VOLUME 1

THE PATIENT'S RIGHTS AND SPECIAL NEEDS

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

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

A **Essential Practice**

If these are not in place then:

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

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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

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

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

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

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

AS - The Kings Fund Organisational Audit Volume 1   **306-060-001**

VOLUME 1

THE PATIENT'S RIGHTS

Standard 1

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

please tick
Yes No

Criteria	Comments	

1.1 The patient is aware of his or her right to:

1.1.1 be referred to a consultant whom they consider acceptable — **A**

1.1.2 seek a second opinion — **A**

1.1.3 be given a clear explanation of their medical condition and any treatment, investigation or procedure proposed, including risks and alternatives, before agreeing on the course of action to be taken — **A**

1.1.4 have access to their own health record (subject to the restrictions of the Data Protection Act 1984, the Access to Health Records Act 1990 and the Access to Health Records (Northern Ireland) Order 1993) and to be sure that the information recorded in the health record will remain confidential — **A**

1.1.5 a full investigation of clinical and non-clinical complaints completed within a timescale specified in a written complaints procedure — **A**

1.1.6 choose whether or not to take part in medical research or medical student training. — **A**

1.2 There is evidence that the hospital/trust recognises and responds to the following:

1.2.1 respecting the personal dignity of patients at all times — **A**

1.2.2 protecting the personal privacy of the patient within the constraints of the individual treatment plan — **A**

1.2.3 the special emotional and physical needs of groups such as children, the confused, the elderly, the mentally ill and people with learning difficulties — **A**

1.2.4 the requirements of those with sensory or physical impairments — **A**

THE PATIENT'S RIGHTS

please tick
Yes No

Comments

1.2.5 maintaining confidentiality between staff and patients (particularly with regard to information given to relatives and carers) **A**

1.2.6 respecting the culture and traditions of ethnic groups within the population served. **A**

(See also Core Standards for Clinical Services chapter, criterion 5.4.)

1.3 The following information is provided to the patient:

1.3.1 waiting time for first outpatient appointment **A**

1.3.2 waiting time in the accident and emergency department after initial assessment **A**

1.3.3 services provided within the hospital/trust (for example, hospital booklet) **B**

1.3.4 treatment/procedure leaflets. **B**

Interpretation

* *all written information is assessed according to an agreed policy on quality which includes the following:*

    content

    graphics and style

    readability ie plain English

    suitability for target audience

    cultural appropriateness

* *written information for patients is kept up to date and reviewed on a systematic basis*

* *information leaflets for patients are translated into other languages where appropriate*

* *health promotion literature is available in all wards and departments*

* *copies of The Patient s Charter are displayed throughout the hospital/trust (NHS only)*

THE PATIENT'S RIGHTS

please tick
Yes No

Comments

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

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

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

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

Interpretation

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

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

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

Interpretation

These policies and procedures include obtaining consent for:

* anaesthesia

* electro-convulsive therapy

* hazardous assessment procedures

* participation in research projects

* participation in teaching exercises

* photographic and audiovisual recording

* surgical procedures

* unusual medications

* other procedures where consent is required by law.

(See also Health Record Content chapter, criterion 1.1.12.)
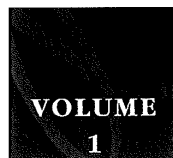
THE PATIENT'S SPECIAL NEEDS

Standard 2

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

please tick
Yes No

Criteria

Care of the Terminally Ill Patient

2.1 Care is managed on an individual basis to ensure that the patient s and family s physical, emotional, spiritual and social needs are assessed and necessary measures to meet them are planned, implemented and evaluated. **A**

2.2 There is a written philosophy of care. **A**

2.3 Staff are trained to meet the special needs of patients and their families. **B**

2.4 Provision is made for relatives/carers to stay overnight with the patient. **B**

2.5 Visiting is unrestricted. **B**

2.6 There is a policy for dealing with advance directives completed by terminally ill patients. **B**

2.7 Support and information is provided to families after the death of a patient (for example, help with the arrangement of burial/cremation arrangements, bereavement counselling). **B**

Chaplaincy and Spiritual Care

2.8 If requested, patients, carers and staff have access to the pastoral and/or spiritual support of their choice. **B**

2.9 There is a mechanism to ensure that patients and carers are aware of the pastoral and/or spiritual support available within the hospital/trust. **B**

2.10 A quiet area is set aside for prayer and meditation. **B**

2.11 Chaplains, visiting clergy, pastoral workers and religious leaders of non-Christian faiths have access to office space and telephones. **B**

Children

2.12 The Department of Health guidelines The Welfare of Children and Young People in Hospital (1991) are used to inform the way in which care is organised and delivered. **A**

2.13 There is a written philosophy of care for children which is understood by all staff in contact with children. **A**

Comments

THE PATIENT'S SPECIAL NEEDS

please tick
Yes No

Comments

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

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

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

Interpretation

These departments include:

* *accident and emergency department (see also Accident and Emergency Service chapter, criterion 2.10.9)*

* *intensive care unit (see also Special Care Service chapter, criterion 2.9.2)*

* *outpatient department (see also Outpatient Service chapter, criterion 2.5)*

* *theatres (see also Operating Theatre Service/Anaesthetic Service chapter, criterion 2.6.4).*

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

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

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

Interpretation

These include:

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

please tick
Yes No
☐ ☐

Comments

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

* *day case admission (see also Acute Day Care Service chapter, criterion 4.1.4)*

* *intensive care unit admission*

* *isolation unit admission*

* *ward visiting*

* *discharge*

* *outpatient attendance*

* *accident and emergency attendance*

* *parents accompanying children to theatre (see also Operating Theatre Service/Anaesthetic Service chapter, criterion 4.1.11)*

* *pain management and pain relief.*

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

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

Interpretation

These include:

* *a procedure to ensure that consent to treat all children under 16 is obtained from the child and the parent/carer or guardian*

* *a procedure for dealing with parents/carers (or children where judged to be competent) refusing urgent or lifesaving treatment.*

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

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

Interpretation

* *ward attendance is monitored and evaluated*

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

please tick
Yes No
☐☐

Comments

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

Interpretation

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

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

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

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

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

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

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

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

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

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

Interpretation

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

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

THE PATIENT'S SPECIAL NEEDS

please tick
Yes No

Comments

2.28 The special needs of adolescents are recognised and used to inform the care provided. ☐☐ **A**

2.29 There is evidence that staff are aware of the special needs of the following:

    2.29.1 children with life-threatening illnesses ☐☐ **A**

    2.29.2 children with physical or sensory disabilities and children with learning difficulties ☐☐ **A**

    2.29.3 unaccompanied children. ☐☐ **A**

2.30 Accommodation is provided for parents staying overnight with their children. ☐☐ **A**

2.31 Provision is made for unrestricted parental involvement in the care of their children (unless the interests of the child preclude this). ☐☐ **A**

2.32 There is evidence that children, adolescents and parents/carers are involved in decision making. ☐☐ **A**

2.33 Play facilities, toys, games and books are provided for children of all ages in the areas of the hospital/trust where:

    2.33.1 they are cared for ☐☐ **B**

    2.33.2 they wait for an appointment/therapy/treatment. ☐☐ **B**

2.34 A play specialist is designated to supervise play activities. ☐☐ **B**

Interpretation

    * *this specialist holds the Hospital Play Specialist Examination Board Certificate (HPSEB).*

2.35 Links are established with the Local Education Authority to ensure that education is provided to children who are admitted to hospital. ☐☐ **A**

2.36 There is a policy for dealing with the death of a child including making arrangements for burial or cremation *(see also Corporate Management chapter, Policies and Procedures standard, criterion 8.12)*. ☐☐ **A**

2.37 Overnight facilities are available for bereaved parents. ☐☐ **B**

2.38 All hospitals which admit children have paediatric equipment and medication available. ☐☐ **A**

THE PATIENT'S SPECIAL NEEDS

please tick
Yes No
☐☐

Comments

Interpretation

This includes:

* *anaesthetic equipment*

* *inhalation therapy equipment*

* *paediatric size needles, cannulae, infusion regulators and other intravenous equipment*

* *paediatric infusion sets*

* *resuscitation equipment.*

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

☐☐ **A**

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

☐☐ **A**

Interpretation

* *power points are fitted with safety shutters*

* *physical barriers prevent entry to hazardous areas*

* *cleaning agents and other hazardous materials are kept in correctly labelled containers with child resistant closures*

* *cupboards containing cleaning agents and other hazardous materials are kept locked.*

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

☐☐ **A**

Interpretation

* *as part of the recruitment and selection procedure, the criminal convictions of staff responsible for the care of children are checked (see also Corporate Management chapter, Human Resources standard, criterion 5.11.2)*

* *staff responsible for the care of children are trained to recognise the symptoms of child abuse and are aware of how to obtain specialist advice and support.*

THE PATIENT'S SPECIAL NEEDS

please tick
Yes No

Comments

Ethics

2.42 Mechanisms exist for:

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

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

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

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

Non-English Speaking Patients

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

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

Interpretation

Consideration is given to:

*   diet and feeding

*   medical examinations and other interventions

*   religious beliefs or traditions in respect of healing, medical treatment and care while dying

*   washing and bathing.

Patients with a Disability

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

Seclusion, Restraint and Emergency Medication

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

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CORPORATE MANAGEMENT

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MISSION AND OBJECTIVES

Standard 1

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

please tick
Yes No

Criteria

Comments

Mission Statement

1.1 There is a written mission statement which is developed with input from medical, nursing and other professional staff.   **B**

1.2 The mission statement is made available to the general public, other health and related organisations and to staff within the hospital/trust.   **B**

Objectives and Business Planning

1.3 There is a written strategic direction document for the hospital/trust.   **A**

1.4 There is an annual business plan for the hospital/trust which is reviewed and updated annually.   **A**

1.5 The business plan and strategic direction document are developed with input from medical, nursing and other clinical and non-clinical staff *(see also Core Standards for Non-Clinical Services chapter, criterion 2.1.3 and Core Standards for Clinical Services chapter, criterion 2.1.3).*   **B**

1.6 The business plan and strategic direction document are publicised widely (NHS only).   **A**

CONTRACT SERVICES

Standard 2

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

please tick
Yes No
☐ ☐

Criteria

Comments

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

☐ ☐ **A**

Interpretation

These agreements include the following dimensions:

*   *price*

*   *quality (clinical and non-clinical)*

*   *volume/activity.*

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

☐ ☐ **B**

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

☐ ☐ **B**

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

☐ ☐ **A**

Interpretation

When drawing up specifications the following aspects are considered:

*   *a specification of the formal lines of communication and responsibility between the service provider/ purchaser and the hospital or trust*

*   *a requirement for the provision of services by trained and qualified staff*

*   *mechanisms for identifying and remedying the problems in service delivery*

*   *planned reviews of each specialty involving consultants/managers and general practitioner users (provided services only)*

CONTRACT SERVICES

please tick
Yes No

Comments

* *progress towards achieving outcomes identified by Health of the Nation (provided services only)*

* *the frequency and content of reporting requirements (provided services only)*

* *protocols of care which indicate the different responsibilities of general practitioners, community health staff and hospital/trust staff (provided services only)*

* *tertiary referral policy and procedures (provided services only)*

* *community health council access to inspect facilities (provided services only)*

* *a mechanism for monitoring and maintaining the quality of service (purchased services only)*

* *participation of the service provider in relevant committees of the hospital/trust (purchased services only)*

* *arrangements for after hours and emergency services (purchased services only)*

* *adequacy of facilities and equipment for the service being provided both in the hospital and at the site of the external service (purchased services only).*

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

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

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MANAGEMENT ARRANGEMENTS

Standard 3

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

please tick
Yes No
☐ ☐

Criteria

Comments

Management Structure

3.1 There is a board of directors for the trust and/or a designated individual manager with overall responsibility for the operation and management of the hospital/trust.

☐ ☐ **A**

3.2 There is a designated deputy for the hospital manager/chief executive (this may be rotated around the executive directors).

☐ ☐ **B**

3.3 There are executive directors on the board with designated responsibility for non-clinical support services (for example, security, fire) and human resources.

☐ ☐ **A**

3.4 There is a clear division of responsibility between the hospital manager/chief executive and the chairman.

☐ ☐ **A**

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

☐ ☐ **A**

Interpretation

The document includes:

   * *a description of the power and duties of the board of directors*

   * *a scheme of delegation*

   * *standing orders*

   * *standing financial instructions*

   * *policies and procedures.*

3.6 The power and the duties of the board of directors and the standing orders are made accessible to all staff.

☐ ☐ **A**

3.7 The standing orders specify those decisions which must be made by the board.

☐ ☐ **A**

MANAGEMENT ARRANGEMENTS

Comments

please tick
Yes No
☐☐

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

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

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

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

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

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

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

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

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

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

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

MANAGEMENT ARRANGEMENTS

please tick
Yes No

Comments

3.14 There is a remuneration and terms of service committee with terms of reference setting out membership, limits to powers and arrangements for reporting back to the board.

A

3.15 There is a designated secretary to the board.

A

3.16 The responsibilities of the secretary are clearly defined.

B

Interpretation

These include:

* *maintaining standing orders*

* *maintaining standing financial instructions in liaison with the director of finance*

* *retaining the corporate seal and its applications*

* *keeping a register of directors interests.*

3.17 The board publishes an annual report and annual accounts.

A

3.18 The annual report and annual accounts are made available to the public.

A

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

A

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VOLUME 1

COMMUNICATION

Standard 4

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

please tick
Yes No

Criteria

4.1 There are mechanisms for communication with:

4.1.1   the local community

4.1.2   staff throughout the hospital/trust

4.1.3   external organisations (for example, community health councils, community services, general practitioners)

4.1.4   the media.

4.2 There are mechanisms for systematically auditing the effectiveness of communication systems.

4.3 There is a written communication strategy for the hospital/trust.

4.4 The effectiveness of the communication strategy is reviewed on a systematic basis.

4.5 There is a clear channel of communication for patients complaints/suggestions/expressions of satisfaction *(see also Policies and Procedures standard, criterion 8.4.1).*

4.6 Opportunities are available for staff to train in communication skills and customer care.

Comments

A

A

A

B

B

B

B

A

C

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HUMAN RESOURCES

Standard 5

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

please tick
Yes No

Criteria

Comments

Human Resource Strategy

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

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

Interpretation

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

* *there are trained and qualified staff available to meet service requirements and maintain high quality patient care*

* *staffing levels are systematically assessed and monitored against workload*

* *the additional requirements of research, local and national committee work, mentoring, teaching, assessment and supervision are reflected in staffing levels*

* *the skill-mix/grading and competence profile of staff are regularly reviewed to ensure their effective deployment*

* *details about the hospital s/trust s workforce are recorded, in order to provide manpower information for management purposes (for example, sickness rates, absence rates, numbers and grades of staff).*

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

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

5.5 Terms and conditions of service of staff are:

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

HUMAN RESOURCES

Comments

please tick
Yes No

5.5.2   reviewed periodically and revised as necessary — **A**

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

5.5.4   dated and signed. — **B**

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

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

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

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

Recruitment and Selection

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

Interpretation

The procedure includes:

* *job definition*

* *selection criteria*

* *obtaining references*

* *health screening*

* *issuing a letter of appointment within one week of the job offer.*

5.11 As part of the recruitment and selection procedure:

5.11.1   qualifications are checked — **A**

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

5.11.3   equal opportunities are monitored. — **A**

please tick
Yes No
☐☐

Comments

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

☐☐ **A**

5.13 Personnel records are maintained.

☐☐ **A**

Interpretation

These records include:

* *application form/curriculum vitae*

* *references*

* *the contract of employment and any amendments issued*

* *an up-to-date job description*

* *details of qualifications held*

* *records of leave and sickness*

* *appraisal details.*

Orientation and Induction

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

5.14.1   fire

☐☐ **A**

5.14.2   health and safety

☐☐ **A**

5.14.3   patient confidentiality

☐☐ **A**

5.14.4   accident and/or untoward incident reporting

☐☐ **A**

5.14.5   security

☐☐ **A**

5.14.6   pay arrangements.

☐☐ **A**

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

Training and Development

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

☐☐ **A**

Interpretation

The strategy addresses:

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

HUMAN RESOURCES

please tick
Yes No
☐☐

Comments

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

* business plan objectives.

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

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

Interpretation

These include:

* occupational standards

* vocational qualifications.

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

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

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

5.21 Records of study leave are maintained.

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

Performance Review

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

Interpretation

The staff appraisal system identifies:

* objectives, strengths and weaknesses in performance
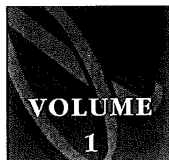
please tick
Yes No

Comments

* areas for personal development and training.

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

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

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

5.24.2 quality.

Employee Relations

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

Interpretation

The policies and procedures:

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

* include:

   disciplinary procedure

   grievance procedure

   disputes procedure

   appeals procedure

   recognition arrangements for trade unions and professional organisations

   arrangements for consultation and negotiation within the hospital/trust

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

   job evaluation.

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

A

B

A

A

FINANCIAL RESOURCES

Standard 6

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

please tick
Yes No
☐☐

Criteria

Comments

Finance

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

☐☐ 🅰

Interpretation

* *the internal audit section carries out appraisals and makes recommendations to management for operations under its control*

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

* *internal auditors exercise due professional care in carrying out their duties*

* *the internal audit section is appropriately staffed in terms of numbers, grades, qualifications and experience, having regard to its responsibilities and objectives*

* *staff are trained to fulfil their responsibilities*

* *the internal auditor seeks to foster constructive working relationships and mutual understanding with management, external auditors, any other review agencies and the audit committee*

* *internal audit work is adequately planned, controlled and recorded in order to achieve the agreed objectives of the internal audit department, to establish audit priorities and to ensure the effective use of audit resources*

FINANCIAL RESOURCES

please tick
Yes No
☐☐

Comments

* *internal auditors use a systems based approach to identify and evaluate the soundness, adequacy and application of financial and other management controls*

* *internal auditors obtain sufficient, relevant and reliable evidence on which to base conclusions and recommendations*

* *internal auditors ensure that findings, conclusions and recommendations arising from each individual internal audit assignment are communicated promptly to the appropriate level of management and actively seek a response*

* *internal auditors ensure that arrangements are made to follow up audit recommendations*

* *the internal auditors report to the audit committee.*

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

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

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

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

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

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

FINANCIAL RESOURCES

please tick
Yes No
☐☐

Comments

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

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

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

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

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

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

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

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

Interpretation

* an analysis of the duration of the debt is routinely produced to the executive management team/trust board

* there are written procedures for debt recovery, which are instigated routinely

* bad debts are reviewed at least six monthly

* there are written procedures for the payment of creditors which are regularly monitored.

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

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

FINANCIAL RESOURCES

please tick
Yes No

Comments

6.18 In the case of NHS trusts, the investment of surplus funds is in accordance with relevant guidelines.   **A**

6.19 There is a system for managing the level and security of stock.   **B**

6.20 There is an up-to-date inventory of attractive items costing less than £5,000 per item (for example, computers, calculators, mobile telephones, slide projectors).   **B**

6.21 There are written and up-to-date policies and procedures for all accounting functions.   **B**

VOLUME 1

INFORMATION SERVICES

Standard 7

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

please tick
Yes No
☐☐

Criteria

7.1 There is a written information management/technology strategy for the hospital/trust.

☐☐ **A**

7.2 Information systems enable the minimum data standards to be met *(see also Health Record Service chapter, criterion 4.5)*.

☐☐ **A**

Interpretation

These information systems:

* *identify the purchasing authority for each patient seen*

* *identify the registered general practitioner for each patient*

* *assign contract numbers to each patient episode*

* *assign clinical codes at discharge or within 14 days, using a current version of the international classification of diseases and OPCS procedure codes (or other approved classifications)*

* *group patients using a current grouping system.*

7.3 The effectiveness of information systems is reviewed on a systematic basis.

☐☐ **B**

Interpretation

* *accuracy and timeliness of coding is monitored*

* *information for management decision making is systematically reviewed.*

7.4 Confidentiality is maintained in accordance with the Data Protection Act 1984 and unauthorised access to the information systems is prevented.

☐☐ **A**

7.5 Coding systems are in place to:

7.5.1 supply information for the national Patient s Charter league table

☐☐ **A**

Comments

INFORMATION SERVICES

please tick
Yes No

Comments

7.5.2   achieve targets for recording completed patient/consultant episodes within specified timescales — **B**

7.5.3   supply data that monitors progress towards Health of the Nation targets. — **B**

7.6   Information is produced which shows:

7.6.1   patient workload per individual consultant per ICD code — **B**

7.6.2   theatre utilisation and overall workload per consultant per OPCS/BUPA classification. — **B**

7.7   Monthly monitoring information integrates activity with finance and manpower information *(see also Financial Resources standard, criterion 6.8).* — **B**

7.8   There are written procedures for computing and network services disaster recovery *(see also Risk Management standard, criterion 10.9).* — **A**

7.9   There are information systems in place to support the needs of clinical (uniprofessional and multidisciplinary) audit. — **B**

Interpretation

These systems:

 *   *are able to access demographic and clinical data held on other operational systems*

 *   *are flexible enough to hold various types of clinical data for routine audit and audit projects*

 *   *are able to collate and aggregate data flexibly for audit purposes.*

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

Standard 8

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

please tick
Yes No
☐ ☐

Criteria

Comments

8.1 Corporate policies and procedures are:

8.1.1   in accordance with statutory requirements ☐ ☐ **A**

8.1.2   centrally indexed/compiled into a policy manual ☐ ☐ **B**

8.1.3   dated ☐ ☐ **B**

8.1.4   subject to a systematic review process. ☐ ☐ **B**

8.2 Mechanisms exist to ensure that corporate policies and procedures are widely communicated throughout the hospital/trust. ☐ ☐ **A**

8.3 The activities of the hospital/trust are monitored to ensure that they are consistent with corporate policies. ☐ ☐ **B**

Complaints and Untoward Incidents

8.4 Policies and procedures are developed for:

8.4.1   patient and staff complaints *(see also Communication standard, criterion 4.5)* ☐ ☐ **A**

8.4.2   patient and staff accidents, errors (for example, medications) and incidents *(see also Risk Management standard, criterion 10.5)*. ☐ ☐ **A**

8.5 Corporate records are kept of complaints, accidents, errors and incidents and include details of the action taken (see also Core Standards for Non-Clinical Services chapter, criterion 4.8 and Core Standards for Clinical Services chapter, criterion 4.8). ☐ ☐ **A**

Admission

8.6 There are written policies and procedures for admission to the hospital/trust which cover at least the following:

8.6.1   routine admission ☐ ☐ **A**

8.6.2   emergency admission ☐ ☐ **A**

8.6.3   conditions for refusing admission ☐ ☐ **A**

please tick
Yes No

Comments

8.6.4   arrangements when admission is refused **A**

8.6.5   cancellation of routine admission **A**

8.6.6   information to be given to the patient pre-admission and on admission. **B**

8.7   There is a system in place to ensure that staff are aware of the admissions policies and procedures. **A**

8.8   The special needs of children are taken into consideration when developing admissions policies *(see also The Patient s Rights and Special Needs chapter, Special Needs standard, criterion 2.19)*. **A**

8.9   There is an individual with designated responsibility for admissions. **B**

Discharge

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

Interpretation

The policy covers the following:

* *period of notice required by a patient in order to prepare for discharge*

* *liaison with the patient s general practitioner*

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

* *information given to the patient concerning future management of their medical condition*

* *information given to the patient concerning the management of their condition at home*

* *information given to the patient concerning any advised changes in lifestyle*

* *information given to the patient s general practitioner (see also Health Record Content chapter, criteria 1.1.16, 1.1.17)*

* *issues relating to supervised discharge of patients*

* *transport arrangements*

POLICIES AND PROCEDURES

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No
☐ ☐

Comments

* the special requirements of the
patient who has no social support

* ensuring that no NHS patient is
discharged to a nursing/residential
home against his/her wishes if he/she
or a relative is personally responsible
for paying the home s fees

* information concerning funding if
long-term nursing care is required.

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

Dealing with the Deceased

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

Interpretation

Procedures include:

* referral to the coroner

* dealing with personal effects

* observing the religious beliefs and
traditions of minority ethnic groups
(see also The Patient s Rights and
Special Needs chapter, The Patient s
Special Needs standard, criterion
2.44)

* arranging burial/cremation if
necessary.   ☐ ☐ **A**

Health Promotion

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

8.14 The following counselling services are
provided:

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

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No

Comments

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

☐☐ **C**

Major Incident Plans (External and Internal)

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

☐☐ **A**

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

8.16.1   emergency services

☐☐ **A**

8.16.2   local authorities.

☐☐ **A**

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

☐☐ **A**

Interpretation

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

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

☐☐ **B**

Interpretation

* *rehearsals are part of a coordinated practice in which other emergency services participate*

* *rehearsals involve medical, nursing, managerial and other staff as appropriate*

* *rehearsals are evaluated and a written report produced.*

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

☐☐ **B**

8.20 The hospital/trust develops internal incident plans.

☐☐ **A**

POLICIES AND PROCEDURES

please tick
Yes No

Comments

Interpretation

* these incidents include:

bomb threats

explosion

fire

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

* the plans include evacuation procedures

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

* staff are made aware of incident plans.

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

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

Interpretation

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

* a record of attendance at practices is maintained.

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

Waiting List Management

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

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

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

Interpretation

This review ensures that:

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

* personal details are up to date.

FACILITIES AND EQUIPMENT

Standard 9

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

please tick
Yes No

Criteria

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

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

A

Interpretation

Consideration is given to:

* service level agreements

* lines of accountability

* estate investment programme

* asset value

* functional suitability and space utilisation

* performance targets for improving asset utilisation

* building, plant and equipment maintenance programme.

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

A

Interpretation

This covers at least the following:

* a development control plan to cover all developments on the site

* a condition survey of all buildings

* identification of any listed buildings or conservation areas

* dates of recent site additions and/or deletions.

9.3 The estate control plan is systematically reviewed and updated.

A

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

A

Comments

VOLUME 1

FACILITIES AND EQUIPMENT

please tick
Yes No

Comments

9.5 There is evidence that provision is made for: **A**

9.5.1 the special needs of children

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

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

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

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

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

Interpretation

* *patient safety devices may include:*

handrails in passageways

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

safety straps on wheelchairs

trolleys with side rails

*variable height beds fitted with
adjustable side rails*

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

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

Interpretation

Consideration is given to:

* *the needs of ethnic minority
populations*

* *the needs of the visually impaired.*

VOLUME 1

FACILITIES AND EQUIPMENT

please tick
Yes No
☐☐

Comments

9.9 Car parking requirements are reviewed on a systematic basis.

☐☐ **B**

Interpretation

The review includes:

* *arrangements for the disabled*

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

RISK MANAGEMENT

Standard 10

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

please tick
Yes No
☐☐

Criteria

Comments

10.1 There is an individual at senior management level who has overall responsibility for the management of risk within the hospital/trust.

☐☐ **A**

10.2 There is a risk management strategy which is endorsed by the hospital manager/trust board and details aims, objectives and individual responsibilities.

☐☐ **A**

10.3 This strategy is made available to all staff and close liaison with the health and safety committee is maintained.

☐☐ **B**

10.4 There is a structure in place to ensure that risks are identified, control measures prioritised and necessary action taken *(see also Health and Safety Management standard, criterion 11.18).*

☐☐ **A**

10.5 There is a standardised incident reporting system *(see also Policies and Procedures standard, criterion 8.4.2, Core Standards for Non-Clinical Services chapter, criterion 4.7.1, Core Standards for Clinical Services chapter, criterion 4.7.1).*

☐☐ **A**

10.6 Information on untoward incidents is collected, monitored and evaluated. Reports are produced on a systematic basis and issued to the relevant department/service area.

☐☐ **B**

10.7 Untoward incidents are individually investigated.

☐☐ **A**

10.8 There is a designated individual responsible for liaising with legal professionals, insurance companies and claimants and for processing claims.

☐☐ **A**

10.9 Potential categories of disaster (for example, environmental, accidental systems failure, fraud, strikes) are assessed and contingency plans drawn up if necessary *(see also Information Services standard, criterion 7.8).*

☐☐ **A**

HEALTH AND SAFETY MANAGEMENT

Standard 11

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

please tick
Yes No
☐ ☐

Criteria

Policy Development

11.1 There is a written hospital/trust-wide health and safety policy which conforms to the requirements of Section 2(3) of the Health and Safety at Work etc Act 1974, is considered in all business practice and decision making and is signed and dated by the hospital manager/chief executive.

11.2 Written departmental health and safety policies and procedures are developed and implemented and are consistent with the hospital/trust health and safety policy.

11.3 Health and safety policies are subject to continuous review.

Organisational Development

11.4 There is a qualified individual at senior management level who has overall responsibility for formulating, implementing and developing health and safety policy.

11.5 Health and safety responsibilities of line managers are clearly defined within their job descriptions.

Interpretation

* *these managers have the necessary authority and competence to carry out their duties effectively and are held accountable for their actions*

* *health and safety objectives are set and reviewed annually as part of the performance review process (see also Human Resources standard, criterion 5.24.1).*

11.6 Suitable arrangements are in place for obtaining competent safety advice.

Interpretation

* *the authority and accountability of the advisor (however named) are clearly defined and a direct reporting line to the executive management team/trust board is established.*

Comments

	☐ ☐	**A**
	☐ ☐	**A'**
	☐ ☐	**A**
	☐ ☐	**A**
	☐ ☐	**A**
	☐ ☐	**A**

HEALTH AND SAFETY MANAGEMENT

please tick
Yes No
☐☐

Comments

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

Interpretation

This:

* *meets a minimum of six times per annum*

* *includes senior management, staff and trade union representation and is consulted on the development, implementation and monitoring of the health and safety policy*

* *is actively involved in the setting and monitoring of performance standards for health and safety.*

☐☐ **A**

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

☐☐ **B**

11.9 An annual health and safety report is produced.

Interpretation

This is:

* *presented to the executive management team/trust board*

* *made available to all staff within the hospital/trust.*

☐☐ **A**

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

☐☐ **A**

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

☐☐ **A**

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

☐☐ **B**

HEALTH AND SAFETY MANAGEMENT

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No
☐☐

Comments

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

Interpretation

This:

* *includes orientation of new employees to safety practices within the hospital/trust (for example, emergency procedures, reporting procedures, work risks and precautions needed) (see also Human Resources standard, criterion 5.14)*

* *is reviewed at least annually to determine its effectiveness.*

☐☐ **A**

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

☐☐ **A**

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

☐☐ **A**

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

☐☐ **A**

Planning and Implementation

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

☐☐ **A**

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

☐☐ **A**

HEALTH AND SAFETY MANAGEMENT

please tick
Yes No
☐ ☐

Comments

Interpretation

The assessment takes into consideration the following:

* *the Control of Substances Hazardous to Health Regulations 1988*

* *the Electricity at Work Regulations 1989*

* *the Genetically Modified Organisms (Contained Use) Regulations 1992*

* *the Health and Safety (Display Screen Equipment) Regulations 1992*

* *the Manual Handling Operations Regulations 1992*

* *the Noise at Work Regulations 1989*

* *the Personal Protective Equipment at Work Regulations 1992*

* *the Pressure Systems and Transportable Gas Containers Regulations 1989*

* *the Provision and Use of Work Equipment Regulations 1992*

* *the Workplace (Health, Safety and Welfare) Regulations 1992.*

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

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

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

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

Performance Measures

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

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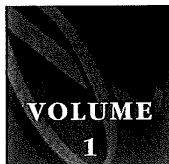
HEALTH AND SAFETY MANAGEMENT

please tick
Yes No

Comments

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

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

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

Audit and Review

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

Interpretation

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

* policy

* organisation

* planning and policy implementation

* measuring systems

* reviewing systems.

FIRE SAFETY

Standard 12

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

please tick
Yes No

Criteria

Policy Development

12.1 There is a written hospital/trust-wide fire safety policy which conforms to the requirements of the Firecode Policy and Principles document and is signed and dated by the hospital manager/chief executive.   **A**

Management Responsibilities

12.2 The chief executive/hospital manager is responsible for ensuring the implementation of Firecode guidance in all premises owned or occupied by the trust.   **A**

12.3 There is a system in place to ensure that all line managers and staff are aware of their responsibility under duty of care to comply with the guidance.   **A**

12.4 An appropriately qualified and experienced fire safety advisor is designated responsible for fire safety.   **A**

12.5 The responsibilities of the fire safety advisor are in accordance with the requirements of Firecode.   **A**

12.6 In each hospital there is a member of staff designated as the nominated officer (fire).   **A**

12.7 The responsibilities of the nominated officer (fire) are in accordance with the requirements of Firecode.   **A**

12.8 There is written evidence of the extent to which buildings comply with legislation relating to fire safety (for example, the Fire Precautions Act 1971, Firecode, Health and Safety at Work etc Act 1974, Building Regulations, EC directives and the proposed Fire Precautions (Places of Work) Regulations).   **A**

12.9 Fire standards for existing buildings conform to the requirements of HTM 85.   **A**

Comments

please tick
Yes No
☐ ☐

Comments

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

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

Interpretation

     * *this sets out the action already taken or proposed by the hospital/trust, the rationale on which it is based and the planned timetable of compliance*

     * *the timetable shows evidence of priority being given to:*

         achieving certification for the relevant parts of the estate

         recommendations which have a direct bearing on issues of patient safety

         eradication of gross fire hazards

         early compliance with recommendations that are readily achievable.

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

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

Fire Systems and Equipment

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

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

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No
☐ ☐

Comments

Interpretation

Attention is given to the following hazardous areas:

*   *designated smoking areas*

*   *engineering plant rooms/boiler rooms*

*   *electrical rooms including special systems for high voltage installations*

*   *fuel and gas storage compounds*

*   *health records storage areas*

*   *incinerators*

*   *kitchens*

*   *laboratories*

*   *laundry storage areas and linen rooms*

*   *maintenance workshops*

*   *pharmacies*

*   *refuse collection and storage areas*

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

*   *shops and other retail outlets*

*   *treatment rooms and patient bed areas where oxygen and other potentially hazardous gases are used.*

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

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

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

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

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

Evacuation

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

FIRE SAFETY

please tick
Yes No

Comments

12.22 Formal means of escape are:

   12.22.1   accessible at all times   **A**

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

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

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

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

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

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

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

Training

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

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

12.30 When drills and exercises are carried out:

   12.30.1   they are evaluated   **B**

   12.30.2   a written report is produced   **B**

   12.30.3   staff attendance is documented.   **B**

12.31 All staff are:

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

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

please tick
Yes No
☐☐

Comments

12.31.3   trained to evacuate patients (where appropriate).   ☐☐ **A**

Policies

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

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

Interpretation

* *there is a policy in place to ensure that all textiles and furniture not complying with HTM 87 are programmed for replacement*

* *all items donated or purchased with donations from voluntary organisations meet the requirements of HTM 87.*

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

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

VOLUME 1

MANAGEMENT OF WASTE

Standard 13

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

please tick
Yes No

Criteria

Comments

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

☐ ☐ **A**

Interpretation

Policies and procedures include:

* *segregating general and contaminated waste at the sight of generation (including colour coding and labelling the place and the date of origin)*

* *disposing of sharp objects in suitable containers*

* *dealing with needlestick injuries*

* *labelling and disposing of cytotoxic and radioactive waste*

* *safe handling of contaminated waste including the use of approved contaminated waste bags, protective clothing, and appropriate storage facility prior to incineration or removal from the site*

* *disposing of special waste (for example, prescription returns).*

(See also Infection Control standard, criterion 14.10.)

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

☐ ☐ **A**

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

☐ ☐ **A**

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

☐ ☐ **A**

13.5 Hospital owned vehicles used to transport waste are cleaned:

13.5.1   at least weekly

☐ ☐ **A**

13.5.2   when leakage or spillage has occurred.

☐ ☐ **A**

please tick
Yes No

Comments

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

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

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

INFECTION CONTROL

Standard 14

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

please tick
Yes No

Criteria

Comments

Structure and Responsibilities

14.1 The hospital manager/chief executive is responsible for establishing and maintaining infection control arrangements across the hospital/trust.

A

14.2 There is an infection control team which comprises an infection control doctor, an infection control nurse and, if the infection control doctor is from another specialty, a consultant medical microbiologist.

A

14.3 The infection control doctor is responsible to the hospital manager/chief executive for the provision of infection control advice and the formulation and promulgation of infection control policy.

A

14.4 The infection control doctor has direct access to the hospital manager/chief executive.

B

14.5 There is evidence that the number of infection control nurses is appropriate to the number of beds, the number of hospitals and area over which they are covered and the patient case mix.

B

14.6 The responsibilities of the infection control team include:

14.6.1 dealing with incidents or outbreaks of infection

A

14.6.2 developing infection control policies and procedures

A

14.6.3 educating staff

A

14.6.4 organising 24 hour emergency cover

A

14.6.5 establishing action groups during significant outbreaks

A

14.6.6 liaising with the Consultant in Communicable Disease Control (CCDC)

A

14.6.7 carrying out surveillance and audit of hospital acquired infection

A

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INFECTION CONTROL

please tick
Yes No

Comments

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

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

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

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

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

Interpretation

The committee:

    *   *reviews the annual infection control programme*

    *   *reviews recent outbreaks*

    *   *reviews all procedures in relation to infection control*

    *   *discusses specific areas of concern from the infection control team*

    *   *agrees guidelines for the surveillance of infections and infection potential*

    *   *reviews anonymised results of infection control audits.*

14.8 The committee membership consists of:

14.8.1   the infection control team   **A**

14.8.2   the CCDC   **B**

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

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

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please tick
Yes No
☐☐

Comments

14.9 The committee meets regularly (as a minimum twice a year) and meetings are minuted. ☐☐ **B**

Policies and Procedures

14.10 There are written infection control policies. ☐☐ **A**

Interpretation

These cover:

* clinical procedures (medical, surgical, nursing and paramedical)

* the disposal of waste (see also Management of Waste standard, criteria 13.1, 13.2)

* outbreaks

* high risk patients (for example, immunosuppressed) and communicable diseases

* sterilisation and disinfection

* engineering and building services

* hotel services (housekeeping, laundry/linen and catering) (see also Housekeeping Service chapter, criterion 1.4)

* mortuary and last office guidance.

14.11 These policies and procedures are:

14.11.1 subject to a systematic review ☐☐ **B**

14.11.2 dated ☐☐ **B**

14.11.3 referenced to appropriate legislation or published professional guidance ☐☐ **B**

14.11.4 contained within a manual. ☐☐ **B**

14.12 The infection control manual is distributed to each ward and department (relevant policies only) (see also Core Standards for Non-Clinical Services chapter, criterion 4.7.8 and Core Standards for Clinical Services chapter, criterion 4.7.11). ☐☐ **A**

14.13 Policies and procedures are reviewed through regular infection control audits. ☐☐ **B**

Education

14.14 There is an on-going, coordinated programme of education for all staff within the hospital/trust. ☐☐ **A**

14.15 Courses are tailored to meet the needs of individual groups of staff. ☐☐ **B**

please tick
Yes No
☐☐

Comments

14.16 The infection control team is involved in:

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

14.16.2 junior doctors orientation and induction programme ☐☐ **B**

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

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

Communication

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

14.18.1 the CCDC

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

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

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

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

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

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

Isolation

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

Surveillance

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

Outbreaks

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

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

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INFECTION CONTROL

please tick
Yes No
☐☐

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

Comments

☐☐ **B**

OCCUPATIONAL HEALTH

Standard 15

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

please tick
Yes No
[ ] [ ]

Criteria

15.1 Staff have access to an occupational health service which is confidential to those using it.

Where the service is provided internally:

Operational Policy

15.2 There is an operational policy for the service.

Interpretation

* *the operational policy details:*

  aims

  functions

  organisation

  reporting lines to senior management

* *the operational policy is developed by occupational health staff in liaison with employer and worker representatives*

* *the operational policy is endorsed by the executive management team/trust board*

* *the operational policy is reviewed systematically.*

Functions

15.3 There are policies on health assessment.

Interpretation

These include:

* *pre-placement assessment*

* *health screening and surveillance*

* *immunisation against, for example, rubella, tuberculosis, hepatitis B*

* *post-sickness absence*

* *referrals to the occupational health department*

* *communicating results of assessment to the referrer.*

Comments

[ ] [ ] **A**

[ ] [ ] **A**

[ ] [ ] **A**

OCCUPATIONAL HEALTH

please tick
Yes No
☐☐

Comments

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

☐☐ **A**

Interpretation

Examples include:

* *gluteraldehyde plus other respiratory sensitisers*

* *noise*

* *display screen units*

* *employees with high levels of sickness absence*

* *employees sustaining certain work accidents or health related problems*

* *exposure to chemicals identified in COSHH assessments.*

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

☐☐ **A**

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

☐☐ **B**

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

☐☐ **B**

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

☐☐ **B**

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

☐☐ **B**

Interpretation

Data systems include:

* *attendance records*

* *clinical information such as immunisation details and surveillance results*

* *environmental reports*

* *ill-health retirement.*

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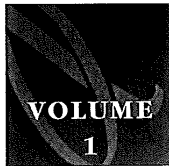
☐☐ **B**

OCCUPATIONAL HEALTH

please tick
Yes No
☐☐

Comments

Interpretation

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

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

Internal and External Communication

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

Interpretation

The departments/personnel include:

* *health and safety officer (however named)*

* *infection control (see also Infection Control standard, criterion 14.8.4)*

* *occupational hygiene*

* *pathology service (see also Pathology Service chapter, criterion 2.2)*

* *radiation protection*

* *human resources.*

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

15.14 The service is represented on the following committees:

15.14.1 health and safety ☐☐ **A**

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

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

Staffing

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

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

OCCUPATIONAL HEALTH

please tick
Yes No

Comments

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

Records

15.19 Occupational health records are maintained by the service. — **A**

Interpretation

These include:

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

    *   *a confidential clinical record.*

15.20 Occupational health records are stored securely. — **A**

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

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

15.23 Sufficient storage space for occupational records is available. — **B**

Facilities

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

QUALITY IMPROVEMENT

Standard 16

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

please tick
Yes No

Criteria

16.1 There is a designated individual at board level responsible for the quality improvement strategy of the hospital/trust.

16.1 There is a written quality improvement strategy for the hospital/trust.

Interpretation

The quality improvement strategy details:

    *   *definition of quality applied*

    *   *objectives of the programme*

    *   *methods to achieve these objectives*

    *   *implementation timetable*

    *   *management responsibility for, and the organisational structure to support, the commitment to quality management*

    *   *a mechanism for providing the necessary resources to support the quality management and evaluation activities.*

16.3 Quality management and evaluation activities include:

16.3.1   the development of locally based standards which are consistent with the content of national charters and (where applicable) Health of the Nation

16.3.2   clinical audit (uniprofessional and multidisciplinary)

      Interpretation

        *   *clinical audit meetings and other peer review activities are supported by the hospital manager/chief executive as part of the quality improvement strategy*

        *   *clinical audit meetings are undertaken regularly and outcomes recorded*

Comments

A

A

B

B

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick

Yes No

Comments

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

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

Interpretation

The routine and systematic review of quality indicators may include:

   *   *cancelled operations*

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

   *   *drug errors*

   *   *incidence of hospital acquired infections*

   *   *patients not arriving for admission/treatment*

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

      avoidable complications

      unexpected death

      untoward occurrences

   *   *staff grievances*

   *   *staff sickness*

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

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

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

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

CORE STANDARDS FOR NON-CLINICAL SERVICES

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

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

A **Essential Practice**

If these are not in place then:

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

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

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

B **Good Practice**

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

C **Desirable Practice**

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

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

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

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

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

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

AIMS AND OBJECTIVES

Standard 1

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

please tick
Yes No

Criteria

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

Interpretation

*When developing aims the following are taken
into consideration:*

* *providing a service based on
professional standards set by the
relevant professional organisation*

* *ensuring patient and staff safety*

* *maintaining and improving a high
standard of service through audit
activities (monitoring, assessing,
taking action, reviewing, feeding
back)*

* *maintaining communication with
other members of the healthcare team
to:*

   meet the needs of the patient

   meet the needs of staff

   coordinate services

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

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

Interpretation

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

* *being courteous and considerate to
patients, carers and staff at all times*

* *respecting the privacy, dignity and
rights of patients, carers and staff*

* *respecting and responding to cultural
differences*

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

Comments

B

B

AIMS AND OBJECTIVES

please tick
Yes No

Comments

1.3 The philosophy statement is:

  1.3.1   developed and endorsed by staff   **B**

  1.3.2   clearly displayed within the department/service area.   **B**

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

1.5 The objectives are:

  1.5.1   developed and endorsed by staff   **B**

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

  1.5.3   reviewed when:

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

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

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

       (d) significant feedback from users is received.   **B**

MANAGEMENT AND STAFFING

Standard 2

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

please tick
Yes No

Criteria

Management Arrangements

2.1 The responsibilities of the head of each service include:

2.1.1 management arrangements — **B**

2.1.2 budgetary accountability — **B**

2.1.3 business planning development *(see also Corporate Management chapter, Mission and Objectives standard, criterion 1.6)* — **B**

2.1.4 development and delivery of contracts/internal service agreements *(see also Corporate Management chapter, Contract Services standard, criterion 2.2)* — **B**

2.1.5 development and training of staff — **B**

2.1.6 involvement in the appointment and deployment of staff — **B**

2.1.7 involvement in grievance and disciplinary procedures — **B**

2.1.8 involvement in the preparation and setting of the budget *(see also Corporate Management chapter, Financial Resources standard, criterion 6.3)* — **B**

2.1.9 liaising with other services — **B**

2.1.10 skill-mix reviews — **B**

2.1.11 staff appraisal. — **B**

2.2 There is a designated individual to take responsibility for the service in the absence of the manager. — **B**

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

2.4 The organisational structure is revised:

2.4.1 annually — **B**

2.4.2 when staffing changes take place — **B**

2.4.3 when the service is restructured. — **B**

Comments

MANAGEMENT AND STAFFING

please tick
Yes No
☐☐

Comments

Finance and Information

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

2.6 Income and expenditure reports are:

2.6.1   timely ☐☐ **B**

2.6.2   accurate ☐☐ **B**

2.6.3   clear. ☐☐ **B**

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

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

2.8 Records and statistics are available on:

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

2.8.2   staff sickness ☐☐ **B**

2.8.3   staff turnover ☐☐ **B**

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

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

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

Communication

2.10 Regular service meetings are held to:

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

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

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

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

MANAGEMENT AND STAFFING

please tick
Yes No

Comments

Health and Safety

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

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

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

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

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

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

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

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

2.20 All staff attend annual fire lectures. **A**

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

Human Resources

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

Interpretation

* job descriptions are reviewed:

annually

on vacation of the post

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

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

Interpretation

The staff appraisal system:

* is based on the job description and work objectives

MANAGEMENT AND STAFFING

please tick
Yes No
☐☐

Comments

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

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

☐☐ **A**
☐☐ **B**

2.25 Access to personnel advice is available.

Staffing

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

☐☐ **A**

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

☐☐ **C**

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

☐☐ **A**

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

☐☐ **A**

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

2.30.1 COSHH assessment

☐☐ **A**

2.30.2 first aid

☐☐ **A**

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

☐☐ **A**

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

☐☐ **A**

STAFF DEVELOPMENT AND EDUCATION

Standard 3

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

please tick
Yes No

Criteria   *Comments*

Orientation and Induction

3.1 All staff receive induction at a corporate level on the following areas:

3.1.1   fire   ☐ ☐ **A**

3.1.2   health and safety   ☐ ☐ **A**

3.1.3   patient confidentiality   ☐ ☐ **A**

3.1.4   accident and/or untoward incident reporting   ☐ ☐ **A**

3.1.5   security   ☐ ☐ **A**

3.1.6   pay arrangements.   ☐ ☐ **C**

(See also Corporate Management chapter, Human Resources standard, criterion 5.14.)

3.2 The head of the service is responsible for ensuring that a record of attendance at the hospital/trust orientation and induction programme is maintained, signed and dated.   ☐ ☐ **B**

3.3 All staff appointed are subject to local orientation and induction arrangements.   ☐ ☐ **A**

3.4 As a minimum the local arrangements:

3.4.1   prepare staff for their role and responsibilities   ☐ ☐ **A**

3.4.2   introduce staff to the policies and procedures of the service and the hospital/trust   ☐ ☐ **A**

3.4.3   explain emergency procedures (for example, fire)   ☐ ☐ **A**

3.4.4   introduce staff to the hospital/trust health and safety policy and current health and safety legislation, explain its impact on the service and highlight the responsibilities of the employee to their employer *(see also Corporate Management chapter, Health and Safety Management standard criterion 11.14)*   ☐ ☐ **A**

3.5 Local orientation and induction arrangements are documented.   ☐ ☐ **B**

STAFF DEVELOPMENT AND EDUCATION

please tick
Yes No

Comments

Continuing Education

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

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

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

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

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

3.9.2 information on advances in practice **B**

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

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

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

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

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

POLICIES AND PROCEDURES

Standard 4

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

please tick
Yes No

Criteria

Service Policies

Comments

4.1 Service policies and procedures are consistent with national or local guidelines. **A**

4.2 Where necessary, service policies and procedures are developed in consultation with representatives from other relevant professions (for example, infection control). **A**

4.3 Staff are involved in the development of service policies and procedures. **B**

4.4 Service policies and procedures are:

4.4.1 reviewed and systematically updated **B**

4.4.2 accessible within the department/service area **B**

4.4.3 contained within a manual. **B**

4.5 There is a system in place for informing staff when changes to policies and procedures occur. **A**

Hospital/Trust Policies

4.6 Senior staff are involved in the development of hospital/trust policies and procedures where these impact on their service. **B**

4.7 Staff have access to hospital/trust policies and procedures, which include as a minimum:

4.7.1 accidents, errors and incidents **A**

4.7.2 all relevant personnel policies (for example, grievance, disciplinary) **A**

4.7.3 complaints from patients, carers and staff **A**

4.7.4 COSHH **A**

4.7.5 emergency/evacuation procedures **A**

4.7.6 fire **A**

4.7.7 health and safety **A**

4.7.8 infection control **A**

4.7.9 management of waste. **A**

POLICIES AND PROCEDURES

please tick
Yes No
☐☐

Comments

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

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

☐☐ **A**

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

☐☐ **A**

FACILITIES AND EQUIPMENT

Standard 5

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

please tick
Yes No
☐☐

Criteria   *Comments*

General Facilities

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

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

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

Staff Facilities

5.4 Access to the following staff facilities is available:

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

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

5.4.3   a rest room   ☐☐ **B**

5.4.4   wash and changing rooms.   ☐☐ **B**

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

Equipment

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

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

5.8 Where necessary, the following are provided:

5.8.1   lifting aids   ☐☐ **A**

5.8.2   personal protective equipment.   ☐☐ **A**

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

FACILITIES AND EQUIPMENT

please tick
Yes No
☐☐

Comments

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

☐☐ **B**

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

☐☐ **A**

QUALITY MANAGEMENT AND EVALUATION

Standard 6

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

please tick
Yes No

Criteria

Comments

6.1 There is a written quality management and evaluation programme for the service (this may form part of business planning documentation). **B**

Interpretation

The quality management programme details:

    *   *objectives of the programme*

    *   *methods to achieve the objectives*

    *   *implementation timetable.*

6.2 The quality management and evaluation programme includes:

    6.2.1   the development of local standards consistent with national charters and purchaser contract requirements **B**

    6.2.2   the assessment of patient/visitor satisfaction **B**

    6.2.3   the use of resources (for example, type of stock, amount, facilities) **B**

    6.2.4   the assessment of service user satisfaction (including staff) **B**

    6.2.5   the assessment of the service against organisational standards **B**

    6.2.6   the systematic review of quality indicators on a service-wide basis **B**

    6.2.7   the training of staff in the development, implementation and review of quality activities. **B**

(See also Corporate Management chapter, Quality Improvement standard, criterion 16.3.)

6.3 Evaluation activities include the following elements:

    6.3.1   monitoring: the routine collection of information/statistics about important aspects of service delivery **B**

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

QUALITY MANAGEMENT AND EVALUATION

please tick
Yes No

Comments

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

6.3.4   review: the effectiveness of action
         taken is evaluated to ensure long-
         term improvements   **B**

6.3.5   feedback: the results of activities are
         regularly communicated to staff.   **B**

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CATERING SERVICE

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

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

A **Essential Practice**

If these are not in place then:

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

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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

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

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

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

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

MANAGEMENT AND STAFFING

Core Standard 2

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

please tick
Yes No

In addition to the core standard criteria:

Comments

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

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

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

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

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

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

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

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

2.5.1　administrative and clerical staff   **B**

2.5.2　portering staff.   **B**

STAFF DEVELOPMENT AND EDUCATION

Core Standard 3

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

please tick
Yes No

In addition to the core standard criteria:

Comments

3.1 All staff, including trainees and agency staff, receive:

3.1.1   training in food handling   **A**

3.1.2   training in hygiene practices.   **A**

3.2 There is a system in place to ensure that all training (initial, refresher and updates):

3.2.1   takes place on a systematic basis   **A**

3.2.2   is recorded.   **A**

POLICIES AND PROCEDURES

Core Standard 4

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

please tick
Yes No
☐ ☐

In addition to the core standard criteria:

Comments

4.1 Service policies and procedures:

4.1.1   reflect the requirements of the Food Safety Act 1990   ☐ ☐ **A**

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

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

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

Interpretation

These cover:

*   *the selection of raw ingredients*

*   *the selection of suppliers*

*   *the carriage of foodstuffs in internal and external delivery vehicles*

*   *checking the quality and quantity of food supplies on arrival and at regular intervals thereafter*

*   *ensuring that the temperature is appropriate to food being stored and complies with current legislation*

*   *ensuring that foods which may contaminate each other are stored separately (for example, cooked and uncooked meats, washed and unwashed salad, Kosher and Halal meals)*

*   *keeping storage facilities clean, hygienic and odour free*

*   *ensuring that the storage of food in dry storage, refrigerators and freezers complies with food hygiene regulations*

*   *rotating stock under the first in, first out system*

POLICIES AND PROCEDURES

please tick
Yes No

Comments

* *preparing and handling food in accordance with food hygiene regulations*

* *minimising the holding times of prepared foods to preserve nutritional value and food acceptability*

* *disposing of waste safely*

* *the care and cleaning of all areas and equipment*

* *machine washing and washing dishes by hand (including refernce to scraping and pre-soaking, water temperature, rinsing and sanitising and quick drying of items)*

* *the safe serving of meals to infectious patients and patients who are immunocompromised*

* *the collection and clearing of trays and dishes after the meal which ensure noise is minimised for patients.*

4.3 There are procedures for:

4.3.1 health screening food handlers prior to appointment **A**

4.3.2 food handlers to report if they are suffering from certain infections and action to be taken **A**

4.3.3 the training of supervisors and food handlers. **A**

4.4 The bulk preparation of food for long-term holding (for example, chilling or freezing) is carried out only if equipment and qualified staff are available to establish and supervise standards of handling, preparation and processing. **A**

4.5 Menus are planned, in discussion with the dietetic service, to provide meals which meet the needs of patients and staff *(see also Dietetic Service chapter, criterion 2.4)*. **B**

Interpretation

Attention is drawn to the following:

* *attractive presentation of food*

* *a flexible menu ordering system*

* *portion size*

POLICIES AND PROCEDURES

please tick
Yes No

Comments

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

4.6 There are documented polices for:

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

4.6.2   fire   **A**

4.6.3   safety.   **A**

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

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

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

FACILITIES AND EQUIPMENT

Core Standard 5

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

please tick
Yes No
☐ ☐

In addition to the core standard criteria:

Comments

5.1 Food premises are registered with the local authority.

☐ ☐ **A**

5.2 There are separate areas within the department for the following:

☐ ☐ **A**

   5.2.1   handwashing

   5.2.2   food delivery (receiving area) including facilities for checking the quality and the quantity of the food received and enabling food to be transferred rapidly to the appropriate storage area

☐ ☐ **A**

   5.2.3   food storage

☐ ☐ **A**

   5.2.4   food preparation (including an area to prepare therapeutic diets, special diets, infant feeds and parenteral and supplementary feeding)

   5.2.5   cooking and reheating/regeneration

☐ ☐ **A**

   5.2.6   holding prepared food

☐ ☐ **A**

   5.2.7   washing dishes

☐ ☐ **A**

   5.2.8   equipment storage

☐ ☐ **B**

   5.2.9   waste disposal.

☐ ☐ **B**

5.3 The layout of the department is designed to allow an efficient and hygienic flow of work.

☐ ☐ **A**

☐ ☐ **B**

5.4 Facilities comply with the requirements of relevant building regulations and statutory requirements.

☐ ☐ **A**

Interpretation

Attention is drawn to the following:

    *   *the cleaning of floors, walls and ceilings and the maintenance of sanitary conditions in all food rooms*

    *   *satisfactory lighting for working conditions and monitoring standards of cleanliness*

FACILITIES AND EQUIPMENT

please tick
Yes No

Comments

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

* fire safety requirements

* health and safety regulations.

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

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

Interpretation

Particular attention is given to:

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

* electrical, gas and pressure equipment

* fish fryers.

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

QUALITY MANAGEMENT AND EVALUATION

Core Standard 6

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

please tick
Yes No

In addition to the core standard criteria:

Comments

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

B

Interpretation

The quality indicators may include the following:

　　　*　special diets*

　　　*　unit cost*

　　　*　waste.*

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

B

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

B

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

A

VOLUME 1

ESTATES MANAGEMENT

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A **Essential Practice**

If these are not in place then:

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

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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

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VOLUME 1

Standard

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

please tick
Yes No
☐ ☐

Criteria

(Reference should also be made to the Facilities and Equipment standard within the Corporate Management chapter.)

Plans and Policies

1.1 There is an estates operational plan in line with the guidance detailed in ESTATECODE which is reviewed and updated at least annually.   ☐ ☐ **A**

1.2 Where maintenance backlog exists, necessary work is identified, costed and prioritised and a programme for elimination drawn up in accordance with the hospital s/trust s development control plan.   ☐ ☐ **A**

1.3 An up-to-date asset register is maintained which is an integral part of the hospital s/trust s management information system.   ☐ ☐ **A**

1.4 The asset register is readily available.   ☐ ☐ **B**

1.5 There is an asset management strategy which is based on investment appraisal techniques and life cycle costing.   ☐ ☐ **B**

1.6 Up-to-date drawings are maintained which detail:

1.6.1   fire zones and escape routes   ☐ ☐ **A**

1.6.2   hospital floor plans   ☐ ☐ **B**

1.6.3   internal routeing and location of building services   ☐ ☐ **B**

1.6.4   roads and traffic direction   ☐ ☐ **B**

1.6.5   site distribution of services and utilities   ☐ ☐ **B**

1.6.6   site layout.   ☐ ☐ **B**

1.7 A fully operational building management system is installed.   ☐ ☐ **B**

1.8 There is a comprehensive maintenance and replacement programme in place in line with the recommendations of ESTATECODE *(see also Core Standards for Clinical Services chapter, criterion 5.15)*.   ☐ ☐ **A**

Comments

please tick
Yes No
☐ ☐

Comments

Interpretation

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

* *building fabric*

* *equipment*

* *footpaths, roadways and external lighting*

* *plant.*

1.9 The maintenance programme includes:

1.9.1 redecorating ☐☐ **B**

1.9.2 upgrading. ☐☐ **B**

1.10 A procedure is in place for reporting defects inside and outside working hours. ☐☐ **B**

1.11 Safe hot water and heating surface temperatures are maintained and monitored. ☐☐ **A**

1.12 There is a system in place for the management of electrical safety which, in addition to the Electricity at Work Regulations 1989, takes into account HTM 2011, HTM 2014, HTM 2020 and HTM 2021. ☐☐ **A**

1.13 Lighting complies with CIBSE Lighting Guide No 2. Hospitals and Healthcare Buildings. 1989. ☐☐ **A**

1.14 The following are in place:

1.14.1 an environmental policy which covers emissions to air, land and water and takes into consideration the general environmental conditions set out in BS7750 ☐☐ **A**

1.14.2 preventative measures against the growth of *Legionella pneumophila* in service plant ☐☐ **A**

1.14.3 a waste management policy which covers the duty of care responsibilities for all waste production (household, clinical and special) *(see also Corporate Management chapter, Management of Waste standard, criterion 13.2)* ☐☐ **A**

1.14.4 an energy policy which sets targets for consumption reductions and ensures optimum procurement prices ☐☐ **B**

please tick
Yes No

Comments

1.14.5   a disposal of surplus land and buildings policy   **B**

1.14.6   a procurement policy which deals with waste minimisation   **C**

1.14.7   a building management system and maintenance programme linked through the use of a computer based asset management and accounting system.   **C**

Operational Requirements

1.15 A project manager is appointed for all capital projects.   **B**

1.16 A cost control system is in place for all capital schemes.   **B**

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

1.17.1   alarm systems   **A**

1.17.2   emergency systems (for example, crash , fire)   **A**

1.17.3   internal and external staff paging   **A**

1.17.4   internal routes (for example, walkways, stairways)   **A**

1.17.5   nurse call systems   **A**

1.17.6   telephones with direct lines for certain services (for example, admissions)   **A**

1.17.7   vertical transportation (for example, lifts, escalators, paternosters, dumb waiters, air tube systems)   **A**

1.17.8   facsimile machines.   **B**

1.18 Natural and mechanical ventilation systems are installed.   **A**

Interpretation

These:

   *   ensure that airborne infections are controlled where appropriate*

   *   meet service needs*

   *   remove dangerous gases.*

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

please tick
Yes No
☐ ☐

Comments

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

☐ ☐ **A**

Interpretation

These include at least the following:

    *   *blood refrigerators, frozen food stores*

    *   *boiler plant*

    *   *electrical systems*

    *   *medical gases*

    *   *water storage.*

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

☐ ☐ **A**

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

☐ ☐ **A**

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

1.22.1   minor adaptations response times

☐ ☐ **C**

1.22.2   routine repair work response times.

☐ ☐ **C**

HEALTH RECORD SERVICE

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A **Essential Practice**

If these are not in place then:

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

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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MANAGEMENT AND STAFFING

Core Standard 2

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

please tick
Yes No
☐ ☐

In addition to the core standard criteria:

Comments

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

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

Interpretation

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

* the health record committee:

  meets regularly

  keeps minutes

  reports regularly to the executive management team/trust board

  has members who attend a majority of meetings

  reviews its membership at an agreed interval

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

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

  introducing new record forms or introducing alterations to existing forms

  agreeing policies and procedures for the health record service
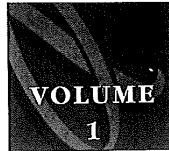
please tick
Yes No

Comments

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

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

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

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

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

A

Interpretation

The type of information collected includes the
following:

* births and deaths

* complications

* diagnoses/conditions

* length of stay

* number of admissions and discharges

* procedures performed

* re-admissions.

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

B

Interpretation

Involvement includes:

* compiling requested patient care
statistical data for utilisation review
and clinical audit (uniprofessional
and multidisciplinary) programmes

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

* reviewing health records to determine
compliance with established
standards

MANAGEMENT AND STAFFING

please tick
Yes No

Comments

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

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

2.5.1 administrative and clerical staff

2.5.2 portering staff.

B

B

Core Standard 4

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

please tick
Yes No

In addition to the core standard criteria:

Comments

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

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

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

4.4 There are documented policies for the following:

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

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

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

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

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

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

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

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

FACILITIES AND EQUIPMENT

Core Standard 5

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

please tick
Yes No
□ □

In addition to the core standard criteria:

Comments

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

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

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

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

5.5 The active and inactive records are:

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

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

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

QUALITY MANAGEMENT AND EVALUATION

Core Standard 6

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

please tick
Yes No
☐☐

In addition to the core standard criteria:

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

☐ ☐ **B**

Interpretation

The quality indicators may include the following:

* missing notes

* time taken to retrieve notes.

Comments

HOUSEKEEPING SERVICE

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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Standard

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

please tick
Yes No
☐ ☐

Criteria

Comments

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

1.1.1 disposal of waste *(see also Corporate Management chapter, Management of Waste standard, criteria 13.1, 13.7)*   ☐ ☐ **A**

1.1.2 food handling (if involved in the serving of drinks, meals)   ☐ ☐ **A**

1.1.3 safety measures in hazardous areas such as the sterile services department, kitchens, workshops, laundry, laboratories and radiology areas   ☐ ☐ **A**

1.1.4 the control of infection and the role of the employee in this control (for example, type and storage of mop heads).   ☐ ☐ **A**

1.2 Staff who are assigned tasks in specialist areas such as the operating theatres, labour suite, accident and emergency departments, special care units and isolation rooms receive additional training in the execution of procedures unique to these departments *(see also Special Care Service chapter, criterion 2.11).*   ☐ ☐ **A**

1.3 There are documented policies and procedures for the following:

1.3.1 health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)*   ☐ ☐ **A**

1.3.2 health screening   ☐ ☐ **B**

1.3.3 stock control.   ☐ ☐ **B**

1.4 Policies and procedures for housekeeping reflect the hospital/trust control of infection policy and include:

1.4.1 cleaning of specialised areas (for example, laboratories, mortuaries, operating theatres, special care units)   ☐ ☐ **A**

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No
☐☐

Comments

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

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

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

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

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

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

1.6 Domestic storage areas are kept uncluttered.

LAUNDRY AND LINEN SERVICES

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B **Good Practice**

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

C **Desirable Practice**

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Standard

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

please tick
Yes No
☐ ☐

Criteria

Comments

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

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

1.1.2   safety measures to be employed.   ☐ ☐ **A**

1.2 There are documented policies for the following:

1.2.1   health and safety *(see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2)*   ☐ ☐ **A**

1.2.2   handling and storage of linen   ☐ ☐ **A**

1.2.3   health screening.   ☐ ☐ **B**

1.3 Linen is available to the following on a daily basis:

1.3.1   wards and departments   ☐ ☐ **A**

1.3.2   on-call rooms *(see also Medical Service chapter, criterion 5.5)*.   ☐ ☐ **A**

1.4 The amount of clean linen supplied is based on calculated need.   ☐ ☐ **B**

1.5 There is a system in place for supplying clean linen out of hours and in emergencies *(see also Accident and Emergency Service chapter, criterion 2.10.5)*.   ☐ ☐ **A**

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

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

1.8 Clean linen is handled and stored in such a way as to:

1.8.1   avoid undue reabsorption of moisture   ☐ ☐ **A**

1.8.2   avoid contamination from surface contact or airborne deposition.   ☐ ☐ **A**

1.9 Stocks are rotated on a first-in, first-out basis.   ☐ ☐ **B**

1.10 A linen inventory is kept.   ☐ ☐ **B**

1.11 There are written procedures for handling linen.   ☐ ☐ **A**

please tick
Yes No

Comments

Interpretation

These include:

*   *physical appearance and condition of linen*

*   *processing techniques*

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

1.12   Soiled linen is collected to avoid spread of infection and is placed in bags or containers at the site of contamination (for example, by the bedside at the time of changing).   **A**

1.13   Clean linen and soiled linen are transported and stored separately.   **A**

1.14   The following are cleaned on a systematic basis:

    1.14.1   containers transporting soiled linen bags   **A**

    1.14.2   storage areas for soiled linen.   **A**

1.15   Infectious linen is clearly identified and suitable precautions are taken in its processing.   **A**

1.16   In-house laundering facilities are separated from:

    1.16.1   the clean linen processing area   **A**

    1.16.2   patient rooms   **A**

    1.16.3   areas of food preparation and storage   **A**

    1.16.4   areas in which clean material and equipment are stored.   **A**

1.17   The laundry area is planned and equipped to prevent the dissemination of contaminants.   **A**

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

1.19   Surfaces and overhead areas in the laundry are cleaned on a systematic basis.   **A**

1.20   To minimise the risk of cross-infection:

    1.20.1   handwashing facilities are readily available   **A**

    1.20.2   staff working with infectious linen change into clean uniforms at the start of each shift or working day.   **A**

please tick
Yes No
☐ ☐

Comments

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

    1.21.1   smoke

    1.21.2   eat.

☐ ☐ **A**
☐ ☐ **B**

LIBRARY SERVICE

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B **Good Practice**

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C **Desirable Practice**

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Activities for the library service may include:

* providing an enquiry and information service

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

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

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

* providing a cataloguing, classification and index system

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

MANAGEMENT AND STAFFING

Core Standard 2

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

please tick
Yes No

In addition to the core standard criteria:	Comments	Yes	No	
2.1 There is a mechanism for consultation with all categories of user (this may be through a library committee).				**B**
2.2 The library opening hours meet the requirements of users *(see also Core Standards for Clinical Services chapter, criterion 3.13).*				**B**
2.3 The service is supported by administrative and clerical staff.				**B**

STAFF DEVELOPMENT AND EDUCATION

Core Standard 3

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

please tick
Yes No
☐☐

In addition to the core standard criteria:

Comments

3.1 Professional librarians are encouraged to participate in continuing professional development (for example, the Library Association s Framework for Continuing Professional Development (CPD)).

☐☐ **B**

3.2 Library assistants are encouraged to acquire appropriate technical qualifications (for example, the City and Guilds certificate) and/or to qualify professionally.

☐☐ **B**

VOLUME 1

POLICIES AND PROCEDURES

Core Standard 4

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

please tick
Yes No
☐☐

In addition to the core standard criteria:

Comments

4.1 There are documented policies and procedures for the following:

4.1.1   patients requesting access to the library   ☐☐ **B**

4.1.2   stock selection   ☐☐ **B**

4.1.3   stock acquisition   ☐☐ **B**

4.1.4   stock withdrawal   ☐☐ **B**

4.1.5   relationships with other information providers within the hospital, trust, district or region   ☐☐ **B**

4.1.6   relationships with other libraries.   ☐☐ **B**

4.2 Library staff are aware of:

4.2.1   copyright law   ☐☐ **A**

4.2.2   the Data Protection Act 1984.   ☐☐ **A**

FACILITIES AND EQUIPMENT

Core Standard 5

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

please tick
Yes No
☐☐

In addition to the core standard criteria: **Comments**

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

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

5.3 There are areas within the library for: ☐☐ **B**

5.3.1   reading current periodicals   ☐☐ **B**

5.3.2   reference and literature searching   ☐☐ **B**

5.3.3   research and private study

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

5.4 The library s collections are:

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

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

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

5.6 The library facilities include: ☐☐ **B**

5.6.1   computers

Interpretation

Computer based services include:

*   *databases and other locally held information*

*   *on-line information retrieval*

*   *computer aided learning programmes*

5.6.2   photocopiers   ☐☐ **B**

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

5.6.4   access to a seminar room   ☐☐ **C**

FACILITIES AND EQUIPMENT

please tick
Yes No

Comments

5.6.5   microform reading

5.6.6   a facsimile machine.

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

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

C

C

B

C

QUALITY MANAGEMENT AND EVALUATION

Core Standard 6

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

please tick
Yes No
☐☐

In addition to the core standard criteria:

Comments

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

☐☐ **B**

Interpretation

The review looks at:

*   *accuracy*

*   *relevance*

*   *timeliness*

*   *long-term significance.*

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

☐☐ **B**

Interpretation

This includes:

*   *numbers of enquiries received*

*   *numbers of interlibrary loans (outgoing and incoming)*

*   *numbers of photocopied book/report extracts and journal articles made by library staff.*

PORTERING SERVICE

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

A **Essential Practice**

If these are not in place then:

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

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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

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Standard

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

please tick
Yes No
[ ][ ]

Criteria

Comments

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

1.1.1 control of infection and the role of the employee in this control (for example, portering of specimens) [ ][ ] **A**

1.1.2 dealing with clinical waste (see also Corporate Management chapter, Management of Waste standard, criteria 13.1, 13.7) [ ][ ] **A**

1.1.3 food handling (for staff involved in the handling of food) [ ][ ] **A**

1.1.4 moving and handling of patients, equipment or other heavy loads [ ][ ] **A**

1.1.5 safety measures in hazardous areas such as the central sterilising service, kitchens, workshops, laundry, laboratories and radiology areas [ ][ ] **A**

1.1.6 handling physical and verbal violence. [ ][ ] **B**

1.2 Staff who are assigned tasks in specialist areas receive additional training in the execution of procedures unique to these departments. [ ][ ] **A**

1.3 There are documented policies for the following:

1.3.1 health and safety (see also Corporate Management chapter, Health and Safety Management standard, criterion 11.2) [ ][ ] **A**

1.3.2 the moving and handling of patients, equipment or other heavy loads [ ][ ] **A**

1.3.3 transporting of specimens (see also Pathology Service chapter, criterion 4.3) [ ][ ] **A**

1.3.4 storage of medical gas cylinders [ ][ ] **A**

1.3.5 changing of nitrous oxide cylinders [ ][ ] **A**

1.3.6 handling physical and verbal violence [ ][ ] **B**

please tick
Yes No
☐☐

Comments

		Yes	No	
1.3.7	health screening	☐	☐	**B**
1.3.8	mortuary duties.	☐	☐	**B**
1.4	Information on response times to requests is collected, monitored and evaluated.	☐	☐	**C**

SECURITY SERVICE

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

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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Standard

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

| | | please tick |
| | | Yes No |

Criteria   Comments

1.1 There is a staff identification system in place.   ☐☐ **A**

1.2 All staff wear name badges.   ☐☐ **A**

1.3 All external doors (with the exception of entrances to the accident and emergency department and fire doors) are locked after a nominated hour at night.   ☐☐ **A**

1.4 There is evidence that the security of unoccupied offices/departmental areas is maintained at all times.   ☐☐ **A**

1.5 Pathways to residential accommodation and other on-call facilities are well-lit *(see also Medical Service chapter, criterion 5.1)*.   ☐☐ **A**

1.6 Internal and external security inspection tours of the hospital/trust buildings are conducted at night.   ☐☐ **B**

1.7 There is evidence that arrangements are made to minimise risk in high risk/vulnerable areas.   ☐☐ **B**

Interpretation

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

* shatterproof glass and coded door locks are installed.

(See also Pharmaceutical Service chapter, criterion 5.2.2 and Special Care Service chapter, criterion 5.16.)

1.8 There is a policy on handling physical and verbal violence.   ☐☐ **B**

1.9 Training in handling physical and verbal violence is provided.   ☐☐ **B**

1.10 There is a key-holding and key issue policy in place across the hospital/trust.   ☐☐ **B**

1.11 There is a structure in place to ensure that security issues are discussed, action plans are developed and reports are produced for the executive management team/trust board.   ☐☐ **B**

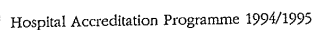*please tick*
Yes No

Comments

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

B

STERILE SERVICES DEPARTMENT

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

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

B **Good Practice**

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

C **Desirable Practice**

Good practice which is not yet standard across the UK.

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Standard

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

please tick
Yes No

Criteria

Comments

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

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

   1.1.2   safety measures in hazardous areas   **A**

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

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

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

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

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

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

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

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

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

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

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

Weighting

Essential Practice **A**

Good Practice **B**

Desirable Practice **C**

please tick
Yes No
☐ ☐

Comments

1.12 Sterilisers, including ethylene oxide, are checked in accordance with statutory regulations.   ☐ ☐ **A**

1.13 Following repair and/or maintenance of sterilisers, tests are conducted and results recorded (for example, potentiometer and/or microbiological).   ☐ ☐ **A**

1.14 There is a policy for the use of items designated as single use by the manufacturer.   ☐ ☐ **B**

1.15 Textiles are inspected, folded and/or assembled into packs in an area which is separate from the main sterilising area.   ☐ ☐ **B**

1.16 Arrangements are made for supplies required out of hours or in emergencies (see also *Accident and Emergency Service chapter*, *criterion 2.10.5*).   ☐ ☐ **A**

VOLUME 1

TELECOMMUNICATIONS SERVICE

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

B **Good Practice**

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C **Desirable Practice**

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Standard

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

please tick
Yes No

Criteria

1.1 There are documented policies for the following:

		Yes	No	
1.1.1	bleep system failure			**A**
1.1.2	board system failure			**A**
1.1.3	bomb threats			**A**
1.1.4	crash calls			**A**
1.1.5	fire in the switchboard area			**A**
1.1.6	fire elsewhere in the hospital/trust			**A**
1.1.7	major incidents			**A**
1.1.8	making calls outside of the hospital/trust (hospital staff)			**B**
1.1.9	telephone complaints.			**B**

1.2 The role of the service during a major incident is tested at least annually. — **B**

1.3 The following equipment is subject to a planned programme of testing:

		Yes	No	
1.3.1	alarms			**A**
1.3.2	crash bleeps			**A**
1.3.3	incident pagers			**A**
1.3.4	emergency back-up/bypass system.			**A**

1.4 Records of these tests are maintained. — **B**

1.5 Staff receive training in the use of the emergency back-up/bypass system. — **B**

1.6 If the bleep system is located within the switchboard area, a stock of spare batteries for bleepers and pagers is held. — **B**

1.7 All crash calls are recorded. — **B**

1.8 An up-to-date list of personnel on call within the hospital/trust is available. — **A**

1.9 All staff are aware of the action to be taken in the event of attack alarms being sounded in the switchboard area (for example, pharmacy). — **A**

Comments

please tick
Yes No

Comments

1.10 There is a system in place to ensure that staff are kept fully informed of the following:

1.10.1   extension number changes   B

1.10.2   direct line changes   B

1.10.3   changes in personnel.   B

1.11 Arrangements are in place for dealing with out-of-hours admissions and queries.   A

1.12 Staff receive training in customer care .   C

1.13 Access to the switchboard area is controlled.   B

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

1.14.1   internal call response times   C

1.14.2   external call response times   C

1.14.3   usage and cost of lines and calls.   C

ABSENTEEISM Absence from work not authorised through the appropriate channels.

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

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

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

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

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

AIMS Overall purpose of a department or service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Accreditation Programme 1994/1995

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISSION STATEMENT Statement of purpose of an organisation.

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

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

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

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

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

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

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

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

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

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

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

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

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

POLICY An operational statement of intent in a given situation.

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

PROCEDURE The steps taken to fulfil a policy.

PROFESSIONAL STANDARDS Professionally agreed levels of performance.

PROJECT 2000 The system of nurse education which places increased emphasis on student centred and research based learning.
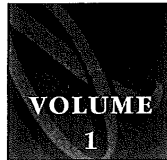
QUALITY IMPROVEMENT STRATEGY A written statement of objectives relating to quality improvement and a plan for meeting those objectives. The strategy should be consistent with the business plan.

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

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

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

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

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

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

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

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

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

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

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

TRAINING AND DEVELOPMENT STRATEGY A written statement and objectives for the training and development of staff and a plan for meeting these objectives. The strategy should be consistent with the business plan.
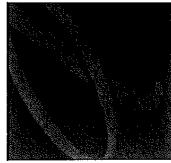
UNIQUE HOSPITAL UNIT NUMBER SYSTEM A combination of numbers and/or letters that identifies a patient's health record as unique.

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

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

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