King's Fund

Organisational Audit

Accreditation UK

An organisational audit programme for acute, community, learning disabilities and mental health services

Volume 1

King's Fund

Organisational Audit

Accreditation UK

An Organisational Audit Programme for Acute, Community, Learning Disabilities and Mental Health Services

Volume 1

Second edition
June 1997

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 1997

ISBN 1 85717 121 7

A CIP catalogue record for this book is available from the British Library

Distributed by
King's Fund Organisational Audit
11-13 Cavendish Square
London W1M 0AN
Tel: 0171 307 2434
Fax: 0171 307 2804

Printed and bound in Great Britain

Edited and produced by Rodgers & Johns
Designed by Two Plus Two Design Partnership

Contents

Volume 1

Preface iv
Introduction v
Acknowledgements ix

Section 1: Corporate Management

Standard 1	Mission and Objectives	3
Standard 2	Management Arrangements and Corporate Governance	7
Standard 3	Contracting for Services	19
Standard 4	Information Management and Technology	26
Standard 5	Financial Resources	31
Standard 6	Human Resources	40
	Human Resources - Occupational Health	47
Standard 7	Communication	54
Standard 8	Estates Management	59
Standard 9	Risk Management	69
	Risk Management - Health and Safety	73
	Risk Management - Fire Safety	77
	Risk Management - Infection Control	82
	Risk Management - Waste Disposal	86
	Risk Management - Security	89
Standard 10	Quality Improvement	95

Volume 2

Section 2: Management of Resources

Standard 11	Individual Service Philosophy and Objectives	102
Standard 12	Management and Staffing	104
Standard 13	Staff Development and Education	114
Standard 14	Business Planning and Contracting	118
Standard 15	Facilities and Equipment	121
Standard 16	Quality Improvement	124

Corporate Management Checklist 127

Section 3: The Patient's Rights and Individual Needs

Standard 17	The Patient's Rights	142
Standard 18	The Patient's Individual Needs	148
Standard 19	Partnership with Patients	154

Section 4: The Patient's Journey

Standard 20	Referrals, Access and Admission	161
Standard 21	Assessment, Planning, Implementation and Review of Treatment and Care	165
Standard 22	Leaving a Service/Discharge	170
Standard 23	Health Record Content	174

Volume 3

Section 5: Service Specific

Standard 24	Accident and Emergency Service	187
Standard 25	Acute Day Care Service	196
Standard 26	Administration	204
Standard 27	Catering Service	207
Standard 28	Children's Services	214
Standard 29	Diagnostic Imaging Service	228
Standard 30	Dietetic Service	234
Standard 31	Health Record Management	237
Standard 32	Housekeeping Service	245
Standard 33	Laundry and Linen Service	248
Standard 34	Learning Disabilities - Advocacy	252
Standard 35	Learning Disabilities - Choice and Decision Making	255
Standard 36	Learning Disabilities - Personal Relationships and Sexuality	258
Standard 37	Learning Disabilities - Personal Financial Arrangements	261
Standard 38	Learning Disabilities - Links with Children's Services/Transfer to Adult Services	263
Standard 39	Learning Disabilities - Relocation	264
Standard 40	Library Service	267
Standard 41	Medical Physics and Biomedical Engineering Service	271
Standard 42	Medical Service	276

Volume 2

Section 5 (continued): Service Specific

Introduction to standards for mental health services		285
Standard 43	Mental Health - Continuity of Care/the Care Programme Approach	286
Standard 44	Mental Health - The Mental Health Act 1983	293
Standard 45	Mental Health - Advocacy	296
Standard 46	Mental Health - Treatment	299
Standard 47	Mental Health - Clinical Risk Management	301
Standard 48	Mental Health - Leave From Hospital	307
Standard 49	Mental Health - Other Specialist Services	309
Standard 50	Maternity Service	312
Standard 51	Nursing Service	321
Standard 52	Occupational Therapy Service	326
Standard 53	Operating Theatre Service/Anaesthetic Service	328
Standard 54	Outpatient Service	338
Standard 55	Pathology Service	349
Standard 56	Pharmaceutical Service	356
Standard 57	Portering Service	364
Standard 58	Radiotherapy Service	367
Standard 59	Special Care Service	372
Standard 60	Sterile Services Department	379
Standard 61	Telecommunications Service	386
Standard 62	Volunteer Service	390

Appendix 1: Glossary of terms	393
Appendix 2: Relevant Legislation, Regulations and Guidance	401

Preface

The publication of this manual of organisational standards is a major milestone for King's Fund Organisational Audit in that it brings together standards for acute hospitals and the newly developed standards for community, learning disabilities and mental health services.

This reflects the changing nature of health care organisations and our ability to respond to these changes. It also acknowledges that all organisations delivering health care have much in common in terms of the organisational systems and processes that are required for the delivery of high quality services. The standards in this manual, applicable to a wide range of organisations and services, bear this out.

The development of this manual also marks new ways of working for King's Fund Organisational Audit. We have worked in partnership with the Sainsbury Centre for Mental Health, jointly developing many of the standards and piloting joint work utilising the QUARTZ materials. We have also worked with users of mental health services during the development of standards, taking into account issues which they consider vital in delivering high quality health care. Other partnerships are starting as a result of this work.

These standards provide those organisations delivering acute, community, learning disabilities and mental health services with a means to review practice and to stimulate development work. They provide an opportunity for staff to contribute to the development of the organisations in which they work in order to provide improved health care services; they can do this consistently over time, by assessing what they do, how they do it and how to do it better.

Introduction

Organisational Audit

Organisational Audit is an independent and voluntary audit of the whole organisation. It is based on a framework of explicit standards which are concerned with the systems and processes for the delivery of health care. It involves evaluation of compliance with those standards by means of external peer review carried out by a team of senior health care professionals, following a period of preparation and self-assessment. The King's Fund Organisational Audit programme complements local and professional initiatives, recognises and spreads good practice and supports continuous organisational development.

Application of the standards

Stage 1: Preparation, self-assessment and implementation

Over a period of 12-18 months the organisation works with the standards and their criteria in the Organisational Audit manual. Identifying a coordinator to lead the process and establishing a steering group are central to maximising success. An initial baseline assessment of compliance with the standards and criteria is carried out to identify priorities for action. Self-assessment questionnaires, contained in the manual, are completed for each department/service. The preparation and implementation period is supported by King's Fund Organisational Audit, which advises the organisation throughout the process. A mock survey may be conducted by the organisation three to four months before the peer review survey. Six weeks prior to the peer review survey, self-assessment forms are completed and returned to King's Fund Organisational Audit with supporting background documentation. This includes a profile of the organisation.

Stage 2: Survey

An independent team of senior health professionals, chosen for their experience, knowledge, credibility and appropriateness for the organisation, undertake the peer review survey. Surveyors are selected and trained by King's Fund Organisational Audit. They receive the self-assessment, organisation profile and supporting documentation in advance of the survey to enable them to build up a picture of the organisation before the survey begins. The survey, which lasts three to five days, involves a documentation review, meetings with staff and patients/users and visits to the different service areas.

Stage 3: Report

A verbal debriefing is given to staff at the end of the survey, summarising key themes and overall observations. A detailed written report follows approximately

eight weeks later. This includes a comprehensive assessment of compliance against the standards. It also highlights good practice and provides a basis for developing future action plans and monitoring progress.

Standards development

These standards and criteria are the culmination of two processes. Firstly, the acute hospital accreditation programme standards and criteria manual was extensively reviewed and updated following comments received from the field and a number of workshops. Secondly, the lessons learnt from the project phase of the community, learning disabilities and mental health services programme enabled us to develop more patient/user focused standards which are applicable to all services. In all, this manual is designed for use by organisations of any configuration providing acute, community, learning disabilities and mental health services.

The revision was led by health professionals, both from client organisations and invited individuals from NHS trusts and the independent sector, including chief executives, consultants and managers. In addition, there was consultation with representatives from professional associations, Royal Colleges and patients/users. In particular, we worked with the Sainsbury Centre for Mental Health on the development of standards for mental health services (standards 43-50), The Patient's Rights and Individual Needs (standards 17-19) and The Patient's Journey (standards 20-23).

The standards and criteria were developed to be:

measurable:	both by the staff implementing the criteria and by the surveyors measuring compliance against them
achievable:	some organisations will find it more difficult to achieve the criteria than others, but there is little point in including criteria that are not achievable
flexible:	so they can be used by all types or sizes of organisations
acceptable:	representing a consensus on currently accepted roles and responsibilities
adaptable:	non-prescriptive - stating what should be in place and not how it should be put in place - so they can be implemented in accordance with local needs
nationally applicable:	a common framework against which health care organisations throughout the UK can be assessed.

Review and revision

To ensure that the King's Fund Organisational Audit standards and criteria reflect ongoing changes and are representative of best practice, the standards and criteria will continue to be reviewed on an ongoing basis.

To assist this process, there is a section at the end of each standard for comments to be recorded.

Interpretation

Guidance information is shown in italics beneath a number of the criteria in the manual. This is to:

- help staff interpret the criteria
- provide guidelines for meeting the criteria
- indicate the areas which the surveyors will assess during the survey.

Cross-referencing

The sections of an organisation do not operate as discrete entities - indeed, one of the benefits of participating in the Organisational Audit process is that it encourages multiprofessional working. For this reason many of the criteria have been cross-referenced to criteria relevant to other disciplines.

Working with the standards and criteria

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

Weighting

All criteria are assigned a priority weighting. This identifies criteria which are fundamental to the way in which the organisation conducts its business. It helps prioritise the work and determine which criteria must be in place in order for an organisation to be awarded accreditation. The weightings have been agreed in consultation with health professionals and with advice from professional associations.

The criteria are weighted as follows:

A Essential practice

Relating to:

- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice

Standard good practice expected to be in place across the UK.

C Excellent practice

Excellent practice which is not yet standard across the UK.

Helen Crisp
Development Worker, Acute Services

Sally-Anne Vidall
Project Manager, Community Services Accreditation

Acknowledgements

The production of this manual would not have been possible without the contribution of many individuals. These include members of:

- the trusts and independent hospitals who developed and commented on the standards during the development and consultation phases

- the professional, consumer and user organisations who ensured that different perspectives are reflected in the standards

- the statutory organisations who provided specific expertise on the relevant regulations and guidelines.

In particular, we are grateful to the Sainsbury Centre for Mental Health for its support in developing standards on mental health services (standards 43-49), The Patient's Rights and Individual Needs (standards 17-19) and The Patient's Journey (standards 20-23). Special mention should be made of Professor Geoff Shepherd for supporting the project, and Libby Gawith for her invaluable and hard work on the standards.

We also acknowledge the work of the King's Fund Share Project and the London Health and Race Purchasers Forum in developing core health and race standards which have been incorporated into the manual.

Contributors

Acute services

A Adam	Medical Vice-President, British Institute of Radiology
John Babb	Manager, Hospital Infection Research Laboratory, City Hospital NHS Trust, Birmingham
John Barker	Member, Institute of Sterile Services Management
Rose Barnes	Matron, Winterbourne Hospital
Sue Berry	Outpatient Services Manager, St Peter's Hospital NHS Trust, Chertsey
Keith Beverley	Estates Manager, Royal Hull Hospitals NHS Trust
Jacqueline Biggs	Nurse Director, Walsall Hospitals NHS Trust
Michael Brindle	President, The Royal College of Radiologists
Jennifer Brown	Physiotherapy Manager, St George's Health Care NHS Trust

Aknowledgements

Philip Brown	Chief Executive, Hillingdon Hospital NHS Trust
Cathy Byrne	Quality Manager, West Lancashire NHS Trust
AS Campbell	Executive Secretary, The Royal College of Surgeons of Edinburgh
Di Caulfield-Stoker	Director of Quality and Consumer Affairs, Richmond, Twickenham and Roehampton Healthcare NHS Trust
Julian Coulden	Operations Manager, BUPA Health Services
Patrick Coyle	Medical Director, Glan-y-Mor NHS Trust
Patricia Dawson	Director, Scottish Association of Health Councils
Keith Dodd	Honorary Secretary, Royal College of Paediatrics and Child Health
Brian Dudding	Estates and Facilities Manager, Pontefract Hospitals NHS Trust
Robert Ellarby	Director of Estates, South Downs Health NHS Trust
Pam Evans	Professional Director, Royal College of Speech and Language Therapists
Anne Fagan	Matron, Hospital of St John and St Elizabeth
David Farrell	Training and Development Manager, BUPA Hospital, Leeds
Alan Finn	Director of Nursing and Mental Health Services, Down and Lisburn NHS Trust
Mary Fox	Council Member, Institute of Medical Laboratory Sciences
Pat Fryer	Nurse in Charge, The Droitwich Private Hospital
Joseph Gaston	Consultant, Royal Hospitals NHS Trust, Belfast
Maxine Godfrey	Member, Institute of Health Record Information and Management
Christine Goldstraw	Director of Operational Services, Nottingham City Hospital NHS Trust
Barry Goodwin	Risk Manager, Brighton Healthcare NHS Trust
Helen Goodwin	The Medical Defence Union Ltd
Zoe Greenwell	Association of Domestic Management
Cathy Gritzner	General Manager, The Patients' Association
Chris Grimes	Secretary, Healthcare Financial Management Association
Barry Hall	Outpatient Services Manager, Southend Health Care NHS Trust
Marguerite Harris	Chief Executive, Dudley Group of Hospitals NHS Trust
David Head	Health and Safety Executive
John Heyworth	Honorary Secretary, British Association for Accident and Emergency Medicine
Colin Hillyard	National Secretary, Health Estate Facilities Management Association
Cheryl Hooper	Operations Director, Action for Sick Children
Ron Hoile	Consultant, Medway NHS Trust

Aknowledgements

Ian Holland	Consultant Radiologist, Queen's Medical Centre, University Hospital, Nottingham NHS Trust
Chris Humphreys	Action For Sick Children
Camilla Jenkins	Outpatients Manager, London Bridge Hospital
Mark Jennings	Director of Corporate Services and Development, St Peter's Hospital NHS Trust, Chertsy
Pam Jelly	Institute of Health Records Information and Management
Jenny Jones	Quality Assurance Manager, Llandough Hospital and Community NHS Trust
Martin Kent	Hospital Manager, Wolverhampton Nuffield Hospital
Alan Kershaw	Assistant Registrar, General Medical Council
Bill Kilvington	Chairman, The British Association of Operating Department Assistants
Felicity Leenders	Nursing Officer, Children's Services, Department of Health
PD Leigh	Secretary, The College of Optometrists
June Levick	Project Manager, NHS Estates
Keith Little	President, The Faculty of Accident and Emergency Medicine
Michael Lowe	Deputy Secretary, British Medical Association
Ros Lowe	Chief Executive, Hounslow and Spelthorne Community Health Services NHS Trust
Natalie-Jane MacDonald	Head of Clinical Services, BUPA Hospitals
Dee May	Chairman, Infection Control Nurses Association
Julie Mason	Quality Manager, The London Clinic
Maggie McDow	Quality Management Consultant, BMI Healthcare
Anne McGuinness	Clinical Director, UCLH NHS Trust
Mark Miller	Director of Contracting and Finance, Suffolk Health Authority
Lyn Mitchell	Chief Executive, National Board for Nursing, Midwifery and Health Visiting in Scotland
Jonathan Morrell	Assistant Director, South Thames Regional Office
John Morton	Head of Operational Services, Royal Bournemouth and Christchurch Hospital NHS Trust
Tony Morton	Estates Manager, Dewsbury NHS Trust
Clive Nattrass	Project Manager, NHS Estates
Katrina Neal	Professional Officer, Adult Nursing, UK Central Council for Nursing, Midwifery and Health Visiting
Sally Nethercott	Paediatric Adviser, Royal College of Nursing
Jill Norman	Clinical Nurse Manager, London Bridge Hospital
Pat Oliver	Director of Education, Institute of Sterile Services Management
Sheila Oliver	KFOA Coordinator, Hartlepool and East Durham NHS Trust

Jayne Pearce	General Secretary, The Association of Medical Secretaries, Practice Managers, Administrators and Receptionists Limited
Rob Pinsent	Director of Facilities, Glenfield Hospital NHS Trust
Janet Pratt	KFOA Coordinator, The Sloane Hospital, Beckenham, Kent
Stephen Purden	Project Manager, NHS Estates
E Pygott	Honorary Secretary, Medico-Legal Society
David Raveny	Chief Executive, Welsh National Board for Nursing, Midwifery and Health Visiting
Mike Ridley	Director of Finance and Performance Management, Sheffield Health Authority
Colin Roberts	Public Health Laboratory Service
Fiona Rowe	Orthoptic Department, Addenbrooke's NHS Trust
John Saunders	Consultant Physician, Nevill Hall and District NHS Trust
Annette Sayburn	Director of Nursing, The Portland Hospital for Women and Children
Christine Sealey	Professional Advisor, College of Occupational Therapists
Mike Shaw	Consultant Radiologist, Chesterfield and North Derbyshire Royal Hospital NHS Trust
Maureen Smillie	Chief Speech and Language Therapist, Yorkhill NHS Trust
John Smith	Practice Manager, Fakenham Medical Centre
Liz Stevens	Director of Nursing and Quality, Poole Hospital NHS Trust
Jan Sutton	Director of Patient Services, Wellhouse NHS Trust, Middlesex
Kirsteen Tait	Director, National Association for the Education of Sick Children
Susan Taylor	Director of Human Resources, BMI Healthcare
J St J Thomas	Fellow and Secretary, Royal College of Physicians of Edinburgh
Ian Torrence	Director of Occupational Health, Royal Hospitals NHS Trust
Ethel Trigg	Honorary General Secretary, Association of British Paediatric Nurses
Peter Verow	Consultant Occupational Physician, Sandwell Healthcare NHS Trust
Sue Vincent	National Chairman, National Association of Theatre Nurses
Stephen Walsh	Director of GP Liaison and Business Development, Southend Health Care NHS Trust
JD Ward	Second Vice President, Royal College of Physicians
Valerie Ward	Outpatient Facilities Manager, King's Healthcare NHS Trust

Helen Welch	Director of Quality, Bassetlaw NHS Trust
Margaret Wheatcroft	Nursing and Patient Services Director, Royal Bournemouth and Christchurch NHS Hospitals Trust
Margaret White	Theatre Services Centre Manager, Queen's Medical Centre, Nottingham, University Hospital NHS Trust
David Wilkinson	Honorary Secretary, The Association of Anaesthetists of Great Britain and Ireland
Richard Wilson	Director of Nutrition and Dietetics, King's Healthcare NHS Trust

Mental health

Gaynor Abbott	Mental Health Services Manager, Thameside Community Healthcare NHS Trust
David Ackroyd	Director of Nursing Services, Stockton Hall Hospital, Partnerships in Care
Louise Adams	Trust Group Manager, National Association of Health Authorities and Trusts
Jan Addis	Quality Nurse, Coventry Healthcare NHS Trust
Cath Arnold	Chief Officer, North Manchester Community Health Council
Simon Barnett	Consultant Psychiatrist, North West Anglia Healthcare NHS Trust
Peter Brotherhood	Complaints Officer, Stockton Hall Hospital
Jim Bosworth	Service Manager, Mental Health, Hillingdon Hospital NHS Trust
Pat Burchell	KFOA Coordinator, Richmond, Twickenham and Roehampton Healthcare NHS Trust
Nadine Butler	Community Sister, Coventry Healthcare NHS Trust
Alison Cobb	Policy Officer, MIND
Edna Conlan	Chairperson, UK Advocacy Network
Frank Corr	Director of Nursing, Partnerships in Care
Tom Foster	Member, Association of Directors of Social Services
Beverlea Frowen	Management Consultant, Centre for Mental Health Services Development
Libby Gawith	Quality Assurance Project, Sainsbury Centre for Mental Health
Jayne Gibb	Training Manager, Ticehurst House Hospital, Libra Health
Heather Gough	Quality Manager, Priory Hospitals Group
Christine Green	Chief Executive, North West Anglia Healthcare NHS Trust
Richard Grover	Community Care Consultant
Peter Handy	Therapy Services Manager, Llanarth Court Hospital
Mark Harris	Manager, Southport and Formby Community Health Services NHS Trust

Brian Hodgeson	Community Services Manager, Mental Health, North West Anglia Healthcare NHS Trust
Robert Hill	Research Associate, Sainsbury Centre for Mental Health
Simon Hiscocks	Quality Assurance Facilitator, Llandough Hospital and Community NHS Trust
Keith Horley	Project Manager, Partnerships in Care
Chris Hurd	Director of Nursing, Kneesworth Hospital
Steve James	Team Leader, Coventry Healthcare NHS Trust
Maureen Jamieson	Senior Nurse, Mental Health, Milton Keynes Community NHS Trust
Chris Ken	Consultant Psychiatrist, Richmond, Twickenham and Roehampton Healthcare NHS Trust
Mary Kong	Director of Operations, Ticehurst House Hospital, Libra Health
Terry Lee	Manager, Priory Hospitals Group
Bridget Macy	Team Leader, Elderly Mental Health, Coventry Healthcare NHS Trust
Liz McClure	Mental Health Development Coordinator, Milton Keynes Community NHS Trust
Celine McCrae	Day Hospital Manager, Coventry Healthcare NHS Trust
Matt Muijen	Director, Sainsbury Centre for Mental Health
Elaine Murphy	Professor, United Medical and Dental Schools, Division of Psychiatry and Psychology, and Chairman, City and Hackney Community NHS Trust
Graeme Pemberton	Service Manager, Mental Health, Southport and Formby Community Health Services NHS Trust
Chris Perring	Regional Director, Trent and Yorkshire MIND
Jim Read	User Consultant, Sainsbury Centre for Mental Health
Chris Riley	Senior Nurse, Cheadle Royal Hospital
Finlay Robertson	Chief Executive, Southport and Formby Community Health Services NHS Trust
Geoff Shepherd	Head of Research, Sainsbury Centre for Mental Health
Robert Stafford	Quality and Audit Manager, Stockton Hall Hospital
Kevin Stanley	Chief Executive, Milton Keynes Community NHS Trust
Philip Thomas	Consultant Psychiatrist, Priory Hospitals Group
Mark Watts	Manager, Priory Hospitals Group

Mental health users

Marion Beeforth	National Consultant to Mental Health Organisations
Colin Bobb	Bromley User Group
Richard Butler	Brent User Group
Paul Craig	Member, Sainsbury Centre for Mental Health User Group
Roberta Graley	National Trainer and User Consultant

Gillian Hedges	Banbury MIND, Oxford Moonlighting User Group
Alice Hicks	Oxford Moonlighting User Group
Gillian Mullins	UK Advocacy Network Trainer
Paul Salako	Kent User Group
Patrick Wood	UK Advocacy Network Trainer

Learning disabilities services

Gina Brocklehurst	Chief Executive, Trecare NHS Trust
Yvonne Cox	Chief Executive, Oxfordshire Learning Disability NHS Trust
Sue Critchley	Service Manager, Learning Disabilities, Milton Keynes Community NHS Trust
Stella Davies	Supporter, People First
Wendy Dodds	R&D Officer, Southend Community Care Services NHS Trust
Yvonne Dovey	Quality Assurance Manager, Mulberry NHS Trust
Malcolm Evans	Home Manager, Coventry Healthcare NHS Trust
Trenton Grieve	Business Manager, Services for People with Learning Disabilities, Richmond, Twickenham and Roehampton Healthcare NHS Trust
Gerry Hughes	Senior Manager, Learning Disabilities Services, North West Anglia Healthcare NHS Trust
Frank Kelleher	Quality Nurse Manager, Richmond, Twickenham and Roehampton Healthcare NHS Trust
Tracy Lazard	Supporter, People First
Chris Lovell	Service Development Manager, Gwent Community Health NHS Trust
Peter Ludlow	Clinical Psychologist, North West Anglia Healthcare NHS Trust
Allison Maynard	Business Planning Manager, Southport and Formby Community Health Services NHS Trust
Ann McArthur	General Manager, Coventry Healthcare NHS Trust
Chris McKenna	Programme Director, Care Perspectives
Gillian Montgomery	Trust Services Manager, Trecare NHS Trust
Dean Moon	Nursing Administration Manager, Stockton Hall Hospital
Steven Scorer	Nurse Manager, Hartlepool and East Durham NHS Trust
Kevin Simpson	Clinical Services Manager, Trecare NHS Trust
Nigel Smith	Director, Care Perspectives
Brian Stocker	Community Worker, People First
Helen Thorne	Freelance Management Consultant, Outlook Associates
Ros Urwin	Head Occupational Therapist, Dorset Healthcare NHS Trust
Tracey Wadham	Business Planning and Contracts Manager, Trecare NHS Trust

Deirdre Ward	Locality Manager, Southend Community Care Services
Chang Weng	Service Manager, North West Anglia Healthcare NHS Trust
Simon Whitehead	Deputy Director, National Development Team for People with Learning Disabilities

Community services

Chris Albani	Management Facilitator, Croydon Community Health NHS Trust
Jenny Balfe	District Nurse, Coventry Healthcare NHS Trust
Pearl Brown	Chief Executive, Riverside Community Health Care NHS Trust
Sally Brown	General Manager, Community Hospitals, Dorset Healthcare NHS Trust
Sue Botes	Professional Officer, Community Practitioners' and Health Visitors' Association
Margaret Buttigieg	Regional Nurse, South and West Region
Christopher Clifford	Senior Nurse, Milton Keynes Community NHS Trust
Margaret Copeland	Director of Speech and Language Therapy, Milton Keynes Community NHS Trust
Liz Cownden	Neighbourhood Manager, Croydon Community Health NHS Trust
Julie Dent	Head of Quality Division, NHS Executive
Allyson Downes	Quality Advisor, Coventry Healthcare NHS Trust
Christine Driscoll	Clinical Audit Coordinator, Croydon Community Health NHS Trust
Graham Elston	Director of Human Resources, Coventry Healthcare NHS Trust
Sue Gooding	Clinical Nurse Specialist, Dorset Healthcare NHS Trust
Valerie Goodwin	Freelance Management Consultant
Ray Gorin	Projects Officer, Thameside Community Healthcare NHS Trust
Sue Gurr	Service Development Manager, North West Anglia Healthcare NHS Trust
Bernie Hartley	Business Development Manager, Southport and Formby Community Health Services NHS Trust
Dawn Harwood	Professional Development Facilitator, North West Anglia Healthcare NHS Trust
Penny Hodgson	Public Health Nurse, Richmond, Twickenham and Roehampton Healthcare NHS Trust
Jenny Hugman	Clinical Practice Development Nurse, Milton Keynes Community NHS Trust
I Ingle	Associate Specialist, Surgery, North West Anglia Healthcare NHS Trust
Sue Johnson	Director of Finance, Southport and Formby Community Health Services NHS Trust

Aknowledgements

William Jones	Locality General Manager, North Derbyshire Community Healthcare NHS Trust
Philip Kennedy	Neighbourhood Manager, Croydon Community Health NHS Trust
Janet Kuduskar	Health Visitor, Coventry Healthcare NHS Trust
Barbara Lamb	Director, Clinical Development Unit, Southport and Formby Community Health Services NHS Trust
Kathy Leeks	Service Manager, Community Hospital, Milton Keynes Community NHS Trust
Huw Lloyd	Member, Royal College of General Practitioners
Sue Machell	Chief Executive, Croydon Community Health NHS Trust
Lyn Moralee	Quality Assurance Facilitator, Dorset Community NHS Trust
Jayne Mottershead	Locality Manager, Southport and Formby Community Health Services NHS Trust
Christopher Palmer	Corporate Support Manager, North West Anglia Healthcare NHS Trust
Malcolm Pringle	Director of Services, Newcastle City Health NHS Trust
Michael Proctor	Director of Patient Services, Northumberland Community Health NHS Trust
Suzanne Rastrick	Community Hospital Manager, Dorset Healthcare NHS Trust
Phyllis Shelton	Deputy Director of Contracting, North West Anglia Healthcare NHS Trust
Helen Smith	Therapy Manager, Croydon Community Health NHS Trust
Pam Smith	Head of Speech and Language Therapy, Southend Community Care Services NHS Trust
June Tripp	Community Hospital Manager, Dorset Healthcare NHS Trust
Richard Walker	Facilities Manager, South Tees Community and Mental Health NHS Trust
Cathy Warlow	Quality and Clinical Audit Coordinator, Southport and Formby Community Health Services NHS Trust
Sue Warner	Community Nurse Manager, North West Anglia Healthcare NHS Trust
Liz Wolstenholme	Head, Community Care Unit, NHS Executive
Tom Woods	Business Planning Manager, Pembrokeshire NHS Trust
Lyn Young	Community Health Advisor, Royal College of Nursing

In addition, the following organisations were consulted on appropriate sections of the manual:

Academy of Medical Royal Colleges and Their Faculties in the UK
Anglia and Oxford Regional Office
Action for Sick Children
Association of British Paediatric Nurses
Association of Anaesthetists of Great Britain and Ireland
Association of Community Health Councils for England and Wales
Association of Clinical Pathologists
Association of Directors of Social Services
Association of Domestic Management
Association of Healthcare Human Resources Management
Association for Improvements in the Maternity Services
Association of Medical Secretaries, Practice Administrators and Receptionists Ltd
Association of National Health Occupational Physicians
Association of Optometrists
British Association for Accident and Emergency Medicine
British Association of Day Surgery
British Association of Occupational Therapy, College of Occupational Therapists
British Association of Operating Department Assistants
British Association of Otorhinolaryngologists
British Dietetic Association
British Institute of Learning Disabilities
British Institute of Radiology
British Medical Association
British Orthoptic Society
Carers National Association
College of Optometrists
Community Hospital Association
Community Practitioners' and Health Visitors' Association
Department of Health Community Care Unit
English National Board for Nursing, Midwifery and Health Visiting
Equal Opportunities Commission
Faculty of Accident and Emergency Medicine
Faculty of Occupational Medicine
General Medical Council
Greater London Association of Community Health Councils
Health and Safety Executive
Healthcare Financial Management Association
Health Estates Facilities Management Association
Independent Healthcare Association
Infection Control Nurses' Association
Institute of Health Record Information and Management (UK)

Institute of Sterile Services Management
Institute of Wastes Management
Local Government Association
Medical Defence Union Limited
Medical Protection Society
Medico-Legal Society
Mental Health Act Commission
Mental Health Foundation
MIND
National Association for Healthcare Security
National Association for the Education of Sick Children
National Association of Hospital Fire Officers
National Association of Hospital Portering Management
National Association of Theatre Nurses
National Board for Nursing, Midwifery and Health Visiting for Scotland
National Consumer Council
National Development Team for People with Learning Disabilities
National Pharmaceutical Association
NHS Confederation
NHS Estates
NHS Executive
North Thames Regional Office
North West Regional Office
Northern and Yorkshire Regional Office
People First
Public Health Laboratory Service
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing of the United Kingdom
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Physicians of London
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Speech and Language Therapists
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal Pharmaceutical Society of Great Britain
Sainsbury Centre for Mental Health
Society of Chiropodists and Podiatrists
Society of Hospital Linen Service and Laundry Managers
Society of Occupational Medicine

Scottish Association for Mental Health
Scottish Association of Health Councils
Scottish Pharmaceutical General Council
South and West Regional Office
South Thames Regional Office
Survivors Speak Out
The Chartered Society of Physiotherapy
The Patients' Association
Trent Regional Office
UK Advocacy Network
United Kingdom Central Council for Nursing, Midwifery and Health Visiting
Welsh Health Authorities Corporate Support Unit
Welsh National Board for Nursing and Midwifery and Health Visiting
West Midlands Regional Office

KFOA contributors:

Jackie Bridges	Survey Manager
Janet Delves	Development Worker, Primary Care
Helen Crisp	Development Worker, Acute Services
Andrea Groom	Survey Manager
Carol Joughin	Survey Manager
Caroline Machray	Development Worker, Health Authorities
Philip Tyler	Client Manager
Sally-Anne Vidall	Project Manager, Community Services Accreditation
Joan Woodcock	Survey Manager
Karen Wright	Standards Development Manager

In particular, thanks go to:

- Judy Roberts and Velda Hinds, project secretaries, for their invaluable help and endless patience during the production of these standards

- Phil Orwin, General Management Training Scheme secondee, for his work in pulling together the workshop results into the first draft of the standards manual.

Section 1

Corporate Management

Standard 1	Mission and Objectives	3
Standard 2	Management Arrangements and Corporate Governance	7
Standard 3	Contracting for Services	19
Standard 4	Information Management and Technology	26
Standard 5	Financial Resources	31
Standard 6	Human Resources	40
	Human Resources - Occupational Health	47
Standard 7	Communication	54
Standard 8	Estates Management	59
Standard 9	Risk Management	69
	Risk Management - Health and Safety	73
	Risk Management - Fire Safety	77
	Risk Management - Infection Control	82
	Risk Management - Waste Disposal	86
	Risk Management - Security	89
Standard 10	Quality Improvement	95

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 1

Mission and Objectives

The organisation has a clear set of objectives that are used as a means of assessing, planning, implementing and evaluating the service offered to the local population.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Mission		
1.1 There is a written mission statement which is developed with input from staff throughout the organisation.	☐☐☐ B	
1.2 The mission statement is made available:		
1.2.1 to the general public	☐☐☐ B	
1.2.2 to staff within the organisation	☐☐☐ B	
1.2.3 to other health and related organisations	☐☐☐ B	
1.2.4 in a variety of formats.	☐☐☐ C	
GUIDANCE *This includes, for example:* • *simple, jargon-free language* • *translations in languages appropriate for the local population* • *braille, audio and visual tapes* • *Makaton symbols, photographs, pictures.*		
1.3 The organisation reviews its mission statement as part of the strategic direction planning cycle.	☐☐☐ B	

CRITERIA

Objectives and business planning

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

1.4 There is a written strategic direction document for the organisation. ☐☐☐ A

1.5 The strategic direction document:

- 1.5.1 identifies the organisation's aims and objectives ☐☐☐ A
- 1.5.2 is developed with input from clinical and non-clinical staff ☐☐☐ A
- 1.5.3 is developed in consultation with the purchasers ☐☐☐ A
- 1.5.4 is in line with Priorities and Planning Guidance for the NHS ☐☐☐ A
- 1.5.5 is available to all staff ☐☐☐ A
- 1.5.6 is publicised widely. ☐☐☐ B

1.6 There is an annual business plan for the organisation. ☐☐☐ A

1.7 The business plan:

- 1.7.1 sets out plans for achieving the organisation's objectives ☐☐☐ A
- 1.7.2 is developed with input from clinical and non-clinical staff ☐☐☐ A
- 1.7.3 is available to all staff ☐☐☐ A
- 1.7.4 is publicised widely ☐☐☐ B
- 1.7.5 is sufficiently measurable to allow annual review by the organisation's board. ☐☐☐ B

1.8 The main purchasers are consulted as part of the business planning process. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 2

Management Arrangements and Corporate Governance

There is a clear management structure in place which enables the organisation to achieve its mission and objectives.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management structure		
2.1 There is a published organisational structure: 2.1.1 with defined lines of accountability and specification of roles 2.1.2 which is regularly reviewed.	☐☐☐ A ☐☐☐ A	
2.2 There are executive directors on the board with designated responsibilities for all aspects of the organisation.	☐☐☐ A	
2.3 There is a designated deputy for the chief executive or equivalent (this may be rotated around the executive directors) to cover in the absence of the chief executive.	☐☐☐ B	
2.4 The roles, functions and responsibilities of the chief executive, the chairman, the non-executive members and the executive members of the board are clearly set out in a public document.	☐☐☐ A	
2.5 There is a document which states the constitutional arrangements of the organisation which: 2.5.1 has regard for central statute and national guidelines on corporate governance	☐☐☐ A	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
2.5 continued		
2.5.2 is approved by the board of directors.	☐☐☐ A	
GUIDANCE *The document includes, for example:* • *a description of the powers and duties of the board of directors* • *a scheme of delegation* • *standing orders* • *standing financial instructions.*		
2.6 This document is made accessible to all staff.	☐☐☐ A	
2.7 The board of directors and designated individual managers ensure that:		
2.7.1 the management board of the organisation meets regularly and that meetings are minuted	☐☐☐ A	
2.7.2 the key issues resulting from board and other meetings are communicated to staff	☐☐☐ B	
2.7.3 the advice of medical, nursing, other clinical and non-clinical staff and specialists on the development of organisational policy is systematically sought	☐☐☐ A	
2.7.4 the views and experiences of patients/users and others in the community are systematically sought in the development of organisational policy and plans.	☐☐☐ B	
2.8 There is a register of directors' interests relevant to NHS business.	☐☐☐ A	
2.9 The register is:		
2.9.1 reviewed on a systematic basis	☐☐☐ A	
2.9.2 open to public inspection.	☐☐☐ A	
2.10 There is an up-to-date register of gifts and hospitality received by directors and members of staff.	☐☐☐ B	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
2.11 There is a financial audit committee with terms of reference.	☐☐☐ A	
GUIDANCE *These include, for example:* • *membership* • *limits to powers* • *arrangements for reporting back to the board.*		
2.12 There is a remuneration and terms of service committee with terms of reference.	☐☐☐ A	
GUIDANCE *The committee's terms of reference should cover at least the executive directors and senior managers of the trust.*		
2.13 There is a designated secretary to the board or one or more designated persons who take responsibility for board secretary activities.	☐☐☐ A	
2.14 The responsibilities of the secretary are defined.	☐☐☐ A	
GUIDANCE *These include, for example:* • *maintaining standing orders* • *maintaining standing financial instructions in liaison with the director of finance* • *retaining the corporate seal and its applications* • *keeping a register of directors' interests.*		
2.15 The board publishes:		
2.15.1 an annual report	☐☐☐ A	
2.15.2 annual accounts.	☐☐☐ A	
2.16 The annual report and annual accounts are made available to the public.	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
2.17 There is a widely publicised procedure enabling staff to raise their concerns about maladministration, breaches of codes of conduct and accountability and other concerns of an ethical nature.	☐☐☐ A	

Corporate policies and procedures

2.18 Corporate policies and procedures are:

2.18.1 developed in accordance with statutory requirements ☐☐☐ A

GUIDANCE
This includes, for example:
- *legislation which affects any aspect of the organisation's work*
- *Health Service Guidelines.*

2.18.2 developed with staff ☐☐☐ A

GUIDANCE:
This includes, for example, staff representatives from professional associations and trade unions.

2.18.3 dated ☐☐☐ B

2.18.4 published with the name of the post/person responsible for drafting and review ☐☐☐ B

2.18.5 centrally indexed and compiled into a policy manual ☐☐☐ A

2.18.6 disseminated throughout the organisation ☐☐☐ A

2.18.7 available to all staff on request ☐☐☐ A

2.18.8 subject to a systematic review process ☐☐☐ A

2.18.9 officially ratified by the organisation and subsequent to policy review all amendments are ratified by the same group. ☐☐☐ B

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

2.18 continued

GUIDANCE
The group that ratifies policies may, for example, be the trust board.

2.19 The activities of the organisation are monitored to ensure that they are consistent with corporate and national policies. ☐☐☐ B

Complaints and untoward incidents

2.20 Policies and procedures are developed for patient/user and staff complaints (see also standards 17-19 The Patient's Rights and Individual Needs). ☐☐☐ A

GUIDANCE
- *There should be a specified complaints procedure in accordance with the Wilson Report and the NHS Complaints Procedure guidance EL (96) 19.*
- *The response to complaints should be completed within a four-week timescale, or acknowledgement sent and explanation of why it will take longer than four weeks to conclude.*
- *The complaints procedure should include details of the independent review panel and how this is activated.*

2.21 There is information for patients/users, carers and staff which details how to complain about the organisation's services. ☐☐☐ A

2.22 Corporate records are kept of all complaints and these records include action taken. ☐☐☐ A

Valid consent

2.23 There are up-to-date, documented corporate policies and procedures for obtaining valid consent from patients/users. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

2.23 continued

GUIDANCE

The policies and procedures include reference to, for example:

- *routine medication*
- *anaesthesia*
- *sedation*
- *electroconvulsive therapy*
- *participation in research projects*
- *photographic and audiovisual recording*
- *surgical procedures*
- *unusual medications and routes of administration*
- *hazardous assessment procedures.*

Admission and discharge

2.24 There is an up-to-date, documented corporate policy for admission to the organisation's services. ☐☐☐ A

GUIDANCE

The corporate policy covers, for example:

- *routine admission*
- *the special needs of children to be taken into consideration when developing admissions policies (see also standard 28 Children's Services)*
- *an individual with designated responsibility for admissions.*

The corporate policy should provide a framework for individual services to build upon for service specific procedures (see also standard 20 Referrals, Access and Admission).

2.25 There is an up-to-date, documented corporate policy for the safe discharge of the patient/user. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

2.25 continued

GUIDANCE
The policy covers, for example:
- *liaison with the patient's/user's general practitioner and other services*
- *issues relating to supervised discharge of patients/users*
- *ensuring that no NHS patient/user is discharged to a nursing/residential home against his/her wishes if he/she or a relative is personally responsible for paying the home's fees*
- *information on funding if long-term nursing care is required*
- *the need for discharge planning to begin on the day of admission or before admission where possible.*

The corporate policy should provide a framework for individual services to build upon for service specific procedures (see also The Patient's Journey, standard 22 Leaving a Service/Discharge).

Advocacy

2.26 There is an up-to-date, documented corporate policy on advocacy. ☐☐☐ B

GUIDANCE
This includes, for example:
- *agreement by the advocacy service, the provider and the purchaser*
- *how the service understands the issues relating to advocacy and how it will respond to the individual needs of the care group (see also standard 45 Mental Health and standard 34 Learning Disabilities - Advocacy).*

Patient/user and carer involvement

2.27 There is an up-to-date, documented policy on patient/user/carer and carer involvement. ☐☐☐ B

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

2.27 continued

GUIDANCE
This sets out, for example, the overall aims of the organisation with regard to the involvement of patients/users and carers in the development and delivery of services in order to provide a framework for individual departments to implement as appropriate (see also standard 19 Partnership With Patients).

2.28 There is an up-to-date, documented policy on obtaining feedback from patients/users of the service and their carers. ☐☐☐ B

GUIDANCE
This sets out, for example, the overall objectives of the organisation with regard to gathering and using this feedback, providing a corporate framework within which individual departments/services can develop mechanisms as appropriate.

Health promotion

2.29 The organisation has a strategy to encourage the general health of patients/users and staff. ☐☐☐ B

GUIDANCE
The strategy includes, for example:
- *a lead person with responsibility for health promotion*
- *objectives for health promotion in service development planning*
- *information systems for disseminating health promotion materials*
- *objectives for staff health checks and health screening (see also standard 6 Human Resources - Occupational Health)*

2.30 The strategy takes into consideration NHS targets and priorities. ☐☐☐ B

GUIDANCE
This may include Health of the Nation targets, where applicable.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Waiting list management

2.31 There is an up-to-date, documented policy for the management of waiting lists. ☐☐☐ B

2.32 A senior manager has designated responsibility for the development, implementation and monitoring of the waiting list management policy. ☐☐☐ B

2.33 Waiting lists are reviewed on a systematic basis in line with current guidance. ☐☐☐ B

GUIDANCE
This review includes, for example:
- *that all patients/users on the list are still in need of treatment*
- *that personal details are up to date.*

Death of a patient/user

2.34 There is a policy for dealing with the deceased (including babies and children) (see also standard 28 Children's Services). ☐☐☐ A

GUIDANCE
Procedures include, for example:
- *referral to the coroner*
- *dealing with personal effects*
- *observing the religious beliefs and traditions of minority ethnic groups (see also standard 18 The Patient's Individual Needs)*
- *arranging burial/cremation if necessary.*

Joint planning

2.35 Members of joint planning groups with other agencies have clear lines of accountability. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

2.36 Joint planning groups develop strategies which are consistent with the mission and objectives of the organisation. ☐☐☐ B

Equality of opportunities and antidiscriminatory practices

2.37 There is an up-to-date, documented policy on equality of opportunity and antidiscriminatory practices. ☐☐☐ A

GUIDANCE
This includes, for example:
- *statements on race, culture, language, gender, disability, sexual orientation, age, religion*
- *statements on patients/users with mental health problems and learning disabilities.*

2.38 The equality of opportunity policy is available to:

2.38.1 staff ☐☐☐ A
2.38.2 patients/users ☐☐☐ A
2.38.3 carers. ☐☐☐ A

2.39 Data collection and monitoring of equal opportunities are carried out. ☐☐☐ A

GUIDANCE
This should be in line with Ethnic Monitoring of Staff in the NHS: a programme of action EL (94) 12 and Collection of Ethnic Group Data for Admitted Patients EL (94) 77.

2.40 Findings from the data collection and monitoring are acted upon. ☐☐☐ A

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 3

Contracting for Services

There are written, signed contracts/agreements for all services (clinical and non-clinical) provided or purchased by the organisation.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
General		
3.1 There is a contract negotiation and review process which is:		
3.1.1 timetabled	☐☐☐ B	
3.1.2 agreed between purchaser and provider	☐☐☐ B	
3.1.3 published.	☐☐☐ B	
3.2 The business planning and contracting cycle links in to the main purchasers' planning cycles.	☐☐☐ B	
3.3 Formal communication links are established with the purchasers.	☐☐☐ B	
3.4 There is ongoing discussion and consultation with the purchasers throughout the contracting, planning, agreement, monitoring and review stages.	☐☐☐ B	
3.5 Roles and responsibilities within the organisation for negotiating and agreeing contracts are defined and documented.	☐☐☐ B	

GUIDANCE
This includes, for example, negotiations and agreements with individual or groups of GP fundholders.

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
3.5 continued		
All people involved in discussions should have a clear level of authority for decision making.		
3.6 The purchasing intentions documents received from the purchasers are disseminated to all directorates to assist with service business planning.	☐☐☐ B	
GUIDANCE *This includes GP fundholder purchasing plans.*		
Contingency arrangements should be considered early on to compensate for changing purchaser priorities or changes in contract currency such as moving from output episodes to packages of care.		
3.7 Costing information is published.	☐☐☐ A	
GUIDANCE *The organisation should produce a tariff which is available to all organisations involved in the contracting process.*		
This includes the use of costed health care resource groupings (HRGs), as set out in EL (96) 64, relating to surgical procedures in England.		
3.8 Clinical and non-clinical staff responsible for delivering the service are involved in:		
3.8.1 contract negotiations	☐☐☐ B	
3.8.2 determination of activity targets	☐☐☐ B	
3.8.3 determination of quality indicators.	☐☐☐ B	
3.9 There is patient/user input to the contracting process through the use of feedback, satisfaction survey results and other initiatives.	☐☐☐ B	
3.10 All contracts are signed by purchasers and providers.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

3.11 There is a central register of contracts. ☐☐☐ A

GUIDANCE
The register is clearly set out and indexed.

All contracts are included in the register.

3.12 Contracts include specifications on:

3.12.1 the length and type of contract (for example: block, cost and volume, cost per case) ☐☐☐ B

3.12.2 the cost of the contract with a definition of the pricing used ☐☐☐ A

3.12.3 the payment method/instalment frequency ☐☐☐ B

3.12.4 defined activity levels ☐☐☐ A

3.12.5 quality monitoring arrangements ☐☐☐ B

3.12.6 currencies ☐☐☐ B

GUIDANCE
Agreed units of measurement, for example, completed consultant episodes.

3.12.7 incentives and penalties and the triggers for these ☐☐☐ B

3.12.8 the notice required for termination ☐☐☐ B

3.12.9 arbitration and conciliation arrangements. ☐☐☐ B

3.13 There are formal arrangements for contract review. ☐☐☐ B

3.14 Records of contract reviews are kept. ☐☐☐ B

GUIDANCE
These records include details of any amendments or additions made to the contract.

3.15 There is an up-to-date, documented procedure for agreeing and authorising amendments to service contracts. ☐☐☐ B

3.16 There are clear monitoring and reporting arrangements to the purchaser. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

3.17 The staff involved in delivering the contracts:

3.17.1 are involved in their monitoring and review ☐☐☐ B

3.17.2 receive copies of any monitoring reports which are sent to the purchaser. ☐☐☐ B

3.18 There are defined contract information systems. ☐☐☐ B

GUIDANCE
There is a named individual to respond to purchaser queries.

Queries are responded to within specified timescales.

Mechanisms to report to the board are in place.

3.19 There is a system for the identification of the purchaser for each patient/user. ☐☐☐ B

3.20 Invoices are issued for all contracts within specified timescales. ☐☐☐ B

GUIDANCE
Invoices must be issued to GP fundholders within the agreed timescale (six weeks) or payment can be affected. Letters from consultants need to be issued promptly and systematically if this is the trigger for invoice issue.

Staff training and development

3.21 There is a programme for updating and training staff on contracting issues. ☐☐☐ C

Service level agreements

3.22 Service level agreements are drawn up and available for all services purchased by the organisation. ☐☐☐ A

GUIDANCE
This includes internal purchasing arrangements.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

When drawing up service level agreements the following aspects are, for example, considered:

- *a definition of the service*
- *a requirement for the provision of services by trained and qualified staff and supervision of unqualified staff*
- *planned reviews of each specialty involving consultants, managers, general practitioner users and patients/users*
- *progress towards achieving outcomes identified by Health of the Nation targets (where applicable) and other national priorities*
- *the frequency and content of reporting requirements*
- *protocols of care which indicate the responsibilities of general practitioners, community health staff and organisation staff*
- *tertiary referral policy and procedures for clinical services*
- *community health council access to inspect facilities for clinical services*
- *a mechanism for monitoring and maintaining the quality of service*
- *arrangements for after hours and emergency services where applicable*
- *adequacy of facilities and equipment for the service being provided both in the organisation and at the site of the external service.*

3.23 Compliance with service level agreements is monitored and reviewed. ☐☐☐ A

Extracontractual referrals

3.24 There is a documented procedure for managing extracontractual referrals. ☐☐☐ B

3.25 There is a documented procedure for managing tertiary referrals. ☐☐☐ B

3.26 Financial and non-financial reporting arrangements are in place. ☐☐☐ B

3.27 These procedures are monitored. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 4

Information Management and Technology

There are systems to collect and produce accurate, timely and relevant information which is used as a basis for decision making.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
4.1 There is an up-to-date, documented information management and technology strategy for the organisation.	☐☐☐ A	

GUIDANCE
This is in line with the Strategy for Information Management and Technology in the NHS (1992) and includes the development of information systems to support, for example:
- *minimum data sets*
- *interpretation of contract minimum data sets*
- *requirements of the contracting framework, for example HRGs (health care resource groupings)*
- *purchaser requirements (GP fundholders and health authorities/boards)*
- *operational requirements*
- *access to demographic and clinical data held on other operational systems*
- *the collation and aggregation of data for audit purposes.*

4.2 The information management and technology strategy is:		
4.2.1 based on the organisation's strategic direction and business plan	☐☐☐ A	
4.2.2 approved by the board	☐☐☐ B	
4.2.3 shared with the main purchasers.	☐☐☐ B	
4.3 There are information systems to:		

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
4.3 continued		
4.3.1 support clinical audit	☐☐☐ B	
4.3.2 collect financial data	☐☐☐ B	
4.3.3 collect data to assist with planning and contracting	☐☐☐ B	
GUIDANCE *This includes, for example:* • *purchaser's requirements for coding using a current version of the ICD and OPCS procedure codes* • *identification of the purchasing authority for each patient/user seen* • *assigning of contract numbers to each patient/user episode* • *ethnic monitoring of all patients in line with Collection of Ethnic Group Data for Admitted Patients EL (94) 77.*		
4.3.4 supply required information to comply with NHS monitoring arrangements (for example, Patient's Charter data and core clinical indicators)	☐☐☐ A	
4.3.5 record completed activity levels within specified timescales	☐☐☐ B	
4.3.6 supply data that monitors progress towards Health of the Nation targets (where applicable)	☐☐☐ B	
4.3.7 record patient/user workload per individual consultant per ICD code (where applicable)	☐☐☐ B	
4.3.8 supply theatre utilisation data and workload per consultant per OPCS code (where applicable).	☐☐☐ B	
4.4 The effectiveness of the information systems is reviewed on a regular basis.	☐☐☐ B	
GUIDANCE *This includes, for example:* • *information for management decision making being systematically reviewed* • *information users' views being regularly sought as a means of improving the collection and dissemination of information* • *data being regularly sampled with regard to accuracy, completeness and timeliness.*		

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
4.5 Confidentiality is maintained in accordance with current legislation.	☐☐☐ A	
GUIDANCE *All information staff and other users of information systems should be aware of the provisions of the Data Protection Act 1984.*		
4.6 Unauthorised access to information systems is prevented.	☐☐☐ A	
4.7 There is an up-to-date, documented data security policy.	☐☐☐ A	
4.8 Monthly monitoring information integrates activity with finance and manpower information.	☐☐☐ B	
4.9 There are up-to-date, documented procedures for computing and network services disaster recovery (see also standard 9 Risk Management).	☐☐☐ A	
4.10 Staff throughout the organisation who use the information systems are trained and supported to:		
4.10.1 input data	☐☐☐ A	
4.10.2 use and interpret information.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 5

Financial Resources

There is a robust financial strategy which enables the organisation to meets its objectives.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Operational issues		
5.1 There is a financial plan which is written annually, in line with the business plan and the strategic direction document.	☐☐☐ A	
5.2 Budgets are devolved to line managers.	☐☐☐ B	
5.3 Budgets are developed in collaboration with budget holders.	☐☐☐ B	
5.4 Budget holders receive financial training and guidance.	☐☐☐ B	
5.5 Each budget holder has a named finance officer to whom to refer.	☐☐☐ B	
5.6 User-friendly extracts from standing orders and standing financial instructions are sent to budget holders.	☐☐☐ B	
5.7 Budget statements are distributed to all managers and budget holders at specified times.	☐☐☐ A	
5.8 A finance report is produced monthly for the executive management team and the trust board.	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

5.8 continued

GUIDANCE
This includes, for example:
- *the financial position to date*
- *year-end forecast*
- *areas requiring action*
- *a balance sheet*
- *cash flow forecast*
- *compliance with the external finance limit*
- *the integration of activity and manpower information.*

5.9 The report is in a format that is approved by the board. ☐☐☐ B

5.10 Reasons for budget variation in either income or expenditure are established. ☐☐☐ B

5.11 Annual audited accounts are produced (see also standard 2 Management Arrangements and Corporate Governance). ☐☐☐ A

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

GUIDANCE
This includes, for example:
- *an analysis of the duration of the debt, routinely produced for the board and the executive management team*
- *written procedures for debt recovery, which are instigated routinely*
- *the review of bad debts at least every six months.*

There are up-to-date, documented procedures for the payment of creditors which are regularly monitored.

There is timely raising of invoices.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
5.13 The investment of surplus funds is in accordance with guidelines issued by the NHS Executive.	☐☐☐ A	

Asset management

5.14 There is a routinely maintained capital asset register.	☐☐☐ A	
5.15 There is a capital asset replacement programme.	☐☐☐ A	
5.16 There is an up-to-date inventory system.	☐☐☐ B	

GUIDANCE
This includes items costing less than £5,000 per item and more than £1,000, previously on the fixed asset register, and portable items such as computers, mobile telephones, fax machines.

5.17 The level and security of stock is managed and regularly audited.	☐☐☐ A	

Management of charitable funds

5.18 Charitable or endowment funds held by the organisation are properly accounted for.	☐☐☐ A	

GUIDANCE
This includes, for example, future commitments and outstanding legacies.

5.19 Any surplus charitable or endowment funds are invested in accordance with current legislation and the investment strategy of the trustees.	☐☐☐ A	

GUIDANCE
In most instances the organisation is the sole corporate trustee. In this instance, charitable or endowment funds should be covered by the standing

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
5.19 continued		
orders of the organisation.		
Organisations holding charitable funds should be aware of the provisions of the Charities Act 1992 and the Trustee Investment Act 1961.		
Further guidance can be found in NHS Charitable Funds, a guide issued by the Charity Commissioners.		
5.20 There is an annual report to the board on the investment performance of charitable funds.	☐☐☐ A	
5.21 The annual accounts and report are filed with the Charity Commissioners.	☐☐☐ A	
Policies and procedures		
5.22 There are up-to-date, documented policies and procedures for all financial and accounting functions.	☐☐☐ A	
GUIDANCE *These include, for example:* • *exchequer services* • *non-exchequer resource management* • *financial accounting* • *management accounting* • *treasury management.*		
5.23 These policies and procedures are reviewed annually.	☐☐☐ B	
5.24 Patients'/users' monies and bank accounts held by the organisation are controlled and accounted for.	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

5.24 continued

GUIDANCE
Policies and procedures are in place regarding safekeeping and expenditure of patients'/users' monies.

5.25 There is information available for patients/users about the systems for holding, managing and accounting for patient/user monies. ☐☐☐ A

GUIDANCE
This information is, for example:
- *written in jargon-free language*
- *translated into appropriate languages for the local population*
- *available in a range of formats including, large print, audio tape and symbols/pictures for learning disability services.*

5.26 Policies and procedures are set up and maintained to prevent fraud at all stages of financial transactions. ☐☐☐ A

GUIDANCE
This includes, for example, all cash arrangements, authorisation for purchasing from the organisation's suppliers, banking and payroll.

Audit arrangements

5.27 The organisation maintains an internal audit system. ☐☐☐ A

GUIDANCE
Internal audit is sufficiently independent to allow the auditors to perform their duties in a manner which enables professional judgements and recommendations to be effective and impartial.

Internal auditors:

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
5.27 continued		
• *seek to foster constructive working relationships and mutual understanding with management, external auditors, any other review agencies and the audit committee* • *use a systems-based approach to identify and evaluate the soundness, adequacy and application of financial and other management controls* • *have direct access to the chair of the audit committee* • *obtain sufficient, relevant and reliable evidence on which to base conclusions and recommendations.*		
5.28 Internal and external audit reports are considered by the organisation's financial audit committee.	☐☐☐ A	
5.29 Recommendations from these reports are acted upon.	☐☐☐ A	
Value for money		
5.30 The organisation carries out value-for-money testing.	☐☐☐ B	
5.31 The reports from value-for-money studies are used to inform future business planning and purchasing of goods and services.	☐☐☐ B	
Purchasing of supplies		
5.32 Responsibility for the purchasing of supplies and equipment is documented.	☐☐☐ B	
5.33 Supplies and equipment are purchased against written specifications.	☐☐☐ B	
GUIDANCE *Specifications are drawn up by or in conjunction with the supplies/equipment end-user service.*		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

5.34 There are documented procedures for checking goods received against the purchase specification. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 6

Human Resources

There is a human resource strategy and human resource policies and procedures which enable the organisation to meet its objectives.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.1 There is an up-to-date, documented human resource strategy.	☐☐☐ A	

GUIDANCE
The following issues are considered when drawing up the strategy:
- *skills and qualifications required to run the organisation's services*
- *recruiting and retaining staff*
- *redundancy/out-placement of staff*
- *staff training and development*
- *health at work*
- *labour utilisation*
- *employee relations*
- *equal opportunities, including the ethnic monitoring of staff*
- *managing performance*
- *pay and reward mechanisms*
- *milestones for review of the strategy.*

6.2 The human resource strategy is communicated throughout the organisation.	☐☐☐ B	
6.3 The human resource strategy is reviewed on an annual basis.	☐☐☐ B	
6.4 Human resource policies and procedures comply with employment legislation.	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

6.4 continued

GUIDANCE
This includes:
- *Sex Discrimination Act 1975*
- *Race Relations Act 1976*
- *Disability Discrimination Act 1995*
- *Welsh Language Act 1993.*

Recruitment and selection

6.5 There is a documented procedure for the recruitment and selection of all staff. ☐☐☐ B

GUIDANCE
The procedure includes, for example, details on:
- *guidelines for advertising posts*
- *job descriptions*
- *person specifications*
- *selection criteria*
- *obtaining references*
- *health screening*
- *issuing the letter of appointment*
- *checking qualifications*
- *checking criminal convictions.*

These points should also apply to the recruitment and screening of volunteers.

6.6 Recruitment procedures adhere to the equality of opportunities policy (see also standard 2 Management Arrangements and Corporate Governance). ☐☐☐ A

GUIDANCE
This includes, for example, the ethnic monitoring of staff in line with Ethnic Monitoring of Staff in the NHS: a programme of action EL (94) 12. Adherence to the policy is monitored.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.7 All staff receive written contracts of employment within eight weeks of appointment.	☐☐☐ A	
6.8 All employees have access to written terms and conditions of service.	☐☐☐ A	
6.9 Individual employees are consulted and/or informed of any changes to the terms and conditions of their employment.	☐☐☐ A	
6.10 Job descriptions are:		
6.10.1 issued for all posts	☐☐☐ B	
6.10.2 reviewed when the job is readvertised.	☐☐☐ B	
6.11 All personnel records are maintained in a confidential manner.	☐☐☐ A	

GUIDANCE
These records include, for example:
- *application form/curriculum vitae*
- *references*
- *the contract of employment and any amendments issued*
- *an up-to-date job description*
- *details of qualifications held*
- *records of leave and sickness*
- *performance review details.*

Orientation and induction

6.12 All newly appointed staff complete a corporate induction system which includes:		
6.12.1 fire	☐☐☐ A	
6.12.2 health and safety	☐☐☐ A	
6.12.3 patient/user confidentiality	☐☐☐ A	
6.12.4 accident and untoward incident reporting	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

6.12 continued

6.12.5 security ☐☐☐ A
6.12.6 pay arrangements ☐☐☐ B
6.12.7 organisational values and objectives ☐☐☐ B
6.12.8 introduction to the staff handbook. ☐☐☐ B

GUIDANCE
Volunteers working in the organisation should have access to the corporate induction programme.

6.13 The completion of the corporate induction programme is recorded. ☐☐☐ A

Training and development

6.14 There is an up-to-date, documented training and development strategy. ☐☐☐ A

GUIDANCE
The strategy addresses, for example:
- *the needs of the individual as identified within the performance review system*
- *the needs which arise as the result of changes in practice, the law and the introduction of new technology*
- *staff development.*

6.15 Educational and developmental opportunities for staff are publicised. ☐☐☐ B

GUIDANCE
These include, for example:
- *courses*
- *vocational qualifications*
- *on-the-job development opportunities.*

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.16 There is access to programmes of continuing education which meet: 6.16.1 the requirements of professional bodies and institutions 6.16.2 the organisation's objectives.	☐☐☐ A ☐☐☐ B	
6.17 Records of study leave are maintained.	☐☐☐ B	
6.18 Where the organisation provides clinical experience for students, there is a written agreement between the organisation and the educational establishment detailing the responsibility for induction, teaching, supervision and assessment.	☐☐☐ B	

Performance management

6.19 There is a documented performance review system for all staff.	☐☐☐ A	

GUIDANCE
The staff performance review system may, for example:
- *identify the function and purpose of review*
- *set objectives, measure achievements and identify learning needs*
- *monitor progress*
- *include upward review*
- *ensure reviewers are trained*
- *identify areas for personal development and training which is in line with the organisation's objectives*
- *include arbiter or 'grandparent' arrangements.*

Employee relations

6.20 There are clear channels of communication open to staff in the event of grievances, disputes or complaints.	☐☐☐ A	
6.21 There are up-to-date, documented policies and procedures for the conduct of employee relations activities.	☐☐☐ A	

↓

CRITERIA

6.21 continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

GUIDANCE
These include, for example:
- *a documented recognition agreement*
- *a disciplinary procedure*
- *a grievance procedure*
- *a disputes procedure*
- *an appeals procedure*
- *the maintenance of records concerning protected and new terms and conditions of service*
- *arrangements for job evaluation.*

Human resources information

6.22 Systems exist for the collection, storage and aggregation of human resource information to meet:

6.22.1 statutory requirements ☐☐☐ A
6.22.2 organisational requirements ☐☐☐ B
6.22.3 workforce planning requirements. ☐☐☐ B

6.23 Records are kept of:

6.23.1 staff absenteeism ☐☐☐ A
6.23.2 staff sickness ☐☐☐ A
6.23.3 staff turnover ☐☐☐ B
6.23.4 special leave (for example maternity/paternity leave) ☐☐☐ A
6.23.5 the ethnic origin of all staff. ☐☐☐ B

GUIDANCE
This should be in line with Ethnic Monitoring of Staff in the NHS: a programme of action EL (94) 12.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Health promotion

6.24 Policies are developed, in line with the organisation's strategy, which encourage the general health of staff (see also standard 2 Management Arrangements and Corporate Governance). ☐☐☐ B

GUIDANCE
These include, for example:
- *a policy on smoking within the organisation*
- *a policy on alcohol consumption*
- *Health of the Nation targets, where applicable*
- *other NHS targets.*

6.25 The following counselling services are provided by qualified staff:

6.25.1 stress counselling ☐☐☐ B

6.25.2 how to stop smoking. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Human Resources - Occupational Health

6.26 All staff have access to a confidential occupational health service. ☐☐☐ A

GUIDANCE
This may be provided in-house, or under contract from another provider.

6.27 The service employs nurses and physicians with qualifications in occupational health. ☐☐☐ A

GUIDANCE
The relevant qualifications are:

- *Nurses* — *BSc Health Studies (Occupational Health)*; *Occupational Health Nursing Certificate/Diploma*
- *Doctors* — *Fellow of the Faculty of Occupational Medicine*; *Member of the Faculty of Occupational Medicine*; *Associate of the Faculty of Occupational Medicine*; *Diploma in Occupational Medicine*
- *Nurses and Doctors Masters Degree in Medical Science (Occupational Health)*

These are all specialist qualifications (with the exception of the Diploma in Occupational Medicine).

Where the service does not employ a qualified occupational health physician, the occupational health staff need to have formal arrangements for access to advice from an accredited specialist in occupational medicine.

6.28 There is an occupational health operational procedure which has been endorsed by the organisation. ☐☐☐ A

6.29 The operational procedure includes:
6.29.1 the aims and objectives of the service ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

6.29 continued

6.29.2 agreement on the range of occupational health services to be provided ☐☐☐ A

6.29.3 the reporting arrangements within the department and to senior management. ☐☐☐ A

6.30 There is a service level agreement for occupational health services. ☐☐☐ A

6.31 The organisation has agreed policies which clearly identify the lead role and responsibilities of the occupational health service and the roles of other relevant departments in the following processes:

6.31.1 pre-employment health assessment ☐☐☐ B

6.31.2 control of infection/immunisation programmes ☐☐☐ A

GUIDANCE

These include, for example:

- *hepatitis B and other blood-borne viruses*
- *TB*
- *polio*
- *rubella*
- *MRSA*
- *varicella*

6.31.3 management of sharps incidents ☐☐☐ A

6.31.4 sickness absence, rehabilitation and retirement ☐☐☐ B

6.31.5 advice on health and safety ☐☐☐ B

6.31.6 risk assessments of workplace hazards and a system to ensure that health surveillance is carried out accordingly ☐☐☐ A

6.31.7 health surveillance for specific hazards ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

6.31 continued

GUIDANCE
These include, for example:
- *glutaraldehyde*
- *noise*
- *display screen equipment*

6.31.8 management of manual handling incidents ☐☐☐ A
6.31.9 stress/counselling services ☐☐☐ B
6.31.10 Health at Work in the NHS initiatives ☐☐☐ B
6.31.11 first aid. ☐☐☐ B

6.32 There is a service policy and procedure on confidentiality and all staff in the department are aware of the contents. ☐☐☐ A

GUIDANCE
A written, signed statement, as outlined in appendix 3 of Guidance on Ethics for Occupational Physicians (Faculty of Occupational Medicine, 1993) may be appropriate.

6.33 All nursing/medical staff working in the occupational health department have had appropriate immunisation such as hepatitis B, BCG. ☐☐☐ A

Communication and liaison

6.34 The service, in conjunction with the health and safety manager, advises the organisation on health and safety training for staff and liaises with other departments as appropriate. ☐☐☐ B

6.35 The service maintains lines of communication with infection control staff. ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
6.36 The occupational health service has regular meetings to review the service with:		
6.36.1 the human resources service	☐☐☐ B	
6.36.2 senior management of the organisation	☐☐☐ B	
6.36.3 staff representatives.	☐☐☐ B	
GUIDANCE *This can be through links with union representatives or users' groups.*		
6.37 The service contributes to the organisation-wide induction programmes on occupational health and safe working practices.	☐☐☐ A	
6.38 The service receives:		
6.38.1 records and statistics relating to staff absenteeism, turnover, retirement	☐☐☐ B	
6.38.2 records and statistics relating to work accidents.	☐☐☐ A	
6.39 The service uses these records and statistics to compile advice to the organisation on:		
6.39.1 the management of absenteeism, turnover and retirement.	☐☐☐ B	
6.39.2 steps to reduce the incidence of work accidents.	☐☐☐ A	
Facilities		
6.40 The occupational health service is delivered in close proximity to the organisation.	☐☐☐ B	
6.41 6.41.1 a reception area which allows auditory privacy from the waiting area	☐☐☐ A	
6.41.2 confidential consulting rooms	☐☐☐ A	
6.41.3 computerised information systems for immunisation and administrative purposes	☐☐☐ B	
6.41.4 health promotion information.	☐☐☐ B	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Records

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

6.43 There are facilities for the safe and confidential storage of clinical records:

6.43.1 during employment ☐☐☐ A

6.43.2 after employment. ☐☐☐ A

6.40 The service complies with the requirements of the Access to Health Records Act 1990 and the Access to Medical Reports Act 1988. ☐☐☐ A

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 7

Communication

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

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

7.1 There is an up-to-date, documented communication strategy for the organisation. ☐☐☐ A

GUIDANCE
This takes into account, for example:
- *the needs of non-English speaking communities in the local population*
- *the needs of people with sensory disabilities*
- *the production of public materials in a range of formats such as large print, simple language, audio tapes, Makaton symbols and pictures.*

7.2 There are mechanisms for communication with:

7.2.1 patients/users ☐☐☐ A

7.2.2 carers ☐☐☐ B

7.2.3 staff throughout the organisation, including upward communication ☐☐☐ A

GUIDANCE
This includes, for example:
- *team briefing*
- *organisation-wide newsletter*
- *staff open meetings*
- *suggestion schemes.*

7.2.4 the local community ☐☐☐ A

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
7.2 continued		
7.2.5 external organisations	☐☐☐ A	
GUIDANCE *These include, for example:* • *community health councils* • *local authority, including social services, housing and education departments* • *general practitioners.*		
7.2.6 the media.	☐☐☐ B	
7.3 The effectiveness of the communication systems and strategy is monitored.	☐☐☐ B	
7.4 There is a defined channel of communication for patients'/users' and carers' complaints and suggestions (see also standard 2 Management Arrangements and Corporate Governance).	☐☐☐ A	
7.5 Action taken in response to patients'/users' and carers' complaints and suggestions is documented.	☐☐☐ A	
7.6 There is a directory of the organisation's services.	☐☐☐ B	
7.7 The directory is:		
7.7.1 easily available on site to patients/users and carers	☐☐☐ B	
7.7.2 circulated to other organisations.	☐☐☐ C	
GUIDANCE: *These include, for example:* • *community health councils* • *citizens' advice bureaux* • *GP practices* • *public libraries.*		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

7.8 All written information for the public is assessed before being distributed/displayed. ☐☐☐ A

GUIDANCE
The assessment covers, for example:
- *content*
- *clarity - written in plain English*
- *suitability for target audience*
- *cultural appropriateness*
- *whether written information for patients/users is kept up to date and reviewed on a systematic basis, with patient/user input where appropriate*
- *whether information leaflets for patients/users need to be translated into other languages to reflect the demography of the local population.*

7.9 There are opportunities for staff to train in communication skills and customer care. ☐☐☐ C

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 8

Estates Management

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

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

General

8.1 There is a documented estates strategy which is consistent with the strategic direction and the business plan of the organisation. ☐☐☐ A

GUIDANCE
The strategy considers, for example:
- *estate investment programme*
- *functional suitability and space utilisation*
- *performance targets for improving asset utilisation*
- *building, plant and equipment maintenance programme*
- *disposal of surplus facilities*
- *plans for site development.*

8.2 The estates strategy is reviewed and updated every three years as a minimum. ☐☐☐ A

8.3 There is an estates operational plan which is reviewed and updated annually. ☐☐☐ A

GUIDANCE
The estates operational plan relates to the longer term estates strategy and the organisation's business plan; it details the planned work for the current year.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.4 There are arrangements in place for monitoring and contributing to the content of development plans put forward by the local planning authority.	☐☐☐ B	
8.5 Space utilisation throughout the organisation is regularly reviewed.	☐☐☐ B	
8.6 There are designated individuals at senior management level responsible for the maintenance of all facilities, grounds, gardens and equipment.	☐☐☐ A	
8.7 There is a planned preventative maintenance plan.	☐☐☐ A	
GUIDANCE *Maintenance work is identified, costed and prioritised in line with the estates strategy and the estates operational plan.* *The maintenance programme is designed to reduce the incidence of equipment/facilities failure and reduce the risks associated with this. The maintenance programme includes redecorating.*		
8.8 Up-to-date drawings are maintained which detail:		
8.8.1 fire zones and escape routes	☐☐☐ A	
8.8.2 floor plans	☐☐☐ B	
GUIDANCE *Including internal routeing and location of building services.*		
8.8.3 site layout.	☐☐☐ B	
GUIDANCE *Including distribution of services and utilities.*		
8.9 There are procedures for:		
8.9.1 reporting defects both during office hours and out of hours	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

8.9 continued

8.9.2 monitoring response times from report to inspection of reported defects ☐☐☐ B

8.9.3 disposal of surplus property ☐☐☐ B

GUIDANCE
This includes, for example:
- *liaising with the Community Health Council as the statutory representative of the public interest in the health service prior to closing facilities and declaring them surplus.*
- *cooperating with the local authority's Registers of Public Bodies' Land scheme*
- *considering the priority purchase requirements of other NHS bodies, original owners and residential tenants.*

8.9.4 acquisition of property. ☐☐☐ B

8.10 Provision is made for:

8.10.1 wheelchair access inside and outside the organisation's building ☐☐☐ A

8.10.2 patients/users, visitors or staff with sensory or physical impairments (see also standard 18 The Patient's Individual Needs). ☐☐☐ A

8.11 Patient/user safety devices are installed across the organisation. ☐☐☐ A

GUIDANCE
These include, for example:
- *handrails in passageways*
- *grab rails and emergency call systems in patient toilets, showers and bathrooms*
- *safety glass where appropriate*
- *safety straps on wheelchairs*
- *trolleys with side rails*
- *variable-height beds fitted with adjustable side rails*
- *provision for emergency entry to toilets, showers and bathrooms.*

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.12 There is clear internal and external signposting (see also standard 20 Referrals, Access and Admissions).	☐☐☐ A	
GUIDANCE *Consideration is given to the needs of, for example:* *• non-English speaking people* *• visually impaired people* *• people with a learning disability.*		
8.13 Access for emergency vehicles is maintained at all times.	☐☐☐ A	
8.14 There are up-to-date, documented traffic management procedures for the organisation.	☐☐☐ B	
GUIDANCE *Procedures include, for example:* *• arrangements for disabled people* *• designated pick-up and drop-off points for patient/user transport services* *• parking facilities for staff who need to travel to different sites and in the community* *• provision of public transport to sites used by patients/users and their carers/visitors* *• procedures for the removal, clamping or fine system for cars that are improperly parked.*		
8.15 Car parking and access requirements are reviewed on a systematic basis.	☐☐☐ B	
GUIDANCE *The review includes, for example:* *• pedestrian access to the organisation's sites* *• incentives for staff to engage in car-sharing and park-and-ride schemes as*		

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.15 continued		
appropriate • *security of vehicles on the organisation's premises covering theft of vehicles, theft from vehicles and vandalism* • *consideration of the needs of bicycle users* • *the allocation of car parking facilities to staff.*		
8.16 Safe hot water and heating surface temperatures are maintained and monitored.	☐☐☐ A	
8.17 All electrical equipment brought into the organisation is subject to a safety inspection.	☐☐☐ A	
GUIDANCE *This takes into account, for example:* • *Electricity at Work Regulations 1989* • *HTM 2011, HTM 2014, HTM 2020 and HTM 2021.*		
Environmental management		
8.18 There is an environmental policy which covers emissions to air, land and water.	☐☐☐ B	
GUIDANCE *In Scotland and Northern Ireland trusts should be working to achieve compliance with the Greencode document.* *The policy should take into consideration, for example, the guidance given in the Greencode document, the requirements of the Environmental Protection Act and the standards set out in ISO 14000 (BS 7750).*		
8.19 The organisation carries out an environmental audit of the site/s.	☐☐☐ C	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

8.1 2 continued

GUIDANCE
For trusts working with the Greencode document this should be in line with the seven steps outlined in the programme.

8.19 Initiatives are developed to:
8.19.1 review the use and type of supplies in order to reduce packaging ☐☐☐ B
8.19.2 recycle suitable waste materials. ☐☐☐ C

GUIDANCE
For example, collecting aluminium cans for recycling where there are soft drinks vending machines.

8.20 There are education programmes/materials for staff on their contribution to implementing the organisation's environmental policy. ☐☐☐ C

8.21 Preventative measures are taken against the growth of Legionella pneumophila in service plant. ☐☐☐ A

8.22 The organisation has an energy policy which sets targets for consumption reductions and optimum procurement prices. ☐☐☐ B

8.23 There is adequate airflow, ventilation and temperature control to ensure safe working conditions. ☐☐☐ A

GUIDANCE
This includes, for example:
- *the control of air-borne infections, where appropriate*
- *the removal of dangerous gases.*

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Premises

8.24 Premises are registered with the appropriate authorities. ☐☐☐ A

GUIDANCE
This includes, for example, community living schemes for people with learning disabilities.

8.25 Premises which are used as domestic settings are in keeping with the local environment. ☐☐☐ B

GUIDANCE
For example, premises such as supported living accommodation in the community should not have large exterior signs and internal notices should be kept to a minimum.

8.26 Notices and signs in domestic settings are kept to a minimum. ☐☐☐ B

Accommodation for resident medical staff

8.27 Accommodation is provided for resident medical staff in line with Junior Doctors -The New Deal. ☐☐☐ A

8.28 The accommodation:

8.28.1 is sited within easy reach of the resident's place of work ☐☐☐ A
8.28.2 is free from leaks or damp ☐☐☐ B
8.28.3 is regularly maintained. ☐☐☐ B

8.29 Each resident's room:

8.29.1 has a telephone which is connected to the internal telephone system ☐☐☐ A
8.29.2 is fitted with a security lock. ☐☐☐ B

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
8.30 The residential accommodation includes access to adequate, clean and well maintained:		
8.30.1 bathroom and shower facilities	☐☐☐ B	
8.30.2 kitchen facilities.	☐☐☐ B	
8.31 Adherence to the requirements for resident medical staff accommodation is monitored on a systematic basis.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 9

Risk Management

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

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
General		
9.1 There is a senior manager who is responsible for the management of risk within the organisation.	☐☐☐ A	
9.2 There is a senior manager who is responsible for the management of clinical risk within the organisation.	☐☐☐ A	
GUIDANCE *This may be the same person as for 9.1.*		
9.3 There is a risk management strategy.	☐☐☐ A	
GUIDANCE *This should be endorsed by the organisation and should detail aims, objectives and individual responsibilities.*		
9.4 There is a strategy for the management of clinical risk.	☐☐☐ A	
GUIDANCE *This may be part of the overall strategy as for 9.3.*		

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
9.5 The risk management strategy is made available to all staff.	☐☐☐ B	
9.6 Risks are assessed in each service/department throughout the organisation.	☐☐☐ A	
9.7 Risk assessment findings are documented.	☐☐☐ A	
GUIDANCE *This should be in line with current guidelines.*		
9.8 Control measures (preventive and protective) are prioritised and implemented.	☐☐☐ A	
9.9 Risk assessments are reviewed and updated on a systematic basis or when circumstances change.	☐☐☐ A	
9.10 There is a standardised incident reporting system.	☐☐☐ A	
9.11 Serious untoward incidents are individually investigated.	☐☐☐ A	
GUIDANCE *There is an organisational procedure which sets out the steps to be taken in an investigation, which includes identifying action needed to prevent reacurrence.*		
9.12 Corporate records of all accidents, errors and incidents are:		
9.12.1 kept	☐☐☐ A	
9.12.2 monitored	☐☐☐ A	
9.12.3 evaluated	☐☐☐ A	
9.12.4 acted upon.	☐☐☐ A	
9.13 Reports on untoward incidents are:		
9.13.1 produced on a systematic basis	☐☐☐ A	
9.13.2 issued to the relevant department/service area for action.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.14 There is a designated individual responsible for:

9.14.1 liaising with legal professionals, insurance companies and claimants ☐☐☐ A

9.14.2 processing claims. ☐☐☐ A

9.15 Potential categories of disaster are:

9.15.1 identified ☐☐☐ A

9.15.2 prioritised ☐☐☐ A

9.15.3 assessed. ☐☐☐ A

GUIDANCE
Examples of categories of disaster would include floods, gales, systems failure, fraud, strikes.

Major incident plans (external and internal)

9.16 The organisation has a major incident, all-hazards plan (it is recognised that not all units will have a role in an external major incident response) (see also standard 24 Accident and Emergency Service). ☐☐☐ A

GUIDANCE
These incidents include, for example:
- *bomb threats and explosions*
- *fire*
- *loss of vital services (for example, electricity, water)*
- *transport disasters*
- *industrial disasters (such as chemical leakage).*

The plans include evacuation procedures.

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

9.17.1 emergency services ☐☐☐ A

9.17.2 local authorities. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.17 continued

GUIDANCE
Only those organisations which are part of the area disaster response plan are expected to have external major incident plans.

9.18 All departments/services having a role in the response to a major incident (external or internal) are involved in the preparation of the action plans. ☐☐☐ A

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

9.19 The organisation rehearses the major incident plan. ☐☐☐ B

GUIDANCE
Rehearsals are part of a coordinated practice in which other emergency services participate and rehearsals involve medical, nursing, managerial and other staff as appropriate.

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

9.21 Major incident plans are reviewed annually and revised as necessary. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Risk Management - Health and Safety

9.22 There is an individual at senior management level who has overall responsibility for formulating, implementing and developing health and safety policy. ☐☐☐ A

9.23 There is an up-to-date, documented, organisation-wide health and safety policy. ☐☐☐ A

GUIDANCE
This should conform to the requirements of current legislation and should be signed and dated by the executive director responsible for health and safety.

9.24 The health and safety policy is reviewed annually. ☐☐☐ A

9.25 Arrangements are in place for obtaining competent health and safety advice. ☐☐☐ A

GUIDANCE
This should be in line with the requirements of the Management of Health and Safety at Work Regulations 1992; all employers must appoint one or more competent' persons to help them comply with health and safety legislation.

The authority and accountability of the advisor (however named) should be defined and a direct reporting line to the organisation's executive management team should be established.

'Competent' refers to someone with sufficient training, experience and knowledge to enable proper assistance to be given. This person may be an employee or may be an independent health and safety expert.

The organisation may need more than one advisor to cover all health and safety matters.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
9.26 There is an organisation-wide, multiprofessional safety committee (or committees).	☐☐☐ A	
GUIDANCE *This includes, for example, senior management, staff and trade union representation - in line with the Health and Safety (Consultation with Employees) Regulations 1996. The committee should be consulted on the development, implementation and monitoring of the health and safety policy. The committee should also be involved in the setting and monitoring of performance standards for health and safety.*		
9.27 The committee reports to the organisation's executive management team/board on a regular basis.	☐☐☐ B	
9.28 The objectives and effectiveness of the safety committee are evaluated annually and modified as required.	☐☐☐ B	
9.29 There is an up-to-date, documented health and safety plan.	☐☐☐ A	
GUIDANCE *The health and safety plan should identify health and safety objectives, set targets, set timescales for action and be developed in consultation with staff.*		
9.30 An annual health and safety report is produced.	☐☐☐ A	
GUIDANCE *This should be presented to the organisation's executive management team and should be made available to all staff within the organisation.*		
9.31 First aid arrangements are in place and are in accordance with current legislation.	☐☐☐ A	
GUIDANCE *Rules for the provision of first aid facilities are laid down in the Health and Safety (First Aid) Regulations 1981.*		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.32 The organisation promotes the awareness of health and safety policies and issues. ☐☐☐ A

GUIDANCE
This could be through, for example, noticeboards, newsletters, suggestion schemes.

9.33 There is a health and safety education programme for all staff. ☐☐☐ A

GUIDANCE
Most health and safety regulations have a requirement for sufficient training for employees to know the risks and the precautions needed in their work. Training includes, for example, :
• induction training programmes for all new recruits including clinical staff
• regular refresher training for all employees
• training for employees who are transferred or promoted (this should be carried out before the post holder moves).

In areas where there is a higher risk of violence, staff should be trained to handle potentially aggressive situations.

9.34 The health and safety education programme is subject to systematic review. ☐☐☐ B

9.35 Records of health and safety training given to staff are maintained. ☐☐☐ A

GUIDANCE
This should be recorded for each employee, together with the date on which the training took place.

9.36 All temporary workers are given information on health and safety matters that may be encountered in their work. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.36 continued

GUIDANCE
Temporary workers include locum staff, contract staff, subcontract staff, bank staff and agency staff.

9.37 The reporting of injuries, diseases and dangerous occurrences is carried out in accordance with current legislation. ☐☐☐ A

GUIDANCE
All reportable injuries, diseases and dangerous occurrences should be reported to the enforcing authority (Health and Safety Executive) within the timescale required by the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995.

9.38 Safety notices and hazard notices are:
9.38.1 disseminated to the relevant staff ☐☐☐ A
9.38.2 acted on, with actions recorded. ☐☐☐ A

9.39 Health and safety systems are regularly reviewed. ☐☐☐ A

GUIDANCE
Elements of the health and safety management system to be reviewed include, for example:
- *policy*
- *organisation*
- *planning and policy implementation*
- *measuring systems*
- *reviewing systems.*

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Risk Management -Fire Safety

9.40 There is an up-to-date, documented, organisation-wide fire safety policy. ☐☐☐ A

GUIDANCE
The Firecode policies and principles document should be referred to.
The policy should be signed and dated by the chief executive or equivalent.

9.41 There is access to an appropriately qualified and experienced fire safety advisor. ☐☐☐ A

GUIDANCE
The responsibilities of the advisor should be in accordance with the Firecode policies and principles document.

9.42 At each site there is a member of staff designated as the nominated fire officer. ☐☐☐ A

GUIDANCE
The responsibilities of the nominated fire officer should be in accordance with the Firecode policies and principles document.

9.43 There is written evidence of the extent to which buildings comply with fire safety legislation. ☐☐☐ A

9.44 For designated areas (as defined by current legislation) there is written evidence that a fire inspection by the local fire authority has taken place within the last three years. ☐☐☐ A

9.45 There is a documented response to recommendations made by the local fire authority. ☐☐☐ A

GUIDANCE
This sets out the action already taken or proposed by the organisation, the rationale on which it is based and the planned timetable of compliance.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

7.15 continued

The timetable shows evidence of priority being given to, for example:
- *achieving certification for the relevant parts of the estate*
- *recommendations which have a direct bearing on issues of patients'/users' safety*
- *eradication of gross fire hazards*
- *early compliance with recommendations that are readily achievable.*

9.46 Comprehensive assessments of fire risks are regularly:

9.46.1 conducted ☐☐☐ A

9.46.2 recorded. ☐☐☐ A

GUIDANCE
These assessments should include carrying out safety checks in unused buildings. Assessments should be made in accordance with the Firecode policies and principles document.

9.47 There is written evidence of approval from the local authority in relation to:

9.47.1 new buildings ☐☐☐ A

9.47.2 major works ☐☐☐ A

9.47.3 alterations, as appropriate. ☐☐☐ A

Fire systems and equipment

9.48 Fire-fighting equipment is:

9.48.1 provided ☐☐☐ A

9.48.2 appropriate to the type of fire most likely to occur in the area in which it is located ☐☐☐ A

9.48.3 clearly marked. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.48 continued

GUIDANCE

Fire-fighting equipment includes, for example:

- *fire extinguishers*
- *hydrants*
- *hose reels*
- *fire blankets.*

Particular attention should be given to hazardous areas, for example:

- *engineering plant rooms/boiler rooms*
- *fuel and gas storage compounds*
- *health records storage areas*
- *kitchens*
- *laundry storage areas and linen rooms*
- *refuse collection and storage areas*
- *rooms or spaces used for permanent or temporary storage of combustible supplies and equipment*
- *treatment rooms and patient/user bed areas where oxygen and other potentially hazardous gases are used.*

9.49 There are records to demonstrate that the testing and maintenance of fire systems and equipment is carried out:

9.49.1 on a systematic basis ☐☐☐ A

9.49.2 by a qualified person. ☐☐☐ A

9.50 Where fire alarm, fire detection and emergency lighting systems do not conform to regulations, a programme for upgrading the equipment is produced. ☐☐☐ A

9.51 Access for fire engines is maintained at all times. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Evacuation

9.52 There is a protected means of escape from all parts of the building(s). ☐☐☐ A

9.53 Formal means of escape are:

9.53.1 accessible at all times ☐☐☐ A

9.53.2 wide enough for the evacuation of non-ambulant patients/users and staff ☐☐☐ A

9.53.3 not used to store combustible materials. ☐☐☐ A

9.54 Fire exit signs are clearly displayed. ☐☐☐ A

9.55 Patients'/users' rooms and fire exit doors are kept unlocked at all times. ☐☐☐ A

GUIDANCE

Liaison between staff responsible for fire safety and for security is essential to ensure that fire exits do not provide a way of unauthorised entry to buildings.

9.56 In areas where doors must be locked there are written and pictorial instructions detailing the means of escape during a fire. ☐☐☐ A

GUIDANCE

This may apply in some psychiatric units; these doors should be on a fire alarm release system.

9.57 Fire instruction notices are clearly displayed throughout the organisation. ☐☐☐ A

GUIDANCE

These should be prominently displayed and should state the essentials of the action to be taken on discovering a fire and on hearing the fire alarm.

9.58 Procedures detailing action to be taken in the event of patients/users having to be moved are displayed in patient/user areas. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Fire training

9.59 There is a fire training programme for staff. ☐☐☐ A

GUIDANCE
Staff should receive training in, for example:
- *fire alarm notification*
- *the operation of fire-fighting equipment*
- *evacuation techniques.*

Training sessions should be held frequently and at different times of the day and night to give all staff the opportunity to attend.

9.60 All staff attend fire training at least annually. ☐☐☐ A

9.61 Staff attendance at fire training is recorded. ☐☐☐ A

9.62 Practice fire drills are held for day and night staff. ☐☐☐ A

9.63 Staff attendance at fire drills is recorded. ☐☐☐ A

GUIDANCE
Fire drills do not need to involve the evacuation of patients/users, however all staff should carry out a practice evacuation within their working environment

9.64 All drills are evaluated and a written report produced. ☐☐☐ A

Fire incidents

9.65 All fire incidents are reported and investigated by the nominated fire officer. ☐☐☐ A

GUIDANCE
This may be in conjunction with the local fire authority, as appropriate.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Risk Management - Infection Control

9.66 The chief executive or equivalent is accountable for establishing and maintaining infection control arrangements across the organisation. ☐☐☐ A

9.67 All infection control advice is provided by a qualified person who is responsible for ensuring that timely and appropriate advice is given, including the formulation and promulgation of infection control policy. ☐☐☐ A

9.68 There is an infection control team. ☐☐☐ A

GUIDANCE
The infection control team includes, for example, an infection control doctor, an infection control nurse and, if the infection control doctor is from another specialty, a consultant medical microbiologist.

Resources provided for infection control should meet Hospital Infection Control - guidance on control of infection in hospitals HSG (95) 10.

9.69 There is a multiprofessional infection control committee which advises and supports the infection control team. ☐☐☐ A

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

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.68 continued

The committee membership includes, for example, the infection control team, the consultant in communicable disease control, representation from medical, nursing and managerial staff and paramedical and support services as appropriate - for example, pharmacy, engineering, sterile services.

9.70 The committee:

9.70.1 meets regularly ☐☐☐ B

9.70.2 minutes its meetings ☐☐☐ B

9.70.3 circulates the minutes throughout the organisation. ☐☐☐ B

GUIDANCE

The committee should meet at least twice a year and should ensure that minutes of its meetings and reports produced are sent to the organisation's executive management team/board and individual directorates where appropriate.

9.71 There are up-to-date, documented infection control policies and procedures. ☐☐☐ A

GUIDANCE

These cover:

- *clinical procedures (medical, surgical, nursing and paramedical)*
- *the disposal of waste*
- *outbreaks*
- *isolation techniques*
- *staff protection and infection*
- *high-risk patients/users (for example, immunosuppressed) and communicable diseases*
- *sterilisation and disinfection*
- *engineering and building services*
- *hotel services (housekeeping, laundry/linen and catering)*
- *mortuary and last office guidance.*

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
9.72 The infection control policies and procedures are distributed throughout the organisation.	☐☐☐ A	
GUIDANCE *The distribution should be appropriate to the work of various services/departments within the organisation.*		
9.73 Policies and procedures are:		
9.73.1 subject to a systematic review	☐☐☐ B	
9.73.2 referenced to appropriate legislation or published professional guidance	☐☐☐ B	
9.73.3 contained within a manual.	☐☐☐ B	
9.74 There is an ongoing education programme for all staff within the organisation.	☐☐☐ A	
GUIDANCE *All courses should be tailored to meet the needs of individual groups of staff.*		
9.75 The infection control team is involved in:		
9.75.1 the organisation's induction programme	☐☐☐ A	
9.75.2 junior doctors' orientation and induction programme	☐☐☐ A	
9.75.3 basic level training of other health care personnel (for example, nursing students, medical students, health care assistants).	☐☐☐ A	
9.76 Communication links are established between the infection control team and:		
9.76.1 the consultant in communicable disease control	☐☐☐ A	
9.76.2 the organisation's laboratory service	☐☐☐ A	
9.76.3 external services	☐☐☐ B	
GUIDANCE *Examples of external services include the local authority, general practitioners, and the public health laboratory service.*		

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.76 continued

9.76.4 the occupational health service ☐☐☐ A

9.76.5 the health and safety committee. ☐☐☐ A

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

9.78 There is an infection surveillance programme in place across the organisation that includes the collection, analysis and dissemination of data. ☐☐☐ A

GUIDANCE
This should be in line with Hospital Infection Control - guidance on control of infection in hospitals HSG (95) 10.

9.79 Arrangements are in place for controlling outbreaks of infection. ☐☐☐ A

9.80 Advice from the infection control team is sought in the following areas:

9.80.1 proposed building constructions to ensure that they are designed in line with infection control requirements ☐☐☐ B

9.80.2 equipment and consumable items intended for patients/users to ensure that they conform with infection control standards ☐☐☐ B

9.80.3 tenders for other services when infection control input is necessary. ☐☐☐ B

CRITERIA

Risk Management -Waste Disposal

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.81 There is a documented waste disposal strategy. ☐☐☐ A

GUIDANCE
This includes the designation of a responsible officer and covers waste segregation and coding, waste reduction, reuse of equipment and recycling, options for cost-effective disposal of waste.

The strategy should be line with NHS Estates document, Safe Disposal of Clinical Waste (Health Guidance Note EPL95/13).

9.82 There are up-to-date, documented procedures for waste disposal which cover:

9.82.1 segregating general and contaminated waste at the site of generation including colour coding and labelling ☐☐☐ A

GUIDANCE
Labelling should enable the waste to be traced back to its point of origin.

9.82.2 disposing of sharp objects in suitable containers ☐☐☐ A
9.82.3 dealing with needlestick injuries ☐☐☐ A
9.82.4 labelling and disposing of cytotoxic and radioactive waste ☐☐☐ A
9.82.5 safe handling of contaminated waste ☐☐☐ A

GUIDANCE
This includes, for example, the use of approved contaminated waste bags, protective clothing, and appropriate storage facility prior to incineration or removal from the site.

9.82.6 disposing of special waste (for example, prescription returns). ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
9.82 continued		
GUIDANCE *Procedures should be in line with NHS Estates document, Safe Disposal of Clinical Waste: whole hospital policy guidance (NHS Executive, 1995).* *Procedures for disposal of clinical waste should be in line with the Environmental Protection Act 1990 which lays a duty of care on organisations to dispose of clinical waste safely.*		
9.83 The implementation of waste handling and disposal procedures is audited.	☐☐☐ B	
GUIDANCE *For example, this may be a function of the health and safety committee.*		
9.84 Approved containers are provided to all departments suitable for the type of waste generated.	☐☐☐ A	
GUIDANCE *This includes the provision of general waste and clinical waste collection sacks, sharps containers and suitable bins/trolleys/pens to hold the sacks and containers.* *Containers used for road transport of clinical waste must meet UN approval requirements for carriage by road, including marking with the biohazard sign and the appropriate UN number.*		
9.85 Storage of waste is kept to a minimum and kept secure at all times.	☐☐☐ A	
GUIDANCE *For example, clinical waste should be stored in lockable wheeled bins that allow for 'single handling' of the waste.* *Sharps containers must be kept in secure areas to prevent the removal of objects from the box.*		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.86 Waste collection schedules are drawn up and agreed with service areas to reflect levels and types of waste generated. ☐☐☐ B

9.87 Protective clothing is readily available for staff transferring and transporting waste. ☐☐☐ A

GUIDANCE
This includes, for example gloves, goggles, boiler suits, overboots, dependent upon the type of waste and the amount of handling involved; as a minimum, gloves should be worn.

9.88 Vehicles used specifically to transport waste are cleaned:

9.88.1 at least weekly ☐☐☐ A

9.88.2 when leakage or spillage has occurred. ☐☐☐ A

9.89 There are separate vehicles to transport waste and non-waste items. ☐☐☐ A

9.90 All staff involved in handling clinical waste receive training. ☐☐☐ A

9.91 The incinerator operator has a valid licence. ☐☐☐ A

GUIDANCE
Even where waste is disposed of off-site under contract, the organisation has a duty of care under the Environmental Protection Act 1990 for the safe disposal of clinical waste produced by the organisation.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Risk Management - Security

9.92 There is a security strategy for the organisation. ☐☐☐ A

GUIDANCE
The strategy includes, for example:
- *management responsibility for security*
- *staff training on security measures*
- *access to buildings*
- *security systems and equipment*
- *recording of security incidents*
- *ongoing review of security issues.*

9.93 There is an organisation-wide security forum/committee. ☐☐☐ B

GUIDANCE
This includes wide representation from service areas.

The remit of the committee includes the discussion of security issues, development of action plans and production of reports for the executive management team/board.

Policies and procedures

9.94 There are up-to-date, documented procedures for:

9.94.1 access to buildings control and entrances to be locked out of hours ☐☐☐ A
9.94.2 patients'/users' property ☐☐☐ A
9.94.3 handling physical and verbal violence ☐☐☐ A
9.94.4 key-holding and key issue ☐☐☐ A

GUIDANCE
This includes, for example:
- *residencies*

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
9.94 continued		
• *patient/user keys (where appropriate)* • *access for emergency services.*		
9.94.5 consultation with the fire safety officer prior to the implementation of security improvements	☐☐☐ A	
9.94.6 liaison with the police and crime prevention services	☐☐☐ B	
9.94.7 communication with the workplace for staff who work in isolation and/or visit people in their own homes	☐☐☐ A	
GUIDANCE *This includes, for example:* • *staff leaving clear information about visiting schedules at their office base* • *procedures for calling-in when working in the community.* *Adherence to the communication procedure and its effectiveness are monitored and reviewed regularly.*		
9.94.8 operation of closed-circuit television, where this is installed.	☐☐☐ B	
9.95 There are up-to-date, documented procedures for security incident:		
9.95.1 reporting	☐☐☐ A	
9.95.2 response	☐☐☐ A	
9.95.3 follow-up.	☐☐☐ A	
GUIDANCE *These cover, for example:* • *reporting of incidents to the police* • *resetting of alarms*		

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

9.95 continued

- *boarding up windows/doors*
- *alerting the head of the affected department*
- *internal recording of incidents*
- *recording of stolen items.*

The policies are in line with NHS Executive guidance and the local purchaser requirements for information on patient/user-related incidents.

Security measures

9.96 There is a staff and contractor identification system in place. ☐☐☐ A

GUIDANCE
All staff, including subcontractors, agency and locum staff, are issued with identification badges, to be worn at all times, which include as a minimum the individual's name and post/designation.

9.97 Security of unoccupied offices/departmental areas is maintained at all times. ☐☐☐ A

GUIDANCE
This includes, for example:
- *empty/disused rooms and buildings*
- *areas which may be temporarily unoccupied during the day or at night.*

9.98 A safety assessment of the site(s) out of hours is undertaken. ☐☐☐ B

GUIDANCE
This is carried out annually, as a minimum.

9.99 Security measures are in place at night. ☐☐☐ A

↓

CRITERIA

9.99 continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

GUIDANCE
This includes, for example:
- *internal and external security inspection tours of the buildings*
- *monitoring via closed-circuit television.*

9.100 Special precautions are taken to minimise risk in high-risk/vulnerable areas. ☐☐☐ B

GUIDANCE
These areas include pharmacies and any drugs storage areas, unoccupied rooms with computer equipment.

There is access to mechanical security aids (for example, personal attack alarms, panic buttons).

9.101 The means of raising an alarm are available for staff if they are in difficulty. ☐☐☐ A

GUIDANCE
These include, for example:
- *panic buttons*
- *personal alarms*
- *mobile telephones.*

Staff development and education

9.102 Security staff receive training in handling physical and verbal violence. ☐☐☐ A

GUIDANCE
This training should also be available to other staff as appropriate.

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 10

Quality Improvement

There is a quality improvement strategy for the organisation which supports the business plan and reflects the mission statement.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
General		
10.1 There is a designated individual at board level responsible for the quality improvement strategy of the organisation.	☐☐☐ A	
10.2 There is a up-to-date documented quality improvement strategy for the organisation.	☐☐☐ A	
GUIDANCE *The quality improvement strategy details, for example:* • *objectives of the programme* • *methods to achieve these objectives* • *implementation timetable* • *management responsibility for, and the organisational structure to support, the commitment to quality management* • *a mechanism for providing the necessary resources to support the quality improvement and evaluation activities.*		
10.3 The strategy is disseminated throughout the organisation.	☐☐☐ B	
10.4 Staff at all levels in the organisation are involved in the implementation of the quality improvement strategy.	☐☐☐ B	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
10.5 The quality improvement strategy is developed in consultation with:		
10.5.1 key staff	☐☐☐ B	
10.5.2 patient/user representatives	☐☐☐ B	
10.5.3 carer representatives	☐☐☐ B	
10.5.4 purchasers.	☐☐☐ B	
10.6 Local standards are developed which are consistent with the content of national, regional and local charters and NHS targets.	☐☐☐ B	
10.7 There is routine and systematic monitoring of all national, regional and local initiatives.	☐☐☐ B	
10.8 There is routine and systematic monitoring of contract standards.	☐☐☐ A	
10.9 There is a systematic approach to, and review of, quality indicators.	☐☐☐ B	

GUIDANCE

The routine and systematic review of quality indicators include, for example:

- *cancelled operations and treatments, where applicable*
- *other appointments cancelled by the organisation*
- *complaints which are unresolved or have unsatisfactory resolutions*
- *drug errors*
- *patients/users not arriving for admission/treatment*
- *mortality and morbidity including at least the following:*
  avoidable complications
  unexpected death
  untoward occurrences
- *staff grievances*
- *staff sickness.*

10.10 Staff are trained in the development, implementation and review of quality activities.	☐☐☐ B	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Clinical audit

10.11 Organisation-wide priorities for clinical audit are identified and documented. ☐☐☐ B

10.12 There are agreed protocols for audit. ☐☐☐ B

Guidance
These include, for example:
- *clinical audit meetings and other peer review activities are supported by the chief executive as part of the quality improvement strategy*
- *clinical audit meetings are undertaken regularly and outcomes recorded*
- *clinical audit reports contain action plans for change*
- *attendance at clinical audit meetings is recorded*
- *there is evidence of management action as a result of audit findings.*

Research and development programmes

10.13 Staff use current research to develop and inform their practice. ☐☐☐ C

10.14 Priorities for research and development are identified and documented. ☐☐☐ B

10.15 There is access to a research database. ☐☐☐ C

10.16 There is a process for obtaining funding for research and development proposals. ☐☐☐ C

10.17 Changes to services are introduced in response to validated research findings. ☐☐☐ B

10.18 There are protocols for obtaining valid consent from patients/users and carers for their participation in research and development. ☐☐☐ A

10.19 Proposals for research programmes are referred to the ethics committee. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Outcomes

10.20 There are up-to-date, documented policies and procedures for the on-going review of patient/user care and treatment. ☐☐☐ B

GUIDANCE
This includes, for example, elements of assessment of outcomes by staff, by patients/users and by carers.

10.21 Outcome measures meet current best-practice guidelines. ☐☐☐ C

GUIDANCE
This includes, for example, Health of the Nation Outcome Scales, Towards Evidenced-Based Practice - a clinical effectiveness initiative for Wales (1995) and the principles included in Caring for People.

10.22 Outcome measurement is incorporated into the quality improvement plan and/or audit programme. ☐☐☐ B

10.23 The impact of quality improvement programmes is evaluated. ☐☐☐ B

10.24 Staff at all levels of the organisation have the opportunity to contribute to, and access, quality and clinical audit reports. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

King's Fund

Organisational Audit

Accreditation UK

An organisational audit programme for acute, community, learning disabilities and mental health services

Volume 2

King's Fund

Organisational Audit

Accreditation UK

An Organisational Audit Programme for Acute, Community, Learning Disabilities and Mental Health Services

Volume 2

Second edition
June 1997

Contents

Volume 2

Section 2: Management of Resources

Standard 11	Individual Service Philosophy and Objectives	102
Standard 12	Management and Staffing	104
Standard 13	Staff Development and Education	114
Standard 14	Business Planning and Contracting	118
Standard 15	Facilities and Equipment	121
Standard 16	Quality Improvement	124
Corporate Management Checklist		127

Section 3: The Patient's Rights and Individual Needs

Standard 17	The Patient's Rights	142
Standard 18	The Patient's Individual Needs	148
Standard 19	Partnership with Patients	154

Section 4: The Patient's Journey

Standard 20	Referrals, Access and Admission	161
Standard 21	Assessment, Planning, Implementation and Review of Treatment and Care	165
Standard 22	Leaving a Service/Discharge	170
Standard 23	Health Record Content	174

Section 2

Management of Resources

Standard 11	Individual Service Philosophy and Objectives	102
Standard 12	Management and Staffing	104
Standard 13	Staff Development and Education	114
Standard 14	Business Planning and Contracting	118
Standard 15	Facilities and Equipment	121
Standard 16	Quality Improvement	124
	Corporate Management Checklist	127

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 11

Individual Service Philosophy and Objectives

The individual service has a philosophy of care which is consistent with the mission statement of the organisation and which is reflected in the objectives and business plan of the service.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Service philosophy		
11.1 There is an up-to-date, documented philosophy statement which reflects the values of the service (see also Corporate Management, standard 1 Mission and Objectives).	☐☐☐ B	
GUIDANCE *This includes, for example:* • *a commitment to developing a service based on good practice* • *involving patients/users and carers in the planning and development of the service where appropriate* • *actively promoting informed choice.*		
11.2 The philosophy statement is developed with input from staff.	☐☐☐ B	
GUIDANCE *This includes, for example, professional, clinical, managerial and support staff.*		
11.3 The philosophy statement is:		
11.3.1 written in simple, jargon-free language that patients/users understand	☐☐☐ B	
11.3.2 clearly displayed within the service area	☐☐☐ B	
11.3.3 referred to in all key documents	☐☐☐ B	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

11.3 continued

GUIDANCE
This includes, for example, the service business plan and annual report.

11.3.4 included in staff induction ☐☐☐ B
11.3.5 included in information packs about the service for patients/users ☐☐☐ B
11.3.6 reviewed annually. ☐☐☐ C

Service objectives

11.4 Measurable objectives are developed for the service which are consistent with the objectives of the organisation (see also Corporate Management, standard 1 Mission and Objectives). ☐☐☐ A

GUIDANCE
Objectives are specific and measurable statements which set out how the aims of the service are to be met.

11.5 The service objectives are:
11.5.1 developed with staff ☐☐☐ B
11.5.2 reviewed at defined intervals in line with the business plan ☐☐☐ B
11.5.3 reviewed in the light of feedback received from patients/users, carers and purchasers. ☐☐☐ C

Standard 12

Management and Staffing

The service is managed and staffed effectively and efficiently in order to achieve its objectives.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management structure and responsibilities		
12.1 There is an organisational chart for the service.	☐☐☐ A	
GUIDANCE *Staff have access to this and are aware of the organisational structure of the service.*		
12.2 The organisational chart is reviewed:		
12.2.1 annually	☐☐☐ B	
12.2.2 when staffing changes	☐☐☐ A	
12.2.3 when the service is restructured.	☐☐☐ A	
12.3 The responsibilities of the director (however named) include:		
12.3.1 overall management of staff in the directorate/service	☐☐☐ A	
GUIDANCE *This includes, for example, being involved in:* • *recruitment of staff* • *grievance and disciplinary procedures* • *planning staff development and training for the service* • *skill mix reviews.*		

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

12.3 continued

12.3.2 developing and implementing operational policies and procedures to achieve service objectives ☐☐☐ B

12.3.3 ensuring that the quality of services provided is monitored and evaluated through the implementation of a quality improvement plan (see also Corporate Management, standard 10 Quality Improvement) ☐☐☐ B

12.3.4 ensuring that staff performance review takes place throughout the service (see also Corporate Management, standard 6 Human Resources) ☐☐☐ B

12.3.5 involvement in the preparation and monitoring of the budget (see also Corporate Management, standard 5 Financial Resources) ☐☐☐ B

12.3.6 promoting the health and safety of patients, staff and visitors (see also Corporate Management, standard 6 Human Resources; Corporate Management, standard 9 Risk Management). ☐☐☐ A

12.4 Arrangements are in place for an individual to take responsibility for the service in the absence of its director. ☐☐☐ B

Staffing

12.5 Clinical staff are registered with the appropriate body. ☐☐☐ A

GUIDANCE
This includes, for example:
- *UKCC*
- *GMC*
- *CPSM*
- *Royal Colleges*
- *British Psychological Society*
- *other professional associations as appropriate.*

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
12.6 There is a system in place to:		
12.6.1 confirm registration at appointment	☐☐☐ A	
GUIDANCE *The registration of nurses should be checked by telephoning the UKCC confirmation line.*		
12.6.2 check the periodic registration of existing staff	☐☐☐ A	
12.6.3 take action if registration is found to have lapsed.	☐☐☐ A	
GUIDANCE *There should be an up-to-date record of staff with names, registration numbers and designations.*		
12.7 The roles and responsibilities and activities of all staff, including those in training and students, are clearly defined.	☐☐☐ A	
GUIDANCE *These may be in job descriptions, contracts, specific information for students etc.*		
12.8 All staff have a up-to-date, written job description (see also Corporate Management, standard 6 Human Resources).	☐☐☐ B	
12.9 Job descriptions are reviewed:		
12.9.1 annually	☐☐☐ B	
12.9.2 on vacation of the post.	☐☐☐ B	
12.10 The post holder is informed of and agrees to any changes in the job description.	☐☐☐ B	
12.11 Staffing levels are assessed and monitored against workload.	☐☐☐ B	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

FAI continued

GUIDANCE
There should be a system for planning staff rotas and allocation of work. The system should be used to collect data which can be used to inform decisions about recruitment and reallocation of staff. The system can be manual or computer-based but should generate clear records which are used to inform management decisions.

12.12 Staffing levels reflect the commitments of staff undertaking additional duties. ☐☐☐ B

GUIDANCE
These include, for example:
- *local committee work*
- *national committee work*
- *teaching*
- *supervising*
- *receiving statutory training*
- *mentoring*
- *assessing.*

12.13 Provision is made for out-of-hours and emergency cover where required. ☐☐☐ A

GUIDANCE
There should be guidance on the maximum number of additional hours to be worked by staff on call or standing by to provide emergency cover.

12.14 The following are clearly displayed and made available to staff:

12.14.1 up-to-date on-call rotas ☐☐☐ A

12.14.2 up-to-date duty rosters. ☐☐☐ A

12.15 The manager of the service has access to records and statistics relating to staff in the service with regard to:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

12.15 continued

12.15.1 staff absenteeism (unauthorised) ☐☐☐ B
12.15.2 staff sickness ☐☐☐ B
12.15.3 staff turnover ☐☐☐ B
12.15.4 special leave (for example, maternity/paternity leave). ☐☐☐ B
(See also Corporate Management, standard 6 Human Resources.)

12.16 These statistics are monitored against agreed targets. ☐☐☐ C

GUIDANCE
The monitoring may be carried out centrally, in which case the service manager should have access to the data for the service.

12.17 The confidentiality of staff records is maintained. ☐☐☐ A

12.18 All temporary staff employed by the service are appropriately qualified. ☐☐☐ A

GUIDANCE
Qualifications should be checked before temporary staff start work. For professionally registered staff, registration should be confirmed by contacting the appropriate body, for example telephoning the UKCC confirmation line for nursing staff.

Staff performance review

12.19 Staff take part in the corporate performance review system (see also Corporate Management, standard 6 Human Resources). ☐☐☐ B

12.20 The system includes:

↓

CRITERIA	YES	NO	PARTIAL	
12.20 continued				
12.20.1 achievements since last review based on previous objectives	☐	☐	☐	B
12.20.2 objectives to be achieved before next review	☐	☐	☐	B
12.20.3 development needs and education plans for the individual and the service	☐	☐	☐	C
12.20.4 the date of the next review, within 12 months.	☐	☐	☐	B

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Staff support and supervision

12.21 There is a clear professional lead for each staff group (for example, a manager/advisor). ☐☐☐ B

12.22 Qualified members of staff supervise the work of all unqualified staff/students working with patients/users within the service. ☐☐☐ A

GUIDANCE
Unqualified staff may include volunteers.

12.23 There is clinical supervision for clinical staff which is:
12.23.1 monitored ☐☐☐ B
12.23.2 given at defined intervals. ☐☐☐ B

GUIDANCE
Supervision in this sense means reflecting on clinical practice.

Team/departmental working

12.24 The service has an up-to-date, documented procedure on team/departmental working. ☐☐☐ B

GUIDANCE
This includes, for example:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

12.24 continued

- *who is in the team/department (this may include staff from other agencies)*
- *leadership of the team/department*
- *the team's/department's agreed purpose*
- *the team's/department's agreed working relationships*
- *team/department guidelines*
- *the developmental needs of the team/department*
- *how team/departmental working is facilitated.*

12.25 The team/department meets at defined intervals. ☐☐☐ B

GUIDANCE
Matters discussed at team/departmental meetings may include, for example:
- *service development issues*
- *policy changes*
- *staff changes*
- *activity reports for the service.*

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

12.27 Notes are kept and made available to all staff. ☐☐☐ B

12.28 There is an up-to-date, documented procedure on working arrangements across services/agencies. ☐☐☐ B

GUIDANCE
This includes, for example:
- *the roles and responsibilities of each service/agency*
- *staff responsibilities when working in a multiprofessional setting*
- *information on referral, transfer and admission.*

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
12.29 There is an up-to-date, documented procedure on the sharing of information across services or external agencies.	☐☐☐ A	

GUIDANCE
This includes, for example:
- *what information can and cannot be shared between services or with external agencies*
- *the process for obtaining patient/user consent on divulging information*
- *cross-service/external agency agreements on the monitoring and review of these agreements.*

Management of health and safety

12.30 Risk assessments are carried out in each department/service area in accordance with the organisation's risk management strategy (see also Corporate Management standard 9, Risk Management).	☐☐☐ A	
12.31 The findings of risk assessments are documented.	☐☐☐ A	
12.32 Preventive and protective measures are implemented as a result of risk assessments.	☐☐☐ A	
12.33 Health and safety inspections are carried out on a planned, systematic basis.	☐☐☐ A	
12.34 The health and safety responsibilities of staff are clearly defined.	☐☐☐ A	

GUIDANCE
Health and safety objectives for staff should be set and reviewed annually as part of the performance review process.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

12.35 Copies of health and safety regulations are readily available to staff. ☐☐☐ A

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

12.36.1 health and safety including COSHH assessment ☐☐☐ A

12.36.2 first aid ☐☐☐ A

GUIDANCE
This depends on the corporate policy for the provision of first aid.

12.36.3 manual handling and lifting. ☐☐☐ A

GUIDANCE
The responsibilities of the representatives are:
- *detailed in their job descriptions*
- *detailed in their objectives*
- *set and reviewed annually.*

12.37 There are local health and safety procedures which are specific to the work of the service. ☐☐☐ A

GUIDANCE
These should:
- *be consistent with the organisation-wide health and safety policy*
- *include the safe use of equipment within the department*
- *cover patient/user and staff safety as appropriate.*

12.38 Records are kept of accidents, errors, incidents and complaints in line with the organisation's policies. ☐☐☐ A

Policies and procedures

12.39 Service procedures are:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

12.39 continued

12.39.1 consistent with national and local guidelines ☐☐☐ A
12.39.2 developed with staff input ☐☐☐ B
12.39.3 developed in consultation with representatives from other professions as appropriate ☐☐☐ B

GUIDANCE
For example, infection control, health record keeping, social care, health promotion.

12.39.4 readily accessible in the service area ☐☐☐ B
12.39.5 subject to a systematic review process ☐☐☐ B

GUIDANCE
This includes, for example, the date of issue for each document, the date for review, stating who is responsible for the review of the document.

12.39.6 contained within a manual. ☐☐☐ B

12.40 There is a system for informing staff of changes to policies and procedures. ☐☐☐ A

Staff appointments for services for people with learning disabilities (where applicable)

12.41 Users and/or carers are involved in staff recruitment and selection. ☐☐☐ B

12.42 Users are involved in the training of staff. ☐☐☐ C

12.43 Where users are unable to participate, advocates are involved. ☐☐☐ C

Standard 13

Staff Development and Education

There is a development and education programme in place which facilitates the professional development of each member of staff and is consistent with the objectives of the organisation.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Orientation and induction		
13.1 All newly recruited staff participate in the organisation's induction programme within a specified timescale (see also Corporate Management, standard 6 Human Resources).	☐☐☐ A	
13.2 The head of the service is responsible for ensuring that a record of participation in the organisation's orientation and induction programme is maintained, signed and dated.	☐☐☐ A	
GUIDANCE *If this information is held centrally the head of the service should receive a copy of the information about members of their staff who have attended corporate induction.*		
13.3 All staff appointed are subject to service-specific orientation and induction arrangements.	☐☐☐ A	
13.4 There are specific arrangements for inducting locum, contract, bank and agency staff.	☐☐☐ A	

↓

CRITERIA

13.1 continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

GUIDANCE
Consideration should also be given to the induction of volunteers.

13.5 Service-specific induction arrangements:

13.5.1 prepare staff for their role and responsibilities ☐☐☐ A

13.5.2 introduce staff to the service procedures ☐☐☐ A

13.5.3 explain local emergency procedures (for example fire, patient/user collapse) ☐☐☐ A

13.5.4 introduce staff to the service risk management legislation, policies and procedures and explain their impact on the service and highlight the responsibilities of the employee (see also Corporate Management, standard 9 Risk Management). ☐☐☐ A

13.6 Local orientation and induction arrangements are documented. ☐☐☐ A

Training and continuing education

13.7 All staff in direct contact with patients/users are trained in basic resuscitation techniques and have update training on an annual basis. ☐☐☐ A

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

13.9 All staff attend fire training annually. ☐☐☐ A

13.10 Staff are given in-service training and updating relevant to the service. ☐☐☐ A

GUIDANCE
This includes, for example:

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

E.13 continued

- *health and safety*
- *control of infection*
- *food handling*
- *waste management*
- *Control of Substances Hazardous to Health (COSHH) Regulations 1988 and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995*
- *general awareness of equal opportunities*
- *the organisation's complaints procedure*
- *health promotion*
- *bereavement*
- *customer care*
- *patients'/users' rights*
- *updated care and treatment practices*
- *Data Protection Act 1984*
- *Access to Health Records Act 1990.*

13.11 The training material used by the service is up-to-date and subject to planned, systematic review. ☐☐☐ B

13.12 Attendance at training and update sessions is recorded. ☐☐☐ A

13.13 The training provided to students working within the service is monitored and reviewed. ☐☐☐ B

13.14 Continuing education and professional up-dating is in accordance with:
13.14.1 local and nationally agreed requirements ☐☐☐ A

GUIDANCE
This includes, for example:

↓

CRITERIA

EHK continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

- *training when relevant legislation changes*
- *training when new technology/equipment is introduced*
- *training when new responsibilities are assigned*
- *support for undertaking research, introducing innovations and applying them to the service*
- *information on advances in practice*
- *information on, and support for taking advantage of, educational opportunities arranged by other institutions, academic and vocational qualifications and other sources of training and development.*

13.14.2 the organisation's overall training and development strategy ☐☐☐ B

13.14.3 the business plan requirements of the service ☐☐☐ B

13.14.4 ongoing evaluation of practice. ☐☐☐ B

13.15 Staff keep up-to-date training portfolios (personal professional profiles). ☐☐☐ B

GUIDANCE
This is a requirement of the UKCC and represents best practice for other staff groups.

13.16 Current reference manuals, pamphlets, journals, statutory guidance, codes of conduct and relevant textbooks are available within the service. ☐☐☐ B

13.17 Records of attendance at conferences, seminars and meetings are kept and reviewed annually. ☐☐☐ B

13.18 The benefits of educational activities are evaluated. ☐☐☐ C

Standard 14

Business Planning and Contracting

There is a clear business plan which sets out the strategy for the delivery of existing and future services, and is consistent with the organisation's strategic direction document and business plan.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Business planning		
14.1 There is a business plan for the service written for each financial year (see also Corporate Management, standard 1 Mission and Objectives).	☐☐☐ A	
GUIDANCE *The business plan contains, for example:* • *the service philosophy and objectives* • *information about the range of services offered* • *the service marketing strategy* • *the service quality improvement plan* • *the capital and revenue costings of new service developments* • *risk management plans.*		
14.2 The business plan takes account of:		
14.2.1 other business plans produced within the organisation (see also Corporate Management, standard 1 Mission and Objectives)	☐☐☐ A	
14.2.2 government directives	☐☐☐ A	
14.2.3 social services legislation and local plans, where relevant	☐☐☐ B	
14.2.4 patients'/users' and carers' views	☐☐☐ B	
14.2.5 purchaser intentions	☐☐☐ A	
14.2.6 planning and priorities guidance for the NHS (NHS only).	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

14.3 There is a service planning group. ☐☐☐ B

14.4 The business plan is developed in consultation with staff. ☐☐☐ B

14.5 Progress against objectives is reviewed. ☐☐☐ B

Annual report

14.6 The service makes a written contribution towards the organisation's annual report. ☐☐☐ B

GUIDANCE
This includes, for example:
- *the range of services available*
- *the number of people who have used the service*
- *achievements for the year*
- *information about complaints and how they have been dealt with*
- *aims for the next 12 months*
- *monitoring and evaluation procedures for the service.*

Contracting

14.7 Staff responsible for delivering the service are involved in the development of the contracts/agreements and service level agreements (see also Corporate Management, standard 3 Contracting for Services). ☐☐☐ B

14.8 There is a local system for monitoring contracts/agreements and service level agreements for which the service is the provider (see also Corporate Management, standard 3 Contracting for Services). ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

14.8 continued

GUIDANCE
This includes, for example, a named person within the service who is responsible for managing each contract/agreement.

14.9 Where services are provided under contract by external contractors, there is a detailed service specification. ☐☐☐ B

14.10 Standards of delivery by external contractors are monitored against the service specification. ☐☐☐ B

Information systems

14.11 All users of information systems receive training to enable them to comply with the organisation's information management and technology strategy (see also 4 Information Management and Technology). ☐☐☐ B

14.12 Local information systems used within the service are registered under the Data Protection Act 1984. ☐☐☐ A

14.13 Data collection by staff enables contract monitoring information to be collated within specified timescales (see also Corporate Management, standard 4 Information Management and Technology). ☐☐☐ B

14.14 The local performance of the information system is evaluated (see also Corporate Management, standard 4 Information Management and Technology). ☐☐☐ B

14.15 All information development and information technology purchases by the service are in line with the corporate information management and technology strategy (see also Corporate Management, standard 4 Information Management and Technology). ☐☐☐ B

Standard 15

Facilities and Equipment

The environment, facilities and equipment ensure safe, efficient and effective care of the patient/user and staff.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
15.1 Where patients/users are examined/treated/consulted with, the following are recognised and responded to:		
15.1.1 visual privacy	☐☐☐ A	
15.1.2 auditory privacy.	☐☐☐ A	
15.1.3 visual impairments	☐☐☐ A	
15.1.4 auditory impairments	☐☐☐ A	
15.1.5 children.	☐☐☐ A	
(See also Standard 18, The Patient's Individual Needs.)		
15.2 Where patients/users attend the department, provision is made for the following:		
15.2.1 sufficient seating facilities to cater for the number and type of patients/users and visitors using the service	☐☐☐ B	
15.2.2 toilet and washroom facilities located within easy reach of the department	☐☐☐ B	
15.2.3 facilities available for bereaved/distressed relatives and carers (where appropriate)	☐☐☐ B	
15.2.4 patient/user information leaflets (for example, health promotion, making/cancelling appointments)	☐☐☐ B	
15.2.5 information on patient/user waiting time, if appropriate	☐☐☐ B	
15.2.6 public transport information	☐☐☐ C	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
15.2 continued		
15.2.7 access to facilities suitable for nursing mothers	☐☐☐ C	
15.2.8 reading material.	☐☐☐ B	
15.3 Access is available to the following staff facilities:		
15.3.1 office space for the designated manager and other senior staff, as appropriate	☐☐☐ B	
15.3.2 office space for staff providing the service	☐☐☐ B	
15.3.3 a rest room	☐☐☐ B	
15.3.4 wash and changing rooms	☐☐☐ B	
15.3.5 equipped teaching/seminar rooms.	☐☐☐ B	
15.4 Storage space is available to meet service needs (for example, equipment, stationery, disposable items, drugs, flammable materials).	☐☐☐ A	
GUIDANCE *This includes, for example, having secure storage, with the correct temperature control, for drugs held by the service.*		
15.5 Materials and equipment are available to enable staff to carry out their duties.	☐☐☐ A	
15.6 There are local procedures for the management of waste which are pertinent to the service area.	☐☐☐ A	
15.7 Corridors and doorways are kept free of obstruction.	☐☐☐ A	
15.8 Fire doors are kept closed but not locked.	☐☐☐ A	
GUIDANCE *It is acceptable for fire doors to be held open by magnetic catches which release automatically when the fire alarm sounds.*		

CRITERIA	YES	NO	PARTIAL		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
15.9 There is ready access to first aid materials.	☐	☐	☐	A	
15.10 Emergency resuscitation equipment is readily accessible.	☐	☐	☐	A	
15.11 Resuscitation equipment (for example, defibrillators) is checked and recorded at least daily (unless otherwise recommended by the manufacturer).	☐	☐	☐	A	
15.12 Specialised equipment is used only by staff trained and competent in its operation (see also Corporate Management, standard 13 Staff Development and Education).	☐	☐	☐	A	
15.13 Where necessary, the following are provided:					
15.13.1 lifting aids	☐	☐	☐	A	
15.13.2 personal protective equipment.	☐	☐	☐	A	
15.14 The service has access to emergency support in the event of equipment failure.	☐	☐	☐	A	
15.15 The head of the service is involved in the process of equipment procurement.	☐	☐	☐	B	
15.16 Furniture and equipment in need of repair are removed from use and stored appropriately.	☐	☐	☐	B	
15.17 Assessments of computer workstations are carried out and action taken to correct deficiencies.	☐	☐	☐	A	

Standard 16

Quality Improvement

Quality and evaluation activities are undertaken by the service, in line with the organisation's quality improvement strategy, to improve the service that patients/users and carers receive.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
General		
16.1 There is an annual, documented quality improvement plan for the service which is consistent with the organisation's quality improvement strategy (see also standard 10 Quality Improvement).	☐☐☐ A	
16.2 The plan addresses:		
16.2.1 how the initiatives for quality improvement are linked to the business plan	☐☐☐ A	
16.2.2 the prioritisation, development and implementation of quality improvement activities	☐☐☐ B	
16.2.3 the involvement of all staff in the development, implementation and evaluation of quality improvements	☐☐☐ B	
16.2.4 the assessment of patient/user and carer satisfaction	☐☐☐ B	
16.2.5 the use of complaints to inform quality improvements	☐☐☐ B	
16.2.6 service evaluation	☐☐☐ B	
16.2.7 reporting and monitoring mechanisms for quality improvements	☐☐☐ B	
16.2.8 the role of clinical audit	☐☐☐ B	
16.2.9 the use of research in developing the service.	☐☐☐ C	
16.3 The plan is developed in consultation with staff and other stakeholders.	☐☐☐ B	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
16.4 A named person is responsible for the coordination of local quality improvement activities.	☐☐☐ B	
Standards		
16.5 National standards are implemented and reviewed.	☐☐☐ B	
GUIDANCE *This includes, for example, professional standards.*		
16.6 Local standards are developed, implemented and reviewed.	☐☐☐ B	
Clinical audit		
16.7 There is a written, annual clinical audit programme for the service which is in line with organisational priorities for clinical audit (see also Corporate Management, standard 10 Quality Improvement).	☐☐☐ B	
GUIDANCE *This includes, for example, clinical, service and organisational audit and areas for joint audit with social services, other health services and voluntary services. The standards for audit are evidence-based where evaluated evidence is available.*		
16.8 Staff and patients/users are able to offer suggestions for the clinical audit programme.	☐☐☐ C	
16.9 The clinical audit programme involves all staff.	☐☐☐ B	
16.10 Records are kept of clinical audit meetings.	☐☐☐ B	
16.11 Recommendations arising from clinical audits are implemented.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Corporate Management Checklist

The following criteria from Corporate Management, standards 1–10 will be followed up at directorate/service level, throughout the survey, as an adjunct to standards 11–16 Management of Resources. The directorate is **not** being assessed against these. The purpose is to follow-up corporate management issues.

CRITERIA

Standard 1: Mission and Objectives

1.1 There is a written mission statement which is developed with input from staff throughout the organisation.

1.2 The mission statement is made available:
1.2.2 to staff within the organisation.

1.5 The strategic direction document:
1.5.2 is developed with input from clinical and non-clinical staff
1.5.5 is available to all staff.

1.7 The business plan:
1.7.2 is developed with input from clinical and non-clinical staff
1.7.3 is available to all staff.

Standard 2: Management Arrangements and Corporate Governance

2.6 This document (which states the constitutional arrangements of the organisation) is made accessible to all staff.

CRITERIA

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

2.7.2 the key issues resulting from board and other meetings are communicated to staff

2.7.3 the advice of medical, nursing, other clinical and non-clinical staff and specialists on the development of organisational policy is systematically sought.

2.17 There is a widely publicised procedure enabling staff to raise their concerns about maladministration, breaches of codes of conduct and accountability and other concerns of an ethical nature.

2.18 Corporate policies and procedures are:

2.18.2 developed with staff

GUIDANCE:
This includes staff representatives from professional associations and trade unions.

2.18.7 available to all staff on request.

2.21 There is information for patients/users, carers and staff which details how to complain about the organisation's services.

2.38 The equality of opportunity policy is available to:

2.38.1 staff

2.38.2 patients/users

2.38.3 carers.

GUIDANCE
The policy should be available in:

↓

CRITERIA

2.3.B continued

- *different formats including Makaton symbols, photographs, simple language, audio tapes translated languages appropriate to the local population.*

Standard 3: Contracting for Services

3.6 The purchasing intentions documents received from the purchasers are disseminated to all directorates to assist with service business planning.

GUIDANCE
This includes GP fundholder purchasing plans.

Contingency arrangements should be considered early on to compensate for changing purchaser priorities or changes in contract currency such as moving from output episodes to packages of care.

3.8 Clinical and non-clinical staff responsible for delivering the service are involved in:
- 3.8.1 contract negotiations
- 3.8.2 determination of activity targets
- 3.8.3 determination of quality indicators.

3.17 The staff involved in delivering the contracts:
- 3.17.1 are involved in their monitoring and review
- 3.17.2 receive copies of any monitoring reports which are sent to the purchaser.

3.21 There is a programme for updating and training staff on contracting issues.

Standard 4: Information Management and Technology

4.10 Staff throughout the organisation who use the information systems are trained and supported to:

↓

CRITERIA

4.10 continued

4.10.1 input data
4.10.2 use and interpret information.

Standard 5: Financial Resources

5.2 Budgets are devolved to line managers.

5.3 Budgets are developed in collaboration with budget holders.

5.4 Budget holders receive financial training and guidance.

5.5 Each budget holder has a named finance officer to whom to refer.

5.6 User-friendly extracts from standing orders and standing financial instructions are sent to budget holders.

5.7 Budget statements are distributed to all managers and budget holders at specified times.

5.24 Patients'/users' monies and bank accounts held by the organisation are controlled and accounted for.

GUIDANCE
Policy and procedures are in place regarding safekeeping and expenditure of patients'/users' monies.

5.25 There is information available for patients/users about the systems for holding, managing and accounting for patient/users monies.

CRITERIA

6.1 continued

GUIDANCE
This information should be:
- *in jargon-free language*
- *translated into appropriate languages for the local population*
- *available in a range of formats including, large print, audio tape and symbols/pictures for learning disability services.*

Standard 6: Human Resources

6.2 The human resource strategy is communicated throughout the organisation.

6.7 All staff receive written contracts of employment within eight weeks of appointment.

6.8 All employees have access to written terms and conditions of service.

6.9 Individual employees are consulted and/or informed of any changes to the terms and conditions of their employment.

6.10 Job descriptions are:
6.10.1 issued for all posts.

6.15 Educational and developmental opportunities for staff are publicised.

GUIDANCE
These include:
- *courses*
- *vocational qualifications*
- *on-the-job development opportunities.*

CRITERIA

6.16 There is access to programmes of continuing education which meet:
- 6.16.1 the requirements of professional bodies and institutions
- 6.16.2 the organisation's objectives.

6.20 There are clear channels of communication open to staff in the event of grievance, disputes or complaints.

6.25 The following counselling services are provided by qualified staff:
- 6.25.1 stress counselling
- 6.25.2 how to stop smoking.

6.26 All staff have access to a confidential occupational health service.

GUIDANCE
This may be provided in-house, or under contract from another provider.

Standard 7: Communication

7.2 There are mechanisms for communication with:
- 7.2.1 patients/users
- 7.2.2 carers
- 7.2.3 staff throughout the organisation, including upward communication.

GUIDANCE
This includes, for example:
- *team briefing*
- *organisation-wide newsletter*
- *staff open meetings*
- *suggestion schemes.*

CRITERIA

7.9 There are opportunities for staff to train in communication skills and customer care.

Standard 8: Estates Management

8.9 There are procedures for:
8.9.1 reporting defects both during office hours and out of hours.

8.10 Provision is made for:
8.10.1 wheelchair access inside and outside the organisation's buildings
8.10.2 patients/users, visitors or staff with sensory or physical impairments (see also standard 18 The Patient's Individual Needs).

8.11 Patient/user safety devices are installed across the organisation.

GUIDANCE
These may include:
- *handrails in passageways*
- *grab rails and emergency call systems in patient/user toilets, showers and bathrooms*
- *safety glass where appropriate*
- *safety straps on wheelchairs*
- *trolleys with side rails*
- *variable-height beds fitted with adjustable side rails*
- *provision for emergency entry to toilets, showers and bathrooms.*

8.12 There is clear internal and external signposting (see also standard 20 Referrals, Access and Admission).

GUIDANCE
Consideration is given to the needs of, for example :
- *non-English speaking people*

↓

CRITERIA

8.12 continued

- *visually impaired people*
- *people with a learning disability.*

8.16 Safe hot water and heating surface temperatures are maintained and monitored.

8.17 All electrical equipment brought into the organisation is subject to a safety inspection.

8.23 There is adequate airflow, ventilation and temperature control to ensure safe working conditions.

GUIDANCE
This should ensure:
- *the control of air-borne infections, where appropriate*
- *the removal of dangerous gases.*

8.24 Premises are registered with the appropriate authorities.

GUIDANCE
This includes community living schemes for people with learning disabilities.

8.25 Premises which are used as domestic settings are in keeping with the local environment.

GUIDANCE
For example, premises such as supported living accommodation in the community should not have large exterior signs and internal notices should be kept to a minimum.

8.26 Notices and signs in domestic settings are kept to a minimum.

CRITERIA

Standard 9: Risk Management

9.5 The risk management strategy is made available to all staff.

9.13 Reports on untoward incidents are:
9.13.2 issued to the relevant department/service area for action.

9.18 All departments/services having a role in the response to a major incident (external or internal) are involved in the preparation of the action plans.

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

Risk Management: Health and Safety

9.33 There is a health and safety education programme for all staff.

GUIDANCE
Most health and safety regulations have requirements for sufficient training for employees to know the risks and the precautions needed in their work. Training should include:
- *induction training programmes for all new recruits including clinical staff*
- *regular refresher training for all employees*
- *training for employees who are transferred or promoted (this should be carried out before the post holder moves).*

In areas where there is a higher risk of violence, staff should be trained to handle potentially aggressive situations.

9.36 All temporary workers are given information on health and safety matters that may be encountered in their work.

↓

CRITERIA

9.36 continued

GUIDANCE
Temporary workers include locum staff, contract staff, subcontract staff, bank staff and agency staff.

Risk Management: Fire Safety

9.48 Fire-fighting equipment is:

9.48.1 provided

9.48.2 appropriate to the type of fire most likely to occur in the area in which it is located

9.48.3 clearly marked.

GUIDANCE
Fire-fighting equipment includes:
- *fire extinguishers*
- *hydrants*
- *hose reels*
- *fire blankets.*

Particular attention should be given to hazardous areas such as:
- *engineering plant rooms/boiler rooms*
- *fuel and gas storage compounds*
- *health records storage areas*
- *kitchens*
- *laundry storage areas and linen rooms*
- *refuse collection and storage areas*
- *rooms or spaces used for permanent or temporary storage of combustible supplies and equipment*
- *treatment rooms and patient/user bed areas where oxygen and other potentially hazardous gases are used.*

CRITERIA

9.57 Fire instruction notices are clearly displayed throughout the organisation.

Guidance
These should be prominently displayed and should state the essentials of the action to be taken on discovering a fire and on hearing the fire alarm.

9.58 Procedures detailing action to be taken in the event of patients/users having to be moved are displayed in patient/user areas.

9.59 There is a fire training programme for staff.

GUIDANCE
Staff should receive training in:
- *fire alarm notification*
- *the operation of fire-fighting equipment*
- *evacuation techniques.*

Training sessions should be held frequently and at different times of the day and night to give all staff the opportunity to attend.

9.60- All staff attend fire training at least annually.

Risk Management: Infection Control

9.70 The (infection control) committee:
9.70.3 circulates the minutes (of its meetings) throughout the organisation.

9.72 The infection control policies and procedures are distributed throughout the organisation.

GUIDANCE
The distribution should be appropriate to the work of various

↓

CRITERIA

9.72 continued

services/departments within the organisation.

9.74 There is an ongoing (infection control) education programme for all staff within the organisation.

GUIDANCE
All courses should be tailored to meet the needs of individual groups of staff.

Risk Management: Waste Disposal

9.84 Approved containers are provided to all departments suitable for the type of waste generated.

GUIDANCE
This includes the provision of general waste and clinical collection waste sacks, sharps containers and suitable bins/trolleys/pens to hold the sacks and containers.

9.90 All staff involved in handling clinical waste receive training.

Risk Management: Security

9.96 There is a staff identification system in place.

GUIDANCE
All staff, including subcontractors, agency and locum staff, are issued with identification badges which include as a minimum the individuals name and post/designation.

9.101 The means of raising an alarm are available for staff if they are in difficulty.

CRITERIA

2.10 continued

GUIDANCE
These include, for example:
- *panic buttons*
- *personal alarms*
- *mobile telephones.*

Standard 10: Quality Improvement

10.3 The (quality improvement) strategy is disseminated throughout the organisation.

10.4 Staff at all levels in the organisation are involved in the implementation of the quality improvement strategy.

10.5 The quality improvement strategy is developed in consultation with:
10.5.1 key staff
10.5.2 patient/user representatives
10.5.3 carer representatives.

10.10 Staff are trained in the development, implementation and review of quality activities.

10.17 Changes to services are introduced in response to validated research findings.

10.24 Staff at all levels of the organisation have the opportunity to contribute to and access quality and clinical audit reports.

Section 3

The Patient's Rights and Individual Needs

Standard 17	The Patient's Rights	142
Standard 18	The Patient's Individual Needs	148
Standard 19	Partnerships with Patients	154

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 17

The Patient's Rights

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

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
General		
17.1 Patients/users are informed of their rights to:		
17.1.1 be referred to a health professional whom they consider acceptable	☐☐☐ A	
17.1.2 seek a second opinion on diagnosis and treatment options, in agreement with their general practitioner, and are aware of the mechanism for doing so	☐☐☐ A	
17.1.3 be given a clear explanation of their condition and any treatment, investigation or procedure proposed, including risks and alternatives, before agreeing on the course of action to be taken	☐☐☐ A	
17.1.4 have access to their own health records (under the Access to Health Records Act 1990) and be sure that the information recorded in the health record will remain confidential	☐☐☐ A	

GUIDANCE
See also The Protection and Use of Patient Information HSG (96) 18, The NHS IM and T Security Manual HSG (96) 15, the Data Protection Act 1984, The Protection and Use of Patient Information in the NHS in Wales DGM (96) 43, Baseline IT Security in the NHS in Wales DGM (96) 100 and IT Security Networking DGM (96) 101 (NHS only).

↓

CRITERIA

YAL continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

17.1.5 give valid consent to take part in medical research ☐☐☐ A

17.1.6 choose whether or not to take part in undergraduate or clinical staff training ☐☐☐ A

17.1.7 receive detailed information about local health services ☐☐☐ A

17.1.8 a full investigation of clinical and non-clinical complaints (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance) ☐☐☐ A

GUIDANCE
There should be a specified complaints procedure in accordance with the Wilson Report and NHS Guidance on Handling Complaints, April 1996, and the NHS Complaints Procedure guidance EL (96) 19 (NHS only).

The response to complaints should be completed within a four-week timescale, or acknowledgement sent and explanation of why it will take longer than four weeks to conclude.

17.1.9 as an elective patient/user, be told whether they will be cared for in mixed, or single sex, accommodation ☐☐☐ A

GUIDANCE
Elective patients/users should be told prior to admission and given the option to wait for single sex accommodation if available/possible.

Emergency patients/users should have their wishes on single sex accommodation respected, if possible, post admission.

17.1.10 where applicable, have an explanation of their rights regarding legal status under the Mental Health Act 1983 and the process of appeal (see also standard 44 Mental Health – The Mental Health Act 1983). ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

17.1 continued

GUIDANCE
Ready access to leaflets such as The Patient's Charter and You, The Children's Charter and the Mental Health Charter will help cover these issues (NHS only).

17.2 The service recognises and responds to the following:

17.2.1 the personal dignity of patients/users at all times ☐☐☐ A

17.2.2 the personal privacy of patients/users ☐☐☐ A

17.2.3 the special emotional and physical needs of groups such as children, confused, elderly or mentally ill people, people with communication impairment, people with physical disability, people with sensory impairments, homeless people and people with learning disabilities (see also standard 8 Estates Management, standard 28 Children's Services, standards 43–49 Mental Health, standards 34–39 Learning Disabilities) ☐☐☐ B

17.2.4 the cultural/religious traditions of the population that it serves ☐☐☐ B

17.2.5 patients'/users' preferences for being cared for/treated by female/male members of staff. ☐☐☐ B

Guidance
Patients'/users' preferences should be noted, even if staffing and rostering limitations mean that it is not possible for the service to respond to these fully.

17.3 Patients/users are addressed by their preferred name and title. ☐☐☐ A

17.4 A named professional is responsible for planning the patient's/user's individualised care. ☐☐☐ A

Guidance
This encompasses the named nurse concept.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

17.5 Patients/users are informed in advance of any change of date or time for their treatment or operation. ☐☐☐ A

GUIDANCE
Any cancellations made within 24 hours of scheduled time must be rebooked in line with the Patient's Charter (NHS only).

17.6 Patients/user are given explanations for any delays in procedures/treatments being carried out. ☐☐☐ A

17.7 Staff ensure that those who take decisions on behalf of mentally incapacitated patients/users have the authority to do so. ☐☐☐ A

GUIDANCE
This includes, for example:
- *guardianship under current legislation, including the Mental Health Act 1983*
- *involvement of staff in substitute decision making which meets current legislation requirements.*

Information

17.8 Patients/users and carers are provided with condition/treatment/procedure leaflets. ☐☐☐ B

GUIDANCE
These include, for example:
- *written information for patients/users kept up to date and reviewed on a systematic basis, with patient/user input where appropriate*
- *information on evidenced-based health care*
- *information leaflets for patients/users are translated into other languages which reflect the demography of the local population*
- *details of patient/user/carer support groups.*

CRITERIA | YES NO PARTIAL | PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

17.9 With the patient's/user's valid consent, carers are informed of the likely benefits and risks of any course of treatment, including the side effects of medication. ☐☐☐ B

Consent

17.10 Valid consent is obtained from patients/users who are undergoing investigations and procedures, in line with the corporate policy (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance). ☐☐☐ A

GUIDANCE
Valid consent requires doctors to listen to patients/users, to ensure that they understand what consent is being given for and to impart as much information as any reasonable doctor would do, while being aware of the specific needs of individual patients/users.

Investigation and procedures include, for example:
- *routine medication*
- *anaesthesia*
- *sedation*
- *electroconvulsive therapy*
- *participation in research projects*
- *photographic and audiovisual recording*
- *surgical procedures*
- *unusual medications and routes of administration*
- *hazardous assessment procedures.*

17.11 There are standardised consent forms which are:
17.11.1 completed in full ☐☐☐ A
17.11.2 kept with the patient's/user's record. ☐☐☐ A

17.12 Where applicable there is a range of communication aids that assist patients/users to understand the information on which to base their consent. ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
17.13 Consent is recorded in the patient's/user's record (see also standard 23 Health Record Content).	☐☐☐ A	
17.14 When the patient/user is unable to give their valid consent, the views of an advocate, parent, next of kin or guardian are taken into consideration, in order to establish what would be in the patient's/user's best interests (see also standards 43–49 Mental Health, standard 34 Learning Disabilities – Advocacy).	☐☐☐ A	

GUIDANCE
The decision to treat or not to treat in these circumstances rests with the consultant and/or the court.

Additional guidance can be found in the BMA/Law Society book, Assessment of Mental Capacity: guidance for doctors and lawyers.

Advocacy

17.15 The service ensures that there is access to an independent advocacy service, in line with corporate policies (see also standard 45 Mental Health – Advocacy, standard 34 Learning Disabilities – Advocacy).	☐☐☐ B	

GUIDANCE
This includes, for example:
- *specific services for people with a learning disability*
- *specific services for users of mental health services*
- *specific services for ethnic minority groups represented in the local population*
- *specific services for elderly people*
- *specific services for children and young adults*
- *services for people with motor, sensory or communication impairment*
- *advocates who are trained in powers of attorney and Court of Protection procedures.*

Standard 18

The Patient's Individual Needs

Staff are aware of, and respond to, the individual needs of patients/users. Care is managed on an individual basis to ensure that the patients'/users' and carers' physical, intellectual, emotional, spiritual and social needs are assessed and care is planned, implemented and evaluated in response to these.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Care of the terminally ill person or those requiring palliative care		
18.1 There is a documented philosophy of care for terminally ill persons and those requiring palliative care.	☐☐☐ A	
18.2 Staff are trained to meet the needs of terminally ill patients/users and their carers/families.	☐☐☐ A	
18.3 Provision is made in inpatient settings for relatives/carers to stay overnight with the patient/user.	☐☐☐ A	
18.4 Visiting is unrestricted in inpatient settings.	☐☐☐ A	
18.5 There is a policy on the organisation's response to advance directives completed by terminally ill patients/users.	☐☐☐ A	

GUIDANCE
This policy needs to address staff training on the legal and ethical status of advance directives (see glossary), how staff become aware of advance directives, how they are stored and how they are implemented.

For further information, reference should be made to the BMA's book, Advance Statements about Medical Treatment.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
18.6 Support and information is provided to families after the death of a patient/user (for example, help with the arrangement of bereavement counselling, burial/cremation arrangements).	☐☐☐ A	
18.7 There is access to continuing community care services.	☐☐☐ B	

Chaplaincy and spiritual care

18.8 In inpatient areas, a quiet area is set aside for prayer and meditation.	☐☐☐ B	

GUIDANCE
Where there is a designated space (for example, a hospital chapel) this should be available at all times.

18.9 Visiting clergy, pastoral workers and religious leaders of non-Christian faiths have access to office space and telephones.	☐☐☐ B	
18.10 Information is readily available to inform patients/users and carers about the pastoral and spiritual support available within the organisation.	☐☐☐ B	
18.11 Multifaith support is available and translated information is made available to staff and patients/users, in consultation with religious groups.	☐☐☐ B	

Care of the deceased

18.12 In the event of a death, dignity of the body is maintained.	☐☐☐ A	
18.13 There is an up-to-date, documented procedure for informing the relatives of a patient's/user's death (see also Corporate Management, standard 2, Management Arrangements and Corporate Governance).	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

18.13 continued

GUIDANCE
This includes, for example:
- *who and when*
- *time spent with the relatives and the keyworker/named nurse/chaplain*
- *viewing the body.*

18.14 The procedures for dealing with the death of a patient/user take into account cultural and religious beliefs and needs, in accordance with national guidance (see also Corporate Management, 2 Management Arrangements and Corporate Governance). ☐☐☐ A

People with a disability

18.15 The organisation's buildings and facilities provide adequate access, internally and externally, for patients/users and visitors with disabilities (see also Corporate Management, standard 8 Estates Management). ☐☐☐ A

GUIDANCE
This is in line with the requirements of the Disability Discrimination Act 1995.

Seclusion, restraint and emergency medication

18.16 There are up-to-date, documented procedures which comply with current legislation, on (see also standard 47 Mental Health – Clinical Risk Management):

18.16.1 seclusion ☐☐☐ A
18.16.2 restraint ☐☐☐ A
18.16.3 emergency medication. ☐☐☐ A

GUIDANCE
The use of seclusion should be minimal and the standard of accommodation

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

18.16 continued

should conform with NHS Estates guidance, Accommodation for People with Mental Illness HBN 35.

The use of emergency medication should take into account the Royal College of Psychiatrists' Consensus Statement on High Dose Anti-psychotic Medication.

Ethics

18.17 There is a local research ethics committee. ☐☐☐ A

GUIDANCE
The remit of the committee includes the consideration of ethical issues such as the implications of research programmes and prevention of harm to patients/users.

Within the independent sector, there should be links with a local ethics committee.

18.18 There is a forum for discussing ethical issues. ☐☐☐ C

GUIDANCE
This encompasses, for example:
- *the adoption of a multiprofessional approach to the consideration of ethical issues*
- *advising on the implementation of policies relating to ethical issues (clinical and non-clinical).*

Ethnic minority and non-English speaking people

18.19 An interpreter service is available to meet the language needs of local non-English speaking populations. ☐☐☐ A

GUIDANCE
In cases of emergency (or out of hours) when an interpreter is not available,
↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

18.19 continued

a telephone interpreter service may be used and the interpreter called in as soon as possible.

18.20 Translated health promotion material, organisation information and forms are available and used where required. ☐☐☐ B

GUIDANCE
Translated material should also be culturally specific.

18.21 Staff are sensitive to the individual needs of patients/users and families of different ethnic, religious or cultural composition. ☐☐☐ A

GUIDANCE
Consideration is given to, for example:
- *the special dietary needs of patients/users*
- *medical examinations and other interventions and the gender of clinical staff*
- *religious beliefs or traditions in respect of healing, medical treatment and care while dying and after death*
- *washing and bathing*
- *mixed sex accommodation.*

18.22 Specialist advice is available to staff working with people from different ethnic backgrounds. ☐☐☐ C

Hearing and visually impaired people

18.23 Patient/user information is available in formats for those with hearing and visual impairment. ☐☐☐ B

GUIDANCE
This includes, for example:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

18.23 continued

- *Braille*
- *audio tapes*
- *minicoms.*

Carers

18.24 There are up-to-date, documented guidelines on carer involvement, support and information requirements. ☐☐☐ C

18.25 The involvement of carers is agreed with patients/users. ☐☐☐ B

18.26 Staff are aware of the rights and responsibilities of carers in line with current legislation. ☐☐☐ A

GUIDANCE
These are contained in the Carers (Recognition and Services) Act 1995 and Carers (Recognition and Services) Act HSG (96) 8.

18.27 Carers are given opportunities to express their views about services. ☐☐☐ A

18.28 Carers are consulted about the format of the information they require. ☐☐☐ C

18.29 Carers receive information about relevant legislation, statutory support and additional available services. ☐☐☐ B

GUIDANCE
This includes, for example, information about financial responsibility for means-tested social care, self-help groups and voluntary services.

18.30 Carers are supported in delivering care and treatment plans in the home environment, where applicable. ☐☐☐ B

18.31 Carers are able to access respite care, where applicable. ☐☐☐ C

Standard 19

Partnership with Patients

Patients/users of the service are actively involved in the development, monitoring and evaluation of the services they receive.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Involvement		
19.1 The service has an up-to-date, documented plan for patient/user involvement which is line with the organisation's objectives and corporate policy (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance).	☐☐☐ B	
19.2 The plan includes:		
19.2.1 who is responsible for implementing the plan	☐☐☐ B	
19.2.2 how ongoing communication between patients/users and providers is to be achieved	☐☐☐ B	
19.2.3 how ongoing involvement between patients/users and providers is to be achieved	☐☐☐ B	
19.2.4 monitoring arrangements for patient/user involvement.	☐☐☐ B	
19.3 Patients/users are actively involved in service development through:		
19.3.1 attending and participating in service development meetings	☐☐☐ C	
19.3.2 involvement in the quality improvement plan	☐☐☐ C	
19.3.3 monitoring and evaluation of services and their environment	☐☐☐ C	
19.3.4 formal and informal access to the management team.	☐☐☐ B	
19.4 Records are kept of meetings where patients/users are involved.	☐☐☐ B	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Resources and information

19.5 Resources are allocated for patient/user involvement activities. ☐☐☐ C

GUIDANCE
This includes, for example:
- *availability of meeting rooms*
- *travel and other reasonable expenses, such as child care*
- *fees for services*
- *office and administration support*
- *training and support in effective participation*
- *advocacy support*
- *wheelchair access*
- *access to a signer for those hard of hearing.*

19.6 Information relating to patient/user involvement is presented in a range of formats ☐☐☐ C

GUIDANCE
This includes, for example:
- *simple, jargon-free language*
- *materials in languages appropriate for the local population*
- *audio and video tapes*
- *Makaton symbols (for people with learning disabilities), photographs, pictures.*

19.7 The service provides information, training and support for patients/users involved in development activities. ☐☐☐ C

GUIDANCE
This includes, for example, a forum to facilitate communication and relationship building.

19.8 The service (in collaboration with patients/users) provides information, training and support to enable staff to work with patients/users on patient/user involvement issues. ☐☐☐ C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Patient/user groups and councils

19.9 The service encourages patient/user groups and councils. ☐☐☐ C

19.10 Patient/user groups and councils meet independently of staff. ☐☐☐ C

Patients'/users' views

19.11 The service actively seeks to obtain feedback from patients/users of the service. ☐☐☐ B

19.12 The views of a wide range of patients/users and carers are used in reviewing the service. ☐☐☐ C

19.13 Surveys of patients'/users' and carers' views are conducted on a range of issues. ☐☐☐ B

GUIDANCE

These include, for example:

- *The Patient's Charter*
- *The User's Charter (developed by the Mental Health Task Force)*
- *locally developed charters*
- *access*
- *privacy, dignity and respect*
- *information needs of patients/users*
- *choice*
- *advocacy*
- *complaints*
- *effectiveness*
- *communication with professional staff*
- *appropriateness of service to minority groups*
- *leaving a service and discharge planning.*

CRITERIA	YES	NO	PARTIAL	
19.14 Summary reports of patients'/users' and carers' views and satisfaction are produced annually.	☐	☐	☐	C
19.15 The summary reports are available to staff, patients/users and carers.	☐	☐	☐	C
19.16 The views and concerns of the patients/users and carers of the service are acted upon.	☐	☐	☐	B

GUIDANCE
The service is able to demonstrate examples of improvements.

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Section 4

The Patient's Journey

Standard 20	Referrals, Access and Admission	161
Standard 21	Assessment, Planning, Implementation and Review of Treatment and Care	165
Standard 22	Leaving a Service/Discharge	170
Standard 23	Health Record Content	174

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 20

Referrals, Access and Admission

The service provides a prompt and effective response to all referrals and is accessible for patients/users and carers, general practitioners and other referring agencies. Patients/users have a planned programme of admission and continuity of care is maintained.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Referrals		
20.1 There is an up-to-date, documented procedure on how to:		
20.1.1 make routine referrals into the service	☐☐☐ A	
20.1.2 make emergency referrals into the service, where applicable	☐☐☐ A	
GUIDANCE *This includes, for example, who can make referrals and general referral criteria (not condition-specific).*		
20.1.3 make out-of-hours contact with the service.	☐☐☐ A	
20.2 The procedure is made widely available to:		
20.2.1 patients/users	☐☐☐ B	
20.2.2 carers	☐☐☐ B	
20.2.3 general practitioners	☐☐☐ A	
20.2.4 other departments/health service providers, as appropriate	☐☐☐ A	
20.2.5 social services/education departments, as appropriate	☐☐☐ A	
20.2.6 voluntary agencies.	☐☐☐ B	
20.3 There is a system for recording all referrals to the service.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

20.4 The referrer is provided with regular updates of the patient's/user's progress. ☐☐☐ B

20.5 Referrals to the service are monitored and evaluated. ☐☐☐ B

Information about the service

20.6 Information is available describing:

20.6.1 response times/waiting lists (NHS only) ☐☐☐ A

20.6.2 what services are available ☐☐☐ A

20.6.3 the location of services. ☐☐☐ A

20.7 Information is available in a variety of formats. ☐☐☐ B

GUIDANCE

This includes, for example:

- *simple, jargon-free language*
- *materials in languages appropriate for the local population*
- *audio and video tapes.*

Access

20.8 Services are:

20.8.1 signposted in a variety of languages appropriate for the local population (see also Corporate Management, 8 Estates Management) ☐☐☐ A

GUIDANCE

- *This includes internal and external signposting in the organisation's grounds.*
- *There may be reasons why some services are not signposted, for example, where there is a need to maintain confidentiality and privacy.*

20.8.2 near public transport routes, where possible ☐☐☐ B

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

20.8 continued

GUIDANCE
This may include outreach clinics, community services and community mental health teams.

20.8.3 well lit ☐☐☐ A
20.8.4 physically accessible. ☐☐☐ A

20.9 Staff are aware how patients/users on Income Support, Family Credit or Low Income schemes, or who fall into other categories, are able to claim travelling expenses. ☐☐☐ B

GUIDANCE
This includes, for example, the Highlands and Isles Travelling Scheme.

20.10 The service is easily contactable by telephone in an emergency and after normal office hours. ☐☐☐ A

GUIDANCE
This may include staff on-call rotas and out-of-hours services.

20.11 The service provides outreach services for out of hours and emergencies, where applicable. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Admissions

20.12 There is an up-to-date, documented procedure for admission to the service which is consistent with the organisation's policy on admission (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance). ☐☐☐ A

20.13 The procedure is made clear to:
20.13.1 patients/users and carers ☐☐☐ B
20.13.2 referrers. ☐☐☐ A

20.14 Extra contractual referrals (ECRs) are identified. ☐☐☐ B

20.15 Where the service is consultant-led, a named consultant is accountable for the clinical care and treatment of each patient/user. ☐☐☐ A

20.16 A named keyworker is responsible for the nursing or other care given to each patient/user. ☐☐☐ A

GUIDANCE
The keyworker should be a registered member of their profession.
The keyworker may be the named nurse.

20.17 There is a standardised admission checklist. ☐☐☐ B

20.18 Carers/next of kin are informed of the admission, if the patient/user agrees. ☐☐☐ B

Standard 21

Assessment, Planning, Implementation and Review of Treatment and Care

All patients/users have individual assessments of their needs and preferences. These are reflected in care and treatment plans which are implemented and reviewed. Care and treatment is centred on the patient/user, who is involved in all aspects of the process.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Assessment		
21.1 All patients/users have individual assessments.	☐☐☐ A	
21.2 The assessment process ensures that:		
21.2.1 all assessments have a clear purpose which is understood by the patient/user	☐☐☐ A	
21.2.2 the patient/user is involved in the assessment	☐☐☐ A	
GUIDANCE *This depends on the mental state and level of consciousness of the patient/user. All attempts at involving the patient/user should be documented.*		
21.2.3 carers participate, where appropriate, in deciding how identified problems are resolved	☐☐☐ B	
21.2.4 assessments are carried out by appropriately qualified staff	☐☐☐ A	
21.2.5 an holistic assessment is made.	☐☐☐ B	
GUIDANCE *This includes, for example, physical, emotional, social, cultural, religious, spiritual, work, financial, housing, educational and recreational needs as applicable.*		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

21.3 Patients/users are given access to their assessment summary and recommendations and are able to discuss these with staff. ☐☐☐ A

GUIDANCE
Where this is not appropriate, the carer receives a copy of the summary and recommendations and is able to discuss them with staff.

21.4 Where specialist support is required patients/users are enabled to access these services. ☐☐☐ A

GUIDANCE
These include, for example:
- *medical specialties*
- *pain management*
- *chiropody*
- *physiotherapy*
- *occupational therapy*
- *psychology*
- *dietary services*
- *dental hygiene*
- *speech and language therapy*
- *optometry*
- *audiology*
- *alternative therapies.*

21.5 Special provision is made for the assessment of need for patients/users who:

21.5.1 are elderly ☐☐☐ A
21.5.2 have additional physical difficulties ☐☐☐ A
21.5.3 have special ethnic or religious requirements ☐☐☐ A
21.5.4 are children or adolescents ☐☐☐ A
21.5.5 have communication impairments ☐☐☐ A
21.5.6 have a sensory impairment ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

21.5 continued

21.5.7 challenge the service with their behaviour ☐☐☐ A

21.5.8 have mental health problems ☐☐☐ A

21.5.9 are detained under the Mental Health Act 1983. ☐☐☐ A

Care and treatment planning

21.6 There is a written care and treatment plan for each patient/user. ☐☐☐ A

GUIDANCE
The care and treatment plan should be integrated and multiprofessional as far as is possible.

21.7 The patient/user is involved in the planning of his or her care and treatment. ☐☐☐ A

21.8 The plan of care and treatment is based on the current assessment of the patient's/user's needs. ☐☐☐ A

GUIDANCE
The care and treatment plan includes, for example:
- *measurable objectives and the steps to achieve these*
- *time frames for achieving objectives.*

21.9 individual care and treatment plan is produced in a format that is understood by the patient/user and carer, where applicable. ☐☐☐ A

21.10 Patients/users have a copy of, or access to, their care and treatment plan. ☐☐☐ A

21.11 Concerns about the patient's/user's capacity to be involved in planning his or her care and treatment:
21.11.1 are discussed with the patient/user, the carer and, where applicable, the advocate

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
21.11 continued		
21.11.2 are documented and reviewed regularly.	☐☐☐ A ☐☐☐ A	
21.12 Care and treatment plans developed by students/unqualified staff are countersigned by qualified staff.	☐☐☐ A	
GUIDANCE *This does not apply to medical staff.*		
Implementation of care and treatment		
21.13 The keyworker is responsible for ensuring that the care and treatment plan is implemented.	☐☐☐ A	
GUIDANCE *This encompasses the named nurse concept.*		
21.14 A written record of the care and treatment given is filed in the patient's/user's health record (see also standard 23 Health Record Content).	☐☐☐ A	
21.15 The record is signed and dated by a registered practitioner.	☐☐☐ A	
21.16 All records stored within the service area are held in a secure storage area.	☐☐☐ A	
Review of care		
21.17 The assessment, planning and implementation of the care and treatment plan is reviewed, at agreed intervals, by the multiprofessional team.	☐☐☐ A	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
21.17 continued		
GUIDANCE *This should be done to:* *• ensure that it is meeting the continuing needs of the patient/user* *• ensure that it is meeting the continuing needs of the carer* *• monitor progress towards objectives.*		
21.18 Where appropriate, there is provision for independent review/second opinion of the care and treatment given to patients/users.	☐☐☐ A	
Partnership with carers		
21.19 Where it is in the best interest of the patient/user, carers participate in:		
21.19.1 the patient's/user's assessment	☐☐☐ A	
21.19.2 planning of treatment and activities	☐☐☐ B	
21.19.3 review of treatment and activities.	☐☐☐ B	
GUIDANCE *Carers may be friends as well as next of kin. Wherever possible, the patients'/users' consent should be obtained prior to involving carers.*		

Standard 22

Leaving a Service/Discharge

Patients/users have a planned programme for leaving a service/discharge which ensures continuity of care.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Leaving a service/discharge policy

22.1 There is an up-to-date, documented procedure for leaving a service/discharge which is consistent with the organisation's policy on discharge (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance). ☐☐☐ A

GUIDANCE

The procedure includes, for example:

- *period of notice required by a patient/user in order to prepare for discharge*
- *liaison with the patient's/user's general practitioner*
- *liaison with, and organisation of, any community/social service support a patient/user may require (for example, home help, district nurse, health visitor)*
- *information given to the patient/user concerning future management of their medical condition*
- *information given to the patient/user concerning management of their condition at home*
- *information given to the patient/user concerning any advised changes in lifestyle*
- *information given to the patient's/user's general practitioner (see also standard 23 Health Record Content)*
- *issues relating to supervised discharge of patients/users (see also standard 43 Mental Health – Continuity of Care/the Care Programme Approach)*

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

22.1 continued

- *transport arrangements*
- *items given to the patient/user to take home, such as medication, dressings, care aids*
- *the special requirements of the patient/user who has no social support*
- *ensuring that no NHS patient/user is discharged to a nursing/residential home against his/her wishes if he/she or a relative is personally responsible for paying the home's fees*
- *information concerning funding if long-term nursing care is required.*

22.2 There is an up-to-date, documented transfer procedure for:

22.2.1 services within the organisation ☐☐☐ A

22.2.2 services outside the organisation. ☐☐☐ A

22.3 These procedures are made clear to:

22.3.1 staff ☐☐☐ A

22.3.2 patients/users ☐☐☐ B

22.3.3 carers/advocates ☐☐☐ B

22.3.4 other agencies. ☐☐☐ B

Leaving a service/discharge planning

22.4 Leaving a service/discharge planning is started prior to or from admission. ☐☐☐ A

22.5 Leaving a service/discharge planning is coordinated with other agencies involved in the patient's/user's ongoing care and treatment. ☐☐☐ A

22.6 The service has a standardised leaving a service/discharge checklist. ☐☐☐ A

22.7 The service has a leaving a service/discharge information pack for patients/users and carers with information on community services and followup. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

22.7 continued

GUIDANCE
For example, this includes information on whom to contact in an emergency, out-of- hours services and general follow-up arrangements.

22.8 A summary of the patient's/user's record and leaving a service/discharge plan is transferred with the patient/user, where applicable. ☐☐☐ A

GUIDANCE
- *Relevant parts of the record only may be transferred but this will be dependent upon the nature of the illness/condition and the consultant's agreed consent. To ensure that vital pieces of information are not lost during the transfer, details of what has been omitted should be included for reference purposes.*
- *Where a patient/user needs follow-up appointments it is the responsibility of the keyworker to ensure that these are recorded in the discharge summary (see also standard 23 Health Record Content).*

22.9 A summary of the patient's/user's record is communicated to the general practitioner and other agencies involved in ongoing care and treatment (see also standard 23 Health Record Content). ☐☐☐ A

GUIDANCE
This includes, for example, information about:
- *particular needs*
- *medication and side effects*
- *any high-risk behaviour*
- *progress notes against objectives.*

22.10 Discharge arrangements are monitored and reviewed. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Patient/user death

22.11 There are up-to-date, documented procedures in place:

22.11.1 on the referral of those deceased patients/users who, by law, require a post mortem examination ☐☐☐ A

22.11.2 to cancel all appointments booked and to stop routine correspondence on the death of a patient/user. ☐☐☐ B

22.12 Where applicable, the death of a detained patient/user is reported to the Mental Health Act Commission. ☐☐☐ A

Standard 23

Health Record Content

There is an accurate health record, which enables the patient/user to receive effective continuing care, enables the health care team to communicate effectively, allows another doctor or professional member of staff to assume the care of the patient/user at any time, enables the patient/user to be identified without risk of error, facilitates the collection of data for research, education and audit and can be used in legal proceedings.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
23.1 The record provides a chronological account of the patient's/user's care (see also standard 21 Assessment, Planning, Implementation and Review of Treatment and Care).	☐☐☐ A	

Patient/user details

23.2 There is a summary in the record that contains all the patient's/user's demographic details and all administrative detail relevant to the admission.	☐☐☐ A	

GUIDANCE

This summary may be found at the front of the notes or may be located throughout the record. Whatever system is used must ensure that the information contained in the summary is immediately accessible, that is, the notes should be in chronological order.

The summary should contain: dates of admission and discharge; consultant in whose care the patient/user is admitted; all diagnoses and procedures using the terminology of the most current edition of the international classification of disease and OPCS coding for operative procedures (or other approved classifications, for example, in the independent sector); and a list of all previous admissions, referrals or attendances with the department attended and the consultant seen.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

23.2 continued

Where summaries are kept on a computer, a hard copy must be inserted in the record.

The summary should be completed at the time of discharge or when the relevant information becomes available.

23.3 The record contains the following patient/user identification data:

23.3.1	unique patient/user number on every page	B
23.3.2	name in full on every page	A
23.3.3	address and postcode	A
23.3.4	date of birth	A
23.3.5	general practitioner	A
23.3.6	name of admitting consultant, where applicable	A
23.3.7	patient's/user's telephone number	A
23.3.8	sex	A
23.3.9	religion	B
23.3.10	ethnic origin	A

GUIDANCE

This should be in line with Collection of Ethnic Group Data for Admitted Patients EL (94) 77.

23.3.11	first language, where this is not English	B
23.3.12	person to notify in an emergency and their telephone number	A
23.3.13	source of referral.	A

GUIDANCE

Identification data that is not required on every page must be held at an accessible point in the record.

CRITERIA

Clinical information

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

23.4 The record contains the following clinical information:

23.4.1 a clinician's written diagnosis and reason for admission/referral with the date and time of the initial consultation ☐☐☐ A

GUIDANCE
Recording the date and time will help to ensure that a complete contemporaneous record is in place. This is particularly important in cases of litigation. In community services, recording the time may not be necessary.

23.4.2 an initial patient/user history ☐☐☐ A

GUIDANCE
This should include, for example, a present and past medical history, family history, details of medication, employment history and social and environmental details, if pertinent.

23.4.3 a report of the initial physical examination performed by a clinician including the patient's/user's height and weight, where appropriate ☐☐☐ A

GUIDANCE
Height and weight would, for example, be needed for calculation of some drug dosages.

23.4.4 regular and timely progress notes, observations and consultation reports made by all health professionals ☐☐☐ A

GUIDANCE
The regularity of progress note recording will be determined by the individual needs of the patient/user. The record must contain a note of all untoward and unexpected events and the action taken to manage them.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

23.4 continued

23.4.5 details of any legal orders to which the patient/user is subject, where applicable ☐☐☐ A

GUIDANCE
This would include details about the section of the Mental Health Act 1983 under which the patient/user is detained.

23.4.6 a note of therapeutic orders, if any ☐☐☐ A

23.4.7 orders for diagnostic tests, if any ☐☐☐ A

23.4.8 all results of investigations (for example, pathology, imaging, ECGs, CTGs) ☐☐☐ A

GUIDANCE
Test results and investigations should be accompanied by a dated signature to say that they have been seen and acted upon.

23.4.9 drug therapy records ☐☐☐ A

23.4.10 written details of verbal instructions/information given to patients/users and/or carers. ☐☐☐ B

GUIDANCE
These details should be recorded by the person who gave the instructions/information.

23.5 There is a system of 'alert' notation in place. ☐☐☐ A

GUIDANCE
This should ensure that any allergies or sensitivities are immediately noticeable in the record. If an 'alert' notation is used on the front cover, then this should be repeated on prescriptions and/or treatment sheets.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Surgery/invasive procedures

23.6 For patients/users undergoing surgery/invasive procedures, the following additional information is recorded in the record:

23.6.1 details of valid consent ☐☐☐ A

GUIDANCE
There is signed evidence that valid consent was obtained by the doctor carrying out the procedure.

Where the procedure is not performed by a doctor, consent may be obtained by the health care professional who is going to perform the procedure. It should be documented that the patient/user was informed that the procedure was not to be performed by a doctor where it is judged that the patient/user might reasonably have expected that a doctor would be performing the procedure.

There is signed evidence that the correct procedure was followed when obtaining valid consent in special circumstances (for example, children under the age of 16, Jehovah's Witnesses, terminations).

If necessary, professional interpreters are used to gain valid consent from patients.

23.6.2 a preoperative diagnosis or indication for surgery/investigation made by a suitably qualified medical practitioner ☐☐☐ A

GUIDANCE
In the independent sector, this would be carried out by a consultant. In the NHS, this could be carried out by a junior grade doctor.

23.6.3 an operation note ☐☐☐ A

GUIDANCE
This should contain: the name and signature of the operating surgeon(s); the

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

23.6 continued

name of the consultant responsible; description of the findings; the diagnosis made and the procedure performed; details of tissue removed, altered or added; details and serial numbers of prostheses used (these may be 'stick on' labels); details of sutures used; details of blood transfusions; an accurate description of any difficulties encountered (including needlestick injuries) and how they were overcome; immediate postoperative instructions; and date and time.

23.6.4 an anaesthetic record. ☐☐☐ A

GUIDANCE
This should be in line with the minimum data set agreed by the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland, and contain:
- *the preoperative assessment, including risk factors, by an anaesthetist, preferably the attending anaesthetist*
- *the name of the anaesthetist and, if different, the name of the consultant anaesthetist responsible*
- *drugs and doses given during anaesthesia and route of administration; monitoring data*
- *intravenous fluid therapy, where given*
- *the method used to secure and maintain the patient airway and any special difficulties encountered*
- *post-anaesthetic instructions where appropriate*
- *name and signature of attending anaesthetist(s)*
- *date and time.*

Discharge

23.7 The record contains the following discharge information:

23.7.1 a copy of the discharge communication (see also standard 22 Leaving a Service/Discharge) ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

23.7 continued

GUIDANCE
This discharge communication should contain a summary of any procedure undertaken, diagnosis, recommendations for follow-up and any legal requirements, for example, section 117 under the Mental Health Act 1983. It should be completed on the day of the patient's/user's discharge.

23.7.2 a copy of the discharge summary/letter ☐☐☐ A

GUIDANCE
The summary/letter should be a precis of the clinical notes and should contain: demographic detail; final diagnosis; any procedures undertaken; summary of history; any abnormalities found on examination; all significant test results; details of medication; any information given to the patient/user; and recommendations for follow-up.

This should be completed within 14 days of the patient's/user's discharge and sent to the general practitioner or other hospital/institution to which the patient/user is discharged.

In the NHS, the requirement for completion within 14 days may vary from purchaser to purchaser

23.7.3 cause of death where death has occurred (if known) (see also standard 22 Leaving a Service/Discharge) ☐☐☐ A

23.7.4 record of the notification to the general practitioner within 24 hours of death. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Post mortem examinations

23.8 Where post mortem examinations are conducted, the following are recorded in the record:

23.8.1 an anatomical diagnosis (provisional within 72 hours and a completed diagnosis within one month of death) ☐☐☐ A

23.8.2 a copy of the post mortem report ☐☐☐ A

23.8.3 a review of the clinical diagnosis and findings of the post mortem examination. ☐☐☐ B

GUIDANCE
Post mortem findings are important for clinical audit purposes. However, it should be noted that the coroner will not always release the post mortem records to the organisation.

Record entry

23.9 Entries in the record are:

23.9.1 dated ☐☐☐ A

23.9.2 timed ☐☐☐ A

GUIDANCE
In community services, recording the time may not be necessary.

23.9.3 signed ☐☐☐ A

23.9.4 accompanied by the name and designation of the signatory. ☐☐☐ A

GUIDANCE
The provision of a rubber stamp with the designation on it is a useful means of helping this process.

23.10 All entries in the record, including alterations, are legible. ☐☐☐ A

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
23.10 continued		
GUIDANCE *Records should not be altered in order to pervert the course of justice. If any point is later found to be inaccurate, misleading or misreported, a separate note should be made to this effect.*		
23.11 All entries are made in black ink.	☐☐☐ A	
GUIDANCE *Dark ink is important for photocopying purposes.*		
23.12 Where abbreviations and symbols are used, they are kept to a minimum and used according to local guidelines.	☐☐☐ A	
GUIDANCE *It should be noted that the UKCC Standards for Records and Record Keeping advises that nurses should not normally use abbreviations.*		
23.13 Offensive comments about the patient/user or their carer are not recorded in the patient's/user's record.	☐☐☐ A	
GUIDANCE *The record should contain objective information which is relevant to continuing care or medicolegal purposes.*		
23.14 All dictated and typed notes are signed by their author within a time specified locally.	☐☐☐ A	
GUIDANCE *Typed notes should be checked for errors, corrected and signed by the author as accurate. This is particularly important in cases of litigation.*		

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

King's Fund

Organisational Audit

Accreditation UK

An organisational audit programme for acute, community, learning disabilities and mental health services

Volume 3

King's Fund

Organisational Audit

Accreditation UK

An Organisational Audit Programme for Acute, Community, Learning Disabilities and Mental Health Services

Volume 3

Second edition
June 1997

Contents

Volume 3

Section 5: Service Specific

Standard 24	Accident and Emergency Service	187
Standard 25	Acute Day Care Service	196
Standard 26	Administration	204
Standard 27	Catering Service	207
Standard 28	Children's Services	214
Standard 29	Diagnostic Imaging Service	228
Standard 30	Dietetic Service	234
Standard 31	Health Record Management	237
Standard 32	Housekeeping Service	245
Standard 33	Laundry and Linen Service	248
Standard 34	Learning Disabilities - Advocacy	252
Standard 35	Learning Disabilities - Choice and Decision Making	255
Standard 36	Learning Disabilities - Personal Relationships and Sexuality	258
Standard 37	Learning Disabilities - Personal Financial Arrangements	261
Standard 38	Learning Disabilities - Links with Children's Services/Transfer to Adult Services	263
Standard 39	Learning Disabilities - Relocation	264
Standard 40	Library Service	267
Standard 41	Medical Physics and Biomedical Engineering Service	271
Standard 42	Medical Service	276

Section 5

Service Specific

Standard 24	Accident and Emergency Service	187
Standard 25	Acute Day Care Service	196
Standard 26	Administration	204
Standard 27	Catering Service	207
Standard 28	Children's Services	214
Standard 29	Diagnostic Imaging Service	228
Standard 30	Dietetic Service	234
Standard 31	Health Record Management	237
Standard 32	Housekeeping Service	245
Standard 33	Laundry and Linen Service	248
Standard 34	Learning Disabilities – Advocacy	252
Standard 35	Learning Disabilities – Choice and Decision Making	255
Standard 36	Learning Disabilities – Personal Relationships and Sexuality	258
Standard 37	Learning Disabilities – Personal Financial Arrangements	261
Standard 38	Learning Disabilities – Links with Children's Services/Transfer to Adult Services	263
Standard 39	Learning Disabilities – Relocation	264
Standard 40	Library Service	267
Standard 41	Medical Physics and Biomedical Engineering Service	271
Standard 42	Medical Service	276

Introduction to standards for mental health services		285
43	Mental Health – Continuity of Care/the Care Programme Approach	286
44	Mental Health – The Mental Health Act 1983	293
45	Mental Health – Advocacy	296
46	Mental Health – Treatment	299
47	Mental Health – Clinical Risk Management	301
48	Mental Health – Leave from Hospital	307
49	Mental Health – Other Specialist Services	309
50	Maternity Service	312
51	Nursing Service	321
52	Occupational Therapy Service	326
53	Operating Theatre Service/Anaesthetic Service	328
54	Outpatient Service	338
55	Pathology Service	349
56	Pharmaceutical Service	356
57	Portering Service	364
58	Radiotherapy Service	367
59	Special Care Service	372
60	Sterile Services Department	379
61	Telecommunications Service	386
62	Volunteer Service	390

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Standard 24

Accident and Emergency Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

24.1 There is at least one designated accident and emergency consultant based in the department who directs the service. ☐☐☐ A

24.2 There is at least one doctor employed by the accident and emergency department on duty at all times in the department. ☐☐☐ A

GUIDANCE
This doctor is trained and sufficiently experienced to deal effectively with the majority of emergencies that present in the department.

The number of doctors on duty should be related to the numbers of patients attending the department, in line with the British Association for Accident and Emergency Medicine document, The Way Ahead.

24.3 Accident and emergency consultant staff or senior staff deputies are available through a 24-hour on-call system and, if required, other specialists are available on call (for example paediatricians, neurosurgeons). ☐☐☐ A

24.4 Nurses with post-registration education and/or experience of accident and emergency services are present on all shifts. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

24.4 continued

GUIDANCE
The nurses are sufficiently experienced to deal effectively with the majority of emergencies that present in the department.

24.5 Nursing staff rotate around the department and onto night duty. ☐☐☐ B

24.6 The following are available on a 24-hour basis:

24.6.1 a cardiac arrest team ☐☐☐ A

24.6.2 a member of staff certified as proficient in advanced cardiac life support techniques ☐☐☐ A

24.6.3 a member of staff certified as proficient in advanced trauma life support techniques ☐☐☐ A

24.6.4 a member of staff certified as proficient in paediatric advanced life support techniques ☐☐☐ A

GUIDANCE
For services which take emergency child cases.

24.6.5 a radiological service (see also standard 29 Diagnostic Imaging Service) ☐☐☐ A

24.6.6 arrangements for the provision of pharmaceutical supplies, intravenous fluids including plasma expanders, sterile items, disposable items and linen (see also standard 56 Pharmaceutical Service, standard 60 Sterile Services Department, standard 33 Laundry and Linen Services) ☐☐☐ A

24.6.7 intensive therapy and high dependency services ☐☐☐ A

24.6.8 facilities for the supply and cross-matching of blood ☐☐☐ A

24.6.9 laboratory services for all routine studies and standard analysis of blood, urine and other body fluids (see also standard 55 Pathology Service) ☐☐☐ A

24.6.10 a nurse whose name appears on either part 8 or part 15 of the UKCC

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
24.6 continued		
Register; that is, Registered Sick Children's Nurse or Registered Nurse (Child) (see also standard 28 Children's Services)	☐☐☐ A	
Guidance *For services which take emergency child cases.*		
24.6.11 emergency theatre facilities and emergency theatre staff (anaesthetists, surgical specialists, operating theatre practitioners) (see also standard 53 Operating Theatre Service/Anaesthetic Service)	☐☐☐ A	
24.6.12 a trauma team.	☐☐☐ B	
24.7 Plaster and ECG technicians are available during office hours.	☐☐☐ B	
24.8 Lines of communication between the accident and emergency service and the following external services are established:		
24.8.1 ambulance service	☐☐☐ A	
24.8.2 local general practitioners	☐☐☐ A	
24.8.3 police service	☐☐☐ A	
24.8.4 social services	☐☐☐ B	
24.8.5 coastguard service (dependent on location)	☐☐☐ B	
24.8.6 community health services	☐☐☐ B	
24.8.7 fire and rescue service	☐☐☐ B	
24.8.8 industry.	☐☐☐ C	
24.9 The service is involved in developing plans for:		
24.9.1 internal emergencies	☐☐☐ A	
24.9.2 external major incidents.	☐☐☐ A	
(See also Corporate Management standard 9 Risk Management)		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Policies and procedures

24.10 There are up-to-date, documented procedures for the following:

24.10.1 assessment of patients'/users' priorities (triage) ☐☐☐ A

24.10.2 handling cardiac arrests ☐☐☐ A

24.10.3 management of children in accident and emergency departments ☐☐☐ A

24.10.4 patients/users refusing treatment ☐☐☐ A

24.10.5 patients/users without identification ☐☐☐ A

24.10.6 access to poisons information service ☐☐☐ A

24.10.7 psychiatric referral procedures ☐☐☐ A

24.10.8 handling physical and verbal violence ☐☐☐ A

24.10.9 dealing with situations where children are identified as possibly being at risk ☐☐☐ A

GUIDANCE
For services which take emergency child cases.

24.10.10 dealing with the police ☐☐☐ B

GUIDANCE
This includes, for example, requests for blood specimens, blood alcohol estimations, evidence, statements, disclosure of information, suspected victims of crime, requests for examination in rape or other violent cases.

24.10.11 patients/users recalled for examination or treatment ☐☐☐ B

24.10.12 dealing with patients'/users' belongings ☐☐☐ B

24.10.13 requests for reports for legal purposes and provision of evidence in court ☐☐☐ B

24.10.14 sudden death (for example, deaths on arrival, patients/users brought in dead) ☐☐☐ B

24.10.15 utilisation of observation beds. ☐☐☐ B

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Facilities and equipment		
24.11 The location is clearly signposted within the grounds of the organisation.	☐☐☐ A	
24.12 There is access and space for ambulances.	☐☐☐ A	
24.13 The location of the emergency access is clearly visible.	☐☐☐ A	
24.14 The ambulance access is under cover.	☐☐☐ B	
24.15 There are separate entrances for ambulant and stretcher arrivals.	☐☐☐ B	
24.16 The ambulance bay is close, and has easy access, to the resuscitation area.	☐☐☐ A	
24.17 Cleaning facilities are available for ambulances/ambulance personnel.	☐☐☐ C	
24.18 There is space and privacy to undertake:		
24.18.1 initial assessment	☐☐☐ A	
24.18.2 resuscitation	☐☐☐ A	
24.18.3 suturing	☐☐☐ A	
24.18.4 plastering	☐☐☐ A	
24.18.5 other forms of medical treatment	☐☐☐ A	
24.18.6 observation of patients/users.	☐☐☐ A	
24.19 Resuscitation bays have full resuscitation and treatment equipment.	☐☐☐ A	
GUIDANCE *Guidelines produced by the Association of Anaesthetists should be referred to.*		
24.20 A range of equipment and instruments is available for:		
24.20.1 adults	☐☐☐ A	
24.20.2 children, where seen by the department (for example, child-sized		

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
24.20 continued		
resuscitation equipment).	☐☐☐ A	
24.21 The following are present in the department:		
24.21.1 information on waiting time from initial assessment	☐☐☐ A	
24.21.2 a designated area for the examination or treatment of children	☐☐☐ A	
24.21.3 separate waiting area for children (see also standard 28 Children's Services)	☐☐☐ B	
24.21.4 play facilities for children (see also standard 28 Children's Services)	☐☐☐ B	
24.21.5 access to public telephones	☐☐☐ B	
24.21.6 refreshments (for example, vending machine).	☐☐☐ C	
24.22 There are storage facilities for major incident equipment.	☐☐☐ B	
24.23 There is access to a visiting room in which relatives can spend time with the deceased.	☐☐☐ B	
Patient/user care		
24.24 On arrival all patients/users are subject to assessment (this may take place before registration).	☐☐☐ A	
GUIDANCE *Procedures should also be in place to ensure that waiting children receive priority and are seen promptly.*		
24.25 Assessment is:		
24.25.1 performed by an appropriately experienced nurse or doctor	☐☐☐ A	
24.25.2 documented and signed.	☐☐☐ A	
24.26 On arrival all patients/users are correctly identified, and a record created which uses a unique number system.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

24.27 An accident and emergency record is maintained. ☐☐☐ A

Guidance
The accident and emergency record contains, for example:
- *the approved minimum data set*
- *details of medical interventions*
- *details of nursing interventions*
- *a description of clinical, laboratory and radiological findings*
- *details of information given to patients/user and/or their carers on discharge*
- *the printed name and signature of the attending clinician and the time the patient/user was attended*
- *the printed name and signature of the attending nurse and the time the patient/user was attended.*

The accident and emergency record is available on a 24-hour basis in accordance with local policy.

24.28 A copy of the accident and emergency record of attendance and treatment in the department is included in the patient's/user's health record if the patient/user is either admitted as an inpatient or referred to the outpatient department (see also standard 23 Health Record Content). ☐☐☐ A

24.29 The record system is computerised. ☐☐☐ B

24.30 Immediate access to the 'child at risk' register is available. ☐☐☐ B

24.31 Seriously ill patients/users are observed and monitored at all times. ☐☐☐ A

24.32 When seriously ill patients/users are transferred to other areas of the hospital or to another organisation they are accompanied by an escort capable of managing likely complications. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Quality improvement

24.33 Patient/user waiting times within the department for initial assessment are monitored. ☐☐☐ A

24.34 The following performance and outcome indicators are reviewed on a service-wide basis:

24.34.1 time spent in department ☐☐☐ B
24.34.2 scheduled and unscheduled return visits ☐☐☐ B
24.34.3 referral (admissions and outpatient) ☐☐☐ B
24.34.4 use of investigations. ☐☐☐ B

24.35 The department participates in national audit projects. ☐☐☐ B

GUIDANCE

The Major Trauma Outcome Study (MTOS) and Scottish Trauma Audit Group are examples.

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 25

Acute Day Care Service

Day surgery may be provided in the following areas:
Day Surgery Unit – a self-contained day surgery unit with its own admission suite, wards, theatre and recovery area and administrative facilities.
Day Case Ward – a day case ward with patients going to the main operating theatre, where lists may be made up entirely of day cases. With a smaller workload, planned day case operations may be incorporated in the routine list.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
25.1 The day care service is directed by a clinician who has overall responsibility for coordinating the activities of the unit.	☐☐☐ A	
25.2 There is an acute day care users' committee.	☐☐☐ B	
GUIDANCE *This committee may, for example:* • *include representation from surgeons, physicians, anaesthetists, general practitioners and nursing staff* • *meet regularly* • *keep minutes of meetings* • *develop and promote policy and procedures including an operational policy for the day care service* • *monitor utilisation* • *participate in planning structural alterations and/or additions* • *coordinate quality assurance activities.*		
25.3 The day care service is represented on any committees where the management of the operating suite is discussed (for example, theatre users' committee).	☐☐☐ C	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
25.4 The following services are readily available:		
25.4.1 blood bank	☐☐☐ A	
25.4.2 the pathology service (see also standard 55 Pathology Service)	☐☐☐ A	
25.4.3 the diagnostic imaging service	☐☐☐ A	
25.4.4 admission to an inpatient bed if required.	☐☐☐ B	
25.5 The day care service has communication links with:		
25.5.1 general practitioners	☐☐☐ B	
25.5.2 community services (NHS only).	☐☐☐ B	
25.6 Clinical procedures are directed by appropriately qualified members of the medical staff.	☐☐☐ A	
25.7 Senior staff are available within the unit to provide guidance and support to the following where they are present:		
25.7.1 house officers	☐☐☐ A	
25.7.2 medical students	☐☐☐ A	
25.7.3 nursing students	☐☐☐ A	
25.7.4 student operating department assistants.	☐☐☐ A	
Policies and procedures		
25.8 There is an operational policy for the day care service.	☐☐☐ A	
25.9 Preoperative selection guidelines are issued to all surgical users.	☐☐☐ A	
25.10 The admission procedure includes reference to at least the following:		
25.10.1 clinical procedures performed on a day basis	☐☐☐ A	
25.10.2 medical fitness	☐☐☐ A	
25.10.3 social fitness	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

25.10 continued

GUIDANCE
When selecting patients for day surgery, for example:
- *housing conditions must allow patients to recover from their operation in comfort*
- *there must be an inside lavatory and access to a telephone*
- *an adult must be available to provide care after discharge*
- *the patient's home must be within a reasonable distance of the hospital.*

25.10.4 admission of children (see also standard 28 Children's Services) ☐☐☐ A
25.10.5 period of notice for admission (NHS only). ☐☐☐ B

25.11 There is a booking system in place.

GUIDANCE
The booking system should ensure that patients is given adequate notice of their admission.

25.12 The general medical and domestic status of the patient are assessed at the initial outpatient visit. ☐☐☐ A

GUIDANCE
This may be carried out:
- *by surgical outpatient staff*
- *in an anaesthetic screening clinic*
- *by nursing staff on the day unit.*

In the independent sector, there may not be an outpatient visit before admission but this information should be gathered before any procedure takes place.

25.13 The patient's general practitioner is informed of the arrangements made. ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
25.14 The following written and verbal information is given to the patient during the initial visit:		
25.14.1 the patient's pre-admission responsibilities and preparation (for example requirements for fasting, shaving, time of arrival)	☐☐☐ A	
25.14.2 post-anaesthetic effects (for example drowsiness, nausea, dizziness, vomiting and headaches)	☐☐☐ A	
25.14.3 provision for out-of- hours contact and emergency care/admission	☐☐☐ A	
25.14.4 the patient's discharge responsibilities.	☐☐☐ A	
GUIDANCE *In the independent sector, as for 25.12 above, there may not be an outpatient visit pre-admission but this information should be given or sent to the patient before the procedure takes place.*		
25.15 There are procedures in place which ensure that:		
25.15.1 case notes and investigation reports are assembled preoperatively	☐☐☐ A	
25.15.2 patient identity bracelets are prepared	☐☐☐ A	
25.15.3 outpatient follow-up appointments are made.	☐☐☐ B	
25.16 The service discharge procedure specifies that:		
25.16.1 the patient is discharged into the care of an adult and is accompanied home	☐☐☐ A	
25.16.2 clear, written postoperative instructions are given to the patient and carer on discharge	☐☐☐ A	
GUIDANCE *These include, for example:* • *constraints of activity following an anaesthetic (for example no driving, no cooking)* • *instructions regarding attendance at the general practitioner's surgery/outpatient department.*		

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

25.16 continued

25.16.3 the patient is provided with a contact number to ring in the event of medical problems arising ☐☐☐ B

25.16.4 the address and telephone number of the person into whose care the patient is discharged are recorded in the patient's health record. ☐☐☐ C

25.17 There is a procedure for managing unexpected overnight admissions. ☐☐☐ B

25.18 A copy of the discharge summary is despatched to the patient's general practitioner on the day of discharge (see also standard 23 Health Record Content). ☐☐☐ B

25.19 Nursing staff telephone the patient the day after discharge. ☐☐☐ C

GUIDANCE
This is to improve the continuity of care.

Facilities and equipment

25.20 The design of the service provides for the following:

25.20.1 reception of the patient awaiting surgery in suitably equipped accommodation, separate from the operating room and access corridors and which accommodates the special needs of children and takes into account patient flow ☐☐☐ A

25.20.2 there is an equipped and staffed area for patients recovering from anaesthesia, which accommodates the special needs of children ☐☐☐ A

25.20.3 there are separate clean and dirty utility areas. ☐☐☐ A

GUIDANCE
Day care facilities should be in line with Health Building Note 52.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

25.20 continued

The recovery area should comply with guidelines issued by the Association of Anaesthetists and/or Royal College of Anaesthetists.

25.21 The day surgical ward is equipped with adjustable trolleys and beds. ☐☐☐ B

25.22 There are areas for the collection of used equipment and waste. ☐☐☐ A

25.23 The following patient facilities are available:

25.23.1 a patient reception area adjacent to the ward in which the patient and escort can wait on arrival and prior to departure ☐☐☐ B

25.23.2 changing rooms with secure cupboards for clothes and valuables ☐☐☐ B

25.23.3 toilets with grab rails, safety locks and wash basin. ☐☐☐ B

25.24 Fire detection and alarm systems are installed. ☐☐☐ A

Patient care

25.25 Day care records are maintained which include:

25.25.1 preoperative assessment ☐☐☐ A

25.25.2 anaesthetic record ☐☐☐ A

25.25.3 operation record ☐☐☐ A

25.25.4 signed consent ☐☐☐ A

25.25.5 nursing record including care given, each entry signed and dated by the nurse responsible ☐☐☐ A

25.25.6 discharge and follow-up instructions given to the patient. ☐☐☐ A

25.26 A register of operations/procedures performed is maintained within the day care unit. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Quality improvement

25.27 The following performance and outcome indicators are reviewed on a service-wide basis:

25.27.1 inappropriate referrals ☐☐☐ B

25.27.2 non-attendance rates ☐☐☐ B

25.27.3 overnight stays or transfers ☐☐☐ B

25.27.4 readmissions ☐☐☐ B

25.27.5 use of investigations. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 26

Administration

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
26.1 Correspondence (by mail or fax) is received, dated, sorted, collated and passed to the correct person promptly, with due regard to issues of confidentiality.	☐☐☐ B	
26.2 Replies to correspondence are typed accurately, signed and posted/faxed and a copy filed promptly, with due regard to issues of confidentiality.	☐☐☐ B	
26.3 Telephone enquiries are made and responded to sympathetically and efficiently.	☐☐☐ B	
26.4 Reports and papers are typed accurately, speedily and according to the agreed house style.	☐☐☐ B	
26.5 Reprographic work is produced economically and attractively.	☐☐☐ B	
26.6 Visitors are received courteously.	☐☐☐ B	
26.7 There is a system for maintaining adequate administrative stocks.	☐☐☐ B	
26.8 Business diaries are managed effectively.	☐☐☐ B	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

26.8 continued

GUIDANCE
For example, appointments and meetings are arranged at mutually convenient times and all involved are informed.

26.9 Meetings are organised in ways which maximise their effectiveness. ☐☐☐ C

GUIDANCE
For example, an agenda is negotiated and logistic issues (room, refreshments and travel) are arranged, papers are circulated in advance of the meeting.

26.10 Minutes/notes of meetings are typed promptly in the agreed style and kept confidential as appropriate. ☐☐☐ B

GUIDANCE
For example, minutes/notes are accurately recorded to include as a minimum the date of the meeting, those present, apologies received and actions agreed. The minutes/notes are typed, checked and circulated in time for action points to be implemented.

26.11 Administrative staff and personal assistants manage their workload efficiently, prioritising accurately, estimating time constraints and seeking help when required. ☐☐☐ B

26.12 The progress of agreed actions is monitored. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 27

Catering Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

27.1 Where food services are provided under contract, or where foodstuffs are purchased from outside sources, the organisation ensures that services and foods conform to current food legislative requirements. ☐☐☐ A

27.2 A close working relationship is established with the chief environmental health officer. ☐☐☐ A

27.3 Lines of communication between the catering service and the dietetic service are established (see also standard 30 Dietetic Service). ☐☐☐ B

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

27.4.1 catering arrangements are available for all staff working day and night shifts ☐☐☐ A

27.4.2 catering arrangements are available for relatives staying on site (for example, parents of children, families/carers of critically or terminally ill patients/users) ☐☐☐ B

27.4.3 there are food outlets within the organisation (for example kiosks, vending machines, trolleys). ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Staff development and education

27.5 All staff, including trainees and agency staff, receive:

27.5.1 training in food handling ☐☐☐ A

27.5.2 training in hygiene practices. ☐☐☐ A

Policies and procedures

27.6 Service procedures:

27.6.1 reflect the requirements of the Food Safety Act 1990 ☐☐☐ A

27.6.2 comply with Management of Food Services and Food Hygiene in the NHS HSG(92)34 or local authority environmental health regulations (Scotland) ☐☐☐ A

27.6.3 are agreed by the dietician and the catering manager (see also standard 30 Dietetic Service). ☐☐☐ B

27.6 There are up-to-date, documented operational procedures for the safe storage, preparation, handling and distribution of food. ☐☐☐ A

GUIDANCE

These cover, for example:

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

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

27.6 continued

- *ensuring that the storage of food in dry storage, refrigerators and freezers complies with food hygiene regulations*
- *rotating stock under the 'first in, first out' system*
- *preparing and handling food in accordance with food hygiene regulations*
- *minimising the holding times of prepared foods to preserve nutritional value and food acceptability*
- *disposing of waste safely*
- *care and cleaning of all areas and equipment*
- *machine washing and washing dishes by hand (including reference to scraping and pre-soaking, water temperature, rinsing and sanitising and quick drying of items)*
- *safe serving of meals to infectious patients/users and patients/users who are immunocompromised*
- *collection and clearing of trays and dishes after the meal which ensure noise is minimised for patient/users.*

27.8 There is a procedure for recording and storing samples of food from each meal prepared to assist in cases of suspected food poisoning. ☐☐☐ A

27.9 There are procedures for:

27.9.1 health screening food handlers prior to appointment ☐☐☐ A

27.9.2 food handlers to report if they have certain infections, and action to be taken ☐☐☐ A

27.9.3 the training of supervisors and food handlers. ☐☐☐ A

27.10 The bulk preparation of food for long-term holding (for example, chilling or freezing) is carried out only if equipment and qualified staff are available to establish and supervise standards of handling, preparation and processing. ☐☐☐ A

27.11 Standards for catering are planned, in discussion with the dietetic service, to

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

27.11 continued

provide meals which meet the needs of patients/users and staff and are in line with The Patient's Charter (see also standard 30 Dietetic Service). ☐☐☐ A

GUIDANCE
The Patient's Charter requires organisations to set local standards which will offer patients/users a choice of meal and portion size, suitable for all diets (NHS only).

Attention is also drawn, for example, to:
- *attractive presentation of food*
- *a flexible menu-ordering system*
- *portion size*
- *variety and texture*
- *requirements of special patient/user populations (for example, children)*
- *menu cycles (taking into account the length of patient/user stay as well as food availability)*
- *needs of patients/users and staff on either restricted or therapeutic diets.*

27.12 Menus are planned to meet the dietary needs of ethnic minority groups. ☐☐☐ B

GUIDANCE
Where appropriate and possible, such menus should be approved by the relevant community leaders.

27.13 There are documented procedures for dealing with a major catering emergency. ☐☐☐ A

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

27.15 There is a stock control system. ☐☐☐ B

27.16 The stock control system deters pilfering. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Facilities and equipment

27.17 Food premises are registered with the local authority. ☐☐☐ A

27.18 There are separate areas within the department for the following:

27.18.1 hand washing ☐☐☐ A

27.18.2 food delivery (receiving area) including facilities for checking the quality and the quantity of the food received and enabling food to be transferred rapidly to the appropriate storage area ☐☐☐ A

27.18.3 food storage ☐☐☐ A

27.18.4 food preparation (including an area to prepare therapeutic diets, special diets, infant feeds and parenteral and supplementary feeding) ☐☐☐ A

27.18.5 cooking and reheating/regeneration ☐☐☐ A

27.18.6 holding prepared food ☐☐☐ A

27.18.7 washing dishes ☐☐☐ B

27.18.8 equipment storage ☐☐☐ B

27.18.9 waste disposal. ☐☐☐ A

27.19 The layout of the department is designed to allow an efficient and hygienic flow of work. ☐☐☐ B

27.20 Facilities comply with the requirements of relevant building regulations and statutory requirements. ☐☐☐ B

GUIDANCE

Attention is drawn, for example, to:

- *cleaning of floors, walls and ceilings and the maintenance of sanitary conditions in all food rooms*
- *satisfactory lighting for working conditions and monitoring standards of cleanliness*
- *ventilation, temperature and humidity control to provide satisfactory working*

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
27.20 continued		
conditions and to promote cleanliness • *fire safety requirements* • *health and safety regulations.*		
27.21 Equipment is purchased from an approved supplier.	☐☐☐ A	
27.22 There is evidence that equipment complies with relevant safety standards.	☐☐☐ A	
GUIDANCE *Particular attention is given, for example, to:* • *safety systems or alarms in walk-in refrigerators and freezers* • *electrical, gas and pressure equipment* • *fish fryers.*		
27.23 Special eating utensils are available to meet the needs of particular patient/user groups (such equipment may include modified eating and drinking utensils for patients/users with special feeding needs, for example paediatric patients/users or those with physical impairments).	☐☐☐ B	
Quality improvement		
27.24 Performance and quality indicators are reviewed on a service-wide basis, including:		
27.24.1 special diets	☐☐☐ B	
27.24.2 unit costs	☐☐☐ B	
27.24.3 waste.	☐☐☐ B	
27.25 Arrangements are in place for patients/users to consult with catering staff and give feedback on the meals provided (for example a patient/user comment card system).	☐☐☐ B	
27.26 A written response to the recommendations of the environmental health officer is produced.	☐☐☐ B	
27.27 Recommendations made by the environmental health officer are complied with.	☐☐☐ A	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 28

Children's Services

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

28.1 The Welfare of Children and Young People in Hospital (Department of Health, 1991) and Child Health in the Community (Department of Health, 1996), the Children's Charter and Health Services for Children and Young People (Action for Sick Children) are used to inform the way in which care is organised and delivered. ☐☐☐ A

GUIDANCE
It is expected that these documents will be readily available, as appropriate, in all the areas where children are cared for.

28.2 There is an up-to-date, documented philosophy of care for children which is understood by all staff in contact with children and is reviewed annually. ☐☐☐ A

GUIDANCE
The philosophy should be drafted with input from a Registered Sick Children's Nurse or Registered Nurse (Child)and a paediatrician. Where there is a corporate philosophy, it should be locally adopted.

28.3 In all dedicated children's services and on each ward dedicated to the care of

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.3 continued

children, there are two trained members of the nursing staff on duty at all times, whose names appear on either part 8 or part 15 of the UKCC Register; that is Registered Sick Children's Nurse or Registered Nurse (Child). ☐☐☐ A

28.4 When it is not possible to nurse a child in a dedicated children's unit (for example, in the independent sector or a specialist department), the named nurse should be a Registered Sick Children's Nurse or Registered Nurse (Child). ☐☐☐ A

28.5 When the named nurse is not on duty, a Registered Sick Children's Nurse is available at all times to provide advice. ☐☐☐ A

GUIDANCE

Advice may be provided by a Registered Sick Children's Nurse based off site (telephone advice) but there must be a formal agreement, for example with a local NHS trust which has a dedicated children's unit, to provide this advice on a 24-hour basis.

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

GUIDANCE

The role of the nursery nurse is to assist in meeting the emotional and physical needs of children, for example bathing, dressing and feeding sick and convalescent children, but this should never extend to the duties appropriate to a registered nurse.

28.7 In a dedicated children's unit, there is a designated children's consultant physician or children's surgeon responsible for supervising the child's care while in hospital. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.8 In a dedicated children's unit, there is resident paediatrician support on call at all times. ☐☐☐ A

GUIDANCE
SHOs with less than 12 months' experience in paediatrics should always be supported by readily available experienced paediatric staff. These can include: SHOs with greater than 12 months' experience in paediatrics, specialist registrars (SpRrs), staff grades, associate specialists or consultant paediatricians.

SHOs working in a unit receiving acutely ill children or where paediatric support is provided for a consultant obstetric unit, should always have 12 months' experience.

28.9 Where a child is admitted to a department other than a children's department, a paediatric consultant is available at all times to provide advice on the child's care and treatment to the consultant concerned. ☐☐☐ A

GUIDANCE
This may be the on-call paediatrician, provided they are free and able to attend. When a child is admitted to a hospital without a paediatric unit, policies must be in place stating what care and procedures can be undertaken. There must be clear arrangements for paediatric cover, advice and transfer of paediatric patients to paediatric facilities.

In the independent sector, the consultant treating the child is responsible for ensuring that there are arrangements for paediatric advice, the hospital should have a procedure for recording the name and contact number of the advising paediatric consultant for each case.

Policies and procedures

28.10 Procedures are developed with multidisciplinary input, including a Registered Sick Children's Nurse or Registered Nurse (Child) and a paediatrician and with multiagency input as appropriate. ☐☐☐ A

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
28.11 There are up-to-date, documented procedures which meet the specific needs of children including:		
28.11.1 routine admission (see also standard 20 Referrals, Access and Admission)	☐☐☐ A	
28.11.2 emergency admission (see also standard 20 Referrals, Access and Admission)	☐☐☐ A	
28.11.3 day case admission (see also standard 25 Acute Day Care Service)	☐☐☐ A	
GUIDANCE *There should be dedicated children's sessions, see the Action for Sick Children publication, Just for the Day, for information and guidance.*		
28.11.4 intensive care unit admission (see also standard 59 Special Care Service)	☐☐☐ A	
GUIDANCE *This should include transfer to another facility for special care.*		
28.11.5 discharge (see also 22 Leaving a Service/Discharge)	☐☐☐ A	
GUIDANCE *In acute services, the procedure should include reference to the links with community services.*		
28.11.6 outpatient attendance (see also standard 54 Outpatient Service)	☐☐☐ A	
28.11.7 accident and emergency attendance (see standard 24 Accident and Emergency Service)	☐☐☐ A	
28.11.8 parents accompanying children to theatre and recovery room (see also standard 53 Operating Theatre Service/Anaesthetic Service)	☐☐☐ A	
28.11.9 pain management and pain relief	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.11 continued

GUIDANCE
For information, refer to The Royal College of Paediatrics and Child Health document, Managing Pain in Childhood.

28.11.10 visiting arrangements for children in hospital ☐☐☐ A
28.11.11 preoperative instructions, for example fasting policy ☐☐☐ A
28.11.12 control of infection policy for children ☐☐☐ A
28.11.13 security arrangements for children in hospital to guard against abduction ☐☐☐ A
28.11.14 dealing with the death of a child including making arrangements for burial or cremation. ☐☐☐ A

GUIDANCE
The policy includes, for example:
- *details of overnight facilities available for bereaved parents*
- *information on how to access bereavement counselling for the family (such as contact numbers for national voluntary agencies).*

Valid consent of children

28.12 There is an up-to-date, documented procedure to guide staff in obtaining the valid consent of the parent/carer or guardian and/or the child. ☐☐☐ A

GUIDANCE
Children may give valid consent if deemed competent, however, consent for a child under 16 can be given by the person with parental responsibility.

The procedure should include:
- *ensuring that consent to treat all children under 16 is obtained from the child and/or the parent/carer or guardian*
- *dealing with parents/guardians (or children where judged to be competent) refusing urgent or lifesaving treatment.*

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.12 continued

The parent's right to decide on a child's medical treatment terminates if and when the child achieves sufficient understanding and intelligence to enable him or her to understand what is proposed. In England and Wales this is covered in the 'Gillick' judgement by the House of Lords in 1985. In Scotland it is covered by the Age of Legal Capacity (Scotland) Act 1991, S.2 (4). However, the Children Act 1989 recognises that there is generally a practical need for the parent/carer to be informed about important events in the child's life.

28.13 Information is available for parents/carers on valid consent prior to the child's planned hospital admission. ☐☐☐ A

GUIDANCE
This should be written specifically for parents/carers and children.

28.14 For inpatient procedures and acute day care, children and parents/carers are offered the opportunity to visit the ward prior to admission. ☐☐☐ B

28.15 There is written information:

28.15.1 available for parents/carers on preparing children for their treatment ☐☐☐ B

GUIDANCE:
The information includes, for example:
- *emotional and psychological preparation as well as physical preparation, such as whether to eat or not and what to bring*
- *encouragement for parents/carers to remain with their child throughout the treatment/admission period*
- *details of teaching arrangements for children who miss school because of serious or chronic illness.*

28.15.2 specifically for children about attending the clinic/hospital for treatment. ☐☐☐ B

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.15 continued

GUIDANCE:
Information is written in understandable language and available for children of different ages.

Facilities and equipment

28.16 Children are cared for in an environment which is child-centred and separate from adults. ☐☐☐ A

GUIDANCE
This includes, for example:
- *provision of toys and books*
- *information materials using appropriate language*
- *facilities for siblings and other family members*
- *facilities for breast-feeding and nappy changing.*

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

28.17.1 the accident and emergency department (see also standard 24 Accident and Emergency Service) ☐☐☐ A

GUIDANCE
There should be a separate area for children in the accident and emergency department.

28.17.2 the day care unit (see also standard 25 Acute Day Care Service) ☐☐☐ A

28.17.3 the operating theatre suite (see also standard 53 Operating Theatre Service/Anaesthetic Service) ☐☐☐ A

Guidance
The recovery area for children should be screened off if a separate area is not available.

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
28.17 continued		
28.17.4 outpatient departments (see also standard 54 Outpatient Service)	☐☐☐ A	
28.17.5 the diagnostic imaging service	☐☐☐ A	
28.17.6 the pathology service.	☐☐☐ A	
28.18 Play facilities, toys, games and books are provided for children of all ages in the areas of the organisation where:		
28.18.1 they are cared for	☐☐☐ B	
28.18.2 they wait for an appointment/therapy/treatment.	☐☐☐ B	
28.19 The special care and separate accommodation needs of adolescents are recognised and addressed.	☐☐☐ A	

GUIDANCE

Where it is impractical to provide a separate adolescent unit within a children's department, a separate area should be designated.

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

Adolescents have distinct and different needs from both child and adult patients; they should have the opportunity to choose either the children's or adults' area if no adolescent unit is available.

Facilities for adolescents include, for example:
- *space and facilities to maintain education*
- *space for socialising, hobbies and homework*
- *flexibility about meal times and visiting times.*

Adolescents should be involved in decisions about their treatment. See: The Patient's Charter: Services for Children and Young People (Department of Health), Welfare of Children and Young People in Hospital (Department of Health) and Health Services for Children and Young People (Action for Sick Children).

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.20 Where children are inpatients, the organisation collaborates with the local education authority to ensure that teachers are in attendance to provide and maintain education. ☐☐☐ A

GUIDANCE
The arrangements for education should comply with the guidance set out by the NHS Executive in The Education of Sick Children HSG (94) 24.

28.21 A play specialist is available to design and supervise play activities. ☐☐☐ B

GUIDANCE
This specialist holds the Hospital Play Specialist Examination Board Certificate (HPSEB) – note this qualification only applies in England. The play specialist should be informed of children's individual conditions and care plans to assist in the design of appropriate play activities.

28.22 All services working with children, including accident and emergency departments, have paediatric equipment and paediatric doses of medication available. ☐☐☐ A

GUIDANCE
This includes, for example:
- *anaesthetic equipment*
- *inhalation therapy equipment*
- *paediatric-sized needles, cannulae, infusion regulators and other intravenous equipment*
- *paediatric infusion sets*
- *resuscitation equipment.*

28.23 All paediatric equipment is regularly maintained. ☐☐☐ A

GUIDANCE
The frequency of maintenance will depend upon the equipment and must be in line with the manufacturer's instructions. Reference should also be made to: The Report of the Working Party on Alarms on Clinical Monitors (Medical Devices Agency, 1995).

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
28.24 Staff using paediatric equipment and paediatric medication are trained in its use and regular updating is provided.	☐☐☐ A	
GUIDANCE *Training and updating should be carried out when staff first join and then on an annual basis.*		
28.25 Paediatric resuscitation training is carried out annually for all clinical staff working with children.	☐☐☐ A	
28.26 A paediatrician is responsible for advising the service on:		
28.26.1 the provision of paediatric equipment	☐☐☐ A	
28.26.2 doses of medication	☐☐☐ A	
28.26.3 regular staff update training.	☐☐☐ A	
28.27 In areas where children are cared for, additional safety precautions are taken (see also standard 32 Housekeeping Service).	☐☐☐ A	
GUIDANCE *For example:* • *power points are fitted with safety shutters* • *physical barriers prevent entry to hazardous areas* • *cleaning agents and other hazardous materials are kept in correctly labelled containers with child-resistant closures* • *cupboards containing cleaning agents and other hazardous materials are kept locked* • *hot water is at a safe temperature and there are safety covers and individual thermostats on radiators in children's areas* • *doors are fitted with high handles* • *windows to which young children have access are non-openable, or provided with safety bars.*		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

28.28 Staff are aware of the special needs of the following:

28.28.1 children with life-threatening illnesses ☐☐☐ A

GUIDANCE
There should be facilities for advice and support for parents/carers on first being informed and when options for care are discussed.

Children should be admitted as inpatients only if this is vital for their treatment/care.

28.28.2 children with physical or sensory disabilities and children with learning disabilities ☐☐☐ A

GUIDANCE
Staff need to demonstrate good links between acute and community services and awareness of appropriate voluntary and statutory services and guidance on multiagency work.

28.28.3 children with behavioural and emotional problems ☐☐☐ A

28.28.4 unaccompanied children ☐☐☐ A

28.28.5 children with a terminal illness. ☐☐☐ A

Involvement of children and carers

28.29 Accommodation is provided for parents/carers staying overnight in hospital with their children. ☐☐☐ A

GUIDANCE
This is a bed, either by the child's bed, or nearby.

28.30 Parents/carers are encouraged to be involved in the ongoing health care of their children (unless the interests of the children preclude this). ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
28.31 Children, adolescents and parents/carers are involved in decision making.	☐☐☐ A	

GUIDANCE
Staff should allow time to explain the condition and treatment to children in terms understandable for their age and development.

Joint working

28.32 Staff work in collaboration with other agencies such as social services and education departments in accordance with the current legislation and guidelines.	☐☐☐ A	

GUIDANCE
These include, for example:
- *Education Act 1993*
- *Children Act 1989*
- *Disabled Persons Act 1986*
- *Disability Discrimination Act 1995.*

Hospital staff should demonstrate awareness of:
- *arrangements for notifying the social services department of long-stay children in hospital*
- *education arrangements for children in hospital.*

Child protection

28.33 The organisation has up-to-date, documented child protection procedures in line with the local Area Child Protection Committee policies and procedures, and these are available to staff.	☐☐☐ A	

GUIDANCE
The procedures should be based upon the guidance in Working Together Under the Children Act 1989 – a guide to arrangements for the protection of

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

children from abuse (Department of Health, 1991).
As part of the recruitment and selection procedure, the criminal convictions of staff responsible for the care of children are checked (see also Corporate Management, standard 6 Human Resources). Independent sector hospitals cannot necessarily gain the cooperation of the area police force to check criminal records; however, procedures should ensure that efforts are made to try to secure cooperation.

Staff responsible for the care of children are trained in their role in relation to child protection and are aware of how to obtain specialist advice and support.

28.34 A named paediatrician and Registered Sick Children's Nurse or Registered Nurse (Child) are responsible for overseeing child protection measures within the organisation. ☐☐☐ A

Health records

28.35 Parent-held personal child health records are developed. ☐☐☐ B

28.36 All health professionals who treat a child who presents with a parent-held record make appropriate entries in the record. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 29

Diagnostic Imaging Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
29.1 The service is clinically directed by a qualified radiologist.	☐☐☐ A	
GUIDANCE *The radiologist may be full or part time depending on the size and complexity of the department.*		
29.2 The following are on duty or available at all times:		
29.2.1 a qualified radiologist	☐☐☐ A	
29.2.2 state-registered radiographers	☐☐☐ A	
29.2.3 a qualified and experienced medical radiation physicist	☐☐☐ B	
29.2.4 registered nurses.	☐☐☐ B	
29.3 Radiographers are accountable to, and supervised by, a designated senior radiographer.	☐☐☐ B	
29.4 There is a radiation protection supervisor for the department.	☐☐☐ A	
29.5 The role of the radiation protection supervisor is clearly defined.	☐☐☐ A	
29.6 There is a radiation protection advisor for the organisation.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

29.7 Arrangements are in place for dealing with out-of-hours or emergency requests (see also standards 24 Accident and Emergency Service, 53 Operating Theatre Service/Anaesthetic Service, 59 Special Care Service). ☐☐☐ A

29.8 All radiographic procedures are conducted by qualified persons or by students under the guidance of an appropriately qualified person. ☐☐☐ A

Staff development and education

29.9 A library of instructive radiographs is maintained for educational and teaching purposes. ☐☐☐ C

Policies and procedures

29.10 Practice conforms to:

29.10.1 Ionising Radiations Regulations 1985 ☐☐☐ A

29.10.2 Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988. ☐☐☐ A

29.11 When developing ionising radiation procedures, staff in the service are consulted and the radiation protection supervisor and radiation protection advisor are involved. ☐☐☐ A

29.12 Diagnostic imaging procedures are performed only upon written request by an approved referral source. ☐☐☐ A

GUIDANCE
This includes health screening schemes, for example.

Urgent requests may be made verbally but should be followed by a written request.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
29.13 Interventional radiology procedures are only performed after consultation with the referring clinical team and confirmed in writing.	☐☐☐ B	
29.14 The clinical justification for requests is assessed in accordance with national or locally approved guidelines.	☐☐☐ A	
GUIDANCE *The request needs to contain enough clinical information for an assessment of whether the procedure is appropriate.*		
29.15 All images are interpreted and reported on by an appropriately trained and qualified person.	☐☐☐ A	
29.16 When there are critical findings the radiologist or, in their absence, the state-registered radiographer, consults with the referring doctor immediately.	☐☐☐ A	
29.17 A duplicate report is kept on file in the department or in some other accessible storage system.	☐☐☐ B	
29.18 There is a local policy for the length of time that films and reports are stored (NHS only).	☐☐☐ B	
29.19 Films and reports are stored using a coding system (organisational/departmental).	☐☐☐ B	
29.20 There are up-to-date, documented procedures for the following:		
29.20.1 care of patients/users with special needs, including those who are critically ill and those needing isolation precautions	☐☐☐ A	
29.20.2 conditions which require immediate notification to the referring doctor	☐☐☐ A	
29.20.3 imaging examinations in areas other than the diagnostic imaging department	☐☐☐ A	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
29.20 continued		
29.20.4 arrangements for urgent referrals	☐☐☐ A	
29.20.5 appointment/open access system.	☐☐☐ B	
29.21 The implementation of radiation safety measures is supervised by the radiation protection supervisor.	☐☐☐ A	
29.22 As a minimum, safety measures include precautions against:		
29.22.1 chemical hazards	☐☐☐ A	
29.22.2 contamination/infection risks	☐☐☐ A	
29.22.3 electrical hazards	☐☐☐ A	
29.22.4 fire and explosion	☐☐☐ A	
29.22.5 mechanical hazards.	☐☐☐ A	
Facilities and equipment		
29.23 There are prominently displayed signs warning pregnant women of radiation dangers to the foetus (where appropriate, these signs are multilingual).	☐☐☐ A	
29.24 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the Ionising Radiations Regulations 1985.	☐☐☐ A	
29.25 Staff working with radiological equipment wear radiation monitoring devices.	☐☐☐ A	
29.26 The radiation monitoring devices are assessed periodically in accordance with statutory regulations.	☐☐☐ A	
29.27 Results are reported to the radiation protection supervisor.	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
29.28 Continuous records of these results are kept for the working lifetime of staff employed by the service.	☐☐☐ A	
29.29 All rooms and equipment are assessed for safety at acceptable intervals by suitably qualified radiation experts.	☐☐☐ A	
29.30 Records of safety assessments are kept.	☐☐☐ A	
29.31 All equipment is calibrated in accordance with regulations.	☐☐☐ A	

Quality improvement

29.32 The service reviews the following quality, performance and outcome measures:		
29.32.1 inappropriate referrals	☐☐☐ B	
29.32.2 appropriateness of investigations requested	☐☐☐ B	
29.32.3 waiting time for appointments	☐☐☐ B	
29.32.4 time spent by patients/users in the department	☐☐☐ B	
29.32.5 patient/user radiation doses arising from common procedures	☐☐☐ B	
29.32.6 time taken to return reports to referring doctors.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 30

Dietetic Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
30.1 Regular meetings are held with the catering department/contract caterers.	☐☐☐ B	
GUIDANCE *The meetings provide an opportunity to discuss, for example:* • *development of catering policies and procedures* • *provision of special diets* • *provision of supplementary foods* • *food choice* • *menu planning* • *monitoring.* *(See also standard 27 Catering Service.)*		
30.2 Staff liaise with the pharmacy service to discuss the provision of nutritional supplements (see also standard 56 Pharmaceutical Service).	☐☐☐ B	
Staff development and education		
30.3 Staff are aware of the Food Safety Act 1990 and are trained in food handling where appropriate.	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
30.4 The service trains other staff on aspects of nutrition and therapeutic diets.	☐☐☐ B	

Policies and procedures

30.5 There are up-to-date, documented procedures for:		
30.5.1 evaluation of nutritional care	☐☐☐ B	
30.5.2 inpatients/users on special diets	☐☐☐ B	
30.5.3 nutritional assessment of all patients/users referred to the service	☐☐☐ B	
30.5.4 provision of diet sheets (for example ward manual).	☐☐☐ B	
30.6 The service is involved in the formulation of policies to promote healthy food choices for patients/users and staff.	☐☐☐ B	
GUIDANCE *This includes, for example, specific dietary information for children, pregnant women, elderly people.*		
30.7 The service is involved in developing information on the different dietary requirements of ethnic minority groups.	☐☐☐ B	
30.8 The service is involved in the formulation of procedures relating to nutrition and special diets (for example, nutritional support, supplementary foods/feeding, food service, food provision and supplies).	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 31

Health Record Management

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

31.1 The health record service is managed by a qualified person. ☐☐☐ B

GUIDANCE
The senior manager of a health record service should be an associate member of the Institute of Health Record Information and Management and hold the diploma in health record management. Managers may also hold the certificate in health record management.

31.2 In an organisation where the employment of a health record manager on a full time or part time basis is not justified, ongoing consultative advice from a qualified person is obtained. ☐☐☐ B

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

GUIDANCE
The membership of the health record committee includes, for example, the manager of the health record service, medical and nursing staff representatives, and other professional staff who contribute substantially to the patient's/user's health record.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

31.3 continued

The health record committee:
- *meets regularly*
- *keeps minutes*
- *reports regularly to the executive management team/trust board*
- *reviews its membership at an agreed interval.*

The responsibilities of the health record committee include, for example:
- *determining standards and policies for the format of the patient's/user's health record*
- *introducing new record forms or introducing alterations to existing forms*
- *agreeing policies and procedures for the health record service*
- *recommending action to be taken when problems arise with health records (for example when records are not returned to the storage area)*
- *analysing the content of the health record on a systematic basis to ensure that the recorded clinical information facilitates the provision and evaluation of patient/user care*
- *regularly reporting the findings of the analysis to the executive management team/trust board.*

31.4 Health record staff are involved in evaluation activities for the organisation. ☐☐☐ B

GUIDANCE
Involvement includes, for example:
- *compiling statistical data as requested on patient/user care for utilisation review and clinical audit programmes*
- *supervising and/or advising on data collection by other staff within the organisation*
- *reviewing health records to determine compliance with established standards*
- *suggesting methods to improve health record information systems.*

31.5 A health record is maintained for every patient/user. ☐☐☐ A

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
31.5 continued		
GUIDANCE *Each patient/user should have a single record. Where this is not possible, the organisation should satisfy itself that it knows the whereabouts of other records at all times.*		
31.6 There is a filing system which:		
31.6.1 enables rapid retrieval of records	☐☐☐ A	
31.6.2 prevents misfiling	☐☐☐ B	
31.6.3 incorporates an effective tracing system.	☐☐☐ B	
31.7 There is a standard health record folder which:		
31.7.1 holds all papers securely and allows insertions to be made	☐☐☐ A	
31.7.2 has clearly indicated contents	☐☐☐ B	
GUIDANCE *This may be done through a printed index of contents or coloured dividers.* *When designing new folders, the views of staff using the folders should be sought.*		
31.7.3 is made of robust material to withstand handling and transport.	☐☐☐ C	
31.8 There is provision for 24-hour access to the record library for authorised personnel.	☐☐☐ A	
Policies and procedures		
31.9 There are up-to-date, documented procedures for the following:		
31.9.1 patient/user numbering	☐☐☐ A	
31.9.2 format of each record	☐☐☐ B	
31.9.3 filing order of documents in each record	☐☐☐ B	
31.9.4 record entry	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

31.9 continued

GUIDANCE
This should include, for example:
- *who is authorised to make entries into the record*
- *dating, signing and printing of name and designation of signatory against each record entry*
- *legibility*
- *abbreviations and symbols that can be used in the record*
- *not recording 'offensive' personal comments about the patient/user or their carer.*

31.9.5 safeguarding the information in the record against loss, damage, or use by unauthorised persons ☐☐☐ A

31.9.6 confidentiality and release of information ☐☐☐ A

GUIDANCE
This should take into account the Data Protection Act 1984, the Access to Medical Reports Act 1988, the Access to Health Records Act 1990 and the Access to Health Records (Northern Ireland) Order 1993.

31.9.7 retention of records ☐☐☐ A

GUIDANCE
See Health Circular HC(89) 20 Preservation, Retention and Destruction of Health Records – Responsibilities of Health Authorities under the Public Records Act.

31.9.8 destruction of records ☐☐☐ A

GUIDANCE
As for criterion 31.9.7, see Health Circular HC(89)20.

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
31.9 continued		
31.9.9 microfilming of records	☐☐☐ B	
31.9.10 compilation of duplicate records	☐☐☐ B	
GUIDANCE *Including, for example, who is authorised to make duplicate records and what these should look like.*		
31.9.11 merging of duplicate records	☐☐☐ B	
GUIDANCE *Including, for example, who is authorised to merge records.*		
31.9.12 transferring of records within the organisation and via internal and external post systems	☐☐☐ A	
31.9.13 storage of records held separately from the main record (for example accident and emergency).	☐☐☐ A	
31.10 Health record procedures are made available to:		
31.10.1 health record service staff	☐☐☐ A	
31.10.2 other disciplines where appropriate.	☐☐☐ B	
GUIDANCE *Procedures for record entries, safeguarding the information and confidentiality should be disseminated to all staff who contribute to and/or use the records.*		
31.11 All records are coded at discharge or within local contracting requirements.	☐☐☐ A	
GUIDANCE *A current version of the international classification of diseases and OPCS procedure codes or other approved classifications should be used (see also Corporate Management, standard 4 Information Management and Technology).*		

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
31.12 Records are checked for misfiling on a systematic basis	☐☐☐ B	
31.13 The patient's/user's details held on the record summary sheet are checked against the corresponding information on the patient/user master index and amended as necessary.	☐☐☐ B	
GUIDANCE *This should be done at each patient/user attendance. Displaying a sign in reception areas asking the patient/user to inform staff of any changes may assist in ensuring this information is correct.*		
31.14 A signature bank is maintained.	☐☐☐ A	
GUIDANCE *A local register of signatures and designations should be kept and procedures put in place for updating the register and monitoring currency and accuracy on an ongoing basis. The signature entry on the register should correspond to the individual's style of signing in the record.*		
Facilities and equipment		
31.15 The location of the department enables records to be retrieved and distributed rapidly.	☐☐☐ B	
31.16 Staff have space to read and work with records, including records on microfilm or other storage retrieval systems.	☐☐☐ B	
31.17 Filing space is sufficient to meet: 31.17.1 current needs 31.17.2 future storage needs.	☐☐☐ B ☐☐☐ C	
31.18 The active storage area includes all records currently in use within the organisation.	☐☐☐ B	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
31.19 The active and inactive records are secured to protect records against loss, damage or use by unauthorised persons. *GUIDANCE* *This may include, for example, having coded locks for the health record service area.*	☐☐☐ A	
31.20 The department is fitted with smoke alarms.	☐☐☐ A	
Quality improvement		
31.21 The following performance and outcome indicators are reviewed on a service-wide basis: 31.21.1 missing notes 31.21.2 time taken to retrieve notes.	☐☐☐ B ☐☐☐ B	
31.22 A designated individual is responsible for monitoring the content of the health records in accordance with local procedures. *GUIDANCE* *This may be at organisation/directorate/service level.*	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 32

Housekeeping Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Staff development and education		
32.1 Staff are given in-service training on the following:		
32.1.1 safety measures to be complied with	☐☐☐ A	
32.1.2 safety measures in specialised areas such as the sterile services department, kitchens, workshops, laundry, laboratories and radiology areas	☐☐☐ A	
32.1.3 control of infection and role of the employee in this control (for example, type and storage of mop heads).	☐☐☐ A	
32.2 Staff who are assigned tasks in specialist areas such as operating theatres, labour suite, accident and emergency departments, special care units and isolation rooms receive additional training in the execution of procedures unique to these departments (see also standard 59 Special Care Service).	☐☐☐ A	
Policies and procedures		
32.3 Procedures for housekeeping reflect the organisation's control of infection policy and include:		
32.3.1 cleaning of specialised areas (for example, laboratories, mortuaries, operating theatres, special care units)	☐☐☐ A	
32.3.2 cleaning processes for all general areas	☐☐☐ B	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

32.3 continued

32.3.3 special purpose cleaning, including for MRSA ☐☐☐ A

32.3.4 disposal of general and contaminated waste (see also Corporate Management, standard 9 Risk Management) ☐☐☐ A

32.3.5 measurement, labelling, storage and proper use of housekeeping and cleaning supplies ☐☐☐ A

32.3.6 use, cleaning, storage and care of cleaning equipment ☐☐☐ B

32.3.7 pest control reporting. ☐☐☐ B

32.4 There is an up-to-date, documented procedure for stock control and stock rotation. ☐☐☐ B

32.5 Domestic storage areas are:

32.5.1 adequate for the storage of the necessary materials and equipment ☐☐☐ B

32.5.2 maintained in a safe condition. ☐☐☐ B

Quality improvement

32.6 There is a documented system for assessing cleaning effectiveness which:

32.6.1 is measured against defined standards of performance ☐☐☐ B

32.6.2 is discussed with the departments using housekeeping services ☐☐☐ B

32.6.3 includes the assessment of cleaning products and equipment ☐☐☐ B

32.6.4 includes the assessment of cost effectiveness of products and equipment. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 33

Laundry and Linen Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Staff development and education

33.1 Staff are given in-service training in:

33.1.1 control of infection and responsibility of the employee ☐☐☐ A

33.1.2 health and safety measures in the linen/and laundry service. ☐☐☐ A

Policies and procedures

33.2 There are up-to-date, documented procedures for treatment, handling, repair and storage of linen. ☐☐☐ A

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

33.3 The amount of clean linen supplied is based on:

33.3.1 calculated need ☐☐☐ B

33.3.2 agreed frequency of supply. ☐☐☐ B

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
33.4 There is a system in place for supplying clean linen out of hours and in emergencies (see also standard 24 Accident and Emergency Service).	☐☐☐ A	
33.5 There is a stock control system.	☐☐☐ B	
33.6 Stocks are rotated on a 'first in, first out' basis.	☐☐☐ B	
33.7 Clean linen is handled and stored in such a way as to:		
33.7.1 avoid undue reabsorption of moisture	☐☐☐ A	
33.7.2 avoid contamination from surface contact or air-borne deposition.	☐☐☐ A	
33.8 A linen inventory is kept.	☐☐☐ B	
33.9 Containers or bags are available to collect soiled linen, at the site of contamination to avoid spread of infection.	☐☐☐ A	
33.10 Clean linen and soiled linen are segregated to avoid cross-infection and are transported and stored separately.	☐☐☐ A	
33.11 The following are cleaned on a systematic basis:		
33.11.1 containers transporting soiled linen bags	☐☐☐ A	
33.11.2 storage areas for soiled linen.	☐☐☐ A	
33.12 Linen which has been exposed to a source of infection is clearly identified and suitable precautions are taken in its processing.	☐☐☐ A	
33.13 In-house laundering facilities are separated from:		
33.13.1 the clean linen processing area	☐☐☐ A	
33.13.2 patient/user rooms	☐☐☐ A	
33.13.3 areas of food preparation and storage	☐☐☐ A	
33.13.4 areas in which clean material and equipment are stored.	☐☐☐ A	

CRITERIA	YES	NO	PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
33.14 Surfaces and overhead areas in the laundry are cleaned on a systematic basis.			A	
33.15 To minimise the risk of cross-infection:				
33.15.1 hand washing facilities are readily available			A	
33.15.2 staff working with infectious linen put on clean uniforms at the start of each shift or working day.			A	
33.16 In linen handling and laundry areas staff do not:				
33.16.1 smoke			A	
33.16.2 eat.			B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 34

Learning Disabilities – Advocacy

An independent advocacy service is provided.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
34.1 The service ensures that there is access to an independent advocacy service (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance).	☐☐☐ A	

GUIDANCE
This includes, for example:
- *specific services for people with a learning disability*
- *specific services for users of mental health services*
- *specific services for black and Asian patients and other ethnic groups represented in the local population*
- *specific services for elderly people*
- *specific services for children and young adults*
- *services for people with sensory impairment*
- *advocates who are trained in powers of attorney and Court of Protection procedures.*

34.2 Individuals who take decisions on behalf of users have the authority to do so.	☐☐☐ A	
34.3 There are up-to-date, documented guidelines on advocacy.	☐☐☐ B	

GUIDANCE
These include, for example:

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
3.3 continued		
• *provision for an annual policy review* • *service level agreements between the advocacy service and the provider* • *how the service understands the issues relating to advocacy and how it will respond to the individual needs of the care group* • *how to respond to areas of conflict between advocates and carers.*		
34.4 There is an agreed advocacy code of practice, which is subject to annual review.	☐☐☐ A	
34.5 Information on advocacy services is presented in a range of formats.	☐☐☐ B	
GUIDANCE *This includes, for example:* • *simple, jargon-free language* • *materials in languages appropriate for the local population* • *audio and video tapes* • *Makaton symbols, photographs, pictures.*		
34.6 Users are able to choose/change, as far as is practicable, the person who will advocate for them.	☐☐☐ B	
34.7 A space is provided for advocacy work in a private setting away from the service.	☐☐☐ C	
34.8 The management team meets on a regular basis with advocates.	☐☐☐ B	
GUIDANCE *There is a written record of these meetings detailing issues raised and outcomes, which is readily available to users and carers.*		
34.9 The service is able to cite examples of changes made as a result of advocacy interventions.	☐☐☐ C	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

34.10 Staff receive training on working with advocates. ☐☐☐ B

34.11 An interpreter service is available to reflect the needs of local non-English speaking populations and hearing-impaired people (see also standard 18 The Patient's Individual Needs). ☐☐☐ A

GUIDANCE
In cases of emergencies (or out of hours) when an interpreter is not available, a telephone interpreter service is used and the interpreter called in as soon as possible.

Minicoms are available.

Standard 35

Learning Disabilities – Choice and Decision Making

Users are enabled to make a wide range of choices and decisions and the service actively seeks ways to help users make choices and decisions about their lives.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Choice		
35.1 Users are supported and encouraged to make daily choices about:		
35.1.1 food and drink	☐☐☐ B	
35.1.2 social and leisure activities	☐☐☐ B	
35.1.3 clothing	☐☐☐ B	
35.1.4 accessing community facilities.	☐☐☐ B	
35.2 Staff support users in making informed choices.	☐☐☐ B	
35.3 All staff receive training in supporting users to make informed choices.	☐☐☐ B	
35.4 Trained staff are available to support users in understanding how to make realistic choices.	☐☐☐ B	
35.5 There is a range of communication aids that support users in making informed choices.		

GUIDANCE
These include, for example:
- *showing and demonstrating the choices available*

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

35.5 continued

- *using Makaton symbols, photos, pictures*
- *using simple language.*

35.6 Where users' choices are restricted, options are offered. ☐☐☐ B

Decision making

35.7 Users are involved in, and have the power to influence, decisions about:

35.7.1 who they live with ☐☐☐ B
35.7.2 their work ☐☐☐ B
35.7.3 voting ☐☐☐ B
35.7.4 sleeping in a single room ☐☐☐ B
35.7.5 smoking in their home ☐☐☐ A
35.7.6 staff behaviour in their home ☐☐☐ B
35.7.7 how they are addressed ☐☐☐ A
35.7.8 decor, furniture and fittings in their home. ☐☐☐ B

35.8 Evaluations of the user's capacity to make decisions are:

35.8.1 made by a multiprofessional team with independent advocate input ☐☐☐ B
35.8.2 documented in the care plan ☐☐☐ A
35.8.3 reviewed regularly. ☐☐☐ A

35.9 Staff support users in decision making. ☐☐☐ B

35.10 All staff receive training in supporting users to make decisions. ☐☐☐ B

GUIDANCE
The type and level of training should be appropriate to the grade of staff.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
35.11 Trained staff are available to support users in understanding how to make decisions.	☐☐☐ B	
35.12 Users make decisions supported by:		
35.12.1 advocates	☐☐☐ A	
35.12.2 carers and guardians	☐☐☐ A	
35.12.3 staff	☐☐☐ B	
35.12.4 keyworkers.	☐☐☐ A	

Standard 36

Learning Disabilities – Personal Relationships and Sexuality

The service supports users in establishing, developing and maintaining social, personal and sexual relationships.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Social relationships		
36.1 Users have social contact with people inside and outside the service if they wish.	☐☐☐ A	
GUIDANCE *This includes, for example, contact with:* • *family* • *peers* • *people from their own ethnic background.*		
36.2 Resources are available for users to initiate and maintain community and social contacts.	☐☐☐ B	
GUIDANCE *This includes, for example:* • *transport* • *personal finances.*		
36.3 Users are able to offer hospitality in their home environment.	☐☐☐ B	
36.4 Particular consideration is given to the maintenance of social contacts in the planning of and changes to services.	☐☐☐ B	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
36.4 continued		
GUIDANCE *Resettlement arrangements maintain social networks.*		
Personal relationships		
36.5 Users are supported in developing personal relationships.	☐☐☐ B	
36.6 Users are supported to maintain relationships with people other than staff.	☐☐☐ B	
Sexuality		
36.7 There is up-to-date, documented guidance on sexual identity and relationships.	☐☐☐ B	
GUIDANCE *This includes, for example, how:* • *the interests of users are considered paramount unless they infringe on another person* • *users are actively supported, where possible, in their sexual development and relationships* • *training on sexuality issues is available to staff* • *ongoing support is given to staff* • *staff are supported when there is a conflict or difficulty in resolving sexuality issues.*		
36.8 The guidance is written:		
36.8.1 with input from clinical staff	☐☐☐ B	
36.8.3 with input from advocates	☐☐☐ B	
36.8.4 in the light of legal requirements.	☐☐☐ A	
36.9 Users have access to guidance and education on all aspects of sexuality.	☐☐☐ B	

CRITERIA

	YES	NO	PARTIAL	
36.10 Users are supported by staff with appropriate training in this area.	☐	☐	☐	B
36.11 Users are able to explore their sexuality in private.	☐	☐	☐	A
36.12 Users have access to confidential family planning and sexual health services.	☐	☐	☐	A
36.13 There is an up-to-date, documented procedure on how the service prevents and responds to cases of sexual abuse or harassment.	☐	☐	☐	A

GUIDANCE
This includes, for example:
- *details of staff training*
- *mechanism for reporting incidents*
- *mechanism used to investigate reported incidents*
- *the obligations of staff.*

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Standard 37

Learning Disabilities – Personal Financial Arrangements

Wherever possible, users manage their own financial affairs with advice and support from staff when necessary.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
37.1 All financial procedures comply with current legislation and guidance.	☐☐☐ A	
37.2 Users have the right to spend their own money.	☐☐☐ A	
37.3 The level of financial management support given to users is tailored to meet their assessed need.	☐☐☐ B	
37.4 Users receive training on how to manage their financial affairs.	☐☐☐ B	
37.5 If the user is not able to manage his/her own affairs, the reason and legal basis for this decision is recorded in the user's health record.	☐☐☐ A	
37.6 Written financial procedures are established for users who are unable to manage their own affairs.	☐☐☐ A	
37.7 Financial structures ensure that users are able to access their personal monies promptly and in accordance with standing financial instructions (see also Corporate Management, standard 5 Financial Resources).	☐☐☐ A	
37.8 The user directly benefits from any item they have purchased for joint use.	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

37.8 continued

GUIDANCE
This includes, for example:
- *cars*
- *videos*
- *televisions.*

37.9 Procedures exist to ensure that financial exploitation does not occur. ☐☐☐ A

Standard 38

Learning Disabilities – Links with Children's Services/Transfer to Adult Services

Children and their carers experience a smooth transition to adult services.
Younger users are assessed by multiprofessional teams to ensure that appropriate programmes are developed.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
38.1 There is an up-to-date, documented procedure on the transfer of children to adult services (see also standard 39 Learning Disabilities – Relocation).	☐☐☐ B	
38.2 Individuals are reassessed to identify their health needs prior to leaving children's services and entering adult services.	☐☐☐ A	
GUIDANCE *This includes, for example, liaising with social services, education, employment.*		
38.3 Carers of children are offered information and support during the transitional period.	☐☐☐ B	
38.4 Children are supported in maintaining friendships/relationships (see also standard 36, Learning Disabilities – Personal Relationships and Sexuality).	☐☐☐ B	
38.5 The multiprofessional team responds to requests to assess the need for specialist services.	☐☐☐ A	
38.6 There is a documented programme of action developed following the assessment process.	☐☐☐ B	

Standard 39

Learning Disabilities – Relocation

All users are fully consulted and actively involved in any form of planned transfer or resettlement.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
39.1 There are up-to-date, documented procedures for transfer and resettlement.	☐☐☐ B	
39.2 The procedures are:		
39.2.1 accessible to users	☐☐☐ B	
39.2.2 accessible to carers/advocates	☐☐☐ B	
39.2.3 explained to users.	☐☐☐ B	
39.3 There is a register of users waiting or requesting alternative accommodation, which is regularly reviewed.	☐☐☐ B	
39.4 Users are informed of any changes to the register.	☐☐☐ C	
39.5 The register is accessible to staff and users.	☐☐☐ B	
39.6 Plans for relocation include:		
39.6.1 maintaining users' personal relationships, friendships and contact with family	☐☐☐ B	
39.6.2 recognition of preferred types of accommodation	☐☐☐ B	
39.6.3 recognition of preferred location	☐☐☐ B	
39.6.4 users' skills and abilities	☐☐☐ B	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
39.5 continued		
39.6.5 daily living activities, and work and leisure patterns	☐☐☐ B	
39.6.6 plans to orientate the user to the area.	☐☐☐ B	
GUIDANCE *This includes, for example:* • *overnight visits* • *initial short stays.*		
39.7 The user's health record is transferred.	☐☐☐ A	
39.8 Continuity of care is taken into account in all review processes.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 40

Library Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
40.1 There is consultation with all categories of user on services provided by the library (this may be through a library committee).	☐☐☐ B	
40.2 The library opening hours meet the requirements of users.	☐☐☐ B	
40.3 The service is supported by administrative and clerical staff.	☐☐☐ B	
Staff development and education		
40.4 Professional librarians are encouraged to participate in continuing professional development, for example the Library Association's Framework for Continuing Professional Development (CPD).	☐☐☐ B	
40.5 Library assistants are encouraged to acquire appropriate technical qualifications, for example, the City and Guilds certificate, and/or to qualify professionally.	☐☐☐ B	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Policies and procedures

40.6 There are up-to-date, documented procedures for the following:

- 40.6.1 patients/users requesting access to the library ☐☐☐ B
- 40.6.2 stock selection ☐☐☐ B
- 40.6.3 stock acquisition ☐☐☐ B
- 40.6.4 stock withdrawal ☐☐☐ B
- 40.6.5 relationships with other information providers within the organisation, district or region ☐☐☐ B
- 40.6.6 relationships with other libraries. ☐☐☐ B

40.7 Library staff are aware of:

- 40.7.1 copyright law ☐☐☐ A
- 40.7.2 The Data Protection Act 1984. ☐☐☐ B

Facilities and equipment

40.8 Collections within the library are accessible to users and library staff and take into consideration the special needs of disabled people. ☐☐☐ B

40.9 There is a readily identifiable service point for users (for example an enquiry desk). ☐☐☐ B

40.10 There are areas within the library for:

- 40.10.1 reading current periodicals ☐☐☐ B
- 40.10.2 reference and literature searching ☐☐☐ B
- 40.10.3 research and private study ☐☐☐ B
- 40.10.4 using audiovisual and electronic information. ☐☐☐ B

40.11 The library's collections are:

- 40.11.1 classified in line with a recognised system ☐☐☐ B
- 40.11.2 arranged in classified order and clearly displayed. ☐☐☐ B

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
40.12 Security arrangements are in place to protect the library's collections and equipment.	☐☐☐ B	
40.13 The library facilities include:		
40.13.1 computers	☐☐☐ B	
GUIDANCE *Computer-based services include, for example:* *• databases and other locally held information* *• on-line information retrieval* *• computer-aided learning programmes.*		
40.13.2 photocopiers	☐☐☐ B	
40.13.3 working space for library staff to receive and process incoming materials and interlibrary loans	☐☐☐ B	
40.13.4 access to a seminar room	☐☐☐ C	
40.13.5 microfilm reading.	☐☐☐ C	
40.14 There is a list of periodicals held in the library.	☐☐☐ B	
40.15 The library is linked to the organisational local area network (LAN), which it uses to distribute and to receive information.	☐☐☐ B	
Quality improvement		
40.16 The quality of the information and documents supplied by the library is periodically reviewed.	☐☐☐ B	
GUIDANCE *The review looks at, for example:* *• accuracy*		

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

40.16 continued

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

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

Guidance
This includes, for example:
- *number of enquiries received*
- *number of interlibrary loans (outgoing and incoming)*
- *number of photocopied book/report extracts and journal articles made by library staff.*

Standard 41

Medical Physics and Biomedical Engineering Service

These criteria are equally applicable to a medical physics and biomedical engineering service and to individual specialty departments.
Please circle the department to which this section applies.
Clinical instrumentation Radiation protection (ionising and non-ionising radiation) Computing and informatics Radiopharmacy Diagnostic radiology physics Radiotherapy physic Equipment management Rehabilitation engineering Nuclear medicine Ultrasound Physiological measurement
(The King's Fund Organisational Audit has additional criteria for all of the above services. They are available for use but will not form part of the audit visit.)

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
41.1 There is a clinical scientist with relevant experience available at all times during normal working hours.	☐☐☐ A	
41.2 Each clinical scientist holds a category of registration recognised by the professional bodies as appropriate to the activities undertaken.	☐☐☐ A	
41.3 Senior medical physics technicians hold an appropriate BTEC, City and Guilds or other suitable technical qualification in a relevant discipline.	☐☐☐ A	
41.4 Lines of communication between departmental staff and other hospital/trust staff are established and, where appropriate, the limits of their responsibilities are clearly defined.	☐☐☐ A	
41.5 Responsibility for the operation of satellite services is clearly defined and documented.	☐☐☐ B	
Staff development and education		
41.6 Information and scientific data from manufacturers concerning their products is available within the department.	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
41.7 Where trainee clinical scientists are in post, training is structured in accordance with IPSM/BES guidelines and under the supervision of a recognised training coordinator.	☐☐☐ B	
41.8 Where technician training is carried out it is done in accordance with requirements of the national training manual.	☐☐☐ B	
Policies and procedures		
41.9 Safety procedures are maintained in accordance with regulatory guidelines (for example, Ionising Radiations Regulations 1985).	☐☐☐ A	
41.10 There are up-to-date, documented procedures for the following:		
41.10.1 care of patients/users having special needs, including those who are critically ill and those needing isolation	☐☐☐ A	
41.10.2 conditions which require immediate notification to the referring clinician or on-take team	☐☐☐ A	
41.10.3 information required for referral to the clinical physics service (for example details of approved referral sources, adequate clinical information to justify the examination)	☐☐☐ A	
41.10.4 maintenance of confidential records	☐☐☐ A	
41.10.5 procedures performed in areas other than the specified department	☐☐☐ A	
41.10.6 reporting procedures employed for each investigation	☐☐☐ A	
41.10.7 scheduling/appointment system	☐☐☐ B	
41.10.8 stock control.	☐☐☐ B	
41.11 As a minimum, safety measures include precautions against:		
41.11.1 electrical hazards	☐☐☐ A	
41.11.2 fire and explosion	☐☐☐ A	

CRITERIA	YES	NO	PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
41.11 continued				
41.11.3 mechanical hazards			A	
41.11.4 radiation hazards			A	
41.11.5 biological hazards			A	
41.11.6 chemical hazards.			A	
41.12 When developing ionising radiation procedures, the radiation protection advisor is involved.			A	
Facilities and equipment				
41.13 Secure storage facilities are available in the department to ensure that all dangerous substances and, in particular, radioactive substances are held under conditions which conform to statutory and manufacturers' requirements.			A	
41.14 Refrigerated storage facilities are available for the safe storage of materials.			A	
41.15 Specialised facilities are available for the safe handling of hazardous materials.			A	
41.16 Specialised equipment has documented levels of operation and performance, allowing traceability to national standards.			A	
41.17 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment, and practice conforms to the requirements of the Ionising Radiations Regulations 1985.			A	
41.18 Equipment is calibrated according to defined protocol.			A	
41.19 All portable electrical equipment (as defined by the Electricity at Work Regulations 1989) is tested to at least the minimum described in this standard.			A	

CRITERIA

Quality improvement

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

41.20 The quality management and evaluation programme includes a list of standards and statutory requirements to be met. ☐☐☐ B

41.21 Standards used are traceable to national standards. ☐☐☐ B

41.22 The service reviews the following performance and outcome measures:

41.22.1 response time ☐☐☐ B

41.22.2 turnaround time for results ☐☐☐ B

41.22.3 appropriateness of requests received by the service ☐☐☐ B

41.22.4 use of clinical investigations. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 42

Medical Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management structure and responsibilities		
42.1 There is a medical committee which is responsible for representing the professional needs and views of medical staff.	☐☐☐ B	
GUIDANCE *This is a formally constituted committee which, for example:* • *meets at least quarterly* • *keeps formal minutes* • *communicates both with the executive management team/trust board and with all consultants and medical staff* • *is responsible for acting in an advisory role and making recommendations to the executive management team/trust board on medical matters* • *may be a multiprofessional group if this is what is agreed within the organisation.*		
42.2 There is an association of junior staff which is responsible for safeguarding the interests and welfare of its members.	☐☐☐ B	
Staffing		
42.3 Consultant staff are appointed in accordance with the relevant health service guidelines (NHS only).	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
42.4 Each consultant and career grade doctor employed has a job plan.	☐☐☐ A	

GUIDANCE:
Job plans should aim to link into the objectives of the service and the organisation's performance review system.

In the independent sector, the admitting rights and scope and limitations of consultants are clearly defined.

42.5 Job plans are reviewed annually.	☐☐☐ A	
42.6 Trainees work rotas which comply with the regulations detailed in Junior Doctors – The New Deal, NHS Executive, 1990.	☐☐☐ A	

Performance management

42.7 All trainees have a named educational supervisor.	☐☐☐ B	

GUIDANCE
The role of educational supervisor is to act as a mentor or guide. They may, or may not, be the consultant for whom the trainee is working. Responsibilities will include agreeing learning plans and objectives at the start of the post/programme placement, measuring progress and providing career support. Other staff, such as the clinical tutor or the respective college tutor, may also be involved.

42.8 There is an ongoing assessment process for doctors in training.	☐☐☐ B	

GUIDANCE
The educational supervisor should meet the trainee to discuss educational objectives, strengths and weaknesses in performance and areas for development. Formal assessments should be carried out at the start and finish of each post/annually. In the interim, progress should be monitored on an informal basis.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Staff support and supervision

42.9 When pre-registration house officers are on duty, a more senior member of staff in an appropriate specialty is available on site to provide cover and help. ☐☐☐ A

42.10 Trainees have 24-hour access to a more senior member of staff to provide advice and assistance when required. ☐☐☐ A

42.11 Trainees are not exposed to clinical duties and responsibilities beyond their competence. ☐☐☐ A

GUIDANCE
Trainees should not be asked to undertake a clinical task for which they have not been trained.

42.12 The qualifications of locum staff are checked prior to their arrival. ☐☐☐ A

42.13 A consultant is responsible for arranging the handover between the outgoing staff and the incoming locum. ☐☐☐ A

42.14 The performance of each junior locum is assessed. ☐☐☐ C

GUIDANCE
The ability of the locum to carry out the job competently may be assessed by the agency providing the locum or after the locum has started work.

Orientation and induction

42.15 All trainees attend an orientation and induction programme on appointment. ☐☐☐ A

GUIDANCE
This includes, for example, induction in areas such as pharmacy, radiology,

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

42.5 continued

pathology, hospital management, fire, health and safety, security, patient care protocols and the postgraduate educational programme.

The induction programme should be appropriate to the grade and level of staff attending. See the General Medical Council publication, The New Doctor, for more details.

42.16 Trainees are provided with an up-to-date organisation handbook. ☐☐☐ B

GUIDANCE
This should contain guidance on local practice and policy. See the General Medical Council publication, The New Doctor, for suggestions on useful contents.

Continuing Education

42.17 There is a structured educational programme for trainees. ☐☐☐ B

GUIDANCE
Examples of formal education include grand rounds, tutorials, journal clubs, lectures, seminars, exam teaching, department meetings, x-ray meetings, autopsy demonstrations and audit meetings. Educational activities should take place regularly and may be based on protected time for academic study of half a day per week.

42.18 There are written training agreements between postgraduate deans and higher specialist trainees. ☐☐☐ B

GUIDANCE
The agreements should define, in terms of education and training, the relationship, duties and obligations on each side.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

42.19 Additional skills training is provided. ☐☐☐ B

GUIDANCE
Examples include admission, referral and discharge procedures, record keeping, communication skills, bereavement counselling, use of information technology, ethical issues, administration and management, handling of drugs, child protection procedures and appropriate use of investigations.

42.20 Trainees do not participate unduly in tasks that are not of benefit to their training and are educationally unproductive. ☐☐☐ B

GUIDANCE
Examples include locating beds for emergency and non-urgent admissions, routinely completing and delivering requests for, and obtaining results of, laboratory and other investigations, portering duties, routine phlebotomy, filing results in case notes.

42.21 Study leave is given. ☐☐☐ C

GUIDANCE
This should be budgeted for with clearly defined rules for allocation.

42.22 Training provision is monitored and reviewed by a designated clinical tutor or specialty tutor. ☐☐☐ B

42.23 Consultant and equivalent staff are supported in meeting the respective Royal College requirements for continuing medical education (CME). ☐☐☐ B

GUIDANCE
See the General Medical Council publication, Duties of a Doctor, section 1, Good medical practice.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

42.24 There is a policy on professional leave. ☐☐☐ C

GUIDANCE
Professional leave covers professional commitments in fields such as examining, visiting and committee work for Royal Colleges, professional associations and advisory bodies.

Clinical audit

42.25 All medical staff participate in a regular programme of clinical audit. ☐☐☐ A

GUIDANCE
Involvement of trainees in audit activity should be documented, for example as part of the assessments made by the educational supervisor.

42.26 There is a nominated consultant within each department responsible for organising and developing audit programmes. ☐☐☐ B

GUIDANCE
In the independent sector, audit programmes for the hospital/unit may be organised and developed by a nominated individual within the hospital/unit.

42.27 Audit includes a structured approach to looking at outcomes from the clinical perspective. ☐☐☐ B

42.28 Audit meetings are held on a regular basis. ☐☐☐ A

42.29 Records of audit meetings are kept. ☐☐☐ A

GUIDANCE
These include, for example:
- *a list of those attending*
- *broad topics discussed*
- *conclusions or recommendations reached.*

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

42.30 Patient/user and clinician anonymity is maintained throughout the audit proceedings. ☐☐☐ A

GUIDANCE
See the General Medical Council publication, Duties of a Doctor, on confidentiality.

Reporting

42.31 Maternal deaths are referred to the Confidential Enquiry into Maternal Deaths. ☐☐☐ B

42.32 Perioperative deaths are referred to the National Confidential Enquiry into Perioperative Deaths. ☐☐☐ B

42.33 Stillbirths and deaths in infancy are referred to the Confidential Enquiry into Stillbirths and Deaths in Infancy. ☐☐☐ B

42.34 Homicides and suicides are referred, as appropriate, to the Confidential Enquiry into Homicide and Suicide by Mentally Ill People (see also standard 47 Mental Health – Clinical Risk Management). ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

King's Fund

Organisational Audit

Accreditation UK

An organisational audit programme for acute, community, learning disabilities and mental health services

Volume 4

King's Fund

Organisational Audit

Accreditation UK

An Organisational Audit Programme for Acute, Community, Learning Disabilities and Mental Health Services

Volume 4

Second edition
June 1997

Contents

Volume 4

Section 5 (continued): Service Specific

Introduction to standards for mental health services		285
Standard 43	Mental Health - Continuity of Care/the Care Programme Approach	286
Standard 44	Mental Health - The Mental Health Act 1983	293
Standard 45	Mental Health - Advocacy	296
Standard 46	Mental Health - Treatment	299
Standard 47	Mental Health - Clinical Risk Management	301
Standard 48	Mental Health - Leave From Hospital	307
Standard 49	Mental Health - Other Specialist Services	309
Standard 50	Maternity Service	312
Standard 51	Nursing Service	321
Standard 52	Occupational Therapy Service	326
Standard 53	Operating Theatre Service/Anaesthetic Service	328
Standard 54	Outpatient Service	338
Standard 55	Pathology Service	349
Standard 56	Pharmaceutical Service	356
Standard 57	Portering Service	364
Standard 58	Radiotherapy Service	367
Standard 59	Special Care Service	372
Standard 60	Sterile Services Department	379
Standard 61	Telecommunications Service	386
Standard 62	Volunteer Service	390

Appendix 1: Glossary of terms	393
Appendix 2: Relevant Legislation, Regulations and Guidance	401

Notes on using the criteria and completing the self-assessment

Priority weighting

Under every standard each supporting criterion has been categorised as A, B or C, to assist with prioritising action plans. The definitions of these categories are as follows:

A Essential practice
Relating to:
- legal and/or professional requirements
- potential risk to patients, staff or visitors
- the patient's rights, in terms of The Patient's Charter.

B Good practice
Standard good practice expected to be in place across the UK.

C Excellent practice
Excellent practice which is not yet standard across the UK.

Guidance and cross-referencing

Guidance material, to assist with interpretation and implementation of criteria, is shown beneath the relevant criteria.

Some criteria are cross-referenced to other sections of the manual, where a criterion relates to another service.

Completing the self-assessment

The self-assessment should be carried out at least twice. Once at the start of the Organisational Audit to give a baseline assessment against which action plans for service development can be drawn up, and again some weeks before the external survey. This final self-assessment will be collated with the other assessments from the organisation and sent to King's Fund Organisational Audit (KFOA).

For each criterion, please indicate the level of compliance by ticking 'yes', 'no' or 'partial' as appropriate. Where the response is 'no' or 'partial', please comment on what is in place and plans for achieving compliance.

Use the comments column for any additional information which may be useful for the surveyors.

A copy of the final self-assessment will be sent to each member of the survey team. This will give the team an overall view of the organisation's progress towards meeting the standards and criteria.

Feedback to KFOA on the criteria

Please use the page at the end of the section to report to KFOA if there are criteria which are difficult to interpret, out of date or unachievable as written.

Introduction to standards for mental health services

Accreditation UK: King's Fund Organisational Audit and Sainsbury Centre for Mental Health

The following seven standards were developed, and are jointly owned, by King's Fund Organisational Audit and the Sainsbury Centre for Mental Health. Both organisations have considerable expertise in service development and working together provided an excellent way of developing appropriate standards for mental health services.

The Sainsbury Centre for Mental Health also brought extensive knowledge about involving users. One of the King's Fund Organisational Audit's objectives was to consult with users on what they considered important practice in mental health; working with the Sainsbury Centre for Mental Health was invaluable for this.

During the pilot phase of the community, mental health and learning disabilities project, the QUARTZ system of quality assurance, developed by the Sainsbury Centre for Mental Health, was used by three of the seven sites providing mental health services alongside the Organisational Audit standards. The results of this project are found in Improving Quality in Mental Health Services – Organisational Audit and QUARTZ (R.G. Hill and G. Shepherd, 1997), an internal report available from the Sainsbury Centre for Mental Health.

The learning that emerged from this project led both King's Fund Organisational Audit and the Sainsbury Centre for Mental Health to a deeper understanding of each other's work. Both organisations will continue to work in partnership to ensure that the standards remain relevant, up to date, challenging and beneficial to users.

For further information about any of the Sainsbury Centre initiatives, please contact:

The Sainsbury Centre for Mental Health
134–138 Borough High Street
London SE1 1LB
Telephone: 0171 403 8790.

Standard 43

Mental Health – Continuity of Care/the Care Programme Approach

Continuity of care/the care programme approach is developed for all patients/users of mental health services.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

General

43.1 There is an up-to-date, documented procedure on continuity of care/the care programme approach (CPA) which is in line with NHS guidance. ☐☐☐ A

GUIDANCE

The procedure should be based on:

- *The Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services HC (90) 23*
- *Developing the Care Programme Approach – Building on Strengths (Department of Health, 1995)*
- *Building Bridges: a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people (Department of Health, 1995).*

In Wales, the approach to continuity of care should be based on:

- *Mental Health Service: a strategy for Wales (1989)*
- *Guidance on the Care of People in the Community with a Mental Illness WHC (96) 26 and WOC 19/96.*

The procedure on continuity of care/the care programme approach should include:

- *the definition of different levels of patient/user need (for example, a tiered approach)*

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

43.1 continued

- *clear criteria for identifying the most vulnerable patients/users*
- *assessment and care plan arrangements*
- *keyworker arrangements*
- *review of care plan arrangements*
- *discharge from hospital (aftercare) arrangements*
- *liaison arrangements with social services and other agencies.*

43.2 There is an identified person who is responsible for coordinating the care programme approach within the service (England only). ☐☐☐ A

43.3 There is readily accessible information available for patients/users and carers on the assessment, coordination and review procedures for ensuring continuity of care. ☐☐☐ B

43.4 There is a care programme approach register (England only) which is:

43.4.1 accessible to staff ☐☐☐ B

43.4.2 regularly updated. ☐☐☐ B

Assessment

43.5 All patients/users admitted to the mental health service are assessed for their health and social needs. ☐☐☐ A

The keyworker

43.6 All patients/users have a keyworker. ☐☐☐ A

43.7 All patients/users are advised of who their keyworker is and this is documented. ☐☐☐ A

43.8 The patient/user is informed of any change to the keyworker. ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
43.9 The patients'/users' views are taken into account if they are not satisfied with their keyworker.	☐☐☐ A	

The care plan

43.10 Patients/users are actively involved in the development of their care plan.	☐☐☐ A	

GUIDANCE
The patient's/user's views are noted in the care plan.

43.11 The individual care plan is developed in partnership with the people involved in delivering the patient's/user's care.	☐☐☐ A	

GUIDANCE
This includes, for example:
- *social workers/community support workers/care managers*
- *carers*
- *general practitioners.*

43.12 Patients/users are given a copy of their care plan.	☐☐☐ A	

GUIDANCE
This may depend on the level of care a patient/user is receiving. A patient/user on level one of the care programme approach (for example an outpatient) may not have a care plan.

Review of the care plan

43.13 The care plan is reviewed at defined and agreed intervals.	☐☐☐ A	
43.14 Patients/users are actively involved in discussions reviewing the care plan.	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
43.15 Patients/users are able to invite an advocate to the care plan review discussions.	☐☐☐ A	

Monitoring of care

43.16 Surveys are carried out to ascertain whether or not patients/users understand the assessment, coordination and review process. ☐☐☐ B

GUIDANCE
This includes, for example, whether patients/users are aware of who their keyworker is, understand the purpose of review meetings and have a copy of their care plan.

43.17 The care is audited at least annually. ☐☐☐ B

GUIDANCE
Information about this can be obtained in the Care Programme Approach Audit Pack obtainable from the Royal College of Psychiatrists Research Unit.

Continuity of care

43.18 There are agreed procedures on regular communication between services/voluntary agencies involved in the individual's care and treatment. ☐☐☐ A

GUIDANCE
This interagency communication should occur on a regular basis and should include all appropriate services.

43.19 The service provides access to:
43.19.1 benefits advice ☐☐☐ B
43.19.2 housing advice. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

43.20 There is a structured approach to re-engaging patients/users who drop out of services. ☐☐☐ A

GUIDANCE
This includes, for example, approaches to ensuring continuity of care contained in national guidelines on interagency working, such as home visits, friendship schemes, community support worker involvement.

43.21 There is an up-to-date, documented procedure on dealing with patients/users who do not want to take their medication. ☐☐☐ B

GUIDANCE
The procedure should balance the rights of the patient/user not to take their medication with the assessed need for them to do so.

The supervision register

43.22 There is a procedure on the supervision register which is in line with guidelines developed by the Department of Health (England only). ☐☐☐ A

GUIDANCE
Reference should be made to Introduction of Supervision Registers for Mentally Ill People HSG (94) 5 and Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94) 27.The procedure should include:
- *monitoring of patients/users on the register to ensure that they are receiving care*
- *monitoring of patients/users who fail to attend appointments*
- *follow-up procedures.*

43.23 There is an identified person who is responsible for the coordination of the supervision register. ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
43.24 All patients/users who are on the supervision register:		
43.24.1 have a keyworker who is a recognised mental health professional	☐☐☐ A	
43.24.2 are informed that they are on the register	☐☐☐ A	
GUIDANCE *Except where this would be detrimental to the patient/user, and in line with current national guidelines*		
43.24.3 are informed of any changes to their status on the register.	☐☐☐ A	
43.25 There is a procedure to review, at defined intervals, patients'/users' inclusion on the register.	☐☐☐ A	
43.26 Patients/users, their carers and staff can request a review of inclusion on the register at any time.	☐☐☐ A	

Aftercare (Section 117 of the Mental Health Act 1983)

43.27 There are up-to-date, documented procedures for providing aftercare services.	☐☐☐ A	
GUIDANCE *These need to prioritise the most vulnerable people and include regular liaison between hospital and community staff prior to, and following, discharge.*		
43.28 Aftercare is coordinated by the keyworker.	☐☐☐ A	

Supervised discharge (aftercare under supervision)

43.29 There is an up-to-date, documented procedure for supervised discharge which is in line with the Mental Health (Patients in the Community) Act 1995.	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

43.29 continued

GUIDANCE
Refer to:
- *Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in the Community HSG (94) 27*
- *Guidance on Supervised Discharge (Aftercare Supervision) and Related Provisions WHC (96) 11 and WOC 6/96.*

43.30 Staff acting as supervisors are trained in the requirements of supervised discharge and their responsibilities under it. ☐☐☐ A

Out of hours (24-hour care)

43.31 There is access to an out-of-hours service. ☐☐☐ B

GUIDANCE
There is a service which is capable of responding to patient/users and carers needs outside of normal working hours. There are arrangements for dealing with emergency and crisis situations.

For example, this includes:
- *non-medical crisis houses*
- *home treatment*
- *non-hospital acute units.*

43.32 There are specific safety mechanisms in place for staff working out of hours (for example, working in pairs). ☐☐☐ A

43.33 There is a 24-hour crisis support help line which is equipped to provide information to people in crisis. ☐☐☐ C

Standard 44

Mental Health – The Mental Health Act 1983

Patients/users of the service detailed for assessment and treatment are cared for ensuring that their legal rights and responsibilities are observed.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

General

44.1 There are up-to-date, documented procedures regarding the implementation of the Mental Health Act 1983 which are in accordance with the most recent version of the Mental Health Act Code of Practice. ☐☐☐ A

44.2 There is an identified person within the service who is responsible for administering the Mental Health Act. ☐☐☐ A

44.3 All staff receive annual training in aspects of the Mental Health Act which are relevant to their role. ☐☐☐ A

GUIDANCE
Training includes, for example:
- *assessments*
- *documentation*
- *rights of appeal*
- *managers' hearings*
- *tribunals*
- *changes to the Act/Code of Practice*
- *powers of carrying and conveying patients/users to hospital.*

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

44.4 Approved social workers are available for Mental Health Act assessments. ☐☐☐ A

44.5 Second medical opinions are available for Mental Health Act assessments. ☐☐☐ A

Rights under the Mental Health Act

44.6 There are procedures for staff explaining to the patient/user and their carers their legal rights and responsibilities under the Mental Health Act. ☐☐☐ A

44.7 Patients/users receive written, jargon-free information explaining their rights under the Mental Health Act, both generally and specifically relating to the section under which they are detained. ☐☐☐ A

GUIDANCE
All attempts at explanation should be documented.

44.8 Patients/users are given information about how to appeal against their section to a managers' hearing or Mental Health Review Tribunal. ☐☐☐ A

44.9 Facilities are made available for:

44.9.1 approved social workers to interview patients/users and/or relatives in private ☐☐☐ A

44.9.2 the Mental Health Act Commissioner to interview patients/users in private ☐☐☐ A

44.9.3 Mental Health Act Commission team visits ☐☐☐ A

44.9.4 Mental Health Review Tribunals ☐☐☐ A

44.9.5 people waiting to be involved in the above activities. ☐☐☐ A

44.10 There is an identified person responsible for coordinating Mental Health Act appeals. ☐☐☐ A

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
44.11 There are arrangements in place to ensure that a panel of managers is available for duties under the Mental Health Act.	☐☐☐ A	
44.12 Ongoing training, development and support is available for people who sit on Mental Health Act panels and serve on managers' hearings.	☐☐☐ A	
44.13 Reports on patients/users who appear before appeal panels, including managers' hearings and Mental Health Tribunals, are completed in time for consideration in advance of the hearing.	☐☐☐ A	
44.14 Decisions from managers' hearings are conveyed to the patient/user verbally and in writing using plain language with clear recommendations.	☐☐☐ A	
44.15 Adherence to the procedures relating to the Mental Health Act and its Code of Practice are monitored internally.	☐☐☐ A	
44.16 Patients/users are involved in the monitoring process.	☐☐☐ B	

GUIDANCE
The service should be able to cite examples of where changes have occurred as a result of monitoring activities.

Standard 45

Mental Health – Advocacy

An independent advocacy service is provided.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

45.1 The service ensures that there is access to independent advocacy services (see also Corporate Management, standard 2 Management Arrangements and Corporate Governance). ☐☐☐ A

GUIDANCE
Independent advocacy services are provided by external people, not staff.

Services include, for example:
- *specific services for people with a learning disability*
- *specific services for users of mental health services*
- *specific services for black and Asian patients and other ethnic groups represented in the local population*
- *specific services for elderly people*
- *specific services for children and young adults*
- *advocates who are trained in powers of attorney and Court of Protection procedures.*

45.2 There are up-to-date, documented guidelines on advocacy. ☐☐☐ A

GUIDANCE
These include, for example:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

45.2 continued

- *provision for an annual policy review*
- *service level agreements between the advocacy service and the provider*
- *how the service understands the issues relating to advocacy and how it will respond to the individual needs of the care group*
- *how to respond to areas of conflict between advocates and carers*
- *how to make changes based on advocacy observations.*

45.3 There is an agreed advocacy code of practice which is subject to annual review. ☐☐☐ A

45.4 Information on advocacy services is presented in a range of formats, appropriate to the service and patients/users of the service. ☐☐☐ B

45.5 Patients/users are able to choose/change, as far as is practicable, the person who will advocate for them. ☐☐☐ B

GUIDANCE
The patient/user has the right to refuse the offer of advocacy.

45.6 A space is provided for advocacy work in a private setting away from the service. ☐☐☐ C

45.7 The management team meets on a regular basis with advocates. ☐☐☐ B

GUIDANCE
There is a written record of these meetings detailing issues raised and outcomes, which is readily available to patients/users and carers.

45.8 The service is able to cite examples of changes made as a result of advocacy interventions. ☐☐☐ C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

45.9 Staff receive training on working with advocates. ☐☐☐ B

45.10 An interpreter service is available to reflect the needs of local non-English speaking populations and hearing impaired people (see also standard 18 The Patient's Individual Needs). ☐☐☐ A

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

Minicoms are made available.

Standard 46

Mental Health – Treatment

Patients/users receive treatment according to identified and expressed need.
The aim of care and treatment is to enable recovery and not just to maintain patients/users.
(See also standard 21 Assessment, Planning, Implementation and Review of Treatment and Care)

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Choice		
46.1 Written information is available to patients/users on the range of therapies or treatment available to meet their expressed and assessed needs.	☐☐☐ B	
46.2 There is a range of therapies or treatments available for patients/users which are actively promoted by the service.	☐☐☐ A	

GUIDANCE
This includes, for example:
- *counselling*
- *cognitive therapy*
- *behavioural therapy*
- *psychology*
- *psychotherapy*
- *social therapies, for example recreational therapy*
- *occupational therapy*
- *alternative therapies.*

CRITERIA

Treatment and medication

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

46.3 Patients/users are as well informed as possible of the likely benefits and known risks of any course of care and treatment, in terms they understand. ☐☐☐ A

46.4 Regularly reviewed written information on medications and their known side effects/risks are readily available. ☐☐☐ B

46.5 Patients/users are offered appropriate treatments involving the least adverse effects and restrictions, as appropriate for their clinical condition. ☐☐☐ A

46.6 Medication is monitored and reviewed at defined and agreed intervals by the responsible medical officer and other members of the multiprofessional team. ☐☐☐ A

46.7 The use of medication, particularly multiple medications, is audited annually. ☐☐☐ B

Standard 47

Mental Health – Clinical Risk Management

All aspects of clinical risk management are effectively monitored.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
47.1 There is an up-to-date, documented procedure on clinical risk management for mental health services which is in line with the organisation's clinical risk management policy (see also Corporate Management, standard 9 Risk Management).	☐☐☐ A	
47.2 There is an identified person within the service who is responsible for coordinating clinical risk management.	☐☐☐ A	

Clinical risk assessment

47.3 A clinical risk assessment is carried out for all patients/users who enter the service.	☐☐☐ A	

GUIDANCE
This needs to be appropriate for the degree and type of risk being assessed, for example self-harm, suicide, violence.

Involving the patient/user in their risk assessment is good practice.

47.4 Staff are trained in identifying high risk and suicidal patients/users.	☐☐☐ A	
47.5 Staff are trained in suicide prevention and related issues.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

47.6 This training is available to other relevant agencies. ☐☐☐ C

GUIDANCE
These include, for example:
- *primary health care teams*
- *accident and emergency staff*
- *social services hostel and day centre staff*
- *secondary schools.*

Violent and aggressive behaviour

47.7 There is an up-to-date, documented procedure on the assessment and management of aggressive and violent behaviour. ☐☐☐ A

GUIDANCE
This includes inpatient, outpatient and community settings.

47.8 There is a programme of therapeutic/diversional activities designed to prevent boredom and to diffuse potentially aggressive behaviours. ☐☐☐ B

47.9 Staff are trained in de-escalation techniques and in defusing potentially violent situations. ☐☐☐ A

Levels of observation

47.10 There is an up-to-date, documented procedure for determining levels of observation. ☐☐☐ A

GUIDANCE
This includes, for example:
- *defined levels of observation*
- *criteria for each level of observation*

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
47.10 continued		
• *criteria for reviewing patient/user levels of observation* • *length of time staff spend on observation.*		
47.11 The reason for the level of observation is recorded in the care plan.	☐☐☐ A	
47.12 Review times and dates are recorded in the care plan.	☐☐☐ A	
47.13 The patient's/user's privacy and dignity is maintained at all times, in line with any constraints defined in the risk management strategy.	☐☐☐ A	
47.14 Adherence to the procedure is monitored.	☐☐☐ A	

Control, restraint and breakaway techniques

47.1 There are up-to-date, documented procedures on using control and restraint, including rapid tranquillisation and emergency medication.	☐☐☐ A	
GUIDANCE *Reference should be made to the Royal College of Psychiatrists' Consensus Statement on High-Dose Anti-psychotic Medication.*		
47.16 Staff receive training and regular updating in control and restraint techniques according to national guidelines.	☐☐☐ A	
47.17 Staff receive training and regular updating in breakaway techniques.	☐☐☐ A	
47.18 There is an up-to-date register of staff who have completed control and restraint courses.	☐☐☐ A	
47.19 The use of control and restraint and emergency medication is regularly audited.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Seclusion

47.20 There are up-to-date, documented procedures on seclusion which are consistent with national guidelines. ☐☐☐ A

GUIDANCE
These should include mechanisms to allow the senior nurse/head of service to monitor the use of seclusion.

47.21 There are designated resources for seclusion. ☐☐☐ A

GUIDANCE
The standards of accommodation used for seclusion should conform with NHS Estates guidance Accommodation for People with Mental Illness HBN 35.

47.22 Reasons for seclusion are recorded in the patient's/user's health record. ☐☐☐ A

47.23 The use of seclusion is regularly audited. ☐☐☐ A

Self-harm service

47.24 There is a locally agreed assessment tool for people who harm themselves. ☐☐☐ B

47.25 There is a clearly defined system of communication between the accident and emergency service, mental health service and general practitioners for people who harm themselves. ☐☐☐ A

47.26 There is an education programme on self-harm in place for accident and emergency staff. ☐☐☐ C

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

47.26 continued

GUIDANCE
This includes, for example, training on sensitive approaches to people who harm themselves and should involve patients/users in delivering the training.

47.27 Where patients/users have a keyworker, the keyworker is informed following the episode of self-harm. ☐☐☐ B

Untoward/potentially disturbing incidents

47.29 There are up-to-date, documented procedures on dealing with untoward/potentially disturbing incidents. ☐☐☐ A

GUIDANCE
This includes the grading of incidents according to their degree of risk and the process for investigating untoward/potentially disturbing incidents.

Such procedures may be included in the risk management policy.

47.30 All serious untoward/potentially disturbing incidents are reported to the appropriate authorities. ☐☐☐ A

47.31 Counselling and support is offered to patients/users in the event of an untoward/potentially disturbing incident. ☐☐☐ B

47.32 Counselling and support is available to staff in the event of an untoward/potentially disturbing incident. ☐☐☐ B

47.33 An annual report is written detailing:

47.33.1 the number and type of untoward/potentially disturbing incidents within the service ☐☐☐ B

CRITERIA

47.33 continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

47.33.2 the management action arising from incident reporting. ☐☐☐ A

47.34 Aggressive and violent incidents are regularly audited and recommendations acted on. ☐☐☐ B

47.35 Homicides and suicides are referred to the Confidential Enquiry into Homicide and Suicide by Mentally Ill People. ☐☐☐ B

Standard 48

Mental Health – Leave from Hospital

Leave is granted when the patient/user is deemed responsible. The service has clear mechanisms for when patients/users leave without permission. (Inpatient services only)

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Authorised leave

48.1 There is an up-to-date, documented procedure on leave from inpatient care and treatment. ☐☐☐ A

GUIDANCE
This includes, for example:
- *the procedure to be followed when planning leave*
- *informing carers*
- *the need to involve or inform other agencies*
- *the consideration of any legal requirements*
- *the need for and use of escorts*
- *how leave is reviewed*
- *the mechanism for extending leave.*

48.2 Leave arrangements are recorded in the care plan and the patient's/user's health care record. ☐☐☐ A

48.3 Adherence to the policy is monitored. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Unauthorised leave

48.4 There is an up-to-date, documented procedure to be followed when a patient/user is absent without authorisation. ☐☐☐ A

GUIDANCE
This includes, for example:
- *local search procedures*
- *missing persons procedure*
- *what to do when a person is detained under the Mental Health Act 1983.*

48.5 Other agencies are kept informed according to the legal status and risk assessment of the patient/user. ☐☐☐ A

48.6 Other agencies are informed if and when the patient/user returns. ☐☐☐ A

48.7 There is a multiprofessional assessment when the patient/user returns. ☐☐☐ A

48.8 Staff liaise with the police in the event of any untoward incidents which involve the police. ☐☐☐ A

48.9 Adherence to the policy is monitored. ☐☐☐ A

Standard 49

Mental Health – Other Specialist Services

There are specialist services provided to cater for patients/users with specific needs.

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Court liaison/diversion		
49.1 There are dedicated resources for working with people who come into contact with the criminal justice system.	☐☐☐ A	
49.2 There are a range of services to divert people who come into contact with the criminal justice system.	☐☐☐ A	
GUIDANCE *These should be in line with the Reed Report (Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services, Department of Health/Home Office, 1992); these include, for example custody and court diversion schemes, bail hostels.*		
49.3 There are liaison staff in each service for court liaison/diversion activities.	☐☐☐ B	
49.4 There are up-to-date, documented guidelines on the use and disclosure of information between services.	☐☐☐ B	
GUIDANCE *These include, for example:*		

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
49.1 continued		
• *the police* • *social services* • *the probation service.*		
49.5 There are up-to-date, documented procedures on the implementation of section 136 of the Mental Health Act.		
49.6 The court liaison/diversion scheme is regularly monitored.	☐☐☐ C	
Forensic service		
49.7 There is access to forensic advice.	☐☐☐ A	
49.8 There are up-to-date, documented procedures on referring patients/users to forensic services.	☐☐☐ A	
49.9 There are arrangements for transferring patients/users to the forensic service.	☐☐☐ A	
Secure provision		
49.10 There is access to a range of secure provision facilities for patients/users.	☐☐☐ A	
49.11 There are up-to-date, documented procedures on referring patient/users to secure provision.	☐☐☐ A	
49.12 There are arrangements for transferring patients/users to secure provision.	☐☐☐ A	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 50

Maternity Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

50.1 A nominated senior midwife has 24-hour responsibility and accountability for the midwives working in the service. ☐☐☐ A

50.2 All midwives have 24-hour local access to professional midwifery advice from a supervisor of midwives. ☐☐☐ A

50.3 There is a system in place for any practising midwife to refer to a consultant when needed. ☐☐☐ A

GUIDANCE
The following are available, for example:
- *24-hour access to a consultant obstetrician*
- *consultant anaesthetic advice during pregnancy and after delivery*
- *access to other professionals as required (for example, consultant physicians, consultant cardiologists).*

50.4 Intensive therapy services are available on a 24-hour basis. ☐☐☐ A

50.5 Staff deployment arrangements are flexible, in order to match the fluctuating demand on the labour ward, as far as possible. ☐☐☐ B

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
50.6 The nominated senior midwife is involved in:		
50.6.1 the development of a local midwifery strategy which reflects national targets (for example, Health of the Nation) and takes into consideration current policy	☐☐☐ B	
50.6.2 disciplinary and grievance procedures.	☐☐☐ B	
GUIDANCE *In cases of alleged professional misconduct, the supervisor of midwives is involved.*		
50.7 Midwifery teams/committees with clearly stated terms of reference meet to develop strategies for the implementation of the objectives of the maternity service.	☐☐☐ B	
GUIDANCE *Local strategies should be in line with the recommendations detailed in Changing Childbirth and other national guidance, for example, Provision of Maternity Services in Scotland.*		
50.8 There is a maternity liaison committee with professional and lay representation (NHS only).	☐☐☐ A	
50.9 All non-registered staff employed within the maternity service work under the supervision of, and have access to, a practising midwife on a 24-hour basis.	☐☐☐ A	
50.10 There is a named supervisor of midwives allocated to each midwife.	☐☐☐ A	
50.11 All newly qualified midwives have a named preceptor.	☐☐☐ B	
50.12 Midwives returning to practice after five years:		
50.12.1 complete an approved return to practice course	☐☐☐ A	
50.12.2 have a named preceptor.	☐☐☐ B	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
50.13 At least one practising midwife is present on each shift in each area.	☐☐☐ A	

Staff development and education

50.14 As part of the ongoing education and professional updating programme the following are provided:

50.14.1 professional learning and study leave days in accordance with the Post-Registration Education and Practice Project recommendations	☐☐☐ B	
GUIDANCE *Up to the year 2000 some midwives will be on five-yearly refresher courses.*		
50.14.2 additional training to support midwives in developing their scope of professional practice	☐☐☐ B	
50.14.3 bereavement training.	☐☐☐ B	

Policies and procedures

50.15 There are up-to-date, documented procedures for:

50.15.1 antenatal screening	☐☐☐ A
50.15.2 the number of antenatal checks routinely offered to women	☐☐☐ B
50.15.3 targeting specialist obstetric care at the women who most need it	☐☐☐ C
50.15.4 the woman's choice regarding place and mode of birth	☐☐☐ A
50.15.5 domino deliveries	☐☐☐ A
50.15.6 home births	☐☐☐ A
50.15.7 determining length of postnatal hospital stay	☐☐☐ B

GUIDANCE
The length of stay should be flexible according to women's needs and should be decided in consultation with the women. See First Class Delivery – Improving Maternity Services in England and Wales (Audit Commission, 1997).

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
50.15 continued		
50.15.8 identifying the baby while in hospital	☐☐☐ A	
GUIDANCE *For example, the baby is identified by two labels put on immediately after birth (one label on the arm, one on the leg) and the labels are checked by the mother as soon as possible.*		
50.15.9 infant feeding	☐☐☐ A	
GUIDANCE *Staff should be trained to give sound and consistent advice on all aspects of infant feeding.*		
50.15.10 information given to parents of babies born with undiagnosed congenital malformations (for example, Down's syndrome)	☐☐☐ A	
50.15.11 neonatal death	☐☐☐ A	
50.15.12 paediatric screening	☐☐☐ A	
50.15.13 arrangements for relatives and friends to visit mother and baby	☐☐☐ B	
50.15.14 stillbirth/miscarriage/termination of pregnancy for abnormality.	☐☐☐ A	
50.16 Maternity procedures are developed with medical and midwifery input and agreed by a professional committee.	☐☐☐ B	
50.17 Responsibilities of doctors and midwives are defined, with local guidelines on who does what, with regard to:		
50.17.1 administration of drugs	☐☐☐ A	
50.17.2 information issued to women, their partners and their families (including all aspects of the birth)	☐☐☐ A	
50.17.3 maintenance of records and reports	☐☐☐ A	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
50.17 continued		
50.17.4 provision of information to media and police and the maintenance of confidentiality	☐☐☐ A	
50.17.5 scope of professional practice.	☐☐☐ A	
GUIDANCE *Local guidelines are in accordance with guidelines from the UKCC, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Midwives.*		
50.18 Security procedures and equipment are in place to guard against abduction.	☐☐☐ A	
50.19 The following information is made available to the woman:		
50.19.1 type of care on offer	☐☐☐ A	
50 19.2 where antenatal care is provided	☐☐☐ B	
50.19.3 where she can have the baby	☐☐☐ A	
GUIDANCE *The information given to the woman on where she can have her baby enables an informed choice to be made.*		
50.19.4 options for pain relief	☐☐☐ A	
50.19.5 what tests will be used and why	☐☐☐ A	
GUIDANCE *This should include information about associated risks.*		
50.19.6 advice on looking after herself, including healthy diet and not smoking	☐☐☐ B	
50.19.7 information to help her choose which method of feeding to use, including the benefits of breastfeeding.	☐☐☐ B	

↓

CRITERIA

50.19 continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

GUIDANCE
The information should include details of voluntary groups who can provide breastfeeding support.

50.20 The information which is made available (verbal, written and other media) is monitored and evaluated. ☐☐☐ C

Facilities and equipment

50.21 Overnight facilities are available for:

50.21.1 bereaved parents ☐☐☐ C

50.21.2 parents who need to develop confidence in handling and managing babies who have been ill and who require special care at home (for example, oxygen therapy for babies with bronchopulmonary dysplasia). ☐☐☐ C

Patient/user care

50.22 A named, practising midwife is responsible for the midwifery care of each woman. ☐☐☐ A

50.23 Women are given the choice of holding their own records or leaving them with the hospital, general practitioner or midwife. ☐☐☐ A

50.24 There is a flexible approach to the provision of parent education. ☐☐☐ B

GUIDANCE
Parent education sessions are held at different times of the day to accommodate working parents, parents of young children.

Parent education sessions are accessible to mothers and other carers who will be involved in the care of the child.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

50.25 The woman is given the choice of having her partner or a friend or relative with her during the birth. ☐☐☐ A

50.26 Staffing levels are sufficient to allow continuity of care throughout the labour. ☐☐☐ B

GUIDANCE
Deployment of staff should aim to keep the number of different professionals involved in caring for the individual women down to the minimum, in accordance with providing a safe service. See First Class Delivery – Improving Maternity Services in England and Wales (Audit Commission, 1997).

50.27 The mother is given the choice of either keeping her baby with her or putting the baby in the nursery. ☐☐☐ B

50.28 A written care plan is developed during the antenatal period. ☐☐☐ A

GUIDANCE
The care plan is developed:
- *after an assessment of the woman*
- *in consultation with, and taking into account the wishes of, the woman and her family*
- *in collaboration with other staff involved directly in the woman's care.*

50.29 Care plans are reviewed, and revised if necessary, during the antenatal, intrapartum and postnatal periods. ☐☐☐ A

50.30 A midwifery record, which conforms to UKCC guidelines, is maintained for each woman and is signed, timed and dated by the midwife responsible. ☐☐☐ A

50.31 On discharge from midwifery care, the midwifery record is incorporated into the woman's health record. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

50.32 All women's maternity records are retained for a minimum of 25 years. ☐☐☐ A

GUIDANCE
- *This includes records of episodes of maternity care that end in stillbirth or neonatal death.*
- *A local policy is developed on which elements are to be regarded as a permanent part of the record.*

Quality improvement

50.33 The following performance and outcome indicators are reviewed on a service-wide basis:

50.33.1 induction, caesarean and forceps deliveries rates ☐☐☐ B
50.33.2 infection rates ☐☐☐ B
50.33.3 perinatal and maternal mortality rates ☐☐☐ B
50.33.4 readmission rates. ☐☐☐ B

50.34 Local infant feeding standards are developed. ☐☐☐ B

50.35 Infant feeding statistics are maintained and audited. ☐☐☐ C

50.36 The following are evaluated:

50.36.1 midwifery practice ☐☐☐ B
50.36.2 record keeping. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 51

Nursing Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

51.1 There is a nominated senior nurse at ward or departmental level with responsibility and accountability at all times when the service is in operation. ☐☐☐ A

GUIDANCE
For 24-hour services, a senior nurse should have 24-hour responsibility.

51.2 A qualified, senior registered nurse manages the nursing staff on each shift. ☐☐☐ A

51.3 All nurses have access to professional nursing advice at all times when the service is in operation. ☐☐☐ A

GUIDANCE
For 24-hour services, there should be 24-hour access to advice.

51.4 There is nursing input into the development of a local strategy for nursing which reflects national targets and takes into consideration current policy. ☐☐☐ A

51.5 Nursing teams/committees with clearly stated terms of reference meet to develop strategies for the implementation of the aims and objectives of the nursing service. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

51.6 All nurses hold qualifications appropriate for the post held. ☐☐☐ A

51.7 All newly qualified staff have a named preceptor. ☐☐☐ B

51.8 Staff returning to practice after five years:

51.8.1 complete an approved return to practice course ☐☐☐ A

51.8.2 have a named preceptor. ☐☐☐ B

GUIDANCE
This applies to staff working for less than 100 days or 750 hours in the previous five years.

51.9 Staff with the relevant qualifications and experience are present on all shifts where specialised nursing care is required. ☐☐☐ A

Staff development and education

51.10 As part of the ongoing education and professional updating programme the following are available:

51.10.1 professional learning and study leave days to support the UKCC's standards for post-registration education and practice ☐☐☐ B

51.10.2 additional education and training and appropriate clinical supervision to support nurses in developing their scope of professional practice. ☐☐☐ B

GUIDANCE
Clinical supervision in this sense means reflecting on clinical practice and for nurses should be in line with the UKCC position statement.

Policies and procedures

51.11 Nursing procedures are agreed by an appropriate professional nursing committee. ☐☐☐ B

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

S.51 continued

GUIDANCE
In the independent sector, this may be through sisters' meetings or a nursing quality circle for example.

51.12 Responsibilities and activities of nursing staff, including pre-registration students, are clearly defined in at least the following areas and are supported by the relevant UKCC guidelines:

51.12.1 administration of medicines ☐☐☐ A
51.12.2 emergency situations ☐☐☐ A
51.12.3 information issued to patients/users and carers ☐☐☐ A
51.12.4 maintenance of records and reports ☐☐☐ A
51.12.5 provision of information to media and police and the maintenance of patient/user confidentiality ☐☐☐ A
51.12.6 scope of professional practice. ☐☐☐ A

Patient/user care

51.13 A nursing record, which conforms to UKCC guidelines, is maintained for each patient/user. ☐☐☐ A

GUIDANCE
This includes, for example:
- *biographical data*
- *assessment data*
- *nursing diagnosis*
- *individual care plan*
- *evaluation of care.*

Quality improvement

51.14 The following performance and outcome indicators are reviewed on a

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

51.14 continued

service-wide basis.

51.14.1 length of patient/user stay ☐☐☐ B

51.14.2 infection rates ☐☐☐ B

51.14.3 medication errors ☐☐☐ B

51.14.4 pressure sore incidence ☐☐☐ B

51.14.5 readmission rates. ☐☐☐ B

51.15 The following are evaluated:

51.15.1 nursing practice ☐☐☐ B

51.15.2 record keeping. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 52

Occupational Therapy Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
52.1 There is regular liaison with social services to discuss equipment, adaptations, discharge and case management planning.	☐☐☐ B	
Policies and procedures		
52.2 There are up-to-date, documented procedures for:		
52.2.1 assessment of the patient's/user's home	☐☐☐ B	
52.2.2 food hygiene	☐☐☐ B	
52.2.3 group activity	☐☐☐ B	
52.2.4 orthotics	☐☐☐ B	
52.2.5 wheelchair provision.	☐☐☐ B	
Information		
52.3 There is information available to staff on the range and availability of disability equipment, appliances, facilities and other resources which could assist the patient/user living in the community.	☐☐☐ B	
52.4 Written information is available to patients/users which is relevant to their condition, up to date and reflects current practice.	☐☐☐ C	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 53

Operating Theatre Service/Anaesthetic Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

53.1 There is a theatre users' forum or equivalent. ☐☐☐ B

GUIDANCE
This forum, for example:
- *meets regularly*
- *keeps minutes of meetings*
- *represents the interests of surgeons, anaesthetists, theatre practitioners and general management.*

53.2 There is a consultant who directs the provision of anaesthetic services. ☐☐☐ A

53.3 A consultant anaesthetist is available at all times. ☐☐☐ A

53.4 The doctor performing the procedure is available in the department before the anaesthetist commences. ☐☐☐ A

53.5 There is an anaesthetist present until the patient recovers from the anaesthetic. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

53.6 The following services are available/accessible on a 24-hour basis:

53.6.1 diagnostic imaging (see also standard 29 Diagnostic Imaging Service) ☐☐☐ A

53.6.2 intensive therapy and high dependency care ☐☐☐ A

GUIDANCE
In the independent sector, this may be by arrangement with NHS facilities. Where these are available in the hospital, the hospital should ensure that staff are adequately trained.

53.6.3 pain management services ☐☐☐ A

53.6.4 pathology (including blood bank) (see also standard 55 Pathology Service) ☐☐☐ A

53.6.5 for services who accept children for treatment, a nurse whose name appears on either part 8 or part 15 of the UKCC Register, that is a Registered Sick Children's Nurse or Registered Nurse (Child) (see also standard 28 Children's Services). ☐☐☐ A

53.7 There is a designated senior theatre nurse practitioner to supervise the theatre practitioner staff. ☐☐☐ A

53.8 Appropriately qualified theatre nurse practitioners are present on all shifts. ☐☐☐ A

53.9 Arrangements are in place to ensure that operating theatre personnel are available on a 24-hour basis to staff an emergency theatre (see also standard 24 Accident and Emergency Service). ☐☐☐ A

53.10 Operating department practitioner staff who are not eligible for registration with the UKCC are included in the BAODA Professional Register. ☐☐☐ C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Records

53.11 Operating theatre records are maintained which satisfy medico-legal requirements.

GUIDANCE
For example, where treatment and procedures previously usually carried out by medical staff are carried out by nurses or paramedic staff, the patient should be made aware of this before consenting to the procedure. This information and the patient's consent should be recorded in the notes.

In addition, the operating theatre record:
- *meets the needs of clinical care*
- *is signed and dated*
- *meets the needs of audit.*

53.12 A record (operation note) of the surgical procedure performed is written into the patient's health record (see also standard 23 Health Record Content). ☐☐☐ A

GUIDANCE
The operation note contains details of, for example:
- *the name and signature of the operating and assisting surgeon(s)*
- *the name of the consultant responsible*
- *description of the findings*
- *the diagnosis made and the procedure performed*
- *details of tissue removed, altered or added*
- *details and serial numbers of prosthetics used (these may be 'stick-on' labels)*
- *details of sutures used*
- *an accurate description of any difficulties encountered and how these were overcome*
- *immediate postoperative instructions*
- *date and time.*

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

53.13 Records are kept which document the conduct of anaesthesia, in a form which enables evaluation of the quality of care given (as recommended by the Association of Anaesthetists and/or Royal College of Anaesthetists). ☐☐☐ A

GUIDANCE
The anaesthetic record contains, for example:
- *the preoperative assessment by an anaesthetist, preferably by the attending anaesthetist*
- *the name of the anaesthetist and, where relevant, the name of the consultant anaesthetist responsible*
- *record of checks of apparatus in the anaesthetic room and theatre*
- *drugs and doses given during anaesthesia and route of administration*
- *monitoring data*
- *intravenous fluid therapy, if given*
- *the method used to secure and maintain the patient airway and any special difficulties encountered*
- *post-anaesthetic instructions where appropriate*
- *records of any untoward events*
- *any warnings for future care*
- *name and signature of attending anaesthetist(s)*
- *date and time.*

53.14 The anaesthetic record is filed in the patient's health record. ☐☐☐ A

53.15 A register of operations is maintained. ☐☐☐ A

53.16 The register is signed by all participants. ☐☐☐ B

GUIDANCE
Where the register is computerised a signature is not practical; however, a computerised equivalent should be in place, for example, a password logging-in system.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Staff development and education

53.17 Refresher training is provided for theatre personnel who do not work regularly in the theatre suite. ☐☐☐ A

Policies and procedures

53.18 There are up-to-date, documented procedures for the following:

53.18.1 scheduling of patients for listed and emergency surgical procedures ☐☐☐ A

53.18.2 ensuring that all information relevant to planning perioperative care is received in the theatre ☐☐☐ A

53.18.3 pre-anaesthetic assessment ☐☐☐ A

GUIDANCE

The pre-anaesthetic assessment of each patient is performed by the anaesthetist who is administering the anaesthetic. Where this is not possible it is done by another anaesthetist who documents the findings and communicates them to the administering anaesthetist.

The assessment is timely and enables satisfactory measures to be taken to prepare the patient for anaesthesia and to perform any additional investigations which may be warranted by the patient's condition.

53.18.4 preoperative instructions for patients (verbal and written) ☐☐☐ A

53.18.5 patient identification ☐☐☐ A

53.18.6 verification of the nature and site of operation ☐☐☐ A

53.18.7 checking for preoperative shaves, false teeth, crowns ☐☐☐ A

53.18.8 checking of consent documents including provision of information to the patient ☐☐☐ A

53.18.9 counting accountable items and what to do in the event of incorrect counts ☐☐☐ A

53.18.10 recording tissue sent for laboratory examination ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

53.18 continued

53.18.11 infection control, including strategies for minimising hazards from blood and body fluids (see also Corporate Management, 9 Risk Management – Infection Control) ☐☐☐ A

53.18.12 preoperative visiting and preparation of patients for surgery (including children) ☐☐☐ B

53.18.13 parents accompanying children to theatre ☐☐☐ B

53.18.14 transporting children to theatre. ☐☐☐ B

53.19 Procedures ensure that the special requirements of children are taken into consideration (see also standard 28 Children's Services). ☐☐☐ A

53.20 There are documented health and safety guidelines for the department which cover:

53.20.1 anaesthetic equipment hazards ☐☐☐ A

53.20.2 controlled drug handling ☐☐☐ A

53.20.3 drug errors ☐☐☐ A

53.20.4 electrical hazards ☐☐☐ A

53.20.5 evaluation and testing of equipment ☐☐☐ A

53.20.6 fire and explosion ☐☐☐ A

53.20.7 instruction on use and maintenance of instruments ☐☐☐ A

53.20.8 notification of biohazards ☐☐☐ A

53.20.9 patient transport ☐☐☐ A

53.20.10 radiation hazards ☐☐☐ A

53.20.11 sharps handling and disposal ☐☐☐ A

53.20.12 use of scavenging equipment for removal of various vapours and waste anaesthetic gases ☐☐☐ A

53.20.13 COSHH hazards ☐☐☐ A

53.20.14 needlestick injury in high risk cases. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

53.20 continued

GUIDANCE
See the National Association of Theatre Nurses publications Principles of Safe Practice in the Operating Theatre and Risk Assessment Guide for more information.

Facilities and equipment

53.21 The design of the operating theatres provides for the following:

53.21.1 reception of the patient awaiting surgery in suitably equipped accommodation, separate from the operating room and access corridors, and which accommodates the special needs of children ☐☐☐ B

GUIDANCE
For example, the design of theatres should allow zoning of areas from outer (changing room) to inner, clean areas (theatre suite).

53.21.2 an equipped and staffed area for patients recovering from anaesthesia, which accommodates the special needs of children ☐☐☐ B

GUIDANCE
The recovery area should comply with guidelines issued by the Association of Anaesthetists and/or Royal College of Anaesthetists.

53.21.3 separate clean and dirty utility areas ☐☐☐ A

53.21.4 access to facilities for the resterilisation of instruments. ☐☐☐ A

GUIDANCE
Legislation should be complied with, for example on product liability and single use only of items so designated (see also standard 60 Sterile Services Department).

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

53.22 There is an up-to-date, documented procedure for making theatre facilities available for emergency use (see also standard 24 Accident and Emergency Service). ☐☐☐ A

GUIDANCE
Surgical and management teams should ensure that adequate provision is made to deal with emergencies during the working day, overnight and at weekends.

53.23 Equipment, drugs and agents are available and maintained for the following:
53.23.1 the safe administration of anaesthetics ☐☐☐ A
53.23.2 related techniques essential to the proper care of the anaesthetised patient. ☐☐☐ A

53.24 Instruments and guidelines for the management of difficult intubation, tracheostomy, massive haemorrhage and the management of malignant hyperpyrexia are available. ☐☐☐ A

53.25 Anaesthetic machines and monitoring equipment are checked before use. ☐☐☐ A

53.26 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the requirements of the Ionising Radiations Regulations 1985. ☐☐☐ A

53.27 Fire detection and alarm systems are installed. ☐☐☐ A

Quality improvement

53.28 The following performance and outcome indicators are reviewed on a service-wide basis:
53.28.1 number and reasons for cancelled operations ☐☐☐ B

↓

CRITERIA

53.28 continued

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

53.28.2 number and reasons for cancelled theatre sessions ☐☐☐ B
53.28.3 return to theatre rates ☐☐☐ B
53.28.4 postoperative infection rates ☐☐☐ B
53.28.5 postoperative morbidity ☐☐☐ B
53.28.6 postoperative mortality ☐☐☐ B
53.28.7 theatre utilisation. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 54

Outpatient Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

54.1 Management responsibility for outpatient services is clearly defined and is made known to users of the service. ☐☐☐ A

54.2 Lines of communication are established between the outpatient service and:

54.2.1 other departments ☐☐☐ B

GUIDANCE
These include, for example:
- *the health records department*
- *the diagnostic imaging service*
- *the pathology service*
- *the pharmaceutical service*
- *the professions allied to medicine services (for example, physiotherapy, dietetics, ECG)*

54.2.2 general practitioners referring to the service ☐☐☐ A

54.2.3 external health-related organisations. ☐☐☐ B

GUIDANCE
These include, for example:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

54.2 continued

- *community and /or acute services*
- *service user support groups*
- *voluntary organisations.*

54.3 Staffing for each clinic is:

54.3.1 determined using a skill mix review ☐☐☐ B

54.3.2 based on identified service needs. ☐☐☐ B

GUIDANCE
This includes nurse-led clinics

54.4 Specialist nurses are available in specialist clinics (for example, diabetes liaison). ☐☐☐ B

GUIDANCE
In the independent sector consultants should be informed of the availability of specialist nurses and encouraged to work with them.

54.5 A nurse whose name appears on either part 8 or part 15 of the UKCC Register, that is a Registered Sick Children's Nurse or Registered Nurse (Child), is available for consultation at all times (see also standard 28 Children's Services). ☐☐☐ A

GUIDANCE
In outpatient clinics with planned children's lists there should be a children's nurse on duty in the clinic.

54.6 At specific children's clinic sessions there is a designated play area. ☐☐☐ C

GUIDANCE
Where there is a designated play area, rather than some toys in a waiting area, the play area must be supervised by qualified child care staff.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

54.7 There is an up-to-date list of clinics scheduled. ☐☐☐ B

GUIDANCE
This includes, for example, the following information:
- *nature of clinic*
- *date of clinic*
- *start and finish time of clinic*
- *person holding the clinic*

54.8 The timing and frequency of clinics takes into account the needs of the particular patient/user group. ☐☐☐ C

54.9 There is a procedure for arranging cover for clinical staff. ☐☐☐ B

54.10 There is an individualised appointment system for patients/users. ☐☐☐ A

GUIDANCE
- *Each patient/user should have specified time; block booking systems should be avoided.*
- *There should be a system for prioritising referrals to the service.*

54.11 Information to patients/users prior to first attendance includes:

54.11.1 the date and time of their appointment ☐☐☐ A

54.11.2 details of any changes to appointment time, venue or staff member involved ☐☐☐ B

54.11.3 a contact telephone number for queries or to cancel the appointment ☐☐☐ A

54.11.5 a map with the location and name of the service and clinic clearly marked ☐☐☐ A

54.11.6 transport arrangements, including car park information ☐☐☐ B

54.11.7 specific instructions for any investigations/treatments such as fasting, or provision of specimens. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

54.12 Patients/users are reminded of their appointment (NHS only). ☐☐☐ B

GUIDANCE
This may be by a telephone call or reminder letter.

54.13 A list of patients/users and time of attendance is available before the clinic. ☐☐☐ B

54.14 Patients/users attending the outpatient service are correctly identified. ☐☐☐ A

GUIDANCE
This includes, for example, the patient's/user's name, date of birth, address and name of referring general practitioner.

The system should be such that the patient/user is required to supply the above information to staff rather than to confirm details presented to them by staff.

54.15 Clinic start and finish times are adhered to. ☐☐☐ B

54.16 Patients/users are informed of requirements for further attendance, treatment or referral before they leave the outpatient service. ☐☐☐ B

GUIDANCE
This includes, for example:
- *date of admission*
- *medication prescribed*
- *investigations required.*

Records

54.17 A clinical record is assembled during, or before, the patient's/user's initial visit. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

54.17 continued

GUIDANCE
The clinical record contains the following, for example:
- *name, address and postcode*
- *record/patient number*
- *sex*
- *next of kin*
- *source of referral*
- *history, including details of present illness and medication*
- *complete physical examination*
- *requests for diagnostic tests*
- *progress notes, reports and consultations*
- *name and signature of doctor*
- *date and time of consultation*
- *the name and signature of the attending nurse if nursing care given*
- *information and advice given to patients/user and/or their carers.*

54.18 If the patient/user has previously attended, the patient's/user's health record is available before the clinic. ☐☐☐ A

GUIDANCE
This only applies to prebooked appointments, not walk-in clinic sessions.

Staff development and education

54.19 Training is provided when nurse-led clinics are set up. ☐☐☐ B

GUIDANCE
An ongoing training programme is required to ensure that staff trained in the specialty are sufficient to cover sickness, holidays and staff turnover.

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
54.20 There is a proactive approach to arranging rotational training posts in the service.	☐☐☐ C	
54.21 Customer care training is provided for reception staff.	☐☐☐ B	

GUIDANCE
This should focus, for example, on the needs of patients/users and carers for clear information and the ability to deal with the type of queries and complaints which are likely to arise in the service area.

Policies and procedures

54.22 There are up-to-date, documented procedures which cover:		
54.22.1 preparation of schedules	☐☐☐ A	
54.22.2 booking patterns	☐☐☐ B	
54.22.3 emergency referrals	☐☐☐ A	

GUIDANCE
This includes walk-in clinics and available on-call rotas.

54.22.4 dealing with enquiries	☐☐☐ B	
54.22.5 dealing with complaints	☐☐☐ B	
54.22.6 dealing with late/overrunning clinics	☐☐☐ A	
54.22.7 what to do if there are staff shortages.	☐☐☐ B	
54.23 There are up-to-date, documented procedures outlining the clinical procedures undertaken on an outpatient basis.	☐☐☐ A	
54.24 There is an up-to-date, documented procedure on maintaining confidentiality of information in the patient's/user's health record.	☐☐☐ A	

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

54.24 continued

GUIDANCE
This includes, for example:
- *storage in the service area*
- *patient access*
- *authorised access*
- *transportation between clinics/sites*
- *data protection.*

54.25 There is an up-to-date, documented procedure for the prescribing of medications. ☐☐☐ A

GUIDANCE
This includes, for example, the safe storage of prescription pads for in-house or external use.

54.26 There is an up-to-date documented procedure for ambulance/patient transport arrangements, which covers:

54.26.1 eligibility ☐☐☐ B

54.26.2 booking procedure ☐☐☐ B

GUIDANCE
This includes, for example, the amount of notice required and the choice of appropriate transport.

54.26.3 dealing with urgent requirements. ☐☐☐ B

54.27 There is up-to-date, documented procedure for patients/users failing to attend for appointments. ☐☐☐ B

GUIDANCE
This includes, for example:
↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

5.1.22 continued

- *making new appointments*
- *requests for re-referral*
- *discharge, as appropriate.*

54.28 There are up-to-date, documented procedures for:

54.28.1 referring patients/users to other services ☐☐☐ B

54.28.2 requesting diagnostic investigations ☐☐☐ B

54.28.3 reporting the results of investigations. ☐☐☐ B

54.29 Details of Patient's Charter rights in relation to waiting times for first outpatient appointment are:

54.29.1 on public display in the department (NHS only) ☐☐☐ A

54.29.2 communicated to all local general practitioners and purchasing authorities (NHS only). ☐☐☐ A

54.30 Information on waiting time from arrival/appointment time to being seen by a clinician:

54.30.1 is displayed in the waiting area ☐☐☐ B

54.30.2 is updated as changes occur. ☐☐☐ B

Facilities and equipment

54.31 The outpatient area has the following facilities:

54.31.1 play facilities/area for children (see also standard 28 Children's Services) ☐☐☐ B

54.31.2 access to public telephones ☐☐☐ B

54.31.3 space for wheelchairs and prams ☐☐☐ B

54.31.4 easy access to refreshments/snacks ☐☐☐ C

54.31.5 a crèche supervised by trained child care staff. ☐☐☐ C

GUIDANCE

Crèche facilities must operate a security registration system.

CRITERIA	YES	NO	PARTIAL		PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
54.32 There are changing facilities for patients/users which maintain visual privacy.	☐	☐	☐	A	
54.33 There is space and privacy to undertake minor procedures, such as changing of dressings or removal of plaster.	☐	☐	☐	A	
54.34 There are separate clean and dirty utility rooms.	☐	☐	☐	A	
54.35 There are designated set down and pick up points for patient/user transport.	☐	☐	☐	B	
54.36 There are designated car parking facilities for disabled patients/users close to the clinic service area, with easy access to the building.	☐	☐	☐	B	
Patient/user care					
54.37 Patients/users are given a choice of appointment time.	☐	☐	☐	C	
54.38 Patients/users are welcomed to the service area on arrival.	☐	☐	☐	C	
54.39 There is a chaperone service available for patients/users undergoing treatment in the clinic.	☐	☐	☐	B	
54.40 Patient/user-held records are developed.	☐	☐	☐	C	
GUIDANCE *These may be paper-based or 'smart cards'.*					
54.41 Each outpatient episode is recorded in the patient's/user's health record.	☐	☐	☐	A	
54.42 There is a process for ensuring that patients/users receive information about treatment and medication options and that possible outcomes are discussed.	☐	☐	☐	A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
54.43 A summary of outpatient care is sent to the patient's/user's general practitioner.	☐☐☐ A	
GUIDANCE *This includes, for example:* • *diagnosis* • *changes in treatment/medication/advice* • *advice on future treatment/patient management.* *There should be an agreed timescale for communication with the general practitioner on both routine and urgent cases.*		
Quality improvement		
54.44 Waiting times for the following are monitored:		
54.44.1 to first outpatient appointment (NHS only)	☐☐☐ A	
54.44.2 from arrival/appointment time to the time seen by clinician (NHS only).	☐☐☐ A	
54.45 The response times to requests for patient/user transport are monitored.	☐☐☐ A	
54.46 The following performance and outcome indicators are reviewed on a service-wide basis:		
54.46.1 the number and reasons for clinic cancellations	☐☐☐ B	
54.46.2 number of patients/users failing to attend	☐☐☐ B	
54.46.3 missing notes before and during clinics	☐☐☐ B	
54.46.4 ratio of follow-up to new patient/users	☐☐☐ B	
54.46.5 doctors' arrival times	☐☐☐ B	
54.46.6 patient/user commendations and complaints	☐☐☐ B	
54.46.7 turnaround times for appointment letters.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 55

Pathology Service

These criteria are equally applicable to a whole Pathology Service or to a Department of Pathology; a separate section is to be completed for each laboratory.
Please circle the department to which this section applies:

Clinical biochemistry Haematology Histopathology Microbiology Immunology

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

55.1 Each discipline is professionally directed by a consultant pathologist or a clinical scientist of equivalent standing. ☐☐☐ A

GUIDANCE
In the independent sector, contracted-out pathology services may be managed by a pathology manager with a consultant pathologist available for advice off-site.

55.2 Lines of communication between the pathology service and other departments are established and maintained. ☐☐☐ B

GUIDANCE
These include, for example:
- *accident and emergency department (see also standard 24 Accident and Emergency Service)*
- *acute day care service (see also standard 25 Acute Day Care Service)*
- *infection control (see also Corporate Management, standard 9 Risk Management – Infection Control)*
- *occupational health (see also Corporate Management, standard 6 Human Resources – Occupational Health)*

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

55.2 continued

- *operating theatre service*
- *special care units (for example, special care baby unit, intensive care unit).*

55.3 Laboratory staff are represented on multiprofessional committees where laboratory involvement is required. ☐☐☐ B

55.4 Where satellite laboratory services are provided (for example, in intensive care units, neonatal nurseries):

55.4.1 operational responsibilities are clearly defined and documented ☐☐☐ A

55.4.2 laboratory staff are involved in maintaining equipment, in quality assurance schemes and in ensuring the application of safety policies. ☐☐☐ A

55.5 All off-site services used are accredited. ☐☐☐ B

Staff development and education

55.6 Where training is provided to medical students and postgraduates in laboratory medicine and infection control, practice is monitored by a designated clinical tutor (see also standard 42 Medical Service). ☐☐☐ B

Policies and procedures

55.7 There are up-to-date, documented procedures for the completion of test request forms and specimen labels. ☐☐☐ A

GUIDANCE
These procedures ensure that the request form contains all relevant clinical and patient/user information which, for example:

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

55.7 continued

- *is legible*
- *includes full name of the patient/user, registration number, date of birth, sex, ethnic origin, occupation and details of any overseas travel*
- *includes name of requesting doctor and contact number*
- *includes source of request, name of consultant/general practitioner and geographical location of the request's origin*
- *includes tests requested*
- *includes type of specimen*
- *details relevant clinical details*
- *details relevant medications*
- *includes date and time specimen collected.*

These procedures ensure that specimens supplied are:
- *readily identifiable*
- *if applicable, clearly labelled as requiring precautionary handling (for example, category three specimens).*

55.8 There are up-to-date, documented procedures for specimen collection. ☐☐☐ A

GUIDANCE

The procedures include, for example, instructions for:
- *collection*
- *labelling (including patient/user identification)*
- *preservation*
- *reception*
- *safety measures to be observed*
- *storage*
- *transport.*

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

55.9 The instructions for specimen collection are accessible to staff involved in obtaining specimens from patients/users or transporting specimens to the laboratory service (see also standard 57 Portering Service). ☐☐☐ A

55.10 The laboratory keeps records of:
55.10.1 all specimens received ☐☐☐ A
55.10.2 all specimens forwarded to other laboratories. ☐☐☐ A

55.11 There are up-to-date, documented and dated test procedures. ☐☐☐ A

55.12 There is an up-to-date, documented procedure for the reporting of test results. ☐☐☐ A

GUIDANCE
The procedure should include, for example, that the results:
- *are validated before despatch*
- *are clearly marked with the patient's/user's identity*
- *are marked with the name and location of the requesting clinician*
- *if requiring immediate clinical attention are reported rapidly*

Procedures should include the use of new technology, for example, fax and e-mail in the reporting of results and safeguarding of confidentiality.

55.13 There is an up-to-date, documented procedure for transmitting results verbally. ☐☐☐ A

GUIDANCE
This ensures that, for example:
- *only designated staff transmit and receive reports by telephone*
- *a confirmatory hard copy follows with minimum delay*
- *the following are recorded:*
  the person providing the report
  the person receiving the report
  patient/user identity

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
55.13 continued		
result(s) *date and time results are telephoned* • *frozen section reports are transmitted directly to the surgeon concerned and followed up by a written report.*		
55.14 Report forms are designed to fit into the patient's/user's health record.		
55.15 There are up-to-date, documented procedures for: 55.15.1 the collection, labelling, storage, preservation, transport and administration of blood and blood products 55.15.2 dealing with transfusion reactions.	☐☐☐ A ☐☐☐ A	
55.16 There is an up-to-date, documented procedure for dealing with out-of-hours test requests.	☐☐☐ A	
55.17 A copy of the laboratory safety rules is given to all laboratory staff on appointment and when the rules are reviewed and revised.	☐☐☐ A	
Facilities and equipment		
55.18 Within the laboratory the following are available: 55.18.1 a designated area for receiving, despatching and handling specimens (including a separate area for dealing with high-risk samples) 55.18.2 storage facilities for specimens, reagents and records (including a separate storage area for high-risk samples) 55.18.3 facilities for the safe and secure storage of blood and blood products (for example, temperature monitoring, temperature alarms) 55.18.4 facilities for the safe disposal of cultures and potentially infectious clinical material.	☐☐☐ A ☐☐☐ A ☐☐☐ A ☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
55.19 The following are provided:		
55.19.1 adequate drainage and control of effluent	☐☐☐ A	
55.19.2 adequate ventilation (for example, fume extraction)	☐☐☐ A	
55.19.3 adequate lighting	☐☐☐ A	
55.19.4 adequate heating	☐☐☐ B	
55.19.5 piped gases	☐☐☐ B	
55.19.6 a deionised water supply.	☐☐☐ C	
55.20 Overnight accommodation is provided for on-call staff, if required.	☐☐☐ A	

Quality improvement

55.21 Staff participate in clinical audit meetings with other specialties.	☐☐☐ B	
55.22 The following performance and outcome indicators are reviewed on a service-wide basis:		
55.22.1 turnaround time for results	☐☐☐ B	
55.22.2 frequency of loss of results.	☐☐☐ B	
55.23 There is an internal quality control system in place.	☐☐☐ A	
55.24 The laboratory participates in:		
55.24.1 external quality assurance	☐☐☐ A	
55.24.2 a national accreditation scheme.	☐☐☐ C	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 56

Pharmaceutical Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

56.1 There are arrangements for the supervision of pharmaceutical products stored, prepared and/or distributed in satellite units. ☐☐☐ A

56.2 An experienced pharmacist is available at all times. ☐☐☐ A

56.3 Each pharmacist holds current registration with the Royal Pharmaceutical Society of Great Britain (RPSGB) or the Pharmaceutical Society of Northern Ireland. ☐☐☐ A

56.4 Pharmacy technicians hold a BTEC, City and Guilds or other suitable technical qualification in an appropriate discipline. ☐☐☐ B

56.5 There is a drug and therapeutics committee, the membership of which is representative of service users. ☐☐☐ B

GUIDANCE
In the independent sector, this may be a subgroup of the medical advisory committee for example.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

56.6 Staff liaise with the dietetic service to discuss the provision of nutritional supplements. ☐☐☐ B

56.7 Staff liaise with medical and surgical supplies staff to ensure that all usage is in accordance with the organisation's policy. ☐☐☐ B

56.8 There is access to a drug information department. ☐☐☐ B

Staff development and education

56.9 Where pre-registration training is provided it is structured in accordance with RPSGB guidelines and is under the supervision of a recognised pharmaceutical tutor. ☐☐☐ A

56.10 The continuing education programme provides experience in academic practice units. ☐☐☐ C

Policies and procedures

56.11 The drugs and therapeutics committee is involved in the development of procedures. ☐☐☐ B

GUIDANCE
In the independent sector, this may be a function of the medical advisory committee, or a sub-group of the MAC.

56.12 There are up-to-date, documented procedures for all activities undertaken by the pharmaceutical service. These include:

56.12.1 the provision of pharmaceutical services during normal working hours and out of hours, where applicable ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

S.S.P. continued

56.12.2 the manufacturing, repackaging and quality control of all medicines prepared within the organisation ☐☐☐ A

56.12.3 the distribution and supply of all medicines to wards and clinics, and to individual patients/users, including the labelling of medicines in line with the Medicines Labelling Regulations 1976 ☐☐☐ A

56.12.4 the ordering, purchase, receipt, storage and stock control of all medicines used in and supplied from the organisation ☐☐☐ A

56.12.5 the safe disposal of medicines where necessary ☐☐☐ A

56.12.6 prescription monitoring and the provision of information and advice to staff, patients/users and other people ☐☐☐ A

56.12.7 the safety and security of staff, medicines, facilities and equipment ☐☐☐ A

56.12.8 the management of error and other risk (for example, drug recall, dispensing errors, drug administration errors, spillage hazards). ☐☐☐ A

Facilities and equipment

56.13 There are secure storage facilities in the department which ensure that all pharmaceutical and related substances are held under conditions which conform to statutory and manufacturers' requirements. ☐☐☐ A

56.14 Security arrangements are in place to protect the following at all times:

56.14.1 medicines storage areas ☐☐☐ A

56.14.2 the department and staff (for example, door access controls, emergency alarms). ☐☐☐ A

56.15 All areas where medicines are used, including wards, operating theatres and other clinical departments and areas, have adequate and properly controlled medicines storage and preparation areas in accordance with statutory

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
56.15 continued		
requirements and any other special conditions (see also standards 29 Diagnostic Imaging Service, 54 Outpatient Service, 58 Radiotherapy Service).	☐☐☐ A	
56.16 Separate designated storage areas are provided for:		
56.16.1 medical gases	☐☐☐ A	
GUIDANCE *Medical gas cylinders should be kept chained up in a designated storage area, away from any potentially inflammatory materials. Full cylinders and empty cylinders should be stored separately.*		
56.16.2 materials under quarantine	☐☐☐ A	
56.16.3 the receipt and unpacking of incoming goods.	☐☐☐ B	
56.17 Hazardous and/or flammable materials are stored in accordance with the relevant regulations.	☐☐☐ A	
56.18 Controlled drugs are stored in conditions as specified in the Misuse of Drugs Act 1971, Safe Custody Regulations (not applicable to all premises).	☐☐☐ A	
56.19 Deep-freeze, refrigerator, cold room and cool area facilities are provided for safe storage of certain medicines.	☐☐☐ A	
56.20 Where the following activities are undertaken, designated and properly equipped areas are provided for:		
56.20.1 regular dispensing functions including extemporaneous dispensing in accordance with the Standards of Good Professional Practice	☐☐☐ A	
56.20.2 the manufacture and repacking of bulk non-sterile products in accordance with the requirements of the Guide to Good Pharmaceutical Manufacturing Practice	☐☐☐ A	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
56.20 continued		
56.20.3 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 BS 5295	☐☐☐ A	
56.20.4 the preparation of cytotoxic medicines and disposal of cytotoxic waste materials in accordance with the requirements of the Guide to Good Pharmaceutical Manufacturing Practice and the UK Cytotoxic Services Working Group Manual for Pharmacists Operating Cytotoxic Drug Services (October 1988)	☐☐☐ A	
56.20.5 quality control procedures to be carried out on raw materials used in manufacture and products prepared in the pharmacy department	☐☐☐ A	
56.20.6 the preparation of radio-pharmaceuticals in accordance with requirements of the Guide to Good Pharmaceutical Manufacturing Practice and Guidance Notes for Hospitals on Premises and Environment for Preparation of Radiopharmaceuticals (October 1983)	☐☐☐ A	
56.20.7 receipt and distribution of medicines used in the organisation.	☐☐☐ A	
56.21 Equipment complies with relevant safety standards and is serviced and/or certified on a regular basis in accordance with manufacturers' recommendations and/or in compliance with the Guide to Good Pharmaceutical Manufacturing Practice.	☐☐☐ A	
Quality improvement		
56.22 The following performance and outcome indicators are reviewed on a service-wide basis:		
56.22.1 dispensing errors	☐☐☐ B	
56.22.2 interventions initiated by the pharmacist	☐☐☐ B	
56.22.3 medicines usage (for example, appropriateness of prescription, drug reactions)	☐☐☐ B	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
56.22 continued		
56.22.4 patient/user waiting time for prescriptions (NHS only).	☐☐☐ B	
Support to community, mental health and learning disabilities services (where applicable)		
56.23 There is a designated pharmacist for coordinating services to the community.	☐☐☐ B	
56.24 There is designated pharmacist time to support community, mental health and learning disabilities services.	☐☐☐ B	
56.25 There is an up-to-date, documented procedure on the delivery of the community pharmacy service which is in line with the guidelines in the Safe and Secure Handling of Medicines Report 1988 (Duthie Report).	☐☐☐ A	
56.26 Community premises have safe and secure storage for:		
56.26.1 medicines	☐☐☐ A	
56.26.2 drugs requiring cold storage	☐☐☐ A	
56.26.3 controlled stationery.	☐☐☐ A	
56.27 There are procedures to maintain the cold chain.	☐☐☐ A	
56.28 Premises where stocks are kept are inspected every three months by a pharmacist.	☐☐☐ B	
56.29 Professional pharmacy advice is available from the planning stage onwards for community service developments.	☐☐☐ B	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
56.30 There are links with: 56.29.1 community mental health teams 56.29.2 community learning disabilities teams.	☐☐☐ B ☐☐☐ B	
56.31 There are agreed pharmaceutical procedures for use within supported living schemes for people with mental health problems or learning disabilities.	☐☐☐ B	
56.32 Arrangements are in place for the monitoring of pharmaceutical practices in supported living schemes.	☐☐☐ B	
56.33 In-service training is available for managers and support workers.	☐☐☐ B	
56.34 A pharmacist advises on the management of medicines for resettled patients/users.	☐☐☐ B	
56.35 There are links with community pharmacists and general practitioners to provide advice and support.	☐☐☐ B	

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 57

Portering Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Staff development and education		
57.1 Staff are given in-service training on the following:		
57.1.1 control of infection and the role of the employee in this control (for example, portering of specimens)	☐☐☐ A	
57.1.2 dealing with clinical waste (see also Corporate Management, standard 9 Risk Management – Waste Disposal)	☐☐☐ A	
57.1.3 food handling (for staff involved in the handling of food)	☐☐☐ A	
57.1.4 moving and handling of patients/users, equipment or other heavy loads	☐☐☐ A	
57.1.5 safety measures in hazardous areas such as the sterile services department, kitchens, workshops, laundry, laboratories and radiology areas	☐☐☐ A	
57.1.6 handling physical and verbal violence.	☐☐☐ B	
57.1.7 handling, storage and changing of medical gas cylinders	☐☐☐ A	
57.1.8 customer care.	☐☐☐ B	
57.2 Staff who are assigned tasks in specialist areas receive additional training in the execution of procedures unique to these departments.	☐☐☐ A	
Policies and procedures		
57.3 There are up-to-date, documented procedures for the following: ↓		

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

57.3 continued

57.3.1 moving and handling of patients/users, equipment or other heavy loads ☐☐☐ A
57.3.2 transporting of specimens (see also standard 55 Pathology Service) ☐☐☐ A
57.3.3 handling, storage and changing of medical gas cylinders ☐☐☐ A
57.3.4 handling physical and verbal violence ☐☐☐ B
57.3.5 mortuary duties. ☐☐☐ B

57.4 There is a system to prioritise requests for portering work and to allocate resources to the requests efficiently. ☐☐☐ B

Quality improvement

57.5 Information on response times to requests is collected, monitored and evaluated. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 58

Radiotherapy Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
58.1 The service is clinically directed by a qualified clinical oncologist.	☐☐☐ A	
GUIDANCE *The oncologist may be full or part time depending on the size and complexity of the department.*		
58.2 The following are on duty or contactable at all times:		
58.2.1 a qualified oncologist	☐☐☐ A	
58.2.2 state-registered radiographers	☐☐☐ A	
58.2.3 a qualified and experienced medical radiation physicist	☐☐☐ A	
58.2.4 registered nurses.	☐☐☐ B	
58.3 There is a radiation protection supervisor for the department.	☐☐☐ A	
58.4 The role of the radiation protection supervisor is clearly defined.	☐☐☐ A	
58.5 There is a radiation protection advisor for the organisation.	☐☐☐ A	
58.6 All radiotherapeutic procedures are conducted by an appropriately qualified person or by students under the guidance of an appropriately qualified person.	☐☐☐ A	

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
58.7 Radiographers are accountable to, and supervised by, a designated senior radiographer.	☐☐☐ B	

Policies and procedures

58.8 Practice conforms to:		
58.8.1 Ionising Radiations Regulations 1985	☐☐☐ A	
58.8.2 Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988.	☐☐☐ A	
58.9 When developing ionising radiation procedures, all professional staff, the radiation protection supervisor and radiation protection advisor are involved.	☐☐☐ A	
58.10 Simulation and planning procedures are performed and radiotherapy treatment given only upon written request by a clinical oncologist employed within the department.	☐☐☐ A	
58.11 The prescription contains sufficient clinical information to justify the treatment.	☐☐☐ A	

GUIDANCE
The prescription should contain enough clinical information for an assessment of whether the procedure is appropriate.

58.12 There is a local procedure for the length of time that films, treatment plans and prescriptions are stored.	☐☐☐ B	
58.13 Films, treatment plans and prescriptions are stored using a coding system that enables speedy retrieval.	☐☐☐ B	
58.14 There are up-to-date, documented procedures for the following:		
58.14.1 care of patients/users with special needs, including those who are critically ill and those needing isolation precautions	☐☐☐ A	
58.14.2 managing emergency referrals	☐☐☐ A	

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
58.14 continued		
58.14.3 appointment system	☐☐☐ B	
58.14.4 information issued to patients/users and relatives or carers.	☐☐☐ B	
58.15 The implementation of radiation safety measures is supervised by the radiation protection supervisor.	☐☐☐ A	
58.16 As a minimum, safety measures include precautions against:		
58.16.1 chemical hazards	☐☐☐ A	
58.16.2 contamination/infection risks	☐☐☐ A	
58.16.3 electrical hazards	☐☐☐ A	
58.16.4 fire and explosion	☐☐☐ A	
58.16.5 mechanical hazards	☐☐☐ A	
58.16.6 radiation hazards.	☐☐☐ A	

Facilities and equipment

58.17 Appropriate shielding and protective clothing is provided in the presence of biohazards or radiographic equipment and practice conforms to the Ionising Radiations Regulations 1985.	☐☐☐ A	
58.18 Staff working with radiological equipment wear radiation monitoring devices.	☐☐☐ A	
58.19 The radiation monitoring devices are assessed periodically in accordance with statutory regulations.	☐☐☐ A	
58.20 Results are reported to the radiation protection supervisor.	☐☐☐ A	
58.21 Continuous records of these results are kept for the working lifetime of staff employed by the service.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

58.22 All staff are given instruction in safety precautions for patients/users and staff. ☐☐☐ A

58.23 All rooms and equipment are assessed for safety at acceptable intervals by suitably qualified experts. ☐☐☐ A

58.24 Records of safety assessment are kept. ☐☐☐ A

58.25 All equipment is calibrated in accordance with regulations. ☐☐☐ A

Quality improvement

58.26 The following performance and outcome indicators are reviewed on a service-wide basis:

58.27.1 referral patterns ☐☐☐ B

58.27.2 waiting times for appointments ☐☐☐ B

58.27.3 time spent by patients/users in the department. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 59

Special Care Service

Special care services are defined as discrete areas specifically organised for the management of critically ill patients which involve the grouping of special facilities and specially trained staff.
A separate section is to be completed for each of such services; please indicate to which service this section applies.

Service: _____

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
Management and staffing		
59.1 The special care unit is directed by a recognised specialist and practising clinician in the area of patient care undertaken by the unit.	☐☐☐ A	
59.2 The functions, responsibilities and authority of the director and the admitting consultants are clearly defined.	☐☐☐ B	
59.3 There is a designated resident doctor available at all times.	☐☐☐ A	
GUIDANCE *This doctor is, for example:* • *experienced enough to deal with the majority of patients within the unit* • *able to deal with emergencies* • *within easy reach of the unit* • *involved in all decisions relating to the clinical care of the patient.*		
59.4 A senior nurse with specialised post-registration qualification and/or experience has overall responsibility for the nursing care provided in the unit.	☐☐☐ A	
59.5 All registered nurses assigned to a special care unit have completed an in-service programme or an appropriate national board course.	☐☐☐ A	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

59.6 Special care service staff are represented on inter-departmental committees and involved in decision making on issues related to service provision. ☐☐☐ C

59.7 There is a users' committee. ☐☐☐ B

GUIDANCE
The users' committee, for example:
- *comprises representatives of medical, management, nursing and paramedical staff*
- *advises the director and full time specialists of the unit on the development, implementation and evaluation of service procedure.*

In the independent sector this may be a function of the medical advisory committee.

59.8 The following are available at all times:

59.8.1 a cardiac arrest team ☐☐☐ A

59.8.2 for units which accept children, a nurse whose name appears on either part 8 or part 15 of the UKCC Register, that is a Registered Sick Children's Nurse or Registered Nurse (Child) (see also standard 28 Children's Services) ☐☐☐ A

59.8.3 adequate supplies of medications and intravenous fluids (see also standard 56 Pharmaceutical Service) ☐☐☐ A

59.8.4 adequate, well maintained equipment for organ support ☐☐☐ A

59.8.5 expert advice concerning the safe use of, and preventive maintenance for, all biomedical devices and electrical installations ☐☐☐ A

59.8.6 pathology services (including blood bank) (see also standard 55 Pathology Service) ☐☐☐ A

59.8.7 a physiotherapist ☐☐☐ A

59.8.8 a radiographic team capable of mobile x-ray (see also standard 29 Diagnostic Imaging Service) ☐☐☐ A

59.8.9 technical support to ensure the safe and effective functioning of equipment. ☐☐☐ A

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

59.9 Patients, relatives and staff are aware of, and have access to, trained counsellors. ☐☐☐ C

59.10 The housekeeping staff are informed of the special nature of the unit and dangers associated with disconnecting patients from equipment (see also standard 32 Housekeeping Service). ☐☐☐ A

Staff development and education

59.11 Staff have training in handling bereavement. ☐☐☐ B

Policies and procedures

59.12 There are up-to-date, documented procedures for the following:

59.12.1 admission criteria (and contingency plans for when the unit is full) ☐☐☐ A

59.12.2 'do not resuscitate' situations, issues of valid consent to treatment and research in incapacitated patients, withdrawal of treatment situations ☐☐☐ A

59.12.3 emergency and established standard care procedures of critically ill patients ☐☐☐ A

59.12.4 people who may perform special procedures, under what circumstances and under what degree of supervision ☐☐☐ A

GUIDANCE

Special procedures in this context include, for example:

- *administration of parenteral fluids and other medications*
- *cardiopulmonary resuscitation*
- *obtaining of blood and other laboratory specimens*
- *ordering of medications*
- *controlled mechanical ventilation*
- *haemofiltration*

59.12.5 what to do in the event of breakdown of essential equipment ☐☐☐ A

↓

CRITERIA	YES	NO	PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
59.12 continued				
59.12.6 requesting donor organs and the training of staff in how to approach relatives or carers			A	
59.12.7 transfer of patients to other hospitals			A	
59.12.8 acquisition, maintenance, cleaning, sterilisation, preparation and location of equipment and supplies			B	
59.12.9 arrangements for diagnostic imaging and laboratory investigations			B	
59.12.10 arrangements for visitors			B	
59.12.11 control oftraffic through and within the unit including access to the unit			B	
59.12.12 discharge criteria.			A	

Facilities and equipment

59.13 The immediate physical environment of the patient is:				
59.13.1 as unobtrusive and aesthetically pleasing as possible			B	
59.13.2 conducive to recovery with minimum sensory deprivation and abuse			B	
59.13.3 situated near outside windows wherever possible.			B	
59.14 The unit is air-conditioned.			B	
59.15 Lighting systems are as similar to natural light as possible.			B	
59.16 The nurses' station allows effective observation of, and ready access to, all patients in the area.			A	
59.17 Sufficient space is provided around each bed to make it accessible for routine and emergency care and to accommodate bulky equipment.			A	
59.18 Patient beds:				

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
59.18 continued		
59.18.1 are adjustable	☐☐☐ A	
59.18.2 are easily moved	☐☐☐ A	
59.18.3 have a locking mechanism	☐☐☐ A	
59.18.4 have cot sides	☐☐☐ A	
59.18.5 have removable headboards.	☐☐☐ A	
59.19 Where electrically operated beds are used, staff are aware of potential electrical hazards.	☐☐☐ A	
59.20 There are facilities for isolation and protective isolation nursing of patients (see also Corporate Management, standard 9 Risk Management – Infection Control).	☐☐☐ A	
59.21 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.	☐☐☐ C	
59.22 Quiet and private areas with tea and coffee making facilities and a telephone are available for waiting, grieving or otherwise distressed relatives or carers.	☐☐☐ B	
59.23 Residential accommodation for relatives or carers is available and within easy reach of the unit.	☐☐☐ C	
59.24 There is a bedroom for the resident doctor adjacent to the patient area.	☐☐☐ A	
59.25 All emergency and life support equipment is readily accessible and functional.	☐☐☐ A	
59.26 Safety testing of equipment is carried out on an agreed regular basis and is documented.	☐☐☐ B	

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Quality improvement

59.27 The following performance and outcome indicators are reviewed on a service-wide basis.

59.27.1 inappropriate referrals (case mix) ☐☐☐ B

59.27.2 morbidity ☐☐☐ B

59.27.3 mortality ☐☐☐ B

59.27.4 severity and illness. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 60

Sterile Services Department

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

60.1 The manager of the service has a qualification in sterile services management recognised by the Institute of Sterile Services Management (ISSM). ☐☐☐ A

GUIDANCE
The recognised qualification is the City & Guilds and ISSM Certificate in Sterile Services Management and Technology.

Other qualifications are ODA, MLSO, Pharmacy Technician, holders of these qualifications should be working towards the ISSM examination.

Where the scope of the department does not warrant a manager the person responsible is trained to a standard recognised by the ISSM.

Staff development and education

60.2 All staff receive health and safety and control of infection training specific to the work of the department. ☐☐☐ A

60.3 All staff receive technical training, relevant to the work of the department and the equipment used. ☐☐☐ A

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

60.3 continued

GUIDANCE
This includes, for example, in-service training by senior sterile services, infection control and engineering staff, training provided by equipment manufacturers, courses run by the Institute of Sterile Services Management, City & Guilds and ISSM technology training courses are awarded at levels 1–3.

Policies and procedures

60.4 There is an awareness of and familiarity with the organisation's policies and procedures for the following :

60.4.1 dangerous occurrences ☐☐☐ A
60.4.2 sharps injuries ☐☐☐ A
60.4.3 provision and use of personal protective equipment ☐☐☐ A
60.4.4 infection control. ☐☐☐ A

60.5 There are up-to-date, documented procedures for all service activities covering:

60.5.1 spillage of chemicals ☐☐☐ A
60.5.2 spillage of infectious material ☐☐☐ A
60.5.3 use of formaldehyde, glutaraldehyde, ethylene oxide ☐☐☐ A
60.5.4 lost instruments ☐☐☐ A
60.5.5 handling equipment known to be infectious ☐☐☐ A
60.5.6 plant operating and testing procedures for washer/disinfectors ☐☐☐ A
60.5.7 assembly and packing procedures ☐☐☐ A
60.5.8 product identification, process recording and recall ☐☐☐ A
60.5.9 use of items designated as single use by manufacturer ☐☐☐ A

GUIDANCE
This includes, for example, a system for identification of limited use items and procedures for their use.

↓

CRITERIA	YES NO PARTIAL	PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION
60.5 continued		
60.5.10 product liability/indemnity	☐☐☐ A	
GUIDANCE *This should include, for example, indemnification of items which are for trial, gifts or on loan.*		
60.5.11 faulty/contaminated products to be sent to the Medical Devices Agency for investigation	☐☐☐ A	
60.5.12 packaging of products to be sent through the post	☐☐☐ A	
GUIDANCE *The outer envelope should contain full details of the items inside and the conditions in which it is safe to open the package.*		
60.5.13 unpacking and checking used instruments	☐☐☐ B	
60.5.14 safe handling and transport of equipment.	☐☐☐ B	
60.6 There are up-to-date, documented specific procedures for departments which are:		
60.6.1 manufacturing units	☐☐☐ B	
60.6.2 sterilisation subcontractors.	☐☐☐ B	
60.7 There are procedures on staff health in relation to clean room environments.	☐☐☐ B	
GUIDANCE *This includes, for example, reference to regular health screening for dermatitis and asthma.*		
Facilities and equipment		
60.8 There are designated areas for:		

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

60.8 continued

60.8.1 dirty reception, sorting and decontamination ☐☐☐ A
60.8.2 tray assembly, inspection and packaging ☐☐☐ A
60.8.3 linen inspection and folding ☐☐☐ A
60.8.4 sterilisation areas ☐☐☐ A
60.8.5 medical equipment cleaning and disinfection area ☐☐☐ A
60.8.6 raw materials preparation and storage ☐☐☐ A
60.8.7 items for repair ☐☐☐ A
60.8.8 processed items store and distribution. ☐☐☐ A

60.9 Staff wear protective clothing, suitable for the work they are doing, at all times in the department. ☐☐☐ C

60.10 There are hand-washing facilities in the department. ☐☐☐ B

60.11 There is a schedule for the cleaning of the department. ☐☐☐ B

60.12 There is a process for cleaning and disinfection of transportation equipment. ☐☐☐ B

60.13 Washer/disinfectors operate to required safety standards. ☐☐☐ A

GUIDANCE
Washer/disinfectors should be in compliance with HTM 2030.

60.14 Instruments are dried mechanically (not by hand). ☐☐☐ B

60.15 There is a dedicated cleaning materials equipment store. ☐☐☐ A

GUIDANCE
There should be separate equipment for cleaning dirty, peripheral and clean areas.

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

60.16 There is separate access for materials. ☐☐☐ B

Sterilising room

60.17 Loading equipment is compatible with sterilisers. ☐☐☐ A

60.18 Sterilisers comply with required safety standards ☐☐☐ A

GUIDANCE
Steriliser maintenance should be in compliance with HTM 2010.

60.19 A steriliser log book is kept with each machine. ☐☐☐ A

GUIDANCE
All sterilisers, including portable units, need to have log books. The log book should have regular entries (daily or weekly depending upon use) and a plant history record for each machine.

60.20 There is separate accommodation for ethylene oxide sterilisers with aeration facilities. ☐☐☐ A

60.21 Where ethylene oxide sterilisers are used there is monitoring equipment to check levels of gas in the room and activate an alarm system. ☐☐☐ B

GUIDANCE
For guidance on occupational exposure limits see EH40/96 published by the Health and Safety Executive.

60.22 In the raw materials and processed items store and despatch area:
60.22.1 all materials are stored off the floor in a dry, clean environment ☐☐☐ A
60.22.2 there are regular checks for signs of infestation ☐☐☐ B

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

60.22 continued

60.22.3 windows are non-openable ☐☐☐ B

60.22.4 there is a cooling area. ☐☐☐ B

GUIDANCE
This should either be in the autoclave room or sterile store.

60.23 Manufacturers' instructions are available for equipment used in the department and are used to inform maintenance and replacement procedures. ☐☐☐ B

Quality improvement

60.24 Monitoring is undertaken of sterilisation and decontamination processes in accordance with HTMs and guidelines relevant to the task. ☐☐☐ B

GUIDANCE
These include, for example, the Institute of Sterile Services Management standards and reference book, HTM 2010, HTM 2030 and guidance on decontamination from the Microbiology Advisory Committee to the Department of Health Medical Devices Agency.

60.25 The service has a quality management system in place. ☐☐☐ B

GUIDANCE
This includes, for example, ISO 9002.

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 61

Telecommunications Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

Management and staffing

61.1 There is an up-to-date, documented service plan for the telecommunications service which is in line with the organisation's strategy for information management and technology. ☐☐☐ B

Staff development and education

61.2 Staff receive up-to-date training in line with technological developments and equipment used. ☐☐☐ B

Policies and procedures

61.3 There are up-to-date, documented procedures for the following:

61.3.1 bleep system failure ☐☐☐ A
61.3.2 board system failure ☐☐☐ A
61.3.3 bomb threats ☐☐☐ A
61.3.4 'crash' calls ☐☐☐ A

GUIDANCE
This includes the logging of crash calls.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

61.3 continued

61.3.5 fire in the switchboard area ☐☐☐ A
61.3.6 fire elsewhere in the organisation ☐☐☐ A
61.3.7 major incidents ☐☐☐ A
61.3.8 telephone complaints. ☐☐☐ B

61.4 The role of the service during a major incident is tested annually. ☐☐☐ B

61.5 The following equipment is subject to a planned programme of testing:
61.5.1 alarms ☐☐☐ A
61.5.2 'crash' bleeps ☐☐☐ A
61.5.3 incident pagers ☐☐☐ A
61.5.4 emergency back-up/bypass system. ☐☐☐ A

61.6 Records of these tests are maintained. ☐☐☐ B

61.7 Service staff receive training in the use of the emergency telephone back-up/bypass system. ☐☐☐ B

61.8 An up-to-date list of personnel on call within the organisation is available. ☐☐☐ A

61.9 Where security alarms are routed to the switchboard area, all staff are aware of the action to be taken. ☐☐☐ A

61.10 The telecommunications service is proactive in keeping the following information up to date:
61.10.1 staff extension numbers ☐☐☐ B
61.10.2 direct line numbers ☐☐☐ B
61.10.3 names of staff in post. ☐☐☐ B

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

61.11 Arrangements are in place for dealing with out-of-hours telephone queries. ☐☐☐ A

Quality improvement

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

61.12.1 internal call response times ☐☐☐ B

61.12.2 external call response times ☐☐☐ B

61.12.3 usage and cost of lines and calls. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Standard 62

Volunteer Service

Weighting: Essential practice A, Good practice B, Excellent practice C

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

62.1 There is an up-to-date, documented policy on the use of volunteers within the organisation. ☐☐☐ B

GUIDANCE
The policy sets out a clear framework for the management and accountability of voluntary activity throughout the organisation.

Allocation of responsibility should be considered for the oversight and development of volunteering to a board member.

62.2 The policy is available to:
62.2.1 staff ☐☐☐ B
62.2.2 patients/users. ☐☐☐ C

62.3 There are up-to-date, documented procedures for the following:
62.3.1 recruitment and screening systems ☐☐☐ B

GUIDANCE
Operational procedures for the recruitment and deployment of volunteers should conform to equal opportunities policies and special attempts should be made to recruit from under-represented groups.

↓

CRITERIA

YES NO PARTIAL

PLEASE COMMENT ON THE PROGRESS YOU HAVE MADE TOWARDS MEETING EACH CRITERION

62.3 continued

62.3.2 training ☐☐☐ B
62.3 3 placement arrangements ☐☐☐ B

GUIDANCE
Screening should ensure that volunteers are matched to tasks within their abilities.

62.3.4 monitoring ☐☐☐ B
62.3.5 evaluation ☐☐☐ C
62.3.6 insurance. ☐☐☐ B

62.4 There are documented agreements about the scope of volunteer activity. ☐☐☐ B

GUIDANCE
Volunteer roles should be defined and shared with staff and volunteers. Refer to Revised Guidelines for Relations Between Volunteers and Paid Workers (National Centre for Volunteering, April 1990) for more details.

62.5 Information about the following is collected:

62.5.1 number of volunteers deployed ☐☐☐ B
62.5.2 hours of service provided ☐☐☐ B
62.5.3 range of work undertaken. ☐☐☐ B

Comments

Please comment on the standards and criteria in the space below. This will help in the continuing review of the standards.

For example, is there anything that is:

- difficult to interpret
- out of date
- not achievable?

Appendix 1

Glossary of terms

Absenteeism

Absence from work not authorised through the appropriate channels.

Accident

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

Accident Report

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

Accountability

Being answerable for one's decisions and actions. Accountability cannot be delegated.

Audit

The process of setting or adopting standards and measuring performance against those standards with the aim of identifying both good and bad practice and implementing changes to achieve unmet standards.

Adolescents

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

Advance Directives

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

Advocate

An individual acting on behalf of, and in the interests of, patients/users who may feel unable to represent themselves in their contacts with a health care or other facility.

Aim

Overall purpose or goal of a department or service.

Annual Report

A report, written annually, which details progress over the last year and plans for the following year, including financial and activity statements.

Business Plan

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

Capital Asset

Land, property, plant or equipment valued at more than £5,000.

Capital Asset Register

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

Capital Asset Replacement Programme

A programme which uses depreciation accounting techniques to spread the cost of the replacement of capital assets.

Care Plan

A document which details the care and treatment that a patient/user receives and identifies who delivers the care and treatment. This term covers the term 'individual plan' (see also Health Record).

Care Programme Approach (CPA)

The individual packages of care (care programmes), developed in conjunction with social services, for all patients/users accepted by the specialist psychiatric services. Care programmes may range from 'minimal' single worker assessment and monitoring for individuals with less severe mental health and social needs, to complex and multiprofessional assessments and treatment.

Carer

A person who regularly helps, without pay, a relative or friend with domestic, physical, emotional or personal care as a result of illness or disability. This term also incorporates friends, relatives and partners.

Checklist

A means of recording observations relating to fixed criteria, used to check compliance with agreed procedures or standards.

Clinical Responsibilities

Range of activities for which a clinician is accountable.

Communication Strategy

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

Continuing Education

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

Contract/Agreement

A document agreed between providers of health care and the purchasers of health care; it details activity, financial and quality levels to be achieved.

Contract Currencies

Agreed units of measurement for contracting, for example finished consultant episodes.

Control Measures

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

Corporate

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

Corporate Seal

A seal used by organisations to certify documents used in legal transactions such as the sale of land to fulfil legal requirements.

COSHH

Acronym for the Control of Substances Hazardous to Health legislation.

Criterion

A measurable component of performance. A number of criteria need to be met to achieve the desired standard.

Disaster Recovery (Computer Services)

Mechanisms for recovering information and/or vital computer services.

Extracontractual Referrals (ECRs)

The referral of an individual for health services that are not covered in the contracts that exist between the purchaser and providers of services.

Errors

Mistakes made by staff in the performance of their duties.

Estates Strategy

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

Evaluation

The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.

Financial Strategy

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

Hazard Assessment Procedures

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

Hazards

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

Health and Safety Policy

A plan of action for the health, safety and well-being of staff, patients/users, residents and visitors.

Health Professional

A person qualified in a health discipline.

Health Promotion

Enabling individuals and communities to increase control over the determinants of health and thereby improve their health.

Health Record

Information about the physical or mental health of someone, which has been made by, or on behalf of, a health professional in connection with the care of that person. These must be kept for a statutory period of time after the patient/user is discharged from the service. Records will be held in addition to care plans.

Hospital-Acquired Infection

An infection acquired by a patient/user during their stay in hospital which is unconnected with their reason for admission.

Human Resource Strategy

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

Incident

An event or occurrence, especially one which leads to problems. An example of this could be an attack on one person by another within a service.

Income and Expenditure Reports

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

Induction Programme

Learning activities designed to enable newly appointed staff to function effectively in a new position.

Interpreter Service

A service providing trained interpreters for patients/users whose first language is not English.

Job Description

Details of accountability, responsibility, formal lines of communication, principal duties, entitlements and performance review. A guide for an individual in a specific position within an organisation.

Keyworker

A keyworker is the person responsible for coordinating the care plan for each individual patient/user, for monitoring its progress and for staying in regular contact with the patient/user and everyone involved. A key worker may be from a variety of different professional or non-professional backgrounds.

Major Incident (External)

A serious external incident which requires the organisation to implement contingency plans or change or suspend some normal functions. An example would be the aftermath of a rail crash.

Major Incident (Internal)

A serious incident occurring within the health care facility resulting in the changing or suspension of some normal functions or threatening the organisation. This requires the drawing up of contingency plans. Examples of this would include the loss of electricity or telecommunications services or bomb threats.

Makaton Symbols

A system of symbols used to communicate with some people who have severe learning disabilities.

Minimum Data Sets

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

Mission Statement

Statement of the overall purpose of an organisation.

Monitoring

The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.

Morbidity

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

Mortality

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

Multiprofessional

A combination of several professions working towards a common aim.

Objective

A specific and measurable statement which sets out how overall aims are to be achieved.

Organisation

The term used throughout the manual to describe the entire organisation, as opposed to the term service, which is used to describe one part of the organisation (see also Service).

Organisation and Management Development Strategy

A written document which sets out the strategy for developing the organisational processes and management skills needed by an organisation.

Organisational Chart

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

Organisational Development (OD)

An educational strategy aimed at changing the beliefs, attitudes, values and structures within an organisation so that it can adapt better to changing requirements. The emphasis is on interventions, rather than the objective assessment of services.

Outcome

The end result of care and treatment, that is the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment.

The Patient's Charter

A list of required national standards and rights set by central government for the NHS.

Patient/User

These terms are used interchangeably by staff across health and social services.

Patients'/Users' Council/Forum/Group

This is a group led and determined by patients/users; it meets independently of staff and has its own agenda and operations. There can be patient/user council/fora/groups within inpatient services, day hospitals, residential or community-based services. These are different to users' groups that are separately funded and legal entities in their own right, for example charities such as the UK Advocacy Network.

Pattern of Delivery

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

Performance Indicator

A standard of work which acts as a measurement of performance, for example response times to requests for maintenance work used to indicate the performance of the service (see also Quality Indicator).

Performance Review

A systematic check on the achievement of organisations and individuals compared to set objectives.

Philosophy

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

Planning

The process by which the service determines how it will achieve its aims and objectives. This includes identifying the resources which will be needed to meet the aims and objectives.

Policy

An operational statement of intent in a given situation.

Preventive Maintenance and Replacement Programme

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

Procedure

The steps taken to fulfil a policy.

Professional Standards

Professionally agreed levels of performance.

Project 2000

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

Protocol

The adoption, by all staff, of national or local guidelines to meet local requirements in a specified way.

Quality Assurance (QA)

A generic term to cover the review of the quality of services provided, along with interventions designed to improve that quality by remedying deficiencies identified by the review process. The review may include both qualitative and quantative measurements and may or may not relate to clearly stated standards.

Quality Improvement Strategy

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

Quality Indicator

A standard of service which acts as a measurement of quality, for example incidence of infection used to indicate the quality of care (see also Performance Indicator).

Research and Development

Searching out knowledge and evidence about the relationship between different factors in the provision of services. Research does not require action in response to findings.

Responsibility

The obligation that an individual assumes when undertaking delegated functions.

Review

The examination of a particular aspect of a service or care setting so that problem areas requiring corrective action can be identified.

Risk Management

A systematic approach to the management of risk to reduce loss of life, financial loss, loss of staff availability, staff and patient/user safety, loss of availability of buildings or equipment, or loss of reputation.

Risk Management Strategy

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

Safe Discharge of Patients/Users

A procedure for the discharge of patients/users who require care in the community which complies with Department of Health guidelines.

Satisfaction Survey

Seeking the views of patients/users through responses to pre-prepared questions and carried out through interview or self-completion questionnaires.

Service

The term used to describe part of an organisation, as opposed to the entire organisation (see also Organisation).

Service Contract

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

Service Level Agreement

The term used to describe a document, agreed between organisations or services that will provide and receive a service, which sets out in detail how the service will be provided.

Skill Mix

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

Staff Incident Reporting System

A standardised system for reporting incidents and near misses. The NHS Executive recommends that no more than two types of forms are used for this.

Standard

An overall statement of desired performance.

Standing Financial Instructions

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

Standing Orders

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

Strategy

A long-term plan.

Survey

The collection of views from a sample of people in order to obtain a representative picture of the views of the total population being studied.

Training and Development Strategy

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

Unusual Medications

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

Valid Consent

The legal principle by which a patient/user is informed about the nature, purpose and likely effects of any treatment proposed before being asked to consent to accepting it.

Vital Services

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

Appendix 2

Relevant legislation, regulations and guidance

Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993

Gives people right of access to their own health records, and provides for the correction of inaccurate information in manually held records (subject to certain exemptions).

Access to Medical Reports Act 1988

Advance Statements about Medical Treatment, BMA, 1995

Guidance on dealing with advance directives.

Assessment of Mental Capacity: Guidance for Doctors and Lawyers, BMA/The Law Society, 1995

Guidance on assessing a person's capacity to give valid consent.

Baseline IT Security Policy in the NHS in Wales, DGM (96) 100, and IT Security Policy in the NHS in Wales, DGM (95) 199

Covers issues of security in relation to patient/user information.

Building Bridges: a guide to requirements for interagency working for the care and protection of severely mentally ill people, Department of Health, 1995

Guidance document describing best practice on caring for the severely mentally ill and the importance of interagency working.

Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services, HC (90) 23

Sets out the principles of the care programme approach.

Carers (Recognition and Services) Act 1995

Covers carers who are either providing, or intend to provide, a substantial amount of care on a regular basis. Under the Act, the carer is entitled to request an assessment, the results of which should be taken into account along with the needs of the patient/user.

Changing Childbirth, HMSO, 1992

Guidelines on the development of maternity services.

Children Act 1989

Provides the foundation for law on children in Britain. The Act requires collaboration between agencies in the provision of services to, and the protection of, children deemed to be in need. The Act emphasises the rights of a child to make informed decisions in relation to her or his own medical care.

Children's (Northern Ireland) Order 1995

Replaces the provisions of the Children and Young Persons Act (Northern Ireland) 1968 and amends the law relating to illegitimacy and guardianship.

Clinical Negligence and Personal Injury Litigation, EL (96) 11

First of a linked series of guidance notes which sets out the action required by trusts and health authorities in claims handling.

Code of Practice on Openness in the NHS, EL (95) 42

Sets out the basic principles underlying public access to information about the NHS. It complements the code of access to information which applies to the Department of Health/NHS Executive and builds upon the progress made by The Patient's Charter in this area. Requests for information should be responded to positively except in certain circumstances, for example patients' records which must be kept safe and confidential.

Codes of Conduct and Accountability Guidance, EL (94) 40, NHS Executive, 1994

Codes concerned with the conduct and account of NHS boards and their members. Standing orders should reflect the guidance which deals mainly with exchequer funds. Areas covered include annual reports, remuneration, terms of service committees, declaration of interests and register of interests.

Collection of Ethnic Group Data for Admitted Patients, EL (94) 77

The introduction of ethnic monitoring systems in hospitals became mandatory from April 1995.

Control of Substances Hazardous to Health Regulations 1988 (COSHH)

These are commonly referred to as the 'COSHH requirements'.

Culyer Report, Department of Health, 1994

Makes a variety of recommendations about the research and development funding systems in the NHS and related topics. An implementation plan was issued by the NHS Executive in April 1995.

Data Protection Act 1984

Brings the UK into line with other Western countries in terms of the rights, duties and obligations of all persons and organisations concerned with computers and computerised data. The Act recognises the specific importance of personal data and an individual citizen's rights. The Act allows individuals right of access to information about themselves held on computer.

Developing the Care Programme Approach – Building on Strengths, NHS Training Division, 1995

A resource pack, developed by the NHS Training Division, to enable organisations to develop good practice around the care programme approach.

Disability Discrimination Act 1995

Makes it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities, and services for the disposal or management of premises. It makes provisions with regard to the employment of disabled persons. This Act is applicable to Great Britain.

Education of Sick Children, HSG (94) 24

Covers aspects of providing education to children in hospital.

Efficiency Scrutiny Report, Seeing the Wood, Sparing the Trees, NHS Executive, 1996

Concerned with bureaucracy in the NHS and the 'burdens' of paperwork in NHS trusts and health authorities.

Electricity at Work Regulations 1989

Emergency Planning in the NHS (Executive Handbook)

Employment Rights Act 1996

Environmental Protection Act 1990

Although not legally binding, this Act is used as the benchmark of good practice, along with Waste Management – the Duty of Care: a code of practice, 1991.

Ethnic Monitoring of Staff in the NHS: a programme of action, EL (94) 12

The aim of this programme is to achieve the equitable representation of minority ethnic groups at all levels in the NHS, reflecting the ethnic composition of the local population.

Firecode (suite of documents), NHS Estates, available from HSMO

Policy, technical guidance and specialist aspects of fire precautions.

Fire Precautions Act 1971

Includes the requirements for certification by the local fire brigade.

Food Safety Act 1990

Guidance and Ethics for Occupational Physicians, Faculty of Occupational Medicine, 1993

Guidance on Supervised Discharge (After-Care under Supervision) and Related Provisions, WHC (96) 11 and WOC 6/96

Covers the discharge of seriously mentally ill people in Wales.

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community, HSG (94) 27

This covers the discharge of people with a serious mental illness. Risk assessment is given extensive coverage.

Heads of Agreement on Junior Doctors Hours, NHS Executive, December 1990

Usually known as Junior Doctors – The New Deal.

Health and Safety at Work etc. Act 1974

Sets out the relevant responsibilities of employers and people at work. The legal obligations ensure, as far as is reasonably possible, that employees and members of the public are not exposed to unacceptable risk as a result of the organisation's activities.

Health and Safety (Consultation with Employees) Regulations 1996

Sets out the requirements for consultation with employees on health and safety issues.

Health and Safety (Display Screen Equipment) Regulations 1992

States the minimum requirements for workstations with display screen equipment (in line with EC directive 90/770 EEC).

Health and Safety (First Aid) Regulations 1981

Identifies the necessary requirements to ensure first aid can be provided in the workplace.

Health of the Nation: a strategy for health in England, HMSO, 1992

Sets 15 targets for the reduction of deaths caused by coronary heart disease, stroke, cancer and accidents, and the improvement of mental and sexual health.

Hospital Doctors: Training for the Future – The Report of the Working Group on Specialist Medical Training (Calman Report), Department of Health, 1993

Reviews the current arrangements for specialist training and calls for changes to be consistent with EC law. It also identifies areas for further review and development. The report reviews progress with the development of structured and planned training programmes and notes the potential for the duration of specialist training to be reduced.

Hospital Infection Control: guidance on the control of infection in hospitals, HSG (95) 10

Contains a number of recommendations for health authorities regarding the surveillance, prevention and control of hospital infection.

Introduction of Supervision Registers for Mentally Ill People, HSG (94) 5

The intention behind the registers is to identify those people with a severe mental illness who may be a significant risk to themselves or others and to ensure that follow-up is effective.

Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988

Ionising Radiations Regulations 1985

Introduction of Supervision Registers for Mentally Ill People, HSG (94) 5

Covers the requirements of the supervision register, set up to ensure continuity of care for mentally ill people.

Management of Food Services and Food Hygiene in the NHS (England and Wales only), HSG (92) 34

Management of Health and Safety at Work Regulations 1992

These regulations set out broad general duties which apply to almost all work activities.

Medicines Labelling Regulations 1976

Mental Health Act 1983

Provides the statutory framework under which mentally ill patients are detained and cared for in hospital.

Mental Health (Patients in the Community) Act 1995

Sets out the requirements for supervised discharge for severely mentally ill people. This Act supplements Section 118 of the Mental Health Act 1983.

Mental Health Act 1983 Code of Practice, HMSO, 1993

Provides guidance on the application of the Mental Health Act, section 118.

Misuse of Drugs Act 1971

Covers dangerous or otherwise harmful drugs and related matters.

New Deal: Plan for Action, EL (94) 17

NHS and Community Care Act 1990

Covers the establishment of NHS trusts, the financing of the practices of medical practitioners, the provision of accommodation and other welfare services by local authorities and the establishment of the Clinical Standards Advisory Group.

NHS Complaints Procedure, EL (96) 19

Arose out of the recommendations of the Wilson Report, Being Heard, and came into force on 1 April 1996.

NHS Information Management and Technology Security Manual, HSG (96) 15

Sets out guidance on the best information systems security practice to be adopted by the NHS.

The Patient's Charter

Launched in April 1995. This expanded charter sets out new rights and standards and aims to reduce waiting times. It also aims to promote the respect of dignity, privacy and patient choice.

The Patient's Charter: a charter for patients in Wales

The Patient's Charter: services for children and young people

Sets out new rights for children and young people.

The Patient's Charter: services for children and young people in Wales

The Patient's Charter: mental health services

This sets out new rights for users of mental health services.

The Patient's Charter Monitoring Guide: key standards, April 1996

The guide covers key Patient's Charter standards which need to be monitored nationally and guidance on monitoring local patient's charter rights and standards.

Planning and Priorities Guidance 1996–97, DGM (96) 43

Planning Guidance for Wales, Welsh Office

Post-Registration Education and Practice for Nurses (PREP), UKCC

Introduces new legislation for the renewal of registration for nurses, midwives and health visitors and restructures all specialist post-registration education.

Priorities and Planning Guidance for the NHS: 1997/98

Identifies the national priorities for the NHS in 1997/98 and the years ahead. It builds upon previous guidance issued to health authorities. The document distinguishes between baseline requirements and objectives and medium-term priorities (Department of Health, 1996).

Promoting Clinical Effectiveness, NHS Executive, 1996

Describes sources of information on clinical effectiveness, suggests ways in which changes to services can be encouraged (based on well-founded information about effectiveness) and describes how changes can be assessed to see whether improvements have resulted.

Protection and Use of Patient Information in the NHS in Wales, DGM (96) 43

Covers issues of confidentially and security.

Protection and Use of Patient Information, HSG (96) 18

Guidance on the protection and use of patient information; builds upon existing legislation and guidance such as the Data Protection Act and Code of Practice on Openness in the NHS.

Provision and Use of Work Equipment Regulations 1992

These regulations govern equipment used at work and list minimum requirements for work equipment to deal with selected hazards, whatever the industry.

Race Relations Act 1976

Aims to eliminate racial discrimination and to remedy individual grievances. It makes unlawful direct or indirect discrimination on the grounds of race, ethnicity, or nationality in the fields of, for example, employment, education or housing.

Reporting of Injuries, Diseases and Dangerous Substances Regulations (RIDDOR), HMSO, 1995

Identifies the injuries, diseases and dangerous substances that must be reported, and the relevant authorities to which they should be reported.

Report of the Working Party on Alarms on Clinical Monitors, Medical Devices Agency, 1995

Safe and Secure Handling of Medicines Report 1988

Safety and Care in the Storage, Handling and Use of Medical Cylinders on Health Authority Premises, HEI No. 163

Sex Discrimination Act 1975

Makes it illegal for employers, professional bodies and trade unions to discriminate either directly or indirectly on the grounds of sex or marital status, except where marital status or a particular sex can be shown to be bona fide requirements.

Strategy for Information Management and Technology (IM&T) in the NHS, NHS Executive, 1992

The strategy describes a common way forward for information management and technology for all sectors of the health service in England. 'Information management' includes both computer and paper-based systems.

Towards Evidence-Based Practice: a clinical effectiveness initiative for Wales, Welsh Office, 1995

Plans to develop evidence-based practice in Wales.

Welfare of Children and Young People in Hospital 1991

Covers all aspects of caring for children and young people in hospital.

Welsh Language Act 1993

Sets out provisions for the use of the Welsh language. This requires health authorities and trusts to translate all documents, information leaflets and signs into Welsh.

Working Together under the Children Act 1989: a guide to arrangements for the protection of children from abuse, Department of Health, 1991

Covers arrangements for cross-agency working on child protection policies and procedures.

Workplace (Health, Safety and Welfare) Regulations 1992

Cover the working environment, safety, facilities and housekeeping.