ☐ N	
1.7.2	☐ Y ☐ N	☐ Y ☐ N	
1.7.3	☐ Y ☐ N	☐ Y ☐ N	
1.7.4	☐ Y ☐ N	☐ Y ☐ N	
1.7.5	☐ Y ☐ N	☐ Y ☐ N	
1.7.6	☐ Y ☐ N	☐ Y ☐ N	

1.7.7 person to notify in an emergency (next of kin)

1.7.8 general practitioner

1.7.9 name of admitting consultant

1.7.10 source of referral

1.8 An "alert" notation for conditions such as allergic responses and drug reactions is prominently displayed on the front cover of the record.

1.9 The record contains a written admission diagnosis by a clinician with date and time of initial consultation. This may often be provisional.

1.10 The record contains a patient history pertinent to the condition being treated, including relevant details of:

1.10.1 present and past medical history

1.10.2 family history

1.10.3 social considerations

1.10.4 relevant medication

1.11 For each admission there is a report of the initial physical examination performed by a clinician.

1.12 A clinical history and examination is available as soon as possible after admission and prior to any surgical procedure.

1.13 When a history and examination have been carried out and recorded prior to admission or transfer, these reports are verified, updated and signed by a clinician, when such reports are pertinent to that admission.

1.14 There is evidence that the patient has given informed consent:

1.14.1 the consent form conforms with the hospital policy

1.14.2 consent is obtained by a clinician

1.14.3 the correct procedure is followed when obtaining informed consent for children under the age of 16 years

1.14.4 where special statutory requirements exist they are adhered to (for example, in the case of electro-convulsive therapy or hospital detention using the Mental Health Act 1983)

1.15 Prescriptions are written by qualified medical staff and the records of drug therapy are filed in the patient's medical record.

1.16 Therapeutic orders and orders for special diagnostic tests are noted in the record and in the nursing plan.

1.17 The medical record contains nursing and medical patient care plans.

1.7.7	☐ Y ☐ N	☐ Y ☐ N
1.7.8	☐ Y ☐ N	☐ Y ☐ N
1.7.9	☐ Y ☐ N	☐ Y ☐ N
1.7.10	☐ Y ☐ N	☐ Y ☐ N
1.8	☐ Y ☐ N	☐ Y ☐ N
1.9	☐ Y ☐ N	☐ Y ☐ N
1.10		
1.10.1	☐ Y ☐ N	☐ Y ☐ N
1.10.2	☐ Y ☐ N	☐ Y ☐ N
1.10.3	☐ Y ☐ N	☐ Y ☐ N
1.10.4	☐ Y ☐ N	☐ Y ☐ N
1.11	☐ Y ☐ N	☐ Y ☐ N
1.12	☐ Y ☐ N	☐ Y ☐ N
1.13	☐ Y ☐ N	☐ Y ☐ N
1.14		
1.14.1	☐ Y ☐ N	☐ Y ☐ N
1.14.2	☐ Y ☐ N	☐ Y ☐ N
1.14.3	☐ Y ☐ N	☐ Y ☐ N
1.14.4	☐ Y ☐ N	☐ Y ☐ N
1.15	☐ Y ☐ N	☐ Y ☐ N
1.16	☐ Y ☐ N	☐ Y ☐ N
1.17	☐ Y ☐ N	☐ Y ☐ N

1.18 The responsibilities of the medical staff, nurses and allied health professionals for the proper and timely completion of medical records are clearly specified.

1.19 Progress notes, observations and consultation reports are written, signed and dated by medical, nursing and allied health staff to ensure that all significant events, such as alterations in the patient's condition and responses to treatment, are recorded.

1.20 There is a record of information given to patients and/or carers.

1.21 The frequency of general progress reports is in accordance with departmental policy.

1.22 All verbal instructions are recorded.

1.23 A clinician records the pre-operative diagnosis prior to surgery and there is an operative report immediately after surgery which includes:

- 1.23.1 the name of the operating surgeon(s) and signature
- 1.23.2 the name of the consultant
- 1.23.3 description of the findings
- 1.23.4 diagnosis and the procedure performed
- 1.23.5 tissue removed, altered or added
- 1.23.6 prosthetics used (details and serial numbers)
- 1.23.7 sutures used
- 1.23.8 complications
- 1.23.9 post-operative instructions

1.24 The record contains information relating to anaesthesia including:

- 1.24.1 evidence of a pre-operative assessment by an anaesthetist, preferably by the attending anaesthetist
- 1.24.2 drugs and doses given during anaesthesia and route of administration
- 1.24.3 monitoring data
- 1.24.4 intravenous fluid therapy, if given
- 1.24.5 post-anaesthetic instructions where appropriate
- 1.24.6 name and signature of attending anaesthetist(s)

1.25 The front sheet is completed at the time of discharge or as soon as the relevant information is available.

1.26 The front sheet contains all diagnoses and procedures using the terminology of a current revision of the International Classification of Disease (ICD a) and OPCS4 coding for operative procedures.

1.18 ☐ Y ☐ N ☐ Y ☐ N

1.19 ☐ Y ☐ N ☐ Y ☐ N

1.20 ☐ Y ☐ N ☐ Y ☐ N

1.21 ☐ Y ☐ N ☐ Y ☐ N

1.22 ☐ Y ☐ N ☐ Y ☐ N

1.23 ☐ Y ☐ N ☐ Y ☐ N

1.23.1 ☐ Y ☐ N ☐ Y ☐ N
1.23.2 ☐ Y ☐ N ☐ Y ☐ N
1.23.3 ☐ Y ☐ N ☐ Y ☐ N
1.23.4 ☐ Y ☐ N ☐ Y ☐ N
1.23.5 ☐ Y ☐ N ☐ Y ☐ N
1.23.6 ☐ Y ☐ N ☐ Y ☐ N
1.23.7 ☐ Y ☐ N ☐ Y ☐ N
1.23.8 ☐ Y ☐ N ☐ Y ☐ N
1.23.9 ☐ Y ☐ N ☐ Y ☐ N

1.24

1.24.1 ☐ Y ☐ N ☐ Y ☐ N

1.24.2 ☐ Y ☐ N ☐ Y ☐ N
1.24.3 ☐ Y ☐ N ☐ Y ☐ N
1.24.4 ☐ Y ☐ N ☐ Y ☐ N
1.24.5 ☐ Y ☐ N ☐ Y ☐ N
1.24.6 ☐ Y ☐ N ☐ Y ☐ N

1.25 ☐ Y ☐ N ☐ Y ☐ N

1.26 ☐ Y ☐ N ☐ Y ☐ N

1.27 For each patient there is a discharge summary/letter which is completed within 14 days of the patient's discharge and sent to the general practitioner, hospital or institution to which the patient is discharged, with a copy remaining in the medical record. The discharge summary/letter includes at least:

1.27.1 the name of the consultant in charge

1.27.2 patient's condition on discharge

1.27.3 discharge diagnosis

1.27.4 procedures performed

1.27.5 brief resumé of significant findings and events of the patient's hospitalisation

1.27.6 follow up arrangements

1.27.7 medication requirements

1.27.8 information given to patients and/or carers

1.28 When a patient is transferred to another hospital, or is returning to the care of another doctor, the patient's medical record is also transferred.

1.29 When a post mortem is performed, a provisional anatomical diagnosis is noted in the medical record within 72 hours and the medical record is completed within one month following the death. A copy of the post mortem report is filed in the medical record.

1.30 A review of the clinical diagnosis and findings of the post mortem examination are recorded in the medical record.

1.27 ☐ Y ☐ N ☐ Y ☐ N

1.27.1 ☐ Y ☐ N ☐ Y ☐ N

1.27.2 ☐ Y ☐ N ☐ Y ☐ N

1.27.3 ☐ Y ☐ N ☐ Y ☐ N

1.27.4 ☐ Y ☐ N ☐ Y ☐ N

1.27.5 ☐ Y ☐ N ☐ Y ☐ N

1.27.6 ☐ Y ☐ N ☐ Y ☐ N

1.27.7 ☐ Y ☐ N ☐ Y ☐ N

1.27.8 ☐ Y ☐ N ☐ Y ☐ N

1.28 ☐ Y ☐ N ☐ Y ☐ N

1.29 ☐ Y ☐ N ☐ Y ☐ N

1.30 ☐ Y ☐ N ☐ Y ☐ N

MEDICAL RECORD CONTENT

Surveyor's General Comments

MEDICAL RECORD CONTENT

Surveyor's Comments

Standard Number	Recommendation

PROFESSIONAL MANAGEMENT

Medical 87
Nursing 99
Professions Allied to Medicine 111

MEDICAL

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

MEDICAL

This section covers the range of medical services offered by an acute hospital. Where appropriate each division/directorate/specialty may complete its own section. If this does apply, please indicate which specialty has completed each section.

Specialty _____

1. PHILOSOPHY AND OBJECTIVES

The medical service has the responsibility for providing high quality medical care to patients and for the ethical conduct and professional practices of its members of staff.

Standards

1.1 A representative group of medical staff participates in the formulation of the philosophy for the hospital in general and for the medical service in particular.

1.2 A representative group of medical staff participates in the development of written objectives to achieve the philosophy of the hospital and the medical service. These objectives are used as a guide to planning, implementing and evaluating all aspects of the medical service.

1.3 The objectives for each service include at least the following:

1.3.1 providing patients with a quality service and care which is based on assessment of patients' needs

1.3.2 providing patients with a quality service and care which is based on professional standards where available

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes

1.3.6 maintaining communication with other members of the health care team to:

(a) meet patient needs

(b) enable co-ordination of services

1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.3.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

1.3.9 clinical limitations

MEDICAL

This section covers the range of medical services offered by an acute hospital. Where appropriate each division/directorate/specialty may complete its own section. If this does apply, please indicate which specialty has completed each section.

Specialty _____

1. PHILOSOPHY AND OBJECTIVES

The medical service has the responsibility for providing high quality medical care to patients and for the ethical conduct and professional practices of its members of staff.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.3.7 ☐ Y ☐ N		☐ Y ☐ N	
1.3.8 ☐ Y ☐ N		☐ Y ☐ N	
1.3.9 ☐ Y ☐ N		☐ Y ☐ N	

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

1.4.3 respect and cater for cultural differences

1.4.4 respond to communication difficulties

1.4.5 identify counselling requirements of the patient and carers

1.5 Individual specialties/divisions develop specific written objectives.

1.6 The objectives for each service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.6.1 the role of the hospital

1.6.2 the provision of services

1.6.3 the pattern of delivery of service

1.6.4 staffing patterns

1.6.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The medical service is organised, managed and staffed to provide a framework within which medical staff can effectively deliver clinical services to all patients in the hospital.

Standards

Management

2.1 There is a formal structure of specialty divisions, departments or directorates for effective delivery of clinical services.

2.2 For each department/divisional structure or directorate there is a designated departmental/ divisional head/chairman or director.

2.3 Where there is a clinical directorate the responsibilities of the director include but are not limited to:

2.3.1 administrative arrangements within the directorate

2.3.2 ensuring that the quality and appropriateness of medical care provided within the directorate are monitored and evaluated

2.3.3 involvement in the appointment and deployment of qualified medical staff

2.4 The designated departmental head (however named) is involved in the preparation of the individual clinical service's budget.

1.4

1.4.1 ☐ Y ☐ N ☐ Y ☐ N

1.4.2 ☐ Y ☐ N ☐ Y ☐ N

1.4.3 ☐ Y ☐ N ☐ Y ☐ N

1.4.4 ☐ Y ☐ N ☐ Y ☐ N

1.4.5 ☐ Y ☐ N ☐ Y ☐ N

1.5 ☐ Y ☐ N ☐ Y ☐ N

1.6

1.6.1 ☐ Y ☐ N ☐ Y ☐ N

1.6.2 ☐ Y ☐ N ☐ Y ☐ N

1.6.3 ☐ Y ☐ N ☐ Y ☐ N

1.6.4 ☐ Y ☐ N ☐ Y ☐ N

1.6.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The medical service is organised, managed and staffed to provide a framework within which medical staff can effectively deliver clinical services to all patients in the hospital.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3			
2.3.1 ☐ Y ☐ N		☐ Y ☐ N	
2.3.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	

2.5 The designated departmental head (however named) is responsible for the efficient and effective management of the budget.

2.6 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.7 The budget reports are accurate.

2.8 Records and statistics are available for the effective management of the medical service:

- 2.8.1 ratio of staff to workload
- 2.8.2 staff absentee rate
- 2.8.3 staff sickness rate
- 2.8.4 staff turnover rate

2.9 Medical staff within specialties or divisions meet regularly to maintain good communications and to review service practices. Minutes of meetings are kept.

2.10 Staff are informed of the outcomes of these meetings.

2.11 Senior medical staff are involved in the development of hospital policies and procedures where appropriate.

2.12 There is an association of medical staff, however named, which is responsible for representing the professional needs of all the medical staff. This is a formally constituted committee which meets regularly and keeps formal minutes. All senior staff are members with full voting rights.

2.13 There is documented evidence that the association of medical staff meets regularly and with a quorum which ensures effective communication with the hospital management and all medical staff.

2.14 The functions and responsibilities of the association of medical staff include:

- 2.14.1 acting in an advisory role and making recommendations to the hospital management on matters concerning medical problems
- 2.14.2 co-ordinating the activities and general policies of the medical staff
- 2.14.3 providing representatives on all committees requiring medical participation
- 2.14.4 ensuring professionally ethical conduct in compliance with statutory regulations and professional standards
- 2.14.5 providing advice on the integration, planning and co-ordination of clinical services
- 2.14.6 providing advice on the requirements for qualified medical staff of appropriate grade and speciality and their most effective deployment

2.15 All medical staff are informed of the activities and outcomes of medical committees and staff meetings.

2.5 ☐ Y ☐ N ☐ Y ☐ N

2.6 ☐ Y ☐ N ☐ Y ☐ N

2.7 ☐ Y ☐ N ☐ Y ☐ N

2.8

2.8.1 ☐ Y ☐ N ☐ Y ☐ N

2.8.2 ☐ Y ☐ N ☐ Y ☐ N

2.8.3 ☐ Y ☐ N ☐ Y ☐ N

2.8.4 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14

2.14.1 ☐ Y ☐ N ☐ Y ☐ N

2.14.2 ☐ Y ☐ N ☐ Y ☐ N

2.14.3 ☐ Y ☐ N ☐ Y ☐ N

2.14.4 ☐ Y ☐ N ☐ Y ☐ N

2.14.5 ☐ Y ☐ N ☐ Y ☐ N

2.14.6 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.16 Written and dated job descriptions are available for all posts, which specify at least the following:

2.16.1 job title and grade

2.16.2 qualifications and/or experience required for the post

2.16.3 functions, responsibilities and accountability

2.16.4 frequency and type of staff appraisal

2.16.5 review date

2.17 A documented staff appraisal system exists for all staff where appropriate to the individual's contract.

2.18 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.19 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.20 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.21 Staffing is calculated and allocated on the basis of workload.

2.22 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.23 When house officers or medical students are involved, senior medical staff are available within the hospital to provide guidance and support.

2.24 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability within specialties and in relation to the hospital management.

2.25 The organisational chart is reviewed annually, revised and dated.

2.26 Medical staff are supported in the delivery of health care by the following personnel:

2.26.1 administrative

2.26.2 ancillary

2.26.3 secretarial

Personnel

2.16

2.16.1 ☐ Y ☐ N ☐ Y ☐ N

2.16.2 ☐ Y ☐ N ☐ Y ☐ N

2.16.3 ☐ Y ☐ N ☐ Y ☐ N

2.16.4 ☐ Y ☐ N ☐ Y ☐ N

2.16.5 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26

2.26.1 ☐ Y ☐ N ☐ Y ☐ N

2.26.2 ☐ Y ☐ N ☐ Y ☐ N

2.26.3 ☐ Y ☐ N ☐ Y ☐ N

2.27 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

2.28 The duty and on-call rotas are available to medical staff within the specialty/directorate.

3. STAFF DEVELOPMENT AND EDUCATION

The hospital and the members of the medical staff provide in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all medical staff appointed to a service and/or a department. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 introduces new staff to the relevant aspects of the service/department
- 3.1.3 explains the relationships within the service and with the hospital
- 3.1.4 prepares staff for their role and responsibilities
- 3.1.5 explains lines of authority both within the service/department and with the hospital
- 3.1.6 explains the method used to evaluate staff performance
- 3.1.7 introduces staff to the policies and procedures of the service and the hospital
- 3.1.8 explains emergency procedures (for example, fire drills)
- 3.1.9 provides information on the occupational health service offered to staff

3.2 All staff are proficient in Basic Life Support:

- 3.2.1 management of the airway
- 3.2.2 control of bleeding
- 3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

- 3.3.1 utilises professional and other resource material
- 3.3.2 supports and encourages relevant research
- 3.3.3 provides information on advances in practice related to the service and/or department
- 3.3.4 provides information on educational opportunities arranged by other institutions
- 3.3.5 provides orientation to new clinical areas

2.27	☐ Y ☐ N	☐ Y ☐ N
2.28	☐ Y ☐ N	☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The hospital and the members of the medical staff provide in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.2	☐ Y ☐ N	☐ Y ☐ N	
3.1.3	☐ Y ☐ N	☐ Y ☐ N	
3.1.4	☐ Y ☐ N	☐ Y ☐ N	
3.1.5	☐ Y ☐ N	☐ Y ☐ N	
3.1.6	☐ Y ☐ N	☐ Y ☐ N	
3.1.7	☐ Y ☐ N	☐ Y ☐ N	
3.1.8	☐ Y ☐ N	☐ Y ☐ N	
3.1.9	☐ Y ☐ N	☐ Y ☐ N	
3.2			
3.2.1	☐ Y ☐ N	☐ Y ☐ N	
3.2.2	☐ Y ☐ N	☐ Y ☐ N	
3.2.3	☐ Y ☐ N	☐ Y ☐ N	
3.3			
3.3.1	☐ Y ☐ N	☐ Y ☐ N	
3.3.2	☐ Y ☐ N	☐ Y ☐ N	
3.3.3	☐ Y ☐ N	☐ Y ☐ N	
3.3.4	☐ Y ☐ N	☐ Y ☐ N	
3.3.5	☐ Y ☐ N	☐ Y ☐ N	

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.7 Where there are medical staff in training, their clinical responsibilities and limitations are detailed in accordance with recommendations of the relevant Royal College or Faculty.

3.8 The training provided to medical postgraduates or medical students is monitored and reviewed by a designated clinical tutor.

4. POLICIES AND PROCEDURES

There are written policies and procedures which reflect current professional knowledge and practice and are consistent with the objectives of the service/specialty, relevant regulations and standing instructions pertaining to medical staff.

Standards

4.1 Written policies and procedures are developed to guide medical staff in the activities and management of each speciality/division.

4.2 Policies and procedures are agreed by the medical advisory committee or equivalent.

4.3 Medical staff are actively involved in the formulation of medical policies and procedures.

4.4 When policies are developed, attention is drawn to practice in other fields, for example infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Policies and procedures include at least the following:

- 4.6.1 infection control
- 4.6.2 information issued to patients and carers
- 4.6.3 patients' rights
- 4.6.4 provision of information to media and police etc.
- 4.6.5 referrals/transfer of patients
  (see Medical Record Service section of this manual)
- 4.6.6 scope and limitations of the responsibilities and activities of clinical staff
- 4.6.7 medical record content
  (see Medical Record Content section of this manual)

3.4 ☐ Y ☐ N ☐ Y ☐ N

3.5 ☐ Y ☐ N ☐ Y ☐ N

3.6 ☐ Y ☐ N ☐ Y ☐ N

3.7 ☐ Y ☐ N ☐ Y ☐ N

3.8 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are written policies and procedures which reflect current professional knowledge and practice and are consistent with the objectives of the service/specialty, relevant regulations and standing instructions pertaining to medical staff.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6			
4.6.1 ☐ Y ☐ N		☐ Y ☐ N	
4.6.2 ☐ Y ☐ N		☐ Y ☐ N	
4.6.3 ☐ Y ☐ N		☐ Y ☐ N	
4.6.4 ☐ Y ☐ N		☐ Y ☐ N	
4.6.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6.6 ☐ Y ☐ N		☐ Y ☐ N	
4.6.7 ☐ Y ☐ N		☐ Y ☐ N	

4.7 There is a policy for dealing with:

4.7.1 accidents

4.7.2 errors

4.7.3 incidents

4.7.4 patient and/or carers complaints in accordance with HC(88)37, Hospital Complaints Procedures)

4.8 Records are kept which indicate to whom items listed in 4.8 have been referred and the action which has been taken.

4.9 Policies and procedures are dated and as a minimum are:

4.9.1 regularly reviewed and updated

4.9.2 readily accessible for reference

4.10 Staff are informed of current policies and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The facilities and equipment ensure the safe, efficient and effective delivery of clinical care.

Standards

5.1 There are office facilities for use by the medical staff.

5.2 There is a rest room and relaxation facilities for all medical staff.

5.3 Washrooms and changing facilities, separate from customers' facilities are available for medical staff.

5.4 There is provision for a teaching/seminar room.

5.5 There are facilities for confidential consultations.

5.6 There is provision for the visual privacy of patients (for example, screens).

5.7 There are systems for effective communication both internal and external:

5.7.1 adequate numbers of telephones giving direct access to key areas

5.7.2 a radio telephone system for key personnel in the hospital and for those on call

5.8 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.9 Where specialised equipment is used, it is operated only by staff trained to do so.

4.7

4.7.1 ☐ Y ☐ N ☐ Y ☐ N

4.7.2 ☐ Y ☐ N ☐ Y ☐ N

4.7.3 ☐ Y ☐ N ☐ Y ☐ N

4.7.4 ☐ Y ☐ N ☐ Y ☐ N

4.8 ☐ Y ☐ N ☐ Y ☐ N

4.9 ☐ Y ☐ N ☐ Y ☐ N

4.9.1 ☐ Y ☐ N ☐ Y ☐ N

4.9.2 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The facilities and equipment ensure the safe, efficient and effective delivery of clinical care.

Standards	Comment		Comment
5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.6 ☐ Y ☐ N		☐ Y ☐ N	
5.7			
5.7.1 ☐ Y ☐ N		☐ Y ☐ N	
5.7.2 ☐ Y ☐ N		☐ Y ☐ N	
5.8 ☐ Y ☐ N		☐ Y ☐ N	
5.9 ☐ Y ☐ N		☐ Y ☐ N	

5.10 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.11 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. PATIENT CARE

There is a systematic approach to clinical care which maintains the patients' rights at all times.

Standards

6.1 The delivery of care is in accordance with agreed standards for clinical practice.

6.2 A named consultant directs the clinical care of each patient.

6.3 A named consultant is accountable for the clinical care of each patient.

6.4 A treatment plan is developed after an assessment of the patient.

6.5 The treatment plan is developed in collaboration with nursing and other relevant staff and in consultation with the patient and carers or advocates.

6.6 The treatment plan is written in the patient's medical record and includes:

- 6.6.1 a statement of the patient's needs
- 6.6.2 details of specific clinical care given
- 6.6.3 health education
- 6.6.4 preparation for discharge
- 6.6.5 continuing assessment and evaluation of clinical needs
- 6.6.6 name and signature of the clinician responsible

6.7 The medical record is signed, timed and dated by the doctor responsible. *(See Medical Record Content section of this manual for the patient details to be recorded.)*

6.8 Medical staff maintain the patient's right to privacy, dignity and confidentiality at all times.

6.9 Medical staff participate in case conferences concerning patients in their care.

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

6. PATIENT CARE

There is a systematic approach to clinical care which maintains the patients' rights at all times.

Standards	Comment	Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N
6.2 ☐ Y ☐ N		☐ Y ☐ N
6.3 ☐ Y ☐ N		☐ Y ☐ N
6.4 ☐ Y ☐ N		☐ Y ☐ N
6.5 ☐ Y ☐ N		☐ Y ☐ N
6.6		
6.6.1 ☐ Y ☐ N		☐ Y ☐ N
6.6.2 ☐ Y ☐ N		☐ Y ☐ N
6.6.3 ☐ Y ☐ N		☐ Y ☐ N
6.6.4 ☐ Y ☐ N		☐ Y ☐ N
6.6.5 ☐ Y ☐ N		☐ Y ☐ N
6.6.6 ☐ Y ☐ N		☐ Y ☐ N
6.7 ☐ Y ☐ N		☐ Y ☐ N
6.8 ☐ Y ☐ N		☐ Y ☐ N
6.9 ☐ Y ☐ N		☐ Y ☐ N

7. EVALUATION AND QUALITY ASSURANCE

The medical staff ensure the provision of high quality care by their involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and clinical specialty/division.

Standards

7.1 There is a written quality assurance plan for clinical services.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The medical staff have a structure to facilitate evaluation activities.

7.4 The evaluation programme includes the review of at least the following:

- 7.4.1 service users' satisfaction
- 7.4.2 the service and/or department in comparison with standards set out in this chapter
- 7.4.3 the performance of all medical staff
  (see Management and Staffing in this section)
- 7.4.4 the evaluation of clinical practice
- 7.4.5 the evaluation of clinical performance through multidisciplinary audit
- 7.4.6 case reviews including histopathology, infection rate statistics, morbidity and mortality
- 7.4.7 the use of resources (for example, length of stay, the use of diagnostic and therapeutic resources)
- 7.4.8 rates of re-admissions
- 7.4.9 rates of patient transfers
- 7.4.10 appropriateness of care given

7.5 Where a national mortality review committee exists (for example, the National Confidential Enquiry into Peri-Operative Deaths or the Confidential Enquiry into Maternal and Peri-Natal Deaths) deaths are referred to this committee and subject to internal review.

7.6 The evaluation activities include the following elements:

- 7.6.1 monitoring: the routine collection of information/statistics about important aspects of delivery of service
- 7.6.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery
- 7.6.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

7. EVALUATION AND QUALITY ASSURANCE

The medical staff ensure the provision of high quality care by their involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and clinical specialty/division.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4			
7.4.1 ☐ Y ☐ N		☐ Y ☐ N	
7.4.2 ☐ Y ☐ N		☐ Y ☐ N	
7.4.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4.4 ☐ Y ☐ N		☐ Y ☐ N	
7.4.5 ☐ Y ☐ N		☐ Y ☐ N	
7.4.6 ☐ Y ☐ N		☐ Y ☐ N	
7.4.7 ☐ Y ☐ N		☐ Y ☐ N	
7.4.8 ☐ Y ☐ N		☐ Y ☐ N	
7.4.9 ☐ Y ☐ N		☐ Y ☐ N	
7.4.10 ☐ Y ☐ N		☐ Y ☐ N	
7.5 ☐ Y ☐ N		☐ Y ☐ N	
7.6			
7.6.1 ☐ Y ☐ N		☐ Y ☐ N	
7.6.2 ☐ Y ☐ N		☐ Y ☐ N	
7.6.3 ☐ Y ☐ N		☐ Y ☐ N	

7.6.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

7.6.5 feedback: the results of activities are regularly communicated to the staff

7.7 Clinical audit meetings are held on a regular basis.

7.8 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

7.9 Confidentiality is maintained throughout evaluation proceedings.

7.10 Medical staff receive a report of results obtained through evaluation of care.

7.11 Medical staff participate in the formulation of plans for improvement.

7.12 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff which is known to all.

7.13 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

7.14 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

7.15 Korner returns are regularly reviewed and used to effect management/practice change.

7.16 There is evidence of local policies for collection of information on key areas relevant to the specialty/division.

See also Medical Record Content, Health and Safety, Infection Control and Hospital Management (major incident plan and patient's rights and special needs) sections of this manual.

7.6.4 ☐ Y ☐ N ☐ Y ☐ N

7.6.5 ☐ Y ☐ N ☐ Y ☐ N

7.7 ☐ Y ☐ N ☐ Y ☐ N

7.8 ☐ Y ☐ N ☐ Y ☐ N

7.9 ☐ Y ☐ N ☐ Y ☐ N

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

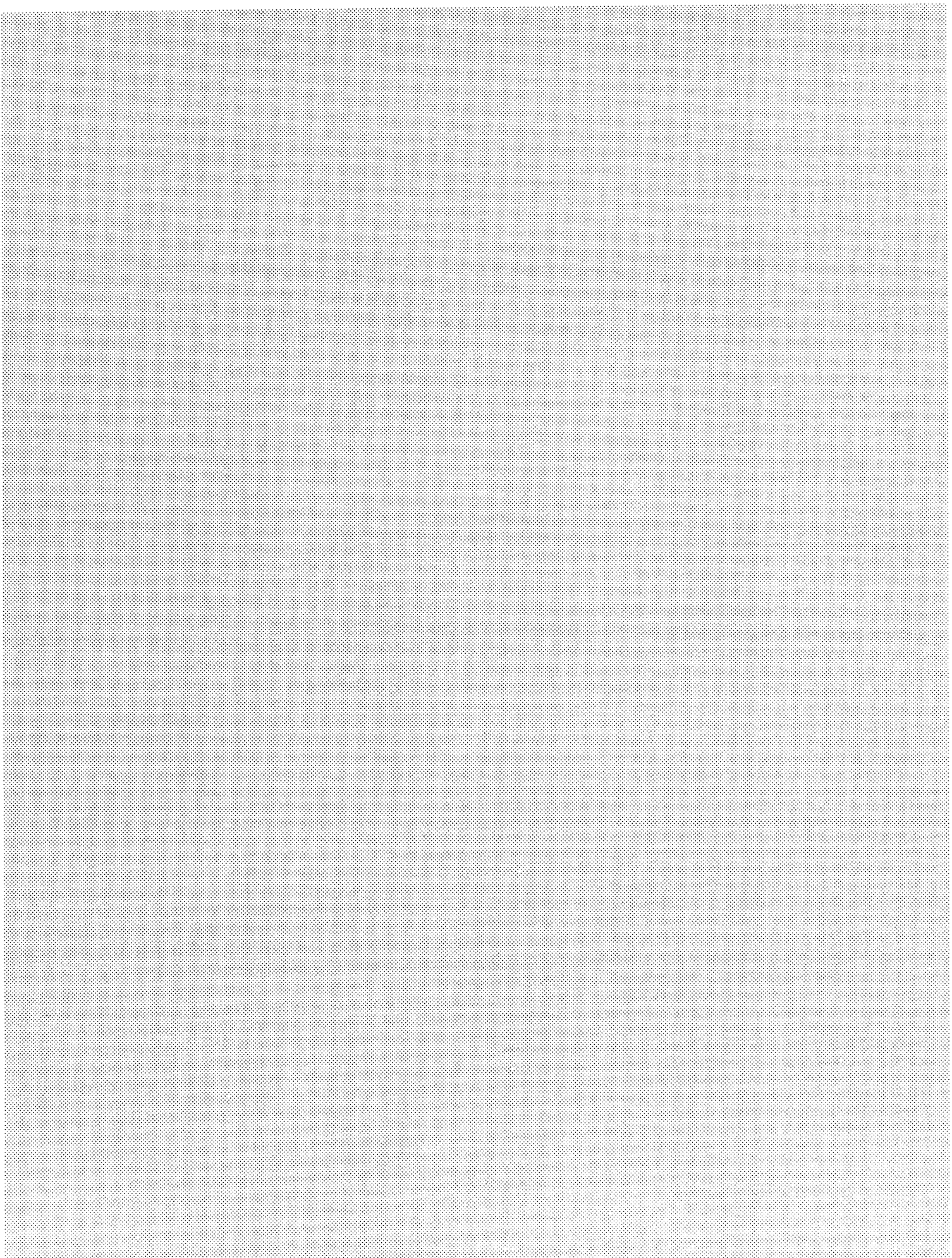
7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15 ☐ Y ☐ N ☐ Y ☐ N

7.16 ☐ Y ☐ N ☐ Y ☐ N

MEDICAL
Surveyor's General Comments



MEDICAL

Surveyor's Comments

Standard Number	Recommendation

NURSING

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

NURSING

This section refers to all nursing services within an acute hospital. The midwifery service may wish to complete its own midwifery section, in which case please indicate by ticking the box below.

Midwifery ☐

1. PHILOSOPHY AND OBJECTIVES

The nursing service is responsible for providing a high standard of nursing care to the patients and for the ethical and professional practices of its staff.

Standards

1.1 A representative group of nursing staff participates in the formulation of the philosophy for the hospital in general and for the nursing service in particular.

1.2 A representative group of nursing staff participates in the development of written objectives to achieve the philosophy of the hospital and the nursing service. These objectives are used as a guide to planning, implementing and evaluating all aspects of the nursing service.

1.3 The objectives for each service include at least the following:

1.3.1 providing patients with a quality service and care which is based on assessment of patients' needs

1.3.2 providing patients with a quality service and care which is based on professional standards where available

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes

1.3.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.3.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

NURSING

This section refers to all nursing services within an acute hospital. The midwifery service may wish to complete its own midwifery section, in which case please indicate by ticking the box below.

Midwifery ☐

1. PHILOSOPHY AND OBJECTIVES

The nursing service is responsible for providing a high standard of nursing care to the patients and for the ethical and professional practices of its staff.

Standards		Comment
1.1	☐ Y ☐ N	☐ Y ☐ N
1.2	☐ Y ☐ N	☐ Y ☐ N
1.3		
1.3.1	☐ Y ☐ N	☐ Y ☐ N
1.3.2	☐ Y ☐ N	☐ Y ☐ N
1.3.3	☐ Y ☐ N	☐ Y ☐ N
1.3.4	☐ Y ☐ N	☐ Y ☐ N
1.3.5	☐ Y ☐ N	☐ Y ☐ N
1.3.6		
(a)	☐ Y ☐ N	☐ Y ☐ N
(b)	☐ Y ☐ N	☐ Y ☐ N
1.3.7	☐ Y ☐ N	☐ Y ☐ N
1.3.8	☐ Y ☐ N	☐ Y ☐ N

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

1.4.3 respect and cater for cultural differences

1.4.4 respond to communication difficulties

1.4.5 identify counselling requirements of the patient and carers

1.5 Individual departments/wards develop specific written objectives.

1.6 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.6.1 the role of the hospital

1.6.2 the provision of services

1.6.3 the pattern of delivery of service

1.6.4 staffing patterns

1.6.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The nursing service is organised, managed and staffed to provide a framework within which nursing staff can deliver effective nursing care to all patients in accordance with established good nursing practice (refer to ENB, UKCC and RCN guidelines).

Standards

Management

2.1 There is a nominated senior nurse (however named) on duty at all times who is responsible for the nursing service.

2.2 The senior nurse (however named) is involved in the preparation of the nursing service budget.

2.3 The senior nurse (however named) is responsible for the efficient and effective management of the budget.

2.4 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.5 The budget reports are accurate.

1.4

1.4.1	☐ Y ☐ N	☐ Y ☐ N
1.4.2	☐ Y ☐ N	☐ Y ☐ N
1.4.3	☐ Y ☐ N	☐ Y ☐ N
1.4.4	☐ Y ☐ N	☐ Y ☐ N
1.4.5	☐ Y ☐ N	☐ Y ☐ N

1.5 ☐ Y ☐ N ☐ Y ☐ N

1.6

1.6.1	☐ Y ☐ N	☐ Y ☐ N
1.6.2	☐ Y ☐ N	☐ Y ☐ N
1.6.3	☐ Y ☐ N	☐ Y ☐ N
1.6.4	☐ Y ☐ N	☐ Y ☐ N
1.6.5	☐ Y ☐ N	☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The nursing service is organised, managed and staffed to provide a framework within which nursing staff can deliver effective nursing care to all patients in accordance with established good nursing practice (refer to ENB, UKCC and RCN guidelines).

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	

2.6 Records and statistics are available for the effective management of the nursing service which as a minimum include:

2.6.1 ratio of staffing to workload

2.6.2 staff absentee rate

2.6.3 staff sickness rate

2.6.4 staff turnover rate

2.7 Senior nursing staff are involved in the development of hospital policies and procedures where appropriate.

2.8 The nursing service is represented at inter-departmental meetings concerned with the planning and formulation of policies.

2.9 Nursing teams/committees with clearly stated terms of reference meet to develop strategies for implementation of the objectives of the service.

2.10 Nursing staff meetings are held at least monthly to discuss issues related to the provision of nursing services. Minutes of meetings are kept.

2.11 All nursing staff are informed of the activities and outcomes of nursing committees and staff meetings.

Personnel

2.12 Written and dated job descriptions are available for all posts, which specify at least the following:

2.12.1 job title and grade

2.12.2 qualifications and/or experience required for the post

2.12.3 functions, responsibilities and accountability

2.12.4 frequency and type of staff appraisal

2.12.5 review date

2.13 A documented staff appraisal system exists for all staff.

2.14 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.15 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.16 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

2.6

2.6.1 ☐ Y ☐ N ☐ Y ☐ N

2.6.2 ☐ Y ☐ N ☐ Y ☐ N

2.6.3 ☐ Y ☐ N ☐ Y ☐ N

2.6.4 ☐ Y ☐ N ☐ Y ☐ N

2.7 ☐ Y ☐ N ☐ Y ☐ N

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.12.1 ☐ Y ☐ N ☐ Y ☐ N

2.12.2 ☐ Y ☐ N ☐ Y ☐ N

2.12.3 ☐ Y ☐ N ☐ Y ☐ N

2.12.4 ☐ Y ☐ N ☐ Y ☐ N

2.12.5 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.17 Each nurse is currently registered with the UKCC to practise nursing and is professionally qualified for the position held.

2.18 There is a nominated senior nurse for each ward or department.

2.19 All unqualified staff working within the nursing service practise under the supervision of a registered nurse.

2.20 Staffing is in accordance with patient needs in individual wards or departments.

2.21 Staffing is calculated and allocated on the basis of workload and a recognised dependency system.

2.22 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.23 Registered nurses with post-registration education and/or experience are present on all shifts where specialised nursing care is required.

2.24 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.25 The organisational chart is reviewed annually, revised and dated.

2.26 Nursing staff are supported in the delivery of nursing care by the following personnel:

2.26.1 administrative

2.26.2 ancillary

2.26.3 secretarial

2.27 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

3. STAFF DEVELOPMENT AND EDUCATION

There is a programme to facilitate the development of each individual nurse as a professional practitioner and to encourage training and development on issues relevant to the objectives of the hospitals.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the nursing service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the ward and/or department

Staffing

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26

2.26.1 ☐ Y ☐ N ☐ Y ☐ N

2.26.2 ☐ Y ☐ N ☐ Y ☐ N

2.26.3 ☐ Y ☐ N ☐ Y ☐ N

2.27 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

There is a programme to facilitate the development of each individual nurse as a professional practitioner and to encourage training and development on issues relevant to the objectives of the hospitals.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	

3.1.3 explains the relationships within the ward and/or department and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 explains the method used to evaluate staff performance

3.1.7 introduces staff to the policies and procedures of the service and the hospital

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.2 All nursing staff are proficient in Basic Life Support:

3.2.1 management of the airway

3.2.2 control of bleeding

3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

3.3.1 utilises professional and other resource material

3.3.2 supports and encourages relevant research

3.3.3 provides information on advances in practice related to the nursing service and the particular specialty

3.3.4 provides information on educational opportunities arranged by other institutions

3.3.5 provides orientation to new clinical areas

3.3.6 provides additional training to support nurses in their extended role

3.4 Staff have access to information and library services. *(See Library Services section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and relevant text books are available within wards or departments for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.7 Where the hospital provides clinical experience for students of nursing there is written agreement between the hospital and the educational establishment detailing the responsibility for induction, teaching, supervision and assessment of students of nursing.

3.1.3 ☐ Y ☐ N ☐ Y ☐ N

3.1.4 ☐ Y ☐ N ☐ Y ☐ N

3.1.5 ☐ Y ☐ N ☐ Y ☐ N

3.1.6 ☐ Y ☐ N ☐ Y ☐ N

3.1.7 ☐ Y ☐ N ☐ Y ☐ N

3.1.8 ☐ Y ☐ N ☐ Y ☐ N

3.1.9 ☐ Y ☐ N ☐ Y ☐ N

3.2

3.2.1 ☐ Y ☐ N ☐ Y ☐ N

3.2.2 ☐ Y ☐ N ☐ Y ☐ N

3.2.3 ☐ Y ☐ N ☐ Y ☐ N

3.3

3.3.1 ☐ Y ☐ N ☐ Y ☐ N

3.3.2 ☐ Y ☐ N ☐ Y ☐ N

3.3.3 ☐ Y ☐ N ☐ Y ☐ N

3.3.4 ☐ Y ☐ N ☐ Y ☐ N

3.3.5 ☐ Y ☐ N ☐ Y ☐ N

3.3.6 ☐ Y ☐ N ☐ Y ☐ N

3.4 ☐ Y ☐ N ☐ Y ☐ N

3.5 ☐ Y ☐ N ☐ Y ☐ N

3.6 ☐ Y ☐ N ☐ Y ☐ N

3.7 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are written policies and procedures which reflect current knowledge and principles of nursing practice and are consistent with relevant regulations and the objectives of the service.

Standards

4.1 Written policies and procedures are developed to guide nursing staff in the activities and management of each ward/department.

4.2 Nursing policies and procedures are agreed by the nursing advisory committee, or equivalent.

4.3 Nursing staff are actively involved in the formulation of nursing policies and procedures.

4.4 When policies and procedures are developed, attention is drawn to practice in other fields, for example, infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Nursing staff act in accordance with legislation affecting nursing practice and current professional guidelines.

4.7 The scope and limitations of the responsibilities and activities of nursing staff are clearly defined. Some examples of these policies are:

- 4.7.1 accepting telephone orders
- 4.7.2 extended role of the nurse
- 4.7.3 information issued to patients and carers
- 4.7.4 maintenance of records and reports
- 4.7.5 provision of information to media and police etc.

4.8 There is a policy for dealing with:

- 4.8.1 accidents
- 4.8.2 errors
- 4.8.3 incidents
- 4.8.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.9 Records are kept which indicate to whom items listed in 4.8 have been referred and the action which has been taken.

4. POLICIES AND PROCEDURES

There are written policies and procedures which reflect current knowledge and principles of nursing practice and are consistent with relevant regulations and the objectives of the service.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6 ☐ Y ☐ N		☐ Y ☐ N	
4.7 ☐ Y ☐ N		☐ Y ☐ N	
4.7.1 ☐ Y ☐ N		☐ Y ☐ N	
4.7.2 ☐ Y ☐ N		☐ Y ☐ N	
4.7.3 ☐ Y ☐ N		☐ Y ☐ N	
4.7.4 ☐ Y ☐ N		☐ Y ☐ N	
4.7.5 ☐ Y ☐ N		☐ Y ☐ N	
4.8			
4.8.1 ☐ Y ☐ N		☐ Y ☐ N	
4.8.2 ☐ Y ☐ N		☐ Y ☐ N	
4.8.3 ☐ Y ☐ N		☐ Y ☐ N	
4.8.4 ☐ Y ☐ N		☐ Y ☐ N	
4.9 ☐ Y ☐ N		☐ Y ☐ N	

4.10 There is a nursing policy and practice manual which as a minimum is:

4.10.1 regularly reviewed (annually) and updated

4.10.2 readily accessible for reference in every ward/department

4.11 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The environment and equipment enable the nursing service to achieve its stated objectives.

Standards

5.1 The space available is consistent with the relevant building note.

5.2 There are office facilities for the head of the nursing service.

5.3 There are office facilities for the nurse in charge located in the ward and/or department.

5.4 There is a rest room and relaxation facilities for all the nursing staff.

5.5 Washrooms and changing facilities, separate from customers' facilities are available for nursing staff.

5.6 There are facilities for confidential consultations.

5.7 There is a room designated for use by grieving and bereaved carers.

5.8 There is provision for the visual privacy of patients (for example, screens).

5.9 There are systems for effective communication both internal and external:

5.9.1 adequate numbers of telephones giving direct access to key areas

5.9.2 a radio telephone system for key personnel in the hospital and for those on call

5.10 Emergency resuscitation equipment is easily accessible within each ward/department and the procedure for summoning assistance is known to all staff.

5.11 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.12 Where specialised equipment is used, it is operated only by staff trained to do so.

5.13 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.14 All equipment and facilities conform to existing health and safety regulations (HC(87)3

4.10		
4.10.1	☐ Y ☐ N	☐ Y ☐ N
4.10.2	☐ Y ☐ N	☐ Y ☐ N
4.11	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The environment and equipment enable the nursing service to achieve its stated objectives.

Standards	Comment	Comment
5.1	☐ Y ☐ N	☐ Y ☐ N
5.2	☐ Y ☐ N	☐ Y ☐ N
5.3	☐ Y ☐ N	☐ Y ☐ N
5.4	☐ Y ☐ N	☐ Y ☐ N
5.5	☐ Y ☐ N	☐ Y ☐ N
5.6	☐ Y ☐ N	☐ Y ☐ N
5.7	☐ Y ☐ N	☐ Y ☐ N
5.8	☐ Y ☐ N	☐ Y ☐ N
5.9		
5.9.1	☐ Y ☐ N	☐ Y ☐ N
5.9.2	☐ Y ☐ N	☐ Y ☐ N
5.10	☐ Y ☐ N	☐ Y ☐ N
5.11	☐ Y ☐ N	☐ Y ☐ N
5.12	☐ Y ☐ N	☐ Y ☐ N
5.13	☐ Y ☐ N	☐ Y ☐ N
5.14	☐ Y ☐ N	☐ Y ☐ N

6. PATIENT CARE

Nursing care is systematic and patient-centred.

Standards

6.1 The delivery of nursing care is in accordance with agreed standards for nursing practice.

6.2 There is evidence that the prime focus of nursing care is on the patient and their carers (for example, primary nursing, patient allocation, team nursing).
(ref. Exercising Accountability — UKCC Advisory Document, March 1989)

6.3 A named registered nurse is accountable for the nursing care of each patient.

6.4 A nursing care plan is developed after an assessment of the patient.

6.5 The care plan is developed in collaboration with medical and other relevant staff and in consultation with the patient and carers or advocates.

6.6 The nursing plan includes:

- 6.6.1 a statement of the patients' needs
- 6.6.2 details of specific nursing care given
- 6.6.3 health education
- 6.6.4 preparation for discharge
- 6.6.5 continuing assessment and evaluation of nursing needs
- 6.6.6 name and signature of the nurse responsible

6.7 Nursing records are signed, timed and dated by the nurse responsible, maintained and incorporated in the patient's medical records. The nursing record includes at least the following:

- 6.7.1 nursing assessment
- 6.7.2 nursing care plan
- 6.7.3 details of nursing care given
- 6.7.4 patient's response to care and significant changes in health status
- 6.7.5 changes in the nursing care plan resulting from evaluation of the patients progress
- 6.7.6 information given to the patient and/or carers on discharge
- 6.7.7 discharge plan, which includes a record of any communication with community services

6.8 Nursing staff maintain the patient's right to privacy, dignity and confidentiality at all times.
(ref. Exercising Accountability — UKCC Advisory Document, March 1989)

6.9 Nursing staff participate in [illegible]

6. PATIENT CARE

Nursing care is systematic and patient-centred.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6			
6.6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6.6 ☐ Y ☐ N		☐ Y ☐ N	
6.7 ☐ Y ☐ N		☐ Y ☐ N	
6.7.1 ☐ Y ☐ N		☐ Y ☐ N	
6.7.2 ☐ Y ☐ N		☐ Y ☐ N	
6.7.3 ☐ Y ☐ N		☐ Y ☐ N	
6.7.4 ☐ Y ☐ N		☐ Y ☐ N	
6.7.5 ☐ Y ☐ N		☐ Y ☐ N	
6.7.6 ☐ Y ☐ N		☐ Y ☐ N	
6.7.7 ☐ Y ☐ N		☐ Y ☐ N	
6.8 ☐ Y ☐ N		☐ Y ☐ N	

7. EVALUATION AND QUALITY ASSURANCE

The nursing service ensures the provision of high quality nursing by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

7.1 There is a written quality assurance plan for the nursing service.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The evaluation and quality assurance plan includes the review of at least the following:

- 7.3.1 service users' satisfaction
- 7.3.2 the nursing service in comparison with standards set out in this chapter
- 7.3.3 the performance of all nursing staff
  (see Management and Staffing in this section)
- 7.3.4 the evaluation of nursing practice
- 7.3.5 the evaluation of clinical performance through multidisciplinary audit
- 7.3.6 the use of resources (type of stock, amounts etc.)
- 7.3.7 appropriateness of care given

7.4 A registered nurse co-ordinates the nursing evaluation programme.

7.5 The evaluation activities include the following elements:

- 7.5.1 monitoring: the routine collection of information/statistics about important aspects of delivery of services
- 7.5.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery
- 7.5.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented
- 7.5.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 7.5.5 feedback: the results of activities are regularly communicated to the staff

7.6 Clinical audit meetings are held on a regular basis.

7.7 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

7.8 Confidentiality is maintained throughout evaluation proceedings.

7.9 Nursing staff receive a report of results obtained through evaluation of care and/or service.

7. EVALUATION AND QUALITY ASSURANCE

The nursing service ensures the provision of high quality nursing by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3			
7.3.1 ☐ Y ☐ N		☐ Y ☐ N	
7.3.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3.3 ☐ Y ☐ N		☐ Y ☐ N	
7.3.4 ☐ Y ☐ N		☐ Y ☐ N	
7.3.5 ☐ Y ☐ N		☐ Y ☐ N	
7.3.6 ☐ Y ☐ N		☐ Y ☐ N	
7.3.7 ☐ Y ☐ N		☐ Y ☐ N	
7.4 ☐ Y ☐ N		☐ Y ☐ N	
7.5			
7.5.1 ☐ Y ☐ N		☐ Y ☐ N	
7.5.2 ☐ Y ☐ N		☐ Y ☐ N	
7.5.3 ☐ Y ☐ N		☐ Y ☐ N	
7.5.4 ☐ Y ☐ N		☐ Y ☐ N	
7.5.5 ☐ Y ☐ N		☐ Y ☐ N	
7.6 ☐ Y ☐ N		☐ Y ☐ N	
7.7 ☐ Y ☐ N		☐ Y ☐ N	
7.8 ☐ Y ☐ N		☐ Y ☐ N	
7.9 ☐ Y ☐ N		☐ Y ☐ N	

7.10 Nursing staff participate in the formulation of plans for improvement.

7.11 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

7.12 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

7.13 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

7.14 Statistics are collected for Korner returns.

7.15 Statistics collected are used to effect management/practice change.

See also Health and Safety, Infection Control and Hospital Management (major incident plan and patients' rights and special needs) sections of this manual.

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

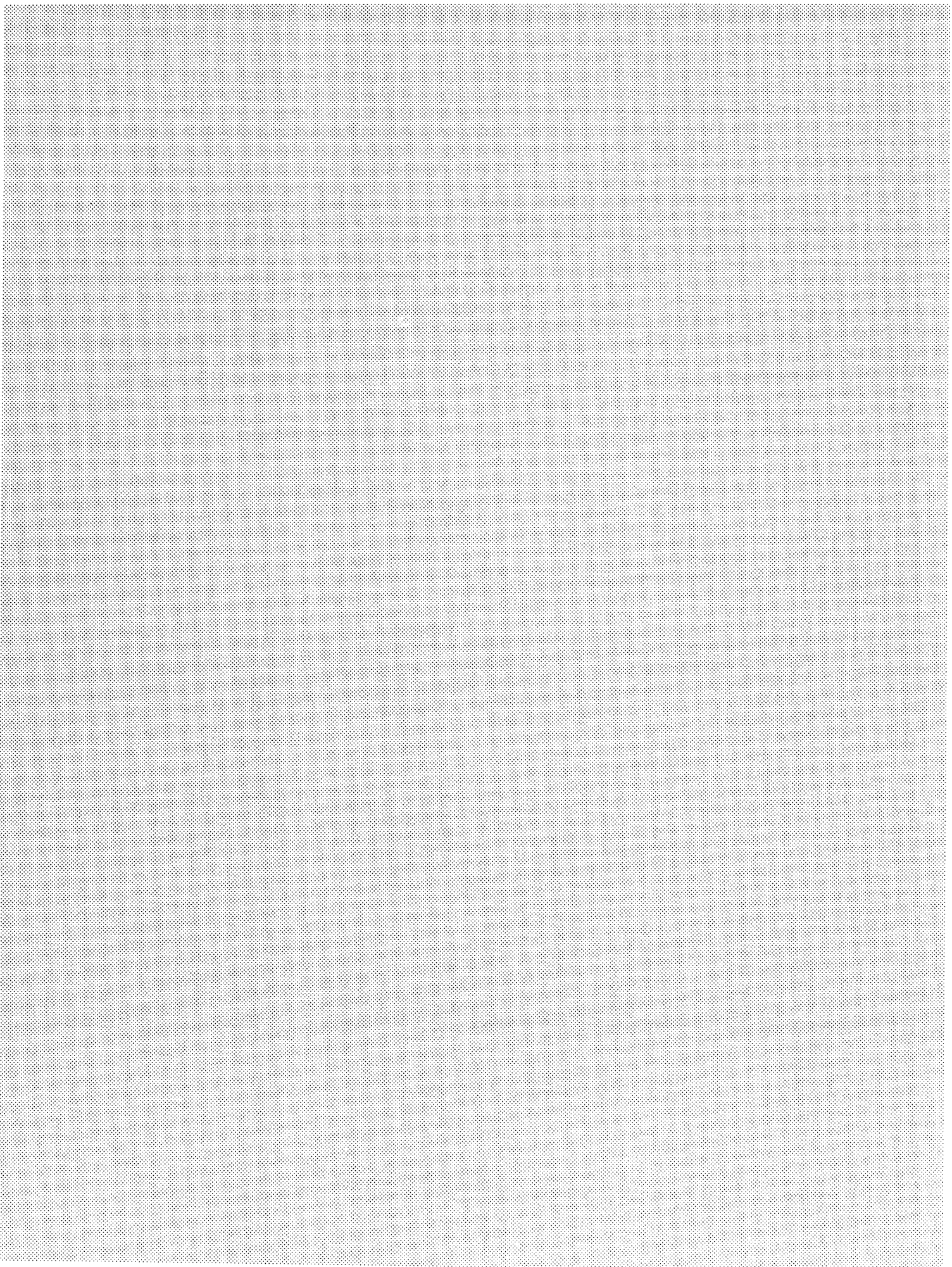
7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15 ☐ Y ☐ N ☐ Y ☐ N

NURSING

Surveyor's General Comments



NURSING

Surveyor's Comments

Standard Number	Recommendation

PROFESSIONS ALLIED TO MEDICINE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

PROFESSIONS ALLIED TO MEDICINE

Standards in this chapter refer to services of professions allied to medicine not identified separately elsewhere in this guide:

Chiropody ☐

Dietetics ☐

Occupational therapy ☐

Physiotherapy ☐

Speech therapy ☐

These services may be provided from outside the hospital. Please tick a box to indicate to which service the section applies.

1. PHILOSOPHY AND OBJECTIVES

Each service is responsible for providing a high standard of patient care and for the ethical and professional practices of its staff.

Standards

1.1 Staff within each service develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within each service develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the service.

1.3 The objectives for each service include at least the following:

1.3.1 providing patients with a quality service and care which is based on assessment of patients' needs

1.3.2 providing patients with a quality service and care which is based on professional standards, where available

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes

1.3.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

PROFESSIONS ALLIED TO MEDICINE

Standards in this chapter refer to services of professions allied to medicine not identified separately elsewhere in this guide:

Chiropody ☐

Dietetics ☐

Occupational therapy ☐

Physiotherapy ☐

Speech therapy ☐

These services may be provided from outside the hospital. Please tick a box to indicate to which service the section applies.

1. PHILOSOPHY AND OBJECTIVES

Each service is responsible for providing a high standard of patient care and for the ethical and professional practices of its staff.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	

1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.3.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

1.4.3 respect and cater for cultural differences

1.4.4 respond to communication difficulties

1.4.5 identify counselling requirements of the patient and carers

1.5 Individual services develop specific written objectives.

1.6 The objectives for each service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.6.1 the role of the hospital

1.6.2 the provision of services

1.6.3 the pattern of delivery of service

1.6.4 staffing patterns

1.6.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

Each service is organised, managed and staffed to provide safe, efficient and effective care to patients referred to their service and to ensure high quality professional practice.

Standards

Management

2.1 Each service is managed by a member of that profession who is qualified by education, training and/or experience.

2.2 The manager of each service is involved in the preparation of the service's budget.

2.3 The manager of each service is responsible for the efficient and effective management of the budget.

2.4 Reports of budgeted expenditure are communicated to budget holders at set intervals throughout the year.

1.3.7 ☐ Y ☐ N ☐ Y ☐ N

1.3.8 ☐ Y ☐ N ☐ Y ☐ N

1.4

1.4.1 ☐ Y ☐ N ☐ Y ☐ N
1.4.2 ☐ Y ☐ N ☐ Y ☐ N
1.4.3 ☐ Y ☐ N ☐ Y ☐ N
1.4.4 ☐ Y ☐ N ☐ Y ☐ N
1.4.5 ☐ Y ☐ N ☐ Y ☐ N

1.5 ☐ Y ☐ N ☐ Y ☐ N

1.6

1.6.1 ☐ Y ☐ N ☐ Y ☐ N
1.6.2 ☐ Y ☐ N ☐ Y ☐ N
1.6.3 ☐ Y ☐ N ☐ Y ☐ N
1.6.4 ☐ Y ☐ N ☐ Y ☐ N
1.6.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

Each service is organised, managed and staffed to provide safe, efficient and effective care to patients referred to their service and to ensure high quality professional practice.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	

2.5 The budget reports are accurate.

2.6 Records and statistics are available for the effective management of the paramedical service which as a minimum include:

2.6.1 ratio of staffing to workload

2.6.2 staff absentee rate

2.6.3 staff sickness rate

2.6.4 staff turnover rate

2.7 Where applicable the manager of each service is involved in the development of service contracts.

2.8 Senior paramedical staff are involved in the development of hospital policies and procedures where appropriate.

2.9 Each service is represented at inter-departmental meetings concerned with the planning and formulations of policies.

2.10 Regular meetings are held to discuss issues related to the provision of services. Minutes of these meetings are kept.

2.11 All paramedical staff are informed of the activities and outcomes of these meetings.

Personnel

2.12 Written and dated job descriptions are available for all posts, which specify at least the following:

2.12.1 job title and grade

2.12.2 qualifications and/or experience required for the post

2.12.3 functions, responsibilities and accountability

2.12.4 frequency and type of staff appraisal

2.12.5 review date

2.13 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.14 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.15 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

1.3.7 ☐ Y ☐ N ☐ Y ☐ N

1.3.8 ☐ Y ☐ N ☐ Y ☐ N

1.4

1.4.1 ☐ Y ☐ N ☐ Y ☐ N

1.4.2 ☐ Y ☐ N ☐ Y ☐ N

1.4.3 ☐ Y ☐ N ☐ Y ☐ N

1.4.4 ☐ Y ☐ N ☐ Y ☐ N

1.4.5 ☐ Y ☐ N ☐ Y ☐ N

1.5 ☐ Y ☐ N ☐ Y ☐ N

1.6

1.6.1 ☐ Y ☐ N ☐ Y ☐ N

1.6.2 ☐ Y ☐ N ☐ Y ☐ N

1.6.3 ☐ Y ☐ N ☐ Y ☐ N

1.6.4 ☐ Y ☐ N ☐ Y ☐ N

1.6.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

Each service is organised, managed and staffed to provide safe, efficient and effective care to patients referred to their service and to ensure high quality professional practice.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	

2.5 ☐ Y ☐ N ☐ Y ☐ N

2.6

2.6.1 ☐ Y ☐ N ☐ Y ☐ N

2.6.2 ☐ Y ☐ N ☐ Y ☐ N

2.6.3 ☐ Y ☐ N ☐ Y ☐ N

2.6.4 ☐ Y ☐ N ☐ Y ☐ N

2.7 ☐ Y ☐ N ☐ Y ☐ N

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.12

2.12.1 ☐ Y ☐ N ☐ Y ☐ N

2.12.2 ☐ Y ☐ N ☐ Y ☐ N

2.12.3 ☐ Y ☐ N ☐ Y ☐ N

2.12.4 ☐ Y ☐ N ☐ Y ☐ N

2.12.5 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.16 Paramedical staff are registered with the appropriate professional organisation (where applicable).

2.17 All unqualified staff working within the service practise under the supervision of a qualified professional from the appropriate profession.

2.18 Staffing is calculated and allocated on the basis of workload and a recognised dependency system.

2.19 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.20 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.21 The organisational chart is reviewed annually, revised and dated.

2.22 Paramedical staff are supported in the delivery of care by the following personnel:

2.22.1 administrative

2.22.2 ancillary

2.22.3 secretarial

2.23 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

3. STAFF DEVELOPMENT AND EDUCATION

Each service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to each service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the service

3.1.3 explains the relationships within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 explains the method used to evaluate staff performance

Staffing

2.16	☐ Y ☐ N	☐ Y ☐ N
2.17	☐ Y ☐ N	☐ Y ☐ N
2.18	☐ Y ☐ N	☐ Y ☐ N
2.19	☐ Y ☐ N	☐ Y ☐ N
2.20	☐ Y ☐ N	☐ Y ☐ N
2.21	☐ Y ☐ N	☐ Y ☐ N
2.22		
2.22.1	☐ Y ☐ N	☐ Y ☐ N
2.22.2	☐ Y ☐ N	☐ Y ☐ N
2.22.3	☐ Y ☐ N	☐ Y ☐ N
2.23	☐ Y ☐ N	☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

Each service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.2	☐ Y ☐ N	☐ Y ☐ N	
3.1.3	☐ Y ☐ N	☐ Y ☐ N	
3.1.4	☐ Y ☐ N	☐ Y ☐ N	
3.1.5	☐ Y ☐ N	☐ Y ☐ N	
3.1.6	☐ Y ☐ N	☐ Y ☐ N	

3.1.7 introduces staff to the policies and procedures of the service and the hospital

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.2 All staff are proficient in Basic Life Support:

3.2.1 management of the airways

3.2.2 control of bleeding

3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

3.3.1 utilises professional and other resource material

3.3.2 supports and encourages relevant research

3.3.3 provides information on advances in practice related to each service

3.3.4 provides information on educational opportunities arranged by other institutions

3.3.5 provides orientation to new clinical areas

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and relevant text books are available within departments for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

4. POLICIES AND PROCEDURES

Written and updated policies and procedures reflect current professional knowledge and principles for each service and are consistent with the objectives of the service and relevant regulations.

Standards

4.1 Written policies and procedures are developed to guide paramedical staff in the activities and management of each service.

4.2 Paramedical staff are actively involved in the formulation of service policies and procedures.

4.3 When policies are developed, attention is drawn to practice in other fields, for example, infection control, medical record keeping and occupational health.

4.4 Policies and procedures are consistent with those of the hospital.

3.1.7	☐ Y ☐ N	☐ Y ☐ N
3.1.8	☐ Y ☐ N	☐ Y ☐ N
3.1.9	☐ Y ☐ N	☐ Y ☐ N
3.2		
3.2.1	☐ Y ☐ N	☐ Y ☐ N
3.2.2	☐ Y ☐ N	☐ Y ☐ N
3.2.3	☐ Y ☐ N	☐ Y ☐ N
3.3		
3.3.1	☐ Y ☐ N	☐ Y ☐ N
3.3.2	☐ Y ☐ N	☐ Y ☐ N
3.3.3	☐ Y ☐ N	☐ Y ☐ N
3.3.4	☐ Y ☐ N	☐ Y ☐ N
3.3.5	☐ Y ☐ N	☐ Y ☐ N
3.4	☐ Y ☐ N	☐ Y ☐ N
3.5	☐ Y ☐ N	☐ Y ☐ N
3.6	☐ Y ☐ N	☐ Y ☐ N

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Standards	Comment		Comment
4.1	☐ Y ☐ N	☐ Y ☐ N	
4.2	☐ Y ☐ N	☐ Y ☐ N	
4.3	☐ Y ☐ N	☐ Y ☐ N	
4.4	☐ Y ☐ N	☐ Y ☐ N	

4.5 Paramedical staff act in accordance with legislation affecting professional practice and current professional guidelines.

4.6 The scope and limitations of the responsibilities and activities of paramedical staff in each service are clearly defined.

4.7 Policies and procedures include at least the following:

- 4.7.1 COSHH regulations
- 4.7.2 direction of support staff
- 4.7.3 infection control
- 4.7.4 information issued to patients
- 4.7.5 on-going care (for example, referral systems within and outside the hospital)
- 4.7.6 patient safety
- 4.7.7 referral to and discharge from the service
- 4.7.8 reporting back to the referrer
- 4.7.9 staff safety (for example, lifting procedures)
- 4.7.10 storage and handling of equipment

4.8 There is a policy for dealing with:

- 4.8.1 accidents
- 4.8.2 errors
- 4.8.3 incidents
- 4.8.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.9 Records are kept which indicate to whom items listed in 4.8 have been referred and the action which has been taken.

4.10 Policies and procedures are dated and contained within a manual which as a minimum is:

- 4.10.1 regularly reviewed (annually) and updated
- 4.10.2 readily accessible for reference in every department

4.11 Staff are informed of current policies and procedures and follow them in all activities.

4.5 ☐ Y ☐ N ☐ Y ☐ N

4.6 ☐ Y ☐ N ☐ Y ☐ N

4.7

4.7.1 ☐ Y ☐ N ☐ Y ☐ N
4.7.2 ☐ Y ☐ N ☐ Y ☐ N
4.7.3 ☐ Y ☐ N ☐ Y ☐ N
4.7.4 ☐ Y ☐ N ☐ Y ☐ N
4.7.5 ☐ Y ☐ N ☐ Y ☐ N
4.7.6 ☐ Y ☐ N ☐ Y ☐ N
4.7.7 ☐ Y ☐ N ☐ Y ☐ N
4.7.8 ☐ Y ☐ N ☐ Y ☐ N
4.7.9 ☐ Y ☐ N ☐ Y ☐ N
4.7.10 ☐ Y ☐ N ☐ Y ☐ N

4.8

4.8.1 ☐ Y ☐ N ☐ Y ☐ N
4.8.2 ☐ Y ☐ N ☐ Y ☐ N
4.8.3 ☐ Y ☐ N ☐ Y ☐ N
4.8.4 ☐ Y ☐ N ☐ Y ☐ N

4.9 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

4.10.1 ☐ Y ☐ N ☐ Y ☐ N
4.10.2 ☐ Y ☐ N ☐ Y ☐ N

4.11 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The environment and equipment facilitate the safe, effective and efficient operation of each service.

Standards

5.1 The space available is consistent with the relevant building note.

5.2 There is office space available for the head of each service.

5.3 There is office space for service staff.

5.4 There is a rest room and relaxation facilities available for all staff.

5.5 Washrooms and changing facilities, separate from customers' facilities are available for staff.

5.6 There are facilities for confidential consultations.

5.7 There is provision for the visual privacy of patients (for example, screens).

5.8 There are systems for effective communication both internal and external:

- 5.8.1 adequate numbers of telephones giving direct access to key areas
- 5.8.2 a radio telephone system for key personnel in the hospital and for those on call

5.9 Emergency resuscitation equipment is easily accessible from each department and the procedure for summoning assistance is known by all staff.

5.10 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.11 Where specialised equipment is used, it is operated only by staff trained to do so.

5.12 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.13 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

5.14 The staff of each service have information on the range and availability of aids, appliances and facilities which could assist patients living in the community.

5. FACILITIES AND EQUIPMENT

The environment and equipment facilitate the safe, effective and efficient operation of each service.

Standards	Comment		Comment
5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.6 ☐ Y ☐ N		☐ Y ☐ N	
5.7 ☐ Y ☐ N		☐ Y ☐ N	
5.8			
5.8.1 ☐ Y ☐ N		☐ Y ☐ N	
5.8.2 ☐ Y ☐ N		☐ Y ☐ N	
5.9 ☐ Y ☐ N		☐ Y ☐ N	
5.10 ☐ Y ☐ N		☐ Y ☐ N	
5.11 ☐ Y ☐ N		☐ Y ☐ N	
5.12 ☐ Y ☐ N		☐ Y ☐ N	
5.13 ☐ Y ☐ N		☐ Y ☐ N	
5.14 ☐ Y ☐ N		☐ Y ☐ N	

6. PATIENT CARE

The care provided is systematic and patient-centred.

Standards

6.1 The delivery of care is in accordance with agreed standards of practice within professions allied to medicine.

6.2 There is evidence that the prime focus of care is on the patient and their carers.

6.3 A named, registered member of the paramedical staff is accountable for each patient referred to their care.

6.4 A treatment plan is developed after an assessment of the patient.

6.5 The treatment plan is developed in collaboration with medical and other relevant staff and in consultation with the patient and carers or advocates.

6.6 The treatment plan is written into the patient's medical record and includes:

- 6.6.1 a statement of the patient's needs
- 6.6.2 details of specific care given
- 6.6.3 health education
- 6.6.4 preparation for discharge
- 6.6.5 continuing assessment and evaluation of needs
- 6.6.6 name and signature of paramedical responsible

6.7 Paramedical staff maintain the patient's right to privacy, dignity and confidentiality at all times.

6.8 Paramedical staff participate in case conferences concerning patients in their care.

6.9 Where the referral source is outside the discharging institution, a copy of the discharge summary is sent to the medical practitioner or other source of referral and to the relevant agencies or organisations involved with the patient on discharge.

6. PATIENT CARE

The care provided is systematic and patient-centred.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6			
6.6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6.6 ☐ Y ☐ N		☐ Y ☐ N	
6.7 ☐ Y ☐ N		☐ Y ☐ N	
6.8 ☐ Y ☐ N		☐ Y ☐ N	
6.9 ☐ Y ☐ N		☐ Y ☐ N	

7. EVALUATION AND QUALITY ASSURANCE

Each service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

7.1 There is a written quality assurance plan for each service.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The evaluation and quality assurance programme of each service includes the review of at least the following:

- 7.3.1 service users' satisfaction
- 7.3.2 the service in comparison with standards set out in this chapter
- 7.3.3 the performance of all staff in each department *(see Management and Staffing in this section)*
- 7.3.4 the evaluation of professional practice
- 7.3.5 the evaluation of clinical performance through multidisciplinary audit
- 7.3.6 the use of resources (type of stock, amount etc.)
- 7.3.7 assessment of the appropriateness of care

7.4 The evaluation activities include the following elements:

- 7.4.1 monitoring: the routine collection of information/statistics about important aspects of delivery of services
- 7.4.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery
- 7.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented
- 7.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 7.4.5 feedback: the results of activities are regularly communicated to the staff

7.5 Clinical audit meetings are held on a regular basis.

7.6 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

7.7 Confidentiality is maintained throughout evaluation proceedings.

7.8 The staff within the service receive a report of results obtained through evaluation of care and/or service.

7. EVALUATION AND QUALITY ASSURANCE

Each service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3			
7.3.1 ☐ Y ☐ N		☐ Y ☐ N	
7.3.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3.3 ☐ Y ☐ N		☐ Y ☐ N	
7.3.4 ☐ Y ☐ N		☐ Y ☐ N	
7.3.5 ☐ Y ☐ N		☐ Y ☐ N	
7.3.6 ☐ Y ☐ N		☐ Y ☐ N	
7.3.7 ☐ Y ☐ N		☐ Y ☐ N	
7.4			
7.4.1 ☐ Y ☐ N		☐ Y ☐ N	
7.4.2 ☐ Y ☐ N		☐ Y ☐ N	
7.4.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4.4 ☐ Y ☐ N		☐ Y ☐ N	
7.4.5 ☐ Y ☐ N		☐ Y ☐ N	
7.5 ☐ Y ☐ N		☐ Y ☐ N	
7.6 ☐ Y ☐ N		☐ Y ☐ N	
7.7 ☐ Y ☐ N		☐ Y ☐ N	
7.8 ☐ Y ☐ N		☐ Y ☐ N	

7.9 The staff within the service participate in the formulation of plans for improvement.

7.10 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

7.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

7.12 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

7.13 Statistics are collected for Korner returns.

7.14 Statistics collected are used to effect management/practice change.

7.15 There are local policies for collection of information on key areas such as:

- 7.15.1 inappropriate attendances
- 7.15.2 waiting time
- 7.15.3 time spent in department
- 7.15.4 discharge
- 7.15.5 follow-up
- 7.15.6 referral

See also Health and Safety, Infection Control and Hospital Management (major incident plan and patients rights) sections of this manual.

7.9 ☐ Y ☐ N ☐ Y ☐ N

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15

- 7.15.1 ☐ Y ☐ N ☐ Y ☐ N
- 7.15.2 ☐ Y ☐ N ☐ Y ☐ N
- 7.15.3 ☐ Y ☐ N ☐ Y ☐ N
- 7.15.4 ☐ Y ☐ N ☐ Y ☐ N
- 7.15.5 ☐ Y ☐ N ☐ Y ☐ N
- 7.15.6 ☐ Y ☐ N ☐ Y ☐ N

PROFESSIONS ALLIED TO MEDICINE

Surveyor's General Comments

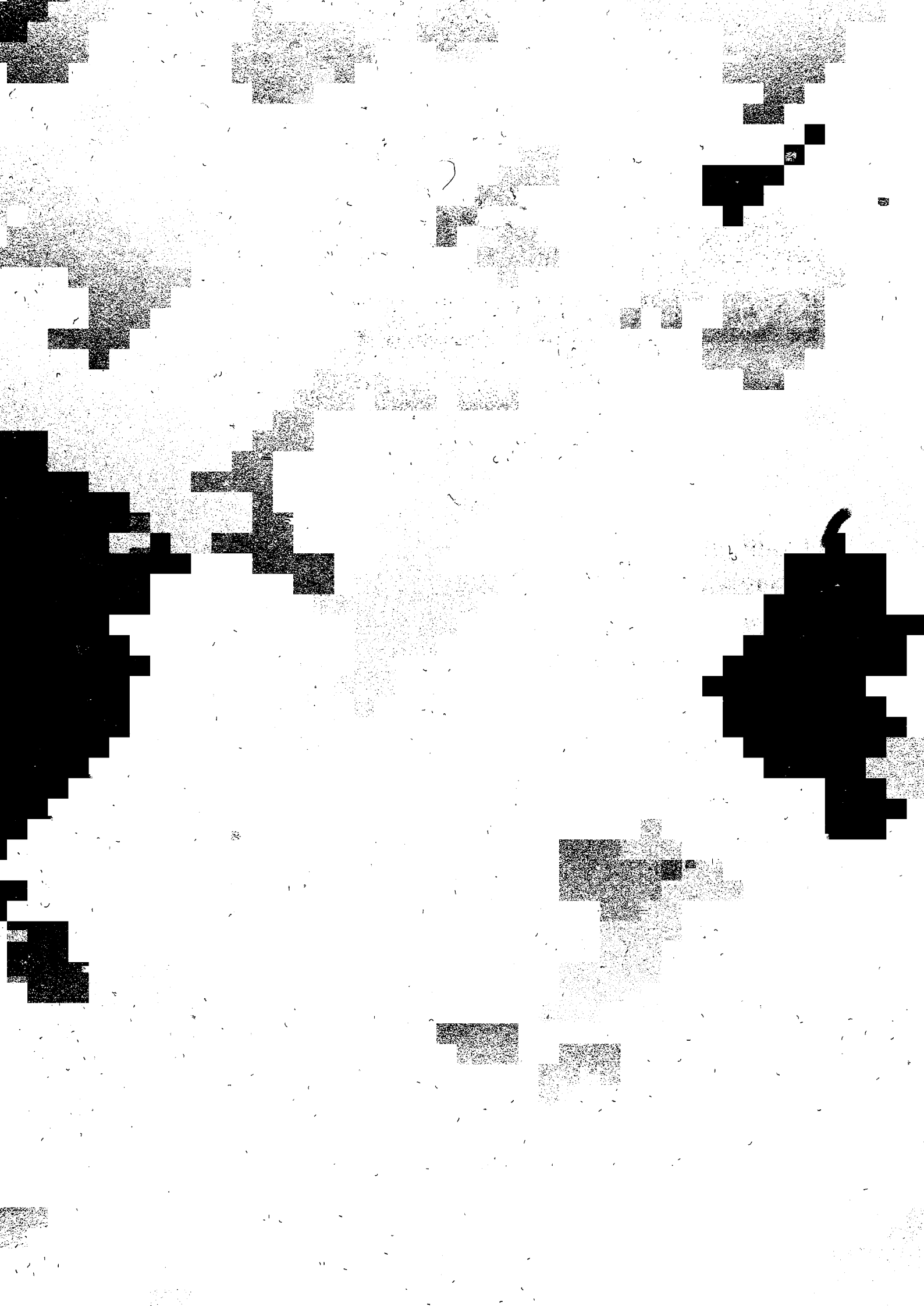
PROFESSIONS ALLIED TO MEDICINE

Surveyor's Comments

Standard Number	Recommendation

DEPARTMENTAL MANAGEMENT

Accident and Emergency Service 123
Acute Day Care Service 139
Laboratory Service 153
Operating Theatre Service 166
Out-Patient Service 180
Pharmaceutical Service 193
Radiology Service 206
Special Care Service 218



ACCIDENT AND EMERGENCY SERVICE — MAJOR UNIT

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

ACCIDENT AND EMERGENCY SERVICE – MAJOR UNIT

1. PHILOSOPHY AND OBJECTIVES

The accident and emergency service provides assessment and initial treatment or advice to any acutely ill or injured person presenting at the department.

Standards

1.1 Staff within the accident and emergency department develop a written philosophy for the service which is consistent with that of the hospital.

1.2 The service operates on a twenty four hour basis.

1.3 The provision of emergency services assumes priority over the provision of services for non-urgent patients.

1.4 The service confines itself to initial assessment and emergency care, any subsequent care being arranged in some other place.

1.5 Staff within the accident and emergency department develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the accident and emergency service.

1.6 The objectives for the service include at least the following:

1.6.1 providing patients with a quality service and care which is based on assessment of patients' needs

1.6.2 providing patients with a quality service and care which is based on professional standards where available

1.6.3 ensuring patient safety

1.6.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.6.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes

1.6.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

1.6.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.6.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

ACCIDENT AND EMERGENCY SERVICE – MAJOR UNIT

1. PHILOSOPHY AND OBJECTIVES

The accident and emergency service provides assessment and initial treatment or advice to any acutely ill or injured person presenting at the department.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4 ☐ Y ☐ N		☐ Y ☐ N	
1.5 ☐ Y ☐ N		☐ Y ☐ N	
1.6			
1.6.1 ☐ Y ☐ N		☐ Y ☐ N	
1.6.2 ☐ Y ☐ N		☐ Y ☐ N	
1.6.3 ☐ Y ☐ N		☐ Y ☐ N	
1.6.4 ☐ Y ☐ N		☐ Y ☐ N	
1.6.5 ☐ Y ☐ N		☐ Y ☐ N	
1.6.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.6.7 ☐ Y ☐ N		☐ Y ☐ N	
1.6.8 ☐ Y ☐ N		☐ Y ☐ N	

1.7 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.7.1 be courteous and considerate to patients and their carers at all times

1.7.2 respect patients' privacy and dignity and that of their carers

1.7.3 respect and cater for cultural differences

1.7.4 respond to communication difficulties

1.7.5 identify counselling requirements of the patient and carers

1.8 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.8.1 the role of the hospital

1.8.2 the provision of services

1.8.3 the pattern of delivery of service

1.8.4 staffing patterns

1.8.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The accident and emergency service meets the needs of the community and is organised, managed and integrated with other departments and services of the hospital to provide safe, efficient and effective care to patients.

Standards

Management

2.1 There is a qualified consultant who directs the service.

2.2 There is a qualified deputy designated to act in the absence of the consultant.

2.3 The director (however named) is involved in the preparation of the budget for the accident and emergency service.

2.4 The director (however named) is responsible for the efficient and effective management of the service's budget.

2.5 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.6 The budget reports are accurate.

1.7

1.7.1	☐ Y ☐ N	☐ Y ☐ N
1.7.2	☐ Y ☐ N	☐ Y ☐ N
1.7.3	☐ Y ☐ N	☐ Y ☐ N
1.7.4	☐ Y ☐ N	☐ Y ☐ N
1.7.5	☐ Y ☐ N	☐ Y ☐ N

1.8

1.8.1	☐ Y ☐ N	☐ Y ☐ N
1.8.2	☐ Y ☐ N	☐ Y ☐ N
1.8.3	☐ Y ☐ N	☐ Y ☐ N
1.8.4	☐ Y ☐ N	☐ Y ☐ N
1.8.5	☐ Y ☐ N	☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The accident and emergency service meets the needs of the community and is organised, managed and integrated with other departments and services of the hospital to provide safe, efficient and effective care to patients.

Standards	Comment	Comment
Management		
2.1 ☐ Y ☐ N		☐ Y ☐ N
2.2 ☐ Y ☐ N		☐ Y ☐ N
2.3 ☐ Y ☐ N		☐ Y ☐ N
2.4 ☐ Y ☐ N		☐ Y ☐ N
2.5 ☐ Y ☐ N		☐ Y ☐ N
2.6 ☐ Y ☐ N		☐ Y ☐ N

2.7 Records and statistics are available for the effective management of the service which as a minimum include:

- 2.7.1 ratio of staff to workload
- 2.7.2 staff absentee rate
- 2.7.3 staff sickness rate
- 2.7.4 staff turnover rate

2.8 Regular multidisciplinary staff meetings are held to:

- 2.8.1 maintain good communications
- 2.8.2 review service practices

2.9 Minutes of meetings are kept.

2.10 Staff are informed of the outcomes of these meetings.

2.11 The accident and emergency service is involved in the development of hospital policies and procedures, where appropriate.

2.12 There are established working relationships between the accident and emergency service and other hospital departments.

2.13 The service has established working relationships with other emergency services. For example:

- 2.13.1 ambulance service
- 2.13.2 coastguard service
- 2.13.3 community health service
- 2.13.4 fire service
- 2.13.5 industry
- 2.13.6 local general practitioners
- 2.13.7 police service
- 2.13.8 social services

2.14 The service has a key role in developing plans to respond to:

- 2.14.1 internal disasters
- 2.14.2 external disasters

(see Hospital Management section of this manual)

2.7

2.7.1 ☐ Y ☐ N ☐ Y ☐ N

2.7.2 ☐ Y ☐ N ☐ Y ☐ N

2.7.3 ☐ Y ☐ N ☐ Y ☐ N

2.7.4 ☐ Y ☐ N ☐ Y ☐ N

2.8

2.8.1 ☐ Y ☐ N ☐ Y ☐ N

2.8.2 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.13.1 ☐ Y ☐ N ☐ Y ☐ N

2.13.2 ☐ Y ☐ N ☐ Y ☐ N

2.13.3 ☐ Y ☐ N ☐ Y ☐ N

2.13.4 ☐ Y ☐ N ☐ Y ☐ N

2.13.5 ☐ Y ☐ N ☐ Y ☐ N

2.13.6 ☐ Y ☐ N ☐ Y ☐ N

2.13.7 ☐ Y ☐ N ☐ Y ☐ N

2.13.8 ☐ Y ☐ N ☐ Y ☐ N

2.14

2.14.1 ☐ Y ☐ N ☐ Y ☐ N

2.14.2 ☐ Y ☐ N ☐ Y ☐ N

2.15 Support services are organised to meet the needs of the service. For example:

2.15.1 up-to-date rosters are kept of medical staff available for consultation or assistance covering all areas of medicine and in particular resuscitation

2.15.2 laboratory services for all routine studies and standard analysis of blood, urine and other body fluids are available at all times

2.15.3 radiology standby cover is available at all times

2.15.4 facilities for the supply and cross matching of blood are available on a twenty four hour basis

2.15.5 arrangements exist for the twenty four hour provision of supplies of pharmaceuticals, IV fluids including plasma expanders, sterile items, disposables and linen

2.15.6 emergency operating facilities and staff (anaesthetists, surgical specialists, operating theatre personnel) are available at all times

Personnel

2.16 Written and dated job descriptions are available for all posts, which specify at least the following:

2.16.1 job title and grade

2.16.2 qualifications and/or experience required for the post

2.16.3 functions, responsibilities and accountability

2.16.4 frequency and type of staff appraisal

2.16.5 review date

2.17 A documented staff appraisal system exists for all staff.

2.18 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.19 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.20 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.21 There is a doctor on duty at all times in the department.

2.22 Consultant staff or equivalent deputies are available via a twenty four hour on call system.

2.23 Specialist teams are available immediately if required by the department.

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.15.1 ☐ Y ☐ N ☐ Y ☐ N

2.15.2 ☐ Y ☐ N ☐ Y ☐ N

2.15.3 ☐ Y ☐ N ☐ Y ☐ N

2.15.4 ☐ Y ☐ N ☐ Y ☐ N

2.15.5 ☐ Y ☐ N ☐ Y ☐ N

2.15.6 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.16

2.16.1 ☐ Y ☐ N ☐ Y ☐ N

2.16.2 ☐ Y ☐ N ☐ Y ☐ N

2.16.3 ☐ Y ☐ N ☐ Y ☐ N

2.16.4 ☐ Y ☐ N ☐ Y ☐ N

2.16.5 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 There is a designated, qualified senior registered nurse to supervise nursing staff.

2.25 Registered nurses with post-registration education and/or experience of accident and emergency services are present on all shifts.

2.26 Staffing is calculated and allocated on the basis of workload.

2.27 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.28 When house officers or medical students are involved, senior clinical staff are available within the department to provide guidance and support.

2.29 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.30 The organisational chart is reviewed annually, revised and dated.

2.31 Staff are supported in the delivery of care by the following personnel:

2.31.1 administrative

2.31.2 ancillary

2.31.3 secretarial

2.32 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

2.33 The duty and on-call rotas are clearly displayed and available to staff within the department.

3. STAFF DEVELOPMENT AND EDUCATION

The accident and emergency service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the accident and emergency service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the accident and emergency service

3.1.3 explains the relationships within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

2.24	☐ Y ☐ N	☐ Y ☐ N
2.25	☐ Y ☐ N	☐ Y ☐ N
2.26	☐ Y ☐ N	☐ Y ☐ N
2.27	☐ Y ☐ N	☐ Y ☐ N
2.28	☐ Y ☐ N	☐ Y ☐ N
2.29	☐ Y ☐ N	☐ Y ☐ N
2.30	☐ Y ☐ N	☐ Y ☐ N
2.31		
2.31.1	☐ Y ☐ N	☐ Y ☐ N
2.31.2	☐ Y ☐ N	☐ Y ☐ N
2.31.3	☐ Y ☐ N	☐ Y ☐ N
2.32	☐ Y ☐ N	☐ Y ☐ N
2.33	☐ Y ☐ N	☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The accident and emergency service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.1	☐ Y ☐ N	☐ Y ☐ N	
3.1.2	☐ Y ☐ N	☐ Y ☐ N	
3.1.3	☐ Y ☐ N	☐ Y ☐ N	
3.1.4	☐ Y ☐ N	☐ Y ☐ N	

3.1.6 explains the method used to evaluate staff performance

3.1.7 introduces staff to the policies and procedures of the service and the hospital

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.2 All staff are proficient in Basic Life Support:

3.2.1 management of the airway

3.2.2 control of bleeding

3.2.3 cardio-pulmonary resuscitation

3.3 A member of staff proficient in Advanced Life Support is available at all times.

3.4 As a minimum the continuing education programme:

3.4.1 utilises professional and other resource material

3.4.2 supports and encourages relevant research

3.4.3 provides information on advances in practice related to the accident and emergency service

3.4.4 provides information on educational opportunities arranged by other institutions

3.4.5 provides orientation to new clinical areas

3.4.6 provides additional training to support nurses in their extended role

3.5 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.6 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.7 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.8 Where the hospital provides clinical experience for students (medical, nursing, post-graduates) there is written agreement between the hospital and the educational establishment detailing the responsibility for induction, teaching, supervision and assessment of students.

3.9 Where there are medical staff in training, their clinical responsibilities are detailed in accordance with recommendations of the relevant Royal College or Faculty.

3.10 The training provided to trainee medical practitioners or medical students is monitored and reviewed by a designated clinical tutor.

3.1.6 ☐ Y ☐ N ☐ Y ☐ N

3.1.7 ☐ Y ☐ N ☐ Y ☐ N

3.1.8 ☐ Y ☐ N ☐ Y ☐ N

3.1.9 ☐ Y ☐ N ☐ Y ☐ N

3.2

3.2.1 ☐ Y ☐ N ☐ Y ☐ N

3.2.2 ☐ Y ☐ N ☐ Y ☐ N

3.2.3 ☐ Y ☐ N ☐ Y ☐ N

3.3 ☐ Y ☐ N ☐ Y ☐ N

3.4

3.4.1 ☐ Y ☐ N ☐ Y ☐ N

3.4.2 ☐ Y ☐ N ☐ Y ☐ N

3.4.3 ☐ Y ☐ N ☐ Y ☐ N

3.4.4 ☐ Y ☐ N ☐ Y ☐ N

3.4.5 ☐ Y ☐ N ☐ Y ☐ N

3.4.6 ☐ Y ☐ N ☐ Y ☐ N

3.5 ☐ Y ☐ N ☐ Y ☐ N

3.6 ☐ Y ☐ N ☐ Y ☐ N

3.7 ☐ Y ☐ N ☐ Y ☐ N

3.8 ☐ Y ☐ N ☐ Y ☐ N

3.9 ☐ Y ☐ N ☐ Y ☐ N

3.10 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are current, written policies, procedures and standards which reflect current knowledge and practice.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the accident and emergency service.

4.2 Policies and procedures are agreed by medical and nursing staff.

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies and procedures are developed attention is drawn to practice in other fields, for example infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Policies and procedures cover at least the following topics:

- 4.6.1 accident reports for NHS staff injured at work
- 4.6.2 admission, discharge and transfer of patients
- 4.6.3 antidotes to poisons/drug overdose
- 4.6.4 cardiac arrest service
- 4.6.5 child abuse
- 4.6.6 contamination with radioactive material
- 4.6.7 deaths in accident and emergency, coroner's cases
- 4.6.8 deaths on arrival
- 4.6.9 disclosure of information (police, media, telephone)
- 4.6.10 head injury charts
- 4.6.11 homeless persons
- 4.6.12 infection control
- 4.6.13 interpreter service
- 4.6.14 major incidents
- 4.6.15 means of obtaining security
- 4.6.16 non-accidental injury to children
- 4.6.17 notifiable diseases
- 4.6.18 notification of and referral to patient's GP
- 4.6.19 patients' belongings
- 4.6.20 patients brought in dead

4. POLICIES AND PROCEDURES

There are current, written policies, procedures and standards which reflect current knowledge and practice.

Standards		Comment		Comment
4.1	☐ Y ☐ N		☐ Y ☐ N	
4.2	☐ Y ☐ N		☐ Y ☐ N	
4.3	☐ Y ☐ N		☐ Y ☐ N	
4.4	☐ Y ☐ N		☐ Y ☐ N	
4.5	☐ Y ☐ N		☐ Y ☐ N	
4.6				
4.6.1	☐ Y ☐ N		☐ Y ☐ N	
4.6.2	☐ Y ☐ N		☐ Y ☐ N	
4.6.3	☐ Y ☐ N		☐ Y ☐ N	
4.6.4	☐ Y ☐ N		☐ Y ☐ N	
4.6.5	☐ Y ☐ N		☐ Y ☐ N	
4.6.6	☐ Y ☐ N		☐ Y ☐ N	
4.6.7	☐ Y ☐ N		☐ Y ☐ N	
4.6.8	☐ Y ☐ N		☐ Y ☐ N	
4.6.9	☐ Y ☐ N		☐ Y ☐ N	
4.6.10	☐ Y ☐ N		☐ Y ☐ N	
4.6.11	☐ Y ☐ N		☐ Y ☐ N	
4.6.12	☐ Y ☐ N		☐ Y ☐ N	
4.6.13	☐ Y ☐ N		☐ Y ☐ N	
4.6.14	☐ Y ☐ N		☐ Y ☐ N	
4.6.15	☐ Y ☐ N		☐ Y ☐ N	
4.6.16	☐ Y ☐ N		☐ Y ☐ N	
4.6.17	☐ Y ☐ N		☐ Y ☐ N	
4.6.18	☐ Y ☐ N		☐ Y ☐ N	
4.6.19	☐ Y ☐ N		☐ Y ☐ N	

4.6.21 patient consent to treatment

4.6.22 patients not in need of treatment

4.6.23 patients refusing treatment

4.6.24 patients suspected of HIV infection

4.6.25 prescription writing (in and out of hours)

4.6.26 procedure in the event of bomb threats, hostage taking etc.

4.6.27 procedures in disasters

4.6.28 procedures in fire, blackouts

4.6.29 psychiatric referral procedures

4.6.30 rape

4.6.31 referral procedures

4.6.32 request by the police for blood specimens

4.6.33 request for blood alcohol estimations

4.6.34 requests for reports for legal purposes

4.6.35 round the clock procurements of records, X-rays, drugs and other vital supplies

4.6.36 suspected criminals

4.6.37 suspected substance abuse

4.6.38 suspected victims of crime (shootings, knifing, poisoning)

4.6.39 triage

4.6.40 unknown persons

4.6.41 victims of violence

4.6.42 violent patients/visitors

4.7 Medical and nursing policy is documented relative to the practices of the accident and emergency service, which as a minimum includes the following:

4.7.1 clarification of the limits of clinical responsibility of the various staff members

4.7.2 clarification of the extent of treatment to be carried out in the department

4.7.3 extended role of the nurse

4.7.4 patients' rights to privacy and dignity at all times

4.7.5 proper utilisation of observation beds

4.7.6 protocols for the management of uncommon conditions about which information may be difficult to obtain

4.7.7 requests for donor organs/tissue

4.6.21 ☐ Y ☐ N ☐ Y ☐ N

4.6.22 ☐ Y ☐ N ☐ Y ☐ N

4.6.23 ☐ Y ☐ N ☐ Y ☐ N

4.6.24 ☐ Y ☐ N ☐ Y ☐ N

4.6.25 ☐ Y ☐ N ☐ Y ☐ N

4.6.26 ☐ Y ☐ N ☐ Y ☐ N

4.6.27 ☐ Y ☐ N ☐ Y ☐ N

4.6.28 ☐ Y ☐ N ☐ Y ☐ N

4.6.29 ☐ Y ☐ N ☐ Y ☐ N

4.6.30 ☐ Y ☐ N ☐ Y ☐ N

4.6.31 ☐ Y ☐ N ☐ Y ☐ N

4.6.32 ☐ Y ☐ N ☐ Y ☐ N

4.6.33 ☐ Y ☐ N ☐ Y ☐ N

4.6.34 ☐ Y ☐ N ☐ Y ☐ N

4.6.35 ☐ Y ☐ N ☐ Y ☐ N

4.6.36 ☐ Y ☐ N ☐ Y ☐ N

4.6.37 ☐ Y ☐ N ☐ Y ☐ N

4.6.38 ☐ Y ☐ N ☐ Y ☐ N

4.6.39 ☐ Y ☐ N ☐ Y ☐ N

4.6.40 ☐ Y ☐ N ☐ Y ☐ N

4.6.41 ☐ Y ☐ N ☐ Y ☐ N

4.6.42 ☐ Y ☐ N ☐ Y ☐ N

4.7

4.7.1 ☐ Y ☐ N ☐ Y ☐ N

4.7.2 ☐ Y ☐ N ☐ Y ☐ N

4.7.3 ☐ Y ☐ N ☐ Y ☐ N

4.7.4 ☐ Y ☐ N ☐ Y ☐ N

4.7.5 ☐ Y ☐ N ☐ Y ☐ N

4.7.6 ☐ Y ☐ N ☐ Y ☐ N

4.7.7 ☐ Y ☐ N ☐ Y ☐ N

4.8 There is a policy for dealing with:

4.8.1 accidents

4.8.2 errors

4.8.3 incidents

4.8.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.9 Records are kept which indicate to whom items listed in 4.8 have been referred and the action which has been taken.

4.10 Policies and procedures are dated and contained within a manual which as a minimum is:

4.10.1 regularly reviewed (annually) and updated

4.10.2 readily accessible for reference in the department

4.11 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The environment, facilities and equipment are such as to ensure safe, efficient and effective emergency care of the patient, and are in accordance with Health Building note 22.

Standards

5.1 The space available is consistent with Health Building note 22.

5.2 There are office facilities for the consultant and nurse in charge, medical, nursing staff and other professional staff as necessary.

5.3 There is a rest room available for all staff.

5.4 There is provision for a teaching/seminar room.

5.5 Washrooms and changing facilities, separate from customer facilities are available for staff.

5.6 There are facilities for confidential consultations.

5.7 There is a room designated for use by grieving and bereaved carers.

5.8 There is provision for the visual privacy of patients (for example, screens).

4.8

4.8.1 ☐ Y ☐ N ☐ Y ☐ N

4.8.2 ☐ Y ☐ N ☐ Y ☐ N

4.8.3 ☐ Y ☐ N ☐ Y ☐ N

4.8.4 ☐ Y ☐ N ☐ Y ☐ N

4.9 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

4.10.1 ☐ Y ☐ N ☐ Y ☐ N

4.10.2 ☐ Y ☐ N ☐ Y ☐ N

4.11 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The environment, facilities and equipment are such as to ensure safe, efficient and effective emergency care of the patient, and are in accordance with Health Building note 22.

Standards	Comment		Comment
5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.6 ☐ Y ☐ N		☐ Y ☐ N	
5.7 ☐ Y ☐ N		☐ Y ☐ N	
5.8 ☐ Y ☐ N		☐ Y ☐ N	

5.9 There are systems for effective communications both internal and external which have the capacity to deal with a major incident. This includes at least the following:

5.9.1 adequate numbers of telephones giving direct access to key areas, such as the police and emergency ambulance service

5.9.2 an internal tannoy system

5.9.3 a radio telephone system for key personnel in the hospital and for those on call

5.10 The location is clearly signposted on roads and approaches to and within the hospital.

5.11 There is access and space for ambulances, which is undercover. The location of the emergency access is clearly visible and accessible.

5.12 The reception and triage area is placed to allow surveillance of ambulant and stretcher arrivals.

5.13 Ambulant and stretcher arrivals are kept separate.

5.14 The ambulance bay is close to and has easy access to the resuscitation area.

5.15 The number of cubicles, beds or trolleys meet the requirements of the workload.

5.16 There is space and privacy for the performance of:

5.16.1 resuscitation

5.16.2 suturing

5.16.3 plastering

5.16.4 other forms of medical treatment

5.16.5 the observation and holding of patients

5.17 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.18 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.19 Resuscitation beds have full resuscitation and treatment equipment which fulfils the requirements of the College of Anaesthetists.

5.20 A range of equipment and instruments is available for both adults and children.

5.21 Drug dosages and size of endotracheal tubes for children by age and weight are defined and clearly displayed on the wall of the emergency room.

5.22 Facilities for sterilisation are available as part of the infection control procedure. *(See Infection Control section of this manual.)*

5.9

5.9.1 ☐ Y ☐ N ☐ Y ☐ N

5.9.2 ☐ Y ☐ N ☐ Y ☐ N

5.9.3 ☐ Y ☐ N ☐ Y ☐ N

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

5.14 ☐ Y ☐ N ☐ Y ☐ N

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16

5.16.1 ☐ Y ☐ N ☐ Y ☐ N

5.16.2 ☐ Y ☐ N ☐ Y ☐ N

5.16.3 ☐ Y ☐ N ☐ Y ☐ N

5.16.4 ☐ Y ☐ N ☐ Y ☐ N

5.16.5 ☐ Y ☐ N ☐ Y ☐ N

5.17 ☐ Y ☐ N ☐ Y ☐ N

5.18 ☐ Y ☐ N ☐ Y ☐ N

5.19 ☐ Y ☐ N ☐ Y ☐ N

5.20 ☐ Y ☐ N ☐ Y ☐ N

5.21 ☐ Y ☐ N ☐ Y ☐ N

5.22 ☐ Y ☐ N ☐ Y ☐ N

5.23 There is a well organised radiological service providing twenty four hour standby cover situated close to the accident and emergency service.

5.24 The following are present in the reception area:

5.24.1 access to public telephones

5.24.2 clean and comfortable toilet and washroom facilities with access for wheelchairs

5.24.3 customer information (for example, how to use the accident and emergency service, prevention of accidents in the home)

5.24.4 designated waiting area

5.24.5 facilities for nursing mothers

5.24.6 information on waiting time

5.24.7 play facilities/separate waiting area for children

5.24.8 refreshments (for example, vending machine)

5.24.9 seating

5.24.10 space for wheelchairs

5.24.11 up-to-date reading material

5.25 Where specialised equipment is used, it is operated only by staff trained to do so.

5.26 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.27 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. PATIENT CARE

There is a systematic approach to patient care which maintains the patient's rights at all times.

Standards

6.1 All patients on arrival are subject to triage. If necessary triage occurs even before identification.

6.2 Triage is performed by a clinician or a senior member of the trained nursing staff.

6.3 On arrival all patients are correctly identified, and a record created which uses a unique hospital unit number system.

6.4 The record of attendance is included in the patient's medical record in which the accident and emergency section is readily identifiable.

5.23	☐ Y ☐ N	☐ Y ☐ N
5.24		
5.24.1	☐ Y ☐ N	☐ Y ☐ N
5.24.2	☐ Y ☐ N	☐ Y ☐ N
5.24.3	☐ Y ☐ N	☐ Y ☐ N
5.24.4	☐ Y ☐ N	☐ Y ☐ N
5.24.5	☐ Y ☐ N	☐ Y ☐ N
5.24.6	☐ Y ☐ N	☐ Y ☐ N
5.24.7	☐ Y ☐ N	☐ Y ☐ N
5.24.8	☐ Y ☐ N	☐ Y ☐ N
5.24.9	☐ Y ☐ N	☐ Y ☐ N
5.24.10	☐ Y ☐ N	☐ Y ☐ N
5.24.11	☐ Y ☐ N	☐ Y ☐ N
5.25	☐ Y ☐ N	☐ Y ☐ N
5.26	☐ Y ☐ N	☐ Y ☐ N
5.27	☐ Y ☐ N	☐ Y ☐ N

6. PATIENT CARE

There is a systematic approach to patient care which maintains the patient's rights at all times.

Standards	Comment		Comment
6.1	☐ Y ☐ N	☐ Y ☐ N	
6.2	☐ Y ☐ N	☐ Y ☐ N	
6.3	☐ Y ☐ N	☐ Y ☐ N	
6.4	☐ Y ☐ N	☐ Y ☐ N	

6.5 This record is available on a twenty four hour basis.

6.6 If a separate accident and emergency record is maintained, this is available on a twenty four hour basis.

6.7 The record contains at least the following:

6.7.1 name, address and post code

6.7.2 next of kin

6.7.3 record/patient number

6.7.4 date and time of arrival

6.7.5 a description of significant clinical, laboratory and radiological findings

6.7.6 details of treatment and time of discharge

6.7.7 details of information given to patients and/or their carers on discharge

6.7.8 the name and signature of the attending clinician

6.7.9 the name and signature of the attending nurse
(see Medical Record Content section of this manual)

6.8 Seriously ill patients receive appropriate observation and monitoring at all times.

6.9 The monitoring of seriously ill patients continues during transfer to other areas of the hospital when the patient is accompanied by an escort capable of managing likely complications.

6.10 There are clear arrangements for the handover of patients and transfer of documentation.

6.11 Patients leaving the service receive clear instructions with reference to their illness and/or follow up if arranged, which is recorded in the notes.

6.12 Staff maintain the patient's right to privacy, dignity and confidentiality at all times.

6.13 Staff participate in case conferences concerning patients in their care.

6.5 ☐ Y ☐ N ☐ Y ☐ N

6.6 ☐ Y ☐ N ☐ Y ☐ N

6.7

6.7.1 ☐ Y ☐ N ☐ Y ☐ N

6.7.2 ☐ Y ☐ N ☐ Y ☐ N

6.7.3 ☐ Y ☐ N ☐ Y ☐ N

6.7.4 ☐ Y ☐ N ☐ Y ☐ N

6.7.5 ☐ Y ☐ N ☐ Y ☐ N

6.7.6 ☐ Y ☐ N ☐ Y ☐ N

6.7.7 ☐ Y ☐ N ☐ Y ☐ N

6.7.8 ☐ Y ☐ N ☐ Y ☐ N

6.7.9 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

7. EVALUATION AND QUALITY ASSURANCE

The accident and emergency service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

7.1 There is a written quality assurance plan for the accident and emergency service.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The evaluation and quality assurance programme includes the review of at least the following:

- 7.3.1 service users' satisfaction
- 7.3.2 the accident and emergency service in comparison with standards set out in this chapter
- 7.3.3 the performance of all accident and emergency staff *(see Management and Staffing in this section)*
- 7.3.4 the evaluation of nursing practice
- 7.3.5 the evaluation of clinical performance through multidisciplinary audit
- 7.3.6 the use of resources (type of stock, amount, etc.)
- 7.3.7 assessment for the appropriateness of care given

7.4 The evaluation activities include the following elements:

- 7.4.1 monitoring: the routine collection of information/statistics about important aspects of delivery of services
- 7.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery
- 7.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented
- 7.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 7.4.5 feedback: the results of activities are regularly communicated to the staff

7.5 Clinical audit meetings are held on a regular basis.

7.6 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

7.7 Confidentiality is maintained throughout evaluation proceedings.

7. EVALUATION AND QUALITY ASSURANCE

The accident and emergency service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3			
7.3.1 ☐ Y ☐ N		☐ Y ☐ N	
7.3.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3.3 ☐ Y ☐ N		☐ Y ☐ N	
7.3.4 ☐ Y ☐ N		☐ Y ☐ N	
7.3.5 ☐ Y ☐ N		☐ Y ☐ N	
7.3.6 ☐ Y ☐ N		☐ Y ☐ N	
7.3.7 ☐ Y ☐ N		☐ Y ☐ N	
7.4			
7.4.1 ☐ Y ☐ N		☐ Y ☐ N	
7.4.2 ☐ Y ☐ N		☐ Y ☐ N	
7.4.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4.4 ☐ Y ☐ N		☐ Y ☐ N	
7.4.5 ☐ Y ☐ N		☐ Y ☐ N	
7.5 ☐ Y ☐ N		☐ Y ☐ N	
7.6 ☐ Y ☐ N		☐ Y ☐ N	
7.7 ☐ Y ☐ N		☐ Y ☐ N	

7.8 The staff within the service receive a report of results obtained through evaluation of care and/or service.

7.9 The staff within the service participate in the formulation of plans for improvement.

7.10 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

7.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

7.12 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

7.13 Statistics are collected for Korner returns.

7.14 Statistics collected are used to effect management/practice change.

7.15 There are local policies for collection of information on key areas such as:

7.15.1 discharge, follow-up and referral patterns

7.15.2 inappropriate attendances

7.15.3 time spent in department

7.15.4 use of investigations

7.15.5 waiting time

See also Health and Safety, Infection Control, Hospital Management (major incident plan, patients rights and special needs) sections of this manual.

7.8 ☐ Y ☐ N ☐ Y ☐ N

7.9 ☐ Y ☐ N ☐ Y ☐ N

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15

7.15.1 ☐ Y ☐ N ☐ Y ☐ N

7.15.2 ☐ Y ☐ N ☐ Y ☐ N

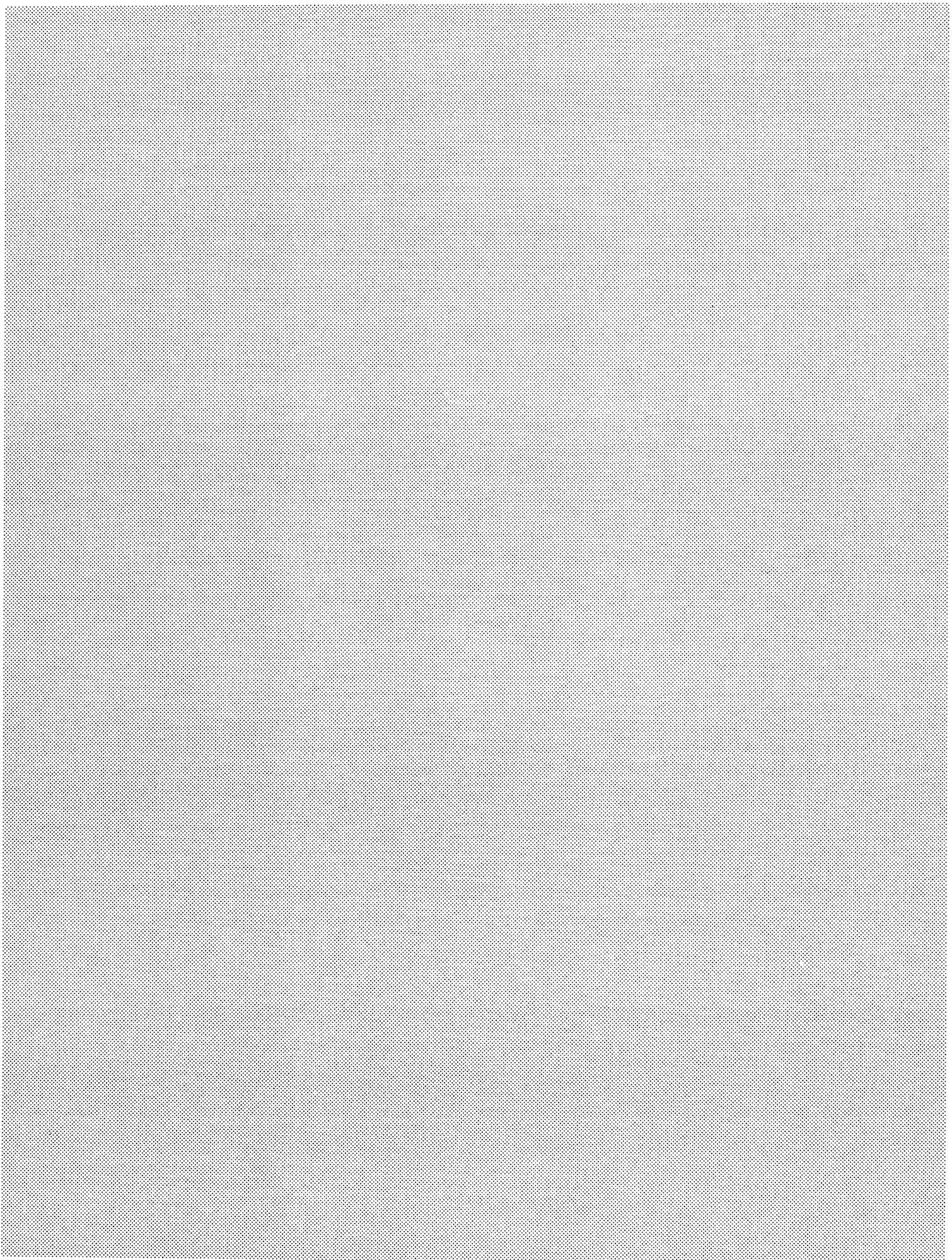
7.15.3 ☐ Y ☐ N ☐ Y ☐ N

7.15.4 ☐ Y ☐ N ☐ Y ☐ N

7.15.5 ☐ Y ☐ N ☐ Y ☐ N

ACCIDENT AND EMERGENCY SERVICE — MAJOR UNIT

Surveyor's General Comments



ACCIDENT AND EMERGENCY SERVICE – MAJOR UNIT

Surveyor's Comments

Standard Number	Recommendation

ACUTE DAY CARE SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

ACUTE DAY CARE SERVICE

1. PHILOSOPHY AND OBJECTIVES

The acute day care service is an in-patient service for patients admitted and expected to be discharged on the same day.

Standards

1.1 Staff within the acute day care department, in consultation with users of the service, develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the acute day care department, in consultation with users of the service, develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the acute day care service.

1.3 The objectives for each service include at least the following:

1.3.1 providing patients with a quality service and care which is based on assessment of patients' needs

1.3.2 providing patients with a quality service and care which is based on professional standards, where available

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes

1.3.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.3.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

1.4.3 respect and cater for cultural differences

1.4.4 respond to communication difficulties

1.4.5 identify counselling requirements of the patient and carers

ACUTE DAY CARE SERVICE

1. PHILOSOPHY AND OBJECTIVES

The acute day care service is an in-patient service for patients admitted and expected to be discharged on the same day.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.3.7 ☐ Y ☐ N		☐ Y ☐ N	
1.3.8 ☐ Y ☐ N		☐ Y ☐ N	
1.4			
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4.4 ☐ Y ☐ N		☐ Y ☐ N	
1.4.5 ☐ Y ☐ N		☐ Y ☐ N	

1.5 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.5.1 the role of the hospital

1.5.2 the provision of services

1.5.3 the pattern of delivery of care

1.5.4 staffing patterns

1.5.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The acute day care service is organised, managed and staffed to provide safe, efficient and effective care for patients and is co-ordinated with other related departments and services of the hospital.

Standards

Management

2.1 There is a designated manager (however named) responsible for the service.

2.2 The manager (however named) is involved in the preparation of the service's budget.

2.3 The manager (however named) is responsible for the efficient and effective management of the budget.

2.4 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.5 The budget reports are accurate.

2.6 Records and statistics are available for the effective management of the service which as a minimum include:

2.6.1 ratio of staff to workload

2.6.2 staff absentee rate

2.6.3 staff sickness rate

2.6.4 staff turnover rate

2.7 Regular multidisciplinary staff meetings are held to:

2.7.1 maintain good communications

2.7.2 review service practices

1.5

1.5.1 ☐ Y ☐ N ☐ Y ☐ N
1.5.2 ☐ Y ☐ N ☐ Y ☐ N
1.5.3 ☐ Y ☐ N ☐ Y ☐ N
1.5.4 ☐ Y ☐ N ☐ Y ☐ N
1.5.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The acute day care service is organised, managed and staffed to provide safe, efficient and effective care for patients and is co-ordinated with other related departments and services of the hospital.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6			
2.6.1 ☐ Y ☐ N		☐ Y ☐ N	
2.6.2 ☐ Y ☐ N		☐ Y ☐ N	
2.6.3 ☐ Y ☐ N		☐ Y ☐ N	
2.6.4 ☐ Y ☐ N		☐ Y ☐ N	
2.7			
2.7.1 ☐ Y ☐ N		☐ Y ☐ N	
2.7.2 ☐ Y ☐ N		☐ Y ☐ N	

2.8 Minutes of meetings are kept.

2.9 Staff are informed of the outcomes of these meetings.

2.10 The acute day care service is involved in the development of hospital policies and procedures, where appropriate.

2.11 There are established working relationships between the day care unit, community services and general practitioners.

2.12 There are established working relationships between the day care service and other hospital departments.

2.13 There is a formal committee of management representing those immediately concerned with the day care unit which includes representation from surgeons, physicians, anaesthetists, general practitioners and nursing staff which meets regularly. Minutes of meetings are kept.

2.14 As a minimum the activities of the committee include:

- 2.14.1 formulating and promulgating policies
- 2.14.2 monitoring utilisation
- 2.14.3 participation in planning structural alterations and/or additions
- 2.14.4 co-ordination of quality assurance

2.15 The day care service is represented on any committees concerning the management of the operating suite.

2.16 Support services are available and organised to meet the needs of the service such as:

- 2.16.1 blood bank
- 2.16.2 pathology
- 2.16.3 radiology

Personnel

2.17 Written and dated job descriptions are available for all posts, which specify at least the following:

- 2.17.1 job title and grade
- 2.17.2 qualifications and/or experience required for the post
- 2.17.3 functions, responsibilities and accountability
- 2.17.4 frequency and type of staff appraisal
- 2.17.5 review date

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14

2.14.1 ☐ Y ☐ N ☐ Y ☐ N
2.14.2 ☐ Y ☐ N ☐ Y ☐ N
2.14.3 ☐ Y ☐ N ☐ Y ☐ N
2.14.4 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16

2.16.1 ☐ Y ☐ N ☐ Y ☐ N
2.16.2 ☐ Y ☐ N ☐ Y ☐ N
2.16.3 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.17

2.17.1 ☐ Y ☐ N ☐ Y ☐ N
2.17.2 ☐ Y ☐ N ☐ Y ☐ N
2.17.3 ☐ Y ☐ N ☐ Y ☐ N
2.17.4 ☐ Y ☐ N ☐ Y ☐ N
2.17.5 ☐ Y ☐ N ☐ Y ☐ N

2.18 A documented staff appraisal system exists for all staff.

2.19 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.20 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.21 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.22 Clinical procedures are directed by appropriately qualified members of the medical and anaesthetic staff.

2.23 There is a qualified, senior registered nurse to supervise nursing staff.

2.24 Staffing is calculated and allocated on the basis of workload and a recognised dependency system.

2.25 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.26 When house officers or medical students are involved, senior medical staff are available within the hospital to provide guidance and support.

2.27 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.28 The organisational chart is reviewed annually, revised and dated.

2.29 Staff are supported in the delivery of care by the following personnel:

2.29.1 administrative

2.29.2 ancillary

2.29.3 secretarial

2.30 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27 ☐ Y ☐ N ☐ Y ☐ N

2.28 ☐ Y ☐ N ☐ Y ☐ N

2.29

2.29.1 ☐ Y ☐ N ☐ Y ☐ N

2.29.2 ☐ Y ☐ N ☐ Y ☐ N

2.29.3 ☐ Y ☐ N ☐ Y ☐ N

2.30 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The day care service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 introduces new staff to the relevant aspects of the acute day care service
- 3.1.3 explains the relationships within the service and with the hospital
- 3.1.4 prepares staff for their role and responsibilities
- 3.1.5 explains lines of authority both within the service and with the hospital
- 3.1.6 explains the method used to evaluate staff performance
- 3.1.7 introduces staff to the policies and procedures of the service and the hospital
- 3.1.8 explains emergency procedures (for example, fire drill)
- 3.1.9 provides information on the occupational health service offered to staff

3.2 All staff are proficient in Basic Life Support:

- 3.2.1 management of the airway
- 3.2.2 control of bleeding
- 3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

- 3.3.1 utilises professional and other resource material
- 3.3.2 supports and encourages relevant research
- 3.3.3 provides information on advances in practice related to the service
- 3.3.4 provides information on educational opportunities arranged by other institutions
- 3.3.5 provides orientation to new clinical areas

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3. STAFF DEVELOPMENT AND EDUCATION

The day care service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3			
3.3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.3.2 ☐ Y ☐ N		☐ Y ☐ N	
3.3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.6 ☐ Y ☐ N		☐ Y ☐ N	

3.7 The training provided to trainee clinicians or medical students is monitored and reviewed by a designated clinical tutor.

4. POLICIES AND PROCEDURES

There are current, written policies and procedures for all activities of the day care service which reflect current standards of practice, relevant regulations, and the objectives of the service.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the acute day care service.

4.2 Policies and procedures are agreed by the users committee.

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies are developed, attention is drawn to practice in other fields, for example infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 There is an admission policy which includes reference to at least the following:

- 4.6.1 age
- 4.6.2 social limitations
- 4.6.3 clinical procedures performed on a day basis
- 4.6.4 period of notice for admission

4.7 The booking and admission of patients complies with the admission policy.

4.8 Information is given to all patients which includes as a minimum:

- 4.8.1 the patient's pre-admission responsibilities and preparation
- 4.8.2 the functioning of the day care service
- 4.8.3 post-anaesthetic effects
- 4.8.4 provision for after hours contact, and emergency care/admission
- 4.8.5 the patient's discharge responsibilities
- 4.8.6 transport arrangements

3.7 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are current, written policies and procedures for all activities of the day care service which reflect current standards of practice, relevant regulations, and the objectives of the service.

Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6			
4.6.1 ☐ Y ☐ N		☐ Y ☐ N	
4.6.2 ☐ Y ☐ N		☐ Y ☐ N	
4.6.3 ☐ Y ☐ N		☐ Y ☐ N	
4.6.4 ☐ Y ☐ N		☐ Y ☐ N	
4.7 ☐ Y ☐ N		☐ Y ☐ N	
4.8			
4.8.1 ☐ Y ☐ N		☐ Y ☐ N	
4.8.2 ☐ Y ☐ N		☐ Y ☐ N	
4.8.3 ☐ Y ☐ N		☐ Y ☐ N	
4.8.4 ☐ Y ☐ N		☐ Y ☐ N	
4.8.5 ☐ Y ☐ N		☐ Y ☐ N	
4.8.6 ☐ Y ☐ N		☐ Y ☐ N	

Day Surgery

(See Operating Theatre section of this manual.)

4.9 There is a discharge policy which includes as a minimum:

- 4.9.1 clear, written post-operative instructions are given to the patient and carer
- 4.9.2 the patient is discharged into the care of a responsible person
- 4.9.3 the address and phone number of the discharge custodian is recorded in the medical record *(see also Medical Record Content section of this manual)*

4.10 The patient's GP and the community nursing services are informed of the discharge procedure.

4.11 The role of the service is included in the fire and disaster plans of the hospital.

4.12 There is a policy for dealing with:

- 4.12.1 accidents
- 4.12.2 errors
- 4.12.3 incidents
- 4.12.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.13 Records are kept which indicate to whom the items listed in 4.12 have been referred and the action which has been taken.

4.14 Policies and procedures are dated and contained within a manual which as a minimum is:

- 4.14.1 regularly reviewed (annually) and updated
- 4.14.2 readily accessible for reference in the department

4.15 Staff are informed of current policies and procedures and follow them in all activities.

Day Surgery

4.9

4.9.1 ☐ Y ☐ N ☐ Y ☐ N

4.9.2 ☐ Y ☐ N ☐ Y ☐ N

4.9.3 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

4.11 ☐ Y ☐ N ☐ Y ☐ N

4.12

4.12.1 ☐ Y ☐ N ☐ Y ☐ N

4.12.2 ☐ Y ☐ N ☐ Y ☐ N

4.12.3 ☐ Y ☐ N ☐ Y ☐ N

4.12.4 ☐ Y ☐ N ☐ Y ☐ N

4.13 ☐ Y ☐ N ☐ Y ☐ N

4.14 ☐ Y ☐ N ☐ Y ☐ N

4.14.1 ☐ Y ☐ N ☐ Y ☐ N

4.14.2 ☐ Y ☐ N ☐ Y ☐ N

4.15 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

Facilities and equipment ensure the safe, efficient and effective functioning of the acute day care service.

Standards

(See Operating Theatre section of this manual.)

5.1 The design of the areas used for day procedures is in accordance with Health Building Note 38: Accommodation for Adult Day Patients. This includes at least the following:

5.1.1 office facilities for the service manager

5.1.2 office facilities for use by the medical staff

5.1.3 a rest room and relaxation facilities for all staff

5.1.4 washrooms and changing facilities, separate from customers' facilities, available for staff

5.1.5 accommodation for patients awaiting surgery which is separate from the operating/procedure room and access corridors

5.1.6 facilities for confidential consultations/counselling

5.1.7 provision for the visual privacy of patients (for example, screens)

5.1.8 systems for effective communication both internal and external:

(a) adequate numbers of telephones giving direct access to key areas

(b) a radio telephone system for key personnel in the hospital and for those on call

5.1.9 waiting area for carers

5.1.10 location of the day care ward with easy access to operating/procedure rooms

5.1.11 a recovery area

5.1.12 storage space for:

(a) equipment

(b) housekeeping equipment

(c) linen

(d) pharmaceutical supplies

(e) storage for controlled drugs

(f) surgical supplies

5.1.13 areas for the collection and disposal of used equipment

5.1.14 if the day care service is not located on the ground floor, there is at least one lift available to accommodate a patient trolley and attendants

5.1.15 car parking facilities to enable the safe discharge of patients

5. FACILITIES AND EQUIPMENT

Facilities and equipment ensure the safe, efficient and effective functioning of the acute day care service.

Standards		Comment		Comment
5.1	☐ Y ☐ N		☐ Y ☐ N	
5.1.1	☐ Y ☐ N		☐ Y ☐ N	
5.1.2	☐ Y ☐ N		☐ Y ☐ N	
5.1.3	☐ Y ☐ N		☐ Y ☐ N	
5.1.4	☐ Y ☐ N		☐ Y ☐ N	
5.1.5	☐ Y ☐ N		☐ Y ☐ N	
5.1.6	☐ Y ☐ N		☐ Y ☐ N	
5.1.7	☐ Y ☐ N		☐ Y ☐ N	
5.1.8				
(a)	☐ Y ☐ N		☐ Y ☐ N	
(b)	☐ Y ☐ N		☐ Y ☐ N	
5.1.9	☐ Y ☐ N		☐ Y ☐ N	
5.1.10	☐ Y ☐ N		☐ Y ☐ N	
5.1.11	☐ Y ☐ N		☐ Y ☐ N	
5.1.12				
(a)	☐ Y ☐ N		☐ Y ☐ N	
(b)	☐ Y ☐ N		☐ Y ☐ N	
(c)	☐ Y ☐ N		☐ Y ☐ N	
(d	☐ Y ☐ N		☐ Y ☐ N	
(e)	☐ Y ☐ N		☐ Y ☐ N	
(f)	☐ Y ☐ N		☐ Y ☐ N	
5.1.13	☐ Y ☐ N		☐ Y ☐ N	
5.1.14	☐ Y ☐ N		☐ Y ☐ N	
5.1.15	☐ Y ☐ N		☐ Y ☐ N	

5.2 The design of the area facilitates the management of clinical services which include at least the following:

5.2.1 ready access for routine and emergency patients

5.2.2 the area for receiving the patient into the operating theatre is close to the junction of sterile and non-sterile zones

5.2.3 clear demarcation of sterile and non-sterile zones

5.2.4 free movement of patient trolleys throughout the suite with a minimum of cross traffic

5.2.5 fire detection, alarm and suppression systems

5.2.6 clearly identifiable fire fighting equipment

5.2.7 doorways, corridors, ramps and stairwells which facilitate the evacuation of non-ambulatory patients

5.2.8 doorways etc. are kept free of obstruction at all times

5.2.9 clearly signposted smoking areas

5.3 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.4 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.5 Where specialised equipment is used, it is operated only by staff trained to do so.

5.6 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.7 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. PATIENT CARE

There is a systematic and patient-centred approach to care within the day care service.

Standards

6.1 There is a planned systematic approach to the provision of patient care, with reference to guidelines for day care surgery issued by the Royal College of Surgeons (Commission on the Provision of Surgical Services 1985) and HM(73)32.

6.2 There is evidence that the prime focus of nursing care is on the patient (for example, primary nursing, patient allocation, team nursing).
(ref. Exercising Accountability — UKCC Advisory Document, March 1989)

5.2		
5.2.1	☐ Y ☐ N	☐ Y ☐ N
5.2.2	☐ Y ☐ N	☐ Y ☐ N
5.2.3	☐ Y ☐ N	☐ Y ☐ N
5.2.4	☐ Y ☐ N	☐ Y ☐ N
5.2.5	☐ Y ☐ N	☐ Y ☐ N
5.2.6	☐ Y ☐ N	☐ Y ☐ N
5.2.7	☐ Y ☐ N	☐ Y ☐ N
5.2.8	☐ Y ☐ N	☐ Y ☐ N
5.2.9	☐ Y ☐ N	☐ Y ☐ N
5.3	☐ Y ☐ N	☐ Y ☐ N
5.4	☐ Y ☐ N	☐ Y ☐ N
5.5	☐ Y ☐ N	☐ Y ☐ N
5.6	☐ Y ☐ N	☐ Y ☐ N
5.7	☐ Y ☐ N	☐ Y ☐ N

6. PATIENT CARE

There is a systematic and patient-centred approach to care within the day care service.

Standards	Comment		Comment
6.1	☐ Y ☐ N	☐ Y ☐ N	
6.2	☐ Y ☐ N	☐ Y ☐ N	

6.3 A named registered nurse is accountable for the nursing care of each patient.

6.4 Day care service records meet the needs for:

- 6.4.1 clinical care
- 6.4.2 medico-legal purposes
- 6.4.3 audit

6.5 The patient's record includes as a minimum:

- 6.5.1 signed consent to the procedure
- 6.5.2 admission diagnosis or reason for admission
- 6.5.3 nursing care given, signed and dated by the nurse responsible
- 6.5.4 information given to patients and their carers

(See also Medical Record Content section of this manual.)

6.6 A record of the procedure performed is written into the patient's medical record which contains details of:

- 6.6.1 anaesthesia
- 6.6.2 personnel involved
- 6.6.3 dressings and drainage systems
- 6.6.4 post-operative instructions:
  - (a) discharge instructions
  - (b) follow-up instructions

6.7 A register of operations/procedures is maintained within the department.

6.8 There is consideration of the emotional impact of the operative experience/investigation on the patient and appropriate explanation, reassurance and care are given.

6.9 Nursing records are signed by the nurse responsible, maintained and incorporated in the patient's medical record. These may include:

- 6.9.1 nursing assessment
- 6.9.2 nursing care plan
- 6.9.3 details of nursing care given
- 6.9.4 patient's response to care and significant changes in health status
- 6.9.5 changes in the nursing care plan resulting from evaluation of the patient's progress
- 6.9.6 information given to the patient and/or carers on discharge
- 6.9.7 discharge plan, which includes a record of any communication with community services

6.3 ☐ Y ☐ N ☐ Y ☐ N

6.4

6.4.1 ☐ Y ☐ N ☐ Y ☐ N

6.4.2 ☐ Y ☐ N ☐ Y ☐ N

6.4.3 ☐ Y ☐ N ☐ Y ☐ N

6.5

6.5.1 ☐ Y ☐ N ☐ Y ☐ N

6.5.2 ☐ Y ☐ N ☐ Y ☐ N

6.5.3 ☐ Y ☐ N ☐ Y ☐ N

6.5.4 ☐ Y ☐ N ☐ Y ☐ N

6.6

6.6.1 ☐ Y ☐ N ☐ Y ☐ N

6.6.2 ☐ Y ☐ N ☐ Y ☐ N

6.6.3 ☐ Y ☐ N ☐ Y ☐ N

6.6.4

(a) ☐ Y ☐ N ☐ Y ☐ N

(b) ☐ Y ☐ N ☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.9.1 ☐ Y ☐ N ☐ Y ☐ N

6.9.2 ☐ Y ☐ N ☐ Y ☐ N

6.9.3 ☐ Y ☐ N ☐ Y ☐ N

6.9.4 ☐ Y ☐ N ☐ Y ☐ N

6.9.5 ☐ Y ☐ N ☐ Y ☐ N

6.9.6 ☐ Y ☐ N ☐ Y ☐ N

6.9.7 ☐ Y ☐ N ☐ Y ☐ N

6.10 Nursing and clinical staff maintain the patient's right to privacy, dignity and confidentiality at all times. (ref. Exercising Accountability — UKCC Advisory Document, March 1989)

6.11 Staff participate in case conferences concerning patients in their care.

7. EVALUATION AND QUALITY ASSURANCE

The acute day care service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the day care service.

Standards

7.1 There is a written quality assurance plan for the acute day care service.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The evaluation and quality assurance programme includes the review of at least the following:

- 7.3.1 service users' satisfaction
- 7.3.2 the acute day care service in comparison with standards set out in this chapter
- 7.3.3 the performance of all day care staff
  (see Management and Staffing within this section)
- 7.3.4 the evaluation of clinical performance through multidisciplinary audit
- 7.3.5 the use of resources (for example, length of stay, use of diagnostic and therapeutic resources)
- 7.3.6 rates of re-admissions
- 7.3.7 rate of overnight stay or transfers
- 7.3.8 assessment of the appropriateness of care given

7.4 Where a national mortality review committee exists (for example, the National Confidential Enquiry into Peri-Operative Deaths), deaths are referred to this committee and subject to internal review.

7.5 The evaluation activities include the following elements:

- 7.5.1 monitoring: the routine collection of information/statistics about important aspects of delivery services
- 7.5.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery
- 7.5.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

7. EVALUATION AND QUALITY ASSURANCE

The acute day care service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the day care service.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3			
7.3.1 ☐ Y ☐ N		☐ Y ☐ N	
7.3.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3.3 ☐ Y ☐ N		☐ Y ☐ N	
7.3.4 ☐ Y ☐ N		☐ Y ☐ N	
7.3.5 ☐ Y ☐ N		☐ Y ☐ N	
7.3.6 ☐ Y ☐ N		☐ Y ☐ N	
7.3.7 ☐ Y ☐ N		☐ Y ☐ N	
7.3.8 ☐ Y ☐ N		☐ Y ☐ N	
7.4 ☐ Y ☐ N		☐ Y ☐ N	
7.5			
7.5.1 ☐ Y ☐ N		☐ Y ☐ N	
7.5.2 ☐ Y ☐ N		☐ Y ☐ N	
7.5.3 ☐ Y ☐ N		☐ Y ☐ N	

7.5.4 evaluation: the effectiveness of action taken is evaluated to ensure the long-term improvements

7.5.5 feedback: the results of activities are regularly communicated to the staff

7.6 Clinical audit meetings are held on a regular basis.

7.7 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

7.8 Confidentiality is maintained throughout evaluation proceedings.

7.9 The staff within the service receive a report of results obtained through evaluation of care and/or service.

7.10 The staff within the service participate in the formulation of plans for improvement.

7.11 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

7.12 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

7.13 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

7.14 Statistics are collected for Korner returns.

7.15 Statistics collected are used to effect management/practice change.

7.16 There are local policies for collection of information on key areas such as:

7.16.1 follow-up arrangements

7.16.2 inappropriate referrals

7.16.3 overnight stays

7.16.4 re-admissions

7.16.5 use of investigations

See also Infection Control, Medical, Nursing, Operating Theatre and Hospital Management (patients rights, special needs and major incident plan) sections of this manual.

7.5.4 ☐ Y ☐ N ☐ Y ☐ N

7.5.5 ☐ Y ☐ N ☐ Y ☐ N

7.6 ☐ Y ☐ N ☐ Y ☐ N

7.7 ☐ Y ☐ N ☐ Y ☐ N

7.8 ☐ Y ☐ N ☐ Y ☐ N

7.9 ☐ Y ☐ N ☐ Y ☐ N

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15 ☐ Y ☐ N ☐ Y ☐ N

7.16

7.16.1 ☐ Y ☐ N ☐ Y ☐ N

7.16.2 ☐ Y ☐ N ☐ Y ☐ N

7.16.3 ☐ Y ☐ N ☐ Y ☐ N

7.16.4 ☐ Y ☐ N ☐ Y ☐ N

7.16.5 ☐ Y ☐ N ☐ Y ☐ N

ACUTE DAY CARE SERVICE

Surveyor's General Comments

ACUTE DAY CARE SERVICE

Surveyor's Comments

Standard Number	Recommendation

LABORATORY SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

LABORATORY SERVICE

These standards and 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 tick the box to indicate to which service the section applies.

Clinical biochemistry ☐

Haematology ☐

Histopathology ☐

Microbiology ☐

Virology ☐

1. PHILOSOPHY AND OBJECTIVES

The laboratory service is responsible for providing a high quality service to patients and for the ethical and professional practices of its staff.

Standards

1.1 Staff within the laboratories develop a written philosophy for the laboratory service which is consistent with that of the hospital.

1.2 Staff within the laboratories develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the laboratory service.

1.3 The objectives for the laboratory service include at least the following:

1.3.1 providing patients with a quality service which is based on assessment of patients' needs

1.3.2 providing patients with a quality service which is based on professional standards where available

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 maintaining effective communication with users concerning the nature and management of clinical conditions and their outcomes

1.3.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

LABORATORY SERVICE

These standards and 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 tick the box to indicate to which service the section applies.

Clinical biochemistry ☐

Haematology ☐

Histopathology ☐

Microbiology ☐

Virology ☐

1. PHILOSOPHY AND OBJECTIVES

The laboratory service is responsible for providing a high quality service to patients and for the ethical and professional practices of its staff.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	

1.3.7 teaching, consultation and collaboration both within the service and with other hospital departments

1.3.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

1.4 Individual laboratories develop specific written objectives.

1.5 Objectives for the laboratory service are based on the functions described in DHSS circular HM(70)50 and are:

1.5.1 to provide a service on a routine, regular and emergency basis

1.5.2 to ensure that tests meet the needs of clinicians

1.5.3 to provide a consultant advisory service supported by diagnostic facilities

1.5.4 to provide analytical results with attention to quality, speed and economy and to control unnecessary demands from any source

1.5.5 to provide interpretation of results and, where necessary, advice on further investigations

1.5.6 to monitor individual patients and provide laboratory control of therapy

1.5.7 to collaborate in the development of new methods of treatment

1.5.8 to undertake fundamental and/or applied research

1.5.9 to participate in research projects generated in the hospital or community

1.5.10 to collaborate in training and continuing education of staff in the hospital and community

1.5.11 to ensure that an interpretive and consultative service is available at all times

1.6 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.6.1 be courteous and considerate to patients and their carers at all times

1.6.2 respect patients' privacy and dignity and that of their carers

1.6.3 respect and cater for cultural differences

1.6.4 respond to communication difficulties

1.6.5 identify counselling requirements of the patient and carers

1.7 The objectives of the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.7.1 the role of the hospital

1.7.2 the provision of services

1.7.3 the pattern of delivery of service

1.7.4 staffing patterns

1.7.5 the nature of professional practice

1.3.7 ☐ Y ☐ N ☐ Y ☐ N

1.3.8 ☐ Y ☐ N ☐ Y ☐ N

1.4 ☐ Y ☐ N ☐ Y ☐ N

1.5 ☐ Y ☐ N ☐ Y ☐ N

1.5.1 ☐ Y ☐ N ☐ Y ☐ N

1.5.2 ☐ Y ☐ N ☐ Y ☐ N

1.5.3 ☐ Y ☐ N ☐ Y ☐ N

1.5.4 ☐ Y ☐ N ☐ Y ☐ N

1.5.5 ☐ Y ☐ N ☐ Y ☐ N

1.5.6 ☐ Y ☐ N ☐ Y ☐ N

1.5.7 ☐ Y ☐ N ☐ Y ☐ N

1.5.8 ☐ Y ☐ N ☐ Y ☐ N

1.5.9 ☐ Y ☐ N ☐ Y ☐ N

1.5.10 ☐ Y ☐ N ☐ Y ☐ N

1.5.11 ☐ Y ☐ N ☐ Y ☐ N

1.6

1.6.1 ☐ Y ☐ N ☐ Y ☐ N

1.6.2 ☐ Y ☐ N ☐ Y ☐ N

1.6.3 ☐ Y ☐ N ☐ Y ☐ N

1.6.4 ☐ Y ☐ N ☐ Y ☐ N

1.6.5 ☐ Y ☐ N ☐ Y ☐ N

1.7

1.7.1 ☐ Y ☐ N ☐ Y ☐ N

1.7.2 ☐ Y ☐ N ☐ Y ☐ N

1.7.3 ☐ Y ☐ N ☐ Y ☐ N

1.7.4 ☐ Y ☐ N ☐ Y ☐ N

1.7.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The laboratory service is organised, managed and staffed to provide high quality clinical laboratory and diagnostic services to meet the needs of clinical services provided by the hospital. The service may be organised to provide clinical laboratory and diagnostic services on a wider basis (for example, regional, supraregional).

Standards

2.1 The laboratory service is directed/chaired by a consultant pathologist or scientist of equivalent standing who is able to assume professional, organisational and managerial responsibility for the services provided.

2.2 The director (however named) and head of each department within the laboratory service are involved in the preparation of the service's budget and the allocation to each laboratory.

2.3 The director (however named) and head of each department within the laboratory service are responsible for the efficient and effective management of the service's budget.

2.4 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.5 The budget reports are accurate.

2.6 Records and statistics are available for the effective management of the service which as a minimum include:

- 2.6.1 ratio of staff to workload
- 2.6.2 staff absentee rate
- 2.6.3 staff sickness rate
- 2.6.4 staff turnover rate

2.7 Regular multidisciplinary staff meetings are held to:

- 2.7.1 maintain good communications
- 2.7.2 review service practices

2.8 Minutes of meetings are kept.

2.9 Staff are informed of the outcomes of these meetings.

2.10 The laboratory service is involved in the development of hospital policies and procedures, where appropriate.

2.11 There are established working relationships between the laboratory service and other hospital departments, in particular accident and emergency, infection control, occupational health, operating theatres and special care units.

2. MANAGEMENT AND STAFFING

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Standards	Comment		Comment
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6			
2.6.1 ☐ Y ☐ N		☐ Y ☐ N	
2.6.2 ☐ Y ☐ N		☐ Y ☐ N	
2.6.3 ☐ Y ☐ N		☐ Y ☐ N	
2.6.4 ☐ Y ☐ N		☐ Y ☐ N	
2.7			
2.7.1 ☐ Y ☐ N		☐ Y ☐ N	
2.7.2 ☐ Y ☐ N		☐ Y ☐ N	
2.8 ☐ Y ☐ N		☐ Y ☐ N	
2.9 ☐ Y ☐ N		☐ Y ☐ N	
2.10 ☐ Y ☐ N		☐ Y ☐ N	
2.11 ☐ Y ☐ N		☐ Y ☐ N	

2.12 Laboratory staff are represented on all committees where clinical and patient care matters are discussed.

2.13 Where satellite laboratory services are provided (for example, intensive care units, neonatal nurseries), responsibility for the operation of those services is clearly defined and instruction and supervision of staff, equipment maintenance and quality control are carried out and documented.

2.14 Authorities or hospitals which do not have their own laboratories or cannot provide a full range of services arrange with an accredited off-site laboratory or laboratories to provide the service needed.

Personnel

2.15 Written and dated job descriptions are available for all posts, which specify at least the following:

2.15.1 job title and grade

2.15.2 qualifications and/or experience required for the post

2.15.3 functions, responsibilities and accountability

2.15.4 frequency and type of staff appraisal

2.15.5 review date

2.16 A documented staff appraisal system exists for all staff.

2.17 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.18 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.19 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.20 The numbers and mix of qualified personnel and support staff employed are calculated against workload and ensure the efficient operation of the service.

2.21 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.22 The organisational chart is reviewed annually, revised and dated.

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.15

- 2.15.1 ☐ Y ☐ N ☐ Y ☐ N
- 2.15.2 ☐ Y ☐ N ☐ Y ☐ N
- 2.15.3 ☐ Y ☐ N ☐ Y ☐ N
- 2.15.4 ☐ Y ☐ N ☐ Y ☐ N
- 2.15.5 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 Staff are supported in the delivery of care by the following personnel:

2.23.1 administrative

2.23.2 ancillary

2.23.3 secretarial

2.24 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

2.25 The duty and on-call rotas are clearly displayed and available to staff within the department.

3. STAFF DEVELOPMENT AND EDUCATION

The laboratory service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the laboratory service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the service

3.1.3 explains the relationships within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 explains the method used to evaluate staff performance

3.1.7 introduces staff to the policies and procedures of the service and the hospital

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.2 As a minimum the continuing education programme:

3.2.1 utilises professional and other resource material

3.2.2 supports and encourages relevant research

3.2.3 provides information on advances in practice related to the service

3.2.4 provides information on educational opportunities arranged by other institutions

3.2.5 provides orientation to new service areas

2.23

2.23.1 ☐ Y ☐ N ☐ Y ☐ N

2.23.2 ☐ Y ☐ N ☐ Y ☐ N

2.23.3 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

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Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.2.4 ☐ Y ☐ N		☐ Y ☐ N	
3.2.5 ☐ Y ☐ N		☐ Y ☐ N	

3.3 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.4 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.5 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.6 Training provided to medical undergraduates and postgraduates is monitored by a designated clinical tutor.

4. POLICIES AND PROCEDURES

There are written, dated policies and procedures which reflect current knowledge and principles of laboratory practice and are consistent with requirements of statutory authorities and the objectives of the service.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the laboratory service.

4.2 Policies and procedures are developed by the laboratory service, in collaboration with other relevant services and management.

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies and procedures are developed, attention is drawn to practice in other fields, for example, infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Policies and procedures relating to requests for laboratory tests include:

4.6.1 authorisation of persons who may request tests

4.6.2 identification of the patient including full name, medical record number, date of birth, sex on the request form and specimen container

4.6.3 name of referring doctor

4.6.4 tests requested

4.6.5 relevant history

4.6.6 relevant medications

4.6.7 identification of the nature of the specimen on the request form

4.6.8 clear labelling of specimens requiring precautionary handling

4.6.9 date and time specimen collected

3.3 ☐ Y ☐ N ☐ Y ☐ N

3.4 ☐ Y ☐ N ☐ Y ☐ N

3.5 ☐ Y ☐ N ☐ Y ☐ N

3.6 ☐ Y ☐ N ☐ Y ☐ N

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Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6			
4.6.1 ☐ Y ☐ N		☐ Y ☐ N	
4.6.2 ☐ Y ☐ N		☐ Y ☐ N	
4.6.3 ☐ Y ☐ N		☐ Y ☐ N	
4.6.4 ☐ Y ☐ N		☐ Y ☐ N	
4.6.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6.6 ☐ Y ☐ N		☐ Y ☐ N	
4.6.7 ☐ Y ☐ N		☐ Y ☐ N	
4.6.8 ☐ Y ☐ N		☐ Y ☐ N	
4.6.9 ☐ Y ☐ N		☐ Y ☐ N	

4.7 Policies and procedures relating to specimen collection and handling include:

4.7.1 There are written instructions concerning specimens, for their proper:

(a) collection

(b) labelling

(c) preservation

(d) reception

(e) safety (measures to be observed)

(f) storage

(g) transport

4.7.2 These instructions are readily accessible to all staff who may be involved in obtaining specimens from patients

4.7.3 Complete records are kept of all specimens received by the laboratory. These are accurately identified and accessible within the laboratory

4.7.4 Records are kept of specimens forwarded to other laboratories

4.7.5 There are written policies to determine the length of time reports and specimens are retained

4.8 There are policies and procedures on the reporting of results:

4.8.1 All laboratory reports are included in the patient's medical record

4.8.2 Report forms are designed to fit in with other patient records and to facilitate comparison of sequential tests

4.8.3 When reports are received by telephone or similar means, they are received by a responsible staff member, a confirmatory hard copy follows with minimum delay and a documented system records:

(a) the person providing the report

(b) the person receiving the report

(c) patient identity

(d) result(s)

(e) date and time of receipt

4.8.4 Frozen section reports are transmitted directly to the surgeon concerned and followed by a written report

4.9 There is a policy regarding the collection, labelling, storage, preservation, transport and administration of blood.

4.10 There is a policy for dealing with transfusion reactions.

4.7

4.7.1

(a) ☐ Y ☐ N ☐ Y ☐ N

(b) ☐ Y ☐ N ☐ Y ☐ N

(c) ☐ Y ☐ N ☐ Y ☐ N

(d) ☐ Y ☐ N ☐ Y ☐ N

(e) ☐ Y ☐ N ☐ Y ☐ N

(f) ☐ Y ☐ N ☐ Y ☐ N

(g) ☐ Y ☐ N ☐ Y ☐ N

4.7.2 ☐ Y ☐ N ☐ Y ☐ N

4.7.3 ☐ Y ☐ N ☐ Y ☐ N

4.7.4 ☐ Y ☐ N ☐ Y ☐ N

4.7.5 ☐ Y ☐ N ☐ Y ☐ N

4.8

4.8.1 ☐ Y ☐ N ☐ Y ☐ N

4.8.2 ☐ Y ☐ N ☐ Y ☐ N

4.8.3 ☐ Y ☐ N ☐ Y ☐ N

(a) ☐ Y ☐ N ☐ Y ☐ N

(b) ☐ Y ☐ N ☐ Y ☐ N

(c) ☐ Y ☐ N ☐ Y ☐ N

(d) ☐ Y ☐ N ☐ Y ☐ N

(e) ☐ Y ☐ N ☐ Y ☐ N

4.8.4 ☐ Y ☐ N ☐ Y ☐ N

4.9 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

4.11 There is a written health and safety procedure specific to laboratory services which takes into account:

4.11.1 current codes of practice

4.11.2 health/hazard notices

4.11.3 relevant legislation

4.12 There is a policy for dealing with:

4.12.1 accidents

4.12.2 errors

4.12.3 incidents

4.12.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.13 Records are kept which indicate to whom items listed in 4.12 have been referred and the action which has been taken.

4.14 Policies and procedures are dated and contained within a manual which as a minimum is:

4.14.1 regularly reviewed (annually) and updated

4.14.2 readily accessible for reference in the department

4.15 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The facilities and equipment available allow for the safe, effective and efficient operation of the service.

Standards

5.1 The space available is consistent with the relevant building note.

5.2 There is office space available for the head of each service.

5.3 There is a rest room and relaxation facilities available for all staff.

5.4 There is provision for the comfort of patients attending the department (for example, for blood tests) which includes:

5.4.1 adequate seating

5.4.2 clean and comfortable toilet and washroom facilities

5.4.3 customer information leaflets

4.11		
4.11.1	☐ Y ☐ N	☐ Y ☐ N
4.11.2	☐ Y ☐ N	☐ Y ☐ N
4.11.3	☐ Y ☐ N	☐ Y ☐ N
4.12		
4.12.1	☐ Y ☐ N	☐ Y ☐ N
4.12.2	☐ Y ☐ N	☐ Y ☐ N
4.12.3	☐ Y ☐ N	☐ Y ☐ N
4.12.4	☐ Y ☐ N	☐ Y ☐ N
4.13	☐ Y ☐ N	☐ Y ☐ N
4.14	☐ Y ☐ N	☐ Y ☐ N
4.14.1	☐ Y ☐ N	☐ Y ☐ N
4.14.2	☐ Y ☐ N	☐ Y ☐ N
4.15	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The facilities and equipment available allow for the safe, effective and efficient operation of the service.

Standards	Comment		Comment
5.1	☐ Y ☐ N	☐ Y ☐ N	
5.2	☐ Y ☐ N	☐ Y ☐ N	
5.3	☐ Y ☐ N	☐ Y ☐ N	
5.4			
5.4.1	☐ Y ☐ N	☐ Y ☐ N	
5.4.2	☐ Y ☐ N	☐ Y ☐ N	
5.4.3	☐ Y ☐ N	☐ Y ☐ N	

5.5 Facilities allow for:

5.5.1 confidential consultations

5.5.2 the privacy of the patient

5.6 Emergency resuscitation equipment is available in those areas used by patients and the procedure for summoning assistance is known by all staff.

5.7 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.8 The location is clearly signposted.

5.9 There is account taken of the need for:

5.9.1 air conditioning/ventilation

5.9.2 use of fume cupboards

5.10 There are facilities for the proper storage of blood in wards and theatre areas as well as in the laboratory.

5.11 Where specialised equipment is used, it is operated only by staff trained to do so.

5.12 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.13 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. EVALUATION AND QUALITY ASSURANCE

The laboratory service ensures the provision of high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the laboratory service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme includes the review of at least:

6.3.1 the service users' satisfaction

6.3.2 the laboratory service in comparison with standards set out in this chapter

5.5

5.5.1 ☐ Y ☐ N ☐ Y ☐ N

5.5.2 ☐ Y ☐ N ☐ Y ☐ N

5.6 ☐ Y ☐ N ☐ Y ☐ N

5.7 ☐ Y ☐ N ☐ Y ☐ N

5.8 ☐ Y ☐ N ☐ Y ☐ N

5.9

5.9.1 ☐ Y ☐ N ☐ Y ☐ N

5.9.2 ☐ Y ☐ N ☐ Y ☐ N

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

The laboratory service ensures the provision of high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	

6.3.3 the performance of all laboratory staff
(see Management and Staffing within this section)

6.3.4 the evaluation of the performance of the service

6.3.5 the evaluation of clinical performance through multidisciplinary audit

6.3.6 the use of resources (type of stock, amount etc.)

6.4 The evaluation activities include the following elements:

6.4.1 monitoring: the routine collection of information/ statistics about important aspects of delivery of services

6.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery

6.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Internal audit meetings are held on a regular basis.

6.6 Staff participate in clinical audit meetings within the hospital.

6.7 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.8 Confidentiality is maintained throughout evaluation proceedings.

6.9 The staff within the service receive a report of results obtained through evaluation of care and/or service.

6.10 The staff within the service participate in the formulation of plans for improvement.

6.11 There is a mechanism for making and dealing with complaints/suggestions from staff and users of the laboratory service, which is known to all.

6.12 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.13 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

6.14 Statistics are collected for Korner returns.

6.15 Statistics collected are used to effect management/practice change.

6.3.3 ☐ Y ☐ N ☐ Y ☐ N

6.3.4 ☐ Y ☐ N ☐ Y ☐ N

6.3.5 ☐ Y ☐ N ☐ Y ☐ N

6.3.6 ☐ Y ☐ N ☐ Y ☐ N

6.4

6.4.1 ☐ Y ☐ N ☐ Y ☐ N

6.4.2 ☐ Y ☐ N ☐ Y ☐ N

6.4.3 ☐ Y ☐ N ☐ Y ☐ N

6.4.4 ☐ Y ☐ N ☐ Y ☐ N

6.4.5 ☐ Y ☐ N ☐ Y ☐ N

6.5 ☐ Y ☐ N ☐ Y ☐ N

6.6 ☐ Y ☐ N ☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

6.15 ☐ Y ☐ N ☐ Y ☐ N

6.16 There are local policies for collection of information on key areas, such as:

6.16.1 numbers of requests

6.16.2 frequency of loss of results

6.16.3 turn-around for results

6.17 The laboratory participates in external quality of results assessment schemes, such as National External Quality Assessment schemes.

See also Health and Safety section of this manual.

6.16

6.16.1 ☐ Y ☐ N ☐ Y ☐ N

6.16.2 ☐ Y ☐ N ☐ Y ☐ N

6.16.3 ☐ Y ☐ N ☐ Y ☐ N

6.17 ☐ Y ☐ N ☐ Y ☐ N

LABORATORY SERVICE

Surveyor's General Comments

LABORATORY SERVICE

Surveyor's Comments

Standard Number	Recommendation

OPERATING THEATRE SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

OPERATING THEATRE SERVICE

1. PHILOSOPHY AND OBJECTIVES

The operating theatre service provides an environment for patients and staff which supports the safe, efficient and effective carrying out of surgical procedures.

Standards

1.1 Staff within the operating theatre department develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the operating theatre department develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the operating theatre service.

1.3 The objectives for the service include at least the following:

- 1.3.1 providing a service on a routine, regular and emergency basis
- 1.3.2 providing patients with a quality service and care which is based on professional standards where available
- 1.3.3 ensuring patient safety
- 1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service
- 1.3.5 maintaining effective communication with medical/nursing staff and operating department assistants (ODAs) concerning the scheduling of operating theatre usage
- 1.3.6 teaching, consultation and collaboration both within the hospital and with other hospitals

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

- 1.4.1 be courteous and considerate to patients and their carers at all times
- 1.4.2 respect patients' privacy and dignity and that of their carers
- 1.4.3 respect and cater for cultural differences
- 1.4.4 respond to communication difficulties

OPERATING THEATRE SERVICE

1. PHILOSOPHY AND OBJECTIVES

The operating theatre service provides an environment for patients and staff which supports the safe, efficient and effective carrying out of surgical procedures.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6 ☐ Y ☐ N		☐ Y ☐ N	
1.4			
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4.4 ☐ Y ☐ N		☐ Y ☐ N	

1.5 The objectives for each service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.5.1 the role of the hospital

1.5.2 the provision of services

1.5.3 the pattern of delivery of service

1.5.4 staffing patterns

1.5.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The operating theatre service is organised, managed and staffed to provide safe, effective and efficient peri-operative care for patients and is co-ordinated with related departments and services of the hospital.

Standards

Management

2.1 There is a qualified person (however named) designated responsible for the day-to-day management of the operating theatre service.

2.2 The designated manager (however named) is involved in the preparation of the service's budget.

2.3 The designated manager (however named) is responsible for the efficient and effective management of the budget.

2.4 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.5 The budget reports are accurate.

2.6 Records and statistics are available for the effective management of the service which as a minimum include:

2.6.1 ratio of staff to workload

2.6.2 staff absentee rate

2.6.3 staff sickness rate

2.6.4 staff turnover rate

2.7 Regular multidisciplinary meetings are held to:

2.7.1 maintain good communications

2.7.2 review service practices

1.5

1.5.1 ☐ Y ☐ N ☐ Y ☐ N

1.5.2 ☐ Y ☐ N ☐ Y ☐ N

1.5.3 ☐ Y ☐ N ☐ Y ☐ N

1.5.4 ☐ Y ☐ N ☐ Y ☐ N

1.5.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The operating theatre service is organised, managed and staffed to provide safe, effective and efficient peri-operative care for patients and is co-ordinated with related departments and services of the hospital.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6			
2.6.1 ☐ Y ☐ N		☐ Y ☐ N	
2.6.2 ☐ Y ☐ N		☐ Y ☐ N	
2.6.3 ☐ Y ☐ N		☐ Y ☐ N	
2.6.4 ☐ Y ☐ N		☐ Y ☐ N	
2.7			
2.7.1 ☐ Y ☐ N		☐ Y ☐ N	
2.7.2 ☐ Y ☐ N		☐ Y ☐ N	

2.8 Minutes of meetings are kept.

2.9 Staff are informed of the outcomes of these meetings.

2.10 The operating theatre service is involved in the development of hospital policies and procedures, where appropriate.

2.11 The operating theatre service staff are represented on inter-departmental committees and involved in decision-making on issues related to the provision of operating theatre services.

2.12 There is a theatre users committee with representatives of surgeons, anaesthetists, theatre nursing staff and general management, which meets regularly. Minutes of meetings are kept.

2.13 As a minimum the activities of this committee include:

- 2.13.1 formulating and promulgating policies
- 2.13.2 monitoring utilisation
- 2.13.3 participation in planning structural alterations and/or additions
- 2.13.4 involvement in the operating theatre service budget
- 2.13.5 co-ordination of quality assurance

2.14 Support services are available and organised to meet the needs of the service such as:

- 2.14.1 blood bank
- 2.14.2 pathology
- 2.14.3 radiology

Personnel

2.15 Written and dated job descriptions are available for all posts, which specify at least the following:

- 2.15.1 job title and grade
- 2.15.2 qualifications and/or experience required for the post
- 2.15.3 functions, responsibilities and accountability
- 2.15.4 frequency and type of staff appraisal
- 2.15.5 review date

2.16 A documented staff appraisal system exists for all staff.

2.17 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.8 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13

2.13.1 ☐ Y ☐ N ☐ Y ☐ N
2.13.2 ☐ Y ☐ N ☐ Y ☐ N
2.13.3 ☐ Y ☐ N ☐ Y ☐ N
2.13.4 ☐ Y ☐ N ☐ Y ☐ N
2.13.5 ☐ Y ☐ N ☐ Y ☐ N

2.14

2.14.1 ☐ Y ☐ N ☐ Y ☐ N
2.14.2 ☐ Y ☐ N ☐ Y ☐ N
2.14.3 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.15

2.15.1 ☐ Y ☐ N ☐ Y ☐ N
2.15.2 ☐ Y ☐ N ☐ Y ☐ N
2.15.3 ☐ Y ☐ N ☐ Y ☐ N
2.15.4 ☐ Y ☐ N ☐ Y ☐ N
2.15.5 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.19 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Development and Education in this section.)*

Staffing

2.20 There is a designated senior registered nurse to supervise theatre nursing staff.

2.21 Staffing is calculated and allocated on the basis of workload.

2.22 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.23 Nursing staff and ODAs qualified and/or experienced in operating theatre service are assigned according to their capabilities.

2.24 Registered nurses with post-registration education and/or experience are present on all shifts.

2.25 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.26 The organisational chart is reviewed annually, revised and dated.

2.27 Staff are supported in the delivery of care by the following personnel:

2.27.1 administrative

2.27.2 ancillary

2.27.3 secretarial

2.28 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

Records

2.29 Operating theatre records are adequate for clinical, medico-legal and evaluation purposes.

2.30 A record of the surgical procedure performed is written into the patient's medical record. Each record contains details of the procedure and personnel involved, the dressings and drainage systems, prostheses and the post-operative orders.

2.31 A permanent record is maintained of evidence of the counting of accountable items.

2.32 A register of operations is maintained.

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27

2.27.1 ☐ Y ☐ N ☐ Y ☐ N

2.27.2 ☐ Y ☐ N ☐ Y ☐ N

2.27.3 ☐ Y ☐ N ☐ Y ☐ N

2.28 ☐ Y ☐ N ☐ Y ☐ N

Records

2.29 ☐ Y ☐ N ☐ Y ☐ N

2.30 ☐ Y ☐ N ☐ Y ☐ N

2.31 ☐ Y ☐ N ☐ Y ☐ N

2.32 ☐ Y ☐ N ☐ Y ☐ N

2.33 Standard anaesthetic and drug administration records are maintained and regulations relating to the control of drugs are followed.

2.34 There is a documented system for recording tissue sent for laboratory examination.

3. STAFF DEVELOPMENT AND EDUCATION

There is a programme to facilitate the development of each individual within the operating theatre service and to encourage training and development on issues relevant to the service and the objectives of the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 introduces new staff to the relevant aspects of the department
- 3.1.3 explains the relationships within the department and with the hospital
- 3.1.4 prepares staff for their role and responsibilities
- 3.1.5 explains lines of authority both within the service and with the hospital
- 3.1.6 explains the method used to evaluate staff performance
- 3.1.7 introduces staff to the policies and procedures of the service and the hospital
- 3.1.8 explains emergency procedures (for example, fire drill)
- 3.1.9 provides information on the occupational health service offered to staff

3.2 All operating theatre staff are proficient in Basic Life Support:

- 3.2.1 management of the airway
- 3.2.2 control of bleeding
- 3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

- 3.3.1 utilises professional and other resource material
- 3.3.2 supports and encourages relevant research
- 3.3.3 provides information on advances in practice related to the operating theatre service
- 3.3.4 provides information on educational opportunities arranged by other institutions
- 3.3.5 provides orientation to new surgical, anaesthetic and operating service procedures
- 3.3.6 covers health and safety at work

2.33 ☐ Y ☐ N ☐ Y ☐ N

2.34 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

There is a programme to facilitate the development of each individual within the operating theatre service and to encourage training and development on issues relevant to the service and the objectives of the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3			
3.3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.3.2 ☐ Y ☐ N		☐ Y ☐ N	
3.3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.3.6 ☐ Y ☐ N		☐ Y ☐ N	

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.7 There is refresher training available for staff who work only occasionally in the operating theatre service.

3.8 Where the hospital provides clinical experience for students (medical, nursing, post-graduate) in operating theatres, there is written agreement between the hospital and the educational establishment detailing the responsibility for induction, teaching, supervision and assessment of students.

4. POLICIES AND PROCEDURES

There are written policies and procedures for all activities of the operating theatre service which reflect current standards of operating theatre practice, relevant regulations and the objectives of the service.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the operating theatre service.

4.2 Policies and procedures are agreed by the theatre users committee or equivalent.

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies are developed attention is drawn to practice in other fields, for example infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Policies and procedures refer to at least the following:

4.6.1 pre-operative instructions for patients

4.6.2 patient identification

4.6.3 verification of the nature and site of operation

4.6.4 checking of consent documents

4.6.5 recording of tissue and specimen collection

4.6.6 scheduling of patients for listed and emergency surgical procedures

3.4 ☐ Y ☐ N ☐ Y ☐ N

3.5 ☐ Y ☐ N ☐ Y ☐ N

3.6 ☐ Y ☐ N ☐ Y ☐ N

3.7 ☐ Y ☐ N ☐ Y ☐ N

3.8 ☐ Y ☐ N ☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are written policies and procedures for all activities of the operating theatre service which reflect current standards of operating theatre practice, relevant regulations and the objectives of the service.

Standards	Comment	Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N
4.2 ☐ Y ☐ N		☐ Y ☐ N
4.3 ☐ Y ☐ N		☐ Y ☐ N
4.4 ☐ Y ☐ N		☐ Y ☐ N
4.5 ☐ Y ☐ N		☐ Y ☐ N
4.6		
4.6.1 ☐ Y ☐ N		☐ Y ☐ N
4.6.2 ☐ Y ☐ N		☐ Y ☐ N
4.6.3 ☐ Y ☐ N		☐ Y ☐ N
4.6.4 ☐ Y ☐ N		☐ Y ☐ N
4.6.5 ☐ Y ☐ N		☐ Y ☐ N
4.6.6 ☐ Y ☐ N		☐ Y ☐ N

4.6.7 counting procedures for accountable items

4.6.8 procedures to be adopted in the event of incorrect counts

4.6.9 an anaesthetist is present until the patient has recovered from the anaesthetic

4.6.10 infection control procedures, including:

(a) aseptic technique

(b) handling infectious and high risk patients

(c) theatre cleaning

4.6.11 instruments required for specific operations

4.7 There are written health and safety guidelines which include:

4.7.1 anaesthetic equipment hazards

4.7.2 control drug handling

4.7.3 drug errors

4.7.4 electrical hazards

4.7.5 evaluation and testing of equipment

4.7.6 fire and explosion

4.7.7 instruction on use and maintenance of instruments

4.7.8 notification of biohazards

4.7.9 patient positioning

4.7.10 patient transport

4.7.11 radiation hazards

4.7.12 sharps handling and disposal

4.7.13 use of scavenging equipment for removal of various vapours and waste anaesthetic gases

4.8 The role of the operating service in the fire and disaster plans of the hospital is documented.

4.9 There is a policy for dealing with:

4.9.1 accidents

4.9.2 errors

4.9.3 incidents

4.9.4 patient complaints (in accordance with HC(88)37, Hospitals Complaints Procedures)

4.10 Records are kept which indicate to whom items listed in 4.9 have been referred and the action which has been taken.

4.6.7 ☐ Y ☐ N ☐ Y ☐ N

4.6.8 ☐ Y ☐ N ☐ Y ☐ N

4.6.9 ☐ Y ☐ N ☐ Y ☐ N

4.6.10

(a) ☐ Y ☐ N ☐ Y ☐ N

(b) ☐ Y ☐ N ☐ Y ☐ N

(c) ☐ Y ☐ N ☐ Y ☐ N

4.6.11 ☐ Y ☐ N ☐ Y ☐ N

4.7

4.7.1 ☐ Y ☐ N ☐ Y ☐ N

4.7.2 ☐ Y ☐ N ☐ Y ☐ N

4.7.3 ☐ Y ☐ N ☐ Y ☐ N

4.7.4 ☐ Y ☐ N ☐ Y ☐ N

4.7.5 ☐ Y ☐ N ☐ Y ☐ N

4.7.6 ☐ Y ☐ N ☐ Y ☐ N

4.7.7 ☐ Y ☐ N ☐ Y ☐ N

4.7.8 ☐ Y ☐ N ☐ Y ☐ N

4.7.9 ☐ Y ☐ N ☐ Y ☐ N

4.7.10 ☐ Y ☐ N ☐ Y ☐ N

4.7.11 ☐ Y ☐ N ☐ Y ☐ N

4.7.12 ☐ Y ☐ N ☐ Y ☐ N

4.7.13 ☐ Y ☐ N ☐ Y ☐ N

4.8 ☐ Y ☐ N ☐ Y ☐ N

4.9

4.9.1 ☐ Y ☐ N ☐ Y ☐ N

4.9.2 ☐ Y ☐ N ☐ Y ☐ N

4.9.3 ☐ Y ☐ N ☐ Y ☐ N

4.9.4 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

4.11 Policies and procedures are dated and contained within a manual which as a minimum is:

4.11.1 regularly reviewed (annually) and updated

4.11.2 readily accessible for reference in the department

4.12 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The facilities and equipment available ensure the safe, effective and efficient functioning of the operating theatre service.

Standards

5.1 There are office facilities for the designated manager.

5.2 There are office facilities for the senior nurse.

5.3 There is a rest room available for all staff.

5.4 There is provision for a teaching/seminar room.

5.5 Washrooms and changing facilities are available for staff.

5.6 The design of the operating theatre service provides space for the reception, anaesthesia, surgery, recovery, and observation of patients. As a minimum this includes:

5.6.1 an area to receive patients awaiting surgery which is separate from the operating theatre and access corridors

5.6.2 direct access to the operating theatres from the receiving area

5.6.3 a recovery area

5.6.4 storage space for:

(a) equipment

(b) housekeeping equipment

(c) linen

(d) pharmaceutical supplies

(e) storage for controlled drugs

(f) surgical supplies

5.6.5 areas for the collection and disposal of used equipment and waste

4.11	☐ Y ☐ N	☐ Y ☐ N
4.11.1	☐ Y ☐ N	☐ Y ☐ N
4.11.2	☐ Y ☐ N	☐ Y ☐ N
4.12	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The facilities and equipment available ensure the safe, effective and efficient functioning of the operating theatre service.

Standards	Comment	Comment
5.1	☐ Y ☐ N	☐ Y ☐ N
5.2	☐ Y ☐ N	☐ Y ☐ N
5.3	☐ Y ☐ N	☐ Y ☐ N
5.4	☐ Y ☐ N	☐ Y ☐ N
5.5	☐ Y ☐ N	☐ Y ☐ N
5.6		
5.6.1	☐ Y ☐ N	☐ Y ☐ N
5.6.2	☐ Y ☐ N	☐ Y ☐ N
5.6.3	☐ Y ☐ N	☐ Y ☐ N
5.6.4		
(a)	☐ Y ☐ N	☐ Y ☐ N
(b)	☐ Y ☐ N	☐ Y ☐ N
(c)	☐ Y ☐ N	☐ Y ☐ N
(d)	☐ Y ☐ N	☐ Y ☐ N
(e)	☐ Y ☐ N	☐ Y ☐ N
(f)	☐ Y ☐ N	☐ Y ☐ N
5.6.5	☐ Y ☐ N	☐ Y ☐ N

5.7 The design of the operating theatre service facilitates the management of clinical services which include at least the following:

5.7.1 ready access for routine and emergency patients

5.7.2 the area for receiving the patient into the operating theatre is close to the junction of sterile and non-sterile zones

5.7.3 clear demarcation of sterile and non-sterile zones

5.7.4 free movement of patient trolleys throughout the service with a minimum of cross traffic

5.7.5 fire detection, alarm and suppression systems

5.7.6 clearly identifiable fire fighting equipment

5.7.7 doorways, corridors, ramps and stairwells which facilitate the evacuation of non-ambulatory patients

5.7.8 doorways etc. are kept free of obstruction at all times

5.7.9 clearly signposted smoking areas

5.8 Systems include:

5.8.1 environmental control of temperature and humidity which is within safe limits for anaesthetised patients

5.8.2 lighting which complies with CIBS Lighting Guide No 12 (1979)

5.8.3 medical gas and suction supplies, complying with HTM(22), Piped Medical Gases, Medical Compressed Air and Medical Vacuum Installations — HMSO 1977 — ISBN 0113206631

5.8.4 general power outlets (GPO's) distributed to meet the needs of each area which comply with the fifteenth edition of the Institute of Electrical Engineers Regulations for Wiring in Buildings

5.8.5 provision for emergency power which complies with HTM(11), Emergency Electrical Services — HMSO 1974 — ISBN 0113201702

5.9 Safety features include:

5.9.1 compliance with electrical standards conforming to BS5724, Safety of Medical Electrical Equipment — British Standards Institution 1979 — ISBN 058010690

5.9.2 a programme to ensure that staff are aware of procedures for the safe use and application of electromedical equipment as detailed in BS5724

5.9.3 scavenging of waste anaesthetic gases and vapours in accordance with HC(76)38

5.9.4 anti-static precautions in accordance with HTM(1), Anti-Static Precautions; Rubber, Plastics and Fabrics — HMSO 1977 — ISBN 01132010208, and HTM(1), Anti-Static Precautions; Flooring and Anaesthetising Areas — HMSO 1977 — ISBN 0113206801

5.9.5 the storage of all portable gas cylinders meets the health and safety regulations

5.7

5.7.1 ☐ Y ☐ N ☐ Y ☐ N

5.7.2 ☐ Y ☐ N ☐ Y ☐ N

5.7.3 ☐ Y ☐ N ☐ Y ☐ N

5.7.4 ☐ Y ☐ N ☐ Y ☐ N

5.7.5 ☐ Y ☐ N ☐ Y ☐ N

5.7.6 ☐ Y ☐ N ☐ Y ☐ N

5.7.7 ☐ Y ☐ N ☐ Y ☐ N

5.7.8 ☐ Y ☐ N ☐ Y ☐ N

5.7.9 ☐ Y ☐ N ☐ Y ☐ N

5.8

5.8.1 ☐ Y ☐ N ☐ Y ☐ N

5.8.2 ☐ Y ☐ N ☐ Y ☐ N

5.8.3 ☐ Y ☐ N ☐ Y ☐ N

5.8.4 ☐ Y ☐ N ☐ Y ☐ N

5.8.5 ☐ Y ☐ N ☐ Y ☐ N

5.9

5.9.1 ☐ Y ☐ N ☐ Y ☐ N

5.9.2 ☐ Y ☐ N ☐ Y ☐ N

5.9.3 ☐ Y ☐ N ☐ Y ☐ N

5.9.4 ☐ Y ☐ N ☐ Y ☐ N

5.9.5 ☐ Y ☐ N ☐ Y ☐ N

5.9.6 the wearing of appropriate shielding and protective clothing in the presence of biohazards or radiographic equipment

5.9.7 areas in which anaesthetics are administered comply with HC(76)38

5.10 Equipment in the service includes at least the following:

5.10.1 a range of basic and general surgical equipment to support the range of surgery undertaken

5.10.2 arrangements to obtain specialised equipment for surgical specialties

5.10.3 facilities for re-sterilization of instruments

5.10.4 a range of basic and general anaesthetic equipment to support the range of anaesthetic work undertaken in the operating theatre service

5.10.5 emergency and resuscitation equipment and supplies with clearly defined instructions for use

5.10.6 access to sterilization and disinfection facilities

5.11 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.12 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.13 Proper documentation is kept of areas to be tested, procedures to be followed and results found.

5.14 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms with the requirements of the Ionising Radiations Regulations 1985.

5.15 Where specialised equipment is used, it is operated only by staff trained to do so.

5.16 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HE1(98) 1982, Management of Equipment.

5.17 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

5.9.6 ☐ Y ☐ N ☐ Y ☐ N

5.9.7 ☐ Y ☐ N ☐ Y ☐ N

5.10

5.10.1 ☐ Y ☐ N ☐ Y ☐ N

5.10.2 ☐ Y ☐ N ☐ Y ☐ N

5.10.3 ☐ Y ☐ N ☐ Y ☐ N

5.10.4 ☐ Y ☐ N ☐ Y ☐ N

5.10.5 ☐ Y ☐ N ☐ Y ☐ N

5.10.6 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

5.14 ☐ Y ☐ N ☐ Y ☐ N

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16 ☐ Y ☐ N ☐ Y ☐ N

5.17 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

The operating theatre service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the operating theatre service.

Standards

6.1 There is a written quality assurance plan for the operating theatre service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 Staff are responsible for ensuring that the operating theatre record is accurately maintained.

6.4 The evaluation and quality assurance programme includes the review of at least the following:

- 6.4.1 service users' satisfaction
- 6.4.2 the operating theatre service in comparison with standards set out in this chapter
- 6.4.3 the performance of all theatre staff
  (see Management and Staffing in this section)
- 6.4.4 the evaluation of clinical performance through multidisciplinary audit
- 6.4.5 case reviews including histopathology, infection rate statistics and morbidity and mortality
- 6.4.6 use of resources (for example, theatre usage, use of supplies)

6.5 Where a national mortality review committee exists (for example, National Confidential Enquiry into Peri-Operative Deaths) deaths are referred to this committee and are subject to internal review.

6.6 The evaluation activities include the following elements:

- 6.6.1 monitoring: the routine collection of information/ statistics about significant aspects of delivery of services
- 6.6.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery
- 6.6.3 action: when significant problems or opportunities to improve service delivery are identified, action is taken and documented
- 6.6.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 6.6.5 feedback: the results of activities are regularly communicated to the staff

6.7 Clinical audit meetings are held on regular basis.

6. EVALUATION AND QUALITY ASSURANCE

The operating theatre service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the operating theatre service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4.5 ☐ Y ☐ N		☐ Y ☐ N	
6.4.6 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6			
6.6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.7 ☐ Y ☐ N		☐ Y ☐ N	

6.8 Records of attendance and minutes of the audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.9 Confidentiality is maintained throughout evaluation proceedings.

6.10 The staff within the service receive a report of results obtained through evaluation of care and/or service.

6.11 The staff within the service participate in the formulation of plans for improvement.

6.12 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

6.13 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.14 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

6.15 Statistics are collected for Korner returns.

6.16 Statistics collected are used to effect management/practice change.

6.17 There are local policies for collection of information on key areas such as theatre utilisation.

See also Medical Record Content, Health and Safety, Infection Control and Hospital Management (major incident plan, patients rights and special needs) sections of this manual.

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

6.15 ☐ Y ☐ N ☐ Y ☐ N

6.16 ☐ Y ☐ N ☐ Y ☐ N

6.17 ☐ Y ☐ N ☐ Y ☐ N

OPERATING THEATRE SERVICE

Surveyor's General Comments

OPERATING THEATRE SERVICE

Surveyor's Comments

Standard Number	Recommendation

OUT-PATIENT SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

OUT-PATIENT SERVICE

1. PHILOSOPHY AND OBJECTIVES

The out-patient department provides specialist consultation and advice to patients, their carers and the general practitioner, or other source of referral.

Standards

1.1 Staff within the out-patient department, in consultation with users, develop a philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the out-patient department, in consultation with users, develop written objectives to achieve the philosophy of the hospital and the service. These objectives are used as a guide to planning, implementing and evaluating all aspects of the out-patient service.

1.3 The objectives for the service include at least the following:

1.3.1 providing patients with a quality service and care which is based on assessment of patients' needs

1.3.2 providing patients with a quality service and care which is based on professional standards where available

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes

1.3.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.3.8 teaching, consultation and collaboration with community services (district nursing, general practices, social services, voluntary agencies)

1.3.9 defining relationship and responsibilities to the community

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

1.4.3 respect and cater for cultural differences

OUT-PATIENT SERVICE

1. PHILOSOPHY AND OBJECTIVES

The out-patient department provides specialist consultation and advice to patients, their carers and the general practitioner, or other source of referral.

Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.3.7 ☐ Y ☐ N		☐ Y ☐ N	
1.3.8 ☐ Y ☐ N		☐ Y ☐ N	
1.3.9 ☐ Y ☐ N		☐ Y ☐ N	
1.4			
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	

1.4.4 respond to communication difficulties

1.4.5 identify counselling requirements of the patient and carers

1.5 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.5.1 the role of the hospital

1.5.2 the provision of services

1.5.3 the pattern of delivery of service

1.5.4 staffing patterns

1.5.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

The out-patient service is organised, managed and staffed to provide safe, efficient and effective care to patients which meets the needs of the people served.

Standards

Management

2.1 There is a manager (however named) responsible for the organisation and management of the out-patient service.

2.2 There is a designated deputy to act in the absence of the out-patient manager.

2.3 The management arrangements for the out-patient service are clearly defined.

2.4 The manager (however named) is involved in the preparation of the service's budget.

2.5 The manager (however named) is responsible for the efficient and effective management of the budget.

2.6 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.7 The budget reports are accurate.

2.8 Records and statistics are available for the effective management of the service which as a minimum include:

2.8.1 ratio of staffing to workload

2.8.2 staff absentee rate

2.8.3 staff sickness rate

2.8.4 staff turnover rate

1.4.4 ☐ Y ☐ N ☐ Y ☐ N

1.4.5 ☐ Y ☐ N ☐ Y ☐ N

1.5

1.5.1 ☐ Y ☐ N ☐ Y ☐ N

1.5.2 ☐ Y ☐ N ☐ Y ☐ N

1.5.3 ☐ Y ☐ N ☐ Y ☐ N

1.5.4 ☐ Y ☐ N ☐ Y ☐ N

1.5.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The out-patient service is organised, managed and staffed to provide safe, efficient and effective care to patients which meets the needs of the people served.

Standards	Comment		Comment
Management			
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7 ☐ Y ☐ N		☐ Y ☐ N	
2.8			
2.8.1 ☐ Y ☐ N		☐ Y ☐ N	
2.8.2 ☐ Y ☐ N		☐ Y ☐ N	
2.8.3 ☐ Y ☐ N		☐ Y ☐ N	
2.8.4 ☐ Y ☐ N		☐ Y ☐ N	

2.9 Regular multidisciplinary staff meetings are held to:

2.9.1 maintain good communications

2.9.2 review service practices

2.10 Minutes of meetings are kept.

2.11 Staff are informed of the outcomes of these meetings.

2.12 The out-patient service is involved in the development of hospital policies and procedures, where appropriate.

2.13 There are established working relationships with other hospital departments, for example medical records.

Personnel

2.14 Written and dated job descriptions are available for all posts, which specify at least the following:

2.14.1 job title and grade

2.14.2 qualifications and/or experience required for the post

2.14.3 functions, responsibilities and accountability

2.14.4 frequency and type of staff appraisal

2.14.5 review date

2.15 A documented staff appraisal system exists for all staff.

2.16 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.17 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.18 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.19 Staffing is calculated and allocated on the basis of workload.

2.20 The nursing skill mix meets the needs of the individual clinics.

2.21 The additional requirements of training, teaching and supervising are reflected in the numbers of staff on duty.

2.9

2.9.1 ☐ Y ☐ N ☐ Y ☐ N

2.9.2 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.14

2.14.1 ☐ Y ☐ N ☐ Y ☐ N

2.14.2 ☐ Y ☐ N ☐ Y ☐ N

2.14.3 ☐ Y ☐ N ☐ Y ☐ N

2.14.4 ☐ Y ☐ N ☐ Y ☐ N

2.14.5 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 Clinic rosters are available and known to the relevant out-patient staff.

2.23 The roster includes at least the following information:

2.23.1 date and nature of clinic

2.23.2 start and finish time of clinic

2.23.3 name of clinic consultant

2.23.4 name(s) of medical officer(s) conducting the clinic

2.24 There is a mechanism for informing the out-patient manager of leave arrangements for medical, nursing and support staff.

2.25 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.26 The organisational chart is reviewed annually, revised and dated.

2.27 Staff are supported in the delivery of care by the following personnel:

2.27.1 administrative

2.27.2 ancillary

2.27.3 secretarial

2.28 Support services, such as portering, are organised to meet the needs of the service.

2.29 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

Appointments

2.30 There is an organised appointment system, which is individualised and not block booked.

2.31 There is a system for informing and reminding patients of appointments.

2.32 There is a list of patients attending the clinic which includes appointment time.

2.33 Patients are given clear information about out-patients and their appointment in advance of their clinic attendance including:

2.33.1 map of the hospital

2.33.2 date and time of appointment

2.33.3 location and name of service and clinic

2.33.4 procedure if not able to attend (for example, direct telephone line)

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23

2.23.1 ☐ Y ☐ N ☐ Y ☐ N

2.23.2 ☐ Y ☐ N ☐ Y ☐ N

2.23.3 ☐ Y ☐ N ☐ Y ☐ N

2.23.4 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27

2.27.1 ☐ Y ☐ N ☐ Y ☐ N

2.27.2 ☐ Y ☐ N ☐ Y ☐ N

2.27.3 ☐ Y ☐ N ☐ Y ☐ N

2.28 ☐ Y ☐ N ☐ Y ☐ N

2.29 ☐ Y ☐ N ☐ Y ☐ N

Appointments

2.30 ☐ Y ☐ N ☐ Y ☐ N

2.31 ☐ Y ☐ N ☐ Y ☐ N

2.32 ☐ Y ☐ N ☐ Y ☐ N

2.33

2.33.1 ☐ Y ☐ N ☐ Y ☐ N

2.33.2 ☐ Y ☐ N ☐ Y ☐ N

2.33.3 ☐ Y ☐ N ☐ Y ☐ N

2.33.4 ☐ Y ☐ N ☐ Y ☐ N

2.33.5 transport arrangements

2.33.6 specific instructions for any investigations, such as fasting, or provision of specimens

Records

2.34 Patients attending out-patient services are correctly identified. This is best achieved by a hospital number system and utilisation of the medical record.

2.35 If the patient has previously attended the hospital, the medical record is available in advance of the clinic attended.

2.36 A clinical record is originated on the initial visit of a patient.

2.37 The clinical record is accurate, complete, current and legible and contains at least the following:

2.37.1 name, address and post code

2.37.2 record/patient number

2.37.3 source of referral

2.37.4 history, including details of present illness and medication

2.37.5 complete physical examination

2.37.6 requests for diagnostic tests

2.37.7 progress notes, reports and consultations

2.37.8 disposal details

2.37.9 name and signature of the medical officer

2.37.10 date and time of consultation

2.37.11 the name and signature of the attending nurse

2.37.12 information and advice given to patients and/or their carers

(See also the Medical Record Content section of this manual.)

2.33.5 ☐ Y ☐ N ☐ Y ☐ N

2.33.6 ☐ Y ☐ N ☐ Y ☐ N

Records

2.34 ☐ Y ☐ N ☐ Y ☐ N

2.35 ☐ Y ☐ N ☐ Y ☐ N

2.36 ☐ Y ☐ N ☐ Y ☐ N

2.37 ☐ Y ☐ N ☐ Y ☐ N

2.37.1 ☐ Y ☐ N ☐ Y ☐ N

2.37.2 ☐ Y ☐ N ☐ Y ☐ N

2.37.3 ☐ Y ☐ N ☐ Y ☐ N

2.37.4 ☐ Y ☐ N ☐ Y ☐ N

2.37.5 ☐ Y ☐ N ☐ Y ☐ N

2.37.6 ☐ Y ☐ N ☐ Y ☐ N

2.37.7 ☐ Y ☐ N ☐ Y ☐ N

2.37.8 ☐ Y ☐ N ☐ Y ☐ N

2.37.9 ☐ Y ☐ N ☐ Y ☐ N

2.37.10 ☐ Y ☐ N ☐ Y ☐ N

2.37.11 ☐ Y ☐ N ☐ Y ☐ N

2.37.12 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The out-patient service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 introduces new staff to the relevant aspects of the service
- 3.1.3 explains the relationships within the service and with the hospital
- 3.1.4 prepares staff for their role and responsibilities
- 3.1.5 explains lines of authority both within the service and with the hospital
- 3.1.6 explains the method used to evaluate staff performance
- 3.1.7 introduces staff to the policies and procedures of the service and the hospital
- 3.1.8 explains emergency procedures (for example, fire drill)
- 3.1.9 provides information on the occupational health service offered to staff

3.2 All staff are proficient in Basic Life Support:

- 3.2.1 management of the airway
- 3.2.2 control of bleeding
- 3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

- 3.3.1 utilises professional and other resource material
- 3.3.2 supports and encourages relevant research
- 3.3.3 provides information on advances in practice related to the service
- 3.3.4 provides information on educational opportunities arranged by other institutions
- 3.3.5 provides orientation to new clinical areas

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and text books are available within the department for reference and guidance.

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3. STAFF DEVELOPMENT AND EDUCATION

The out-patient service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3			
3.3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.3.2 ☐ Y ☐ N		☐ Y ☐ N	
3.3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.6 ☐ Y ☐ N		☐ Y ☐ N	

4. POLICIES AND PROCEDURES

Written and dated policies and procedures reflect current knowledge and principles for the service and are consistent with the objectives of the service.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the out-patient service.

4.2 Policies and procedures are developed in consultation with management, medical, nursing and other health care professionals as appropriate.

4.3 When policies are developed attention is drawn to practice in other fields, for example infection control, medical record keeping and occupational health.

4.4 Policies and procedures are consistent with those of the hospital.

4.5 Policies and procedures refer to, but are not limited to, the following:

- 4.5.1 ambulance and hospital transport arrangements
- 4.5.2 complaints/suggestions
- 4.5.3 confidentiality of information
- 4.5.4 discharge
- 4.5.5 equipment (for example, use, location, care and maintenance)
- 4.5.6 infection control
- 4.5.7 information provided to patients
- 4.5.8 notification of patient's GP
- 4.5.9 patient appointment system, including follow-up appointments
- 4.5.10 patient referrals to out-patients and within the hospital
- 4.5.11 patient's right to privacy
- 4.5.12 prescribing of medications
- 4.5.13 procedures undertaken on an out-patient basis
- 4.5.14 requesting diagnostic investigations
- 4.5.15 waiting time

4.6 There is a policy for dealing with:

- 4.6.1 accidents
- 4.6.2 errors

4. POLICIES AND PROCEDURES

Written and dated policies and procedures reflect current knowledge and principles for the service and are consistent with the objectives of the service.

Standards		Comment		Comment
4.1	☐ Y ☐ N		☐ Y ☐ N	
4.2	☐ Y ☐ N		☐ Y ☐ N	
4.3	☐ Y ☐ N		☐ Y ☐ N	
4.4	☐ Y ☐ N		☐ Y ☐ N	
4.5				
4.5.1	☐ Y ☐ N		☐ Y ☐ N	
4.5.2	☐ Y ☐ N		☐ Y ☐ N	
4.5.3	☐ Y ☐ N		☐ Y ☐ N	
4.5.4	☐ Y ☐ N		☐ Y ☐ N	
4.5.5	☐ Y ☐ N		☐ Y ☐ N	
4.5.6	☐ Y ☐ N		☐ Y ☐ N	
4.5.7	☐ Y ☐ N		☐ Y ☐ N	
4.5.8	☐ Y ☐ N		☐ Y ☐ N	
4.5.9	☐ Y ☐ N		☐ Y ☐ N	
4.5.10	☐ Y ☐ N		☐ Y ☐ N	
4.5.11	☐ Y ☐ N		☐ Y ☐ N	
4.5.12	☐ Y ☐ N		☐ Y ☐ N	
4.5.13	☐ Y ☐ N		☐ Y ☐ N	
4.5.14	☐ Y ☐ N		☐ Y ☐ N	
4.5.15	☐ Y ☐ N		☐ Y ☐ N	
4.6				
4.6.1	☐ Y ☐ N		☐ Y ☐ N	
4.6.2	☐ Y ☐ N		☐ Y ☐ N	

4.6.3 incidents

4.6.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.7 Records are kept which indicate to whom items listed in 4.6 have been referred and the action which has been taken.

4.8 Policies and procedures are dated and contained within a manual which as a minimum is:

4.8.1 regularly reviewed (annually) and updated

4.8.2 readily accessible for reference in the department

4.9 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

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

Standards

5.1 The design and space comply with the Department of Health's Health Building Note 12, Out-patient Departments.

5.2 There are office facilities for the consultant and nurse in charge, medical, nursing staff and other professional staff as necessary.

5.3 There is a rest room available for all staff.

5.4 There is provision for a teaching/seminar room.

5.5 Washrooms and changing facilities, separate from customer facilities, are available for staff.

5.6 There are facilities for confidential consultations.

5.7 There are changing facilities for patients, which maintain visual privacy.

5.8 The location is clearly signposted.

5.9 There are facilities and equipment for the conducting of minor procedures such as changing of dressings, removal of plaster.

5.10 There is a safe and secure store for pharmaceuticals etc. essential to the clinic.

5.11 There are both clean and dirty utility rooms.

4.6.3	☐ Y ☐ N	☐ Y ☐ N
4.6.4	☐ Y ☐ N	☐ Y ☐ N
4.7	☐ Y ☐ N	☐ Y ☐ N
4.8	☐ Y ☐ N	☐ Y ☐ N
4.8.1	☐ Y ☐ N	☐ Y ☐ N
4.8.2	☐ Y ☐ N	☐ Y ☐ N
4.9	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

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

Standards	Comment	Comment
5.1	☐ Y ☐ N	☐ Y ☐ N
5.2	☐ Y ☐ N	☐ Y ☐ N
5.3	☐ Y ☐ N	☐ Y ☐ N
5.4	☐ Y ☐ N	☐ Y ☐ N
5.5	☐ Y ☐ N	☐ Y ☐ N
5.6	☐ Y ☐ N	☐ Y ☐ N
5.7	☐ Y ☐ N	☐ Y ☐ N
5.8	☐ Y ☐ N	☐ Y ☐ N
5.9	☐ Y ☐ N	☐ Y ☐ N
5.10	☐ Y ☐ N	☐ Y ☐ N
5.11	☐ Y ☐ N	☐ Y ☐ N

5.12 The reception area has:

5.12.1 clean toilet and washroom facilities located within easy reach of the clinic

5.12.2 customer information leaflets (for example, health promotion, making/cancelling appointments)

5.12.3 facilities suitable for nursing mothers

5.12.4 information on waiting time

5.12.5 play facilities/area for children

5.12.6 public transport details

5.12.7 seating facilities to cater for the number and type of patients attending the clinic

5.12.8 space for wheelchairs

5.12.9 up-to-date reading material

5.13 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.14 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.15 Where specialised equipment is used, it is operated only by staff trained to do so.

5.16 Equipment is subjected to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.17 All facilities and equipment conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. EVALUATION AND QUALITY ASSURANCE

The out-patient service ensures the provision of high quality care and service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the out-patient service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme of the service includes the review of at least the following:

6.3.1 service users' satisfaction

6.3.2 the out-patient service in comparison with standards set out in this

5.12

5.12.1 ☐ Y ☐ N ☐ Y ☐ N

5.12.2 ☐ Y ☐ N ☐ Y ☐ N

5.12.3 ☐ Y ☐ N ☐ Y ☐ N

5.12.4 ☐ Y ☐ N ☐ Y ☐ N

5.12.5 ☐ Y ☐ N ☐ Y ☐ N

5.12.6 ☐ Y ☐ N ☐ Y ☐ N

5.12.7 ☐ Y ☐ N ☐ Y ☐ N

5.12.8 ☐ Y ☐ N ☐ Y ☐ N

5.12.9 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

5.14 ☐ Y ☐ N ☐ Y ☐ N

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16 ☐ Y ☐ N ☐ Y ☐ N

5.17 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

The out-patient service ensures the provision of high quality care and service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	

6.3.3 the performance of all out-patient staff
(see Management and Staffing within this section)

6.3.4 the evaluation of clinical performance through multidisciplinary audit

6.3.5 the use of resources (type of stock, amount etc.)

6.3.6 assessment of the appropriateness of care

6.4 The evaluation activities include the following elements:

6.4.1 monitoring: the routine collection of information/ statistics about important aspects of delivery of services

6.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery

6.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Clinical audit meetings are held on a regular basis.

6.6 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.7 Confidentiality is maintained throughout evaluation proceedings.

6.8 The staff within the service receive a report of results obtained through evaluation of care and/or service.

6.9 The staff within the service participate in the formulation of plans for improvement.

6.10 There is a mechanism for making and dealing with complaints/suggestions from staff and users of the out-patient service, which is known to all.

6.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.12 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

6.13 Statistics are collected for Korner returns.

6.14 Statistics collected are used to effect management/practice change.

6.3.3 ☐ Y ☐ N ☐ Y ☐ N

6.3.4 ☐ Y ☐ N ☐ Y ☐ N

6.3.5 ☐ Y ☐ N ☐ Y ☐ N

6.3.6 ☐ Y ☐ N ☐ Y ☐ N

6.4

6.4.1 ☐ Y ☐ N ☐ Y ☐ N

6.4.2 ☐ Y ☐ N ☐ Y ☐ N

6.4.3 ☐ Y ☐ N ☐ Y ☐ N

6.4.4 ☐ Y ☐ N ☐ Y ☐ N

6.4.5 ☐ Y ☐ N ☐ Y ☐ N

6.5 ☐ Y ☐ N ☐ Y ☐ N

6.6 ☐ Y ☐ N ☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

6.15 There is evidence of local policies for collection of information on key areas such as:

6.15.1 waiting time

6.15.2 investigations undertaken at a single visit

6.15.3 time taken to receive out-patient appointment (in accordance with DA(85)6, Reducing Waiting Time in Out-Patient Departments)

6.15.4 time spent in the department

6.15.5 the number of attendances

6.15.6 the number of patients failing to attend

6.15.7 general practitioner referral patterns

6.15

6.15.1 ☐ Y ☐ N ☐ Y ☐ N

6.15.2 ☐ Y ☐ N ☐ Y ☐ N

6.15.3 ☐ Y ☐ N ☐ Y ☐ N

6.15.4 ☐ Y ☐ N ☐ Y ☐ N

6.15.5 ☐ Y ☐ N ☐ Y ☐ N

6.15.6 ☐ Y ☐ N ☐ Y ☐ N

6.15.7 ☐ Y ☐ N ☐ Y ☐ N

OUT-PATIENT SERVICE

Surveyor's General Comments

OUT-PATIENT SERVICE

Surveyor's Comments

Standard Number	Recommendation

PHARMACEUTICAL SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

PHARMACEUTICAL SERVICE

1. PHILOSOPHY AND OBJECTIVES

Pharmaceutical services are primarily concerned with patients and their safe and effective treatment with medicines, in accordance with statutory requirements. Pharmacy practice is governed by the Code of Ethics of the Royal Pharmaceutical Society of Great Britain (Code of Ethics).

Standards

1.1 Staff within the pharmacy department develop a written philosophy which is consistent with that of the hospital.

1.2 Staff within the pharmacy department develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the pharmaceutical service.

1.3 The objectives of the pharmaceutical service include at least the following:

1.3.1 providing a routine, regular and emergency service

1.3.2 providing patients and users with a quality service and care which is based on assessment of patients needs

1.3.3 providing patients with a quality service and care which is based on professional standards

1.3.4 ensuring patient safety

1.3.5 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.6 maintaining effective communication with patients and carers concerning the pharmaceutical management of their clinical conditions

1.3.7 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

1.3.8 complying with current Department of Health guidance, particularly HC(88)54, Way Forward for Hospital Pharmacy Service

1.3.9 account is taken of the Standards for Pharmaceutical Services in Health Authorities in England 1989, latest edition

1.3.10 the safe handling and control of medicinal products and dressings in accordance with legal requirements and relevant codes of practice

1.4 The objectives are agreed by the pharmacy manager in consultation with pharmacy staff, prescribers, managers and other health care professionals.

PHARMACEUTICAL SERVICE

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Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6 ☐ Y ☐ N		☐ Y ☐ N	
1.3.7			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.3.8 ☐ Y ☐ N		☐ Y ☐ N	
1.3.9 ☐ Y ☐ N		☐ Y ☐ N	
1.3.10 ☐ Y ☐ N		☐ Y ☐ N	
1.4 ☐ Y ☐ N		☐ Y ☐ N	

1.5 All staff are aware of the objectives of the service. This includes an awareness of the need to:

1.5.1 be courteous and considerate to patients and their carers at all times

1.5.2 respect patients' privacy and dignity and that of their carers

1.5.3 respect and cater for cultural differences

1.5.4 respond to communication difficulties

1.5.5 identify counselling requirements of the patient and carers relating to use of medicines

1.6 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.6.1 the role of the hospital

1.6.2 the provision of services

1.6.3 the pattern of delivery of the service

1.6.4 staffing patterns

1.6.5 the nature of professional practice

1.6.6 the changing pharmaceutical needs of patients

2. MANAGEMENT AND STAFFING

The pharmaceutical service is organised, managed and staffed to provide the safe, efficient and effective dispensing and use of medicines within the hospital.

Standards

Management

2.1 Specific services may include:

2.1.1 negotiating, purchasing and stock control systems

2.1.2 manufacturing service including re-packaging which is consistent with the Guide to Good Manufacturing Practice, HC(88)54

2.1.3 providing a drug distribution service to in-patient areas, out-patients and where applicable to satellite hospitals and other specified dependent services in accordance with RPSG Guide to Good Dispensing Practice

2.1.4 providing a drug information service to staff

2.1.5 providing a medication counselling service to patients

2.2 The pharmaceutical service is managed by a qualified and experienced pharmacist.

1.5

1.5.1	☐ Y ☐ N	☐ Y ☐ N
1.5.2	☐ Y ☐ N	☐ Y ☐ N
1.5.3	☐ Y ☐ N	☐ Y ☐ N
1.5.4	☐ Y ☐ N	☐ Y ☐ N
1.5.5	☐ Y ☐ N	☐ Y ☐ N

1.6

1.6.1	☐ Y ☐ N	☐ Y ☐ N
1.6.2	☐ Y ☐ N	☐ Y ☐ N
1.6.3	☐ Y ☐ N	☐ Y ☐ N
1.6.4	☐ Y ☐ N	☐ Y ☐ N
1.6.5	☐ Y ☐ N	☐ Y ☐ N
1.6.6	☐ Y ☐ N	☐ Y ☐ N

2. MANAGEMENT AND STAFFING

The pharmaceutical service is organised, managed and staffed to provide the safe, efficient and effective dispensing and use of medicines within the hospital.

Standards	Comment		Comment
Management			
2.1			
2.1.1	☐ Y ☐ N	☐ Y ☐ N	
2.1.2	☐ Y ☐ N	☐ Y ☐ N	
2.1.3	☐ Y ☐ N	☐ Y ☐ N	
2.1.4	☐ Y ☐ N	☐ Y ☐ N	
2.1.5	☐ Y ☐ N	☐ Y ☐ N	
2.2	☐ Y ☐ N	☐ Y ☐ N	

2.3 The pharmacy manager is involved in the preparation of the budget for the pharmaceutical service.

2.4 The pharmacy manager is responsible for the efficient and effective management of the service's budget.

2.5 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.6 The budget reports are accurate.

2.7 Records and statistics are available for the effective management of the service which as a minimum include:

- 2.7.1 ratio of staff to workload
- 2.7.2 staff absentee rate
- 2.7.3 staff sickness rate
- 2.7.4 staff turnover rate

2.8 Regular multidisciplinary staff meetings are held to:

- 2.8.1 maintain good communications
- 2.8.2 review service practices

2.9 Minutes of meetings are kept.

2.10 Staff are informed of the outcomes of these meetings.

2.11 There is a designated deputy to act in the absence of the pharmacy manager.

2.12 The pharmaceutical service is involved in the development of hospital policies and procedures, where appropriate.

2.13 There is a drug and therapeutics committee, the membership of which is representative of service users.

2.14 Each section of the department is under the control of an appropriately experienced and qualified manager.

2.15 Where the pharmaceutical service is decentralised, a pharmacist, responsible to the pharmacy manager, supervises each organisational unit.

2.3 ☐ Y ☐ N ☐ Y ☐ N

2.4 ☐ Y ☐ N ☐ Y ☐ N

2.5 ☐ Y ☐ N ☐ Y ☐ N

2.6 ☐ Y ☐ N ☐ Y ☐ N

2.7

2.7.1 ☐ Y ☐ N ☐ Y ☐ N

2.7.2 ☐ Y ☐ N ☐ Y ☐ N

2.7.3 ☐ Y ☐ N ☐ Y ☐ N

2.7.4 ☐ Y ☐ N ☐ Y ☐ N

2.8

2.8.1 ☐ Y ☐ N ☐ Y ☐ N

2.8.2 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.16 Written and dated job descriptions are available for all posts, which specify at least the following:

2.16.1 job title and grade

2.16.2 qualifications and/or experience required for the post

2.16.3 functions, responsibilities and accountability

2.16.4 frequency and type of staff appraisal

2.16.5 review date

2.17 A documented staff appraisal system exists for all staff.

2.18 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.19 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.20 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.21 There is an experienced pharmacist available at all times.

2.22 Each pharmacist holds current registration with the Royal Pharmaceutical Society of Great Britain.

2.23 Pharmacy technicians hold a BTEC, City and Guilds or other suitable technical qualification in an appropriate discipline.

2.24 Staffing is calculated and allocated on the basis of workload.

2.25 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.26 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.27 The organisational chart is reviewed annually, revised and dated.

Personnel

2.16

2.16.1 ☐ Y ☐ N ☐ Y ☐ N

2.16.2 ☐ Y ☐ N ☐ Y ☐ N

2.16.3 ☐ Y ☐ N ☐ Y ☐ N

2.16.4 ☐ Y ☐ N ☐ Y ☐ N

2.16.5 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27 ☐ Y ☐ N ☐ Y ☐ N

2.28 Staff are supported in the delivery of care by the following personnel:

2.28.1 administrative

2.28.2 ancillary

2.28.3 secretarial

2.29 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

2.30 The duty and on-call rotas are clearly displayed and available to staff within the department.

3. STAFF DEVELOPMENT AND EDUCATION

The pharmaceutical service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

3.1.1 introduces new staff to the relevant aspects of the hospital

3.1.2 introduces new staff to the relevant aspects of the pharmaceutical service

3.1.3 explains the relationships within the service and with the hospital

3.1.4 prepares staff for their role and responsibilities

3.1.5 explains lines of authority both within the service and with the hospital

3.1.6 explains the method used to evaluate staff performance

3.1.7 introduces staff to the policies and procedures of the service and the hospital

3.1.8 explains emergency procedures (for example, fire drill)

3.1.9 provides information on the occupational health service offered to staff

3.1.10 provides basic instruction in resuscitation of unconscious patients

3.2 As a minimum the continuing education programme:

3.2.1 utilises professional and other resource material

3.2.2 supports and encourages relevant research

3.2.3 provides information on advances in practice related to the pharmaceutical service

3.2.4 provides information on educational opportunities arranged by other institutions

2.28

2.28.1 ☐ Y ☐ N ☐ Y ☐ N

2.28.2 ☐ Y ☐ N ☐ Y ☐ N

2.28.3 ☐ Y ☐ N ☐ Y ☐ N

2.29 ☐ Y ☐ N ☐ Y ☐ N

2.30 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The pharmaceutical service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.1.10 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.2.4 ☐ Y ☐ N		☐ Y ☐ N	

3.2.5 includes support for relevant post-graduate qualifications including experience in academic practice units

3.2.6 provides orientation to new clinical areas

3.3 Staff have access to information and library services. *(See Library Service section of the manual.)*

3.4 Current reference manuals, pamphlets, journals and relevant text books are available within the department for reference and guidance.

3.5 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.6 Where pre-registration training is provided it is structured in accordance with RPSGB guidelines and under the supervision of a recognised pharmaceutical tutor.

4. POLICIES AND PROCEDURES

There are written, dated policies and procedures for all services provided by the pharmacy department. These reflect current legislation, guidance and scientific knowledge.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of all services provided by the pharmacy department.

4.2 Pharmacy staff (and where appropriate the drugs and therapeutic committee) are actively involved in the formulation of policies and procedures.

4.3 When policies are developed, attention is drawn to practice in other fields, for example, infection control, medical record keeping and occupational health.

4.4 Policies and procedures are consistent with those of the hospital.

4.5 Policies and procedures cover at least the following:

4.5.1 admixture of parenteral products and their labelling

4.5.2 arrangements for service outside normal pharmacy hours

4.5.3 automatic stop-orders and a list of medications to which these orders apply

4.5.4 control of sample drugs brought into the hospital

4.5.5 disposal of discontinued, out-dated and inappropriately labelled drugs

4.5.6 drug information and advice provided to hospital staff

4.5.7 drug recall procedure

4.5.8 education and counselling service offered to patients and their families

3.2.5	☐ Y ☐ N	☐ Y ☐ N
3.2.6	☐ Y ☐ N	☐ Y ☐ N
3.3	☐ Y ☐ N	☐ Y ☐ N
3.4	☐ Y ☐ N	☐ Y ☐ N
3.5	☐ Y ☐ N	☐ Y ☐ N
3.6	☐ Y ☐ N	☐ Y ☐ N

4. POLICIES AND PROCEDURES

There are written, dated policies and procedures for all services provided by the pharmacy department. These reflect current legislation, guidance and scientific knowledge.

Standards	Comment		Comment
4.1	☐ Y ☐ N	☐ Y ☐ N	
4.2	☐ Y ☐ N	☐ Y ☐ N	
4.3	☐ Y ☐ N	☐ Y ☐ N	
4.4	☐ Y ☐ N	☐ Y ☐ N	
4.5			
4.5.1	☐ Y ☐ N	☐ Y ☐ N	
4.5.2	☐ Y ☐ N	☐ Y ☐ N	
4.5.3	☐ Y ☐ N	☐ Y ☐ N	
4.5.4	☐ Y ☐ N	☐ Y ☐ N	
4.5.5	☐ Y ☐ N	☐ Y ☐ N	
4.5.6	☐ Y ☐ N	☐ Y ☐ N	
4.5.7	☐ Y ☐ N	☐ Y ☐ N	
4.5.8	☐ Y ☐ N	☐ Y ☐ N	

4.5.9 handling of all investigational drugs and drugs used in clinical trials

4.5.10 information leaflets issued to patients

4.5.11 information provided to patients on use and storage of medications

4.5.12 labelling of drugs

4.5.13 manufacturing procedures specified in the guide to Good Pharmaceutical Manufacturing Practice, and Department of Health Medicines Inspectorate quality control procedures and records for manufactured goods

4.5.14 medications brought into the hospital by patients

4.5.15 prepackaging of drugs

4.5.16 preparation, handling and disposal of cytotoxic drugs

4.5.17 recording in the patient's medical record of each dose of medication administered

4.5.18 reporting of adverse reactions to drugs

4.5.19 security of the pharmaceutical service and drug storage

4.5.20 spillage and/or contamination of staff

4.5.21 stock control and ordering of drugs

4.5.22 storage and handling of toxic materials in accordance with COSHH regulations

4.5.23 storage of all medications within the hospital with respect to statutory regulations and the Duthie Report (September 1988)

4.5.24 storage of out-patient prescriptions

4.6 The role of the pharmaceutical service in emergencies and major incidents is documented.

4.7 There is a policy for dealing with:

4.7.1 medication errors

4.7.2 incidents

4.7.3 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.8 Records are kept which indicate to whom items listed in 4.7 have been referred and the action which has been taken.

4.9 Policies and procedures are contained within a manual which as a minimum:

4.9.1 is regularly reviewed (annually) and updated

4.9.2 is readily accessible for reference in the department

4.10 Staff are informed of current policies and procedures and follow them in all activities.

4.5.9 ☐ Y ☐ N ☐ Y ☐ N

4.5.10 ☐ Y ☐ N ☐ Y ☐ N

4.5.11 ☐ Y ☐ N ☐ Y ☐ N

4.5.12 ☐ Y ☐ N ☐ Y ☐ N

4.5.13 ☐ Y ☐ N ☐ Y ☐ N

4.5.14 ☐ Y ☐ N ☐ Y ☐ N

4.5.15 ☐ Y ☐ N ☐ Y ☐ N

4.5.16 ☐ Y ☐ N ☐ Y ☐ N

4.5.17 ☐ Y ☐ N ☐ Y ☐ N

4.5.18 ☐ Y ☐ N ☐ Y ☐ N

4.5.19 ☐ Y ☐ N ☐ Y ☐ N

4.5.20 ☐ Y ☐ N ☐ Y ☐ N

4.5.21 ☐ Y ☐ N ☐ Y ☐ N

4.5.22 ☐ Y ☐ N ☐ Y ☐ N

4.5.23 ☐ Y ☐ N ☐ Y ☐ N

4.5.24 ☐ Y ☐ N ☐ Y ☐ N

4.6 ☐ Y ☐ N ☐ Y ☐ N

4.7

4.7.1 ☐ Y ☐ N ☐ Y ☐ N

4.7.2 ☐ Y ☐ N ☐ Y ☐ N

4.7.3 ☐ Y ☐ N ☐ Y ☐ N

4.8 ☐ Y ☐ N ☐ Y ☐ N

4.9 ☐ Y ☐ N ☐ Y ☐ N

4.9.1 ☐ Y ☐ N ☐ Y ☐ N

4.9.2 ☐ Y ☐ N ☐ Y ☐ N

4.10 ☐ Y ☐ N ☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

Facilities and equipment are available for the safe, effective and efficient operation of the service.

Standards

5.1 There are office facilities for the pharmacy manager.

5.2 There is a rest room available for all staff.

5.3 There is provision for a teaching/seminar room.

5.4 There are facilities for confidential consultations.

5.5 The location is clearly signposted.

5.6 Secure storage facilities are available in the department to ensure that all pharmaceuticals and related substances for which the pharmaceutical service is responsible are held under conditions which conform to statutory and manufacturers' requirements.

5.7 Arrangements and alarm systems exist to ensure the security at all times of:

- 5.7.1 medicines storage areas
- 5.7.2 pharmacy department
- 5.7.3 pharmacy staff

5.8 All areas where medicines are used, including wards, theatres and the accident and emergency department have adequate and properly controlled medicines storage and preparation areas in accordance with statutory requirements and any other special conditions.

5.9 Pharmacy security aims to protect staff and ensures door access controls, emergency alarms and alarms on vaults/safes used to store controlled drugs are in place.

5.10 Separate designated storage areas for medical gases are provided in accordance with HEI No. 163 (February 1987).

5.11 Separate designated storage areas are provided for the receipt and unpacking of in-coming goods.

5.12 Separate designated storage areas are provided for materials under quarantine.

5.13 Hazardous and/or flammable materials are stored in accordance with the relevant regulations.

5.14 Controlled drugs are stored in conditions as specified in the Misuse of Drugs Act, Safe Custody Regulations.

5. FACILITIES AND EQUIPMENT

Facilities and equipment are available for the safe, effective and efficient operation of the service.

Standards	Comment		Comment
5.1 ☐ Y ☐ N		☐ Y ☐ N	
5.2 ☐ Y ☐ N		☐ Y ☐ N	
5.3 ☐ Y ☐ N		☐ Y ☐ N	
5.4 ☐ Y ☐ N		☐ Y ☐ N	
5.5 ☐ Y ☐ N		☐ Y ☐ N	
5.6 ☐ Y ☐ N		☐ Y ☐ N	
5.7			
5.7.1 ☐ Y ☐ N		☐ Y ☐ N	
5.7.2 ☐ Y ☐ N		☐ Y ☐ N	
5.7.3 ☐ Y ☐ N		☐ Y ☐ N	
5.8 ☐ Y ☐ N		☐ Y ☐ N	
5.9 ☐ Y ☐ N		☐ Y ☐ N	
5.10 ☐ Y ☐ N		☐ Y ☐ N	
5.11 ☐ Y ☐ N		☐ Y ☐ N	
5.12 ☐ Y ☐ N		☐ Y ☐ N	
5.13 ☐ Y ☐ N		☐ Y ☐ N	
5.14 ☐ Y ☐ N		☐ Y ☐ N	

5.15 Deep freeze, refrigerator, cold room and cool area facilities are provided for safe storage of certain medicines.

5.16 There is a designated waiting area for patients using the service which as a minimum provides:

5.16.1 clean and comfortable toilet and washroom facilities with access for wheelchairs

5.16.2 customer information leaflets

5.16.3 information on waiting time

5.16.4 up-to-date reading material

5.17 Designated and properly equipped areas as defined in Building Note No 29, Pharmacy, are provided for:

5.17.1 regular dispensing functions including extemporaneous dispensing

5.17.2 the manufacture and repacking of bulk non-sterile products in accordance with the requirements of the Guide to Good Pharmaceutical Manufacturing Practice

5.17.3 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

5.17.4 the preparation of cytotoxic medicines in accordance with the requirements of the Guide to Good Pharmaceutical Manufacturing Practice, the UK Cytotoxic Services Working Group Manual for Pharmacists Operating Cytotoxic Drug Services (October 1988) and British Standard BS5725 — (The pharmaceutical service ensures that cytotoxic waste materials are contained and disposed of in a safe and approved manner.)

5.17.5 quality control procedures to be carried out on raw materials used in manufacture and products prepared in the pharmacy department

5.17.6 the preparation of radiopharmaceuticals in accordance with requirements of the Guide to Good Pharmaceutical Manufacturing Practice and Guidance Notes for Hospitals on Premises and Environment for Preparation of Radio-pharmaceuticals (October 1983)

5.18 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.

5.19 Where specialised equipment is used, it is operated only by staff trained to do so.

5.20 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.21 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16

5.16.1 ☐ Y ☐ N ☐ Y ☐ N

5.16.2 ☐ Y ☐ N ☐ Y ☐ N

5.16.3 ☐ Y ☐ N ☐ Y ☐ N

5.16.4 ☐ Y ☐ N ☐ Y ☐ N

5.17

5.17.1 ☐ Y ☐ N ☐ Y ☐ N

5.17.2 ☐ Y ☐ N ☐ Y ☐ N

5.17.3 ☐ Y ☐ N ☐ Y ☐ N

5.17.4 ☐ Y ☐ N ☐ Y ☐ N

5.17.5 ☐ Y ☐ N ☐ Y ☐ N

5.17.6 ☐ Y ☐ N ☐ Y ☐ N

5.18 ☐ Y ☐ N ☐ Y ☐ N

5.19 ☐ Y ☐ N ☐ Y ☐ N

5.20 ☐ Y ☐ N ☐ Y ☐ N

5.21 ☐ Y ☐ N ☐ Y ☐ N

6. EVALUATION AND QUALITY ASSURANCE

The pharmaceutical service ensures the provision of a high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the pharmaceutical service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme for the service includes the review of at least the following:

- 6.3.1 service users' satisfaction
- 6.3.2 the pharmaceutical service in comparison with standards set out in this chapter
- 6.3.3 the performance of all pharmacy staff
  (see Management and Staffing in this section)
- 6.3.4 the evaluation of the service, including clinical pharmacy, through multidisciplinary audit
- 6.3.5 dispensing errors
- 6.3.6 the use of resources (for example, analytical equipment, computers)
- 6.3.7 medicines usage (for example, appropriateness of prescription, drug reactions)

6.4 The evaluation activities include the following elements:

- 6.4.1 monitoring: the routine collection of information/statistics about significant aspects of delivery of services
- 6.4.2 assessment: the periodic assessment of information in order to identify significant problems and to improve service delivery
- 6.4.3 action: when important problems or opportunities to improve service delivery are identified, action taken and documented
- 6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long term improvements
- 6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Clinical audit meetings are held on a regular basis.

6.6 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.7 Confidentiality is maintained throughout evaluation proceedings.

6. EVALUATION AND QUALITY ASSURANCE

The pharmaceutical service ensures the provision of a high quality service by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3.3 ☐ Y ☐ N		☐ Y ☐ N	
6.3.4 ☐ Y ☐ N		☐ Y ☐ N	
6.3.5 ☐ Y ☐ N		☐ Y ☐ N	
6.3.6 ☐ Y ☐ N		☐ Y ☐ N	
6.3.7 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4.4 ☐ Y ☐ N		☐ Y ☐ N	
6.4.5 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6 ☐ Y ☐ N		☐ Y ☐ N	
6.7 ☐ Y ☐ N		☐ Y ☐ N	

6.8 The staff within the service receive a report of results obtained through evaluation of care and/or service.

6.9 The staff within the service participate in the formulation of plans for improvement.

6.10 There are mechanisms for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which are known to all.

6.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.12 There is a mechanism for the systematic testing of users' views and implementation of change as a result.

6.13 Statistics are collected for Korner returns.

6.14 Statistics collected are used to effect management/practice change.

6.15 There are local policies for collection of information on key areas such as waiting time.

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

6.15 ☐ Y ☐ N ☐ Y ☐ N

PHARMACEUTICAL SERVICE

Surveyor's General Comments

PHARMACEUTICAL SERVICE

Surveyor's Comments

Standard Number	Recommendation

RADIOLOGY SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

RADIOLOGY SERVICE

1. PHILOSOPHY AND OBJECTIVES

The aim of the radiology service is to provide the hospital with a high quality of service and to ensure safe and effective patient care which complies with the relevant statutory instruments (currently the Ionising Radiation Regulations 1985, 1986, 1987 and 1988).

Standards

1.1 Staff within the radiology department develop a written philosophy for the service which is consistent with that of the hospital.

1.2 Staff within the radiology department develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the radiology service.

1.3 The objectives for the service include at least the following:

1.3.1 providing services on a routine, regular and emergency basis

1.3.2 providing patients and users with a quality service which is based on professional standards set by the relevant professional organisations (for example, the Royal College of Radiologists, the Society of Radiographers)

1.3.3 ensuring patient safety

1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service

1.3.5 consulting with medical staff concerning the provision and interpretation of diagnostic imaging

1.3.6 maintaining communication with other members of the healthcare team to:

(a) meet patient needs

(b) enable co-ordination of services

1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.3.8 teaching, consultation and collaboration with community services (general practices, district nursing)

1.3.9 complying with Ionising Radiation Regulations and such other local rules as may be agreed by the Radiation Protection Adviser

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

1.4.1 be courteous and considerate to patients and their carers at all times

1.4.2 respect patients' privacy and dignity and that of their carers

RADIOLOGY SERVICE

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Standards		Comment		Comment
1.1	☐ Y ☐ N		☐ Y ☐ N	
1.2	☐ Y ☐ N		☐ Y ☐ N	
1.3				
1.3.1	☐ Y ☐ N		☐ Y ☐ N	
1.3.2	☐ Y ☐ N		☐ Y ☐ N	
1.3.3	☐ Y ☐ N		☐ Y ☐ N	
1.3.4	☐ Y ☐ N		☐ Y ☐ N	
1.3.5	☐ Y ☐ N		☐ Y ☐ N	
1.3.6				
(a)	☐ Y ☐ N		☐ Y ☐ N	
(b)	☐ Y ☐ N		☐ Y ☐ N	
1.3.7	☐ Y ☐ N		☐ Y ☐ N	
1.3.8	☐ Y ☐ N		☐ Y ☐ N	
1.3.9	☐ Y ☐ N		☐ Y ☐ N	
1.4				
1.4.1	☐ Y ☐ N		☐ Y ☐ N	
1.4.2	☐ Y ☐ N		☐ Y ☐ N	

1.4.3 respect and cater for cultural differences

1.4.4 respond to communication difficulties

1.4.5 identify counselling requirements of the patient and carers

1.5 The objectives for the service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.5.1 the role of the hospital

1.5.2 the provision of services

1.5.3 the pattern of delivery of service

1.5.4 staffing patterns

1.5.5 the nature of professional practice

2. MANAGEMENT, STAFFING AND RECORDS

The radiology service is organised, managed and staffed to provide a safe environment for patients and staff and a safe, efficient and effective service to patients.

Standards

2.1 The service is directed by a qualified radiologist.

2.2 The director (however named) may be full or part-time depending on the size and complexity of the department.

2.3 The director (however named) is involved in the preparation of the budget for the radiology service.

2.4 The director (however named) is responsible for the efficient and effective management of the service's budget.

2.5 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.6 The budget reports are accurate.

2.7 Records and statistics are available for the effective management of the service which as a minimum include:

2.7.1 ratio of staff to workload

2.7.2 staff absentee rate

2.7.3 staff sickness rate

2.7.4 staff turnover rate

1.4.3 ☐ Y ☐ N ☐ Y ☐ N

1.4.4 ☐ Y ☐ N ☐ Y ☐ N

1.4.5 ☐ Y ☐ N ☐ Y ☐ N

1.5

1.5.1 ☐ Y ☐ N ☐ Y ☐ N

1.5.2 ☐ Y ☐ N ☐ Y ☐ N

1.5.3 ☐ Y ☐ N ☐ Y ☐ N

1.5.4 ☐ Y ☐ N ☐ Y ☐ N

1.5.5 ☐ Y ☐ N ☐ Y ☐ N

2. MANAGEMENT, STAFFING AND RECORDS

The radiology service is organised, managed and staffed to provide a safe environment for patients and staff and a safe, efficient and effective service to patients.

Standards	Comment		Comment
2.1 ☐ Y ☐ N		☐ Y ☐ N	
2.2 ☐ Y ☐ N		☐ Y ☐ N	
2.3 ☐ Y ☐ N		☐ Y ☐ N	
2.4 ☐ Y ☐ N		☐ Y ☐ N	
2.5 ☐ Y ☐ N		☐ Y ☐ N	
2.6 ☐ Y ☐ N		☐ Y ☐ N	
2.7			
2.7.1 ☐ Y ☐ N		☐ Y ☐ N	
2.7.2 ☐ Y ☐ N		☐ Y ☐ N	
2.7.3 ☐ Y ☐ N		☐ Y ☐ N	
2.7.4 ☐ Y ☐ N		☐ Y ☐ N	

2.8 Regular multidisciplinary staff meetings are held to:

2.8.1 maintain good communications

2.8.2 review service practices

2.9 Minutes of meetings are kept.

2.10 Staff are informed of the outcomes of these meetings.

2.11 The radiology service is involved in the development of hospital policies and procedures, where appropriate.

2.12 There are established working relationships between the radiology service and other hospital departments.

Personnel

2.13 Written and dated job descriptions are available for all posts, which specify at least the following:

2.13.1 job title and grade

2.13.2 qualifications and/or experience required for the post

2.13.3 functions, responsibilities and accountability

2.13.4 frequency and type of staff appraisal

2.13.5 review date

2.14 A documented staff appraisal system exists for all staff.

2.15 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.16 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.17 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.18 A qualified radiologist and qualified radiographers are on duty or available at all times.

2.19 There is a designated senior radiographer to supervise the radiographers.

2.20 There is a radiation protection supervisor(s) for the service.

2.21 All radiographic procedures are conducted by appropriately qualified personnel.

2.8

2.8.1 ☐ Y ☐ N ☐ Y ☐ N

2.8.2 ☐ Y ☐ N ☐ Y ☐ N

2.9 ☐ Y ☐ N ☐ Y ☐ N

2.10 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.13

2.13.1 ☐ Y ☐ N ☐ Y ☐ N

2.13.2 ☐ Y ☐ N ☐ Y ☐ N

2.13.3 ☐ Y ☐ N ☐ Y ☐ N

2.13.4 ☐ Y ☐ N ☐ Y ☐ N

2.13.5 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

2.16 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 ☐ Y ☐ N ☐ Y ☐ N

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 Staffing is calculated and allocated on the basis of workload.

2.23 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.24 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.25 The organisational chart is reviewed annually, revised and dated.

2.26 Staff are supported in the delivery of care by the following personnel:

2.26.1 administrative

2.26.2 ancillary

2.26.3 secretarial

2.27 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

Records

2.28 Radiology reports are filed in the patient's medical record within twenty four hours of interpretation wherever possible.

2.29 A duplicate report is kept on file in the radiology department or in some other accessible storage system. (When cumulative or serial reporting systems are used the role of original and duplicate report is reversed.)

2.30 The radiologist consults with the clinician immediately when there are critical or unexpected findings.

2.31 Films or other hard copy images are made for investigations where appropriate.

2.32 Films and records are kept for at least seven years in accordance with statutory requirements.

2.33 Films and records are stored using the accepted hospital coding system.

2.34 The coding system facilitates retrieval of films and records.

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26

2.26.1 ☐ Y ☐ N ☐ Y ☐ N

2.26.2 ☐ Y ☐ N ☐ Y ☐ N

2.26.3 ☐ Y ☐ N ☐ Y ☐ N

2.27 ☐ Y ☐ N ☐ Y ☐ N

Records

2.28 ☐ Y ☐ N ☐ Y ☐ N

2.29 ☐ Y ☐ N ☐ Y ☐ N

2.30 ☐ Y ☐ N ☐ Y ☐ N

2.31 ☐ Y ☐ N ☐ Y ☐ N

2.32 ☐ Y ☐ N ☐ Y ☐ N

2.33 ☐ Y ☐ N ☐ Y ☐ N

2.34 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

The radiology service provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the radiology service. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 introduces new staff to the relevant aspects of the department
- 3.1.3 explains the relationships within the department and with the hospital
- 3.1.4 prepares staff for their role and responsibilities
- 3.1.5 explains lines of authority both within the service and with the hospital
- 3.1.6 explains the method used to evaluate staff performance
- 3.1.7 introduces staff to the policies and procedures of the service and the hospital
- 3.1.8 explains emergency procedures (for example, fire drill)
- 3.1.9 provides information on the occupational health service offered to staff

3.2 All radiology staff are proficient in Basic Life Support:

- 3.2.1 management of the airway
- 3.2.2 control of bleeding
- 3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

- 3.3.1 utilises professional and other resource material
- 3.3.2 supports and encourages relevant research
- 3.3.3 provides information on advances in practice related to the radiology service and the particular specialty
- 3.3.4 provides information on educational opportunities arranged by other institutions
- 3.3.5 provides orientation to new clinical areas

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and reference text books are available within the department for reference and guidance.

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Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3			
3.3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.3.2 ☐ Y ☐ N		☐ Y ☐ N	
3.3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.5 ☐ Y ☐ N		☐ Y ☐ N	

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

3.7 A file of instructive X-rays is maintained for educational and teaching purposes.

4. POLICIES AND PROCEDURES

There are written policies and procedures for all activities of the radiology service which reflect current knowledge and principles, the relevant regulations, statutory requirements and objectives of the service.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of the radiology service.

4.2 The policies and procedures are developed by the radiology staff and the radiation protection adviser in consultation with representatives from other relevant professions.

4.3 Staff are actively involved in the formulation of policies and procedures.

4.4 When policies are developed, attention is drawn to practice in other fields, for example, infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 Diagnostic imaging or radiological investigation or procedures are performed only upon written request by an approved referral source.

4.7 The request contains sufficient clinical information to justify the examination.

4.8 All radiological images are interpreted by a doctor who is a radiologist.

4.9 When a radiograph is interpreted and treatment initiated by the attending doctor, a record of the interpretation is entered in the clinical record and a copy transmitted with the form to the radiologist.

4.10 Policies and procedures cover at least the following:

- 4.10.1 care of patients having special needs, including those who are critically ill and those needing isolation precautions
- 4.10.2 conditions which require immediate notification of attending doctor
- 4.10.3 health and safety
- 4.10.4 information required for a referral to the diagnostic imaging services
- 4.10.5 information issued to patients and/or carers
- 4.10.6 radiological examinations in areas other than the radiology department

3.6 ☐ Y ☐ N ☐ Y ☐ N

3.7 ☐ Y ☐ N ☐ Y ☐ N

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Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6 ☐ Y ☐ N		☐ Y ☐ N	
4.7 ☐ Y ☐ N		☐ Y ☐ N	
4.8 ☐ Y ☐ N		☐ Y ☐ N	
4.9 ☐ Y ☐ N		☐ Y ☐ N	
4.10			
4.10.1 ☐ Y ☐ N		☐ Y ☐ N	
4.10.2 ☐ Y ☐ N		☐ Y ☐ N	
4.10.3 ☐ Y ☐ N		☐ Y ☐ N	
4.10.4 ☐ Y ☐ N		☐ Y ☐ N	
4.10.5 ☐ Y ☐ N		☐ Y ☐ N	
4.10.6 ☐ Y ☐ N		☐ Y ☐ N	

4.10.7 scheduling

4.10.8 treatment of anaphylactic response to radiological drugs

4.11 Radiation safety policies and procedures are developed and supervised by the director of radiology services in consultation with the radiation protection adviser.

4.12 As a minimum safety measures include precautions against:

4.12.1 electrical hazards

4.12.2 fire and explosion

4.12.3 mechanical hazards

4.12.4 radiation hazards

4.13 There is a policy for dealing with:

4.13.1 accidents

4.13.2 errors

4.13.3 incidents

4.13.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.14 Records are kept which indicate to whom items listed in 4.13 have been referred and the action which has been taken.

4.15 Policies and procedures are contained within a manual which as a minimum is:

4.15.1 regularly reviewed (annually) and updated

4.15.2 readily accessible for reference in the department

4.16 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The radiology service is provided with facilities, equipment and supplies for the safe, effective and efficient performance of all services provided.

Standards

5.1 The space available is consistent with the relevant health building note.

5.2 There are office facilities for the consultant radiologist.

5.3 There are office facilities for the senior radiographer.

5.4 There is a rest room available for all staff.

4.10.7	☐ Y ☐ N	☐ Y ☐ N
4.10.8	☐ Y ☐ N	☐ Y ☐ N
4.11	☐ Y ☐ N	☐ Y ☐ N
4.12		
4.12.1	☐ Y ☐ N	☐ Y ☐ N
4.12.2	☐ Y ☐ N	☐ Y ☐ N
4.12.3	☐ Y ☐ N	☐ Y ☐ N
4.12.4	☐ Y ☐ N	☐ Y ☐ N
4.13		
4.13.1	☐ Y ☐ N	☐ Y ☐ N
4.13.2	☐ Y ☐ N	☐ Y ☐ N
4.13.3	☐ Y ☐ N	☐ Y ☐ N
4.13.4	☐ Y ☐ N	☐ Y ☐ N
4.14	☐ Y ☐ N	☐ Y ☐ N
4.15	☐ Y ☐ N	☐ Y ☐ N
4.15.1	☐ Y ☐ N	☐ Y ☐ N
4.15.2	☐ Y ☐ N	☐ Y ☐ N
4.16	☐ Y ☐ N	☐ Y ☐ N

5. FACILITIES AND EQUIPMENT

The radiology service is provided with facilities, equipment and supplies for the safe, effective and efficient performance of all services provided.

Standards	Comment		Comment
5.1	☐ Y ☐ N	☐ Y ☐ N	
5.2	☐ Y ☐ N	☐ Y ☐ N	
5.3	☐ Y ☐ N	☐ Y ☐ N	
5.4	☐ Y ☐ N	☐ Y ☐ N	

5.5 There is provision for a teaching/seminar room.

5.6 Washrooms and changing facilities, separate from customer facilities, are available for staff.

5.7 There are facilities for confidential consultations.

5.8 There is provision for the visual privacy of patients (for example, screens).

5.9 The location is clearly signposted.

5.10 There are suitable signs, prominently displayed, warning of radiation dangers to the foetus if pregnant. Where appropriate these should be multilingual.

5.11 The reception area has:

- 5.11.1 clean toilet and washroom facilities located within easy reach of the clinic
- 5.11.2 customer information leaflets (for example, health promotion, making/cancelling appointments)
- 5.11.3 facilities suitable for nursing mothers
- 5.11.4 information on waiting time
- 5.11.5 play facilities/area for children
- 5.11.6 public transport details
- 5.11.7 seating facilities to cater for the number and type of patients attending the clinic
- 5.11.8 separate facilities for staff
- 5.11.9 space for wheelchairs
- 5.11.10 up-to-date reading material

5.12 There is a safe and secure store for pharmaceuticals etc. essential to the service.

5.13 Personnel working with radiological equipment wear appropriate monitoring devices.

5.14 The monitoring devices are assessed periodically in accordance with statutory regulations and the results reported to the director.

5.15 Continuous records of these results are kept.

5.16 All staff are given instruction in safety precautions necessary for the protection of patients and staff.

5.17 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.18 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.5 ☐ Y ☐ N ☐ Y ☐ N

5.6 ☐ Y ☐ N ☐ Y ☐ N

5.7 ☐ Y ☐ N ☐ Y ☐ N

5.8 ☐ Y ☐ N ☐ Y ☐ N

5.9 ☐ Y ☐ N ☐ Y ☐ N

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11

5.11.1 ☐ Y ☐ N ☐ Y ☐ N

5.11.2 ☐ Y ☐ N ☐ Y ☐ N

5.11.3 ☐ Y ☐ N ☐ Y ☐ N

5.11.4 ☐ Y ☐ N ☐ Y ☐ N

5.11.5 ☐ Y ☐ N ☐ Y ☐ N

5.11.6 ☐ Y ☐ N ☐ Y ☐ N

5.11.7 ☐ Y ☐ N ☐ Y ☐ N

5.11.8 ☐ Y ☐ N ☐ Y ☐ N

5.11.9 ☐ Y ☐ N ☐ Y ☐ N

5.11.10 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

5.14 ☐ Y ☐ N ☐ Y ☐ N

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16 ☐ Y ☐ N ☐ Y ☐ N

5.17 ☐ Y ☐ N ☐ Y ☐ N

5.18 ☐ Y ☐ N ☐ Y ☐ N

5.19 There is evidence that all rooms and equipment are assessed for safety, at acceptable intervals, by independent radiation experts. Records of assessment are kept.

5.20 Calibration of equipment, and all safety measures followed, are in compliance with regulations.

5.21 Where specialised equipment is used, it is operated only by staff trained to do so.

5.22 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982, Management of Equipment.

5.23 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

6. EVALUATION AND QUALITY ASSURANCE

The radiology service ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and the service.

Standards

6.1 There is a written quality assurance plan for the radiology service.

6.2 The quality assurance plan includes the development of locally based standards.

6.3 The evaluation and quality assurance programme includes the review of at least the following:

6.3.1 service users' satisfaction

6.3.2 the radiology service in comparison with standards set out in this chapter

6.3.3 the performance of all radiology service staff
(see Management and Staffing in this section)

6.3.4 the evaluation of clinical performance through multidisciplinary audit

6.3.5 use of diagnostic and therapeutic resources

6.4 The evaluation activities include the following elements:

6.4.1 monitoring: the routine collection of information/statistics about important aspects of delivery of services

6.4.2 assessment: the periodic assessment of this information in order to identify important problems and to improve service delivery

6.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented

5.19 ☐ Y ☐ N ☐ Y ☐ N

5.20 ☐ Y ☐ N ☐ Y ☐ N

5.21 ☐ Y ☐ N ☐ Y ☐ N

5.22 ☐ Y ☐ N ☐ Y ☐ N

5.23 ☐ Y ☐ N ☐ Y ☐ N

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Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3			
6.3.1 ☐ Y ☐ N		☐ Y ☐ N	
6.3.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3.3 ☐ Y ☐ N		☐ Y ☐ N	
6.3.4 ☐ Y ☐ N		☐ Y ☐ N	
6.3.5 ☐ Y ☐ N		☐ Y ☐ N	
6.4			
6.4.1 ☐ Y ☐ N		☐ Y ☐ N	
6.4.2 ☐ Y ☐ N		☐ Y ☐ N	
6.4.3 ☐ Y ☐ N		☐ Y ☐ N	

6.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements

6.4.5 feedback: the results of activities are regularly communicated to the staff

6.5 Clinical audit meetings are held on a regular basis.

6.6 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

6.7 Confidentiality is maintained throughout evaluation proceedings.

6.8 The staff within the service receive a report of results obtained through evaluation of care and/or service.

6.9 The staff within the service participate in the formulation of plans for improvement.

6.10 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

6.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

6.12 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

6.13 Statistics are collected for Korner returns.

6.14 Statistics collected are used to effect management/practice change.

6.15 There are local policies for collection of information on key areas such as:

6.15.1 follow-up

6.15.2 inappropriate attendances

6.15.3 referrals

6.15.4 time spent in department

6.15.5 use of investigations

6.15.6 waiting time

See also Health and Safety, Infection Control, Out-Patient Service, Hospital Management (major incident plan, patients rights and special needs) sections of this manual.

6.4.4 ☐ Y ☐ N ☐ Y ☐ N

6.4.5 ☐ Y ☐ N ☐ Y ☐ N

6.5 ☐ Y ☐ N ☐ Y ☐ N

6.6 ☐ Y ☐ N ☐ Y ☐ N

6.7 ☐ Y ☐ N ☐ Y ☐ N

6.8 ☐ Y ☐ N ☐ Y ☐ N

6.9 ☐ Y ☐ N ☐ Y ☐ N

6.10 ☐ Y ☐ N ☐ Y ☐ N

6.11 ☐ Y ☐ N ☐ Y ☐ N

6.12 ☐ Y ☐ N ☐ Y ☐ N

6.13 ☐ Y ☐ N ☐ Y ☐ N

6.14 ☐ Y ☐ N ☐ Y ☐ N

6.15

6.15.1 ☐ Y ☐ N ☐ Y ☐ N

6.15.2 ☐ Y ☐ N ☐ Y ☐ N

6.15.3 ☐ Y ☐ N ☐ Y ☐ N

6.15.4 ☐ Y ☐ N ☐ Y ☐ N

6.15.5 ☐ Y ☐ N ☐ Y ☐ N

6.15.6 ☐ Y ☐ N ☐ Y ☐ N

RADIOLOGY SERVICE
Surveyor's General Comments

RADIOLOGY SERVICE
Surveyor's Comments

Standard Number	Recommendation

SPECIAL CARE SERVICE

The self-assessment forms have been included in the main body of the document. Their purpose is to provide each of the participating hospitals with an opportunity to give feedback on their progress towards meeting the standards. The "mirror image" page includes the main headings and numbers of each standard, a column for YES/NO answers, and space for comments. Please indicate whether each standard has or has not been complied with by ticking YES/NO as appropriate. Where the response is NO, please comment and/or indicate whether there is an intention to comply. If the space for comments is insufficient, please continue on a separate sheet.

The remaining half of the page is to be completed by the survey team member.

Completion of the document serves two main purposes:

1. It will greatly assist the King's Fund in the task of developing and improving the standards. The comments will be included in the re-draft of the Organisational Audit Manual.
2. A copy of the completed document is sent to each member of the survey team. This will provide the team, in advance of the survey, with some indication of the hospital's progress towards meeting the standards, and will assist them in the planning of the survey.

The completed form MUST be returned to the King's Fund six weeks prior to the survey date for your hospital.

SPECIAL CARE SERVICE

PREAMBLE

Special care units are defined as discrete areas within a hospital specifically organised for the management of the critically ill patient which involve the grouping of special facilities and specially trained staff. They can be subdivided into:

(a) **Multipurpose units: to cater for the treatment of ill patients with a wide variety of diagnoses. These are further subdivided as follows:**

- **Acute care units: applicable to peripheral hospitals where limitation of facilities, skills and staffing restrict levels of care**
- **General intensive care/critical care units: staffed by full-time intensive care specialists and providing a more comprehensive and higher standard of care**

(b) **Coronary care**

(c) **Post cardiac surgery**

(d) **Neonatal intensive care**

(e) **Dialysis and haemofiltration**

(f) **Acute burns unit**

(g) **Intensive nursing care areas which compare with acute care units but are situated in hospitals which also provide general intensive critical care unit standards (for example, neurosurgical)**

(h) **Low pathogen units for the care of transplant and immunologically suppressed patients**

A separate section is to be completed for each service; please indicate to which service this section applies.

Service: _____

_____

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A separate section is to be completed for each service; please indicate to which service this section applies.

Service: _____

_____

1. PHILOSOPHY AND OBJECTIVES

The special care unit provides for the care of patients who have an actual or a potential life-threatening illness, which requires a higher level of care and supervision than can be provided on an ordinary ward.

Standards

1.1 Staff within the special care unit develop a written philosophy which is consistent with that of the hospital.

1.2 Staff within the special care unit develop written objectives to achieve the service philosophy. These objectives are used as a guide to planning, implementing and evaluating all aspects of the special care service.

1.3 The objectives for the service include at least the following:

- 1.3.1 providing patients with a quality service and care which is based on assessment of patients' needs
- 1.3.2 providing patients with a quality service and care which is based on professional standards where available
- 1.3.3 ensuring patient safety
- 1.3.4 providing and maintaining high standards of care through analysis, review and evaluation of service
- 1.3.5 maintaining effective communication with patients and carers concerning the nature and management of clinical conditions and their outcomes
- 1.3.6 maintaining communication with other members of the healthcare team to:
  - (a) meet patient needs
  - (b) enable co-ordination of services
- 1.3.7 teaching, consultation and collaboration both within the hospital and with other hospitals

1.4 All staff are aware of the objectives of the service. This includes awareness of the need to:

- 1.4.1 be courteous and considerate to patients and their carers at all times
- 1.4.2 respect patients' privacy and dignity and that of their carers
- 1.4.3 respect and cater for cultural differences
- 1.4.4 respond to communication difficulties
- 1.4.5 identify counselling requirements of the patient and carers

1.5 Written specific objectives are developed for each special care unit.

1. PHILOSOPHY AND OBJECTIVES

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Standards	Comment		Comment
1.1 ☐ Y ☐ N		☐ Y ☐ N	
1.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3			
1.3.1 ☐ Y ☐ N		☐ Y ☐ N	
1.3.2 ☐ Y ☐ N		☐ Y ☐ N	
1.3.3 ☐ Y ☐ N		☐ Y ☐ N	
1.3.4 ☐ Y ☐ N		☐ Y ☐ N	
1.3.5 ☐ Y ☐ N		☐ Y ☐ N	
1.3.6			
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
1.3.7 ☐ Y ☐ N		☐ Y ☐ N	
1.4			
1.4.1 ☐ Y ☐ N		☐ Y ☐ N	
1.4.2 ☐ Y ☐ N		☐ Y ☐ N	
1.4.3 ☐ Y ☐ N		☐ Y ☐ N	
1.4.4 ☐ Y ☐ N		☐ Y ☐ N	
1.4.5 ☐ Y ☐ N		☐ Y ☐ N	
1.5 ☐ Y ☐ N		☐ Y ☐ N	

1.6 The objectives for each service are reviewed annually and discussed and endorsed by staff, as a minimum when there is a change in:

1.6.1 the role of the hospital

1.6.2 the provision of services

1.6.3 the pattern of delivery of service

1.6.4 staffing patterns

1.6.5 the nature of professional practice

2. MANAGEMENT AND STAFFING

Special care units are organised, managed and staffed to meet patients' needs and the objectives of the service. They are integrated with other departments and services of the hospital.

Standards

Management

2.1 Each special care unit is directed by a recognised specialist and practising clinician in the area of patient care undertaken by the unit.

2.2 The director (however named) of the special care unit is a member of the consultant medical staff.

2.3 There is a designated deputy to act in the absence of the director of the service.

2.4 The functions and authority of the director (however named) are clearly defined, with special emphasis on the working relationships between the attending doctors and the director.

2.5 The director (however named) is involved in the preparation of the budget for the special care unit.

2.6 The director (however named) is responsible for the efficient and effective management of the service's budget.

2.7 Reports of budget expenditure are communicated to the budget holders at set intervals throughout the financial year.

2.8 The budget reports are accurate.

1.6

1.6.1	☐ Y ☐ N	☐ Y ☐ N
1.6.2	☐ Y ☐ N	☐ Y ☐ N
1.6.3	☐ Y ☐ N	☐ Y ☐ N
1.6.4	☐ Y ☐ N	☐ Y ☐ N
1.6.5	☐ Y ☐ N	☐ Y ☐ N

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Special care units are organised, managed and staffed to meet patients' needs and the objectives of the service. They are integrated with other departments and services of the hospital.

Standards	Comment		Comment
Management			
2.1	☐ Y ☐ N	☐ Y ☐ N	
2.2	☐ Y ☐ N	☐ Y ☐ N	
2.3	☐ Y ☐ N	☐ Y ☐ N	
2.4	☐ Y ☐ N	☐ Y ☐ N	
2.5	☐ Y ☐ N	☐ Y ☐ N	
2.6	☐ Y ☐ N	☐ Y ☐ N	
2.7	☐ Y ☐ N	☐ Y ☐ N	
2.8	☐ Y ☐ N	☐ Y ☐ N	

2.9 Records and statistics are available for the effective management of the service which as a minimum include:

2.9.1 ratio of staff to workload

2.9.2 staff absentee rate

2.9.3 staff sickness rate

2.9.4 staff turnover rate

2.10 Regular multidisciplinary staff meetings are held to:

2.10.1 maintain good communications

2.10.2 review service practices

2.11 Minutes of meetings are kept.

2.12 Staff are informed of the outcomes of these meetings.

2.13 The special care service is involved in the development of hospital policies and procedures, where appropriate.

2.14 The special care service staff are represented on inter-departmental committees and involved in decision-making on issues related to the provision of special care services.

2.15 There is a committee comprising representatives of medical, management, nursing and paramedical staff to advise the director and full-time specialists of that unit on the formulation, implementation and evaluation of policies for each special care unit.

Personnel

2.16 Written and dated job descriptions are available for all posts, which specify at least the following:

2.16.1 job title and grade

2.16.2 qualifications and/or experience required for the post

2.16.3 functions, responsibilities and accountability

2.16.4 frequency and type of staff appraisal

2.16.5 review date

2.17 A documented staff appraisal system exists for all staff.

2.18 The appraisal system is based on the job description and work objectives and must identify strengths in performance, areas for development and educational needs.

2.19 All staff receive a contract of employment on appointment which clearly states terms and conditions of service.

2.9

2.9.1 ☐ Y ☐ N ☐ Y ☐ N

2.9.2 ☐ Y ☐ N ☐ Y ☐ N

2.9.3 ☐ Y ☐ N ☐ Y ☐ N

2.9.4 ☐ Y ☐ N ☐ Y ☐ N

2.10

2.10.1 ☐ Y ☐ N ☐ Y ☐ N

2.10.2 ☐ Y ☐ N ☐ Y ☐ N

2.11 ☐ Y ☐ N ☐ Y ☐ N

2.12 ☐ Y ☐ N ☐ Y ☐ N

2.13 ☐ Y ☐ N ☐ Y ☐ N

2.14 ☐ Y ☐ N ☐ Y ☐ N

2.15 ☐ Y ☐ N ☐ Y ☐ N

Personnel

2.16

2.16.1 ☐ Y ☐ N ☐ Y ☐ N

2.16.2 ☐ Y ☐ N ☐ Y ☐ N

2.16.3 ☐ Y ☐ N ☐ Y ☐ N

2.16.4 ☐ Y ☐ N ☐ Y ☐ N

2.16.5 ☐ Y ☐ N ☐ Y ☐ N

2.17 ☐ Y ☐ N ☐ Y ☐ N

2.18 ☐ Y ☐ N ☐ Y ☐ N

2.19 ☐ Y ☐ N ☐ Y ☐ N

2.20 On commencement of duties, all staff are given a comprehensive orientation and induction programme, which is part of continuing education and development. *(See Staff Development and Education in this section.)*

Staffing

2.21 There is a doctor resident twenty four hours and within easy reach of the unit.

2.22 The resident doctor is involved in all decisions concerning patients and is the final common pathway for the delivery of all clinical care.

2.23 A senior nurse with specialised post-registration qualification and/or experience is responsible for the supervision of nursing staff.

2.24 Staffing is calculated and allocated on the basis of workload and a recognised dependency system.

2.25 The ratio of registered nurses to patients in special care units meets the standards set by a body of medical and nursing specialists (professional and statutory bodies).

2.26 All registered nurses assigned to a special care unit have completed an in-service programme or a recognised course (ENB100).

2.27 The additional requirements of teaching, supervising and assessing are reflected in the numbers of staff on duty.

2.28 There is a current, written organisational chart which clearly states lines of authority, responsibility and accountability.

2.29 The organisational chart is reviewed annually, revised and dated.

2.30 Staff are supported in the delivery of care by the following personnel:

2.30.1 administrative

2.30.2 ancillary

2.30.3 secretarial

2.31 The numbers and mix of other professional and technical staff ensure that the objectives of the service are achieved.

2.32 There is technical support available at all times to ensure the safe and effective functioning of equipment in each special care unit.

2.33 The services of a physiotherapist are available at all times.

2.34 The services of a radiographic team capable of mobile X-ray are available at all times.

2.35 The cleaning staff are aware of the special nature of the unit and dangers associated with disconnecting patients from equipment.

2.20 ☐ Y ☐ N ☐ Y ☐ N

Staffing

2.21 ☐ Y ☐ N ☐ Y ☐ N

2.22 ☐ Y ☐ N ☐ Y ☐ N

2.23 ☐ Y ☐ N ☐ Y ☐ N

2.24 ☐ Y ☐ N ☐ Y ☐ N

2.25 ☐ Y ☐ N ☐ Y ☐ N

2.26 ☐ Y ☐ N ☐ Y ☐ N

2.27 ☐ Y ☐ N ☐ Y ☐ N

2.28 ☐ Y ☐ N ☐ Y ☐ N

2.29 ☐ Y ☐ N ☐ Y ☐ N

2.30

2.30.1 ☐ Y ☐ N ☐ Y ☐ N

2.30.2 ☐ Y ☐ N ☐ Y ☐ N

2.30.3 ☐ Y ☐ N ☐ Y ☐ N

2.31 ☐ Y ☐ N ☐ Y ☐ N

2.32 ☐ Y ☐ N ☐ Y ☐ N

2.33 ☐ Y ☐ N ☐ Y ☐ N

2.34 ☐ Y ☐ N ☐ Y ☐ N

2.35 ☐ Y ☐ N ☐ Y ☐ N

3. STAFF DEVELOPMENT AND EDUCATION

Each special care unit provides in-service and continuing education programmes for all levels of staff to encourage training and development on issues relevant to the needs of the individual and to the objectives of the service and the hospital.

Standards

3.1 There is an orientation and induction programme for all staff appointed to the service. As a minimum the programme:

- 3.1.1 introduces new staff to the relevant aspects of the hospital
- 3.1.2 introduces new staff to the relevant aspects of the service
- 3.1.3 explains the relationships within the service and with the hospital
- 3.1.4 prepares staff for their role and responsibilities
- 3.1.5 explains lines of authority both within the service and with the hospital
- 3.1.6 explains the method used to evaluate staff performance
- 3.1.7 introduces staff to the policies and procedures of the service and the hospital
- 3.1.8 explains emergency procedures (for example, fire drill)
- 3.1.9 provides information on the occupational health service offered to staff

3.2 All staff are proficient in Basic Life Support:

- 3.2.1 management of the airway
- 3.2.2 control of bleeding
- 3.2.3 cardio-pulmonary resuscitation

3.3 As a minimum the continuing education programme:

- 3.3.1 utilises professional and other resource material
- 3.3.2 supports and encourages relevant research
- 3.3.3 provides information on advances in practice related to the service
- 3.3.4 provides information on educational opportunities arranged by other institutions
- 3.3.5 provides orientation to new clinical areas
- 3.3.6 covers stress management

3.4 Staff have access to information and library services. *(See Library Service section of this manual.)*

3.5 Current reference manuals, pamphlets, journals and text books are available within the unit for reference and guidance.

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Standards	Comment		Comment
3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.1 ☐ Y ☐ N		☐ Y ☐ N	
3.1.2 ☐ Y ☐ N		☐ Y ☐ N	
3.1.3 ☐ Y ☐ N		☐ Y ☐ N	
3.1.4 ☐ Y ☐ N		☐ Y ☐ N	
3.1.5 ☐ Y ☐ N		☐ Y ☐ N	
3.1.6 ☐ Y ☐ N		☐ Y ☐ N	
3.1.7 ☐ Y ☐ N		☐ Y ☐ N	
3.1.8 ☐ Y ☐ N		☐ Y ☐ N	
3.1.9 ☐ Y ☐ N		☐ Y ☐ N	
3.2			
3.2.1 ☐ Y ☐ N		☐ Y ☐ N	
3.2.2 ☐ Y ☐ N		☐ Y ☐ N	
3.2.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3			
3.3.1 ☐ Y ☐ N		☐ Y ☐ N	
3.3.2 ☐ Y ☐ N		☐ Y ☐ N	
3.3.3 ☐ Y ☐ N		☐ Y ☐ N	
3.3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.3.5 ☐ Y ☐ N		☐ Y ☐ N	
3.3.6 ☐ Y ☐ N		☐ Y ☐ N	
3.4 ☐ Y ☐ N		☐ Y ☐ N	
3.5 ☐ Y ☐ N		☐ Y ☐ N	

3.6 The service facilitates the attendance of staff at relevant conferences, meetings or seminars. Records of attendance are kept.

4. POLICIES AND PROCEDURES

There are specific written policies and procedures for each special care unit, which reflect current knowledge and principles of practice in each special care unit and statutory requirements.

Standards

4.1 Written policies and procedures are developed to guide staff in the activities and management of special care units.

4.2 Policies and procedures are developed and approved by the representatives of all staff concerned with each special care unit, in consultation with other relevant hospital departments.

4.3 A special care committee comprising representatives of nursing, management and paramedical staff advises the director and full-time specialists of that unit on the formulation, implementation and evaluation of policies and procedures for each unit.

4.4 When policies are developed, attention is drawn to practice in other fields, for example, infection control, medical record keeping and occupational health.

4.5 Policies and procedures are consistent with those of the hospital.

4.6 The policies and procedures include at least the following:

4.6.1 working relationships between the attending clinicians and the director of the service

4.6.2 admission criteria, including priority determinations which must be made by the clinical staff and contingency plans if the unit is full

4.6.3 discharge criteria

4.6.4 specifications as to who may perform special procedures, under what circumstances and under what degree of supervision. Special procedures in this context include as a minimum:

(a) administration of parenteral fluids and other medications

(b) cardio-pulmonary resuscitation

(c) obtaining of blood and other laboratory specimens

(d) ordering of medications

(e) tracheostomy

4.6.5 arrangements for diagnostic imaging and laboratory investigations

4.6.6 priority of orders for laboratory tests

3.6 ☐ Y ☐ N ☐ Y ☐ N

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Standards	Comment		Comment
4.1 ☐ Y ☐ N		☐ Y ☐ N	
4.2 ☐ Y ☐ N		☐ Y ☐ N	
4.3 ☐ Y ☐ N		☐ Y ☐ N	
4.4 ☐ Y ☐ N		☐ Y ☐ N	
4.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6			
4.6.1 ☐ Y ☐ N		☐ Y ☐ N	
4.6.2 ☐ Y ☐ N		☐ Y ☐ N	
4.6.3 ☐ Y ☐ N		☐ Y ☐ N	
4.6.4 ☐ Y ☐ N		☐ Y ☐ N	
(a) ☐ Y ☐ N		☐ Y ☐ N	
(b) ☐ Y ☐ N		☐ Y ☐ N	
(c) ☐ Y ☐ N		☐ Y ☐ N	
(d) ☐ Y ☐ N		☐ Y ☐ N	
(e) ☐ Y ☐ N		☐ Y ☐ N	
4.6.5 ☐ Y ☐ N		☐ Y ☐ N	
4.6.6 ☐ Y ☐ N		☐ Y ☐ N	

4.6.7 use and location of special equipment and supplies

4.6.8 assignment of responsibility for a preventive and corrective maintenance programme, including procedures to follow in the event of the breakdown of essential equipment

4.6.9 emergency and established standard care procedures of critically ill patients

4.6.10 requesting donor organs

4.6.11 infection control policy and procedures

4.6.12 arrangements for visitors

4.6.13 control of traffic through and within the department

4.6.14 fire, emergency and disaster procedures for the unit

4.7 There is a policy for dealing with:

4.7.1 accidents

4.7.2 errors

4.7.3 incidents

4.7.4 patient and/or carers' complaints (in accordance with HC(88)37, Hospital Complaints Procedures)

4.8 Records are kept which indicate to whom items listed in 4.7 have been referred and the action which has been taken.

4.9 Policies and procedures are dated and contained within a manual which as a minimum is:

4.9.1 regularly reviewed (annually) and updated

4.9.2 readily accessible for reference in the department

4.10 Staff are informed of current policies and procedures and follow them in all activities.

5. FACILITIES AND EQUIPMENT

The environment, facilities and equipment are such as to ensure the safe, efficient and effective care of the patient.

Standards

5.1 The main planning guide for minimum requirements is Hospital Building note 27 (1970); see also Standards for Intensive Care Units.

5.2 The selection and quality of equipment in the special care unit is designed to meet the needs of the patients and staff.

5.3 There is an office for the clinical director/department head.

4.6.7	☐ Y ☐ N	☐ Y ☐ N
4.6.8	☐ Y ☐ N	☐ Y ☐ N
4.6.9	☐ Y ☐ N	☐ Y ☐ N
4.6.10	☐ Y ☐ N	☐ Y ☐ N
4.6.11	☐ Y ☐ N	☐ Y ☐ N
4.6.12	☐ Y ☐ N	☐ Y ☐ N
4.6.13	☐ Y ☐ N	☐ Y ☐ N
4.6.14	☐ Y ☐ N	☐ Y ☐ N
4.7		
4.7.1	☐ Y ☐ N	☐ Y ☐ N
4.7.2	☐ Y ☐ N	☐ Y ☐ N
4.7.3	☐ Y ☐ N	☐ Y ☐ N
4.7.4	☐ Y ☐ N	☐ Y ☐ N
4.8	☐ Y ☐ N	☐ Y ☐ N
4.9	☐ Y ☐ N	☐ Y ☐ N
4.9.1	☐ Y ☐ N	☐ Y ☐ N
4.9.2	☐ Y ☐ N	☐ Y ☐ N
4.10	☐ Y ☐ N	☐ Y ☐ N

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Standards	Comment		Comment
5.1	☐ Y ☐ N	☐ Y ☐ N	
5.2	☐ Y ☐ N	☐ Y ☐ N	
5.3	☐ Y ☐ N	☐ Y ☐ N	

5.4 Separate offices are available for the medical and nursing staff.

5.5 The nurses' station is positioned in such a way as to allow direct vision of and ready access to all patients in the area.

5.6 Suitably quiet and private areas are available for staff. These areas should include facilities for tea/coffee making, change room and toilets.

5.7 There is a properly equipped seminar room for formal teaching of the staff.

5.8 There is a properly equipped bedroom for the resident doctor.

5.9 Facilities for appropriate counselling support for all patients, relatives and staff are available.

5.10 Suitably quiet and private areas with tea/coffee making facilities are available for waiting relatives and for grieving or otherwise distressed relatives or carers.

5.11 There is residential accommodation for relatives within easy reach of the unit.

5.12 The immediate physical environment of the patient is as unobtrusive and aesthetically pleasing as possible. The environment is conducive to recovery with minimum sensory deprivation and abuse and wherever possible situated near outside windows.

5.13 The unit is air-conditioned for the benefit of the patient, staff and equipment.

5.14 Whatever the design or purpose of the unit, enough space is provided around each bed to make it easily accessible for routine and emergency care of the patient, and to accommodate bulky equipment which may be needed.

5.15 The bed is readily adjustable to various therapeutic positions, easily moved for transport, has a locking mechanism for a secure stationary position, cot sides and a removable headboard.

5.16 Where electrically operated beds are used, potential electrical hazards should be recognised.

5.17 There are efficient and variable lighting systems as near to natural light as possible. Lighting conforms to HBN(27) 1970 Intensive Therapy Unit, and to recommendations of the CIBS Lighting Guide No 12, Hospitals and Health Care Buildings.

5.18 There are alternate emergency lighting and power sources or other appropriate mechanisms available to operate all life support systems including suction apparatus, in accordance with HTM(11) 1974 Emergency Electrical Services.

5.19 Special safety precautions related to proper grounding, current leakage and device safety will be observed when any electronic devices are used on patients. The electricity supply is in accordance with HTM(7) 1977 Electrical Services: Supply and Distribution.

5.4 ☐ Y ☐ N ☐ Y ☐ N

5.5 ☐ Y ☐ N ☐ Y ☐ N

5.6 ☐ Y ☐ N ☐ Y ☐ N

5.7 ☐ Y ☐ N ☐ Y ☐ N

5.8 ☐ Y ☐ N ☐ Y ☐ N

5.9 ☐ Y ☐ N ☐ Y ☐ N

5.10 ☐ Y ☐ N ☐ Y ☐ N

5.11 ☐ Y ☐ N ☐ Y ☐ N

5.12 ☐ Y ☐ N ☐ Y ☐ N

5.13 ☐ Y ☐ N ☐ Y ☐ N

5.14 ☐ Y ☐ N ☐ Y ☐ N

5.15 ☐ Y ☐ N ☐ Y ☐ N

5.16 ☐ Y ☐ N ☐ Y ☐ N

5.17 ☐ Y ☐ N ☐ Y ☐ N

5.18 ☐ Y ☐ N ☐ Y ☐ N

5.19 ☐ Y ☐ N ☐ Y ☐ N

5.20 Expert advice concerning the safe use of, and preventive maintenance for, all biomedical devices and electrical installations is readily available at all times. Documentation of safety testing is provided on a regular basis to the unit director.

5.21 There are an adequate number of oxygen, compressed air and suction facilities as well as properly grounded electrical outlets with duplicate or independent circuits available to every patient. Installations conform to HTM(22) 1977 Piped Medical Gases, Medical Compressed Air and Medical Vacuum Installations.

5.22 All other emergency/life support equipment is readily accessible and functional.

5.23 There is an alarm system for special care unit personnel to summon additional staff in an emergency.

5.24 Emergency resuscitation equipment is easily accessible from every section of the department and the procedure for summoning assistance is known by all staff.

5.25 Emergency resuscitation equipment (for example, defibrillators) is discharged and output checked at least daily or after each use, whichever is the sooner of the two, and this is recorded.

5.26 There is a specific purpose refrigerator available for the storage of blood products, medications, serum and specimens.

5.27 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.

5.28 There are adequate supplies of medications and intravenous fluids available twenty four hours a day.

5.29 There is an ice-making machine available for those units where the nature of the care demands it.

5.30 There are appropriate facilities for isolation and protective isolation nursing of patients.

5.31 There are appropriate areas available for the cleaning and storage of equipment.

5.32 Where specialised equipment is used, it is operated only by staff trained to do so.

5.33 Equipment is subject to a planned preventative maintenance and replacement programme in accordance with HEI(98) 1982 Management of Equipment.

5.34 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]).

5.20 ☐ Y ☐ N ☐ Y ☐ N

5.21 ☐ Y ☐ N ☐ Y ☐ N

5.22 ☐ Y ☐ N ☐ Y ☐ N

5.23 ☐ Y ☐ N ☐ Y ☐ N

5.24 ☐ Y ☐ N ☐ Y ☐ N

5.25 ☐ Y ☐ N ☐ Y ☐ N

5.26 ☐ Y ☐ N ☐ Y ☐ N

5.27 ☐ Y ☐ N ☐ Y ☐ N

5.28 ☐ Y ☐ N ☐ Y ☐ N

5.29 ☐ Y ☐ N ☐ Y ☐ N

5.30 ☐ Y ☐ N ☐ Y ☐ N

5.31 ☐ Y ☐ N ☐ Y ☐ N

5.32 ☐ Y ☐ N ☐ Y ☐ N

5.33 ☐ Y ☐ N ☐ Y ☐ N

5.34 ☐ Y ☐ N ☐ Y ☐ N

6. PATIENT CARE

Nursing care is systematic and patient-centred.

Standards

6.1 The delivery of nursing care is in accordance with agreed standards for nursing practice.

6.2 There is evidence that the prime focus of nursing care is on the patient and their carers (for example, primary nursing, patient allocation, team nursing).
(ref. Exercising Accountability — UKCC Advisory Document, March 1989)

6.3 A named registered nurse is accountable for the nursing care of each patient.

6.4 A nursing care plan is developed after an assessment of the patient.

6.5 The care plan is developed in collaboration with medical and other relevant staff and in consultation with the patient and carers or advocates.

6.6 The nursing plan includes:

- 6.6.1 a statement of the patient's needs
- 6.6.2 details of specific nursing care given
- 6.6.3 health education
- 6.6.4 preparation for discharge
- 6.6.5 continuing assessment and evaluation of nursing needs
- 6.6.6 name and signature of the nurse responsible
- 6.6.7 preparation for transfer

6.7 Nursing records are signed, timed and dated by the nurse responsible, maintained and incorporated in the patient's medical record. The nursing record includes at least the following:

- 6.7.1 nursing assessment
- 6.7.2 nursing care plan
- 6.7.3 details of nursing care given
- 6.7.4 patient's response to care and significant changes in health status
- 6.7.5 changes in the nursing care plan resulting from evaluation of the patient's progress

6.8 Nursing staff maintain the patient's right to privacy, dignity and confidentiality at all times.
(ref. Exercising Accountability — UKCC Advisory Document, March 1989)

6.9 Nursing staff participate in case conferences concerning patients in their care.

6. PATIENT CARE

Nursing care is systematic and patient-centred.

Standards	Comment		Comment
6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6			
6.6.1 ☐ Y ☐ N		☐ Y ☐ N	
6.6.2 ☐ Y ☐ N		☐ Y ☐ N	
6.6.3 ☐ Y ☐ N		☐ Y ☐ N	
6.6.4 ☐ Y ☐ N		☐ Y ☐ N	
6.6.5 ☐ Y ☐ N		☐ Y ☐ N	
6.6.6 ☐ Y ☐ N		☐ Y ☐ N	
6.6.7 ☐ Y ☐ N		☐ Y ☐ N	
6.7 ☐ Y ☐ N		☐ Y ☐ N	
6.7.1 ☐ Y ☐ N		☐ Y ☐ N	
6.7.2 ☐ Y ☐ N		☐ Y ☐ N	
6.7.3 ☐ Y ☐ N		☐ Y ☐ N	
6.7.4 ☐ Y ☐ N		☐ Y ☐ N	
6.7.5 ☐ Y ☐ N		☐ Y ☐ N	
6.8 ☐ Y ☐ N		☐ Y ☐ N	
6.9 ☐ Y ☐ N		☐ Y ☐ N	

7. EVALUATION AND QUALITY ASSURANCE

Each special care unit ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and each special care service.

Standards

7.1 There is a written quality assurance plan for each special care unit.

7.2 The quality assurance plan includes the development of locally based standards.

7.3 The evaluation and quality assurance programme of each service includes the review of at least the following:

- 7.3.1 service users' satisfaction
- 7.3.2 the special care service in comparison with standards set out in this chapter
- 7.3.3 the performance of all staff in each special care unit *(see Management and Staffing within this section)*
- 7.3.4 the evaluation of nursing practice
- 7.3.5 the evaluation of clinical performance through multidisciplinary audit
- 7.3.6 the use of resources (type of stock, amount etc.)
- 7.3.7 assessment of the appropriateness of care

7.4 The evaluation activities include the following elements:

- 7.4.1 monitoring: the routine collection of information/ statistics about important aspects of delivery of services
- 7.4.2 assessment: the periodic assessment of this information in order to identify significant problems and to improve service delivery
- 7.4.3 action: when important problems or opportunities to improve service delivery are identified, action is taken and documented
- 7.4.4 evaluation: the effectiveness of action taken is evaluated to ensure long-term improvements
- 7.4.5 feedback: the results of activities are regularly communicated to the staff

7.5 Clinical audit meetings are held on a regular basis.

7.6 Records of attendance and minutes of audit meetings are kept which accurately reflect conclusions, recommendations, action taken and results of action.

7.7 Confidentiality is maintained throughout evaluation proceedings.

7.8 The staff within the service receive a report of results obtained through evaluation of care and/or service.

7. EVALUATION AND QUALITY ASSURANCE

Each special care unit ensures the provision of high quality care by its involvement in evaluation activities of the hospital in line with the quality assurance plan for the hospital and each special care service.

Standards	Comment		Comment
7.1 ☐ Y ☐ N		☐ Y ☐ N	
7.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3			
7.3.1 ☐ Y ☐ N		☐ Y ☐ N	
7.3.2 ☐ Y ☐ N		☐ Y ☐ N	
7.3.3 ☐ Y ☐ N		☐ Y ☐ N	
7.3.4 ☐ Y ☐ N		☐ Y ☐ N	
7.3.5 ☐ Y ☐ N		☐ Y ☐ N	
7.3.6 ☐ Y ☐ N		☐ Y ☐ N	
7.3.7 ☐ Y ☐ N		☐ Y ☐ N	
7.4			
7.4.1 ☐ Y ☐ N		☐ Y ☐ N	
7.4.2 ☐ Y ☐ N		☐ Y ☐ N	
7.4.3 ☐ Y ☐ N		☐ Y ☐ N	
7.4.4 ☐ Y ☐ N		☐ Y ☐ N	
7.4.5 ☐ Y ☐ N		☐ Y ☐ N	
7.5 ☐ Y ☐ N		☐ Y ☐ N	
7.6 ☐ Y ☐ N		☐ Y ☐ N	
7.7 ☐ Y ☐ N		☐ Y ☐ N	
7.8 ☐ Y ☐ N		☐ Y ☐ N	

7.9 The staff within the service participate in the formulation of plans for improvement.

7.10 There is a mechanism for making and dealing with complaints/suggestions from patients, their carers, visitors and staff, which is known to all.

7.11 Incident reports/complaints/suggestions are compiled, recorded, investigated and discussed at an appropriate level within the hospital.

7.12 There is a mechanism for the systematic testing of consumers' views and implementation of change as a result.

7.13 Statistics are collected for Korner returns.

7.14 Statistics collected are used to effect management/practice change.

7.15 There are local policies for collection of information on key areas, such as inappropriate referrals.

See also Infection Control and Hospital Management (patient rights, special needs and major incident plan) sections of this manual.

7.9 ☐ Y ☐ N ☐ Y ☐ N

7.10 ☐ Y ☐ N ☐ Y ☐ N

7.11 ☐ Y ☐ N ☐ Y ☐ N

7.12 ☐ Y ☐ N ☐ Y ☐ N

7.13 ☐ Y ☐ N ☐ Y ☐ N

7.14 ☐ Y ☐ N ☐ Y ☐ N

7.15 ☐ Y ☐ N ☐ Y ☐ N

SPECIAL CARE SERVICE
Surveyor's General Comments

SPECIAL CARE SERVICE
Surveyor's Comments

Standard Number	Recommendation