The Regulation and Quality Improvement Authority

Acute Hospital Inspection Core Indicators

Date	
Trust	
Ward	
Inspector/Peer Reviewer Name	

Contents Page

Inspection Details and Participants

Date of Inspection:	
Trust/Hospital:	
Ward* and Speciality: *Term ward denotes: department, unit, patient area	
Name of Inspectors:	
Name of Clinician:	
Name of Peer Reviewers:	
Name of Lay Assessor:	

The Inspection Framework

The RQIA Acute Hospital Inspection Programme is designed to support HSC trusts to understand how they deliver care, identify what works well and where further improvements are needed. The inspection framework has been designed to support the Acute Hospital Inspection Programme and to assess 4 key stakeholder outcomes (See Section 3 of the Inspection Guidance).

Is Care Safe? Is Care Effective? Is Care Compassionate? Is The Area Well Led?

The inspection framework includes:

- The use of data, evidence and information to inform the inspection process
- Core Indicators
- Feedback from patients, relatives/carers
- Feedback from staff
- Direct observation
- Observation sessions (QUIS)
- The review of relevant documentation and patients care records

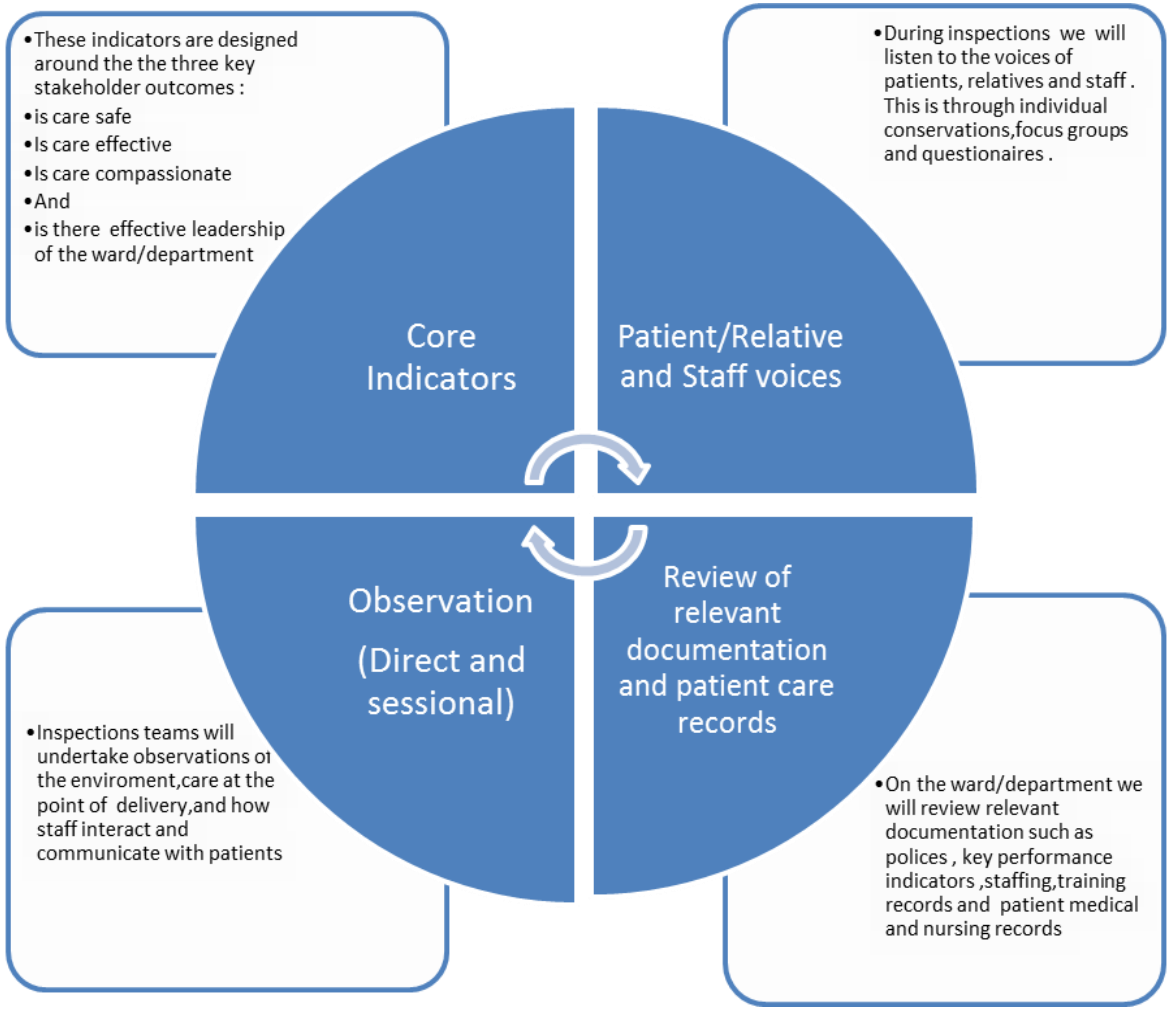
Supported by:

- The use of peer reviewers (staff who are engaged in the day to day delivery of health and social care)
- The use of lay assessors (who are service users and members of the public and who bring their own experience, fresh insight and a public focus to our inspections)

The Inspection Framework draws from a range of sources including Department of Health (DoH) standards and guidelines, NICE Guidelines and other best practice standards and guidelines which are relevant to the delivery of safe, high quality care and treatment in a hospital setting. In addition the inspection teams will rely on other sources of published information such as HSC trust Quality Reports. The framework for the inspection is explained more fully in the inspection guidance.

To enable the inspection team to reach an overall outcome assessment as to the performance of the wards or departments subject to inspection the inspection will be based on the framework shown below:

Inspection Framework



Core Indicators

The core indicators are designed around 14 areas for inspection, each area of inspection is underpinned by relevant criteria. Each indicator will correlate to one aspect the four domains of Safe, Effective, Compassionate care and Leadership and Management of the Clinical Area.

Is Care Safe?	Is Care Effective?	Is Care Compassionate?
Environmental Safety and Infection Prevention and Control Patient Safety Medicines Management	Nursing Care Records Medical Care Records Nutrition and Hydration Pain Management Pressure Ulcers Promotion of Continence and the Management of Incontinence	Person Centred Care Communication End of Life Care This section includes the outcomes of Patient and Relative Questionnaires and Observation Sessions'

Is the Area Well Led?
Leadership and Management of the Hospital

The assessment process is detailed in the **Acute Hospital Inspection Guidance** available online at www.rqia.org.uk.

The inspection framework is designed to enable the inspection team to reach a rounded conclusion as to the performance of the wards or departments subject to inspection.

General Information

This page should be used to record any general information about the area being inspected e.g. number of beds, ward layout, handover times, names of key staff etc.

Number of beds	
Number of patients	
Number of patient outliers/inliers (breakdown of type)	
Name and Grade of nurse currently in charge of the ward	
Number of cubicles/ side rooms (include en suite/isolation rooms)	
Additional information from nurse in charge on types of patient on ward e.g. infections, diabetes, end of life, pain management etc.	
Ask for copies of Medical and Nursing handover sheets	

Additional Information

Staffing Information

Normative Staffing Requirements (WTE) Funded staffing levels Actual staffing levels Deficit in staffing levels ***Complete Documentation Booklet**	
Medical staff (dedicated to ward as well as those cross-covering)	
Medical rounds (number/timing)	
Allied Health Professionals e.g. **Occupational Therapist,** **SALT,** **Dietician,** **Physiotherapists,** **Social Worker,** **Pharmacist**	
Others e.g. **Domestic staff** **Specialist nurse/nurse practitioner**	
Administrative	

Additional Information

WELL LED

AREA FOR INSPECTION: Leadership and Management of the Clinical Area **OUTCOME: Effective leadership is displayed, the clinical area is managed and organised in a way that patients and staff feel safe, secure and supported. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Governance					
1. The ward sister*/nurse in charge is easily identifiable, visible and available to support ward activities. *Term ward sister denotes: Charge Nurse, Ward Sister and Ward Manager	Ask staff				
2. Staff have access to a range of policies and guidance documents at ward level.	Ask staff Review Documentation *(Documentation Booklet)*				
3. Staff are aware of how to report incidences and near misses to promote a safety culture.	Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
Staffing					
4. Has normative staffing been implemented in the ward. Outline constraints	Ask ward sister				
5. Where there are identified deficits in nursing staffing, appropriate escalation systems are in place. Check normative staffing range/ratio has been agreed	Review Documentation (Duty rota/Agreed staffing complement/use of bank/ agency staff)				
6. Does the skill mix meet the needs of the ward.	Ask ward sister				
7. Are there concerns in the turnover in staffing over the last year.	Ask staff				
8. There is evidence that absence/sickness levels are monitored and effectively managed (staff cover is easily accessible).	Ask staff Review Documentation				
9. There is evidence of forward planning when vacancies arise.	Ask staff Review Documentation				
10. The ward sister is supervisory and there is evidence of clinical leadership and management.	Ask staff (named lead/staff) Review Documentation (Duty rota/Agreed staffing complement)				

	SOURCE	YES	NO	N/A	COMMENTS
11. The ward sister has the necessary support to carry out their role (dedicated ward administration/ward support, deputy staff carry out designated duties).	Ask staff				
12. There is evidence of effective MDT working including AHPs and social workers.	Ask staff Review Documentation (Whiteboards etc.)				
13. Has patients care or discharge been compromised due to delays in AHP assessments and intervention.	Ask staff				
14. AHP services are available seven days a week e.g. mental health/protocols, older people's care, safeguarding, social services.	Ask staff				
15. Staff have the necessary skills to discharge their responsibilities and effective delegation is in place. **(3)** (e.g. Triage, mandatory training)	Ask staff				
16. Staff feel comfortable raising concerns with others on the ward when they see something that may negatively affect patient care. **(3)**	Ask staff Review Documentation Refer to focus group				

	SOURCE	YES	NO	N/A	COMMENTS
17. Staff feel supported when safety/ security issues arise.	Ask staff				
18. There is adequate medical staffing to provide care and appropriate escalation procedures when deficits are identified. (Are there agreed medical staffing numbers for the ward and is this achieved).	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check
19. Escalation of clinical concerns to colleagues within or between teams is in keeping with local policy. (Discussion between the relevant medical staff, either in person or by telephone conversation).	Ask staff *(Medical Booklet)*				*Clinician to check

	SOURCE	YES	NO	N/A	COMMENTS
Patient Flow					
20. Nursing staff are aware of the patient care needs* and can identify and expedite the patients journey when appropriate. **(3)** *blood/x-ray results, investigations, discharge letters Outline any issues that affect staff from carrying this out	Observe Ask staff				
21. There is evidence of effective engagement with patient flow.	Observe Ask staff				
22. What care pathways are in place to optimise patient care if applicable e.g. stroke, chest pain.	Ask staff				
23. There is evidence of an effective system* in use for medical handovers. *please describe/ note current system	Observe Ask staff *(Medical Booklet)*				*Clinician to check
24. Where there are patients outlying, there is a system in place to ensure that these patients are reviewed and a plan of care updated daily.	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check
25. Junior medical staff are supported with decision making. **(3)**	Ask staff Review Documentation *(Medical Booklet)*				Clinician to check
26. The IT system is regularly updated and effective in tracking the patient location throughout the hospital.	Ask staff *(Medical Booklet)*				*Clinician to check

	SOURCE	YES	NO	N/A	COMMENTS
Communication					
27. The ward displays up to date results of safety/performance/patient experience audits for both patients and staff e.g. preventable pressure ulcers, cardiac arrests, HCAIs, falls, hand hygiene, environmental cleanliness.	Observe				
28. All ward clinical staff have access to the Electronic Care Record (ECR).	Ask staff *(Medical Booklet)*				*Clinician to check
Safeguarding					
29. Are staff aware of local safeguarding arrangements for both adult and children safeguarding and escalation protocols. (A nominated safeguarding champion is in place).	Ask staff				
30. Medical staff have been trained to complete a Understanding the Needs of Children in Northern Ireland (UNOCINI). **(3)**	Ask staff *(Medical Booklet)*				

Additional for Emergency Department (ED)					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Clinical Quality Indicators ***** Inspector to ask for statistics relating to past year					
31. An effective internal ED escalation policy is in place and links with overall trust policy (does it work, how often used, does it effectively link into the overall trust policy).	Review Documentation Ask staff *(Documentation Booklet)*				
32. Nursing and medical staff with overall clinical responsibility and leadership for the ED are present and effective. (staff know who is in charge)	Observe Ask staff				
33. There is safe and effective patient flow from ED to the ward (outline any reasons for delay that contribute to flow/crowding in the ED).	Observe Ask staff				
34. Is there direct admission to all specialities to assist patient flow.	Observe Ask staff				
35. Are services co-located beside the ED to assist with flow. e.g. x-ray, clinics	Observe Ask staff				
36. Current staffing levels facilitate a 1:1 nurse to patient ratio in resuscitation, based on the patient care needs.	Observe Ask sister				

	SOURCE	YES	NO	N/A	COMMENTS
37. Emergency departments have an effective IT system for tracking patients, integrated with other communications.	Review Documentation Ask staff Observe				
38. An ambulatory care service is in place and staff are aware and use it.	Ask staff Observe				
39. A consultant in emergency medicine is present and available to the team in the emergency department.* (*For level 1 EDs - a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety).	Review Documentation Ask staff *(Medical Record Booklet)*				*Clinician to check
40. A trained ST4 and above in emergency medicine is present in the emergency department.* (*For level 1 EDs - 24 hours a day, seven days a week) Quality and Safety Programme: ED London Quality Standards	Review Documentation Ask staff *(Medical Record Booklet)*				*Clinician to check

The following questions will be discussed with the ward sister/nurse in charge, evidence to support these questions should be provided at this time. **A list of documentation required to evidence these questions will be provided to the ward sister/nurse in charge of Day 1 of the inspection.**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Governance					
41. Staff have access to a range of policies and guidance documents at ward level. How are new policies disseminated to staff and embedded into practice. (Outline system in place/education/audit to ensure effective)	Ask staff Review Documentation *(Documentation Booklet)*				
42. Provide evidence of key performance indicators measured at ward level, compliance levels achieved and any action plans in place to improve practice.	Review Documentation (*Documentation Booklet)*				
43. How many of the following did you have in the last year: • SAIs • Complaints/compliments • RCAs • IR1 - completed for hospital acquired pressure ulcers (Grade 2 and above). • RCA completed for hospital acquired pressure ulcers (Grade 3 & 4)	Ask staff Review Documentation *(Documentation Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
44. Provide evidence that there is a mechanism in place to ensure staff learn from ward: • Key performance indicators • Incidents, accidents, near misses • Complaints/compliments • Audits/action plans • HCAIs and post infection review Staff are aware of these and any associated learning Standing agenda item that complaints are discussed at staff meetings	Ask staff Review Documentation *(Documentation Booklet)*				
45. Evidence of trend analysis in relation to complaints, compliments, incidents, accidents, and SAIs at corporate level and shared down professional lines.	Ask staff Review Documentation *(Documentation Booklet)*				
46. Are there mortality and morbidity meetings conducted in the organisation and shared down professional lines.	Ask staff Review Documentation *(Documentation Booklet)*				
47. There is evidence that the ward sister is tracking CDI and MRSA rates in their wards.	Ask staff Review Documentation *(Documentation Booklet)*				
48. Has a patient suffered a cardiac arrest in this ward in the last 3 months and a review of events leading up to arrest examined.	Ask staff Review Documentation *(Documentation Booklet)*				
49. There is evidence that the directorate risk register is examined, updated and mitigated in relation to issues identified on the ward.	Ask staff Review Documentation *(Documentation Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Staff Training & Supervision					
50. Is there a link person system in operation within the ward. Evidence dissemination of information to ward staff for learning.	Ask staff *(Documentation Booklet)*				
51. There is evidence of effective nursing induction, mentorship mandatory training, role specific training, with supportive documentation.	Review Documentation *(Documentation Booklet)*				
52. To support learners, the ward has sufficient number of nursing mentors and preceptors, with appropriate training.	Ask staff Review Documentation *(Documentation Booklet)*				
53. There is evidence of ongoing supervision and appraisal evidenced by records.	Review Documentation *(Documentation Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Communication					
54. There is evidence of effective communication and dissemination of information to all staff day/night duty. For example: • Safety briefing/handovers • Ward staff meeting – standard agenda • Patient safety/medical devices alerts • Vulnerable patients • Ward rounds • Nursing handover *please describe/note current system	Observe Ask staff Review Documentation *(Documentation Booklet)*				
55. Provide evidence of the mechanism in place to ensure the dissemination of information though the professional lines. For example/include frequency of meeting: • Improvement groups • Directorate sisters meeting • Lead nurse meetings • Governance meetings • Multi-professional meetings	Ask staff Review Documentation *(Documentation Booklet)*				
56. Patient experience data is captured, recorded and routinely analysed and acted on.	Ask staff Review Documentation *(Documentation Booklet)*				

Questions for Ward Sister	COMMENTS
1. What are the safety issues on this ward, do you have an improvement plan to address them.	
2. Are you aware of the trust, directorate quality safety plan and how do you input into it.	
3. Are you aware of the trust dress code policy and how do you monitor it.	
4. Is there a meeting on this ward to discuss ward governance issues.	
5. How are issues of patient flow escalated within the ward and trust.	
6. Tell us about good practice initiatives. Where changes in practice that have been made, please evidence improvement.	

Questions for Consultant On Ward	COMMENTS
1. What are the safety issues on this ward, do you have an improvement plan to address them.	
2. Are you aware of the trust, directorate quality safety plan and how do you input into it.	
3. Are you aware of the infection rates on this ward.	
4. How are you implementing the trust antibiotic prescribing guidance.	
5. Are you aware of the trust dress code policy and how do you monitor it.	

6. Is there a meeting on this ward to discuss ward governance issues.	
7. How are issues of patient flow escalated within the ward and trust.	
8. Tell us about good practice initiatives. Where changes in practice that have been made, please evidence improvement.	

Please use this box to identify any additional organisation and management initiatives/issues on the ward.

Have any areas for development been identified for the ward in the next 12 months? (e.g. lean, productive ward, dignity and care, butterfly scheme) Have staff received any additional training to enhance their skill? How are compliments recorded?

Comment on Best Practice/Failures/ Escalation

SAFE

AREA FOR INSPECTION: Environmental Safety and Infection Prevention and Control **OUTCOME: The environment is safe for patients, staff and visitors. Patients are cared for in an environment where the risk of cross infection is minimised. (SAFE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Environmental Safety					
1. The ward* environment is clutter free, in a good state of repair and free of trip and fall hazards. Equipment not in use is stored appropriately. *Term ward denotes: department, unit, patient area	Observe				
2. Ward lighting is sufficient to provide access to patients, devices and equipment. Monitoring equipment is audible.	Observe				
3. The needs of patients with dementia or mobility issues have been considered e.g. large clocks, calendars, signage, hand rails).	Observe				
4. Crowding/congestion/lack of space in the area does not comprise patient safety, infection prevention and control and the use of patient equipment (a timely response to emergency situation such as resuscitation, fire can be achieved).	Observe Ask staff				
5. There is no unauthorised access to the area.	Observe Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
6. Areas used as an overflow with additional beds have the appropriate equipment specification available e.g. resuscitation area or escalation bed on ward.	Observe Ask staff				
7. The space is adequate to meet the current footfall of patients, and the available space is used effectively.	Observe Ask staff				
8. Patient emergency exits are clearly identified, kept closed and not blocked.	Observe				
Infection Prevention and Control					
9. A patient equipment cleaning schedule is available. Equipment is clean, free from damage and in good repair. **(3)**	Observe				
10. The resuscitation trolley is: easily accessible, clean and sealed*, equipment is maintained and replaced, checks are carried out on a daily basis (checking schedules should identify and record that daily checking procedures have been completed). The contact details for the resuscitation crash team are clearly displayed.	Observe Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
11. Hand washing sinks are clean, accessible, located near to the point of care and are in accordance with local and national policy. **(3)**	Observe				
12. Alcohol rub is available at the ward entrance and directly accessible at the point of care/ treatment/ bed space.	Observe				
13. Clinical staff are compliant with the HSC trust dress code policy. **(3)**	Observe				
14. A range of Personal Protective Equipment (PPE) is available on the ward and worn appropriately.	Observe				
15. Invasive devices are managed in line with best practice guidance. **(3)**	Observe Ask staff Review Documentation *(Nursing Booklet)*				
16. Patients requiring isolation are in a single room or an appropriate cohort area with transmission based precautions in place and poster displayed.	Observe Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
17. Hand hygiene is performed at each of the WHO 5 moments of care using the 7 step technique. **(3)**	Observe Ask staff				
18. Staff are compliant with ANTT practices and can demonstrate when ANTT procedures are applied. **(3)** If ANTT practices are poor recommend ANTT competency training for staff	Observe Ask staff				
19. A bundle/care pathway/care plan is in place for patients with alert organisms. There is evidence of appropriate sampling, Bristol stool chart, daily review, timely administration of medications (e.g. MRSA/CDI).	Review Documentation				
20. If blood cultures were taken there is documentation of date, time, site and clinical indication for taking. **(3)**	Review Documentation *(Medical Record Booklet)*				*Clinician to check

The following questions will be discussed with the ward sister/nurse in charge, evidence to support these questions should be provided at this time. **A list of documentation required to evidence these questions will be provided to the ward sister/nurse in charge of Day 1 of the inspection.**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Environmental Safety					
21. The ward sister has considered the health and safety of her staff and patients and there is a health and safety risk assessment completed for this area. (There is an effective plan in place that has identified risks and actions in place to address same)	Review Documentation *(Documentation Booklet)*				
22. There is evidence of actions being addressed against the health and safety plan.	Observe Review Documentation *(Documentation Booklet)*				
Infection Prevention and Control					
23. Environmental cleanliness and hand hygiene audits currently meet trust compliance levels.	Observe Review Documentation *(Documentation Booklet)*				
24. The appropriate evidence based practice is used to prevent surgical site infections.	Review Documentation (*Documentation Booklet)*				

Please use this box to identify any additional environmental safety and infection control initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Patient Safety **OUTCOME: The delivery of patient care avoids, prevents and ameliorates outcomes or injuries stemming from healthcare. (SAFE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Does the ward comply with the NPSA alert in relation to armbands.* **(3)** *standardised hospital armband	Observe				
2. Patients who require supervision are risk assessed and located where their safety can be maintained. (Consideration is given to patient placement, safety, staffing and vulnerability).	Observe Ask staff				
3. The ward sister is satisfied that she and her team have the appropriate equipment to care for patients.	Ask Staff Observe				
4. Patients National Early Warning Score (NEWS) are accurate and trigger set. **(3)**	Review Documentation *(Nursing Booklet)*				
5. There is an appropriate clinical response to NEWS triggers. They are, documented and discussed at handover as per algorithm*. Actions include referral to more senior or specialised staff when certain scores are reached.***refer to Trust NEWS chart* (3)**	Ask staff Review Documentation *(Nursing Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
6. Staff are aware of who to contact for critically ill patients e.g. trauma team, anaesthetist. **(3)**	Ask Staff Observe				
7. If a patient has been identified for Sepsis management the appropriate measures* are in place or implemented in line with the care bundle. *(blood culture, urine output, fluids, antibiotics, lactate, oxygen)	Review Documentation *(Medical Booklet)*				*Clinician to check.
8. 24/7 key diagnostics are available.	Ask Staff *(Medical Booklet)*				*Clinician to check.
9. There is documented evidence that the patient has been involved in the decision making. **(3)**	Review Documentation *(Medical Booklet)*				*Clinician to check.
10. Consent forms are completed fully and appropriately in line with DHSSPS guidance. **(3)**	Review Documentation *(Medical Booklet)*				*Clinician to check.
11. A WHO Surgical Safety Checklist has been completed if necessary. **(3)**	Review Documentation *(Medical Booklet)*				*Clinician to check.

	SOURCE	YES	NO	N/A	COMMENTS
12. There is a VTE risk assessment completed for each patient on admission. **(3)**	Review Documentation *(Medical Booklet)*				*Clinician to check.
13. If a patient has been identified as at risk, VTE prophylaxis has been commenced. **(3)**	Review Documentation *(Medical Booklet)*				*Clinician to check.

Additional for Emergency Department (ED)					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
14. Regular patient reviews and safety rounds are carried out by the consultant and sister in charge. (identifying and dealing with issues of patient care/flow)	Observe Ask staff				
15. There is a protocol is in place to triage children and staff are aware of its contents.	Review Documentation Ask staff				
16. A system/ protocol is in place to follow up patients who leave the ED without being discharged or who have results/abnormal results. Staff are aware and implement. (ask for protocol/guidance)	Ask staff Observe				
Nursing Documentation (Flimsy)					
17. Patients waiting for a bed have their nursing treatment plan commenced. **(3)**	Review Documentation				
18. Patients have the appropriate nursing risk assessment completed if applicable (e.g. pressure care, dependency level). **(3)**	Review Documentation				

	SOURCE	YES	NO	N/A	
19. All documentation is completed in line with the NMC Code* written legibly, with clear signatures, dated, timed and signed, contemporaneous. **(3)** *Professional standards of practice and behaviour for nurses and midwives	Ask staff Review Documentation				
Medical Documentation(Flimsy)					
20. Patients have a documented ED medical assessment and plan of treatment. **(3)**	Review Documentation *(Medical Booklet)*				
21. All documentation is completed in line with best practice guidance written legibly, with clear signatures, GMC number, dated, timed and signed, contemporaneous. **(3)**	Review Documentation *(Medical Booklet)*				
22. There is evidence of investigation results being actioned. **(3)**	Review Documentation *(Medical Booklet)*				

	SOURCE	YES	NO	N/A	
23. Patients who have been triaged and not received an initial assessment and management by ED clinicians are re-triaged as their condition changes to ensure an appropriate medical management plan. (check local policy/procedure in place aswell)	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check
24. Patients who have undergone an initial assessment and management by ED clinicians who are referred to another specialist team, have a medical management plan (including the decision to admit or discharge) within one hour from referral to that team. (Quality and Safety Programme: ED. London Quality Standards)	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check
25. Is there evidence that frailty was considered in an older person, where appropriate.	Review Documentation *(Medical Booklet)*				*Clinician to check
26. Does the trust meet the clinical standards for Thrombolysis treatment in acute stroke.* *Assessment by Stroke team within 30 minutes CT scan within 45 minutes Door to needle time 60 minutes Onward transfer to acute stroke unit, or appropriate environment, within 90 minutes	Review Documentation *(Medical Booklet)*				*Clinician to check
27. Are staff aware of the thrombolysis pathway.	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check

	SOURCE	YES	NO	N/A	COMMENTS
28. How are lessons learnt from non-compliant issues identified and actioned in relation to Thrombolysis.	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check
29. 24/7 minimum key diagnostics are available and timely **(3)**: • X-ray: immediate access with formal report received by the ED within 24 hours of examination • CT: immediate access with formal report received by the ED within one hour of examination • Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination • 24/7 lab services (note delays/deficits)	Review Documentation Ask staff Observe *(Medical Booklet)*				*Clinician to check
30. Is hot reporting available.	Ask staff Review Documentation *(Medical Booklet)*				*Clinician to check
31. When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	Ask staff Review Documentation Observe *(Medical Booklet)*				*Clinician to check
32. Are all abnormal reports are reviewed by the appropriate senior clinician. (within 24 hours by an appropriate clinician and acted upon within 48 hours).	Ask staff Review Documentation				*Clinician to check

	SOURCE	YES	NO	N/A	COMMENTS
33. Where a junior doctor is on duty in ED, all images are reviewed by a senior clinician.	Ask staff Review Documentation				*Clinician to check
34. What are the incidents/complaints relating to imaging issues.	Ask staff Review Documentation				*Clinician to check
The following questions will be discussed with the ward sister/nurse in charge, evidence to support these questions should be provided at this time. **A list of documentation required to evidence these questions will be provided to the ward sister/nurse in charge of Day 1 of the inspection.**					
35. There is a system in place to monitor falls and preventable pressure ulcers. Figures are available at ward level.	Ask Staff Review documentation *(Documentation booklet)*				
36. A Sepsis bundle is in place for the recognition and timely management of sepsis (Sepsis 6 care bundle). (Blood culture, urine output, fluids, antibiotic, lactate, oxygen)	Review Documentation *(Documentation Booklet)*				
37. Right Patient Right Blood training records in place.	Review documentation *(Documentation Booklet)*				
38. Clinical Standards for the ED are being implemented.	Ask staff Review Documentation *(Documentation Booklet)*				

Please use this box to identify any additional patient safety initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Medicines Management **OUTCOME: Avoidable patient harm in relation to medicines management will be eliminated. (SAFE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. All medicines are stored securely. Locked patient medication lockers, designated cupboards/trolley/fridges are not left unattended.	Observe				
2. All medicines are stored safely. Different medicines with similar packaging and medicines with different strengths are not stored next to each other. Alphabetical order for generic names, well segregated, orderly, internal and external medicines segregated. Local anaesthetic agents are stored separately from other injectable medicines.	Observe				
3. Controlled drugs are stored and administered safely (second signatory and second person at bedside for administration).	Observe Review Documentation				
4. Ward records confirm that stock checks of controlled drugs are carried out at least once a day. (check trust policy) Morphine and diamorphine 30mg or greater only stocked if currently in use.	Observe Review Documentation				
5. All IV infusions are stored in their original boxes or in appropriately labelled containers, with potassium-containing solutions kept separately from other solutions. Epidural infusions are stored separately from IV infusions.	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
6. Drug preparation areas are available, well lit, uncluttered and positioned appropriately to prevent unnecessary interruptions.	Observe				
7. IV medications are drawn up, checked and administered straightaway by two staff members who are both present at the bedside for administration. If there is more than one unlabelled syringe including flushes and it leaves the hand of the operator, it should be labelled.	Observe				
8. IV medications are not drawn up en masse.	Observe				
9. Medication is taken when administered and not left unattended on the bedside table/locker.	Observe				
10. Does observed medication administration meet good practice guidance e.g. NMC standards.	Observe				
11. Medication administered is recorded and in all cases where medicines have been delayed or omitted, the reason for the delay or omission has been documented. **(3)**	Review Documentation Kardex				

	SOURCE	YES	NO	N/A	COMMENTS
12. All patients have their allergy/medicine sensitivity status documented. **(3)**	Review Documentation				
13. When insulin is prescribed blood glucose levels are monitored at the correct frequency or before administration of insulin. **(3)**	Review Documentation				
14. When outside the usual blood glucose range, appropriate action is taken. **(3)**	Review Documentation				
15. Self-administration of medication is in accordance with trust policy.	Ask staff				
16. The ward has access to pharmaceutical advice at all times.	Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
17. There is evidence of Integrated Medicines Management (IMM) service being implemented on the ward with pharmacy involvement in the completion of medicines reconciliation on admission, during inpatient stay and on discharge. **(3)**	Observe Review Documentation Kardex				
18. In the absence of IMM service, there is reconciliation of the kardex and discharge prescription as part of the pharmacist clinical check at discharge.	Observe				
19. There is evidence that patients are involved in decisions about their medicines e.g. decision making regarding new or as required medicines and receive the information they need to take their medicines safely and effectively. **(3)** When patients are discharged, they should receive written and verbal information about their medicines and any changes.	Ask patients				
20. There is evidence of compliance with best practice in the handling of critical medicines where timelines of administration is crucial. A list of critical medicines is available (includes, anti-infectives, insulin, resuscitation medicines, medicines for Parkinson's disease and any other high risk medications identified locally). Medication procedures should include guidance on timeliness issues and what to do if medication has been delayed or omitted. Staff show awareness of what a critical medication is and how to obtain a medicine that is not available	Ask staff Observe (poster/card on trolley) Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
21. There is ready access to critical medicines where timeliness of administration is crucial.	Observe				
22. The ward has a stock of and uses enteral/oral syringes where a syringe is required for oral/enteral administration.	Observe Ask Staff				
23. Where oxygen is administered, it is prescribed and an administration record completed. **(3)**	Review Documentation Kardex				
24. Patient weight is measured on admission and recorded on the kardex. **(3)**	Review Documentation Kardex				
25. Nutritional supplements are prescribed and administered appropriately (not at mealtimes/as a substitute for meals). **(3)**	Review Documentation Kardex				
26. Nutritional supplements are offered to adults at risk of, or who have pressure ulcers, or who have a nutritional deficiency. **(3)** *check Trust policies	Review Documentation Kardex				

	SOURCE	YES	NO	N/A	COMMENTS
27. Pain medication is administered as prescribed in the medicine kardex**.(3)**	Review Documentation Kardex				
28. There is evidence that the trust Antimicrobial Policy is being implemented within the ward.	Ask Staff Review Documentation				
29. There is evidence of medication incidents being reported, investigated, learning identified and shared.	Review Documentation				
Additional for Emergency Department (ED)					
30. A process is in place to identify those patients who are on time critical medicines.	Ask staff Review Documentation				
31. Staff are aware of patients who are on critical medicines and measures have been put in place to ensure the correct administration of medicines. **(3)**	Observe Ask staff				

Please use this box to identify any additional medicines management initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

EFFECTIVE

AREA FOR INSPECTION: Nursing Care Records **OUTCOME: Records are completed in line with best practice standards. (EFFECTIVE)**					
Completed only on wards	**SOURCE**	**YES**	**NO**	**N/A**	**COMMENTS**
1. On admission a comprehensive assessment, of the patients' needs has been undertaken. **(3)** (This includes nursing assessment booklet/risk assessments)	Review Documentation *(Nursing Booklet)*				
2. Where risks are identified assessments have been completed with the agreed timescale. Where there is variation this is reported. **(3)**	Review Documentation *(Nursing Booklet)*				
3. A nursing care plan is in place for the patient needs. Care records demonstrate on-going assessment and evaluation of the daily care. **(3)**	Review Documentation *(Nursing Booklet)*				
4. Patient movement between wards is based on clinical need. Rationale is documented. **(3)**	Review Documentation *(Nursing Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
5. There is documented evidence that the patient and/or family has been involved in agreeing the plan of care. **(3)**	Review Documentation *(Nursing Booklet)*				
6. Based on risk assessment MDT referrals have been appropriately made. **(3)**	Review Documentation *(Nursing Booklet)*				
7. All documentation is completed in line with the NMC Code* written legibly, with clear signatures, dated, timed and signed, contemporaneous. **(3)** *Professional standards of practice and behaviour for nurses and midwives	Review Documentation *(Nursing Booklet)*				

Please use this box to identify any additional care record initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Medical Care Records **OUTCOME: Records are completed in line with best practice standards. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Completed only on wards					
1. Are care records organised in a coherent way.	Review Documentation *(Medical Booklet)*				
2. Does the ward have a signature assessment proforma.	Review Documentation *(Medical Booklet)*				
3. Does the ward have a standardised discharge summary proforma.	Review Documentation *(Medical Booklet)*				
Within the CURRENT admission entry/inpatient episode is there:					
4. A documented patient length of stay **(days). (3)**	Review Documentation *(Medical Booklet)*				
5. A record of the presenting problems and a management plan. **(3)**	Review Documentation *(Medical Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
6. The patient's name, ID number, date, time recorded on every page. **(3)** (% of pages with all criteria present)	Review Documentation *(Medical Booklet)*				
7. An entry author identified in block capitals and GMC number. **(3)** (% of enteries with all criteria present)	Review Documentation *(Medical Booklet)*				
8. A signature at all entries.**(3)** (% of pages with signature present)	Review Documentation *(Medical Booklet)*				
9. All entries completed legibly. **(3)** (% of entries that are legible)	Review Documentation *(Medical Booklet)*				
10. Deletions or alterations are countersigned. **(3)** Medical Defence Union – Good Record Keeping	Review Documentation *(Medical Booklet)*				
11. A date and time recorded at all deletions or alterations. **(3)** Medical Defence Union – Good Record Keeping	Review Documentation *(Medical Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
12. A timely entry in the medical notes commensurate with the clinical need of the patient. **(3)**	Review Documentation *(Medical Booklet)*				
13. On the occasions where this is a gap of more than the expected standard time period, has an explanation been provided. **(3)**	Review Documentation *(Medical Booklet)*				
14. Evidence in the medical notes that a consultant review is carried out commensurate with the clinical need of the patient. **(3)**	Review Documentation *(Medical Booklet)*				
15. Evidence of investigation results actioned. **(3)**	Review Documentation *(Medical Booklet)*				
16. A documented record of any change in the specialist consultant responsible for the patient's care. **(3)** check if this occurs on a frequent basis, include the number of times	Review Documentation *(Medical Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Within inpatient notes, is there evidence of information given to the patient or relative about:					
17. The diagnosis and management plan. **(3)**	Review Documentation *(Medical Booklet)*				
Within the CURRENT discharge/transfer summary is there (only if applicable to the patient on this admission):					
18. Is the discharge/transfer summary complete. **(3)** Includes • Name of author, Admission Date, Discharge date, List of current diagnoses with dates, List Of medications Follow-up arrangements	Review Documentation *(Medical Booklet)*				
Discharge Communication					
19. Is the discharge letter completed in a timely manner. **(3)** *Please comment on any lengths of delay	Review Documentation *(Medical Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Allied Health Professionals					
20. AHP entries are comprehensive, demonstrate on-going assessment and evaluation of daily care and outline the patient management. **(3)**	Review Documentation *(Medical Booklet)*				
21. Entries include: date, time, entry author, legible signature. Deletion and alterations are signed and dated. **(3)**	Review Documentation *(Medical Booklet)*				

Please use this box to identify any additional care record initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Nutrition and Hydration **OUTCOME: Patients are enabled to consume food (orally) and fluids which meet their individual needs. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Protected meal times are adhered to by staff. *Relatives may assist with meals	Observe				
2. A menu choice/beverages/snacks* are available this includes specialised dietary requirements and smaller portion sizes as appropriate. *(check availability of snacks/beverages on ward/out of hours and if restaurant facilities open 24/7).	Observe Ask staff				
3. A designated person is responsible to supervise and co-ordinate the service of meals.	Observe				
4. Staff prepare the patient for mealtimes (toileting, positioning in chair/bed, remove obstacles from the bedside tables, hand hygiene).	Observe				
5. Effective mechanisms are in place to identify patients that require assistance at mealtimes (red trays or other system to identity patients who require assistance are in use).	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
6. There are sufficient staff allocated to support and supervise those who need assistance.	Observe				
7. Food is appropriately placed in front of patients and assistance given with any food which requires opening/cutting. Assistance with eating is given in an appropriate manner (timely/staff not standing over patients).	Observe				
8. Patients have a drink* available and accessible at the bedside (fresh water is available for all patients, water in reach of patients, frequency of assistance to offer and encourage patients to drink). *Exceptions for NBM and restricted intake	Observe				
9. Appropriate tableware is available for all patients including those with reduced dexterity (crockery, cutlery, drinking cups).	Observe				
10. All staff participate in the collection of food trays after meal service to accurately identify/report patients' intake at mealtimes.	Observe Ask staff				
11. Where a meal is interrupted or missed a replacement meal can be accessed. Outline system	Observe Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
12. Where a decision to fast is made, there is evidence in the record of a review and alternative means of hydration considered. **(3)**	Observe Review Documentation *(Nursing Booklet)*				
13. The regional fluid balance chart is used appropriately and completed effectively. **(3)**	Review Documentation *(Nursing Booklet)*				
14. Food charts are used appropriately and completed effectively. **(3)**	Review Documentation *(Nursing Booklet)*				
15. Nutritional supplements are prescribed and administered appropriately (not at mealtimes/as a substitute for meals). **(3)**	Review Documentation Kardex				*Pharmacist to check
16. Nutritional supplements are offered to adults at risk of, or who have pressure ulcers, or who have a nutritional deficiency. **(3)** *check Trust policies	Review Documentation Kardex				*Pharmacist to check

Please use this box to identify any additional nutrition and hydration initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Pain Management **OUTCOME: Pain will be controlled to an acceptable level by the medical and nursing team. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Is there evidence that pain has been assessed* and evaluated with effective relief prescribed. **(3)** (Pain assessment is carried out as part of routine practice including prior to wound dressings and movement (NEWS charts, body map and suitable method for patients unable to communication e.g. Abbey pain score). In ED all patients are assessed for pain using an appropriate standardised pain score within 15 minutes of first contact.	Observe (*Nursing Booklet)*				
2. There are adequate pain relieving measures available for patients i.e. simple comfort measures: pillows and repositioning.	Observe				
3. Patients report they are comfortable and are not in pain or distressed. **(3)**	Observe Ask patient				
4. Staff respond promptly to patients' requests for pain relief. **(3)**	Observe Ask patient				

	SOURCE	YES	NO	N/A	COMMENTS
5. Where pain management advice is required appropriate professionals are available and responsive. **(3)**	Observe Review documentation				
6. Pain medication is administered as prescribed in the medicine kardex. **(3)**	Review Documentation Kardex				*Pharmacist to check
7. Is there evidence of pain assessment and appropriateness of prescribing when assessed by medical staff. **(3)**	Review Documentation *(Medical Booklet)*				*Clinician to check.

Please use this box to identify any additional pain management initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Pressure Ulcers **OUTCOME: The condition of the patients skin will be maintained or improved. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Patients report that they are comfortable and are appropriately positioned e.g. not on draw sheets, hoist slings. **(3)**	Ask patient Observe				
2. Pressure relieving equipment (including beds, cushions/seating) is available and used appropriately to meet individual patient needs.	Observe				
3. Pressure relieving equipment is ordered and is delivered promptly when required.	Ask staff Review documentation				
4. A visual aid is available to assist nursing staff in the classification and management of ulcers e.g. International NPUAP-EPUAP (2009) Pressure Ulcer Classification System or similar.	Review documentation				
5. A SSKIN care bundle* is in place and evaluated to reflect the patient's ongoing care needs (surface, skin, keep moving, incontinence, nutrition). **(3)** *check Trust policies	Observe Review documentation *(Nursing Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
6. Tissue viability services are responsive.	Observe Ask staff Review documentation				
7. Mattress audits are carried out as per trust policy.	Review documentation				

Please use this box to identify any additional pressure ulcer initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Promotion of Continence & Management of Incontinence **OUTCOME: Continence and incontinence will be appropriately managed by the medical and nursing team. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Is there evidence that a continence assessment has been made and an appropriate pathway is in place. **(3)**	Observe Review Documentation *(Nursing Booklet)*				
2. Patients have the opportunity for hand hygiene after toileting.	Observe				
3. A Stool chart is in place and reviewed as appropriate for condition. **(3)**	Review Documentation *(Nursing Booklet)*				
4. Staff have access to continence/stoma specialist services during in patient episodes and on discharge. Specialist services are responsive.	Observe Ask staff				
5. Stoma/continence aids (commode, bedpans etc.) are available on the ward if required.	Observe				

Please use this box to identify any additional promotion of continence & management of incontinence initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

COMPASSIONATE

AREA FOR INSPECTION: Person Centred Care **OUTCOME: Every patient is treated as an individual, with compassion all of the time. (COMPASSIONATE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. A call bell system is in place, in working order and available in all patient areas e.g. bedside/sanitary facilities.	Observe				
2. Patient call bells are appropriately positioned, within easy reach (not unplugged).	Observe				
3. Staff respond promptly to call bells and patient requests for assistance e.g. general assistance, mobility, toileting (how long).	Observe Ask Staff				
4. Patients are not bothered by noise or light. Auditory clutter is minimised, the environment is quiet and ward noise is kept to a safe level (noise levels do not disturb patients sleep, increase patient stress).	Observe				
5. Patient privacy is maintained by the use of curtains, screens, and appropriate clothing. Curtains are fully closed (appropriate length/good state of repair).	Observe				
6. Patient dignity is maintained at all times (including moving between areas).	Observe				
7. There are adequate supplies of laundry to meet the needs of the ward/department.	Observe Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
8. Toileting is not carried out at the bedside during meal service (where appropriate, patients are taken to the toilet when others are eating).	Observe				
9. Patients' personal hygiene needs have been attended to as appropriate, comfortable and suitability clothed e.g. no stains on clothing, clean nails, shaved, dental/mouth care.	Observe				
10. Staff advise/alert the patient before entering any private areas i.e. curtains, bathrooms, cubicles.	Observe				
11. There is evidence that comfort rounds are completed and carried out on a risk based approach (standardised tool used e.g. **T**oilet, **R**efreshment, **I**nformation, **P**ain and **P**ressure Areas (TRIPP) in ED.) **(3)**	Observe Review Documentation *(Nursing Booklet)*				
12. Personal items are available for patients to use and are easily accessible and e.g. glasses, hearing aid, dentures, mobility aids, bedside table.	Observe				
13. Bed bays are single sex and not mixed gender.	Observe				
14. Appropriate sanitary facilities are available and accessible (which take account of individual preferences).	Observe				
15. A patient quiet room is available and used appropriately for private conversation & relaxation (includes patients/visitors/staff).	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
16. Patients have access to public/ward telephones, as required.	Observe				
17. Patient personal details are displayed in a way that promotes patient dignity. Patient information is not easily viewed (except name) e.g. on boards/computer. Health care records are stored in a way that ensures confidentiality.	Observe				
18. Staff can access hospital chaplaincy services.	Ask staff				
19. There is signposting to advocacy services.	Ask staff				

Please use this box to identify any additional person centred initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: Communication **OUTCOME: Patient and carers experience effective communication, sensitive to their individual needs and preferences, which promote high quality care for the patient. This includes communication to staff which identified an individual's communication needs. (COMPASSIONATE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. There is signage to direct visitors (including visiting times/ward staff).	Observe				
2. Staff treat patients and ward visitors courteously. Staff introduce themselves before carrying out care and include patients in general conversations. "Hello my name is" initiative is in place (expected more frequently for patients with dementia).	Observe				
3. Staff show an encouraging, sensitive attitude to patients and relatives. Patients are addressed by their chosen name.	Observe Ask patient				
4. Hospital staff are easily identified from their name badges.	Observe				
5. Where required there is discreet signage relating to (e.g. fasting, infection prevention & control, patients with cognitive impairment, communication aids).	Observe				
6. Patients with cognitive impairment are identified on admission and this information is communicated to all staff.	Observe Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
7. Before care is carried out, staff provide an easily understood explanation of the care for patients (Staff stay with the patient whilst undertaking observations).	Observe				
8. Staff speak discretely e.g. patient's medical condition is not discussed within hearing of others.	Observe				
9. Communication aids are available e.g. picture cards/booklets/loop system.	Observe				
10. Patients, carers and relatives have access to appropriate information and leaflets within the ward area, both general and specific to that ward (including infection prevention & control, safeguarding).	Observe				
11. Information is available in various formats (Braille, sign language, different languages etc.) including access to interpreting services as and when required.	Observe				
12. Information regarding the Trust's complaints procedure is available.	Observe				

Please use this box to identify any additional communication initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

AREA FOR INSPECTION: End of Life Care **OUTCOME: Patients have control over their own health care and promote independence. (COMPASSIONATE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. The use of tools or an integrated care pathway/care plan for the dying is used and embedded in practice (e.g. Gold Standards Framework).	Review Documentation				
2. Information and support systems are available for patients and carers before and after a patient dies (including printed information: coping with dying, what to do after death, bereavement booklet).	Observe Ask staff				
3. Staff can access guidance on end of life care (includes information on care of the patient after death, different cultural practices).	Ask staff Review Documentation *(Documentation Booklet)*				
4. Patients are cared for in a ward environment appropriate to end of life care.	Observe				
5. Family/carers have access to; car parking, washing/toilet/sleeping/dining facilities/spiritual guidance where appropriate.	Ask staff Review Documentation				
6. The palliative team is responsive.	Ask staff Observe				

	SOURCE	YES	NO	N/A	COMMENTS
7. Where a decision to apply a DNAR order is in place, is the form fully completed and is there evidence of patient and family involvement. **(3)**	Review Documentation *(Medical Booklet)*				*clinician to check
8. Staff completing the DNAR order are appropriately trained and aware of the trust policy. **(3)**	Review Documentation *(Medical Booklet)*				*clinician to check
Additional for Emergency Department (ED)					
9. Where an end of life diagnosis is made staff are aware and take measures to ensure the patient care is delivered in the appropriate care setting.	Observe Ask staff				

Please use this box to identify any additional end of life initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

Appendix 1: Supporting Standards, Guidance and Legislation

The indicators above are supported by the following standards, guidance and legislation:

1. The Quality Standards for Health and Social Care, 2006:
2. DHSSPS Improving the Patient and Client Experience http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf
3. The Human Rights Act 1998 particularly Articles 2,3,5 & 8
4. Controls Assurance Standards including:
   - Environmental Cleanliness http://www.dhsspsni.gov.uk/cas-ec.pdf
   - Infection Control http://www.dhsspsni.gov.uk/cas-infectioncontrol.pdf
   - Medical Devices & Equipment Management http://www.dhsspsni.gov.uk/medical_devices_and_equipment_management_2014-15.pdf
   - Medicines Management http://www.dhsspsni.gov.uk/medicines_management_for_2014_15.pdf
5. *Promoting Good Nutrition: A strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016*. http://www.dhsspsni.gov.uk/gn-intro
6. http://www.nmc.org.uk/globalassets/siteDocuments/NMC-Publications/NMC-Standards-for-medicines-management.pdf
7. Information on 'MUST' visit http://www.bapen.org.uk
8. National Institute for Health and Clinical Excellence (NICE) (2006) *Nutrition Support in Adults: oral nutrition support, enteral tube feeding and parenteral nutrition CG 32.* London: NICE.
9. Get your 10 a Day: Nursing Care Standards for Patient Food in Hospital (PDF 2MB), 2007HSS(MD) 21/2014 - Advice to Health and Social Care professionals for the care of the dying person in the final days and hours of life – phasing out of the Liverpool care pathway in Northern Ireland by 31 October 2014
10. Northern Ireland Health and Social Care Services Strategy for Bereavement Care
11. Living Matters; Dying Matters (LMDM) Palliative and End of Life Care Strategy (DHSSPS, 2010)
12. Northern Ireland Practice and Education Council for Nursing and Midwifery: *Improving Record Keeping* http://www.nipec.hscni.net/recordkeeping/docs/Guidance_notes_by_indicator_and_glossary.pdf XX
13. DHSSPS Improving the Patient and Client Experience http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf
14. N.I Regional Infection Prevention and Control Manual Available from http://www.infectioncontrolmanual.co.ni

15. Nursing and Midwifery Council. How to achieve personal centred writing style in care plans. Available http://www.nmc-uk.org/media/Latest-news/How-to-achieve-person-centred-writing-style-in-care-plans/
16. NMC Record Keeping. Guidance for Nurses and Midwives. http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf
17. DHSSPS Improving Dementia services in NI. A regional Strategy November 2011 http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-a-regional-strategy-november-2011.pdf
18. *Living Matters; Dying Matters (LMDM) Palliative and End of Life Care Strategy* (DHSSPS, 2010)
19. LMDM Strategy and other relevant guidance - including the Department's "*Strategy for Bereavement Care*" (2009)
20. HSS(MD) 21/2014 - Advice to Health And Social Care professionals for the care of the dying person in the final days and hours of life – phasing out of the Liverpool care pathway in Northern Ireland by 31 October 2014
21. Patient safety First "The how to guide for Reducing Harm from High Risk Medicines"
22. National Patient Safety Agency: Lessons from High Hazard Industries for Healthcare
23. NPSA, Rapid response report NPSA /2010/RRR009:Reducing harm from omitted and delayed medicines in hospitals
24. Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance (September 2006) http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf
25. The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007http://www.legislation.gov.uk/nisi/2007/1351/contents/made
26. Mental Health Order 1986 http://www.legislation.gov.uk/nisi/1986/595
27. DHSSPSNI, Area Child Protection Committees Regional Policies and Procedures, 2005 http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf
28. WHO definition of Elder Abuse http://www.who.int/aging/projects/elder_abuse/en/
29. DHSSPSNI, Adult Safeguarding in Northern Ireland. Regional and Local Partnership Arrangements. The NI Adult Safeguarding Partnership (NIASP 2010). http://www.dhsspsni.gov.uk/asva-_march_2010.pdf
30. Public Protection Arrangements NI (PPANI) http://www.publicprotectionni.com/
31. Domestic Violence advice available from http://www.nidirect.gov.uk/protecting-yourself-and-your-child-from-domestic-abuse-2
32. DHSSPSNI, 2005. Tackling Violence at Home. A Strategy for Addressing Domestic Violence and Abuse in Northern Ireland. http://www.dhsspsni.gov.uk/tackling_violence_strategy.pdf
33. SCIE, 2011. IMCA and paid relevant person's representative roles in the Mental Capacity Act Deprivation of Liberty Safeguards Available from http://www.scie.org.uk/publications/guides/guide41/files/guide41.pdf

34. British Geriatrics Society, 2011. Mental Capacity Act and Deprivation of Liberty Safeguards. http://www.bgs.org.uk/index.php/ethicslaw/1195-bpgmcaliberties15
35. Age UK, 2013. Deprivation of Liberty Safeguards http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS62_Deprivation_of_Liberty_Safeguards_fcs.pdf?dtrk=true
36. Valuing Carers – Proposals for a Strategy for Carers in NI DHSSPS (2002) http://www.dhsspsni.gov.uk/valuing_carers-2.pdf
37. A Healthier Future: A Twenty Year Vision for Health and Wellbeing DHSSPS (2005) http://www.dhsspsni.gov.uk/sfmhw_-_standards_for_improving_the_experience_of_service_users_and_carers.pdf
38. Mental Health Partnerships, 2011 Psychiatric Liaison Accreditation Network (PLAN). http://mentalhealthpartnerships.com/network/psychiatric-liaison-accreditation-network/
39. Seeking Consent. Working with prisoners and detainees (DHSSPS 2006) http://www.dhsspsni.gov.uk/ph_seeking_consent.pdf
40. The Children (Northern Ireland) Order 1995 Available from http://www. legislation.gov.uk/nisi/1995/755/contents/made
41. National Patient Safety Agency: Lessons from High Hazard Industries for Healthcare (March 2010) Available from www.nrls.npsa.nhs.uk
42. Breaking Bad News, Regional Guidelines: Developed from Partnerships in Caring (2000) DHSSPS (February 2003) http://www.dhsspsni.gov.uk/breaking_bad_news.pdf
43. http://survivesepsis.org/the-sepsis-six/
44. Disability Discrimination Act 1995 (legislation.gov.uk website) http://www.legislation.gov.uk/ukpga/1995/50/contents
45. Disability Discrimination (NI) Order 2006 (legislation.gov.uk website) http://www.legislation.gov.uk/nisi/2006/312/contents/made
46. Salford Royal NHS Foundation Trust's 'Safe, Clean, Personal' approach to service delivery.
47. Royal college of Emergency Medicine: The clinical standards for Emergency Departments http://www.rcem.ac.uk/Shop-Floor/Clinical%20Standards/default.asp
48. Royal college of Emergency Medicine: Emergency Department Clinical Quality Indicators: A CEM guide to implementation www.rcem.ac.uk/code/document.asp?ID=5832
49. CEM (2011) Emergency Medicine The Way Ahead: London standards for inter-hospital transfers http://www.rcem.ac.uk/Public
50. Regional ACPC Policy and Procedures http://www.welbni.org/uploads/File/ACPC_Policy_Procedures_Amendments_-_PDF.pdf
51. Area Child Protection Committee's Regional Policy and Procedures 2005 http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf
52. The Children (Northern Ireland) Order 1995 http://www.legislation.gov.uk/nisi/1995/755/contents/made
53. The General Medical Council 'Leadership and Management for all doctors' guidance of 2012 http://www.gmc-uk.org/Leadership_and_management_for_all_doctors_FINAL.pdf_47234529.pdf

54. Escalating Clinical Concerns – Use Phone Rather Than Using Text Messages or Emails, PHA Circular
http://www.nimdta.gov.uk/escalating-clinical-concerns-use-phone-rather-than-using-text-messages-or-emails/

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