WM QRS West Midlands Quality Review Service

Isle of Man Government
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Review of:

- Musculo-Skeletal Patient Pathway
- Care of People with Chronic Pain
- Care of People with Drug and Alcohol Problems
- Screening Services
- Transfer from Acute Hospital Care and Intermediate Care and Care of Older People Living with Frailty (Workshop)

Isle of Man Department of Health and Social Care – Appendix 2

Visit Date: 3rd, 4th and 5th October 2017 Report Date: January 2018

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UKAS INSPECTION 8831

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, Table 7 summarises the percentage compliance for each of the services reviewed.

Service	Standards Reviewed
Orthopaedics (elective orthopaedics, trauma and orthopaedic therapies)	WMQRS Musculo-skeletal Patient Pathway Quality Standards V1.1 2017
Chronic Pain Team	WMQRS Quality Standards for the Care of People with Chronic Pain V1.3 2014
Drug and Alcohol Team	Community Substance Misuse Services - Quality Standards Framework: The Recovery Partnership 2016

Table 7 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Isle of Man Department of Health and Social Care			
Musculo-Skeletal Patient Pathway – Specialist Service	**50**	**14**	**28**
Care of People with Chronic Pain	**31**	**9**	**29**
(Primary Care)	(2)	(1)	(50)
(Chronic Pain Team)	(29)	(8)	(28)
Care of People with Drug and Alcohol Problems - Community Substance Misuse Services - Quality Standards Framework: The Recovery Partnership 2016	**75**	**63**	**84**
Total Health and Social Care for services reviewed with Quality Standards	**187**	**95**	**51**

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MUSCULO-SKELETAL PATIENT PATHWAY

SPECIALIST SERVICE

Ref	Quality Standard	Met? Y/N	Comments
BN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours, clinic times and visiting times b. Transport options c. Staff and facilities available d. How to contact the service for help and advice, including out of hours e. Range of other services available locally, including rehabilitation services f. How to access information on outcomes of local services, including achievement of Key Performance Indicators	N	Good general and ward-specific information was available on Wards 11 and 12. Little information was available about the therapy part of the pathway. It was not clear what information was given to patients by therapists Therapy Services was not visible on the in-patient wards.

Ref	Quality Standard	Met? Y/N	Comments
BN-102	**Condition-Specific Information** Written information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Self-care c. Self-management training and support available d. Possible complications and how to prevent these e. Pharmacological and non-pharmacological therapeutic interventions offered by the service, in particular: i. choice of anaesthesia ii. choice of analgesia iii. choice of implants and fixation method iv. pre-and post-operative care v. casts, splints, slings and other appliances f. Rehabilitation programme, including: i. exercise ii. aids and equipment iii. falls prevention iv. bone health g. Possible side-effects of therapeutic and rehabilitation interventions h. Symptoms and action to take if unwell i. DVLA regulations and driving advice (if applicable) j. Health promotion and support available for healthy living, covering smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being k. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues l. Sources of further advice and information	Y	A good range of condition-specific information was available in the evidence folder. Arrangements for ensuring this information was routinely given to patients were not clear.

Ref	Quality Standard	Met? Y/N	Comments
BN-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned assessments, therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice g. A named person with responsibility for coordination of the patient's rehabilitation (in-patient and rehabilitation services only) The Care Plan should be communicated to the patient's GP and to relevant other services involved in their care.	Y	The general leaflet included a brief care plan, although this could be more explicit about agreed goals, including lifestyle goals. The plan in this leaflet was available to patients. There were also care plans in the medical notes and, for patients undergoing knee replacement surgery, in the nursing notes. Therapists had some input to the in-patient general leaflet plan, with more detail documented in the medical or nursing notes. Out-patient physiotherapists completed an assessment sheet which was given to the patient.
BN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	N	Processes to review care plans were in place on the wards although it was not clear that the patient received written communication about changes to the plan. Therapists had arrangements for reviewing care plans but the outcome was not routinely communicated in writing to the patient or the GP.
BN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	N	Reviewers saw no evidence of documentation of contacts for advice and response times. Ward staff said that they got back to people straight away.
BN-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed with each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	N	Reviewers saw no evidence of school health care plans for children being cared for by the orthopaedic service. (This QS is not applicable to Wards 11 & 12 and to the adult therapies team.)

Ref	Quality Standard	Met? Y/N	Comments
BN-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	N	This QS was applicable to the therapy part of the pathway. Formal arrangements for transition between children's and adult therapies teams were not yet in place. The QS was not applicable to the orthopaedic medical team who provided care for both children and adults.
BN-196	**Letting Go' Plan** Patients should be involved in planning their discharge from the service and should be offered a written plan covering at least: a. Evaluation of achievement of agreed goals b. Self-care and self-management of their condition, including exercise regimes c. Return to normal activities d. Care after discharge e. Possible problems and complications and what to do if these occur including, where appropriate, arrangements for easy re-access to the service f. Who to contact with queries or concerns	N	This QS was met for the in-patient part of the pathway through the ward booklet, involving patients in discussions about discharge from hospital, and giving patients a copy of their discharge letter. Therapy discharge letters were written for GPs and were not copied to patients. Letters discharging patients from orthopaedic out-patient care were not routinely copied to patients and reviewers did not see examples to show that these met the requirements of the QS.
BN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	Neither ‘b’ nor ‘g’ was met but support to patients was generally good.
BN-198	**Carers’ Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	N	No information for carers was visible on the wards although ward staff said that they would try hard to involve carers. Arrangements for offering carers information during the orthopaedic out-patient and therapy parts of the pathway were not clear.

Ref	Quality Standard	Met? Y/N	Comments
BN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	N	a' was met on the wards and for therapy out-patients (but was not clear for orthopaedic out-patients). 'b' was not met in any part of the service and reviewers saw no evidence of 'c'.
BN-201	**Lead Clinician and Manager** A nominated lead clinician and manager should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	

Ref	Quality Standard	Met? Y/N	Comments
BN-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales Staffing levels should be based on a competence framework covering the staffing levels and competences expected, and should ensure an appropriate skill mix of staff with specialist Musculo-skeletal knowledge and interest including: i. consultant surgeons, including for: • support to the trauma team and trauma lists (7/7) • monitoring less experienced surgeons and for complex cases requiring two surgeons ii. other medical staff iii. nursing and allied health professionals with extended roles or extended scope of practice iv. nursing staff for wards, out-patient, fracture clinic and other settings where care is delivered v. physiotherapy and occupational therapy staff (7/7) vi. plaster technicians vii. hand therapist (5/7) viii. orthogeriatrician ix. social worker Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away. All staff should have time in their job plans allocated to their work with the Musculo-skeletal team.	N	Physiotherapy and occupational therapy staff were not available 7/7 and the service did not have an orthogeriatrician (see main report). Ward staffing levels appeared adequate although ward nurses reported that it was sometimes difficult to be released for study activities.

Ref	Quality Standard	Met? Y/N	Comments
BN-203	**Service Competences and Training Plan** The specialist Musculo-skeletal competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining these competences should be in place. Specific competence requirements include: a. Services providing 'triage': Registered healthcare professionals with appropriate specialist competences in assessment of people with Musculo-skeletal problems, giving advice on Musculo-skeletal problems and the therapeutic interventions offered by the service b. Registered nurses: Post-registration orthopaedic training in the care of patients with musculo-skeletal problems c. Staff undertaking unsupervised application of casts: Competences equivalent to the British Certificate of Casting Techniques d. Surgeons: IRMER (2000) regulations e. Surgeons using mini C-arms or fluoroscopy equipment: Designated 'practitioner' following completion of assessment of Trust-defined competences Competences should cover the care of children and/or adults depending on the ages cared for by the service.	Y	a' was not applicable although triage competences for an advanced physiotherapist were in place. 'b', 'c' and 'd' were met. 'e' was not yet applicable as mini C-arms and flouroscopy equipment were not yet used.
BN-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation f. Moving and handling	N	Reviewers saw evidence of compliance for physiotherapists, nurses and HCAs but not for occupational therapists or medical staff.

Ref	Quality Standard	Met? Y/N	Comments
BN-205	**Sub-Specialty Leadership** A consultant and a lead nurse or allied health professional with special interests in each the following should be identified: a. Trauma b. Care of people with problems of the: i. spine ii. shoulder iii. hand, wrist and/or elbow iv. hip and/or knee v. foot and/or ankle c. Care of children The area of special interest should form a major part of the day to day clinical practice of the consultants identified.	N	Most staff were aware of surgeons' particular interests but the service's self-assessment did not identify a lead for orthopaedic trauma or for knee surgery. It was also not clear that either the identified leads or other staff understood the leadership role expected of them.
BN-206	**Lead Professionals** The nominated lead clinician (QS BN-201) should be supported by professional leads for: a. Consultant orthopaedic surgeons b. Nursing c. Physiotherapy d. Occupational Therapy e. Orthotics	Y	
BN-207	**Ward Nursing Competences** At least one nurse per shift should have completed the expected post-registration competences in care of patients with musculo-skeletal problems.	Y	This QS was very nearly met on both wards and was achieved through flexibility of staffing between wards 11 & 12.
BN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Although the self-assessment for wards 11 & 12 was that sufficient support was available, nearly all the clinical staff who met the visiting team reported that they were spending unreasonable amounts of time which could be used for clinical work on administrative tasks.

Ref	Quality Standard	Met? Y/N	Comments
BN-301	**Support Services** Timely access to the following support services should be available: a. Pathology services b. Pharmacy c. Weight management service d. Counselling e. Clinical psychology f. Dietetics g. Wheelchair service h. Chronic pain team i. Podiatry j. Falls prevention team (or staff with specialist falls prevention competences) k. Tissue viability team (or staff with specialist competences) l. Orthotics m. Frailty team (Care of Older People) n. Social worker o. Services specialising in the care of people with: i. dementia ii. mental health problems iii. palliative care p. Access to hydrotherapy	N	c', 'd', 'e', 'm' and 'p' were not met. Some other support services were provided by single members of staff with no cover for absences.
BN-302	**Support Services: Acute hospital services only** Timely access to the following support services should be available: a. Other members of the Trauma Team b. Respiratory physiotherapist 24/7 c. Intensive and high dependency care d. Acute pain management team e. Pathology services f. Plastic surgery service g. Vascular surgery service h. Acute oncology service i. Neurology j. Neurophysiological diagnostic service k. Rheumatology service l. Fracture Liaison Service (Consultant or GP with special interest in osteoporosis management) m. Bone and Tissue Bank accredited by the Medicines and Healthcare Products Regulatory Agency	Y	All aspects were met on site ('a' to 'e') or through referral to Liverpool ('f' to 'l'). Reviewers did not see evidence for 'm' but compliance was based on the service's self-assessment.

Ref	Quality Standard	Met? Y/N	Comments
BN-303	**Theatres and Anaesthetics** Timely access to appropriate theatre and anaesthetic services should be available, including: a. Anaesthetic staff with capacity to support required pre-operative assessment and theatre lists b. Theatre teams with specific experience in orthopaedic procedures and equipment c. Theatres with ultraclean air (UCA) vertical laminar flow systems for, at least, joint replacements and major orthopaedic implant surgery d. Theatres with adequate imaging facilities, including image intensification with memory, the ability to produce a permanent image and appropriate back-up facilities e. Dedicated trauma list 7/7 f. Separate theatre lists for emergency and elective patients g. Appropriate arrangements for the care of children h. Facilities for day surgery	N	a' was met (although see main report). 'b' was achieved on weekdays but not always at weekends. 'c' was met. 'd' was met although there were some problems with availability of radiographers. 'e' was not met at weekends. 'f' was met. 'g': children were placed at the start of lists wherever possible. 'h' was met.
BN-304	**Imaging** Timely access to appropriate imaging should be available including: **In-patient services:** a. Plain X-ray, ultrasound and CT imaging available 24/7 with reporting within: i. urgent: one hour ii. routine: 24 hours b. MRI available 7/7 c. Radiographer support for theatre sessions **Triage, out-patient and rehabilitation services:** a. Plain X-ray, ultrasound, CT and MRI b. Agreed timescales for imaging and for reporting	N	In-patient services: 'a' was met. MRI was available only 5/7. 'c': radiographers were not always available when required. Out-patient and rehabilitation services: 'a' was met. Waiting times for MRI were long with waits of up to a year for physio-requested MRI scans. Agreed timescales for imaging and reporting were not yet in place.

Ref	Quality Standard	Met? Y/N	Comments
BN-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients, including: **In-patient Services:** a. 'Ring-fenced' orthopaedic beds with sufficient side rooms or other isolation facilities with bathrooms b. Plaster room c. Therapy room/s for assessment and rehabilitation (in-patient and out-patient) d. Appropriately equipped treatment rooms with space for storage of drugs and equipment e. Space for storage of equipment **Out-patient Services:** a. Fracture clinic with appropriate access to imaging and plaster facilities b. Therapy room/s for assessment and rehabilitation (in-patient and out-patient) c. Appropriately equipped treatment rooms with space for storage of drugs and equipment **Rehabilitation:** a. Day room or comfortable waiting area b. Therapy room c. Space for storage of equipment All facilities should provide privacy and dignity for patients and should be appropriate for the use of people with mobility problems, including: i. toilet risers ii. wide doors iii. large bathrooms and toilets iv. a high ratio of toilets per patient	Y	Facilities were good. An additional couch was needed for ward attenders (examinations and dressings) but this issue was being addressed.

Ref	Quality Standard	Met? Y/N	Comments
BN-402	**Equipment** Timely access to equipment appropriate for the service provided should be available, including: a. Wheelchairs b. Range of walking appliances and specialised walking aids c. Splints, collars and supports d. Facilities for making custom splints e. Continuous Passive Motion machine f. Tilt table g. Cryocuffs **In-Patient only:** a. Implants b. Access to theatre 'loan kits' c. Braun frames for limb elevation d. Spinal beds e. Bone stimulating devices f. Flowtrons g. Bradford slings and drip standards to which they can be attached. h. VAC pumps All equipment should be appropriately maintained and user manuals should be easily available.	Y	Staff reported that they had access to adequate equipment with storage facilities within the ward area.
BN-403	**Equipment for Bariatric Patients** Timely access to appropriate equipment for the care of bariatric patients should be available including hoists, mattresses and walking aids.	Y	Staff reported good access to bariatric equipment to include hoists.
BN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, imaging, outcome information and other data to support service improvement, audit and revalidation.	N	See main report.
BN-501	**Guidelines on Triage/Screening of Referrals** Guidelines on triage/screening of referrals should be in use. These guidelines should ensure that referrals are considered for: a. Self-management advice and education only b. Referral for further primary care management c. Referral to another consultant or service for advice, investigation or intervention d. Acceptance of patients by the Musculo-skeletal service The patient and their GP should be notified of the outcome of the referral triage/screening.	N	See main report. A therapies paediatric guideline was available.

Ref	Quality Standard	Met? Y/N	Comments
BN-502	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be covering the care of people with problems of the: a. Spine b. Shoulder c. Hand, wrist and/or elbow d. Hip and/or knee e. Foot and/or ankle Guidelines should be specific about: i. emergency (including trauma) and elective presentations ii. presentation in children and adults iii. Guidelines should cover, where applicable: iv. investigations, including type and modality of imaging v. confirmation of diagnosis vi. provision of information to the patient (QS BN-102) and consent vii. advice on self-care and self-management, including specific pre-surgery advice viii. choice of anaesthesia ix. choice of analgesia x. choice of implants and fixation method xi. identification if theatre loan equipment required xii. any further investigations required in order to establish fitness for surgery xiii. choice of ambulatory, day case or in-patient care xiv. suitability for Early Supported Discharge pathway	N	Orthopaedic guidelines were in place for the care of people with fractured neck of femur and for pre-operative testing but not for other conditions. The Therapy Services operational document included guidelines for several patient pathways.
BN-503	**Onward Referral Guidelines** Guidelines should be in use covering: a. Referral and clinical handover to other teams within the hospital b. Onward referral to other hospitals within the network for patients needing complex procedures not provided by the service or procedures for which the service undertakes low volumes.	N	Referral forms were available but not guidelines indicating the criteria for referral or arrangements for clinical handover.

Ref	Quality Standard	Met? Y/N	Comments
BN-504	**Pre-Operative Assessment Guidelines** Guidelines should be in use covering pre-operative assessment of people with problems of the: a. a. spine b. b. shoulder c. c. hand, wrist and/or elbow d. d. hip and/or knee e. e. foot and/or ankle Guidelines should cover, at least: i. multi-disciplinary involvement in pre-operative assessment, including arrangements for involvement of a surgeon, nurse, physiotherapist, occupational therapist, social worker and anaesthetist ii. criteria for referral for high risk anaesthesia assessment iii. MRSA and other screening test iv. identification of rehabilitation goals v. consent for surgery	N	Examples of emails and letters were available but guidelines were not yet in place except for consent. The consent policy was beyond its review date.
BN-505	**Out-Patient Procedures** Guidelines should be in use covering management of out-patient procedures, including use of the WHO *'Safer Surgery'* or other appropriate checklist.	N	A correct site policy was available for theatres but there were no guidelines covering out-patient procedures.
BN-506	**Peri-Operative Management Guidelines** Guidelines should be in use covering peri-operative management of patients with problems of the: a. Spine b. Shoulder c. Hand, wrist and/or elbow d. Hip and/or knee e. Foot and/or ankle Guidelines should cover at least: i. responsibility for phlebotomy, blood group testing and ordering of blood for transfusion ii. infection control iii. pain management iv. post-operative mobilisation	N	Guidelines were not peri-operative or condition-specific. Hospital policies were available (although beyond their review dates) for infection control and pain management but these were not specific to peri-operative orthopaedics.

Ref	Quality Standard	Met? Y/N	Comments
BN-507	**Rehabilitation and Follow Up** Guidelines should be in use covering rehabilitation and follow up of patients with problems of the: a. Spine b. Shoulder c. Hand, wrist and/or elbow d. Hip and/or knee e. Foot and/or ankle Guidelines should cover at least: i. timescales for start of rehabilitation, including timescales following referral to community services ii. frequency of interventions iii. review arrangements, including consultant review (if required)	Y	The Therapy Services operational document linked to a good range of guidelines. Some orthopaedic guidelines were evident, based on those in use in the trauma network, although these were not detailed.
BN-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. nvolvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	N	Guidelines were not available. For comments on applicability see QS BN-195.
BN-596	**Letting Go' Guidelines** Guidelines on discharge from the service should be in use covering at least: a. Criteria for discharge from the service b. Evaluation of achievement of agreed goals c. Self-care and self-management advice, including exercise regimes d. Return to normal activities e. Care after discharge Guidelines should cover discharge home or to an orthopaedic rehabilitation service.	N	A good policy was available covering people who wanted to discharge themselves from hospital. Other evidence provided related to the mechanism for discharge and did not cover the requirements of the QS.

Ref	Quality Standard	Met? Y/N	Comments
BN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	Y	Several policies were beyond their review date.
BN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for booking theatre time for 'planned' cases f. Arrangements for accessing 'loan kits' (IP only) g. Arrangements for specialist orthopaedic nursing, physiotherapy and occupational therapy outreach to patients on non-orthopaedic wards (7/7), including for patients with both orthopaedic and other medical or surgical problems h. Arrangements for monitoring less experienced surgeons and for complex cases requiring two surgeons i. Arrangements for continuity of surgeon between initial consultation and treatment j. Ensuring consultant review of all hospital in-patients at least daily (7/7) k. Arrangements for photographic documentation and handling and storage of photographic images of patients	N	Two operational policies were available, one for wards 11 & 12 and one for Therapy Services. The ward policy was not specific about expected timescales. Neither policy covered the out-patient orthopaedic service. Neither policy covered 'g', 'h' or 'I'. A good policy on photography was available.

Ref	Quality Standard	Met? Y/N	Comments
BN-602	**Multi-disciplinary Discussion** Formalised arrangements for multi-disciplinary discussion of appropriate patients should be in place, including with: a. Musculo-skeletal triage service (if provided separately) b. Child Development Team and relevant paediatricians (children and young people only) c. Rheumatology service d. Chronic pain team	N	Formalised arrangements for multi-disciplinary discussion involving medical, nursing and therapy staff within the musculo-skeletal service were not in place, except during 'race weeks'. Formalised arrangements covering 'b', 'c' and 'd' were not in place.
BN-696	**Theatre Liaison** Review meetings should be held with theatre services at least quarterly to consider: a. Availability of appropriately staffed and equipped emergency and elective theatres (QS BN-303) b. Cancellations c. Review of and implementing learning from positive feedback, complaints, incidents and near misses relating to orthopaedic theatre usage	Y	A theatre user group was in place. Theatre staff who met the visiting team commented that theatres representation at these meetings was the Theatre Manager and they would appreciate the opportunity to attend. It was not clear whether other relevant staff, for example, radiographers, were able to attend these meetings.
BN-697	**Imaging Liaison** Review meetings should be held with imaging services at least quarterly to consider: a. Achievement of expected timescales for imaging and for reporting b. Availability of radiographers for theatre sessions (in-patient only) c. Review of and implementing learning from positive feedback, complaints, incidents and near misses relating to musculo-skeletal imaging.	N	Review meetings were not yet in place. Reviewers considered that these would help the service, including for forecasting and managing demand.

Ref	Quality Standard	Met? Y/N	Comments
BN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of triage, assessments and therapeutic and /or rehabilitation interventions d. Number of operations cancelled and reasons for cancellation e. Number of discharges from the service and type of care after discharge f. Key performance indicators including: i. achievement of expected waiting times targets ii. ratio of follow up to new out-patients iii. operations performed between 10pm and 8am iv. proportion of operations performed in a laminar flow theatre v. proportion of patients needing hip or knee replacement who had a multi-disciplinary pre-operative assessment vi. waiting times for post-discharge assessment and rehabilitation g. Collection and submission of data to: i. National Joint Registry ii. National Hip Fracture Database iii. Trauma Audit Research Network	N	Some data were collected for individual patients and input to various systems (see main report). Some data were available for Therapy Services. Data were not available covering the whole musculo-skeletal service and its pathways. Data were collected and submitted to the National Joint Registry, National Hip Fracture Database and Trauma Audit Research Network although the lead person identified for National Joint Registry data collection and submission was working part-time.
BN-702	**Audit** The services should have a rolling programme of audit of: a. Compliance with evidence-based clinical guidelines (QS BN-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway d. Long-term outcomes	N	Therapies were starting a quarterly audit cycle. An orthopaedic Associate Specialist had lead responsibility for medical audits but a rolling programme of audit was not yet in place. Some nursing audits were undertaken on wards 11 and 12. Multi-disciplinary audit was not in place.
BN-703	**Key Performance Indicators** Key performance indicators (QS BN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Key performance indicators had not been identified.
BN-704	**Minimum Procedures per Surgeon** The minimum number of each type of procedure surgeons should undertake should be agreed and achievement of minimum numbers should be reviewed at least annually.	N	Minimum numbers per surgeon had not been formally agreed and documented. Informal arrangements were in place to monitor procedure-specific activity levels.

Ref	Quality Standard	Met? Y/N	Comments
BN-705	**Pathway Liaison** If local 'triage' and rehabilitation services for people with Musculo-skeletal problems are provided by separate services, liaison meetings should be held at least every three months to review the local pathway, including: a. Criteria and arrangements for referral and handover between the services b. Indications and arrangements for joint discussion of patients c. Review of and implementing learning from positive feedback, complaints, incidents and near misses relating to more than one service or the overall patient pathway	N	Reviewers saw evidence of a hip fracture group but no evidence of liaison meetings for other clinical pathways. Therapy services were provided separately from orthopaedic services. Handover and collaboration took place but not liaison meetings to review the arrangements. There was no evidence of documented multi-disciplinary discussion of patients, except during 'race weeks' when therapists attended the weekly trauma meetings, and no review of these arrangements.
BN-706	**Network Liaison** The service should take part in network arrangements for: a. Care of patients with trauma b. Liaison with specialist services to which patients needing complex or low volume procedures are referred	Y	Isle of Man staff were actively trying to link with specialist services at Liverpool. Trauma staff were actively participating in the trauma network. Discussions were taking place about liaison for other pathways. NB. This comment is based on the information given to reviewers by Isle of Man staff. Reviewers did not have the opportunity to validate this conclusion through discussion with staff in tertiary centres.
BN-797	**Research** The service should actively participate in research relating to the care of patients with Musculo-skeletal disorders.	N	A systematic approach to research and development was not evident. Some individual therapists were working for MSc's which included a research element. Reviewers commented that the service had a unique opportunity to carry out trauma-related research during race weeks.

Ref	Quality Standard	Met? Y/N	Comments
BN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency d. Review of National Joint Registry (if available)	N	The service had no arrangements for multi-disciplinary review and learning involving all members of the core team (QS BN-202). Weekly trauma meetings were held involving medical staff and the trauma coordinator. Ward nurses were not usually able to attend these meetings. Therapy representatives attended only during race weeks. The weekly meetings were clinical case reviews rather than reflections on the way the service was working. Audit meetings were held for medical staff but other disciplines did not attend. Therapists held quarterly audit meetings. A weekly safety advisory group was in existence and wards 11 & 12 held monthly ward meetings. At no time did medical, nursing and therapy staff sit down together to undertake the activities listed in the QS.
BN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	The document control policy was 'in date' but most other hospital policies were beyond their review date.

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CARE OF PEOPLE WITH CHRONIC PAIN

PRIMARY CARE

Ref	Quality Standard	Met? Y/N	Comments
JA-299P	**Primary Care Training and Development Programme – Chronic Pain** The primary care training and development programme should include community physiotherapists and others working with people with chronic pain and should cover all aspects of QS JA-501P.	Y	
JA-501P	**Primary Care Guidelines – Chronic Pain** Guidelines on diagnosis and management of chronic pain, including low back pain, should include: a. Indications for urgent referral due to suspected serious pathology ('red flags') b. Primary care management including: i. Self-management advice and education ii. Physiotherapy iii. Pain relief iv. Cognitive behavioural techniques v. 'Sign-posting' to lifestyle interventions or local voluntary and community support c. Criteria for referral to the chronic pain team and information to be sent with each referral	N	Referral guidelines, including referral criteria, were not in place and reviewers were told that the service received a large number of inappropriate referrals.

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CHRONIC PAIN TEAM

Ref	Quality Standard	Met? Y/N	Comments
JS-102	**Service Information** Each service should offer patients and carers information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours (if applicable)	Y	

Ref	Quality Standard	Met? Y/N	Comments
JS-103	**Condition-Specific Information** Discussion and written information for patients with chronic pain should also cover (when applicable): a. Description of their condition and its implications b. Self-management training and support c. Pain management programmes, interventional procedures and other interventions offered d. Supervision of drug withdrawal e. Sources of support (for example, Expert Patient's Programme, patient resources from The British Pain Society, condition-related self-help groups)	Y	Good examples of condition-specific information were available for use by physiotherapists. Some national information was also used. The two patients who met the visiting team said that they had not received any condition-specific information. Reviewers commented on the lack of a patient involvement group and suggested that this may be a helpful development.
JS-104	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Name of 'care coordinator' d. Planned pain management programmes, interventional procedures and other interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Planned review date and how to access a review more quickly, if necessary	N	Letters were sent to the GP and patients did not receive a copy unless they requested one. The two patients who met the visiting team were not aware that they could request a copy of their GP letter. This approach created a lack of transparency and did not encourage active patient engagement in their own care.
JS-105	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, every six months. This review should involve the patient and, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	N	Reviews were undertaken on a uni-disciplinary basis and did not involve appropriate members of the multi-disciplinary team. Reviewers were given several examples of patients attending the service for very long periods of time.
JS-106	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear. Response times should be not more than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	Timescales for response were not clear.

Ref	Quality Standard	Met? Y/N	Comments
JS-195	**Transition to Adult Services** Young people transferring to the care of adult services should be offered written information covering at least: a. Their involvement in the decision about transfer and, with their agreement, the involvement of their family or carer b. A joint meeting between children's and adult services to plan the transfer c. A named coordinator for the transfer of care d. A preparation period prior to transfer and, if appropriate, a period of shared care e. Arrangements for monitoring during the time immediately after transfer	N	Children with chronic pain were referred to tertiary centres but arrangements for transition back to the Isle of Man adult service were not in place.
JS-196	**'Letting Go' Plan** Patients should be involved in planning their discharge from the service and should be offered a written plan covering at least: a. Evaluation of achievement of agreed goals b. Self-care and self-management of their condition c. Care after discharge from the service (if any) d. Possible problems and what to do if these occur, including, where appropriate, arrangements for easy re-access to the service *e.* Who to contact with queries or concerns	N	The extent to which patients were involved in planning their discharge was not clear. See QS JS-104 in relation to copies of GP letters. Self-care and self-management was not covered in any of the letters seen by reviewers.
JS-197	**General Support for Service Users and Carers** Patients and carers should have easy access to the following services. Information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. Independent advocacy services c. Complaints procedures d. Spiritual support e. *HealthWatch* or equivalent organisation	N	Neither 'b' nor 'e' was met.
JS-199	**Involving Users and Carers** The service should have: a. Mechanisms for receiving feedback from patients and carers about their care and treatment b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of the feedback and involvement of patients and carers	N	'a' was met but not 'b' or 'c'. Reviewers saw no examples of changes made as a result of patient feedback.

Ref	Quality Standard	Met? Y/N	Comments
JS-201	**Lead Clinician** A doctor specialising in chronic pain should have lead responsibility for staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. This doctor should be a consultant specialising in chronic pain or a doctor with competences and experience in advanced pain medicine, as defined by the FPMRCA, who undergoes revalidation in pain medicine.	Y	
JS-202	**Chronic Pain Team** The service should have sufficient staff with appropriate competences to deliver the expected number of triage/screening of referrals (if undertaken by the service itself), assessments and procedures for the usual case mix of patients within expected timescales. Staffing levels should be based on a competence framework covering the staffing levels and competences expected, and should ensure an appropriate skill mix of staff with specialist pain management knowledge and interest including: a. Consultants in pain medicine b. Medical staff with appropriate training and competences c. Nurses d. Clinical psychologists or staff with appropriate competences in psychological therapy e. Physiotherapists f. Occupational therapists All staff should have time in their job plans allocated to their work with the chronic pain team. If the service cares for children, staff should have competences in the care of children as well as in pain management.	N	See main report in relation to psychology and physiotherapy staff. There was no cover for the lead consultant but an additional consultant with sessional time for the chronic pain team was due to take up post in the near future. Reviewers suggested that the specialist nurses would benefit from developing additional competences in motivational interviewing, cognitive behavioural principles and self-management support.
JS-203	**Training Plan** A training and continuing professional development plan should ensure that all members of the chronic pain team achieve and maintain the expected competences (QS JS-202).	N	A training plan for the service was not yet in place. Appraisals and personal development plans for the consultant and nurses had taken place but these were not specific to the care of people with chronic pain.
JS-204	**Triage Team** If triage/screening of referrals is undertaken by staff who are not part of the chronic pain team (QS JS-202), sufficient staff with competences in triage or screening of referrals should be available to ensure referrals are dealt with within agreed timescales.	N/A	

Ref	Quality Standard	Met? Y/N	Comments
JS-205	**Training for Other Staff** The service should offer a programme of education in the nature and effective management of persistent pain and the triage of referrals for GPs, the triage team (if separate from the chronic pain team) and other health professionals in the local area who care for patients with chronic pain.	Y	Training had been offered to GPs and community staff although documentary evidence of this was not seen and some GPs were not aware that the training had taken place.
JS-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available to support the work of the chronic pain team.	N	Patient-related letters were not typed for six to eight weeks. See also QS JS-701 in relation to the lack of service-level data collection.
JS-301	**Support Services** Timely access to the following services should be available: a. Spinal/neurosurgery (24/7 access is required if neuromodulation is offered) b. Imaging (24/7 access is required if neuromodulation is offered) c. Pharmacy, including a sterile preparation unit if intrathecal therapy is given d. Vocational counsellors/employment advisors e. Social workers f. Mental health services	N	'a', 'b', 'd' and 'e' were available. Sterile preparation of drugs including intrathecal therapy was not provided by the hospital pharmacy and had to be brought in, with some resulting wastage due to short expiry dates. 'f': see main report in relation to psychology support including for assessment of suicide risk.
JS-401	**Facilities and Equipment** The service should have appropriate facilities and equipment to deliver the expected number of assessments and procedures for the usual case mix of patients within expected timescales, including: a. Designated operating theatre sessions supported by fluoroscopy and radiographers for performance of diagnostic and therapeutic procedures b. Access to fluoroscopy c. Ultrasound (if undertaken by the service) d. Facilities for: i. Neuromodulation ii. Physiotherapy e. Ability to store and retrieve images f. Facilities for group work g. Office space including access to space for multi-disciplinary discussion of patients Facilities and equipment should comply with all relevant Quality Standards and should ensure: h. Appropriate privacy, dignity and security for patients i. Appropriate separation of children and adults j. Access for disabled patients k. Availability of specialist equipment when required	Y	Facilities were adequate for all except neuromodulation which was not provided. Office space and space for multi-disciplinary discussion of patient care was limited. Reviewers suggested that minor improvements to facilities could improve the patient experience, for example the minor treatment area had no chair.

Ref	Quality Standard	Met? Y/N	Comments
JS-402	**Equipment – Tertiary Services** Tertiary chronic pain services should have specialist equipment for: a. Cordotomy b. Spinal cord stimulation *c.* In-patient pain management programmes	N/A	
JS-403	**IT Systems** IT systems for storage, retrieval and transmission of patient information should be in use for patient bookings, clinical records, outcome information and other data to support service improvement, audit and revalidation.	Y	Six different IT systems were in use (Medi-viewer, Medway, i-Viewer and PACS, Rio and Phillips isite) which made it difficult to access the full electronic record when treating patients. There were plans to make greater use of Medway. Clinical nurse specialists had only one laptop for two members of staff.
JS-501	**Guidelines on Triage/Screening of Referrals** Guidelines on triage/screening of referrals to the chronic pain team should be in use. These guidelines should ensure that referrals are considered for: a. Self-management advice and education only b. Referral for further primary care management (QS JA-501P) c. Referral to another consultant or service for advice, investigation or intervention d. Acceptance of patients meeting the criteria for acceptance by the service The patient and their GP should be notified of the outcome of the referral triage/screening.	N	Screening / triage of referrals was not in place with all referrals being accepted, even if they were considered inappropriate. Referrals were reviewed by the consultant and classified as routine or urgent. The physiotherapy operational document described the process for handling referrals but not guidelines for ensuring appropriate management.

Ref	Quality Standard	Met? Y/N	Comments
JS-502	**Clinical Guidelines** Clinical guidelines should be in use covering diagnosis, assessment and pain management programmes, interventional procedures and other interventions provided by the service. Clinical guidelines should cover pharmacological and non-pharmacological interventions.	N	Pain Management Programmes were no longer undertaken on the Isle of Man. Patients identified as potentially benefiting from a Pain Management Programme were referred to a tertiary centre. Some RCOA and NICE guidelines were in use, but these did not cover all aspects of the QS and the guidelines were not localised to show how they would be implemented on the Isle of Man. The review team suggested that further reference to the British Pain Society Guidelines for Pain Management Programmes and NHS England Spinal Pathfinder Pathway may be helpful. The principles of chronic pain management and recommended further training are clearly identified. See also main report in relation to the potential for further local service development.
JS-503	**Referral to Tertiary Chronic Pain Services** Guidelines on referral to tertiary chronic pain services should be in use covering at least: a. Criteria for referral to tertiary chronic pain services b. Services to which referrals should be made c. Information to be sent with each referral d. Shared care arrangements, if applicable	N	Reviewers were told that guidelines within the RCOA Core Standards for Pain Management Services in the UK (2015) were followed but these were not localised to show how they would be implemented on the Isle of Man.
JS-597	**Discharge Guidelines** Guidelines on discharge from the chronic pain service should be in use covering at least: a. Criteria for discharge from the service b. Self-management advice and education to be given on discharge *c.* Discharge information to be given to the patient and their GP	N	As QS JS-503. See main report in relation to patients staying a long time with the service (which suggests that national guidance on long term conditions was not being followed).

Ref	Quality Standard	Met? Y/N	Comments
JS-598	**Transition Guidelines** Guidelines on transition of young people to adult services should be in use covering at least: a. Involvement of the young person and, where appropriate, their family or carer in planning the transfer of care b. Involvement of the young person's GP c. Joint meeting between children's and adult services to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer and, if appropriate, a period of shared care f. Arrangements for monitoring during the time immediately after transfer	N	As QS JS-195. Informal arrangements were in place.
JS-601	**Operational Policy** An operational policy for the chronic pain service should be in use covering at least: a. A minimum appointment time of 45 minutes for new patients b. Regular multi-disciplinary team meetings or clinics to discuss the management plans for new patients and those with more complex needs c. Allocation of a 'care coordinator' d. Arrangements for liaison with: i. Acute pain services ii. Triage team (if separate from the chronic pain team) iii. Support services (QS JS-301) iv. Palliative care services in hospital and in the community v. Tertiary chronic pain services (QS JZ-601P) e. Arrangements for the treatment of patients who are particularly vulnerable f. Any special arrangements for the care of children (if applicable) g. Arrangements for patients admitted to hospital for care by the chronic pain service h. Management of non-engagement with the service i. Maintenance contracts and a rolling replacement programme for equipment	N	'b': Regular multi-disciplinary team meetings did not take place however; medical and nursing staff did discuss management plans. Other aspects of the QS were not covered by the operational document. The physiotherapy operational document covered clinics, follow up and staffing but not other aspects of the QS.
JS-699	**Primary Care Training and Development** The service should contribute to the primary care training and development programme (QS JA-299P).	Y	A GP training day had been held but GPs who met the visiting team were not aware that this training had taken place.

Ref	Quality Standard	Met? Y/N	Comments
JS-701	**Data Collection** Data should be collected routinely on: a. Referrals and sources of referrals b. Triage or screening of referrals: number of patients referred, time to completion of triage or screening and outcome for each referral c. Number of patients accepted by the service d. Therapeutic programmes and interventions provided e. Outcomes of therapeutic programmes and interventions f. Length of time with the service and reason for discharge g. Key performance indicators	N	Some data were collected on new and follow up attendances and 'did not attend', and on numbers of interventions. 'b' and 'f' were not met. Reviewers were also told of some concerns about whether the Medway system was capturing data accurately.
JS-702	**Audit** The service should have a rolling programme of audits of compliance with guidelines and protocols [QSs JS-500s] and related outcomes.	N	Occasional audits were completed, including physiotherapy audits, but there was no rolling programme of audit for the service as a whole. The limited data collection and lack of administrative and data collection support meant that undertaking audits required significant additional work for clinical staff.
JS-703	**Research** The chronic pain team should actively participate in research relating to the care of patients with chronic pain.	N	The service was not taking part in research.
JS-798	**Multi-Disciplinary Review and Learning** The service should have appropriate multi-disciplinary arrangements for the review of, and the implementation of learning from: a. Positive feedback, complaints, outcomes, incidents and 'near misses' b. Published scientific research and guidance relating to pain services	N	Staff in the service did attend the patient safety forum meetings
JS-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	The evidence seen by reviewers did not have appropriate document control by either the Noble's Hospital or community services systems.

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CARE OF PEOPLE WITH DRUG AND ALCOHOL PROBLEMS

COMMUNITY SUBSTANCE MISUSE SERVICES - QUALITY STANDARDS FRAMEWORK: THE RECOVERY PARTNERSHIP 2016

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard One: Safe prescribing for detoxification and stabilisation (opiates and alcohol). The organisation: 1. Ensures that there is a written policy outlining the provision of an opiate reduction or stabilisation treatment programme.	**1. An opiate substitution prescribing policy which includes details of:** a. The clinical guidance used to inform prescribing practice. b. The organisational clinical governance procedures to be followed when prescribing controlled drugs. • The procedures for ordering, distributing and storing FP10 prescribing pads and for reporting their misuse or loss. The procedures for maintaining an audit trail of prescriptions for controlled drugs. c. The procedures used to ensure that dose titration and optimisation supports engagement and stabilisation of the service user. d. The training and experience of the prescriber. i. Who supplies the medication ii. How medication is ordered. iii. How medication is stored. iv. Who administers the medication. v. How medication is administered, e.g. supervised consumption. e. The training that staff administering controlled drugs are required to attend. f. i. How records of medicines are kept. ii. How medicine records are used for audit purposes. iii. How unused medication is safely disposed. iv. How missing medication will be reported to the relevant authorities. v. The safeguarding approach to supporting the safety of others in the home with regard to medication.	Y	DAT did not have responsibility for supply of medication.
2. Ensures there is a written policy outlining the provision of a pharmacologically managed alcohol detoxification.	**2. Appointed a controlled drug accountable officer, or identified a local lead controlled drugs accountable officer.**	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
3. Establishes and implements substance testing protocols and procedures, including breathalysing in alcohol detoxification.	**3. A prescribing policy that sets out details of the prescribing regimes used for alcohol detoxification which includes:** a. The clinical guidance used to inform prescribing practice. • The role of prescribing as part of an overall plan of care. b. Who supplies the substitute medication. c. How medication is ordered. d. How medication is stored. e. Who administers the medication. f. How records of medicines are kept. g. How medicine records are used for audit purposes. h. How unused medication is safely disposed. i. How missing medication will be reported to the relevant authorities.	Y	
4. Audits and reviews prescribing practice at planned intervals.	**4. Protocols and procedures which set out how testing for substances will be managed during treatment.** These will include details of: a. The type of equipment used. b. How testing equipment is ordered. c. How testing equipment is stored. d. How testing equipment is maintained. e. Frequency of testing. f. How test results are recorded. g. How test results will be used to review a medication plan.	Y	
	5. Clinical audit procedures that include the collection of information about prescribing practice and its effectiveness.	N	Prescribing audits could not be conducted due to IT problems but this was being addressed.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Two: Needle Exchange provision The organisation: 1. Ensures that it maintains a supply of a range of syringes and needles to meet the needs of users of a range of substances, including those who use Image and Performance Enhancing Drugs (IPEDs).	**1. Develops and reviews its needle exchange policies which include details of:** a. Current good practice guidance and the legal requirements relating to needle exchange. b. How service users' needs related to their specific injecting behaviour will be determined, e.g. the substance injected, frequency of injection and injecting techniques. c. The advice that will be given to service users on safe storage of equipment and disposal of used equipment. d. How service users will be given opportunities to engage with other interventions offered by the service. e. The health advice and information that will be provided to service users based on their injecting behaviour, including information on safer injecting techniques and sites. i. Responses to signs of injecting-related injuries, including the processes for making referrals for treatment. ii. Access to Hepatitis B vaccination with GP surgeries. iii. Access to Hepatitis C and HIV testing. f. Procedures for the storage of used injecting equipment returned by service users. (Not DAT) i. Procedures for the safe handling of returned equipment. (Not DAT) ii. Procedures for disposing of used injecting equipment. (Not DAT) iii. Methods for collating and analysing records of equipment supply and exchange. (Not DAT)	Y	
2. Assesses and responds to the health needs of users of the needle exchange service.	**2. Develops and regularly reviews procedures for maintaining stock levels in the community service site and pharmacy-based needle exchange, including equipment that meets the needs of a range of substance users, including those who use IPEDs, including:** • A range of needle sizes.• A range of syringe barrel sizes.• Foil.• Systems for ordering and transporting needle exchange supplies, including usedinjecting equipment.	N/A	The Drug and Alcohol Team was not responsible for this aspect of the service. The Team took part in the Service Provider Liaison Group at which relevant issues were discussed.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
3. Develops and regularly reviews written policies and procedures that outline the delivery of needle exchange provision in both community service site based and pharmacy-based needle exchange, including access to Hepatitis B vaccination and Hepatitis C & HIV testing. 4. Develops and reviews care pathways with a range of health services, including sexual health, hepatology and mental health. 5. Audits and reviews its needle exchange provision at planned and regular intervals**.**	**3. Develops pathways with relevant health services, including:** a. Sexual health. b. Hepatology. c. Mental health	Y	
Standard Three: Initial Assessment The organisation: 1. Informs a service user of the organisation's confidentiality policy prior to initial assessment.	**1. A confidentiality policy and protocol, which is discussed with a service user before the initial assessment is conducted.**	Y	
2. Conducts a full initial assessment of service user need prior to starting treatment.	**2. An assessment protocol which outlines:** a. The information that is collected at assessment. b. The form in which information is recorded.	Y	See main report in relation to assessments recorded on Rio.
3. Ensures the service user is fully involved in the assessment.	**3. An assessment procedure which addresses how the assessment process:** a. Engages and involves the service user in discussing the implications of their needs and identified risks. b. Addresses recovery to determine the strengths and aspirations of the service user. c. Uses a range of methods to obtain the service user's view of their needs and strengths, including using node link mapping and outcome tools. d. Is culturally appropriate.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
4. Obtains written permission from service users to share or access information from other organisations, funders or family member, carers and significant others.	**4. A protocol for discussing the reasons for sharing information with service users.**	Y	
5. Assesses risks to the service user and others as part of the assessment. Where a service carries out community care assessments:	**5. A record of permission to share information that is signed by the service user.**	Y	
6. Conduct Community Care Assessments in line with the requirements of the Local Authority and social care legislation, including using required documentation and complying with local systems for presenting assessments and making decisions based on the assessment	**6. A risk assessment tool that is completed at initial assessment and reviewed at regular intervals. This may include:** a. Risk of suicide or self-harm. b. Risk of harm to children. c. Parenting capacity. d. Risk of harm to others, including family members, carers and significant others, other residents and staff. e. Risk of self-neglect. f. Risk of harm from others, including family member, carers and significant others.	N	See main report in relation to recording of risk assessments.
	7. A protocol to be followed where immediate risks are identified. This may include: a. Referral to other agencies such as mental health or domestic abuse services. b. Reporting safeguarding issues of neglect or abuse to the appropriate organisations, c. Breaching confidentiality, including the circumstances when this will happen and the procedures to be followed.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Four: Care Planning The organisation: 1. Develops care plans that address the needs identified at assessment in partnership with the service user.	**1. Develops care planning documentation which:** a. Clearly specifies the service user's needs. b. Identifies how needs and risks have changed as treatment progresses. c. Sets out the service user's recovery goals for treatment targets that set out plans for reintegration and aftercare from the outset of treatment. d. Identifies the phased and layered interventions and/or activities that are planned to meet the service user's needs as they progress on their treatment journey e.g. e. Counselling or psychotherapy. f. Other psychosocial interventions. g. Parenting capacity development. h. Group work. i. Education and training . Identifies service users recovery capital, and ways to maximise its use, including: j. Housing support/ move on accommodation. k. Employment and volunteering opportunities. l. Strengthening and developing social networks or other opportunities to develop social capital. m. Access to mutual aid. n. Sets out the details of other health, social care and criminal justice services involved in the service user's recovery. o. Sets out targets and timescales for interventions. p. Includes review dates to determine changes in needs and recovery capital so that interventions are optimised in terms of their range and intensity. q. Is signed and dated by the service user and the key worker when initially created and at reviews.	Y	A mental health care planning policy was in place plus a DAT assessment form B. Service users were asked to sign the assessment. The assessments were not easy to use by service users and could be in a more accessible format.
2. Establishes collaborative care plans that have clear recovery goals and targets that set out plans for reintegration and aftercare from the outset of treatment and include timescales and review dates with service users.	**2. Uses outcome-based tools (such as TOP) to map service user's progress as a basis for discussion with the service user and for data and monitoring purposes.**	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
3. Develops care plans that are culturally appropriate and which are presented in a way that service users can use and refer to, e.g. graphics based.	**3. In agreement with the service user, includes peers and family members as part of their care planned recovery.**	Y	
4. Develops and reviews risk management plans.	**4. Completes and regularly reviews risk management plans**	Y	
5. Regularly reviews care plans to ensure that needs and risks are reassessed and addressed.	**5. Regularly updates care plans that reflect a service user's changing needs and risks.**	N	Of the 10 clinical records seen, three had not been reviewed within three months.
6. Maintains records of care plans in service user notes, which are stored securely.	**6. Stores care plans securely and ensures that service users have access to their own care plan.**	Y	
Standard Five: Psychosocial Interventions The organisation: 1. Offers service users access to a range of psychosocial interventions with a focus on achieving recovery outcomes over and above the provision of key working sessions. This may include the following interventions: • Contingency management. • Behavioural couples therapy. • Community reinforcement approach. • Social behaviour network therapy. • Cognitive behavioural relapse prevention-based therapy. • Psychodynamic therapy.	**1 Policies and procedures related to the delivery of psychosocial interventions.** This may include: a. A role description for staff delivering psychosocial interventions, including content on required competence, qualifications and professional registration. b. A protocol that sets out the psychosocial interventions that may be used at different stages of service users' treatment journeys. c. A protocol that sets out the psychosocial interventions that may be offered to family members and carers affected by someone's substance use. d. A policy and procedure setting out the clinical supervision requirements for staff delivering psychosocial interventions. e. The evidence base for the psychosocial interventions delivered by the service. f. The process for clinical audit of psychosocial interventions.	N	Clinical audit of psychosocial interventions did not take place.
2. Takes a stepped care approach to the provision of psychosocial interventions, using interventions to engage and support a service user at each stage of their treatment journey.	**2. Up to date information on external providers of psychosocial interventions and psychological therapies**	N	See main report in relation to the lack of access to psychology and counselling services.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
3. Provide specific interventions to family members and carers that do not require that the substance using family member is in treatment or, if in treatment with the service, does not include the substance using family member. This may include: • One-to-one family support interventions. • Family and carer groups. • Advice and signposting. • Informal training/skills development around coping skills, setting boundaries etc.	**3. Care pathways with external providers of psychosocial interventions and psychological therapies**	N	See main report in relation to the lack of access to psychology and counselling services.
4. Ensures that all staff delivering psychosocial interventions are appropriately trained. 5. Provides clinical supervision for staff delivering psychosocial interventions. 6. Conducts regular clinical audit into the delivery of psychosocial interventions. 7. Ensures that service users are supported to identify and access external providers of psychosocial and psychological therapies.	**4. Information for service users to support their self-referral to local services such as IAPT.**	N	See main report in relation to the lack of access to psychology and counselling services.
Standard Six: Organisational governance. Statutory sector providers: 1. Ensures that lines of management accountability are clear and made known to staff.	**1. Graphic and written content which sets out the organisational lines of management accountability.**	Y	
2. Ensure that corporate strategic developments include inputs from the substance misuse operational part of the organisation.	**2. Systems that include operational input into the strategic development of the organisation.**	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
3. Support and develop service users to contribute to strategic developments.	**3. Policies and procedures that support the involvement of service users in strategic developments. This should include:** • Service user involvement policies and procedures. • Reward and recognition policies and procedures. • Training plans for service user development	N	Policies and procedures to support service user involvement in strategic developments for the drug and alcohol service were not yet in place.
4. Inform the appropriate regulatory authorities of the staff who undertake required statutory roles within the organisation.	**4. Inform the appropriate regulatory authorities of the staff who undertake required statutory roles within the organisation.**	Y	
5. Ensures information about the organisation's Caldicott Guardian is made available to staff and service users.	**5. Makes information publicly available naming the organisation's Caldicott Guardian.**	Y	
Standard Seven: Clinical Governance The organisation: 1. Establishes an accountability structure that is made known to all staff, service users and family members, carers and significant others.	**1. An accountability structure which includes details of:** a. Trustees or Company Directors. b. Senior managers. c. Operational managers. d. Processes for making decisions about changes to policy and/or practice.	Y	
2. Ensures its complaints procedures is made known to all staff, service users and family members, carers and significant others.	**2. A complaints procedure which outlines:** a. The ways to make complaints. b. The processes the organisation uses to consider complaints.	Y	
3. Ensures that a service user and family members, carers and significant others compliments procedure is in place and is implemented.	**3. A plan that sets out a cycle of policy and procedure reviews.**	Y	
4. Takes a planned approach to reviewing policies and procedures to ensure that they remain fit for purpose.	**4. Policies and procedures that have a previous review date and a planned future review date indicated on them.**	Y	
5. Implements methods of gathering and analysing feedback from service users.	**5. Mechanisms to gather and analyse feedback from service users, such as:** a. Suggestion boxes. b. Service user satisfaction surveys. c. Feedback groups. d. Focus groups.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
6. Utilises an approach to clinical governance which regularly reviews practice and which responds to incidents and complaints.	**6. A clinical governance policy which sets out the organisation's approach to:** a. A proactive clinical audit cycle. b. Using clinical audit to investigate incidents. c. Using the evidence from clinical audits to develop and improve interventions. d. Demonstrating compliance with CQC and other regulatory requirements.	Y	
7. Maintains a record of statutory notifications to CQC so that it can continually evaluate its compliance with CQC expectations.	**7. Processes, procedures or records which show:** a. Discussions about complaints, reviews, audit or evaluation reports between managers and staff, which demonstrate the ways in which information has been used to develop practice. b. The use of monitoring data to review practice. c. The use of ongoing evaluation of interventions to consider their implementation and adjust them as indicated by the evaluation. d. The use of information from compliments to motivate staff.	Y	
8. Establishes a learning culture where evidence is used to make improvements and consolidate good practice.	**8. Processes and procedures for collecting and analysing data that demonstrate the impact of the service on service users.**	Y	
9. Evaluates the interventions it employs on an ongoing basis and uses this information to make improvements and consolidate good practice.	**9. Processes for using the analysis of impact to inform the work of the organisation.**	Y	
10. Uses data to measure and demonstrate the impact of the service.	**10. A process to disseminate reports of impact to commissioners, other funders of the service, service users and family members, carers and significant others of service users.**	Y	
11. Ensures that emergency disruptions to the service have minimal impact.	**11. An emergency disruption policy and procedure which includes:** a. Evacuation procedures if there is a fire, flood or gas leak. b. Management of prescribing regimes if access to medications is limited c. Management of medical conditions. d. Plans for relocation of residents if disruption closes a building overnight or longer. e. Off-site secure back-up of computer records.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
12. Supports and promotes high quality research as part of a service culture that is receptive to the development and implementation of best practice in the delivery of care. 13. Provides strong leadership of research and a clear strategy linking research to national priorities and needs, the organisation's business, clinical governance and delivery of best value. 14. Maintains information on all research being undertaken in the organisation on a database containing details of research providers, funding, intellectual property rights, recruitment, research outputs and impact. 15. Ensures patients, service users and carers, care professionals and other staff have easy access to information on research.	**12. A research governance policy and procedure which includes:** a. A procedure to be undertaken if the organisation is approached by external research organisations. b. The processes to be undertaken if the organisation intends to conduct research, including the procedures for obtaining ethical approval. c. Procedures for utilising research evidence to review practice. d. Processes for making information on research available.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Eight: Service information. The organisation: 1. Develops a content that describes the service and the interventions it offers and is individual to the service where it is part of a group of providers or a larger organisation.	**1. Content describing the service and its interventions that is included in any written information or promotional material(s) and prominently displayed on its website. This can include:** a. A clear description of the aims of the service. b. The service user group(s) the service works with, e.g. gender, ethnicity comorbidities. c. Eligibility criteria. d. Information about confidentiality and its limits, e.g. in relation to safeguarding. e. The professionals and services available to service users, e.g. complementary therapists, mutual aid groups.	Y	
2. Provides access to information about its quality of service and is clear about its registration with inspectorate bodies, such as CQC. 3. Ensures that information about the service, its approach and its staff is made available to service users.	**2. Information about other forms of accreditation gained by the organisation displayed on its website, e.g. Investors in People accreditation.**	N/A	The service did not have other forms of accreditation. Staff were members of the Federation for Drug and Alcohol Practitioners.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Nine: Service environment The organisation: 1. Ensures that service users can address their needs in a safe environment. 2. Defines the collaborative nature of its programme of interventions to service users and staff. 3. Offers service users person-centred care which addresses their specific needs in the context of the organisation's philosophy and approach. 4. Recognizes, respects and is sensitive to diversity issues. 5. Supports service users to observe their beliefs, religion or faith. 6. Ensures that both male and female workers are available who are trained in gender specific work. 7. Ensures that the organisation and its staff are responsive to service user's sexuality	a. Policies and procedures that outline the action that will be taken if there is harassment or bullying of either service users or staff. b. A health and safety policy and procedure. c. A managing violence and aggression policy and procedure. d. A service user rights and responsibilities policy, which is clearly displayed in communal and treatment areas. e. Policies and procedures that outline how it will take a person-centred approach. f. Policies and procedures that set out the organisations approach to diversity. g. Policies and procedures that outline how the organisation approaches service user's beliefs, religion and beliefs. h. Policies and procedures that set out the criteria for selecting a specific gender of worker for a service user. i. Policies and procedures that set out the competences required to work with service users on gender specific issues. j. Policies and procedures that set out the organisation's approach to service user's sexuality. k. An approach to service provision that is imparted to staff in team meetings and supervision, that recognizes that staff are able to provide therapeutic interventions in all situations while at work and that this is not limited to keyworking sessions, counselling interventions or group work. This should include a discussion of boundaries.	Y	
Standard Ten: Joint working. The organisation: 1. Develops and maintains effective relationships with a range of external organisations.	**1. Protocols and procedures with external organisations that detail the nature of the relationship. This will include:** a. Information sharing. b. Joint meetings. c. Reviewing care. d. Reviewing the efficacy of the joint working relationship.	Y	Arrangements for joint working were strong and well-documented.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
2. Develops care pathways with organisations identified as common key elements of service users' recovery plans.	**2. Referral (into and out of the substance misuse service) procedures with external services, such as:** a. Acute hospital settings, including Emergency Departments and hepatology. b. Primary Care. c. Mental health, including community mental teams and local inpatient provision. d. Social Care, including children's services and adult services. e. Maternity services. f. Mutual Aid including 12-step and /SMART Recovery, and informal, user-led advocacy or peer support organisations. g. Children and Young People's services. h. Criminal Justice, including the National Probation Service (NPS), Community Rehabilitation Companies (CRCs), police and prisons.	Y	
3. Maintains contact with service users while they are in residential rehabilitation or residential crisis care to ensure that appropriate support is put into place upon their discharge from residential care.	**3. Procedures that set out how contact will be maintained with service users while they are in residential rehabilitation or residential crisis care.**	Y	
Standard Eleven: Health and Wellbeing. The organisation: 1. Provides harm reduction advice and information to service users and their families/carers.	**1. Harm reduction literature made available to service users. This advice will include advice on:** a. Wellbeing and mental health. b. Diet, obesity and physical exercise. c. Blood-borne viruses and sexual health. d. Smoking cessation. e. Overdose prevention.	Y	
2. Promotes health and wellbeing advice and support with service users, including smoking cessation.	**2. Mandatory training for staff on giving harm reduction advice and information.**	Y	
3. Provides service users with access to blood-borne virus testing.	**3. Harm reduction interventions that are a part of all service user care plans.**	Y	
4. Offers access to vaccinations.	**4. Provision to offer smoking cessation, including nicotine patches, gum and smoking cessation groups.**	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
5. Supports service users to access local primary care services.	**5. Provision of programmes for vaccinations to service users.**	N	Vaccinations were provided by primary care and not by DAT, despite DAT's willingness to provide this service.
6. Promotes the health and wellbeing of staff.	**6. Facilities to provide testing of blood-borne viruses to service users.**	Y	
	7. Policies and procedures relating to staff support and access to occupational health and employee assistance programmes.	Y	
	8. Provides access to a range of external providers of health advice and support, including: a. Wound care. b. Well woman clinics. c. Diabetes. d. Exercise. e. Nutrition. f. Dentistry. g. Opticians. h. GUM clinics. i. Podiatry	Y	
Standard Twelve: Developing and managing service user involvement. The organisation: 1. Develops a service user involvement strategy and implementation plan.	**1. A service user consultation process including processes for gathering service user feedback such as:** a. Focus group. b. Regular service user surveys.	N	See further consideration 2 in the main report
2. Ensures that service users are offered training that develops them to be effectively involved.	**2. A service user involvement strategy which may include:** a. Procedures and processes for involving current and ex-service users in approaches to making recovery visible, including developing them as peer mentors, advocates and coaches. b. Processes for identifying service users who may want to be involved in organisational processes. • The activities that service users may be involved in (membership of the board, working groups, staff recruitment). c. The organisation's expectations of involved service users. d. Building links with local peer support and user-led services where appropriate. e. The support that the organisation will provide for involved service users.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
3. Clarifies the role boundaries for service users involved in organisational processes.	**3. A process for identifying the training needs of involved service users. This may include:** a. Understanding business processes. b. Being involved in staff recruitment. c. Confidentiality and data protection. d. Providing advocacy. An agreement or contract with service users about their involvement.	N	Processes for involving service users in 'a' and 'c' were not yet in place. Some work was being undertaken as part of the implementation of the DHSC Service User Experience and Engagement Strategy
Standard Thirteen: Developing and managing family member, carers and significant others involvement in service user recovery. The organisation: 1. Promotes and explains family members, carers and significant others involvement with service users and their family member, carers and significant others.	**1. Information about the evidence of the benefits of family, carers and significant others involvement to give to service users.**	Y	
2. Offers opportunities to involve family members, carers and significant others at all stages of care.	**2. Provides informal avenues for family members to become involved in care and support. This may include awareness raising activities such as:** • Open days. • Coffee mornings.	Y	DAT had a good range of approaches to enabling family members to become involved.
	3. Policies and procedures that describe how family members, carers and significant others may be involved in care and support. This may include: a. Service user consent for family, carers and significant others involvement b. Family, carers and significant others involvement in assessment. c. Family, carers and significant others involvement in care planning. d. Family, carers and significant others involvement in reviewing care.	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Fourteen: Human resource management. The organisation: 1. Ensures that it develops and maintains a policies and procedures handbook that includes policies relating to staff management.	**1. A policies and procedures handbook which may include content on:** a. quality and diversity. b. Health and Safety and Hygiene. c. Disciplinary, grievance and capability. d. Annual leave. e. Compassionate leave. f. Management of absence. g. Maternity and Paternity leave. h. Pay structure. i. Supervision and appraisal and personal development plans. j. Drug and alcohol in the workplace policy. k. Disclosure of personal information policy. l. Work/life balance policy. m. A relapse policy for staff in recovery. n. Employee gifts and beneficiaries policy. o. Information technology policy (use of e-mail/internet and virus protection/firewalls). p. Access to occupational health. q. Harassment Policy. r. Access to an Employee Assistance Programme	Y	
2. Develops managers to implement the policies and procedures handbook.	**2. A training needs analysis process that includes an assessment of manager competence.**	Y	
3. Implements staff retention strategies. 4. Provides staff with access to occupational health.	**3. Strategies to support the retention of staff. This may include:** a. Providing mentoring or coaching to staff. b. Involving staff in operational decisions. c. Involving staff in innovating the service. d. Providing a safe and confidential mechanism for staff to make complaints or register concerns. e. Having a work/life balance policy	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Fifteen: Recruiting staff and volunteers. The organisation: 1. Conducts recruitment procedures in a fair and transparent way.	**1. Policies and procedures that outline the organisation's approach to recruitment of both paid staff and volunteers. This should include:** a. Advertising procedures. b. Competence based job descriptions. c. Person specifications that include any qualification requirements. d. Application procedures, including compliance with equalities and data protection legislation. e. Membership of interview panels (including the presence of trained and supported service users on interview panels). f. Processes for assessing the suitability of candidates at interview, e.g. scoring schedules. g. Processes for supporting volunteers in recovery? h. Processes for informing candidates of the outcome of interviews. i. Processes for requesting references.	Y	
2. Conducts recruitment checks, including of references, Disclosure and Barring Service (DBS) checks and required insurance, on prospective paid staff and volunteers. 3. Provides a contract for volunteers.	**2. A volunteer contract which sets out:** • The volunteer role. • The role of the volunteer. • The behaviours expected of volunteers. • The boundaries of the volunteer role. • The support and development the volunteer can expect the organisation to provide, including the frequency of supervision. • The support available to volunteer if they are in recovery.	N	Volunteers had previously not been allowed within Isle of Man mental health services but this policy was being reviewed and DAT was actively involved in developing and implementing the new policy.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Sixteen: Staff and volunteer induction. The organisation: 1. Develops and maintains a policies and procedures handbook.	**1. A regularly updated policies and procedures handbook that is prominently displayed and accessible to all paid staff and volunteers.**	Y	
2. Ensure that all new paid staff and volunteers undergo a formal induction procedure, procedure that includes the philosophy, ethos and methodology of the service.	**2. An agreed formal induction process. This may include:** a. Required reading of policies and procedures. b. Meetings with internal staff. c. Meetings with external organisations. d. Opportunities to discuss the philosophy of the service, expectations of staff behaviour and the boundaries of relationships between staff members and between staff and service user, including the use of social media. e. Attendance at open mutual aid meetings to gain insight into service user support options.	Y	
3. Conducts an analysis of a staff member or volunteer's training needs during induction.	**3. A procedure to review a staff member's or volunteer's competence and consider any training needs.**	Y	
4. Applies a formal probationary period policy and procedure.	**4. A policy and procedure for assessing a staff member or volunteer's suitability during their probationary period and giving feedback on this to the staff member or volunteer. This may include:** • The duration of the probationary period. • The points during the probationary period when performance will be reviewed. • The procedures that will be followed during the probationary period if performance is not satisfactory. • The process to be followed if a probationary period is extended. • The procedures that will be followed at the end of the probationary period if performance is not satisfactory, including procedures for terminating employment.	N/A	The Isle of Man Department of Health and Social Care did not use a probationary period of employment. Other mechanisms were in place to ensure maintenance of key competences for staff. Reviewers suggested that DAT may want to develop a process of active assessment of competence following induction.

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Seventeen: Managing staff and volunteer development. The organisation: 1. Monitors and develops the competence of its paid staff and volunteers.	**1. Policies and procedures to benchmark and measure paid staff and volunteers competence. This may include:** a. Job descriptions mapped to standards of competence that relate to the paid staff members and volunteer's job role and the activities of the service. b. Organisational competence frameworks.	Y	
2. Provides regular management supervision to its paid staff and volunteers.	**2. Policies and procedures that establish the organisational approach to supervision and appraisal. This may include:** a. Information about the frequency of supervision and appraisal. b. A pro-forma supervision record. (i) A pro-forma appraisal record. c. Procedures for documenting and storing supervision and (i) appraisal records. d. Arrangements for individual, external and group supervision	Y	
3. Ensures that clinical staff have access to regular clinical supervision.	**3. Processes in place to monitor and support to monitor and support paid staff and volunteers to maintain their professional** a. accreditation; or b. registration	Y	
4. Offers regular appraisal to paid staff and volunteers.	**4. Audit and incident analysis policies and procedures, which involve paid staff and volunteers and which include opportunities to learn from their findings.**	Y	
5. Ensures that paid staff and volunteers are supported to meet their professional registration requirements.	**5. Processes to identify training needs. This may include:** a. Formal training needs analyses or skills audits. b. Information collated from supervision and appraisal and service user feedback	Y	
6. Creates a learning environment for paid staff and volunteers. 7. Analyses paid staff and volunteers training needs and plans to meet these needs.	**6. Information about mandatory training and where this can be accessed.**	Y	

Standards Content	Organisational Evidence required to meet the Standard	Met? Y/N	Comments
Standard Eighteen: Managing trainee/student placements and apprenticeships. The organisation: 1. Develops and manages students, trainees or apprentice placements. 2. Provides training placements for students, trainees or apprentices and post-qualifying professional development opportunities for qualified practitioners. 3. Offers induction to the organisation to the person on placement. 4. Liaise with the person's educational establishment. 5. Provides written reports on the person's progress as required.	**1. Policies and procedures that address the organisation's approach to placements. This should include:** a. Recruitment processes, including compliance with equalities and data protection legislation. b. An induction procedure. c. Arrangements for ongoing support and supervision. d. Arrangements for communication with the person's tutor(s)	Y	

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