Consumer
Checklist

ORGANISATIONAL
Audit

Consumer Checklist

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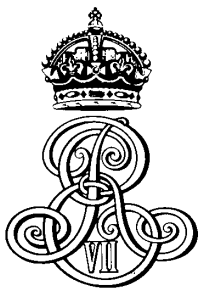

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Foreword

The foreword to the Patient's Charter makes explicit the government's expectation of the NHS. It must:

'provide services that meet clearly defined national and local standards in ways responsive to people's views and needs.'

The Charter also sets out a number of specific standards which the NHS should seek to achieve. These standards are detailed at Appendix I. In addition, from 1 April 1992, health authorities are required to develop and publish their own local Charter Standards.

The provision of an effective service which is responsive to the patient's needs is central to the organisational audit approach both within the standards and the survey process itself. The consumer checklist highlights this and reflects the implications of the Patient's Charter. It is a composite of those standards within the manual *Organisational Audit (Accreditation UK) Standards for an Acute Hospital*, which relate directly to the patient and his or her carers. It is intended that the checklist will be used by hospitals and surveyors participating in the organisational audit process as a reference manual relating to consumer issues. But the document also represents a detailed charter of standards which can be used by any hospital to monitor its own performance, or by health authority members, purchasing organisations and local user groups such as community health councils, to carry out an independent evaluation of an organisation's performance in this area.

We are indebted to those individuals who have made an input into the development of the checklist standards, who have encouraged us in our task and never allowed us to forget that the patient *must* come first.

Our thanks go to: Carole Auchertlonie, Association of Community Health Councils; Christine Hogg; Linda Lamont, The Patients' Association; Ros Levenson, The Greater London Association of Community Health Councils; Shirley McIver, Consumer Feedback Resource Manager, King's Fund Centre; and Rosemary Thornes. Particular thanks go to Alex Greenwood who started this work when working at the King's Fund Centre.

Tessa Brooks
Director, Organisational Audit Programme

Introduction

The quality of patient care depends not only on good medical treatment but also on how services are managed and delivered. Organisational Audit is a programme run by the King's Fund which helps hospitals to improve the way in which they organise their services.

THE ORGANISATIONAL AUDIT PROGRAMME

The Organisational Audit Programme began in 1990 and to date over 100 volunteer hospitals are participating in the scheme. It provides hospitals with standards by which to measure their own performance. In the light of local requirements hospital staff examine their own systems and processes using the manual *Organisational Audit (Accreditation UK) Standards for an Acute Hospital* as a guide. This manual has been developed by NHS practitioners and tested extensively in the field. The standards cover the following areas:

The Patient's Rights and Special Needs

Management and Support Services

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

Professional Management

Medical
Professions allied to Medicine
Nursing

Departmental Management

Anaesthetic Service
Operating Theatre Service
Accident and Emergency Service
Outpatient Service
Acute Day Care Service
Pharmaceutical Service
Laboratory Service
Radiology Service
Special Care Service

A 'core' set of standards has also been developed (not published) which is applicable to any service or department area not listed above.

Each section has the same internal format, the main headings of which are:
Philosophy and Objectives
Staff Development and Education
Management and Staffing
Facilities and Equipment
Policies and Procedures
Evaluation and Quality Assurance

Over a period of a year the hospital looks in detail at every aspect of its organisation, measuring this against the standards, and identifies areas of non-compliance. A programme of action is developed by each department/service in order to achieve compliance. At the end of the preparatory year an external team of senior healthcare professionals visit the hospital, to assess the hospital's progress towards meeting the standards. A full description of the organisational process can be found in Appendix II.

BENEFITS OF ORGANISATIONAL AUDIT

Those hospitals which have taken part in the programme indicate that the benefits of organisational audit include:

- the provision of a systematic, hospital-wide review of services with a clear patient focus;

- the validation of good practice and the identification of areas requiring improvement;

- the bringing together of all levels and groups of staff for a common purpose and the encouragement of multidisciplinary working;

- the stimulation of local quality assurance activities and other forms of audit;

- a public demonstration of the hospital's commitment to quality.

By taking part in organisational audit the hospital develops an environment capable of supporting a high quality of clinical care. There is no 'pass' or 'fail'; the survey process helps everyone to look at both the challenges to be faced, and at the successes, in order to change things for the better.

THE CONSUMER CHECKLIST

The Consumer Checklist is a composite of those standards to be found in *Organisational Audit (Accreditation UK) Standards for an Acute Hospital* which relate directly to the patient and their carers. The Checklist has been divided into 3 main sections:

— Patient's rights and special needs
— Inpatient episode
— Outpatient/day care episode.

It aims to track the patient through the hospital from:

— pre-admission preparation
— admission
— episode of care/treatment
— through to discharge.

In addition the standards cover the care or treatment undertaken on an outpatient or day care basis.

The standards are numbered chronologically (left side of the page) and have been cross-referenced to the standard number within the manual (bracketed, right side of page).

Certain standards, such as those covering philosophy and objectives, follow the same format in each section of the manual and have not been cross-referenced. These appear within the Inpatient section of the document.

The following abbreviations have been used:

A&E — accident and emergency service
ACD — acute day care service
HM — hospital management
HS — hotel services
EM — estates management
DS — domestic service
L/LS — laundry/linen service
IC — infection control
MRC — medical record content
MRS — medical record service
MS — medical services
N — nursing service
OPT — operating theatre service
OPS — outpatient service
PAM — paramedical services
PS — pharmacy service
RS — radiology service
SPC — special care (burns, coronary care, intensive care, neonatal)

Christine Pitt
Programme Development Manager

1. Patient's Rights and Special Needs

The standards which follow relate to the rights of the patient and the special needs of particular groups of patients which are listed alphabetically. These standards should be clearly reflected in all activities, both of the hospital and of the various staff groups.

PATIENT'S RIGHTS

These standards refer to the rights of all patients, regardless of age, disability, race, sex, sexuality, which must be recognised, respected and complied with by all staff involved in the care or treatment of patients.

Standards

1.1 There are written standards which describe the rights of the patient. These standards:

1.1.1 reflect the content of the Patient's Charter

1.1.2 are made known to the patient and his or her carer

1.1.3 are made known to staff

1.2 Such standards address the following issues:

1.2.1 respect for personal dignity in the provision of care and treatment (Patient's Charter)

1.2.2 protection of personal privacy within the constraints of the individual treatment plan (Patient's Charter)

1.2.3 patient's preference to be treated or cared for by a female/male nurse and/or doctor within the constraints of the individual treatment plan

1.2.4 referral to a consultant who is acceptable to the patient (Patient's Charter)

1.2.5 confidentiality of all information recorded in the patient's medical records

1.2.6 maintenance of confidentiality between staff and the patient particularly regarding information shared with relatives and/or carers

1.2.7 right to refuse or terminate a service or treatment after full consultation

1.2.8 right to seek a second opinion (Patient's Charter)

1.2.9 complaints procedure in accordance with HC(88)37, Hospital Complaints Procedures (Patient's Charter)

1.2.10 right to the speedy and full investigation of clinical and non-clinical complaints (Patient's Charter)

1.2.11 special emotional and physical needs of various groups such as children, the confused, the elderly, the mentally ill and people with learning difficulties (Patient's Charter)

1.2.12 requirements of those with hearing, visual or physical impairment. (See also facilities and equipment within each section of this document.)

1.2.13 attention to the patient who has no social support

1.2.14 information given to the patient concerning the nature of his or her medical condition and any treatment (including associated risks), investigation or procedure, and alternatives available, before agreement on the course of action to be taken

1.2.15 access to own medical record in accordance with the Access to Health Records Act 1990 and the Patient's Charter

1.2.16 access to an advocacy service

1.2.17 access to an interpreting service

1.2.18 access to, and communication with, people outside hospital

1.2.19 access to information concerning service provision and waiting times (for admission or referral to an outpatient clinic or service) (Patient's Charter)

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

1.3.1 anaesthesia

1.3.2 surgical procedures

1.3.3 electro-convulsive therapy

1.3.4 unusual medications

1.3.5 hazardous assessment procedures

1.3.6 participation in teaching exercises (Patient's Charter)

1.3.7 participation in any research project (Patient's Charter)

1.3.8 photographic and audiovisual recording

1.3.9 other procedures where consent is required by law

(See also **Medical Record** section of this document.)

1.4 The patient has the right to expect that all safety requirements are enforced in relation to the hospital's environment and procedures.

PATIENT'S SPECIAL NEEDS

Care of the non-English speaking patient

1.5 Designated interpreter services are available and made known to the patient and staff.

1.6 Translated health promotion material, hospital information and hospital forms (for example, consent forms) are available as necessary, used, and explained where required.

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

(See also **Catering Service** and **Ward sections** of this document.)

Care of the terminally ill patient

1.8 The particular physical, emotional, spiritual and social needs of the terminally ill patient and his or her relatives/carers are recognised and catered for.

1.9 Families and carers are encouraged to participate in the care of the patient.

1.10 Consideration is given to the special needs of the family (particularly the respect for dignity and the maintenance of privacy), caring for the terminally ill patient.

1.11 Consideration is given to the special needs of staff caring for the terminally ill patient (for example, training /counselling).

1.12 Facilities for overnight stays are available for relatives and carers.

1.13 There are written policies and procedures for staff to help them to support relatives and/or carers after the death of a patient.

Chaplaincy and spiritual care

1.14 All patients, relatives/carers and staff have access to the pastoral and/or spiritual support of their choice.

1.15 There is a mechanism to ensure that the patient, relatives/carers are aware of the pastoral and/or spiritual support available within the hospital.

1.16 A quiet area is set aside for prayer and meditation.

Children

1.17 A philosophy of care for children based on the Department of Health guidelines *The Welfare of Children and Young People in Hospital* (1991), is used as the basis for the organisation and delivery of patient care.

1.18 The philosophy of care is understood and followed by all staff in contact with children.

1.19 There are written policies and procedures specific to the needs of children, based on the philosophy of care which covers at least the following:

1.19.1 day case admission

1.19.2 routine admission

1.19.3 emergency admission

1.19.4 intensive care unit

1.19.5 isolation unit

1.19.6 visiting wards

1.19.7 ward attendees

1.19.8 outpatient attendance

1.19.9 accident and emergency attendance.

1.20 Data are collected separately for children in all the areas listed in 1.19.

1.21 Children are cared for by staff trained to understand the special needs of children and all children are in the care of a registered sick children's nurse (or a nurse trained in the child branch of Project 2000).

1.22 Children are cared for in an appropriate environment, which is separate from adults. This applies to:

1.22.1 accident and emergency departments

1.22.2 day care units

1.22.3 outpatient departments

1.22.4 ward areas.

1.23 Where children are cared for in adult facilities (for example, x-ray departments, intensive care) every effort is made to reduce unnecessary stress and to minimise the length of time spent in inappropriate surroundings.

1.24 Provision is made for unrestricted parental involvement in the care of their children, and parents are encouraged to share care with nursing staff.

1.25 Children and parents are involved in decision making and the current guidance on consent to treatment is known to staff.

1.26 Arrangements are made for parents and children to be prepared prior to admission (where appropriate) and for procedures and treatment.

1.27 Accommodation is provided for parents in accordance with the standards indicated in *Parents Staying Overnight with their Children in Hospital* (this document is referred to in the DoH guidelines, written by Caring for Children in the Health Services and is available from Action for Sick Children).

1.28 Arrangements are made for the education of children who are admitted to hospital for long periods.

1.29 Play facilities are provided for children and a suitably qualified or experienced person is designated to supervise these activities.

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

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

1.31.1 anaesthetic equipment

1.31.2 inhalation therapy equipment

1.31.3 paediatric size needles, cannulae and other intravenous equipment

1.31.4 paediatric infusion sets

1.31.5 resuscitation equipment.

Ethics

1.32 A mechanism exists for the consideration of ethical issues (such as the implications of research programmes) and prevention of harm to patients (reference: Guidelines for Local Research Committees, Department of Health, 1991).

1.33 There is a multidisciplinary approach to the consideration of ethical issues.

1.34 A mechanism exists for the implementation of policies relating to ethical issues.

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

Seclusion, Sedation and Restraint

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

1.37 There is a mechanism to ensure that all staff are aware of these standards and the relevant legislation.

1.38 A regular review of all uses of restraint, sedation or seclusion is carried out, which includes recording, monitoring and reporting of all instances of use.

1.39 No undue physical discomfort is caused to the patient.

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

2. Hospital management

The following standards relate to the responsibilities of the hospital as a whole, which should be understood and followed by all staff.

Mission and Objectives (HM 1)

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

Standards

2.1 There is a clearly worded statement which outlines the mission of the hospital (HM 1.1).

2.2 The hospital management develops objectives to achieve the hospital mission statement (HM 1.2).

Mission Statement

2.3 The mission statement is developed with input from the medical, nursing and other professional staff (HM 1.3).

2.4 The statement includes the hospital's responsibility for ensuring that the rights and dignity of the patient and his or her carers are respected (HM 1.4).

2.5 The statement includes the hospital's role and responsibility to the local community and people served (HM 1.5).

2.6 The statement identifies the relationship with other local health and social service organisations (HM 1.6).

2.7 The statement demonstrates the hospital's commitment to quality (HM 1.8).

2.8 The mission statement is made available to the general public, other health and related organisations and to staff within the hospital (HM 1.9).

Management Arrangements

2.9 There is a board of directors and/or a designated individual manager having overall responsibility for the operation and management of the hospital (HM 2.1).

2.10 There is a designated deputy to act in the absence of the hospital manager, to provide the hospital with direction at all times (HM 2.2).

2.11 There is a document(s) which states the constitutional arrangements of the hospital which is appropriate to trusts, directly managed units or independent sector hospitals, and has regard to central statute and local by-laws (HM 2.3).

2.12 The document includes:

2.12.1 a description of the power and duties of hospital management (HM 2.4.1).

2.12.2 standing orders (HM 2.4.2).

2.12.3 standing financial instructions (HM 2.4.3).

2.13 The power and the duties of the hospital management and the standing orders are made accessible to hospital staff, the general public and new staff (HM 2.5).

2.14 The board of directors and designated individual managers ensure that (HM 2.6):

2.14.1 there is a system for staff identification (for example, name badges) (Patient's Charter) (HM 2.6.3).

2.15 The board of directors and designated individual managers ensure that (HM 2.7):

2.15.1 there are effective mechanisms for communication with (HM 2.7.3):

a) the patient and carers (HM 2.7.3a)

b) external organisations (for example, the FHSA, Community Services etc) (HM 2.7.3c)

2.15.2 there are effective mechanisms for the regular auditing of the effectiveness of communication systems (HM 2.7.4)

Policies and Procedure (HM 3)

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

Standards

2.15 There is evidence that in determining policies and procedures the hospital management considers the relevant influences both internal and external to the hospital as a provider of health services (HM 3.1).

2.16 Policies and procedures are developed for at least the following (HM 3.3):

2.16.1 confidentiality of information (HM 3.3.2)

2.16.2 complaints (from the patient, carers and staff) in accordance with (HC(88)37, Hospital Complaints Procedures (Patient's Charter) (HM 3.3.6)

2.16.3 accidents (the patient and staff) (HM 3.3.7)

2.16.4 errors (for example, medications) (HM 3.3.8)

2.16.5 incidents (HM 3.3.9).

2.17 Records are kept which indicate to whom standards 2.16.2 - 2.16.5 have been referred and the action which has been taken (Patient's Charter) (HM 3.4).

Admission

2.18 There is a written admissions policy which reflects the content of the Patient's Charter and covers at least the following (HM 3.7):

2.18.1 information given to the patient pre-admission and on admission (HM 3.7.1):

a) map of the hospital (HM 3.7.1a)

b) date and time of arrival (HM 3.7.1b)

c) location of admissions office (HM 3.7.1c)

d) procedure if not able to attend (for example, direct telephone line) (HM 3.7.1d)

e) parking facilities (HM3.7.1e)

f) transport arrangements (HM 3.7.1f)

g) visiting hours (HM 3.7.1g)

h) clear instructions regarding the responsibilities of the patient (for example, what to bring into hospital) (HM 3.7.1h)

i) specific instructions for any investigations, such as fasting, or provision of specimens (HM 3.7.1i).

2.18.2 routine admission including maximum waiting time for admission (Patient's Charter) (HM 3.7.2)

2.18.3 emergency admission (HM 3.7.3)

2.18.4 conditions for refusing admission (HM 3.7.4)

2.18.5 arrangements when admission is refused (HM3.7.5)

2.18.6 cancellation of routine admission (Patient's Charter, Implementing the Patient's Charter HSG (92)4) (HM 3.7.6).

2.19 There is a mechanism to ensure that all staff and patients are aware of the admissions policy and procedure (HM 3.8).

2.20 There is a mechanism for monitoring and reporting all admisions and cancellations (Patient's Charter).

Discharge

2.21 There is a policy for the safe discharge of the patient which reflects HC(89) 5 and the Patient's Charter and covers at least the following (HM 3.12):

2.21.1 period of notice required by a patient in order to prepare for discharge (HM 3.12.1)

2.21.2 liaison with the patient's GP (HM 3.12.2)

2.21.3 liaison with, and organisation of any community service support a patient may require (for example, home help, district nurse, health visitor) (HM 3.12.3)

2.21.4 information given to the patient concerning the future management of his or her medical condition (HM3.12.4)

2.21.5 information given to the patient concerning the management of his or her condition at home (HM 3.12.5)

2.21.6 transport arrangements (HM 3.12.6)

2.21.7 the special requirements of the patient who has no social support (HM 3.12.8 and PR&SN 1.2.13).

2.22 For each patient there is a discharge summary/letter which is completed within 14 days of the patient's discharge and sent to the general practitioner, hospital or institution to which the patient is discharged, with a copy remaining in the medical record. The discharge summary/letter includes at least (MRC 1.27):

2.22.1 name of the consultant in charge (MRC 1.27.1)

2.22.2 patient's condition on discharge (MRC 1.27.2)

2.22.3 discharge diagnosis (MRC 1.27.3)

2.22.4 procedures performed (MRC 1.27.4)

2.22.5 brief resume of significant findings and events of the patient's hospitalisation (MRC 1.27.5)

2.22.6 follow-up arrangements (MRC 1.27.6)

2.22.7 medication requirements (MRC 1.27.7)

2.22.8 information given to the patient and/or carers (MRC 1.27.8).

2.23 There is a mechanism for making and dealing with complaints/suggestions from the patient, his or her carers, visitors and staff, which is known to all (Patient's Charter) (N 7.11).

Facilities and Equipment (HM 4)

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

(See also **Facilities and Equipment** within each section of this document.)

Standards

2.24 The hospital management is responsible for the maintenance of the facilities and equipment of the hospital (HM 4.3).

2.25 The facilities and equipment available enable all staff to carry out their duties efficiently, effectively and safely (HM 4.4).

2.26 There is provision for the special needs of children, (for example, play areas, separate accident and emergency facilities)

(See also the **Patient's Rights and Special Needs** section of this document) (HM 4.5).

2.27 There is provision for access to facilities for wheelchairs (HM 4.6).

2.28 There is provision for those with visual, hearing or physical impairment (HM 4.7).

2.29 All equipment and facilities conform to existing health and safety regulations (HC(87)3, Health and Safety at Work [in Wales WHC(87)8]) (HM 4.8).

2.30 There is clear external signposting to the hospital and departments (HM 4.11).

2.31 There is clear internal signposting to wards/departments/services within the hospital (HM 4.12).

Security

2.32 There are comprehensive arrangements for the internal security of the hospital (Security 10.2, Hotel Services section).

2.33 There are comprehensive arrangements for the external security arrangements of the hospital (Security 10.3, Hotel Services section).

Quality Management and Evaluation (HM 5)

The hospital management has overall responsibility for maintaining and improving patient care through an effective quality management and evaluation programme.

Standards

2.34 There is a written quality management and evaluation programme for the whole hospital (HM 5.1).

2.35 The quality management programme includes the development of locally based standards and is consistent with the content of the Patient's Charter (HM 5.2).

2.36 Quality indicators are routinely and systematically reviewed on a hospital-wide basis. These include at least (HM 5.12):

2.36.1 incidence of complaints regarding patient care or services (HM 5.12.1)

2.36.2 patient and staff accidents (HM 5.12.2)

2.36.3 drug errors (HM 5.12.3)

2.36.4 incidence of hospital-acquired infections (HM 5.12.4)

2.36.5 patients not arriving for admission/treatment (HM 5.12.5)

2.36.6 cancelled admissions (HM 5.12.6)

2.36.7 cancelled operations (HM 5.12.7)

2.36.8 mortality and morbidity including the following (HM 5.12.8):

a) avoidable complications

b) unexpected death

c) untoward occurrences

d) readmission rates

2.36.9 patient and customer satisfaction (HM 5.12.9).

3. Medical Record Service

Philosophy and Objectives (MRS 1)

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

Standards

3.1 The objectives for the service include at least the following (MRS 1.3):

3.1.1 maintaining confidentiality in accordance with the Data Protection Act 1984 (MRS 1.3.1).

Policies and Procedures (MRS 4)

Written policies and procedures reflect current standards of medical record management and guide staff responsible for maintaining medical records.

Standards

3.2 A hospital record is maintained for every patient (MRS 4.6).

3.3 There are policies for at least the following (MRS 4.9):

3.3.1 safeguarding information in the record against loss, damage, or use by unauthorised persons (MRS 4.9.1)

3.3.2 where computer records are maintained specific measures are taken to protect confidentiality in accordance with the Data Protection Act 1984 (MRS 4.9.2)

3.3.3 confidentiality and release of information which takes into account the Data Protection Act 1984 and Access to Medical Record Act 1990 (MRS 4.9.3).

3.4. The active and inactive records store is secure to protect records against loss, damage, or use by unauthorised persons (MRS 5.8).

4. Medical Record (content)

An accurate medical record is maintained which facilitates a high standard of patient care and allows for evaluation of care provided. A medical record is a composite of all data on a given patient whether as an inpatient, outpatient or emergency patient. The entire medical record is contained in a folder with a unique identification number.

Standards

4.1 The record enables (MRC 1.1):

- 4.1.1 the patient to receive effective continuing care (MRC 1.1.1)
- 4.1.2 identification of the patient without risk of error (MRC 1.1.5)
- 4.1.3 use in legal interest of the patient or professional staff (MRC 1.1.7).

4.2. Each record contains at least the following identification data (MRC 1.7):

- 4.2.1 a unique medical record number or reference on every page (MRC 1.7.1)
- 4.2.2 name in full on every page (MRC 1.7.2)
- 4.2.3 address and postcode (MRC 1.7.3)
- 4.2.4 telephone number (MRC 1.7.4)
- 4.2.5 date of birth (MRC 1.7.5)
- 4.2.6 sex (MRC 1.7.6)
- 4.2.7 person to notify in an emergency (next of kin) (MRC 1.7.7)
- 4.2.8 general practitioner (MRC 1.7.8)
- 4.2.9 name of admitting consultant (MRC 1.7.9)
- 4.2.10 source of referral (MRC 1.7.10).

4.3 An 'alert' notification for conditions such as allergic response and drug reaction is prominently displayed on the front cover of the record (MRC 1.8).

4.4 There is evidence that the patient has given informed consent (MRC 1.14):

4.4.1 the consent form conforms with the hospital policy (1.14.1)

4.4.2 consent is explained and obtained by a doctor (1.14.2)

4.4.3 the correct procedure is followed when obtaining informed consent for children under the age of 16 years (1.14.3)

4.4.4 where special statutory requirements exist they are adhered to (for example, in the case of electro-convulsive therapy or hospital detention using the Mental Health Act 1983) (MRC 1.14.4).

4.5 There is a record of information given to the patient and/or carers (MRC 1.20).

5. Inpatient Episode

The following standards are specific to the points of contact the patient may have with the hospital as an inpatient. The section includes admission procedures (which may be planned or as a result of an emergency episode), inpatient stay on the ward and/or in special care units such as intensive care or coronary care, support facilities, such as operating theatres, and concludes with the arrangements for discharge.

ROUTINE ADMISSIONS

Standards

5.1 There is a written admissions policy which reflects the content of the Patient's Charter and covers at least the following (HM 3.7):

5.1.1 information given to the patient pre-admission and on admission (HM 3.7.1)

a) map of the hospital (HM 3.7.1a)

b) date and time of arrival (HM 3.7.1b)

c) location of admissions office (HM 3.7.1c)

d) procedure if not able to attend (for example, direct telephone line) (HM 3.7.1d)

e) parking facilities (HM3.7.1e)

f) transport arrangements (HM 3.7.1f)

g) visiting hours (HM 3.7.1g)

h) clear instructions regarding the responsibilities of the patient (for example what to bring into hospital) (HM 3.7.1h)

i) specific instructions for any investigations, such as fasting, or provision of specimens (HM 3.7.1i)

5.1.2 routine admission including maximum waiting time for admission (Patient's Charter) (HM 3.7.2)

5.1.3 emergency admission (HM 3.7.3)

5.1.4 conditions for refusing admission (HM 3.7.4)

5.1.5 arrangements when admission is refused (HM3.7.5)

5.1.6 cancellation of routine admission (Patient's Charter, Implementing the Patient's Charter HSG (92)4) (HM 3.7.6).

5.2 There is a mechanism to ensure that all staff and patients are aware of the admissions policy and procedure (HM 3.8).

5.3 There is a mechanism for monitoring and reporting all admissions and cancellations (Patient's Charter) (HM 3.9)

TRANSFER TO WARD: PORTERING

Philosophy and objectives

The portering service is organised to provide the safe, effective and efficient movement of the patient and goods through the hospital (HS; PS 10).

(See also **Philosophy and Objective** standards common to all staff working in the hospital, within the **Ward section** of this document.)

Standards

5.4 The objectives of the portering service include at least the following (HS 1.3):

5.4.1 ensuring patient safety (HS 1.3.1)

5.4.2 maintaining effective communication with other members of the hospital staff to (HS 1.3.2):

(a) meet patient needs

(b) enable co-ordination of services.

(See also **Quality Management and Evaluation** and standards which are common to all staff working in the hospital, within the **Inpatient section** of this document.)

WARD AREAS

(See also the **Patient's Rights and Special Needs** section of this document.)

Philosophy and Objectives

Each professional service (for example medical, nursing, etc) is responsible for providing high quality care to the patient and for the ethical conduct and professional practice of the members of staff.

Standards

The following standards can be found within each of the professional management sections of the manual, but for simplicity have been cross-referenced to the nursing section only.

5.6 Staff within each ward/department/service develop written objectives to achieve both the mission of the hospital and their respective ward/department/service. These objectives are used as a guide to planning, implementing and evaluating all aspects of the service (NS 1.2).

5.7. The objectives for each ward/department/service include at least the following (NS 1.3):

5.7.1 providing the patient with a quality service which is based on an assessment of patients' needs (NS 1.3.1)

5.7.2 providing the patient with a quality service which is based on professional standards where available (NS 1.3.2)

5.7.3 ensuring patient safety (NS 1.3.3)

5.7.4 maintaining effective communication with the patient and carers concerning the nature and management of clinical conditions and their outcomes (NS 1.3.5)

5.7.5 maintaining communication with the other members of the health care team to (NS 1.3.6):

a) meet patient needs

b) enable co-ordination of services.

The following standard (5.8) can be found in each section of the manual and so has not been cross-referenced.

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

5.8.1 be courteous and considerate to the patient and carers at all times

5.8.2 respect the patient's privacy and dignity and that of the carers (Patient's Charter)

5.8.3 respect and cater for cultural differences (Patient's Charter)

5.8.4 respond to communication difficulties

5.8.5 identify counselling requirements of the patient and carers.

PATIENT CARE

There is a systematic approach to clinical care which maintains the patient's rights at all times (MS).

Patient care is systematic and patient-centred (NS; PAM).

(See also the **Patient's Rights and Special Needs** section of this document.)

Standards

5.9 A named consultant directs the clinical care of each patient (MS 6.2).

5.10 A named consultant is accountable for the clinical care of each patient (MS 6.3).

5.11 A named registered nurse is accountable for the nursing care of each patient (Patient's Charter) (NS 6.3).

5.12 There is evidence that the prime focus of care is on the patient and his or her relatives and/or carers (NS; PAM 6.2.)

5.13 The treatment/care plan is developed after an assessment of the patient (MS; NS; PAM 6.4).

5.14 The treatment plan is developed in collaboration with all relevant staff (for example, medical, nursing and professions allied to medicine) and in consultation with the patient and carers or advocates (MS; NS; PAM 6.4).

5.15 The treatment/care plan is written in the patient's medical record. (See medical record content of this document) and includes (MS; NS; PAM 6.6):

5.15.1 a statement of the patient's needs

5.15.2 details of specific clinical/nursing care given

5.15.3 health education

5.15.4 preparation for discharge. (See also discharge policies and procedures within the hospital management section of this document)

5.15.5 continuing assessment and evaluation of clinical/nursing needs

5.15.6 name and signature of the doctor/nurse/paramedical responsible.

5.16 All staff maintain the patient's right to privacy, dignity and confidentiality at all times (MS; NS; PAM 6.8).

VISITING

5.17 Catering services are available for relatives staying in the hospital, for example parents of children, relatives/carers of critically or terminally ill patients (C 2.13).

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

5.19 Facilities for overnight stays are made available to relatives and carers (PR&SN 1.12).

5.20 There are facilities for patient access to and communication with people outside the hospital (PR& SN 1.2.18).

5.21 There is clear external signposting to the hospital (Patient's Charter) (HM 4.11).

5.22 There is clear internal signposting to wards, departments and services (Patient's Charter) (HM 4.12).

5.23 There is a policy for visiting hours which is communicated to all staff, patients and carers (HM 3.7.1g).

5.24 The facilities available for car parking and public transport arrangements are made known to visitors (HM 3.7.1e and 3.7.1f).

CATERING

Philosophy and Objectives (C 1)

The catering department is responsible for providing a high quality service to patients, staff and visitors.

Standards

5.25 The objectives of the service include at least the following (C 1.3):

5.25.1 health promotion (C 1.3.6).

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

5.26.1 respect and cater for cultural and religious dietary requirements (C 1.4.3).

(See also **Philosophy and Objective** standards common to all staff working in the hospital, within the **Ward section** of this document.)

5.27 Catering services are available for relatives staying in the hospital, for example parents of children, relatives/carers of critically or terminally ill patients (C 2.13).

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

5.28.1 attractive presentation of food (C 4.15.1)

5.28.2 appropriate portion size (C 4.15.1)

5.28.3 menus allow for a variety of food and food textures (C 4.15.1)

5.28.4 menu cycles, taking into account the length of patient stay as well as food availability (C 4.15.1).

5.28.5 cultural preferences (C 4.15.1)

5.28.6 requirements of special patient populations (for example, children) (C 4.15.1)

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

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

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

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

5.33 Special eating utensils are available to meet the needs of particular patient groups. Such equipment may include modified eating and drinking utensils for patients with special feeding needs (for example, paediatric patients or those with physical impairments) (C 5.13).

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

FACILITIES AND EQUIPMENT

The standards within this section are a composite of those detailed in Estates Management/Hotel Services/Infection Control/Health and Safety.

Estates Management

The hospital is constructed, equipped, operated and maintained in a manner which supports the patient care objectives and the physical safety and comfort of the patient, staff and visitors (HS; EM 7).

Domestic Service

The domestic service ensures and maintains a high standard of cleanliness and hygiene in all wards and departments (HS; DS 8).

Linen/Laundry Service

There is a daily supply of clean linen to wards and departments which is based on calculated need (HS; L/L 9).

Portering Service

The portering service is organised to provide the safe, effective and efficient movement of the patient and goods through the hospital (HS; PS 10).

Standards

5.35 There is provision for the visual privacy of the patient (for example, screens) (MS 5.6; NS 5.8; PAM 5.7).

5.36 There is provision for those with visual, hearing or physical impairment (HM 4.7).

5.37 There is provision for wheelchair access (HM 4.6).

5.38 There are facilities for confidential consultations (MS 5.5; NS 5.6; PAM 5.6).

5.39 There is a room designated for use by grieving and bereaved carers (NS 5.7).

5.40. Accommodation for isolated patients enables them to receive care of the same quality as is provided throughout the hospital (IC 1.13.2).

5.41. Isolation facilities are available for all clinical services. These include, for example, adequate provision for the patient with compromised immune systems or who are infectious, including the newborn (IC 1.13.4).

5.42 Smoking by patients , staff and visitors is discouraged and only permitted in specifically designated areas (FS 1.15.3).

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

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

5.45 Patient safety devices are installed and include (H&S 2.18):

5.45.1 hand rails in passage ways (H&S 2.18.1)

5.45.2 nurse call systems to which the patient has access (H&S 2.18.2)

5.45.3 patient toilets, showers and bathrooms equipped with grab rails and emergency call systems (H&S 2.18.3)

5.45.4 provision for emergency entry to toilets, showers and bathrooms (H&S 2.18.4)

5.45.5 provision of variable height beds fitted with adjustable side rails where possible (H&S 2.18. 5)

5.45.6 safety straps on wheelchairs and trolleys which are not fitted with side rails (H&S 2.18.6).

5.45.7 side rails in accordance with criteria established to ensure patient safety (H&S 2.18. 7).

5.46 In areas where there may be children, special precautions are taken, including (H&S 2.19):

5.46.1 power points with safety shutters (H&S 2.19.1)

5.46.2 physical barriers prevent entry to hazardous areas (H&S 2.19.2)

5.46.3 storage of cleaning agents and other hazardous materials in properly labelled containers with child-resistant closures (H&S 2.19.3).

5.47 The hot water supply in patient areas is automatically controlled to prevent accidental scalding (H&S 2.20).

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

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

5.50. Where there is a system of energy management, this does not compromise the safety and welfare of patients and staff (EM 7.1).

5.51 Air-conditioning and ventilation systems are installed for the purpose of safety and comfort of patients and staff (EM 7.8)

5.52 The patient has the right to expect that all safety requirements are enforced in relation to the hospital's environment and procedures (PR 6.33).

QUALITY MANAGEMENT AND EVALUATION

Each service/ward/department ensures the provision of high quality service/care by its involvement in the evaluation activities of the hospital in line with the quality managment programme for the hospital and the service/ward/department.

Standards

The following is a composite of the standards expected to be reflected in the quality management and evaluation of each service/ward/department and therefore has not been cross-referenced.

5.53 There is a written quality management plan.

5.54 The quality management and evaluation plan includes the review of at least the following:

5.54.1 service users' satisfaction

5.54.2 the service in comparison with standards set out in this section

5.54.3 performance of staff

5.54.4 evaluation of professional practice

5.54.5 evaluation of clinical performance by means of multidisciplinary audit

5.54.6 appropriateness of care given.

5.55 The evaluation activities include the following elements:

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

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

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

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

5.55.5 feedback: the results of activities are regularly communicated to the staff.

5.56 There is a mechanism for making and dealing with complaints/suggestions from the patient, the carers, visitors and staff, which is known to all.

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

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

OPERATING THEATRES

Philosophy and Objectives

The operating theatre service provides an environment for patients and staff which supports the safe, efficient and effective carrying out of surgical procedures.

(See also **Philosophy and Objective** standards common to all staff working in the hospital, within the **Ward section** of this document.)

Policies and Procedures (OPT 4)

There are written policies and procedures for all activities of the operating theatre service which reflect current standards of operating theatre practice, relevant regulations and the objectives of the service.

Standards

5.59 Policies and procedures refer to at least the following (OPT 4.6).

5.59.1 pre-operative instructions for the patient (OPT 4.6.1)

5.59.2 patient identification (OPT 4.6.2)

5.59.3 verification of the nature and site of operation (OPT 4.6.3)

5.59.4 checking of consent documents (OPT 4.6.4)

5.59.5 recording of tissue and specimen collection (OPT 4.6.5)

5.59.6 scheduling of the patient for listed and emergency surgical procedures (OPT 4.6.6)

5.59.7 counting procedures for accountable items (OPT 4.6.7)

5.59.8 procedures to be adopted in the event of incorrect counts (OPT 4.6.8)

5.59.9 an anaesthetist is present until the patient has recovered from the anaesthetic (OPT 4.6.9)

5.59.10 infection control procedures including (OPT 4.6.10):

(a) aseptic technique

(b) handling infectious and high risk patients

5.59.11 instruments required for specific procedures (OPT 4.6.11).

5.60 There are written health and safety policies which include (OPT 4.7):

5.60.1 anaesthetic equipment hazards (OPT 4.7.1)

5.60.2 drug errors (OPT 4.7.3)

5.60.3 patient positioning (OPT 4.7.9)

5.60.4 patient transport (OPT 4.7.10).

Facilities and Equipment

The facilities and equipment available ensure the safe, effective and efficient functioning of the operating theatre service.

Standards

5.61 The design of the operating theatre service provides space for the reception, anaesthesia, surgery, recovery and observation of the patient. As a minimum this includes (OPT 5.6):

5.61.1 an area to receive the patient awaiting surgery which is separate from the operating theatre and access corridors (OPT 5.6.10).

(See also the **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient section** of this document.)

SPECIAL CARE SERVICE (BURNS, CORONARY CARE, NEONATAL, INTENSIVE CARE)

Philosophy and Objectives (SPC 1)

The special care unit provides for the care of the patient who has an actual or a potential life-threatening illness, who requires a higher level of care and supervision than can be provided on an ordinary ward.

(See also **Philosophy and Objective** standards common to all staff working in the hospital, within the **Ward section** of this document.)

Policies and Procedures (SPC 4)

There are specific written policies and procedures for each special care unit, which reflect current knowledge and principles of practice in each special care unit as well as statutory requirements.

Standards

5.62 The policies and procedures include at least the following (SPC 4.6):

5.62.1 admission criteria including priority determinations which must be made by the clinical staff and contingency plans if the unit is full (SPC 4.6.2)

5.62.2 discharge criteria (SPC 4.6.3)

5.62.3 requesting donor organs (SPC 4.6.10)

5.62.4 arrangements for visitors (SPC 4.6.12)

5.62.5 patient and/or carers' complaints (SPC 4.7.4).

Facilities and Equipment (SPC 5)

The environment, facilities and equipment are such as to ensure safe, efficient and effective patient care.

Standards

5.63 Facilities for appropriate counselling support for the patient, relatives, carers and staff are available (SPC 5.9).

5.64 Suitably quiet and private areas with tea/coffee making facilities are available for waiting relatives and for grieving or otherwise distressed relatives or carers (SPC 5.10).

5.65 Residential accommodation is available for relatives within easy reach of the unit (SPC 5.11).

5.66 The immediate physical environment of the patient is as unobtrusive and aesthetically pleasing as possible. The environment is conducive to recovery with minimum sensory deprivation and abuse and wherever possible is situated near outside windows (SPC 5.12).

5.67 The unit is air-conditioned for the benefit of patient, staff and equipment (SPC 5.13).

(See also the **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient section** of this document.)

DISCHARGE

Standards

5.68 There is a policy for the safe discharge of the patient which reflects HC (89) 5 and the Patient's Charter and covers at least the following (HM 3.12):

5.68.1 period of notice required by a patient in order to prepare for discharge (HM 3.12.1)

5.68.2 liaison with the patient's GP (HM 3.12.2)

5.68.3 liaison with, and organisation of the community service support a patient may require (for example, home help, district nurse, health visitor) (HM 3.12.3)

5.68.4 information given to the patient concerning the future management of his or her medical condition (HM3.12.4)

5.68.5 information given to the patient concerning the management of his or her condition at home (HM 3.12.5)

5.68.6 transport arrangements (HM 3.12.6)

5.68.7 the special requirements of the patient who has no social support (HM 3.12.8 and PR&SN 1.2.13).

5.69 For each patient there is a discharge summary/letter which is completed within 14 days of the patient's discharge and sent to the general practitioner, hospital or institution to which the patient is discharged, with a copy remaining in the medical record. The discharge summary/letter includes at least (MRC 1.27):

5.69.1 name of the consultant in charge (MRC 1.27.1)

5.69.2 the patient's condition on discharge (MRC 1.27.2)

5.69.3 discharge diagnosis (MRC 1.27.3)

5.69.4 procedures performed (MRC 1.27.4)

5.69.5 brief resume of significant findings and events of the patient's hospitalisation (MRC 1.27.5)

5.69.6 follow-up arrangements (MRC 1.27.6)

5.69.7 medication requirements (MRC 1.27.7)

5.69.8 information given to the patient and/or carers (MRC 1.27.8).

5.70 There is a mechanism for making and dealing with complaints/suggestions from the patient, carers, visitors and staff, which is known to all (Patient's Charter) (N 7.11).

6. Outpatient/Day Patient Episode

OUTPATIENT SERVICE

Philosophy and Objectives

The outpatient service is organised, managed and staffed to provide safe, efficient and effective care to the patient which meets the needs of the people served.

(See also **Philosophy and Objective** standards common to all staff working in the hospital, within the **Ward section** of this document.)

Appointments

Standards

6.1 There is an organised appointment system, which is individualised and not block booked (OPS 2.30).

6:2 There is a system for informing and reminding the patient of appointments (OPS 2.31).

6.3 There is a list of patients attending the clinic which includes appointment time (OPS 2.32).

6.4 The patient is given clear information about outpatients and his or her appointment in advance of clinic attendance including (OPS 2.33):

6.4.1 map of the hospital (OPS 2.33.1)

6.4.2 date and time of appointment (OPS 2.33.2)

6.4.3 location and name of service and clinic (OPS 2.33.3)

6.4.4 procedure if not able to attend (for example, direct telephone line) (OPS 2.33.4)

6.4.5 transport arrangements (OPS 2.33.5)

6.4.6 facilities available for car parking and public transport arrangements (HM 3.7.1e and 3.7.1f)

6.4.7 specific instructions for any investigations, such as fasting, or provision of specimens (OPS 2.33.6).

6.5 There is a mechanism for monitoring and reporting the patient who does not turn up for appointments (HM 5.12.4).

6.6 There is a mechanism for monitoring and reporting all cancellations of appointments (HM 5.12.4).

Records

(See also **Medical Record Content** section of this document.)

6.7. The patient attending outpatient services is correctly identified. This is best achieved by a hospital number system and utilisation of the medical record (OPS 2.34).

6.8. If the patient has previously attended the hospital, the medical record is available in advance of the clinic attendance (OPS 2.35).

6.9. A clinical record is originated on the initial visit (OPS 2.36).

6.10 The clinical record is accurate, complete, current and legible and contains at least the following (OPS 2.37):

6.10.1 name, address and post code (OPS 2.27.1)

6.10.2 record/patient number (OPS 2.27.2)

6.10.3 source of referral (OPS 2.27.3)

6.10.4 history, including details of present illness and medication (OPS 2.27.4)

6.10.5 complete physical examination (OPS 2.27.5)

6.10.6 requests for diagnostic tests (OPS 2.27.6)

6.10.7 progress notes, reports and consultations (OPS 2.27.7)

6.10.8 discharge/referral details (OPS 2.27.8)

6.10.9 name and signature of doctor (OPS 2.27.9)

6.10.10 date and time of consultation (OPS 2.27.10)

6.10.11 name and signature of attending nurse (OPS 2.27.11)

6.10.12 information and advice given to the patient and/or carers (OPS 2.27.12).

Policies and Procedures (OPS 4)

Written and dated policies and procedures reflect current knowledge and principles for the service and are consistent with the objectives of the service.

Standards

6.11 Policies and procedures refer to, but are not limited to the following (OPS 4.5):

6.11.1 ambulance and hospital transport arrangements (OPS 4.5.1)

6.11.2 complaints/suggestions (OPS 4.5.2)

6.11.3 confidentiality of information (OPS 4.5.3)

6.11.4 discharge (OPS 4.5.4)

6.11.5 information provided to the patient (OPS 4.5.7)

6.11.6 notification of patient's GP (OPS 4.5.8)

6.11.7 patient appointment system, including follow-up appointments (OPS 4.5.9)

6.11.8 patient referrals to outpatients and within the hospital (OPS 4.5.10)

6.11.9 the patient's right to privacy (OPS 4.5.11)

6.11.10 prescribing medications (OPS 4.5.12)

6.11.11 procedures undertaken on an outpatient basis (OPS 4.5.13)

6.11.12 waiting time (Patient's Charter) (OPS 4.5.15).

Facilities and Equipment (OPS 5)

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

Standards

6.12 There are facilities for confidential consultations (OPS 5.6).

6.13 There are changing facilities for the patient which maintain visual privacy (OPS 5.6).

6.14 The location is clearly signposted (OPS 5.6).

6.15 The reception area has (OPS 5.6):

6.15.1 clean toilet and washroom facilities located within easy reach of the clinic (OPS 5.12.1)

6.15.2 customer information leaflets (for example, health promotion, making/cancelling appointments) (OPS 5.12.1).

(See also **Patients' Special Needs, Non-English Speaking** section of this document.)

6.15.3 facilities suitable for nursing mothers (OPS 5.12.1)

6.15.4 information about waiting times (OPS 5.12.1)

6.15.5 play facilities/area for children (OPS 5.12.1)

6.15.6 public transport details (OPS 5.12.1)

6.15.7 seating facilities to cater for the number and type of patients attending the clinic (OPS 5.12.1)

6.15.8 space for wheelchairs (OPS 5.12.1)

6.15.9 up-to-date reading material (OPS 5.12.1).

6.16 There is provision for those with visual, hearing or physical impairment (HM 4.7).

(See also the **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient section** of this document.)

ACCIDENT AND EMERGENCY

Philosophy and Objectives (A&E 1)

The accident and emergency service provides assessment and initial treatment or advice to any acutely ill or injured person presenting at the department.

(See also **Philosophy and Objective** standards common to all staff working in the hospital, within the **Ward section** of this document.)

Standards

6.17 The service operates on a twenty-four hour basis (A&E 1.2).

6.18 The provision of emergency services assumes priority over the provision of services for non-urgent patients (A&E 1.3).

6.19 The service confines itself to initial assessment and emergency care, any subsequent care being arranged in some other place (A&E 1.4).

Policies and Procedures (A&E 4)

There are up-to-date, written policies, procedures and standards which reflect current knowledge and practice.

Standards

6.20 Policies and procedures cover at least the following topics (A&E 4.6):

6.20.1 admission, discharge and transfer of the patient (A&E 4.6.2)

6.20.2 antidotes to poison/drug overdose (A&E 4.6.3)

6.20.3 child abuse (A&E 4.6.5)

6.20.4 deaths in accident and emergency, coroner's cases (A&E 4.6.7)

6.20.5 deaths on arrival (A&E 4.6.8)

6.20.6 disclosure of information (police, media telephone) (A&E 4.6.9)

6.20.7 homeless persons (A&E 4.6.11)

6.20.8 interpreter service (A&E 4.6.13)

6.20.9 non-accidental injury to children (A&E 4.6.16)

6.20.10 notifiable diseases (A&E 4.6.17)

6.20.11 notification of and referral to patient's GP (A&E 4.6.18)

6.20.12 patient's belongings (A&E 4.6.19)

6.20.13 patients brought in dead (A&E 4.6.20)

6.20.14 patient's consent to treatment (A&E 4.6.21)

6.20.15 patients not in need of treatment (A&E 4.6.22)

6.20.16 patients refusing treatment (A&E 4.6.23)

6.20.17 patients suspected of HIV infection (A&E 4.6.24)

6.20.18 prescription writing and dispensing (in and out of hours) (A&E 4.5.2)

6.20.19 psychiatric referrals (A&E 4.6.29)

6.20.20 rape (A&E 4.6.30)

6.20.21 requests by the police for blood specimens (A&E 4.6.32)

6.20.22 requests for blood alcohol estimations (A&E 4.6.33)

6.20.23 requests for reports for legal purposes (A&E 4.6.34)

6.20.24 round the clock procurements of records, x-rays, drugs and other vital supplies (A&E 4.6.35)

6.20.25 suspected substance abuse (A&E 4.6.37)

6.20.26 triage (A&E 4.6.39) (Patient's Charter)

6.20.27 unknown persons (A&E 4.6.40)

6.20.28 victims of violence (A&E 4.6.41)

6.21 Medical and nursing policy is documented relative to the practices of the accident and emergency service, which as a minimum includes the following (A&E 4.7):

6.21.1 clarification of the extent of treatment to be carried out in the department (A&E 4.7.2)

6.21.2 the patient's rights to privacy and dignity at all times (A&E 4.7.4)

6.21.3 requests for donor organs/tissue (A&E 4.7.7)

Patient Care (A&E 6)

There is a systematic approach to patient care which maintains the patient's rights at all times.

Standards

6.22 All patients on arrival are subject to triage. If necessary triage occurs even before identification (Patient's Charter) (A&E 6.1).

6.23 Triage is performed by a doctor or a senior member of the trained nursing staff (A&E 6.2).

6.24 On arrival, all patients are correctly identified, and a record created which uses a unique hospital numbering system (A&E 6.3).

6.25 The record of attendance is included in the patient's medical record in which the accident and emergency section is readily identifiable (A&E 6.4).

6.26 This record is available on a twenty four hour basis (A&E 6.5).

6.27 If a separate accident and emergency record is maintained, this is available on a twenty-four hour basis (A&E 6.6).

6.28 The record contains at least the following (A&E 5.6):

6.28.1 name, address and post code (A&E 6.7.1)

6.28.2 next of kin (A&E 6.7.2)

6.28.3 record/patient number (A&E 6.7.3)

6.28.4 date and time of arrival (A&E 6.7.4)

6.28.5 a description of significant clinical, laboratory and radiological findings (A&E 6.7.5)

6.28.6 details of treatment and time of discharge (A&E 6.7.6)

6.28.7 details of information given to the patient and/or carers on discharge (A&E 6.7.7)

6.28.8 name and signature of attending doctor (A&E 6.7.8)

6.28.9 name and signature of attending nurse (A&E 6.7.9)

(See also **Medical Record Content** section of this document.)

6.29 The seriously ill patient receives appropriate observation and monitoring at all times (A&E 6.8).

6.30 The monitoring of the seriously ill patient continues during transfer to other areas of the hospital when the patient is accompanied by an escort capable of managing likely complications (A&E 6.9).

6.31 There are clear arrangements for the handover of patients and transfer of documentation (A&E 6.10).

6.32 Patients leaving the service receive clear instructions with reference to their illness and/or follow up if arranged, which is recorded in the notes (A&E 6.11).

6.33 Staff maintain the patient's rights to privacy, dignity and confidentiality at all times (A&E 6.12).

(See also the **Discharge Arrangements** within the hospital management (policies and procedures) and at the end of the **Inpatient** section of this document.)

Facilities and Equipment (A&E 5)

The environment, facilities and equipment are such as to ensure safe, efficient and effective emergency care of the patient, and are in accordance with Health Building Note 22.

Standards

6.34 There are facilities for confidential consultations (A&E 5.6).

6.35 There is a room designated for use by grieving and bereaved carers (A&E 5.7).

6.36 There is provision for the visual privacy of the patient (for example, screens) (A&E 5.8).

6.37 The location is clearly signposted on roads and approaches to and within the hospital (A&E 5.10).

6.38 There is space and privacy for the performance of (A&E 5.16):

- 6.38.1 resuscitation (A&E 5.16.1)
- 6.38.2 suturing (A&E 5.16.2)
- 6.38.3 plastering (A&E 5.16.3)
- 6.38.4 other forms of medical treatment (A&E 5.16.4)
- 6.38.5 the observation and holding of patients (A&E 5.16.5)

6.39 The following are present in the reception area (A&E 5.24):

- 6.39.1 access to public telephones (A&E 5.24.1)
- 6.39.2 clean and comfortable toilet and washroom facilities with access for wheelchairs (A&E 5.24.1)
- 6.39.3 customer information (for example, how to use the accident and emergency service, prevention of accidents in the home) (A&E 5.24.1)

(See also standards for **Non-English Speaking Patients** within the **Patient's Special Needs** section of this document.)

6.39.4 designated waiting area (A&E 5.24.1)

6.39.5 facilities for nursing mothers (A&E 5.24.1)

6.39.6 information about waiting times (for patients and waiting relatives or carers) (A&E 5.24.6)

6.39.7 play facilities/separate waiting area for children (A&E 5.24.7)

6.39.8 refreshments (for example, vending machine) (A&E 5.24.8)

6.39.9 seating (A&E 5.24.9)

6.39.10 space for wheelchairs (A&E 5.24.10)

6.39.11 up-to-date reading material (A&E 5.24.11)

(See also the **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

ACUTE DAY CARE SERVICE

(See also **Operating Theatre Service** section within this document.)

Philosophy and Objectives (ACD 1)

The acute day care service is an inpatient service for patients admitted and expected to be discharged on the same day.

(See also **Philosophy and Objective** standards common to all staff working in the hospital within the **Inpatient** section of this document.)

Policies and Procedures (ACD 4)

There are current, written policies and procedures for all activities of the day care service which reflect current standards of practice, relevant regulations, and the objectives of the service.

Standards

6.40 There is an admissions policy which includes reference to at least the following (ACD 4.6):

6.40.1 age (ACD 4.6.1)

6.40.2 social limitations (ACD 4.6.2)

6.40.3 clinical procedures performed on a day basis (ACD 4.6.3)

6.40.4 period of notice for admission (ACD 4.6.4).

6.41 The booking and admission of the patient complies with the admission policy (ACD 4.7).

6.42 Information is given to all patients (pre-admission) which includes as a minimum (ACD 4.8):

6.42.1 the patient's pre-admission responsibilities and preparation (ACD 4.8.1)

6.42.2 the functioning of the day care service (ACD 4.8.2)

6.42.3 post-anaesthetic effects (ACD 4.8.3)

6.42.4 provision for after hours contact, and emergency care/admission (ACD 4.8.4)

6.42.5 the patient's discharge responsibilities (ACD 4.8.5)

6.42.6 transport arrangements (ACD 4.8.6).

(See also the **Admissions Policies and Procedures** in the **Hospital Management** and **Inpatient** sections of this document.)

Patient Care

There is a systematic and patient-centred approach to care within the day care service.

Standards

6.43 There is a planned, systematic approach to the provision of patient care, with reference to guidelines for day care surgery issued by the Royal college of Surgeons (Commission on the Provision of Surgical Services 1985 and HM (73) 32 (ACD 6.1)

6.44 There is evidence that the prime focus of nursing care is on the patient (for example, primary nursing, patient allocation, team nursing) (ACD 6.2).

6.45 A named registered nurse is accountable for the nursing care of each patient (Patient's Charter) (ACD 6.3)

6.46 Day care records meet the needs for (ACD 6.4):

6.46.1 clinical care (ACD 6.4.1)

6.46.2 medico-legal purposes (ACD 6.4.2)

6.46.3 audit (ACD 6.4.3).

6.47 The patient's record includes as a minimum (ACD 6.5):

6.47.1 signed consent to the procedure (ACD 6.5.1)

6.47.2 admission diagnosis or reason for admission (ACD 6.5.2)

6.47.3 nursing care given, signed and dated by the nurse responsible (ACD 6.5.3)

6.47.4 information given to the patient and his or her carers (ACD 6.5.40).

6.48 A record of the procedure performed is written into the patient's medical record which contains details of (ACD 6.6):

6.48.1 anaesthesia (ACD 6.6.1)

6.48.2 personnel involved (ACD 6.6.2)

6.48.3 dressings and drainage (ACD 6.6.3)

6.48.4 post-operative instructions (ACD 6.6.4):

a) discharge instructions

b) follow-up instructions.

6.49 There is consideration of the emotional impact of the operative experience/investigation on the patient and appropriate explanation, reassurance and care given (ACD 6.8).

6.50 Nursing records are signed by the nurse responsible, maintained and incorporated in the patient's medical record. These may include (ACD 6.9):

6.50.1 nursing assessment (ACD 6.9.1)

6.50.2 nursing care plan (ACD 6.9.23)

6.50.3 details of nursing care given (ACD 6.9.3)

6.50.4 the patient's response to care and significant changes (ACD 6.9.4)

6.50.5 changes in the care plan resulting from evaluation of the patient's progress (ACD 6.9. 5)

6.50.6 information given to the patient and/or carers on discharge (ACD 6.9.6)

6.50.7 discharge plan, which includes a record of any communication with community services (ACD 6.9.7).

6.51 Nursing and clinical staff maintain the patient's right to privacy, dignity and confidentiality at all times (ACD 6.10).

Facilities and Equipment (ACD 5)

Facilities and equipment ensure the safe, efficient and effective functioning of the acute day care service.

Standards

6.52 The design of the areas used for day procedures is in accordance with the Health Building Note 38: Accommodation for Adult Day Patients. This includes at least the following (ACD 5.1):

6.52.1 accommodation for the patient awaiting surgery which is separate from the operating/procedure room and access corridors (ACD 5.1.1)

6.52.2 facilities for confidential consultations/counselling (ACD 5.1.6)

6.52.3 provision for the visual privacy of the patient (for example, screens) (ACD 5.1.7)

6.52.4 waiting areas for relatives/carers (ACD 5.1.9)

6.52.5 location of the day care ward with easy access to operating/procedure room (ACD 5.1.10)

6.52.6 car parking facilities to enable the safe discharge of patients (ACD 5.1.15).

Discharge

(See also **Discharge Policy and Procedure** within the **Hospital Management** and **Inpatient** sections of this document.)

Standards

6.53 There is a discharge policy which includes as a minimum (ACD 4.9):

6.53.1 discharge criteria (ACD 6.9.7)

6.53.2 clear, written, post-operative instructions for the patient and carer (ACD 4.9.1)

6.53.3 the discharge of the patient into the care of a responsible person (ACD 4.9.2)

6.53.4 a record of the address and phone number of the discharge custodian in the medical record

(See also **Medical Record Content** section of this document) (ACD4.9.3).)

6.54 The patient's GP and the community nursing services are informed of the discharge (ACD 4.10).

(See also **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

7. Departmental Areas

The following standards relate to the departmental areas, which provide a service both on an inpatient and outpatient basis.

LABORATORY SERVICE

Philosophy and Objectives (LS 1)

The laboratory service is responsible for providing a high quality service to the patient and for the ethical and professional practices of its staff.

(See also **Philosophy and Objectives** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

Standards

7.1 Objectives for the laboratory service are based on the functions described in DHSS circular HM(70)50 and are (LS 1.5):

7.1.1 to provide a service on a routine, regular and emergency basis (LS 1.5.1)

7.1.2 to provide analytical results with attention to quality, speed and economy and to control unnecessary demands from any source (LS 1.5.2)

7.1.3 to monitor the individual patient and provide laboratory control of therapy (LS 1.5.6)

7.1.4 to ensure that interpretive and consultative service is available at all times (LS 1.5.11).

Facilities and Equipment (LS 5)

The facilities and equipment available allow for the safe, effective and efficient operation of the service.

Standards

7.2 There is provision for the comfort of the patient attending the department (for example, for blood tests) which includes (LS 5.4):

7.2.1 adequate seating (LS 5.4.1)

7.2.2 clean and comfortable toilet and washroom facilities (LS 5.4.2)

7.2.3 customer information leaflets (LS 5.4.3).

7.3 Facilities allow for (LS 5.5):

7.3.1 confidential consultations (LS 5.5.1)

7.3.2 the privacy of the patient (LS 5.5.2).

7.4 The location is clearly signposted (LS 5.8).

(See also **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

PHARMACEUTICAL SERVICE

Philosophy and Objectives

The pharmaceutical services are primarily concerned with the patient and his or her safe and effective treatment with medicines, in accordance with statutory requirements. Pharmacy practice is governed by the Code of Ethics of the Royal Pharmaceutical Society of Great Britain (Code of Ethics).

(See also **Philosophy and Objectives** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

Standards

7.5 Specific services may include (PS 2.1):

7.5.1 a medication counselling service to patients (PS 2.1.5).

Policies and Procedures (PS 4)

There are written, dated policies and procedures for all services provided by the pharmacy department. These reflect current legislation, guidance and scientific knowledge.

Standards

7.6 Policies and procedures cover at least the following (PS 4.5):

7.6.1 admixture of parenteral products and their labelling (PS 4.5.1)

7.6.2 arrangements for service outside normal pharmacy hours (PS 4.5.2)

7.6.3 automatic stop-orders and a list of medications to which these orders apply (PS 4.5.3)

7.6.4 control of sample drugs brought into the hospital (PS 4.5.4)

7.6.5 disposal of discontinued, outdated and inappropriately labelled drugs (PS 4.5.5)

7.6.6 drug information and advice provided to hospital staff (PS 4.5.6)

7.6.7 drug recall procedure (PS 4.5.7)

7.6.8 education and counselling service offered to patients and their families (PS 4.5.8)

7.6.9 handling of all investigational drugs and drugs used in clinical trials (PS 4.5.9)

7.6.10 information leaflets issued to the patient (PS 4.5.10)

7.6.11 information provided to the patient on use and storage of medications (PS 4.5.11)

7.6.12 medications brought into the hospital by the patient (PS 4.5.14).

Facilities and Equipment (PS 5)

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

Standards

7.7 There are facilities for confidential consultations (PS 5.4)

7.8 The location is clearly signposted (PS 5.5)

7.9 There is a designated waiting area for patients using the service which as a minimum provides (PS 5.16):

- 7.9.1 clean and comfortable toilet and washroom facilities with access for wheelchairs (PS 5.16.1)
- 7.9.2 customer information leaflets (PS 5.16.2)
- 7.9.3 information on waiting time (PS 5.16.2)
- 7.9.4 up-to-date reading material (PS 5.16.3).

(See also **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

RADIOLOGY SERVICE

Philosophy and Objectives (RS 1)

The aim of the radiology service is to provide the hospital with a high quality of service and ensure safe and effective patient care which complies with the relevant statutory instruments.

(See also **Philosophy and Objectives** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

Standards

7.10 The objectives for the service include at least the following (RS 1.3):

7.10.1 providing services on a routine, regular and emergency basis (RS 1.3.1)

7.10.2 providing the patient and users with a quality of service which is based on professional standards set by the relevant professional organisation (for example, the Royal College of Radiologists, the College of Radiographers) (RS 1.3.2)

7.10.3 providing and maintaining a high standards of care through analysis, review and evaluation of service (RS 1.3.4)

7.10.4 complying with Ionising Radiation Regulations and other such local rules as may be agreed by the Radiation Protection Adviser (RS 1.3.9).

Policies and Procedures (RS 4)

There are written policies and procedures for all activities of the radiology service which reflect current knowledge and principles, the relevant regulations, statutory requirements and objectives of the service.

Standards

7.11 Policies and procedures cover at least the following (RS 4.10):

7.11.1 care of the patient having special needs, including those who are critically ill and those needing isolation precautions (RS 4.10.1)

7.11.2 information issued to the patient and/or carers (RS 4.10.5).

Facilities and Equipment (RS 5)

The radiology service is provided with facilities and equipment and supplies for the safe, effective and efficient performance of all services.

Standards

7.12 There are suitable signs, prominently displayed, warning of radiation dangers to the foetus if pregnant. Where appropriate these should be multilingual (RS 5.10).

7.13 The reception area has (RS 5.11):

7.13.1 clean toilet and washroom facilities located within easy reach of the clinic (RS 5.11.1)

7.13.2 customer information leaflets (for example, health promotion, making/cancelling appointments) (RS 5.11.2)

7.13.3 facilities suitable for nursing mothers (RS 5.11.3)

7.13.4 information about waiting times (RS 5.11.4)

7.13.5 play facilities/area for children (RS 5.11.5)

7.13.6 public transport details (RS 5.11.6)

7.13.7 seating facilities to cater for the number and type of patients attending the clinic (RS 5.11.7)

7.13.8 space for wheelchairs (RS 5.11.9)

7.13.9 up-to-date reading material (RS 5.11.10).

7.14 All staff are given instruction in safety precautions necessary for the protection of the patient and staff (RS 5.16).

(See also **Quality Management and Evaluation** standards which are common to all staff working in the hospital, within the **Inpatient** section of this document.)

Appendix 1

NATIONAL CHARTER STANDARDS

There are nine standards of service which the NHS will be aiming to provide:

1. Respect for privacy, dignity and religious and cultural beliefs.

2. Arrangements to ensure everyone, including people with special needs, can use the services.

3. Information to relatives and friends about the progress of your treatment, subject, of course, to your wishes.

4. An emergency ambulance should arrive wihtin 14 minutes in an urban area, or 19 minutes in a rural area.

5. When attending an accident and emergency department, you will be seen immediately and your need for treatment assessed.

6. When you go to an outpatient clinic, you will be given a specific appointment time and will be seen within 30 minutes of it.

7. Your operation should not be cancelled on the day you are due to arrive in hospital. If, exceptionally, your operation has to be postponed twice you will be admitted to hospital within one month of the second cancelled operation.

8. A named qualified nurse, midwife or health visitor responsible for your nursing or midwifery care.

9. A decision should be made about any continuing health or social care needs you may have, befoe you are discharged from hospital.

Appendix 2

ORGANISATIONAL AUDIT STANDARDS AND THE AUDIT PROCESS

Introduction

For the past two and a half years the King's Fund has been working with hospitals, and national and consumer organisations to develop both standards which cover the range of services provided by an acute hospital and a tool to monitor compliance with these. The standards relate to the organisation of services and to the systems and processes which must be in place in order to ensure that a safe, effective and efficient service is given to patients. The approach is termed Organisational Audit and was established in 1989 as a feasibility study involving nine hospitals (five district general, two teaching and two independent), full details of which can be found in *The Quality Question*.[1]

The feasibility study has now evolved into an established programme within the King's Fund.

Standards

The standards are contained in a manual — *Organisational Audit (Accreditation UK) Standards for an Acute Hospital* — and cover the following areas:

The Patient's Rights and Special Needs

Management and Support Services

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

Professional Management

Medical Nursing
Professions allied to Medicine

Departmental Management

Anaesthetic Service
Accident and Emergency Service
Acute Day Care Service
Laboratory Service
Operating Theatre Service
Outpatient Service
Pharmaceutical Service
Radiology Service
Special Care Service

A 'core' set of standards has also been developed (not published) which is applicable to any service or department area not listed above.

Each section has the same internal format, the main headings of which are:

Philosophy and Objectives
Management and Staffing
Staff Development and Education
Policies and Procedures
Facilities and Equipment
Evaluation and Quality Assurance

The Audit Process

The logic of the approach is, that in meeting the standards, a hospital is ensuring that the organisational systems and processes are in place to support staff in their activities, which should enable staff to concentrate on providing a high quality of care or service.

Currently, over one hundred hospitals are participating in the programme and further expansion is planned — surveys are being scheduled for 1993 and beyond. The organisational audit process follows the same pattern in all hospitals.

- The hospital requests to be included in the organisational audit programme.

- An agreement is drawn up between the hospital and the King's Fund which details their respective responsibilities and the agreed survey date.

- The length of the survey and the number of surveyors required are determined by the size of the hospital — no survey lasts more than five days.

- The preparation period begins one year prior to the survey date. The hospital sets up a multidisciplinary steering group comprising senior representatives of the various staff groups and identifies a survey co-ordinator.

  — The steering group is responsible for establishing a standards implementation programme for the hospital and the necessary education of staff about the standards and the audit process.

  — The co-ordinator, supported by the steering group, is responsible for overseeing the standards implementation programme.

- Each hospital is allocated a King's Fund survey manager who will work with the steering group and the co-ordinator to facilitate the necessary preparation for the survey and act as an observer during the survey itself.

- Six weeks prior to the survey the hospital completes and returns two questionnaires.

  — The hospital profile form, which provides information on the range and activity levels of each service within the hospital.

  — The self-assessment form, which is an assessment by hospital staff of their own progress towards meeting the standards. Completing the form provides a useful checklist and is an opportunity for staff to comment on the standards.

- The two completed questionnaires and a survey timetable are then sent to the survey team.

- The hospital is surveyed.

The Survey

The survey lasts from three to five days depending on the size and complexity of the hospital.

The survey team usually consists of a chief executive, a director of nursing or equivalent, and a senior consultant. For larger hospitals or those with multi-site

services, a fourth and fifth member may be added, to include a member of the professions allied to medicine.

The surveyors are selected from nominations from those hospitals participating in the programme and from professional organisations. Each attends a three-day training programme and would then normally undertake two surveys per year.
The assessment of compliance with the standards involves interviewing staff, patients and visitors; observation of the environment, etc.; and the checking of documentation such as policies and procedures and ensuring that these are followed in practice.

The survey concludes with a detailed verbal feedback to the hospital management team. A written report of the feedback is sent to the hospital six to eight weeks following the survey. This gives a comprehensive assessment of progress towards meeting the standards and includes recommendations for change and commendations of good practice. Hospitals will then be re-visited at three-yearly intervals.

At this stage we are not awarding accreditation status (that is, there is no pass or fail), but are emphasising the developmental aspects of the process and encouraging hospitals to look for continual improvement. Hence the term organisational audit rather than accreditation is currently used as this more aptly describes the approach that we have developed.

Direction of the Organisational Audit Programme

The growth of the Organisational Audit Programme has been rapid. In addition to the increasing number of volunteer hospitals taking part in the process, we have now trained approximately 90 senior health care professionals to act as surveyors.

An Advisory Council has been established to provide advice on the future management and development of the programme. The membership comprises: Association of Community Health Councils; Conference of Colleges; Chairman and Secretaries of the Professional Bodies of the Professions Allied To Medicine; Independent Healthcare Association; Institute of Health Service Management; National Association of Health Authorities; National Consumer Council; Royal College of Nursing; United Kingdom Council; Central Council for Nursing, Midwifery and Health Visiting.

As a natural and necessary extension of the programme, a two-year project has been set up to look at extending the organisational audit approach to the community setting, specifically within health centres/GP practices. This project will be complete (that is, the standards and the survey process developed and tested) by the

autumn of 1993. In addition we are exploring the applicability of the approach to the area of mental health and to the long-term residential/nursing home setting.

Reference

1. Brooks, Tessa and Pitt, Christine. *The Quality Question: A report on the first year of the Organisational Audit Project*. London, King's Fund Centre, 1990.

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