Independent Hospitals

Core Standards

Registration & Inspection Unit

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Department of Social Care

Rhyenn Kiarail y Theay
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Introduction

Aims
This document sets out the Standards that registered providers are expected to apply to their service. These are the minimum standards required and the Regulation of Care Act requires that the DSC considers these standards when making regulatory decisions; there are opportunities within the Standards for registered providers to be creative, innovative and dynamic when applying them to their service, and providers should use them as a baseline from which to deliver and develop services to the people who use them.

Regulatory Context
The Regulation of Care Act (ROCA) 2013 and associated regulations has replaced existing legislation on the Isle of Man that governed the care of adults and children receiving services that were subject to regulation. This has resulted in some services being re-categorised and a number of services not previously subject to regulation being included. Independent hospitals are the re-categorisation of nursing homes providing a certain type of service and of mental nursing homes.

These standards will form the basis for judgements made by the DSC as to how providers are meeting their obligations under the ROCA, the Registration Regulations and the Care Service (Monitoring) regulations and will therefore consider the degree to which a regulated service complies with the standards when determining whether or not a service should be registered or have its registration cancelled, or whether to take any action for breach of regulations.

Structure and Approach
The standards for independent hospitals focus on ensuring that service recipients receive treatment and services in independent hospitals that are safe and quality-assured and are, as a minimum, compatible with standards in the NHS. They are the core standards applied to a range of hospitals providing specific services and are supplemented by service-specific standards that apply to each prescribed service coming under the definition of an independent hospital.

Each standard is preceded by a statement of the intended outcome for service recipients. Whilst the standards are qualitative – they provide a tool for judging if people are receiving safe and quality-assured treatment and services – they are also measurable. Regulators will look for evidence that the requirements are being met through:

- Discussions with service recipients, staff and managers and others;
- Observation of arrangements in the hospital;
- Scrutiny of written policies, procedures and records.

The Standards have been developed to require and encourage registered providers/managers to deliver services to people that promote the following values:

- Privacy
- Dignity
- Safety
- Choice
- Realising Potential
- Equality and Diversity
INTRODUCTION, ASSESSMENT AND ADMISSION

Standard 1

Outcome
Service recipients receive clear and accurate information about the service, their treatment and its likely costs

1.1 The hospital has available for prospective service recipients and their families a statement of purpose and a service recipient guide expressed in clear, relevant language and in a format suitable for the profile of the establishment or with regard to language and translation, people with sensory disabilities or people with learning disability.

1.2 The service recipient guide is reviewed annually to ensure the information in it remains up to date.

1.3 The guide includes information about
- The services philosophy and ethos.
- The terms and conditions of treatment if any.
- A copy of the hospitals complaints procedure.
- A statement of service recipient rights.
- An outline of the policies and procedures that affect the people receiving treatment; for example confidentiality, risk assessments, accident reporting etc.
- A brief outline of staffing arrangements, training and qualifications.

1.4 Service recipients are actively encouraged to make suggestions and comments about the service recipient guide.

1.5 The registered person ensures that information on the treatment provided by the hospital is not misleading and information provided to people and is accurate and that any claims made in respect of treatment are justified.

QUALITY OF TREATMENT AND CARE

STANDARD 2

OUTCOME
The treatment and care provided are person-centred. Treatment provided is in line with the relevant clinical guidelines. Dying and death is handled appropriately and sensitively

2.1 The registered person has policies and procedures in place to ensure that the care provided is person-centred, as follows:
- assessment of service recipients health needs is timely, appropriate and accurate;
- service recipients are informed of the recommended interventions for treatment and/or care;
• service recipients give verbal consent to all intimate examinations, and are offered a chaperone if undergoing such an examination, or are able to bring a relative or friend with them if they wish;
• service recipients, and their relatives if appropriate, are consulted about the planning and delivery of services provided to them, which includes taking into account their preferences and requests;
• service recipients have access to their health records in line with the:
  - Data Protection Act 2002;
  - recommendations of the Caldicott Committee report,
  - Report on the review of service recipient-identifiable information; and
  - guidelines from professional bodies
• people’s rights are central to the resuscitation policy;
• services are provided in such a way that facilitates access by people of different cultural and ethnic backgrounds and those with physical disabilities, sensory disabilities and learning disabilities;
• privacy, dignity and confidentiality are respected at all times;
• service recipients are addressed by their preferred name and title; and are treated with courtesy, consideration and respect

2.2 DH guidance (Department of Health Guidance Reference Guidance to Consent for Examination or Treatment) on consent to treatment, including consent by children and the concept of ‘Gillick Competencies’ is followed.

2.3 Clinical procedures are explained to people so that they understand the implications of the treatment and any options available to them, allowing them to give valid consent or refusal (including discharging themselves against medical advice), which is documented in the service recipient’s health record.

2.4 People give written consent before receiving treatment where:
• the treatment or procedure is complex, or involves significant risks or side-effects;
• general/regional anaesthetic or sedation is to be used;
• clinical care is not the primary purpose of the procedure;
• there may be significant consequences for the person’s employment, social or personal life;
• the treatment is part of a project or programme of research.

2.5 Completed consent forms are kept with the person’s notes. Any changes to a form, made after the form has been signed by the person, are initialled and dated by both service recipient and health care professional.

2.6 There is a written policy and procedure to follow when the person does not have the capacity to give valid consent to treatment. (In the absence of capacity legislation on the Isle of Man, the guidance provided by the Department is to be followed).

2.7 There is a written policy and procedure on how to respond to advance directives (living wills).

2.8 There are facilities for people to have confidential discussions with health care professionals that ensure privacy.
2.9 Service recipients who choose not to discuss health related matters with members of the opposite sex receive, where possible, consultations with health care professionals of the same sex.

2.10 There are written policies on the prevention of harassment and bullying of service recipients by staff and or other service recipients, in line with the UKCC guidance: ‘Practitioner/client relationships and the prevention of abuse.’

2.11 The management of specific conditions takes account of evaluations by the National Institute for Clinical Excellence (NICE) in relation to effective clinical practice and service recipient safety and specific clinical guidelines from the relevant medical Royal Colleges, healthcare professional institutions and the NHS National Service Frameworks.

2.12 Training for health care professionals is provided in meeting the needs of people with physical disability, sensory disability and/or learning disabilities, appropriate to the profile for the establishment.

2.13 Care and comfort are given to people who are dying, their death is handled with dignity and propriety, and their emotional, psychological and spiritual needs, rites and functions observed.

2.14 Clinical staffing levels are such to allow attention to the physical care needs of the people and to provide pain relief and symptom control as required.

2.15 The person’s wishes concerning terminal care and arrangements after death are discussed, and documented in the care plan. If a person does not wish to discuss these matters this should also be recorded. The person’s family and friends are involved (if that is what the person wants) in planning for and dealing with terminal illness and death.

2.16 People’s wishes in the event of their death are ascertained and recorded in their plan. The homes staff team follow a written policy that promotes dignity when supporting people who are dying and at death. The privacy and dignity of the person who is dying are maintained at all times.

2.17 In situations where the service recipient’s death is anticipated, palliative care, practical assistance and advice, and bereavement/support counselling are provided by trained professionals/specialist agencies trained volunteers.

2.18 There is a written resuscitation policy for the establishment/agency, which is:
   • developed in discussion with (as a minimum) the senior health care professionals
   • in line with Resuscitation Council (UK) guidelines;
   • includes a section on ethical/legal consideration.

2.19 The resuscitation policy is brought to the attention of all personnel.

2.20 There is a member of staff on duty at all times trained in basic resuscitation techniques with up-date training on an annual basis.

2.21 Every effort is made to have in place arrangements in regard to a competent person’s wishes for resuscitation and where it is the wish of the person not to be resuscitated, this is discussed with the persons medical practitioner and a do not resuscitate (DNR) form is completed that includes the doctors signature. DNR instructions should be reviewed regularly.
ENVIRONMENTAL AND PERSONAL SAFETY AND COMFORT

Standard 3

<table>
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<th>Outcome</th>
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<tr>
<td>Systems, checks, policies, procedures and staff training ensure that people’s dignity, well-being and safety is promoted and protected.</td>
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3.1 The registered person has written processes that comply with relevant guidance and instruction to ensure the safety of the premises and environment. Robust policies, procedures and training, support people to be safeguarded and protected from poor practice and abuse.

3.2 All staff have access at all times to a detailed process that describes the steps they will take if they receive an allegation or suspect abuse is occurring.

3.3 There is a whistle blowing policy that staff understand and use to make known their concerns. Detailed records are made and retained on issues raised around safeguarding. A copy of the most current Isle of Man Adult Protection Procedures is read, understood and complied with by all staff in the home.

3.4 Mandatory safeguarding training is undertaken with 6 months of appointment for all new staff. Staff are aware of the types of abuse including physical, sexual, psychological, financial or material neglect, acts of omission and discriminatory or institutional abuse. Prior to the training, and within one week of the start date, the registered person reviews and explains the safeguarding process to the new employee.

3.5 The hospitals complaints procedure is written in plain language, displayed at the service and is accessible to all people. Where required the procedure is available in an easy to read version, audio version and Braille etc. The complaints policy and/or procedure includes the following:

- It provides assurance to people receiving a service that their complaint will be taken seriously and there will be no retribution for making a complaint
- Provides information as to who the complaint may be referred to if not satisfied with the outcome
- Provides information on how people can access an independent advocate to support them in making a complaint.
- Makes appropriate provision for handling any complaint against the registered provider/manager of the service

3.6 The registered person ensures that when complaints are accepted they are recorded. The complainant receives a written acknowledgement, and following an investigation, a written outcome. The acknowledgement will be received by the complainant within seven days of making the complaint. The outcome will be received by the complaint within twenty eight days. Where the outcome is delayed the complainant will be advised in writing of the delay.

3.7 Fire precautions and fire safety is managed in the home:

- The home has a written Fire Risk Assessment that is compliant with the Isle of Man Fire Safety guidance and instructions.
• Staff are trained in fire safety as soon after their appointment as is reasonably practicable and within three months.

• Records confirm that weekly alarm tests monthly fire fighting equipment (including emergency lighting) checks, and fire drills carried out at least twice per annum are carried out.

• Compliance with the Isle of Man Fire Safety Department requirements, recommendations and advice is evident.

3.8 The registered person makes available a range of policies and procedures that support safety, health and hygiene and ensures the home complies with relevant legislation including the Health and Safety at Work Act 1974.

3.9 Staff have received training and follow robust policies in relation to cross infection and hygiene control and are able to demonstrate their understanding and practice in their routines.

3.10 The Food Hygiene Regulations 2007 are complied with and records made to demonstrate compliance.

3.11 Advice, guidance and records in relation to the Control of Substances Hazardous to Health Regulations (COSHH) 1999 are maintained.

3.12 Reporting Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) are complied with and recorded.

3.13 Electricity at Work Regulations 1989 is complied with. A certificate of conformity/safety is available for the homes electrical installations that are in compliance with “The 17th Edition, Wiring Regulations” or equivalent. Portable Electrical Appliance Tests are carried out and recorded in compliance with current guidance and instruction.

3.14 Regulation of water temperatures and design solutions to control the risk of exposure to Legionella micro-organisms (water stored in tanks at 60 degrees c) and risk from hot water temperatures (not exceeding 44 degrees C for baths and 41 degrees for showers and wash hand basins) are carried out in keeping with requirements and guidance and recorded. (Water Supply (Water Fittings) Regulations 1999).

3.15 Central heating and boiler maintenance is carried out and recorded, and where appropriate compliance with Gas Safety (Installation and Use) Regulations 1998 is complied with.

3.16 Passenger lifts and pressure vessels have periodic inspections by a competent person and records are kept.

3.17 Where there is a medical gas line(s), there is a written procedure for any interruption of such a line to be authorised by the registered manager or by a person authorised by the registered manager.

3.18 The service has in place, and displayed, appropriate public liability insurance

3.19 Waste is segregated into clinical and non-clinical items and stored in colour-coded bags and containers.

3.20 Clinical waste is labelled to enable it to be traced back to its point of origin.

3.21 Clinical waste stored outside the building is kept in locked containers.
3.22 Health care workers (including practitioners with practising privileges) comply with Department of Health guidelines on health care workers infected with blood borne virus (hepatitis B, hepatitis C, HIV).

3.23 There are written instructions for health care workers and practitioners with practising privileges on the steps required by the establishment in order to ensure their compliance and notification of infection status in line with the guidelines.

3.24 Health care workers who perform exposure-prone procedures are required to provide documentary evidence of their vaccination status with regard to hepatitis B, or to be tested for, and vaccinated against, hepatitis B if there is no evidence of previous vaccination produced.

3.25 The establishment/agency keeps vaccination records, or other documentary evidence of the vaccination status, for all health care workers employed and all practitioners with practising privileges.

3.26 Medical devices intended for single use are not reprocessed for reuse and re-usable medical devices are decontaminated in accordance with legislative and best practice requirements.

**EQUIPMENT & SUPPLIES**

**STANDARD 4**

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<th>OUTCOME</th>
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<td>All equipment is checked for safety and is maintained in good condition. All supplies are deemed suitable and safe for the purpose.</td>
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4.1 There is a comprehensive risk assessment and a maintenance plan that covers all areas of the registered premises and the equipment.

4.2 Equipment is installed, checked and serviced in compliance with the manufacturer’s instructions.

4.3 Equipment is not modified unless the manufacturer’s advice has been sought, and no risk has been identified.

4.4 All equipment conforms to current health and safety regulations and, where appropriate, there is a planned preventive maintenance and replacement programme.

4.5 Records are kept of the maintenance and servicing of all equipment.

4.6 **Stock** products used in the establishment are used in date order to ensure that at the time of use they are in optimum condition and within expiry dates.

4.7 Heat sensitive and/or light sensitive items are stored in a controlled environment to keep the items in optimum condition.

**STAFFING**
Standard 5

**Outcome**

Staff are recruited following a rigorous and robust recruitment programme. There are sufficient numbers of trained competent staff to meet the needs of the people at the home.

5.1 The registered person operates an Equal Opportunities Employment Policy when recruiting staff. The policy is a written one and it demonstrates that applicants are treated equally and fairly when applying for employment. Robust tests determine the applicant’s character and fitness for the post. Current employment legislation is followed.

5.2 Staff are provided with a clear definition of their roles and responsibilities (job description etc.). Contracts of employment and/or terms and conditions of employment detail their employment obligations.

5.3 Staff files (including volunteers) contain:

- A completed application form and interview notes
- The names and addresses of two referees who may be approached to comment on the applicant’s suitability (one of those referees is the applicant last employer). Those references are taken up and contained in the file by the employer.
- Evidence of a relevant Disclosure and Barring Scheme check.
- A statement that the applicant has no known medical condition that will debar them from carrying out their duties.
- Certificates of qualifications and achievements, for qualified nurses an up to date PIN number.

5.4 Successful applicants are employed under a minimum 3 month induction/probationary period which consist of regular one to one meetings with their direct line manager. A written induction programme is followed and signed off by supervisor and inductee.

5.5 All new staff working directly with service recipients work supernumery during their first week, shadowing experienced workers.

5.6 Induction training for staff working directly with service recipients consists of mandatory training including:

- First aid
- Moving and handling (if appropriate)
- Medication training
- Physical Intervention
- Safeguarding/ Adult and Child Protection.
- Fire Training
- Communication
- Food Hygiene (if appropriate)
- Health and Safety
• Infection Control
• Nutrition
• Value based training (privacy dignity, resident’s rights etc.)

5.7 Training for ancillary staff is designed to meet the needs of their specific role and induction training will consist of mandatory training relevant to that role.

5.8 The training is completed within the induction/probationary period time scales, unless extended by agreement; the employee’s line manager along with the employee reviews and evaluates the effect of the training on performance prior to confirming the appointment in writing.

5.9 Individual training needs and gaps are identified by the manager of the service and the staff member during an ongoing programme of regular one to one/supervision sessions. One to one sessions are, as a minimum, held every 6 weeks unless the manager regularly works alongside each staff member in which case, sessions may occur less frequently.

5.10 All staff will have an annual appraisal of their performance.

5.11 Records of one to one supervision sessions and annual performance appraisals will be maintained on the person’s individual file and a copy provided to the person.

5.12 Where specialist support is provided to people, for example, people with dementia, people with learning disabilities, people with mental health problems and people with physical disabilities. A discrete and separate training programme is in place.

5.13 Health care professionals are required to abide by published codes of professional practice relevant to their professional role.

5.14 There is written information for health care professionals that explicitly states that any breach of such codes is regarded as a disciplinary offence. This may be included in the contract of employment, practising privileges agreement, or staff handbook.

5.15 Health care professionals take part in the on-going continuing professional development (CPD) required by their professional body and /or Specialist College, including revalidation requirements of the GMC.

5.16 A written training policy and programme is in place to ensure that non nursing staff are trained and competent to do their jobs, and qualified staff maintain and update their training. The programme contains a commitment to have a minimum of 50% of its care/support staff trained to QCF (Quality Care Framework) level 2/3 standards (or equivalent), according to job role and, in this regard, the skills for care recommendations are to be followed. The training programme makes provision for refresher training to take place.

5.17 Training programmes are delivered by competent and knowledgeable trainers, and are regularly evaluated to ensure continuing fitness for purpose.

5.18 Following all staff training an evaluation check is carried out and recorded by the manager of the service indicating that the training is being practiced by the staff team.

5.19 Team meetings that discuss the business of the care service and its operation occur regularly; as a minimum two per annum for services where managers and staff work alongside each other and, as a minimum, six per annum for other services. Agendas are set prior to the meeting taking place and minutes of the meeting are provided and retained following the decisions and agreement made at the meeting.
5.20 Staffing levels and staff deployment are determined following a regular written dependency assessment of residents needs. Assessments are also undertaken when people’s needs change, for example an outbreak of a contagious illness, admissions to the home etc. The assessments include reference to the layout of the home and the skills mix and experience of the staff team.

5.21 Staff rotas are accurate and reflective of actual persons and hours worked on each day. Where changes are made these are clear and able to be understood. Shift leaders are clearly identified on the rota.

5.22 Where staff are employed through an agency it is the responsibility of the registered person to ensure that rigorous checks and balances are in place to ensure competence and suitability to perform the role.

**MANAGEMENT, QUALITY AND IMPROVEMENT**

**Standard 6**

<table>
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<th>Outcome</th>
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<tr>
<td>People have confidence that the systems in place support the smooth running of the hospital. The registered manager is qualified and competent to manage the hospital. People are consulted about how the hospital is run and their opinions are taken into account. The hospital has an annual development plan that makes provision for the home to develop and improve.</td>
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6.1 The registered manager is qualified and experienced in his/her role. Improvements and development items are identified by the registered manager, the staff team and the people living or coming into contact with the home. Those forming part of the management team are assisted and supported to develop their management skills.

6.2 The registered manager has a relevant professional qualification and experience of working with the people being cared for and in addition is qualified to a:

- QCF level 5 Diploma in Leadership for Health and Social Care and Children and Young People Services or equivalent.

There are clear lines of accountability within the team. People forming part of the management team and deputising for the registered manager have a relevant professional qualification and significant experience of working with the people being cared for, and are qualified to a:

- QCF level 3 Diploma in Health and Social Care and Children and Young Peoples Services or equivalent.

Shift leaders are nominated at all shifts and those shift leaders have a relevant professional qualification and significant experience of working with the people being cared for, and are qualified to, or are enrolled on:

- QCF level 3 Diploma in Health and Social Care and Children and Young People’s Services or equivalent.

With regard to the above qualifications all existing staff should have commenced the appropriate award within 4 years of the inception of these standards. Managers new to registration will be given a time frame that is
appropriate to the date of their registration. From 1st April 2019 managers will not be registered unless they have gained or are in the process of gaining the QCF level 5 in Leadership for Health and Social Care and Children and Young people Services, or equivalent.

6.3 The registered person makes available to staff a comprehensive policy and procedure file. The policy documents cover all aspects of work including practical task, administrative tasks and legal/ethical responsibilities such as Health and Safety (legal), promoting dignity (ethical). The documents underpin all staff practice and provide a framework from which service is delivered. The registered manager sets in place systems to ensure the staff team are familiar with and comply with the policy documents whilst at work. People receiving treatment can ask for copies of the policy and procedure documents.

6.4 Policy and Procedure documents are regularly reviewed and dated on the front cover to indicate the date of the review and when the next review is due.

6.5 People receiving treatment and their relative/representative and those visiting the hospital, including healthcare professionals, are provided with opportunities, and where appropriate, canvassed for their views on how the home is run, for example a suggestion box or written questionnaire is provided.

6.6 Formal quality assurance systems are in place and the registered person uses a range of tools to measure the quality of the service provided. This will include:

- numbers and types of complaints received and any learning resulting from this
- comments and compliments about the service from a range of stakeholders
- accident and incident reports
- observations of those using the service
- views of staff working at the service
- the outcomes of clinical and nursing audits;
- the use of comparative information on clinical outcomes;
- evaluation against research findings and evidence based practice;
- effective information and clinical record systems;
- procedures for identifying and learning from adverse health events and near misses;

6.7 An annual report lists the success of the service and introduces a written development/improvement plan based on the outcomes of the quality assessment exercise. The plan is displayed and available to all.

6.8 The registered person has in place systems to check and monitor staff activity to ensure compliance with the terms and conditions of their employment and the homes policy and procedural requirements.

6.9 Paperwork, records and documents are maintained in good order, are legible and are kept up to date.

6.10 A written policy is displayed in the home informing people of their rights to access their files and records at any time. Where access is restricted this is explained to the individual.

6.11 The registered person ensures confidentiality of personal information and complies with the principles outlined within the Data Protection Act 2002.
6.12 Where the registered manager and the registered person are not the same person, biannual visits are made to the home by a person not working at the home. This visit is part of the quality assessment and the visitor carries out an assessment in relation to the premises, staffing levels and skills, customer/resident satisfaction and record making. Where the registered person and the manager are the same person the manager carries out their own assessment. Written reports are produced following the assessments.

6.13 The registered person makes provision for people to have their small personal belongings (i.e. jewellery) stored safely. A record is kept of all such items stored and of when the items are returned to the person. The record to be signed and witnessed by persons other than the service recipient.

Practising Privileges

Standard 7

**OUTCOME**

Service recipients receive treatment from appropriately recruited, trained and qualified health care professionals.

7.1 Where health care professionals are granted practising privileges (ie the grant to a person who is not employed in the establishment of permission to practise in that establishment) there are written policies and procedures on allowing practising privileges.

7.2 The following pre and post-employment checks are carried out before a health care professional is granted practising privileges:

- that the practitioner is registered with the appropriate professional regulatory body;
- that the practitioner is trained and is experienced in the type of treatment he/she is given practising privileges to perform;
- that the practitioner declares whether or not he/she:
  - is currently the subject of any police investigation and/or prosecution, in the UK or any other country;
  - has ever been convicted of any criminal offence required by law to be disclosed, received a police caution in the UK, or a criminal conviction in any other country;
  - is currently the subject of any investigation or proceedings by any body having regulatory functions in relation to health/social care professionals including such a regulatory body in another country;
  - has ever been disqualified from the practice of a profession or required to practise it subject to specified limitations following a fitness to practise investigation by a regulatory body, in the UK or another country.
- that the practitioner is interviewed before employment, and that records of interview and written references are retained;
- that qualifications relevant to the post applied for are verified by validation at the interview;
that the practitioner is appropriately registered, whether that registration covers the duties to be undertaken and whether there are any restrictions in place or investigations underway by the relevant regulatory/licensing body;

that employment references are sought from the two most recent employers prior to making an offer of employment;

that a DBS check is carried out at the level required for people working directly with service recipients;

that indemnification is checked and authenticated;

that documentary proof is maintained of the continuing registration with the respective professional regulatory body;

that the procedures for practitioners to follow when gifts are offered from service recipients, and what may and may not be accepted, are set out;

that the practitioner who is offered practising privileges has his/her identity confirmed through the presentation of a valid birth certificate, and passport or driving licence;

that there are arrangements in place for ensuring the validity of work permits are verified and that their status is clarified.

7.3 There is a written agreement with the practitioner setting out:

• the details of the practising privileges, which includes a stated requirement of the practitioner’s availability to attend the establishment within a certain time limit if notified of a problem with a service recipient;

• that he/she will comply with the organisation’s policies and procedures including the complaints procedure, and which requires the practitioner to inform the appropriate person if a complaint is made directly to him/her in the first instance.

• that the practitioner is required to place a copy of all clinical notes relating to care or treatment at the establishment in the person’s health record retained by the hospital.

7.4 There are arrangements in place for continuing professional development.

7.5 The practitioner is made aware of the current policies and procedures in the hospital, and a list of the relevant policies and procedures that he or she is expected to be familiar with, is provided.

7.6 Practising privileges are reviewed for each practitioner every two years, as a minimum and may be reviewed more frequently as a result of concerns about practice or complaints received by the hospital.

CATERING AND NUTRITION
Standard 8

OUTCOME
Service recipients are provide with wholesome and nutritious meals and food is handled, stored, prepared and delivered in accordance with food safety legislation

8.1 Staff who handle food undertake initial training in food hygiene on appointment and annual up-date training thereafter.
8.2 Food is nutritious, balanced and varied and meets any special needs of the service recipient, including age-related requirements for children and the elderly.
8.3 Special diets are provided on the advice of professional staff or a dietician, including dietary supplements.
8.4 Religious or cultural needs are catered for.
8.5 Food is presented in a manner which is attractive and appealing in terms of texture and flavour.
8.6 Drinking water is available at all times of the day/night and hot drinks and snacks are available to service recipients outside of mealtimes.
8.7 Staff assist people to eat, when necessary due to illness or disability.

RISK MANAGEMENT

Standard 9

OUTCOME
Service recipients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately.

9.1 The registered person ensures that there is a comprehensive written risk management policy and procedures, which cover:
   • the identification and assessment of risks throughout the establishment;
   • the precautions in place control the risks identified;
   • health and safety;
   • infection control;
   • decontamination;
   • arrangements for the identification, recording, analysing and learning from adverse health events or near misses;
   • arrangements for responding to emergencies;
   • protection of vulnerable children and adults, including protection from abuse.
9.2 Arrangements are in place for dealing with ‘alert letters’ in accordance with Department of Health guidance and directions.
9.3 Arrangements are in place for dealing effectively with ‘hazard notices’ when these are received.

9.4 There is a written procedure setting out the responsibilities for informing the DSC and national professional bodies such as the GMC about staff who have been suspended on clinical or professional grounds, or practitioners whose practising privileges have been suspended, restricted or withdrawn on professional or clinical grounds.

9.5 A named member of staff is identified to receive information from the Medical Devices Agency, and report relevant matters to the Agency (including failure of, and accidents in connection with, medical devices).

9.6 A named member of staff is identified to receive information from the Medicines Control Agency, and report relevant matters to the Agency.

9.7 Where in-patient care is provided there is a nurse call system installed throughout the service recipient care areas of the establishment including all service recipient bedrooms, toilet and shower/bathrooms.

**Medicines Management**

**Standard 10**

**OUTCOME**

Measures are in place to ensure the safe management and secure handling of medicines. Medicines, dressings and medical gases are handled in a safe and secure manner. Controlled drugs are stored, administered and destroyed appropriately.

10.1 Medicines are handled according to the requirements of the Medicines Act 1968 and the Misuse of Drugs Act 1971; and with nursing staff following the UKCC Guidelines for the Administration of Medicines (October 2000) and pharmacists their professional Code of Ethics.

10.2 There is a written medicines policy and procedure, accessible to staff, covering all aspects of medicines systems and medical gases in the establishment/agency, which covers:

- ordering, procurement, receipt, storage, administration and disposal of medicines;
- the action to be taken in case of adverse reactions;
- error reporting.

10.3 The medicines required for resuscitation or other medical emergency are accessible and in suitable packaging.

10.4 All medicine is administered to a service recipient with a written prescription or, internal to the hospital, a drug administration chart that has been signed by an authorised prescriber.

10.5 There is a written policy for the steps to be followed in the exceptional circumstances where a medicine is administered without a written direction, for example, a life threatening situation.

10.6 All medicine doses are prepared immediately prior to their administration from the container in which they are dispensed.
10.7 Medicines prescribed and labelled received against a prescription for named service recipients are not used for any other person.

10.8 Information is given to people about the use, benefits and potential harms of medication prescribed.

10.9 The establishment has access to up-to-date, relevant reference sources, for example the British National Formulary, the Summary of Product Characteristics for every product used and access to evaluated information about medicines.

10.10 Medicines are used as specified in the Summary of Product Characteristics, unless there is a body of evaluated evidence to support any use outside this licence, in which case service recipients are informed that the medicine is used outside the Summary of Product Characteristics.

10.11 When clinical trials take place they are undertaken in accordance with relevant legislation and best practice guidelines and with local research ethics committee approval.

10.12 When service recipient group directions are used they comply with Department of Health/Medicines Control Agency guidance.

10.13 A record is kept of ordering, receipt, supply, administration and disposal of all medicines dressings and medical gases in order to maintain an audit trail.

10.14 Lockable storage is provided for:
- controlled drugs in accordance with the Misuse of Drugs (Safe Custody) Regulations 1973;
- medicines for external use;
- medicines for internal use;
- medicines requiring cold storage;
- diagnostic reagents (other than test strips);
- flammable substances.

10.15 The storage of medical gases should be in accordance with guidance set out in Health Equipment Information No 163,2/87.

10.16 The keys of all cupboards used for the storage of medicines are held securely, including spare keys.

10.17 Medicines requiring cold storage are not kept in refrigerators used for domestic purposes but in a separate, designated refrigerator.

10.18 There is daily monitoring of the temperature of the refrigerator used to store medicinal products, using a maximum/minimum thermometer, which is recorded and signed by the person monitoring the temperature and a written procedure is in place indicating the action to be taken if the temperature is outside the normal range.

10.19 Controlled drugs are handled in compliance with the requirements of the Misuse of Drugs Act and its regulations.

10.20 A hospital that holds stocks of controlled drugs listed in Schedule 2 of the Misuse of Drugs Act has a Home Office licence (unless the hospital is wholly or mainly maintained by voluntary funds or by a registered charity).

10.21 Where a pharmacist is employed, the purchase and issue of controlled drugs must be under his or her direct supervision and includes authorising orders to suppliers.
10.22 Where no pharmacist is employed, a medical practitioner or a dentist must countersign orders signed by the registered nurse for a controlled drug.

10.23 In the case of Schedule 2 controlled drugs (except those in Schedules 4 and 5) an appropriate record is kept of the invoices, receipt, administration and disposal of the drugs in accordance with the Misuse of Drugs Regulations 1985.

10.24 Controlled drugs are either destroyed in the presence of an authorised person (that is a police officer, an inspector of the Home Office Drugs Branch or an inspector of the Royal Pharmaceutical Society of Great Britain), or the person to whom this function has been formally delegated, such as the registered manager or registered nurse of the hospital or sealed and returned to the Pharmacy for destruction in accordance with a written policy and procedure.

Completion of Health Records

Standard 11

**OUTCOME**

Service Recipients are assured of appropriately completed health records.

11.1 Entries made in the people’s health records by health care professionals are dated, timed and signed, with the signature accompanied by the name and designation of the signatory.

11.2 Entries in health records are legible.

11.3 Any alterations or additions are dated, timed and signed, and made in such a way that the original entry can still be read.

11.4 Health care professionals record all treatment given and recommendations made in the service recipients health record.

11.5 A summary of the health record is sent to the person’s GP within a locally agreed timescale, but which is no more than four weeks.

11.6 When the referral is not from the service recipient’s GP, the service recipient is asked to formally sign a form to give or refuse consent for sending details of the treatment provided (the consultant’s discharge letter) to his/her GP.

11.7 If the service recipient does not give consent for details to be sent to his/her GP, a summary of the treatment provided is given direct to the service recipient so that he/she has it for future reference, to pass on to the GP.

Research
Standard 12

**OUTCOME**
Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any service recipients involved, in line with published guidance on the conduct of research projects.

12.1 There is a written policy which states whether or not research is carried out in the establishment.

12.2 Where the policy states that research is carried out within the establishment, there are written procedures that set out the requirements to be met concerning research projects.

12.3 All clinical research projects are conducted in accordance with the Department of Health research governance framework.

12.4 Any new interventional procedures to be carried out in the establishment are referred to NICE.

12.5 All clinical research projects are approved by a Research Ethics Committee.

12.6 There are documented agreements in place for the allocation of responsibilities between all parties involved.

12.7 The lead professional for each research project is documented.

12.8 The responsibilities of the lead professional include:
- the management of the research project;
- the monitoring of progress on the project.

12.9 There are documented agreements in place between the establishment/agency and their personnel and between the establishment/agency and funders about ownership, exploitation and income from any intellectual property that may arise from research conducted on their premises.

12.10 Records are kept of all research projects, including information about the service recipients involved, or service recipients whose data or tissue has been used in the project, for 15 years after the conclusion of the treatment.

12.11 Lawful consent or authorisation is obtained for the participation of any service recipient in a research project.

12.12 The registered person is responsible for ensuring that all research projects undertaken are appropriate for the organisation to be involved in and are properly managed.
Appendix 1.

Glossary

**Accident**
Any unexpected or unforeseen occurrence, especially one that results in injury or damage.

**Accident report**
A written report of an accident. The format of the report is laid down in health and safety legislation.

**Accountability**
The state of being answerable for one's decisions and actions. Accountability cannot be delegated.

**Audit**
The process of setting or adopting standards and measuring performance against those standards with the aim of identifying both good and bad practice and implementing changes to achieve unmet standards.

**Adolescents**
Young people in the process of moving from childhood to adulthood. Adolescents may have special needs as service recipients/users.

**Adverse clinical incident**
An incident, accident or occurrence, relating to clinical systems or procedures which results in harm, or an injury, or near miss to a service recipient/user or member of staff.

**Advocate**
An individual who acts independently on behalf of, and in the interests of, service recipients/users who may feel unable to represent themselves in their contacts with a health care or other facility.

**Aim**
Overall purpose or goal of a department or service.

**Annual report**
A report, written annually, which details progress over the last year and plans for the following year, which includes financial and activity statements.

**Care plan**
A document which details the care and treatment that a service recipient receives and identifies who delivers the care and treatment. This term covers the term 'individual plan' (see also health record).

**Care programme approach (CPA)**
The individual packages of care (care programmes), developed in conjunction with social services, for all service recipients accepted by the specialist psychiatric services. Care programmes may range from 'minimal' single worker assessment and monitoring, for individuals with less severe mental health and social needs, to complex and multi professional assessments and treatment.
Carer
A person who may be paid or unpaid, who regularly helps another person, often a relative or friend with domestic, physical, emotional or personal care as a result of illness or disability. This term incorporates spouses, partners, parents, guardians, paid carers, other relatives, and voluntary carers who are not health professionals.

Checklist
A means of recording observations relating to fixed criteria, used to check compliance with agreed procedures or standards.

Clinical governance
A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical responsibilities
Range of activities for which a clinician is accountable.

Consultant
Medical Practitioner who works independently without supervision.

Continuing education
Activities which provide education and training to staff. These may be used to prepare for specialisation or career development as well as facilitating personal development.

Contract/agreement
The document agreed between providers of health care and the purchasers of health care detailing activity, financial and quality levels to be achieved.

COSHH
Acronym for the control of substances hazards to health legislation.

Criterion
A measurable component of performance. A number of criteria need to be met to achieve the desired standards.

Critical care – Level 1
Service recipients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward without additional advice and support from the critical care team.

Critical care – Level 2
Service recipients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those stepping down from higher levels of care.

Critical care – Level 3
Service recipients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex service recipients requiring support for multi-organ failure.
Duty of care
Duty of health care staff to put the care and safety of the service recipient/user first in all circumstances.

Errors
Mistakes made by staff in the performance of their duties.

Evaluation
The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.

Food hygiene
Taking all measures necessary to ensure the safety and wholesomeness of foodstuffs.

Hazards
The potential to cause harm, including ill-health and injury, damage to property, plant, products or the environment, production losses or increased liabilities.

Health and safety policy
A plan of action for the health, safety and well-being of staff, service recipients/users, residents and visitors.

Healthcare workers
Any staff who come into direct contact with service recipients who are receiving treatment, including ancillary staff as well as healthcare professionals.

Health record
The record of all aspects of the service recipients treatment, otherwise known as the service recipients notes.

Hospital acquired infection
An infection acquired by a service recipient/user during their stay in hospital which is unconnected with their reason for admission.

ICD code
International classification of diseases coding system.

Incident
An event or occurrence, especially one which leads to problems. An example of this could be an attack on one person by another within a service.

Induction programme
Learning activities designed to enable newly appointed staff to function effectively in a new position.

Job description
Details of accountability, responsibility, formal lines of communication, principal duties, entitlements and performance review. A guide for an individual in a specific position within an organisation.
Keyworker
A keyworker is the person responsible for co-ordinating the care plan for each individual service recipient/user, for monitoring its progress and for staying in regular contact with the service recipient/user and everyone involved. A keyworker can come from a variety of different professional or non-professional backgrounds.

Manual handling
Any transportation of a load by picking up, setting down, pushing, pulling, carrying or moving thereof, by hand or bodily force.

Monitoring
The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.

Multiprofessional
A combination of several professions working towards a common aim.

Near miss
An incident, or an incident avoided, which it is realised had the potential to cause harm on injury.

Objective
A specific and measurable statement which set out how overall aims are to be achieved.

Organisation
The term used in this publication to describe the entire organisation, as opposed to the term service, which is used to describe one part of the organisation (see also service).

Organisational chart
A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.

Outcome
The end result of care and treatment, that is the change in health, functional ability, symptoms or situation of the person, which can be used to measure the effectiveness of care and treatment.

Service recipient survey
Seeking the views of service recipients through responses to pre-prepared questions and carried out through interview or self-completion questionnaires.

Personnel
All those who work in the regulated establishment/agency i.e. those with practising privileges as well as staff.

Planning
The process by which the service determines how it will achieve its aims and objectives. This includes identifying the resources which will be needed to meet the aims and objectives.

Policy
An operational statement of intent in a given situation.
**Procedure**
The steps taken to fulfil a policy.

**Professional standards**
Professionally agreed levels of performance.

**Protocol**
The adoption, by all staff, of national or local guidelines to meet local requirements in a specified way.

**Quality Assurance (QA)**
A generic term to cover the review of the quality of services provided, along with interventions designed to improve that quality through theremedying of deficiencies identified by the review process. The review may include both qualitative and quantitative measurements and may or may not relate to clearly stated standards.

**Research and development**
The searching out of knowledge and evidence about the relationship between different factors in the provision of services. Research does not require action in response to findings.

**Review**
The examination of a particular aspect of a service or care setting so that problem areas requiring corrective action can be identified.

**Risk management**
A systematic approach to the management of risk, to reduce loss of life, financial loss, loss of staff availability, staff and service recipient/client/user safety, loss of availability of buildings or equipment, or loss of reputation.

**Risk management strategy**
A written statement of objectives for the management of risk and a plan for meeting those objectives. The strategy should be consistent with the business plan.

**Serious untoward incident**
An accident or occurrence which results in significant injury to a service recipient/user, member of staff, carer or visitor.

**Skill mix**
The balance of skill, qualifications and experience of nursing and other clinical staff employed in a particular area.

**Staff**
Those employed by the regulated establishment/agency.

**Standard**
An overall statement of desired performance.

**Survey**
The collection of views from a sample of people in order to obtain a representative picture of the views of the total population being studied.
Untoward incident
Any incident, accident or occurrence, relating to clinical or non clinical work which could result in an injury or near miss to a service recipient/user member of staff or visitor.

Valid consent
The legal principle by which a service recipient/user is informed about the nature, purpose and likely effects of any treatment proposed before being asked to consent to accepting it.

Vital services
These services are essential to the normal operation of the organisation. Examples include electricity, water, medical gases and telecommunications.