Department of
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Minimum Care Standards for Independent Healthcare Establishments

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Introduction

This document sets out minimum standards for independent health care. The standards specify the arrangements, facilities and procedures that need to be in place and implemented to ensure the delivery of a quality service.

Standards are based on the provisions of the Independent Healthcare Regulations (Northern Ireland) 2005 and the amendments set out in the Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011.

Compliance with the regulations is mandatory and non-compliance with some specific regulations is considered an offence. The Regulation and Quality Improvement Authority (RQIA) must take into account the extent to which the minimum standards have been met in determining whether or not a service maintains registration or has its registration cancelled, or whether to take action for breach of regulations.

The regulations and minimum standards have been prepared in response to extensive consultation. **They are the minimum standards below which no provider is expected to operate**.

Additionally, each establishment is expected to comply with all other relevant legislation, regulations, guidance and best practice. A key responsibility of the Registered Manager is to ensure that the treatments, procedures and services provided are evidence based and in line with current best practice, for example as defined by professional bodies and national standard setting organisations.

The scope of these standards is wide-ranging. They apply to any establishment registered with RQIA as an independent hospital, clinic, hospice, independent hospital providing in-patient mental health services or independent medical agency as defined by the regulations. Some establishments are registered by virtue of providing what are known as “prescribed techniques or technology”. These are:

- In-Vitro Fertilisation (IVF);

- Hyperbaric Oxygen Therapy;
- Dialysis;
- Laser treatments using class 3B lasers, class 4 lasers and intense light sources; and
- Endoscopy.

Due to the wide scope of the standards, not all establishments will have to comply with all standards or even all criteria within the standards. The Statement of Purpose for each establishment will determine the extent to which compliance with standards and criteria is expected.

The safety and quality of services provided in an independent healthcare establishment is the responsibility of every person working in the establishment but ultimately the Registered Persons are accountable for the delivery of the services in accordance with these Minimum Standards.

Providers of services must be committed to continuous improvement through systematically auditing practice and reviewing policies and procedures, taking account of results from patient surveys, complaints investigations and risk assessments, and making changes as required.

The manager must be in control of the operations within the establishment and provide leadership and direction for the staff team. Investing in staff, providing learning and development opportunities, and supporting and valuing the staff team are vital.

Using these standards

The standards are split into sections explained below.

Standards 1–28 cover common areas for the range of independent healthcare services and will be applicable to every establishment. All regulated establishments should comply with most, if not all, of these standards and then proceed through the book to find the other standards that apply to the individual setting.

Standards 29-36 are applicable to hospitals, clinics, independent medical agencies and hospices. However, it is recognised that not all establishments will comply with all standards – for example an establishment may not provide surgery or treat children – and in these cases RQIA will not look for evidence of compliance.

Standards 37-43 are applicable only to hospices.

Standards 44-47 are only applicable to establishments providing IVF and assisted conception services.

Standard 48 is only for services providing laser treatments using class 3B lasers, class 4 lasers and intense light sources.

Standard 49 is only for services providing dialysis.

Standard 50 applies only to settings providing hyperbaric oxygen therapy.

Standards 51-67 apply only to independent hospitals providing in-patient mental health services.

Section two covers the standards for registration. The statement of purpose defines what services and facilities the establishment will provide and the operational policy describes how they will be provided.

An individual who intends to carry on an establishment must be registered and is referred to as the Registered Person. An organisation that intends to carry on an establishment is also required to nominate one person to be registered on behalf of the organisation, who is the Registered Person.

The manager of the establishment must also be registered and is referred to as the Registered Manager. The Registered Person may also be the Registered Manager. Those applying for registration as the Registered Person and/or the Registered Manager must meet the relevant criteria for fitness of these positions.

At the time of commissioning new premises for the provision of independent health care services, the design and construction of the building must meet the standards for health care premises as detailed in Health Building Notes, Health Technical Memoranda, Health Facilities Notes and Design Guides. These technical documents are complex and extensive and cannot be summarised in this document therefore they need to be referred to when requiring information on the construction and design of independent health care premises and facilities.

Values Underpinning the standards

The standards are based on a set of values that recognise the rights that people have as citizens and all aspects of planning, delivery and review of services must reflect these values.

Managers and staff must base their practice on these values, recognising peoples rights and aim to provide quality services that are patient-centred.

Patients should experience quality care and support. They are fully informed and involved in all decisions affecting their treatment and care, and contribute to the planning and evaluation of services.

Dignity and Respect
The uniqueness and intrinsic value of individual patients is acknowledged and each person is treated with respect.

Independence
Patients have as much control as possible over their lives whilst being protected against unreasonable risks.

Rights
Patients' individual and human rights are safeguarded.

Equality and Diversity
Patients are treated equally and their background and culture are valued.

Choice
Patients are offered the opportunity to select independently from a range of options based on clear and accurate information.

Privacy

Patients have the right to be left alone, undisturbed and free from unnecessary intrusion into his or her affairs and there is a balance between the consideration of the individual's own and others' safety.

Confidentiality

Patients know that information about them is managed appropriately and will not be disclosed without permission, except when required by legislation or the need to protect the well-being of others.

Safety

Patients feel safe in all aspects of their treatment and care, and are free from exploitation, neglect and abuse.

The belief that people in receipt of services are central in all aspects of planning, delivery, review and improvements of the service is a conviction that underpins these standards.

Standards for Patients and Clients

- **Informed Decision Making**
- **Informed Consent**
- **Safeguarding Children and Vulnerable Adults**
- **Dignity, Respect and Rights**
- **Patient Partnerships**
- **Care Pathway**
- **Complaints**
- **Records**
- **Clinical Governance**

Informed Decision Making

Standard 1

Patients and clients and prospective patients and clients have access to clear, accurate information about the establishment and the services it offers.

Criteria

1.1 Information is written without jargon and if requested available in languages and formats required to make it accessible to all patients and clients and prospective patients and clients. This information reflects the content of the Statement of Purpose.

1.2 The Patients' Guide is made available to patients.

1.3 Information is accurate and up to date and does not make claims for treatments or services that cannot be justified.

1.4 Information on the price of treatment or services is clear, accurate, up to date and reflective of all associated costs.

1.5 All publicity material conforms to the general principles in the guidelines of the General Medical Council, Code of Professional Conduct of the Nurses and Midwives Council and any other appropriate regulatory body.

1.6 Advertising and marketing campaigns comply with guidance issued by professional bodies and national standard setting organisations. They are legal, factual and not misleading. Where discounts linked to a deadline for booking appointments or surgery or other date-linked incentives are offered, best practice guidance must be adhered to.

Informed Consent

Standard 2

Patients and clients are involved in decision making in line with the Department's guidance on consent, treatment and care.

Criteria

2.1 There is a written policy and procedures on obtaining informed consent which covers capacity and withdrawal of consent in line with the Department of Health Social Services and Public Safety (DHSSPS) guidance on Consent, Treatment and Care.[1]

2.2 Patients and clients are effectively involved in making decisions about their treatment and are provided with information about the implications of the treatment and any options available to them.

2.3 Valid consent or refusal is documented in the patient or client's record and completed consent forms are kept with patient and client records.

2.4 Patients and clients are clear about what is involved in the procedures for their treatment and care as well as the skills and experience of those undertaking the procedures.

2.5 Patients and clients have a planned programme of care setting out what they can expect from the time of accessing a service to discharge.

2.6 Patients and clients have accessible written information about their treatment that is available for them to take away after a consultation, procedure or operation. This includes general and procedure-specific information and where appropriate identifies any complications associated with the treatment.

[1] DHSSPS guidance on Consent, Treatment and Care can be accessed at: http://www.dhsspsni.gov.uk/public_health_consent

Safeguarding Children and Vulnerable Adults

Standard 3

There are arrangements in place for safeguarding in accordance with current regional guidance.

Criteria

3.1 There is a written policy and written procedures for safeguarding children and vulnerable adults, consistent with current regional guidance.

3.2 All suspected, alleged or actual incidents of abuse are fully and promptly investigated in accordance with procedures and written records maintained of the investigation, outcome and actions taken.

3.3 Procedures for safeguarding are included in the induction process for all staff and volunteers.

3.4 Within 3 months of commencing employment, staff complete training and can demonstrate knowledge of safeguarding principles including:

- Protection from abuse;
- Indicators of abuse;
- Responding to suspected, alleged or actual abuse; and
- Reporting suspected, alleged or actual abuse.

3.5 Safeguarding training is refreshed for all staff in accordance with RQIA's mandatory training requirements.[2]

3.6 Where any shortcomings in systems are highlighted as a result of an investigation, additional identified safeguards are put in place.

[2] RQIA mandatory training requirements can be found at: http://rqia.org.uk/cms_resources/Mandatory%20Training%20Guidance%202012-2013%20.pdf

Dignity, Respect and Rights

Standard 4

Patients and clients are respected and their rights are recognised and upheld.

Criteria

4.1 Patients and clients, visitors and staff are treated and cared for in accordance with legislative requirements for equality and rights.

4.2 Patients and clients are treated in line with the DHSSPS standards for patient & client experience[3].

4.3 Patients' and clients' rights to make decisions about care and treatment are acknowledged and respected.

4.4 Patients' and clients' modesty, dignity and respect are protected at all times and their personal space is respected. They can access an area that safely provides privacy for consultation and (where appropriate) for visitors.

[3] DHSSPS standards for patient and client experience can be found at http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

Patient Partnerships

Standard 5

The views of patients, carers and family members are obtained and acted on in the evaluation of treatment, information and care.

Criteria

5.1 Patients and clients, carers (and family members where appropriate) are asked for their comments on the quality of treatment, information and care received. This information is obtained from all patients and clients. The information is collected in an anonymised format, summarised and used by the establishment to make improvements to services.

5.2 The summary of patients' and clients' comments is made available to patients, prospective patients and other interested parties.

5.3 Reports summarising patients' and clients' comments and action taken by the organisation are presented quarterly to the setting's management group (where appropriate) and are made available to staff.

Care Pathway

Standard 6

Patients and clients have a planned programme of care from the time of referral to a service through to discharge; and continuity of care is maintained.

Criteria

6.1 Patients and clients receive all the necessary information about their admission and treatment. This is available in an alternative language or format when required.

6.2 Patients and clients receive an explanation of the clinical assessments, which will be carried out by different members of the health care team.

6.3 On admission, patients and clients have a comprehensive assessment of their health care needs using validated assessment tools. The results of assessments are used to draw up an individualised, person-centred care plan.

6.4 There are arrangements in place to meet the patient or client's assessed needs - including, if necessary, referral to specialised services.

6.5 The treatment plan and ongoing care needs are agreed with the patient or client and communicated to the multidisciplinary care team.

6.6 The results of investigations and treatment are clearly explained to patients and clients and any options available to them are discussed.

6.7 All treatment and care is recorded in the patient or client's clinical record.

6.8 There are arrangements for immediate post operative care in line with the patient or client's assessed needs.

6.9 There is a planned programme for discharge from the establishment that provides the patient or client with information on:

- Future management of the condition;
- Supply of medicines;
- Where appropriate, liaison with community services; and

- Follow up advice and support including what to do if complications or problems occur.

6.10 Where appropriate to the setting and in line with the patient or client's wishes, a discharge letter summarising the patient or client's treatment and care is sent to their general practitioner and other professionals involved in their ongoing treatment and care.

6.11 When specialist services including radiology and chemotherapy are provided, these are carried out in accordance with legislation, regulations and current best practice.

6.12 Arrangements are in place to enable relevant professionals to contribute to the multidisciplinary review of outcomes of patient care.

Complaints

Standard 7

Complaints are taken seriously and dealt with appropriately and promptly.

Criteria

7.1 The organisation operates a complaints procedure in accordance with the relevant legislation and DHSSPS guidance on complaints handling. There are clear arrangements for the management of complaints from NHS and private patients and clients.

7.2 Arrangements for dealing with complaints are publicised.

7.3 A copy of the complaints procedure is provided to patients and clients and to any person acting on their behalf. The procedure is available in a range of formats if required.

7.4 Staff know how to receive and deal with complaints.

7.5 Complaints are investigated and responded to within 28 working days (in line with regulations) and when this is not possible, complainants are kept informed of any delays.

7.6 Records are kept of all complaints and these include details of all communications with complainants, the result of any investigation and the action taken. These records then become official records and are treated in line with data protection law.

7.7 When required, a summary of all complaints, outcomes and actions taken is made available to the RQIA.

7.8 Information from complaints is used to improve the quality of services.

Records

Standard 8

Records are maintained for every patient and client in accordance with legislative requirements and best practice guidelines.

Criteria

8.1 There is a written policy and procedures in line with the Independent Healthcare Regulations for the management of records including detail on their:

- Creation;
- Use;
- Retention;
- Storage;
- Transfer; and
- Disposal.

Access to records is also covered.

8.2 The policy and procedure for record keeping in relation to patient treatment and care comply with guidelines and standards from professional bodies.

8.3 Records required under the Independent Healthcare Regulations are available for inspection in the establishment at all times.

8.4 Appropriate staff are trained in records management in line with good practice and legislative requirements. All staff are aware of and understand the importance of effective records management.

8.5 Patients and clients have access to their records in accordance with the Data Protection Act 1998 and, where appropriate, the Information Commissioner's Office regulations and Freedom of Information legislation.

Clinical Governance

Standard 9

Patients and service users are provided with safe and effective treatment and care based on best-practice guidance, demonstrated by procedures for recording and audit.

Criteria

9.1 Treatment, care and service improvement is delivered in line with best practice guidance.

9.2 When new procedures are introduced, these are linked to appropriate training to support effective implementation.

9.3 Working practices are systematically audited to ensure they are consistent with legislation, best practise guidance and the establishment's documented policies and procedures. Remedial action is taken when necessary.

9.4 There are procedures in place to facilitate clinical audit where appropriate.

9.5 The Registered Person/Manager monitors the quality of services in accordance with the establishment's written procedures and completes a monitoring report on a 6-monthly basis. This report summarises patients' and clients' comments about the quality of the service provided and any actions taken by the Registered Person/Registered Manager to ensure that the establishment is being managed in accordance with the relevant regulations.

9.6 The quality of services provided is evaluated on at least an annual basis and follow-up action taken. Key stakeholders are involved in this process.

9.7 Where appropriate, there are clear arrangements for monitoring the quality of clinical care that include as a minimum the following clinical indicators:

- Unplanned returns to theatre;
- Peri-operative deaths as defined by the National Confidential Enquiry into peri-operative deaths;
- Unplanned re-admissions to hospital;
- Unplanned transfers to other hospitals;
- Adverse clinical incidents; and
- Post-operative infection rates for the hospital and/or clinic.

9.8 Where appropriate, there is a written agreement and written procedures between the establishment and an HSC provider for accessing additional services and where the clinic does not provide overnight stay; arrangements are in place to access inpatient beds.

9.9 All accidents, incidents, communicable diseases and deaths occurring in the establishment are reported to the RQIA and other relevant organisations in accordance with legislation and procedures.

9.10 The Registered Person/Manager has arrangements in place for dealing with alert letters, managing identified lack of competence and poor performance for all staff including those with practising privileges, and reporting incompetence in line with guidelines issued by the DHSSPS and professional regulatory bodies.

9.11 The Registered Person/Manager ensures all staff abide by published codes of professional practice relevant to their professional role and obtains evidence that professional registration and revalidation requirements are met.

9.12 The Registered Person/Manager has arrangements in place to ensure that before any research involving patients and clients takes place, a research proposal is prepared and approval is obtained from the appropriate Research Ethics Committee.

Standards for Workforce Governance

- **Qualified Practitioners and Indemnity**
- **Practising Privileges**
- **Staffing**
- **Staff Supervision, Training and Development**
- **Recruitment**
- **Volunteers**

Qualified Practitioners and Indemnity

Standard 10

Staff are trained and qualified for their roles and responsibilities and maintain their training and qualifications.

Criteria

10.1 All practitioners are registered with the relevant regulatory body and comply with that body's codes of practice or rules of professional conduct.

10.2 All practitioners have the necessary training, qualifications, experience and expertise to safely and competently undertake the treatments and services they offer.

10.3 All registered medical practitioners with a licence to practice must meet the GMC's requirements for revalidation. The organisation must support them in fulfilling those requirements through:

- Acting as a designated body where required under The Responsible Officer Regulations (NI) 2010;
- Providing an annual appraisal consistent with the GMC's appraisal and assessment framework where they employ a doctor; or
- Providing sufficient information to a doctor's responsible officer to support their revalidation where they are not an employee.

10.4 All practitioners who are employed by the establishment have an annual appraisal by an appropriately trained appraiser.

10.5 All practitioners are covered by appropriate professional indemnity ***either*** as specifically identified employees of the establishment or through the policies of insurance maintained by the establishment ***or*** as members of a professional body.

10.6 Clinical Nurse Specialists working in hospice care have a specialist practice qualification in palliative care nursing or are working towards this or have appropriate experience of working in a specialist palliative care environment.

10.7 Care assistants work as part of the multi-disciplinary team and are supervised by a registered nurse.

10.8 Care assistants are encouraged and supported to achieve an appropriate qualification

10.9 All newly appointed staff receive an appropriate induction. Induction for newly appointed social care staff complies with the Northern Ireland Social Care Council's (NISCC) Induction Standards for new workers in social care[4].

10.10 Social work staff are registered with NISCC and have 3 years post-qualifying experience.

[4] Information about NISCC's Induction Standards can be accessed at: http://www.niscc.info/workforce_development-5.aspx

Practising Privileges

Standard 11

Medical practitioners may only use facilities in the establishment if they have been granted practising privileges.

Criteria

11.1 There is a written procedure that defines the process for application, granting, maintenance and withdrawal of practising privileges.

11.2 Before practising privileges are granted:

- The applicant's identity is confirmed;
- AccessNI and police checks are carried out (where applicants come from countries outside UK or Republic of Ireland, pre-employment checks are carried out with the national agency in the country of origin);
- Registration status with relevant regulatory body is confirmed;
- Qualifications, training and experience of the practitioner for the type of treatment he/she has requested practising privileges is checked; and
- Indemnity arrangements are confirmed.

11.3 Consultants and practitioners are interviewed before practising privileges are granted.

11.4 The practising privileges granted define the specialty or specialities in which the practitioner may treat patients and clients.

11.5 There is a written agreement between the practitioner and the establishment that sets out the terms and conditions of granting practising privileges. Practising privileges agreements are reviewed at least every 2 years.

11.6 There is a written procedure for the sharing of information between the establishment and HSC employers to enable 'whole practice appraisal' to take place.

11.7 Medical practitioners with practising privileges (including those who are employed by a HSC Trust and those who are retired and continue to work within the private sector) are required to provide evidence of their

annual appraisal and meet the regulatory requirements of their professional body or council.

Staffing

Standard 12

The number and ratio of staff on duty at all times meets the care needs of patients and clients.

Criteria

12.1 At all times, the number and ratio of staff on duty meets the assessed care needs of all patients and clients and takes into account the size and layout of the establishment, the Statement of Purpose and fire safety requirements.

12.2 There are arrangements in place to provide cover at all times by appropriately trained and experienced practitioners. The procedure for contacting a medical practitioner where necessary and appropriate is clearly defined and known to all staff.

12.3 Where necessary, appropriate administrative and ancillary staff are employed to ensure that standards relating to food and meals, transport, laundry, cleaning and maintenance of the premises and administration are fully met.

12.4 There is a competent and capable person in charge of the establishment at all times.

12.5 Records are kept of all staff. These records include names, starting and leaving dates, posts held, training and hours of employment. In relation to professional staff, records must also include details of timely and updated renewal of professional registration and qualifications.

12.6 Where appropriate, a record is kept which shows staff working over a 24 hour period and the capacity in which they were working.

12.7 Where appropriate, staff meetings take place on a regular basis and at least quarterly. Records are kept which include:

- The date of all meetings;
- The names of those attending;
- Minutes of discussions; and
- Any actions agreed.

Staff Supervision, Training and Development

Standard 13

Staff are supervised and their performance appraised to promote the delivery of quality care. Effective training is given as part of the process of professional development.

Criteria

13.1 Mandatory training needs (as outlined by RQIA) of all staff are met[5].

13.2 The training needs of individual staff are identified and arrangements are in place to meet them.

13.3 Newly appointed staff, agency staff, students and those with practising privileges are required to complete a structured induction and orientation. Records of the completed induction are retained.

13.4 A record is kept of all training (including induction) and professional development activities undertaken by staff. The record includes:

- The names and signatures of those attending the training event;
- The dates of the training;
- The name and qualification of the trainer or training agency; and
- Content of the training programme.

13.5 There is a written training and development programme that is kept under review and updated at least annually. It reflects the training needs of individual staff and the aims and objectives of the establishment.

13.6 The effect of training on practice and procedures is evaluated as part of quality improvement.

13.7 Managers and supervisory staff are trained in supervision and performance appraisal and there is a written policy and written procedures that detail the arrangements for the supervision and appraisal of staff.

[5] http://rqia.org.uk/cms_resources/Mandatory%20Training%20Guidance%202012-2013%20.pdf

13.8 The supervision and support for staff and volunteers corresponds to their role and responsibilities. Staff have a recorded annual appraisal to review their performance against their job description and agree personal development plans.

Recruitment

Standard 14

Staff are recruited and employed in accordance with relevant employment legislation.

Criteria

14.1 The policy and procedures for staff recruitment detail the recruitment process and comply with legislative requirements.

14.2 Before making an offer of employment:

- The applicant's identity is confirmed;
- Two written references, linked to the requirements of the job are obtained, one of which is from the applicant's present or most recent employer;
- Any gaps in an employment record are explored and explanations recorded;
- AccessNI checks are carried out (where applicants come from countries outside the United Kingdom or Republic of Ireland, pre-employment checks are carried out with the national agency in the country of origin);
- Professional and vocational qualifications are confirmed;
- Registration status with relevant regulatory bodies is confirmed;
- A pre-employment health assessment is obtained; and
- Current status of work permit/employment visa is confirmed.

14.3 Records are kept of all the documentation relating to the recruitment process. AccessNI disclosures should only be retained in line with AccessNI's Code of Practice.

14.4 The Registered Person has arrangements in place to ensure that if international recruitment of health and social care professionals is carried out, it is in accordance with inter-country arrangements and complies with legislative requirements and DHSSPS guidance.

14.5 Staff are issued with a written statement of main terms and conditions of employment prior to commencing employment and no later than 13 weeks after appointment.

14.6 Job descriptions are issued to staff on appointment.

Volunteers

Standard 15

Where appropriate, volunteers contribute to the service in the best interests of patients and clients.

Criteria

15.1 The procedure for the involvement of volunteers details the arrangements for their recruitment, induction, training and management.

15.2 Volunteers are not taken into account in the overall staffing complement.

15.3 AccessNI checks are completed on any person who volunteers before he or she begins to contribute to the work of the establishment.

15.4 Patients and clients and staff are informed about individual volunteers' roles and responsibilities.

15.5 The scope of activity and responsibility of each volunteer is specified in writing.

15.6 Records are kept of the recruitment, training, and monitoring and support arrangements for volunteers.

15.7 A record is kept of volunteers deployed, the hours of service and the range of work undertaken.

Standards for Management of the Establishment

- **Management and Control of Operations**
- **Risk Management**
- **Dealing with Medical Emergencies**
- **Policies and Procedures**

Management and Control of Operations

Standard 16

Management systems and arrangements are in place that ensure the delivery of quality treatment and care.

Criteria

16.1 There is a defined management structure that identifies the lines of accountability, specifies roles and details responsibilities for areas of activity.

16.2 The Registered Person/Manager ensures the establishment delivers services effectively on a day-to-day basis with good professional relationships in accordance with legislative requirements, DHSSPS Minimum Standards and other standards set by professional bodies and national standard setting organisations. Issues arising are reported to the Registered Person.

16.3 Any absence of the Registered Person/Manager of more than 28 days is notified to the RQIA. Arrangements for managing the establishment in the absence of the Registered Person/Manager are approved by the RQIA.

16.4 The Registered Person/Manager undertake training to ensure they are up-to date in all areas relevant to the management and provision of services.

16.5 Services are delivered in accordance with the Statement of Purpose as approved by the RQIA at the time of registration.

16.6 The Statement of Purpose is kept under review.

16.7 Any changes to:

- The Statement of Purpose; or
- The person registered on behalf of the organisation;

Or any change in:

- The Registered Manager; or
- The Registered Premises

may only be made with the approval of the RQIA.

16.8 The patient/client guide is kept under review, revised when necessary and up-dated versions are provided to the RQIA.

16.9 Where meals are provided, there are arrangements in place to ensure these are nutritionally balanced, suited to the needs of the patient or client and are prepared and served by staff who are appropriately trained and qualified. There is assistance and support with meals for those patients and clients who need it.

16.10 The Registered Person/Manager has arrangements in place to confirm that staff supplied by an agency have been recruited and checked in accordance with the recruitment procedures used by the establishment.

16.11 There is a written policy on "Whistle Blowing" and written procedures that identify to whom staff report concerns about poor practice. There are appropriate mechanisms to support staff in reporting concerns about poor practice.

16.12 Insurance cover is in place against loss or damage to the assets of the business. The level of cover should reflect the full replacement value of buildings, fixture, fittings and equipment.

16.13 Insurance cover is held (to limits commensurate with the level and extent of activities undertaken by the establishment or to the minimum required by the RQIA) for:

- Employer's liability;
- Public and third party liabilities;
- Business interruption costs;
- Loss of earnings; and
- Costs to providers of meeting contract liabilities.

16.14 All legally required certificates and licences are kept up to date, displayed if required and are accessible for the purpose of inspection.

Risk Management

Standard 17

All risks in connection with the establishment, treatment and services are identified, assessed and managed.

Criteria

17.1 There are comprehensive risk management procedures that, where appropriate, comply with legislation for the following areas:

- The identification and assessment of risks throughout the establishment;
- Health and safety;
- Fire safety;
- Infection control;
- Management of medicines;
- Decontamination;
- Blood and blood products;
- Control of Substances Hazardous to Health (COSHH);
- Moving and handling; and
- Accidents, incidents and near misses.

17.2 There are designated members of staff to send, receive and act on information from the Northern Ireland Adverse Incident Centre (NIAIC). A record is kept of guidance issued by NIAIC and warning notices are distributed and recommendations contained in the notices are implemented.[6]

17.3 Where blood and blood products are used, this should be in line with good practice including DHSSPS circular HSS (MD) 17/2011.[7]

17.4 The Registered Person/Manager reviews all information relating to accidents, incidents, near misses and claims and ensures that corrective action is taken and learning disseminated through the organisation. Regular audits are carried out.

[6] The NIAIC website can be accessed at http://www.dhsspsni.gov.uk/index/hea/niaic.htm
[7] Circular HSS (MD) 17/2011 can be accessed at: http://www.dhsspsni.gov.uk/hss-md-17-2011.pdf

Dealing with Medical Emergencies

Standard 18

There are arrangements in place in case of medical emergencies.

Criteria

18.1 There is a written protocol for dealing with recognised medical emergencies.

18.2 Appropriate staff are trained in immediate basic life support skills and such training is provided in line with timescales stated on the validation certificate.

18.3 In line with resuscitation guidance, any emergency resuscitation equipment is readily accessible and monitored to ensure it is in good working order. A record is maintained with the signature of the person carrying out the check.

Policies and Procedures

Standard 19

There are policies and procedures in place that are in line with legislation and promote safe, high-quality treatment, care and services.

Criteria

19.1 The policies and procedures for all operational areas of the establishment are in accordance with statutory requirements.

19.2 The policies and procedures for clinical treatment and care are evidenced-based and in line with current best practice (for example as defined by professional bodies and national standard setting organisations).

19.3 Where appropriate, there are arrangements to ensure that policies and procedures are developed and reviewed with input from staff and patients and clients.

19.4 Policies and procedures are centrally indexed and compiled in a policy manual and dated when issued, reviewed or revised.

19.5 Policies and procedures are subject to a systematic three yearly review, and the Registered Person ratifies any introduction of new policies and procedures as well as the revision of those already existing.

19.6 Systems are in place to ensure that all relevant persons are notified of any changes to policies and procedures.

19.7 Staff sign to state they have read, understood and agree to abide by policies and procedures.

Standards for Infection Prevention and Control and Decontamination

- **Infection Prevention and Control**
- **Decontamination**

Infection Prevention and Control[8]

Standard 20

There is a managed environment that minimises the risk of infection for patients and clients, visitors and staff.

Criteria

20.1 Responsibility for infection prevention and control is clearly defined. There are clear lines of accountability throughout the establishment and key members of staff have responsibility for the implementation of infection prevention and control policies and procedures (including identification of the lead person for infection prevention and control).

20.2 There are policies and procedures that are applicable to the setting in line with regional infection control guidelines.

20.3 All staff (including those employed in support services) receive education and training in infection prevention and control that is commensurate with their work activities and responsibilities.

20.4 There are written guidelines for staff on making referrals for advice and support to infection control nurses, microbiology services and public health medical staff who have expertise in infection prevention and control.

20.5 The risk of cross-infection to patients and clients, staff and visitors is minimised by single-use equipment (where possible) or decontamination of reusable medical devices and equipment.

20.6 There is information available on infection prevention and control for patients and clients, their representatives and staff. This is accessible and available in a range of formats where appropriate.

20.7 There is an annual infection control audit programme appropriate to the setting or service provided.

20.8 Outbreaks of infection are managed in accordance with procedures, reported to the RQIA and records kept.

[8] http://www.infectioncontrolmanual.co.ni/

Decontamination

Standard 21

Decontamination is carried out in line with current best practice and standards.[9]

Criteria

21.1 In order to eliminate the need for decontamination, single-use medical devices should be used where possible and cost effective - provided this does not compromise clinical outcomes.

21.2 The establishment has comprehensive policies and procedures covering all aspects of decontamination, including lines of accountability, ensuring appropriate training of all staff involved in the use, procurement, reprocessing and maintenance of surgical instruments.

Re-useable medical devices

21.3 There is a register of all re-useable medical devices outlining individual decontamination arrangements.

21.4 The policies and procedures for the decontamination of medical devices and equipment are in accordance with manufacturers' guidance and DHSSPS requirements.

21.5 All contaminated re-usable medical devices and equipment are handled, collected and transported for decontamination in a manner that avoids the risk of contamination to handlers, patients and clients, staff and visitors to the establishment.

21.6 There is a policy to ensure that decontamination of all medical devices, equipment and surfaces used on a patient known to have, or suspected of having CJD, or in a risk category for CJD, is carried out in accordance with DHSSPS guidance.

21.7 Where offsite decontamination is used, there must be a contract with an appropriately accredited establishment.

[9] It is recognised that not all facilities will use re-usable medical devices or equipment. This standard only applies to those that do.

21.8 There is a designated senior member of staff with responsibility for managing all aspects of decontamination, ensuring best practice is implemented and maintained and that future developments and improvements in technology are implemented as appropriate. An annual report on decontamination issues is submitted to the medical advisory committee.

21.9 Decontamination of reusable medical devices is carried out in a sterile services department accredited under the Medical Devices Directive 93/42/EEC. The department complies with DHSSPS requirements.

21.10 Local decontamination should be the exception, and, where unavoidable, must be carried out in accordance with the Protocol for Local Decontamination of Surgical Instruments issued by DHSSPS.

Endoscopes

21.11 Decontamination of flexible endoscopes should be carried out in line with current best practice and DHSSPS guidance.

21.12 Personnel exposure to chemicals and other agents including detergents, disinfectants and sterilants is such that exposure limits set out in the Control of Substances Hazardous to Health (COSHH) legislation are not exceeded.

21.13 Decontaminated medical devices are transported with appropriate documentation and stored in a manner which does not lead to degradation of their packaging system, compromise their microbiological status or lead to increased risk to handlers, patients and clients, staff and the public. Organisations must comply with the “Safe Management of Healthcare Waste” (HSENI/ADR Regulations)

Standards for Premises, Equipment and Grounds

- **Premises and Grounds**
- **Medical Devices and Equipment**
- **Fire Safety**

Premises and Grounds

Standard 22

The premises and grounds are safe, well-maintained and suitable for their stated purpose.

Criteria

22.1 The procedures for maintaining the premises, grounds, engineering services and clinical equipment are in line with legislation and manufacturers' and suppliers' guidance that are regularly reviewed and up-dated.

22.2 All structural changes or change of use to the registered building and/or alterations to engineering services, since the last inspection are approved by the RQIA, and (where relevant) other statutory authorities.

22.3 The premises, engineering services, plant and clinical equipment are kept safe and suitable, maintained in line with relevant legislation and the manufacturers' and installers' guidance, and records kept of work undertaken. All required maintenance certificates and documents are available for inspection.

22.4 Where used, there is an authorised person for medical gas pipeline systems who has responsibility for the storage, identification, quality and purity of all medical gases and maintenance of gas pipelines in accordance with DHSSPS requirements.

22.5 The establishment complies with the requirements of the Health and Safety Executive for Northern Ireland, Northern Ireland Fire and Rescue Services Board and the Environmental Health Department of the relevant District Council.

22.6 There are emergency contingency plans for major plant failure or loss of utilities such as electricity, gas or water supplies.

22.7 Security measures are operated that restrict unauthorised access to the establishment.

22.8 There is adequate access for emergency vehicles, where appropriate.

22.9 Where appropriate, there is clear signage from the approach to the site, entering the building, around the building and to the way out.

22.10 Front entrance and reception areas are welcoming and staff provide assistance to patients and clients and visitors as required.

22.11 The building is kept clean, hygienic and in good decorative order at all times.

22.12 Furniture, fittings and any equipment or mobility aids are positioned to take into account the mobility and overall needs of the patients and clients including those with sensory impairments.

22.13 The expected temperature in areas occupied or used by patients and clients is 19°C - 22°C.

22.14 The temperatures at all hot water outlets at wash hand basins, and (where appropriate) showers and baths accessible to patients and clients are maintained in accordance with Safe Hot Water and Surface Temperature Health Guidance Note.

22.15 The procedures for storage, segregation, collection, transport and disposal of clinical and non-clinical waste is in accordance with current legislation and DHSSPS guidelines.

22.16 All areas used by patients and clients are well lit, internally and externally.

Additional Standards for Establishments with Beds for In-Patients or Day Patients

22.17 Space around beds facilitate all clinical care, the use of equipment (including, where appropriate, hoists), and accommodates visitors in comfort.

22.18 All in-patients have access to single sex washing and toilet facilities.

22.19 The procedure for the handling and storage of clean laundry and storage and collection of used laundry is agreed with all relevant disciplines and is in line with the regional infection control manual.

22.20 There are call systems throughout the patient care areas including all patient bedrooms, toilets and shower/bathrooms and these are fully operational.

Medical Devices and Equipment

Standard 23

Medical devices and clinical equipment are purchased, maintained, used, and stored in accordance with legislation, Standard Operating Procedures, and manufacturers' instructions.

Criteria

23.1 There are clearly defined lines of accountability for the management of medical devices and equipment.

23.2 The policies and procedures for the management and use of medical devices and equipment are in accordance with manufacturers' guidance.

23.3 Designated staff are trained in the management and use of medical devices and equipment.

23.4 Medical devices designated by the manufacturer for single-use are not reused under any circumstances.

23.5 There are systems in place for confirming that any medical device or equipment on loan has been maintained and checked in accordance with manufacturers' and installers' guidance and records kept of the confirmation received.

23.6 There is a planned preventative maintenance (PPM) and replacement programme for all equipment and records are kept of all maintenance and servicing carried out.

Fire Safety

Standard 24

Fire safety precautions are in place that reduce the risk of fire and protect patients and clients, staff and visitors in the event of fire.

Criteria

24.1 There is a current Fire Safety Risk Assessment and Fire Safety Policy and Emergency Fire Action Plan that is revised and actioned when necessary or whenever the fire risk has changed.

24.2 The physical fire safety precautions are provided and maintained in accordance with relevant legislation, manufacturers and installers' guidance, current guidance documents and British Standards.

24.3 Action required following fire inspections is taken. The Registered Person/Manager sends any report made by fire inspectors that highlights areas for action following an inspection by them to the RQIA.

24.4 At the start of their employment, all staff undertake training provided by a competent person in the fire precautions to be taken or observed in the establishment, including the action to be taken in case of fire. This is repeated once every year.

24.5 At all times, there is a competent person who has responsibility for fire safety in the establishment.

24.6 All staff attend a fire evacuation drill at least once a year. Where this identifies problems or defects, action is taken and recorded.

24.7 There must be a record kept of all fire drills.

Standards for Medication[10]

- **Management of Medicines**
- **Medicines Storage**
- **Controlled Drugs**
- **Medicines Records**

[10] It is acknowledged that not all settings will hold or use medication on site. If your setting is one of these, the standards do not apply in your case. However, as the majority of settings will carry some sort of medications, this chapter has been included as a set of common standards.

Management of Medicines

Standard 25

Medicines are managed safely, securely and effectively in compliance with legislative requirements, professional standards, guidelines and best practice.

In this standard the management of medicines encompasses the entire way that medicines are procured, stored, prescribed, dispensed, administered, reviewed and disposed of.[11]

Criteria

25.1 Within the organisation the pharmacist has overall responsibility for the safe, secure and effective management of medicines. Where there is no pharmacist, these responsibilities are defined with clear lines of accountability leading to the Chief Executive or Board, where applicable.

25.2 A pharmacist (or where there is no pharmacist employed, a named medical practitioner) authorises any orders to obtain prescription only medicines and medicinal products from suppliers.

25.3 Written policies and procedures for the management of medicines are up to date and cover all aspects of medicines management within the organisation.

25.4 The management of medicines is conducted by appropriately qualified, trained and competent staff. Systems are in place to monitor and review staff competency in the management of medicines. Records of training and competency are maintained.

25.5 Destruction or otherwise disposal of medicines no longer required is carried out by appropriately authorised, qualified, trained and competent staff and in compliance with all legislative requirements, professional standards and good practice guidance.

25.6 The organisation has an effective system for the management of drug alerts, medical device alerts and safety warnings about medicines.

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[11] Adapted from the Audit Commission's definition of medicines management:
Medicines management defined - Medicines management in hospitals encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care.

25.7 There are systems in place to report safety problems relating to medicines, medical devices, blood and defective medicines to the Medicines and Healthcare Regulatory Agency (MHRA) and the appropriate management of any subsequent action required.

25.8 The organisation has an effective incident reporting system in place for the identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products.

25.9 The risk management process contained within the risk management standard is applied to the safe and secure handling of medicines.

25.10 The organisation accesses and uses up-to-date information relating to relevant legislation, medicines references sources and guidance relating to the safe and secure handling of medicines.

25.11 The organisation has internal arrangements in place to audit all aspects of the management of medicines. Evidence of the activity is maintained. The organisation can demonstrate if necessary that mechanisms have been put in place to change practice.

25.12 Patient Group Directions (PGDs) are used in compliance with current legislation, professional standards and best practice.

25.13 The use of unlicensed and off label medicines is in line with current legislation, professional standards and best practice.

25.14 Medicines are prepared immediately prior to their administration from the container in which they are dispensed under appropriate conditions in accordance with their Summary of Product Characteristics.

25.15 Robust arrangements are in place for the management of self administered medicines. This includes an agreed protocol to assess patients' suitability for self administration of medicines, which documents informed consent to participate if applicable.

Medicines Storage

Standard 26

Medicines are safely and securely stored in compliance with legislative requirements, professional standards, guidelines and best practice.

Criteria

26.1 Medicines are stored in compliance with the manufacturer's requirements as stated in the Summary of Product Characteristics and equipment to store medicines (e.g. fridges, freezers) is approved, monitored and serviced regularly.

26.2 Patients' own medicines that are brought into the establishment are assessed before use. Where these medicines are not used they are kept separate from other medicines and held in a safe place until discharge of the patient when they are returned to them or their representative.

26.3 Systems are in place to ensure that the security of all medicines storage is monitored.

26.4 There are clear lines of responsibility with regard to the control of medicines' keys.

26.5 Medicines which are self-administered are kept in a locked storage space that the patient and clinical staff may access.

26.6 Medicines required for resuscitation or other medical emergency are clearly defined. These medicines are readily accessible in suitable packaging and available for use at all times.

Controlled Drugs

Standard 27

The management of controlled drugs is in compliance with legislative requirements, professional standards, guidelines and best practice.

Criteria

27.1 The organisation, where appropriate, appoints an Accountable Officer (AO) who has responsibility for securing the safe management and use of controlled drugs in accordance with the Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009.

27.2 The organisation, unless specifically exempted by the Misuse of Drugs Regulations (Northern Ireland) 2002, holds a controlled drug licence issued by DHSSPS, relevant to the activities it undertakes.

27.3 There is an internal auditing and monitoring process in place which evaluates and documents findings in relation to the organisation's management and use of controlled drugs.

27.4 The organisation has systems in place to alert the AO - or where there is no AO, a senior person - of any complaints or concerns involving the management or use of controlled drugs.

27.5 The organisation has adequate and up to date standard operating procedures in place to cover access, storage, security, destruction, disposal and record keeping of controlled drugs.

27.6 Only appropriately authorised persons may requisition, dispense and supply controlled drugs in accordance with legislative provisions and best practice guidance.

27.7 Where a pharmacist is employed, and is responsible for the dispensing and supply of medicines, the purchase and issue of controlled drugs are under his or her direct supervision, including authorisation of orders to suppliers. Where no pharmacist is employed in that role, orders to suppliers are signed by the person in charge or acting person in charge of the hospital countersigned by a doctor or dentist employed or engaged by the organisation.

27.8 Controlled drugs are stored in accordance with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973 and published guidance.

27.9 The key of the controlled drugs' cabinet is held separately from other medicine cupboard keys and is held/carried by the person in charge.

27.10 Quantities of Schedule 2 and Schedule 3 controlled drugs which are subject to safe custody legislation, and other controlled drugs when deemed appropriate by the organisation, are reconciled in accordance with DHSSPS guidance.

Medicines Records

Standard 28

Medicines records comply with legislative requirements, professional standards, guidelines and best practice.

Criteria

28.1 Medicine records are legible and constructed, completed and retained in such a manner as to ensure that there is a clear audit trail.

28.2 The following medicine records are maintained:

- Medicines prescribed;
- Medicines administered;
- Medicines received;
- Medicines refused;
- Omitted doses of medicines;
- Medicines that are self-administered; and
- Transfers and/or disposals of medicines.

28.3 Suitable arrangements are in place to ensure medicine records are fully and accurately completed on each occasion.

28.4 The organisation ensures that there are robust audit trails in place relating to the management and use of controlled drugs including a record of the ordering, receipt, supply, administration and disposal of controlled drugs.

28.5 A system is in place to manage recording errors.

28.6 Where medicines are prescribed on a ‘when required’ basis, parameters of use are clearly defined in the patient’s records.

Standards for Hospitals, Clinics and Hospices

- **Medical Cover**
- **Medical Advisory Committee**
- **Resuscitation**
- **Surgery**
- **Services for Children and Young People**
- **Pathology**
- **Breaking Bad News**
- **Care of the Dying**

Medical Cover

Standard 29

Medical cover in the setting is provided at all times by appropriately skilled and trained practitioners.

Criteria

29.1 Staff providing medical cover have post-registration clinical experience relevant to the clinical work undertaken in the hospital or clinic.

29.2 The roles and responsibilities of staff providing medical cover are clearly defined and include who they report to, shift patterns, hours required to be on-call and handover arrangements.

29.3 Staff providing medical cover have access to advice and support from medical consultants with practising privileges. Consultants' responsibilities in this area are documented and communicated to resident medical officers.

29.4 There is a member of staff providing medical cover available on immediate call at all times.

29.5 There is a medical cover rota displayed in all clinical areas.

29.6 Staff providing medical cover are trained in resuscitation to the appropriate level (including defibrillation and intubation skills). This training is up-dated in line with RQIA mandatory training requirements. If the establishment treats children, this training includes Paediatric Advanced Life Support.

Medical Advisory Committee

Standard 30

Where appropriate, the establishment has a medical advisory committee that grants practising privileges and provides the Registered Manager with professional medical advice.

Criteria

30.1 There are written terms of reference for the medical advisory committee and procedures for granting practising privileges.

30.2 The medical advisory committee meets quarterly as a minimum, formal minutes are kept, and a record of meetings maintained. There are arrangements for extraordinary meetings where necessary.

30.3 The medical advisory committee makes recommendations to the Registered Person/Manager regarding eligibility for practising privileges.

30.4 The medical advisory committee, together with the Registered Manager, reviews all members' practising privileges every two years. Individual reviews may be undertaken more frequently as a result of concerns about practice or complaints received.

30.5 The medical advisory committee advises the hospital or clinic management on developments in clinical practice.

30.6 The medical advisory committee reviews information collated by the Registered Manager on adverse clinical incidents (broken down by specialty, procedure and by clinical responsibility) on a quarterly basis to include as a minimum:

- All deaths at the hospital or clinic;
- All unplanned re-admissions to hospital or clinic;
- All unplanned returns to theatre;
- Adverse events;
- All unplanned transfers to other hospitals or clinics;
- Other relevant clinical incidents; and
- Complaints and compliments.

The committee advises the hospital or clinic management on corrective action when necessary. This information is made available to the RQIA.

Resuscitation

Standard 31

Resuscitation equipment is readily accessible and resuscitation is carried out by trained competent staff and in line with the Statement of Purpose.[12]

Criteria

31.1 There are policies and procedures in relation to resuscitation which are appropriate to the establishment.

31.2 Patient's rights are central to decision making on resuscitation, including taking account of advance directives (living wills).

31.3 All 'do not resuscitate' decisions are documented by the consultant in charge of the patient's care, with the reason and date for review in the patient's clinical record. This information is provided to other relevant health professionals and is reviewed and documented daily.

31.4 There is a health care professional available at all times designated to make resuscitation decisions.

31.5 There is a written procedure for the steps to be undertaken in reaching a decision to withdraw treatment.

31.6 There are identified members of staff with responsibility for ensuring that resuscitation is carried out in accordance with policies and procedures.

31.7 There is at least one person with Advanced Life Support (ALS) training on duty at all times. They undertake simulation exercises at regular intervals, at least annually.

31.8 Where children are admitted for treatment there is at least one person with Paediatric Advanced Life Support (PALS) training on duty at all times. They undertake simulation exercises at regular intervals, at least annually.

31.9 Equipment for resuscitating patients is in line with the Resuscitation Council (UK) [13]and includes:

[12] It is recognised that not all facilities will require this level of resuscitation however where the establishment provides surgery or inpatient care all criteria will apply.

- A charged defibrillator and ECG monitor;
- Portable oxygen with appropriate valves, mask, metering and delivery system;
- First line resuscitation drugs;
- Equipment for maintaining and securing the airway of a patient;
- Equipment to insert and maintain intravenous infusions;
- Latex free alternative equipment; and
- Paediatric intubation tray where children are treated.

31.10 Resuscitation equipment is checked and restocked to ensure all equipment remains in working order and suitable for use at all times. Checks are carried out daily by a designated person and recorded.

31.11 Resuscitation equipment is cleaned and decontaminated after each usage, including practice use.

[13] http://www.resus.org.uk/pages/mediMain.htm

Surgery

Standard 32

There are arrangements in place to support the provision of safe and effective surgical practices.

Criteria

32.1 The policies and procedures for surgical services are in accordance with best practice guidelines as defined by professional bodies and national standard setting organisations including the WHO Surgical Checklist and Surgical Pause.

32.2 There is a defined staffing structure for surgical services that defines lines of accountability, specifies roles and details responsibilities for areas of activity. Staffing levels are in line with professional guidance for the procedures being undertaken.

32.3 A senior registered nurse or operating department practitioner who has operating theatre experience is in charge at all times in the operating theatre.

32.4 Equipment, installations and facilities are in place to provide services in accordance with the Statement of Purpose and are used, serviced and maintained in line with DHSSPS requirements and manufacturers' and installers' guidance.

32.5 Scheduling of patients and clients for surgical procedures takes into account patient and client requirements, staffing levels, nature of surgical procedure, facilities and equipment available. Any associated risks are managed.

32.6 The anaesthetist is present in the operating theatre throughout the operation and is present on-site until the patient or client has recovered from the immediate effects of anaesthesia.

32.7 An appropriate register of all surgical operations performed in the establishment is kept in accordance with the Independent Health Care Regulations (Northern Ireland) 2005.

Patient Care

32.8 Patients and clients receive verbal and written pre-operative information on:

- Fasting;
- Taking of existing medication; and
- Arrangements for escort to and from theatre.

32.9 The anaesthetist who is to give the anaesthetic, visits the patient or client, assesses the general medical fitness, and reviews any medication being taken prior to surgery. Possible plans of management are discussed with the patient and available options are explained, to enable the patient or client to make an informed choice.

32.10 The surgeon/practitioner who is to undertake the surgical procedure visits the patient or client and obtains consent for the proposed surgery and ensures the consent form(s) are signed prior to surgery.

32.11 Patients and clients are observed during surgery and in the recovery room on a one-to-one basis by staff trained in anaesthetics and resuscitation.

32.12 The anaesthetist who administered the anaesthesia discharges patients and clients in accordance with recovery room procedures.

32.13 There is written information for patients and clients post-operatively on:

- Pain relief;
- Bleeding;
- Care of the post-operative site; and
- The potential effects of anaesthesia.

Services for Children and Young People[14]

Standard 33

Services for children and young people are child-centred and based on a partnership with the family and the health care team. They are provided by trained staff, using appropriate equipment and facilities.

Criteria

33.1 The philosophy of care for children and young people is developed in line with current best practice and national guidelines.

33.2 The policies and procedures for services to children and young people promote safe practice within a safe physical environment that is child-centred, and address the specific needs of children and young people including those from different ethnic, cultural or religious backgrounds.

33.3 There are dedicated services to meet the need of children and young people in accordance with the statement of purpose.

33.4 Information is provided to children, young people and their families about the planned programme of treatment and care from the time of referral through to discharge.

33.5 Children and young people are provided with a range of written and verbal information appropriate to their age and understanding about treatment and care.

33.6 The information on consent to treatment is explained to children, young people and their families prior to admission.

33.7 Children and young people are admitted to single rooms or those shared with other children or young people of the same gender. Accommodation is available for a parent or carer to stay overnight in the child or young person's room or close by.

33.8 Children under the age of 12 are supervised in their rooms at all times either by hospital staff or by their parents.

[14] Children as defined in the Children Order 1995.

Staffing

33.9 There are staff to meet the needs of children and young people in accordance with the Statement of Purpose.

33.10 In dedicated children's services and on each inpatient ward dedicated to the care of children, there is a minimum of two registered children's nurses (either Registered Sick Children's Nurses (RSCN) or registered Nurse (RN) Child Branch certificate) on duty at all times.

33.11 When children and young people are cared for in a hospital that does not have a dedicated children's unit, there is at least one registered children's nurse (either Registered Sick Children's Nurses (RSCN) or registered Nurse (RN) Child Branch certificate) on duty at all times.

33.12 The registered children's nurse is responsible for implementing a care plan that is based on the child or young person's assessed needs.

33.13 The procedure for preoperative care of children and young people includes scheduling child-only lists or scheduling children and young people at the start of a general operating list.

Anaesthesia

33.14 Anaesthesia is administered to children and young people by a consultant anaesthetist who has additional paediatric training, undertakes regular child lists and maintains CPD in this specialty.

33.15 There are registered nurses and operating department practitioners with paediatric training and experience available at all times to assist with anaesthesia.

33.16 Recovery staff have awareness, training and experience on the needs of children and young people.

Equipment

33.17 A paediatrician is responsible for advising the Registered Manager on the provision of paediatric equipment and paediatric medication.

33.18 Paediatric equipment and paediatric doses of medication are available.

33.19 Paediatric resuscitation equipment is separate from adult equipment and the same system is used for wards and theatres.

Admission to Theatre

33.20 The admission to theatre is made as pleasant as possible with reduction in the number of frightening or painful procedures while the child is conscious.

33.21 Parents are facilitated and encouraged to be with the child or young person during induction of anaesthesia and immediately after recovery from anaesthesia.

33.22 Post-operative procedures include the provision of a one to one ratio of nurse to child in the recovery room and adequate post-operative pain relief.

33.23 The paediatric anaesthetist examines children and young people prior to discharge from the recovery room.

Pathology

Standard 34

Pathology services are provided by a laboratory enrolled in an accreditation scheme accredited by the UK Accreditation Service (UKAS).

Criteria

34.1 There are procedures for the collection, labelling, storage, preservation, transport and administration of specimens.

34.2 Written procedures include arrangements for the integrated management of requests for collection of pathology specimens with documentation to ensure continuous identification of the individual from whom the specimen is collected.

34.3 The procedure for reporting test results includes the use of information technology and safeguards confidentiality.

34.4 Reports are filed in the patient or client's clinical record after review by the relevant clinical staff.

Breaking Bad News

Standard 35

Patients and clients have bad news delivered by professionals who are well informed and in a manner that is sensitive and understanding of their needs.

Criteria

35.1 The procedure for delivering bad news to patients and clients, their families and other significant people is developed in accordance with guidance such as Breaking Bad News regional guidelines.

35.2 Bad news is delivered to patients and clients by professionals who are trained in communication skills and in accordance with the procedure.

35.3 The patient or client's consent is obtained before information regarding their bad news is shared with others.

35.4 The outcome of breaking bad news to patients and clients, the options discussed, and future treatment plans are recorded, and with the patient's and client's consent shared with their general practitioners and relevant health professionals.

Care of the Dying

Standard 36

The dying and death of patients and clients is handled with care and sensitivity and families and carers are supported in a sensitive and appropriate manner.

Criteria

36.1 Care and comfort are given to patients and clients who are dying, and their death is handled with sensitivity.

36.2 Palliative or end of life care and after-death arrangements are discussed with the patient or client and documented in the care plan. This takes account of cultural and spiritual preferences.

36.3 The privacy and dignity of the patient or client who is dying are maintained at all times and their cultural and spiritual needs and rights are respected and observed.

36.4 The care delivered to the dying patient or client is planned by the multi-disciplinary team.

36.5 There is evidence of use of a recognised end of life care pathway or tool. (This is not applicable for children).

36.6 There are arrangements in place for referral to specialist palliative care services to meet patients' and clients' palliative care needs.

36.7 The family and other significant people of the dying patient or client are offered support during this period.

36.8 The body of a patient or client who has died is handled with dignity, sensitivity and respect in accordance with their expressed social, cultural and religious preferences.

Additional Standards for Hospices

- **Arrangements for the Provision of Specialist Palliative Care**
- **Discharge Planning**
- **Bereavement Care Services**
- **Specialist Palliative Care Team**
- **Assessment and Care of Children and Young People in Hospices**
- **Qualifications and Training for Staff Caring for Children in Hospices**
- **Hospice Environment for the Care of Children and Young People**

Arrangements for the Provision of Specialist Palliative Care

Standard 37

Patients, prospective patients, their families and carers are clear about the arrangements for the provision of specialist palliative care. The needs of patients and carers are appropriately assessed and kept under review.

Criteria

37.1 The referral procedure includes information about the treatment and care provided by the hospice and how to access this.

37.2 Patients receive all the necessary information about the specialist palliative care services provided by the hospice. This is accessed in an alternative language or suitable format when required.

37.3 Patients receive an explanation of the assessments that will be carried out by different members of the care team.

37.4 A holistic assessment of patients' care needs using validated tools is carried out in accordance with procedures and within agreed timescales. The results of the assessments are used to draw up an individualised patient-centred care plan.

37.5 Options for treatment and care are clearly explained to patients and carers giving sufficient information, time and support to enable them to make decisions and to give consent.

37.6 The care plan and ongoing care needs are agreed with the patient and carer and communicated to the multidisciplinary care team.

37.7 There is a member of the multi-professional team identified as the principal contact for each patient and carer.

37.8 The care plan is reviewed with the patient and carer in keeping with their changing needs.

37.9 The multi-professional team, with the patient's consent, provides information and support to carers and family members.

37.10 Information about carer support services and how they may be accessed is easily accessible in a variety of formats and places.

Discharge Planning

Standard 38

Patients have a planned programme for discharge from the hospice to ensure continuity of care.

Criteria

38.1 Discharge planning is agreed with the patient and carer in accordance with the discharge procedure.

38.2 The discharge plan is co-ordinated with the services involved in the patient's ongoing care and treatment.

38.3 The planned programme for discharge from the hospice provides the patient and carers with written information on:

- The discharge arrangements;
- Future management of care;
- Liaison with community services; and
- Advice and support available.

38.4 Written information on the patient's treatment and care is provided to the patient's general practitioner, other professionals and services involved in the patient's ongoing treatment and care.

Bereavement Care Services

Standard 39

The patient's family and significant others have access to bereavement care services.

Criteria

39.1 The hospice offers bereavement care services and support to the patient's family and significant others in accordance with the Statement of Purpose.

39.2 The patient's family and significant others are provided with information about the range of bereavement services available and how to access these.

39.3 There are written referral and assessment procedures for accessing bereavement services.

39.4 Support is available from staff trained in the provision of bereavement support.

Specialist Palliative Care Team

Standard 40

Patients are cared for by a multi-professional team with expertise and training in providing specialist palliative care.

Criteria

40.1 The provision of specialist palliative care is in accordance with current best practice and national guidelines.

40.2 The policies and procedures for specialist palliative care services promote safe practice by a multi-professional team.

40.3 The multi-professional team includes staff with specialist palliative care expertise to ensure that the holistic care needs of patients and carers are met.

40.4 Multi-professional team meetings are held at least weekly to review the management of patient care with arrangements in place for ethical decision-making and patient advocacy where this is indicated and required.

Assessment and Care of Children and Young People in Hospices

Standard 41

The special needs of children and young people are addressed.

Criteria

41.1 The child or young person and their family's needs are assessed (prior to admission if possible) and their unique wishes are taken into account in the development of an individualised care plan.

41.2 There should be facilitated arrangements for the child or young person and family members to visit the hospice before admission to become familiar with the establishment and staff.

41.3 The assessment process includes the child or young person's physical, developmental and educational needs and builds on information provided by other services.

41.4 The child or young person, their parents or significant others are fully involved in all decisions about treatment and care and options are explained with sufficient information, time and support to enable them to make decisions and to give consent.

41.5 The child or young person's care plan is reviewed on each visit to the hospice or during each episode of care in the community but also updated as and when changes in care are indicated.

41.6 The services provided are child and family-centred and promote a child-orientated routine.

41.7 Parents or significant others accompany the child or young person on the first admission to the hospice to assist the care team to develop and implement the care plan.

41.8 The treatment and care provided encourages involvement of parents in their child's care.

41.9 Care and treatment is provided in accordance with the child or young person's established routine especially in relation to feeding and sleeping.

41.10 The child or young person and their parents are kept informed about any changes or deterioration in the child or young person's condition.

41.11 In partnership with parents, information is provided to the child or young person and their siblings about treatment and care. Such information is appropriate to their age, understanding and the specific circumstances.

41.12 Children and young people are aware of their rights and responsibilities in relation to their behaviours and the range of methods and controls that may be used by staff to influence them.

41.13 Symptom control is used to promote comfort and enhance quality of life for the child or young person.

41.14 Symptom control is evaluated at least daily by a designated member of the multi-professional team and involves the family, and where necessary other services and agencies contributing to the care of the child or young person and their family.

41.15 The symptom control and evaluation takes account of the particular vulnerabilities of children and young people with sensory impairment and those who are unable to communicate.

41.16 The body of a deceased child or young person is handled with care and respect and takes account of religious and cultural requirements.

41.17 Facilities are provided in a separate room where the child or young person's body can remain until the time of the funeral in accordance with the parents' wishes.

41.18 The family is offered accommodation at the hospice during this period and a designated team member is available to give emotional support and information about, or practical help with, organising the funeral and any other aspects relating to the death.

41.19 Bereavement care is offered in accordance with the wishes of the family, which includes pre- and post -bereavement support for siblings.

41.20 Staff communicate regularly and work in close co-operation with the primary health care team or voluntary health care workers involved in the care of the child or young person and their family.

Qualifications and Training for Staff Caring for Children in Hospices

Standard 42

Children and young people are cared for by a multi-professional team with expertise and training in providing palliative care for children.

Criteria

42.1 The multi-professional team at a children's hospice is led by a qualified children's nurse with a further qualification in paediatric palliative care and/or experience in the palliative care of children and young people.

42.2 There are arrangements in place to provide cover at all times by appropriately trained and experienced medical and health care practitioners. The procedure for contacting a doctor is clearly defined and known to staff.

42.3 There is a minimum of one children's nurse on duty at all times.

42.4 The staffing complement meets the assessed care needs of all children, taking into account the size and layout of the hospice, the statement of purpose and fire safety requirements.

42.5 Staff are trained in the calculation and administration of medicines to children, and only these trained staff are allowed to check drugs for children.

42.6 All care staff are trained in paediatric resuscitation.

Hospice Environment for Care of Children and Young People

Standard 43

Children and young people's special needs are addressed by the facilities provided.

Criteria

43.1 The hospice is furnished and equipped to meet the needs of children and young people, with particular efforts made to minimise the clinical and institutional environment and to promote a homely and welcoming setting.

43.2 Accommodation is provided for the child or young person's family, including siblings, and unrestricted parental involvement in the child or young person's care is promoted.

43.3 Children and young people are cared for alongside other children and young people and their play and educational needs are assessed, planned and met, and recorded in the care plan.

43.4 Arrangements are made to ensure that:

- Qualified play staff are employed;
- Indoor and outdoor play areas are accessible to all (including children and young people in wheelchairs); and
- There is a wide variety of play equipment to meet the needs of infants and children and young people of different ages, developmental stages, and differing intellectual abilities, and to help them express their feelings and prepare for experiences ahead.

43.5 There is access to teaching staff, educational facilities, and equipment for children and young people when required.

43.6 Children and young people should be cared for alongside children and young people in similar peer groups and not in an establishment unsuitable for their age.

43.7 The use of cameras, mobile phones and the internet is controlled to ensure the safety and well-being of children and young people.

43.8 Provision is made to meet the needs of children and young people with disabilities.

43.9 Meals are a family occasion, centred on a communal dining area with a varied menu. Choice of where to take meals is also available.

43.10 A children's menu is available which complies with current nutritional guidance and can be adapted for children and young people of different age groups in terms of size, content and timing of meals.

43.11 The children's menu should cater for the tastes and preferences of children and young people and include therapeutic diets.

43.12 Cutlery and utensils are available which suit the needs of children and young people of different ages and abilities.

43.13 Planning of the environment for children and young people includes preventing access by a child or young person to hot surfaces, hot water, storage of cleaning materials, and access to power points.

43.14 Security measures are operated that restrict unauthorised access to the hospice to protect children and young people.

Standards for Fertility Services and Assisted Conception

- **Facilities for Assisted Conception Services**
- **Information and Decision Making for Patients and Clients Undergoing Fertility Treatment**
- **Counselling and Support for Patients and Clients Undergoing Fertility Treatment**
- **Management of Patients and Clients Undergoing Fertility Treatment**

Facilities for Assisted Conception Services

Standard 44

The facilities are appropriate for fertility treatment.

Criteria

44.1 The service facilities and layout of the clinic are designed to ensure that the need for privacy and protection of confidentiality of people seeking treatment is met.

44.2 There is a dedicated room for the production of semen specimens.

44.3 The room used for egg collection for in-vitro fertilisation is close to the laboratory where fertilisation is to take place.

44.4 There are written protocols for the delivery of specimens to the laboratory.

44.5 There is secure atmospheric and temperature controlled storage for gametes, embryos and reagents.

44.6 There are written procedures for the indelible labelling of material from individual patients and clients to ensure the unique identification of a patient's material and records at all stages of treatment.

44.7 Gametes and embryos are stored in a secure designated area with access only by authorised personnel.

44.8 There are written protocols for the storage and handling of liquid nitrogen that comply with current health and safety requirements.

Information and Decision Making for Patients and Clients Undergoing Fertility Treatment

Standard 45

Patients and clients are effectively involved in making decisions about treatment.

Criteria

45.1 Services are provided in line with licensing arrangements.

45.2 There is a written policy and procedures for ensuring that written information for patients and clients who are seeking treatment includes risks and safeguarding confidentiality.

45.3 The guidelines for diagnosis and fertility treatment are evidence based and in line with current best practice as defined by e.g. Royal College of Obstetricians and Gynaecologists and national standard setting organisations.

45.4 Prior to commencing treatment each patient or client is given information that specifies associated risks to the individual.

45.5 There is written information for patients and clients setting out the factors that will be taken into consideration before treatment can be confirmed.

45.6 All publicity material conforms to the general principles in the guidelines of the General Medical Council and the Code of Professional Conduct of the Nurses and Midwives Council.

Counselling and Support for Patients and Clients Undergoing Fertility Treatment

Standard 46

Counselling and support is offered to all patients and clients before, during and after treatment.

Criteria

46.1 A dedicated counselling and support service that complies with HFEA specific requirements is offered to patients and clients throughout all stages of fertility investigations and treatment.

46.2 There are referral arrangements to specialist genetic counselling when required.

46.3 There is information for patients and clients on local and national counselling and support organisations.

Management of Patients and Clients Undergoing Fertility Treatment

Standard 47

Patient and client care is managed, delivered and reviewed by professional staff who provide care safely and effectively in line with HFEA Guidance.

Criteria

47.1 Local protocols for the management of patients and clients are developed and agreed by all professionals.

47.2 The protocols for the prevention and management of ovarian hyper stimulation syndrome are evidence-based in line with current best practice as defined by professional bodies and national standard setting organisations.

47.3 All deaths, including those from ovarian hyper stimulation, are reported to the Confidential Enquiry into Maternal and Child Health (CEMACH) whether or not the woman had a positive pregnancy test.

47.4 There are written protocols for healthcare professionals on semen cryostorage in cases where men are undergoing medical treatment likely to make them infertile so the situation is dealt with quickly and effectively.

47.5 There are written protocols for the close monitoring of patients and clients in order to avoid unnecessary complications, including multiple pregnancy.

47.6 There are written up to date protocols setting out the number of embryos placed in a woman in any one cycle that comply with the HFEA's Code of Practice.

Standards for Lasers and Intense Light Sources

These standards cover both Class 3B and Class 4 lasers and intense light procedures that are carried out in a variety of settings and for a variety of purposes.

These powerful devices which, if faulty or incorrectly used, have the potential to cause serious injury to those operating them, recipients of treatment and other persons in the vicinity, and to ignite flammable materials.

The Independent Healthcare Regulations define these lasers as:

(a) a Class 3B or Class 4 laser product, as defined in Part I of British Standard EN 60825-1 (Radiation safety of laser products and systems)
(b) an intense light, being broadband non-coherent light which is filtered to produce a specified range of wavelengths; such filtered radiation being delivered to the body with the aim of causing thermal, mechanical or chemical damage to structures such as hair follicles and skin blemishes while sparing surrounding tissues.

Lasers and Intense Light Sources

Standard 48

***Laser and intense light source procedures are carried out by appropriately trained staff in accordance with best practice*.**

Criteria

48.1 All patients and clients have an appointment consultation with the authorised operator who will be carrying out the laser or intense light procedure to assess the patient or client. This is documented in the treatment record.

48.2 Laser and intense light source procedures are carried out by authorised operators in accordance with a treatment protocol produced by a named registered medical or dental practitioner who is trained and experienced in the relevant discipline within which treatment is provided. The protocol sets out:

- Treatment Contra-indications;
- Technique;
- Pre-treatment tests;
- Pre–treatment checks;
- Post-treatment care;
- Recognition of treatment-related problems;
- Procedure if anything goes wrong with treatment;
- Permitted variation on machine variables; and
- Procedure in the event of equipment failure.

48.3 There is a system in place for the continuous review of the treatment protocol by the named registered medical or dental practitioner.

48.4 The treatment protocol is supported by written procedures known as local rules that detail the normal operation of equipment including when it is being used on a trial or demonstration basis, and these cover:

- The potential hazards associated with lasers and intense light sources including a risk assessment;
- Controlled and safe access;
- Authorised operators' responsibilities;
- Methods of safe working;
- Safety checks;
- Personal protective equipment;
- Prevention of use by unauthorised persons; and

- Adverse incident procedures.

48.5 Authorised operators sign to indicate that they accept and understand the procedures known as local rules drawn up for the use of lasers and intense light sources.

48.6 There is written confirmation of the appointment and duties of a certificated laser protection advisor that is renewed annually.

48.7 There is written confirmation of the appointment and duties of a person who has overall onsite responsibility for safety during laser and intense light procedures.

48.8 Provision is made for a follow-up service to ensure effective continuity of care for the patient or client.

48.9 A register is maintained every time the laser or intense light is operated including:

- The name of the person treated;
- The date;
- The operator;
- The treatment given;
- The precise exposure; and
- Any accidents or adverse incidents.

48.10 There is an accurate and up to date treatment record for every patient or client which includes:

- Patient or client details;
- Medical history;
- Signed consent form;
- Skin assessment (where appropriate);
- Patch test (where appropriate); and
- Record of treatment delivered including number of shots and fluence settings (where appropriate).

48.11 A risk assessment has been undertaken by the Laser Protection Advisor which is reviewed in agreement with LPA and provider at least every three years

Training for Staff

48.12 Laser and intense light source authorised operators have up to date training in laser and intense light source safety and their use that complies with current legislative requirements and professional guidelines.

48.13 All support staff have up to date awareness training in laser and intense light source safety.

Safe Operation of Lasers and Intense Light Sources

48.14 The area around lasers and intense light sources is controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when treatment is being carried out.

48.15 While the equipment is in use, the safety of all persons in the controlled area is the responsibility of a named member of staff. No other laser or intense light source is in use in the same controlled area at the same time.

48.16 Warning signs that comply with current legislation, directives and standards are displayed on the equipment and on the outside of doors to the controlled area (and removed when the equipment is not in use).

48.17 Protective eyewear is available for the patient and authorised operator in accordance with the local rules.

48.18 The door of the treatment room is locked when the laser or intense light equipment is in use which can be opened from the outside in the event of an emergency.

48.19 For all lasers and intense light sources with a key switch, there are formal written arrangements for the safe custody of the key, separate from the equipment. The key is not left unattended with the equipment.

48.20 Lasers and intense light sources are serviced and maintained in accordance with manufacturer's instructions to ensure they are operating within their design specification. A detailed record of all servicing and repairs is kept.

48.21 A laser safety file is in place which contains all of the relevant information in relation to laser or intense light equipment.

Standards for Dialysis

Standard 49

Dialysis is carried out according to best practice guidance.

Criteria

49.1 There is an accurate and up to date treatment record for every patient.

49.2 Dialysis units are staffed according to guidance set out in British Renal Society document: The Renal Team. A Multi-Professional Renal Workforce Plan for Adults and Children with Renal Disease[15].

49.3 Establishments comply with guidance set out in the UK Renal Association and Association of Renal Technologists Guideline on water treatment facilities, dialysis water and dialysis fluid quality for haemodialysis and related therapies Clinical Practice Guideline[16].

49.4 Establishments comply with guidance set out in the Health Building Note 07-01[17] for Satellite Units and Health Building Note for 07-02 for Main Renal Units.

49.5 Dialysis is carried out according to the Renal Association Guidelines for Haemodialysis[18].

[15] http://www.britishrenal.org/getattachment/Workforce-Planning/WFP_Renal_Book1.pdf.aspx

[16] http://www.renal.org/Libraries/Guidelines/RA_and_ART_guideline_final_version_20_01_12_1.sflb.ashx

[17] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147869/HBN_07-01_Final.pdf

[18] http://www.renal.org/Clinical/GuidelinesSection/Haemodialysis.aspx

Standards for Hyperbaric Oxygen Treatment

Hyperbaric Oxygen Treatment (HBOT) involves specialised equipment and experienced staff to deliver oxygen (which may be combined with other gases) at higher than atmospheric pressures. Patients receive the treatment through a mask whilst in a chamber which is gradually pressurised with compressed air.

Treatment is carried out by or under the supervision of a medical practitioner.

HBOT is used to treat a variety of conditions, including the following:

- Air or gas embolism;
- Decompression illness;
- Carbon monoxide poisoning;
- Gas gangerene;
- Necrotizing fasciitis; and
- Thermal burns.

Regulations state that Hyperbaric Therapies must be regulated except where the primary use of the chamber is:

"*pursuant to regulation 6(3)(b) of the Diving at Work Regulations (Northern Ireland) 2005(a) or regulation 8 or 12 of the Work in Compressed Air Regulations (Northern Ireland) 2004 (b); or otherwise for the treatment of workers in connection with the work which they perform*."

Hyperbaric Therapies

Standard 50

Hyperbaric therapies are carried out in suitable premises, using appropriate equipment and in accordance with legislative and best practice guidance.

Criteria

50.1 All treatment is carried out by or under the supervision of a medical practitioner.

50.2 Treatment is carried out in accordance with standards and best practice guidance as developed by standard setting organisations.

50.3 All patients and clients have an appointment consultation for assessment with the medical practitioner who will be carrying out or supervising the procedure. This is documented in the treatment record.

50.4 There are written procedures that detail the treatment protocol and normal operation of equipment (including when it is being used on a trial or demonstration basis) and these cover:

- Treatment Contra-indications;
- Technique;
- Pre-treatment tests;
- Pre–treatment checks;
- Post-treatment care;
- Recognition of treatment-related problems;
- Procedure if anything goes wrong with treatment;
- Permitted variation on machine variables;
- Procedure in the event of equipment failure;
- The potential hazards associated with hyperbaric oxygen treatment including a risk assessment;
- Controlled and safe access;
- Operators' responsibilities;
- Methods of safe working;
- Safety checks;
- Personal protective equipment;
- Prevention of use by unauthorised persons; and
- Adverse incident procedures.

50.5 There is an accurate and up to date treatment record for every patient or client which includes:

- Patient or client details;
- Medical history;
- Signed consent form; and
- Record of treatment delivered.

Training for Staff

50.6 Operators of hyperbaric treatment chambers have up to date training in safety and their use that complies with current legislative requirements and professional guidelines.

50.7 All support staff have up to date awareness training in hyperbaric oxygen chamber safety.

Equipment

50.8 Providers comply with the NI HTM 83 Fire Safety in Healthcare Premises (2010).

50.9 Decompression Chambers and Hyperbaric Chambers manufactured in Carbon Steel conform to PD5500 and Quality Standard ISO 9001:2000.

50.10 Decompression Chambers and Hyperbaric Chambers are:

- Built in accordance with the European Pressure Directive (PED);
- Certified by Lloyds Register as “Pressure Vessels Safe for Human Occupancy” (PVHO);
- Lloyds Register “design appraised”; and
- CE marked.

50.11 Chambers are operated in accordance with the limits set out in PD5500 Cat 1.

50.12 Hyperbaric chambers are serviced and maintained in accordance with manufacturer’s instructions to ensure they are operating within their design specification. A detailed record of all servicing and repairs is kept.

Standards for Mental Health Hospitals

This section contains standards specific to establishments treating people with mental health problems, and in particular those detained for assessment and treatment under the Mental Health (NI) Order 1986[19].

The standards apply to all units providing in-patient mental health services, whether for adults or children and young people.

In addition, the Mental Health (Private Hospitals) Regulations (NI) 2013 apply additional safeguards to patients detained in private hospitals.

Providers should also be aware of the standards set out in the DHSSPS Service Framework for Mental Health and Wellbeing[20].

[19] The Act can be accessed at: http://www.nidirect.gov.uk/the-mental-health-act.

[20] This can be found at: http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards-service-frameworks/sqsd_service_frameworks_mental_health.htm

Standards for Mental Health Hospitals

- **Admission and Assessment**
- **Empowerment**
- **Risk Assessment and Management**
- **Levels of Observation**
- **Children and Adolescents in Adult Mental Health Wards**
- **Electro-convulsive Therapy (ECT)**
- **Specific Treatments**
- **Managing Disturbed Behaviour**
- **Unexpected Patient Death**
- **Patients Absent Without Leave**
- **Patient Restraint and Physical Interventions**
- **Detained Patients**
- **The Rights of Patients under the Mental Health (Northern Ireland) Order 1986 as amended**
- **Seclusion of Patients**
- **Leave**
- **Absent Without Leave under Article 29**
- **Staff Training on the Mental Health (Northern Ireland) Order 1986**

Admission and Assessment

Standard 51

Patients are admitted and assessed appropriately.

Criteria

51.1 There are written policies and procedures for admission, which are compliant with the Mental Health (Northern Ireland) Order 1986 and the Mental Health (Private Hospitals) Regulations (NI) 2013.

51.2 Patients receive a comprehensive assessment (including a physical health assessment) on admission or transfer from another team.

51.3 The assessment process includes an assessment of the family (including consideration of assessment under Understanding the Needs of Children in Northern Ireland (UNOCINI) as appropriate), employment and social circumstances of patients, forensic history and in the case of children their educational needs, (especially those with behavioural problems) after admission and prior to discharge.

Empowerment

Standard 52

***Patients and their carers are informed about their rights and their care and have access to independent advocacy*.**

Criteria

52.1 Patient information leaflets are written in plain language which the patient will understand and are published and disseminated to patients, their family and carers. This should include information on:

- Patient's rights;
- Responsibilities;
- Care plan;
- Medication; and
- Therapies.

52.2 All patients are given written details of local organisations providing independent advocacy. There are proactive approaches to ensure that patients are aware of, and enabled, to access appropriate advocacy services. Additionally, the establishment should, under contract, retain the services of at least one such organisation.

52.3 Details of organisations retained by the establishment to provide independent advocacy are displayed in the establishment.

Risk Assessment and Management

Standard 53

All potential environmental and clinical risks are assessed and managed to ensure a safe environment is maintained for patients, staff and the general public.

Criteria

53.1 There are written policies, protocols and procedures on the prevention of self harm/suicide, which take account of the recommendations of the Mental Health Clinical Outcome Review Programme and all relevant National Institute for Clinical Excellence (NICE) guidance[21].

53.2 Individual clinical risk assessments are undertaken by the multidisciplinary team on admission and an appropriate care plan put in place and reviewed in line with Departmental guidance, contained in Promoting Quality Care (PQC)[22] unless a specific incident demands an immediate review.

[21] NICE guidance endorsed by DHSSPS can be found at: http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance/sqsd-guidance-nice-guidance.htm. Other NICE guidance can be found at www.NICE.org.uk

[22] http://www.dhsspsni.gov.uk/mhld-good-practice-guidance-2010.pdf

Levels of Observation

Standard 54

Appropriate arrangements are made for the observation of patients.

Criteria

54.1 There are written policies and procedures which are reviewed at least every three years for determining levels of observation, engagement, communication and supervision for inpatients. The policies follow the Health and Social Care Board (HSCB)/Public Health Agency's (PHA) Regional Guidance on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland[23].

54.2 All patients on a residential unit are considered subject to general observation, which includes staff actively engaging and interacting with the patient.

54.3 The reasons for imposing or altering the observation level are recorded in the clinical and nursing notes.

54.4 There are regular clinical audits of the use of observation and the results are discussed with all members of the multi-professional team.

[23] http://www.publichealth.hscni.net/publications/regional-guideline-use-observation-and-therapeutic-engagement-adult-psychiatric-inpatie

Children and Adolescents in Adult Mental Health Wards

Safeguarding Children

Standard 55

Arrangements are in place to safeguard children and young people whilst on an adult ward.

Criteria

55.1 The unit must adhere to protocols set out in the DHSSPS guidance – Co-operating to Safeguard Children [24].

[24] http://www.dhsspsni.gov.uk/show-publications?txtid=14022

Electro-convulsive Therapy (ECT)

Standard 56

ECT is provided in a suitable clinical environment to patients by trained competent practitioners, who maintain an appropriate level of skill.

Criteria

56.1 There are written policies and procedures, reviewed at least every three years, on the use of electro-convulsive therapy (ECT) which are followed by staff. These adhere to NICE guidance and the Royal College of Psychiatrists ECTA Scheme[25].

56.2 The unit must have access to appropriate resuscitation services.

[25] http://rcpsych.ac.uk/default.aspx

Specific Treatments

Standard 57

Specific treatments are administered in keeping with the requirements under the Mental Health (Northern Ireland) Order 1986.

Criteria

57.1 There is a policy to include consent to treatment and administration to patients detained under the Mental Health (Northern Ireland) Order 1986. A copy of the current Certificate of Consent to Treatment (Form 22) or Certificate of Second Opinion (Form 23) – and if relevant Article 67 Review of Treatment/MHAC 1 – is attached to the patient's medicine card and checked by a registered nurse each time the relevant medication is administered. The written policy on consent to treatment includes clear guidance on:

- Treatment under Article 63 requiring consent and a second opinion, ie psychosurgery, implantation of hormones;
- Treatment under Article 64 requiring consent or a second opinion, e.g. electroconvulsive therapy (ECT) and medication beyond 3 months;
- Withdrawal of consent;
- Review of Treatment under Article 67; and
- Urgent treatment under Article 68.

57.2 All Certificates of Consent to Treatment (Form 22) and Certificates of Second Opinion (Form 23) are audited on a regular basis.

57.3 All medicine is administered to a patient with a written prescription or, internal to the establishment, a drug administration chart that has been authorised by a legally authorised prescriber taking the provisions of Part IV of the Mental Health (Northern Ireland) Order 1986 into account where appropriate.

57.4 A medication record is kept for each patient, the entries signed by the prescriber, showing:

- The name and date of birth of the patient;
- Registration number and ward where appropriate;
- The name of the medicine;
- The dose and dose frequency;
- The date of prescribing; and
- Known allergies.

57.5 There are clear policies for the administration of ‘when required’ medicines.

57.6 When medicines are no longer required by the named patient they are returned to the pharmacy or pharmacist for disposal.

57.7 The establishment must comply with DHSSPS policy on Safe Storage of Medicines.

Managing Disturbed Behaviour

Standard 58

Patients displaying aggressive and violent behaviour are managed in the least restrictive manner.

Criteria

58.1 There is a specific individual treatment plan for all those patients who are seriously disturbed which is recorded in the multi-disciplinary patient records.

58.2 The policies for dealing with disturbed behaviour include the levels of observation to be used and the degree of restriction required.

58.3 The degree of restriction is communicated and implemented by all staff involved in each patient's care.

58.4 Where a staff member has been threatened or attacked by a patient, when possible any immediate decision about that patient's treatment plan is taken by other members of the clinical team.

58.5 The nurse in charge will communicate all major changes in the treatment of disturbed or potentially violent patients (including changes of medication) to all nursing and other relevant staff in contact with the patient. Responsibility for this belongs to the registered nurse in charge at the start of the shift.

58.6 Facilities are available for the separate care of seriously disturbed patients and, where this is not possible, they are nursed separately from other patients. If this involves the use of seclusion, see standard 65.

58.7 There are written policies and procedures for staff in relation to responding to patients who:

- Refuse to participate in therapeutic programmes;
- Verbally abuse and/or threaten physical harm to others; or
- Destroy property.

Unexpected Patient Death

Standard 59

Appropriate procedures are in place to manage circumstances in which a patient dies unexpectedly.

Criteria

59.1 There are arrangements in place for informing family members and carers following a patient's death.

59.2 Support and information is provided to family members and carers following an unexpected patient death.

59.3 There are arrangements in place to support staff following an unexpected patient death.

59.4 There are procedures in place to secure the records following an unexpected death.

59.5 There is a procedure in place for an investigation into the death to be instigated in keeping with HSCB/PHA guidance[26].

59.6 The manager informs the RQIA of any review into the death of detained patients, and relevant dates of inquiry and inquest.

59.7 Management and members of internal investigating teams are trained in the investigative process so that they understand the stages of investigation.

[26] http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/nursing/safety-and-quality

Patients Absent Without Leave

Standard 60

Effective arrangements are in place to manage situations when patients absent themselves without leave.

Criteria

60.1 There are written policies and procedures, reviewed at least every 3 years, for dealing with patients absent without leave.

60.2 There are clearly visible notices for patients requesting their co-operation in informing staff of their whereabouts at all times.

60.3 Patients with a high incidence of being absent without leave should be reviewed regularly and care plans re-adjusted to minimise re-occurrence.

60.4 The establishment records levels of absconding and formally reviews them at least annually. Reviews explore the reasons for absconding and ways of minimising recurrence following any significant increase in number of absences or following the absconding of any high-risk patient.

Patient Restraint and Physical Interventions

Standard 61

Patients who require restraint are managed appropriately and safely.

Criteria

61.1 There are written policies and procedures on using restraint and physical interventions with patients.

61.2 The policy includes procedures for rapid tranquillisation and emergency medication.

61.3 Staff receive training every 3 years on the prevention of violence and aggression including de-escalation techniques and the management of aggression.

61.4 All clinical areas have resources to minimise/intervene in episodes of violence or dangerous behaviour and staff are aware of these and the procedures for use.

61.5 Patient mix, environment and staffing levels are reviewed to minimise incidents of disturbed behaviour requiring the use of physical intervention techniques.

61.6 Physical intervention procedures are reviewed to ensure that they are employed appropriately by the team.

61.7 When it has been necessary for a patient to be restrained, a full nursing and medical review, including a physical examination, is carried out as soon as practicable.

61.8 There is an up-to-date register of staff who have completed courses in restraint and physical intervention.

61.9 The number, duration and form of restraint of patients is recorded and included on documentation available to the RQIA.

Detained Patients

Standard 62

Detained patients receive care and treatment as per the Mental Health (Northern Ireland) Order 1986 as amended, its consequential regulations and its Code of Practice.

Criteria

62.1 Copies of the following documents are available in the establishment:

- Mental Health (Northern Ireland) Order 1986;
- Mental Health (Northern Ireland) Order 1986 Code of Practice;
- The Mental Health (Private Hospitals) Regulations (NI) 2013;
- The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulation (Northern Ireland) 1986, as amended;
- Guide to the Mental Health (Northern Ireland) Order 1986;
- Transfers of Mentally Disordered Patients (August 2011)[27]
- Promoting Quality Care; and
- Mental Health Services Charter.

62.2 There are written policies and procedures for the assessment, care, treatment and discharge of detained patients, which are drafted in accordance with the most recent version of the Code of Practice, and include policies on:

- Patients' correspondence;
- Medical practitioners' and nurses' holding powers under Article 7 of the Mental Health (Northern Ireland) Order 1986;
- Patients presenting with particular management problems, including the use of seclusion;
- Physical restraint;
- Psychological treatments, including "time out";
- Review of treatment (Article 67 of the Mental Health (Northern Ireland) Order 1986);
- Patients concerned with criminal proceedings;
- Leave of absence;
- Absence without leave;
- The re-taking of a detained patient in the community;

[27] http://www.dhsspsni.gov.uk/guidance-on-the-transfer-of-mentally-disordered-patients-2011.pdf

- Mental Health Review Tribunals;
- Managers' hearings;
- The giving of information to detained patients;
- Treatment requiring the patient's consent or a second opinion (Article 64 of the Mental Health (Northern Ireland) Order 1986);
- Urgent treatment (Article 68 of the Mental Health (Northern Ireland) Order 1986); and
- Personal searches.

62.3 The policies and procedures for services for detained patients are reviewed at least every 3 years.

62.4 Guidelines for assessment of patients for admission under the Mental Health (Northern Ireland) Order 1986 as amended, which spell out the roles of all involved, are jointly developed, implemented and reviewed regularly.

62.5 A form is completed by the responsible medical practitioner every time urgent treatment is given under Article 68 of the Mental Health (Northern Ireland) Order 1986, as amended.

62.6 The use of Article 68 of the Mental Health (Northern Ireland) Order 1986 is regularly monitored by managers.

62.7 Staff, are aware of their obligations under the Mental Health Review Tribunal Regulations, to produce timely and appropriate reports and to be available to give evidence at a tribunal.

62.8 Appropriate accommodation is made available for Mental Health Review Tribunal hearings, including appropriate facilities for witnesses, and with due regard to the need for confidentiality.

62.9 There are written policies and procedures covering all the statutory functions of the hospital managers, reviewed at least every three years.

Discharge of Detained Patients

62.10 Arrangements for the discharge of detained patients are appropriate and clear, and in accordance with the requirements of the 1986 Mental Health (Northern Ireland) Order, as amended, and its Code of Practice.

62.11 The medical practitioner should not delegate his or her discharge function to persons who are either on the staff of the hospital or have a financial interest in it.

The Rights of Patients under the Mental Health (Northern Ireland) Order 1986, as amended

Standard 63

Patients must be informed of all relevant rights.

Criteria

63.1 Detained patients and their nearest relatives are made aware of their rights and entitlements under the Mental Health (Northern Ireland) Order 1986, as amended, and its Code of Practice.

63.2 Written information is produced, displayed and disseminated to all new patients and, subject to the patient's consent, given to their nearest relative. This should include:

- The patient's current legal position;
- The provision of advocacy;
- The patient's right to apply to a Mental Health Review Tribunal;
- The role and function of RQIA; and
- The availability of solicitors recognised by the Law Society as being proficient in mental health work.

63.3 There is a written policy and procedure, reviewed at least every 3 years, detailing the implementation of Part IV of the 1986 Mental Health (Northern Ireland) Order as amended (see 15.2).

Seclusion of Patients

Standard 64

There must be clear written protocols which deal with the seclusion of patients.

Criteria

64.1 There are written policies and procedures on seclusion which are consistent with the Mental Health (Northern Ireland) Order 1986, as amended, its Code of Practice and DHSSPS Guidance on Restraint and Seclusion[28].

64.2 The written policies include guidance on:

- Minimising the use of seclusion;
- The roles of professionals in initiation and review;
- Monitoring by care teams and senior management;
- The appropriate use of seclusion;
- Not removing the patient's clothing during or following an incident; and
- The presence of same sex staff.

64.3 Each episode of seclusion is reviewed by professionals independent of those staff in direct contact with the patient.

64.4 Where a patient in seclusion has been sedated, a registered nurse remains in sight and sound of the patient and vital signs are recorded at regular intervals.

64.5 Rooms used for seclusion:

- Provide privacy from other patients;
- Enable staff to observe the patient at all times;
- Do not contain anything which could cause harm to the patient or others;
- Are comfortably furnished and lit;
- Have controllable heating and ventilation; and
- Are quiet but not soundproofed and include a means of calling for attention.

[28] http://www.dhsspsni.gov.uk/restraint_and_seclusion_august_2005.pdf

64.6 A quarterly report of episodes of seclusion is produced for senior management and RQIA, with a brief explanation of each occasion.

Leave

Standard 65

Arrangements for Article 15 leave of absence are appropriate and clear, and in accordance with the requirements of the Mental Health (Northern Ireland) Order 1986, as amended, and its Code of Practice.

Criteria

65.1 There are written policies and procedures for detained patients going on Article 15 (Mental Health (Northern Ireland) Order 1986 as amended) leave.

65.2 The policies and procedures for Article 15 leave include requirements that:

- The level of the patient's co-operation with assessment and treatment is taken into account in deciding to grant leave;
- Leave is not granted until the patient has been resident for sufficient time to allow an adequate risk assessment to be undertaken; and
- The named nurse/escort attends the patient reviews to report on previous leave and is party to discussion about future leave.

65.3 All conditions pertaining to the leave are recorded on the Article 15 form including:

- Whether it is escorted, including number of escorts, or unescorted;
- Level of observation;
- Period of leave;
- Location at which the leave will be taken;
- The purpose of the leave;
- The expected date and time of return; and
- Any other specific conditions.

65.4 Careful consideration is given to the choice of venue taking account of:

- Its purpose and suitability;
- The level of risk posed to the patient in that setting;
- The patient's reason for choosing it; and
- Public sensitivities.

65.5 Leave is cancelled if an appropriate escort or appropriate transport is not available.

Absence Without Leave under Article 29

Standard 66

Procedures on dealing with the situation of when patients are absent without leave are appropriate and clear, and in accordance with the requirements of the Mental Health (Northern Ireland) Order 1986, as amended, and its Code of Practice.

Criteria

66.1 Procedures on dealing with the situation when patients are absent without leave are reviewed regularly and made known to all staff who comply with procedures.

66.2 Appropriate arrangements are made for missing patients.

Staff Training on the Mental Health (Northern Ireland) Order 1986 as amended.

Standard 67

Patients receive care and treatment from staff trained and conversant with, the provisions of the Mental Health (Northern Ireland) Order 1986, as amended, and its Code of Practice.

Criteria

67.1 All staff are trained and aware of their responsibilities under the Mental Health (Northern Ireland) Order 1986, as amended, and its Code of Practice and receive regular updates on aspects of mental health legislation.

67.2 There are written policies, which are reviewed at least every 3 years, to guide staff in explaining to patients (and their carers/family members) their legal rights and responsibilities under the mental health legislation.

67.3 All clinical staff receive training on Article 15 (leave procedures) which forms part of the induction of new staff, and are updated when necessary.

67.4 All care staff receive training and regular updating on consent to treatment matters including compliance with Part IV of the Mental Health (Northern Ireland) Order 1986, as amended.

67.5 All staff receive training on responsibilities regarding Mental Health Review Tribunals and patients have full access to relevant advice.

Section 2 - Requirements for Registration

Statement of Purpose
Fitness of the Registered Person
Fitness of the Registered Manager
Suitability of the Premises to be Registered

Statement of Purpose

The written Statement of Purpose for the establishment includes the following information:

- Details of the person or organisation with overall responsibility for the establishment;
- The status and constitution of the establishment;
- The organisational structure of the establishment;
- The aims and objectives of the establishment;
- The philosophy of care;
- The types of treatment, services and facilities provided by the establishment;
- Where there are inpatient facilities the number of patients and clients that can be accommodated;
- Operational Policy for the establishment which includes the following:

    - The arrangements in place to ensure the fitness of persons to work at the establishment;
    - The arrangements for the training and development of people who work in the establishment;
    - The arrangements in place to ensure the adequacy of numbers of persons working in the establishment;
    - Admission arrangements for patients and clients including information pack;
    - The arrangements for safeguarding and promoting the health, well-being and spiritual needs of the patients and clients;
    - The care planning process;
    - The arrangements for securing nursing, medical, psychiatric treatment or listed services;
    - The arrangements for the management and control of the establishment;
    - The accounting and financial control arrangements for the establishment;
    - The insurance arrangements;
    - The arrangements for the keeping of documents and records;
    - The arrangements for the notification of reportable events;
    - The arrangements for dealing with complaints and the steps for publicising the arrangements;
    - The arrangements for the management of medicines;
    - A Fire Safety Policy and Emergency Fire Action Plan that demonstrates compliance with 'fire code' and The Fire Precautions (Workplace) Regulations (Northern Ireland) 2001;

- A written agreement or contract detailing the responsibilities of each party involved for the maintenance, safety and fire precautions for the property where the Registered Person does not own the building; and
- The policies and procedures listed in Appendix 1.

Fitness of Registered Person

To determine the fitness of the person applying for registration the following are required:

- Two satisfactory written references;
- A pre-employment health assessment;
- Satisfactory AccessNI checks and police checks;
- Evidence of qualifications (if any) and registration with professional regulatory bodies;
- Confirmation of identity;
- Financial/Business plan; and
- Adequate insurance arrangements.

In addition the RQIA is assured through the registration process that the person:

- Has knowledge and understanding of his or her legal responsibilities;
- Intends to carry on the establishment in accordance with legislative requirements, DHSSPS Minimum Standards and other standards set by professional bodies and standard setting organisations;
- Intends to undertake update training to ensure he or she has the necessary knowledge and skills; and
- Will adhere to the professional codes of conduct of the relevant regulatory bodies.

Fitness of Registered Manager

To determine the fitness of the person applying for registration as the Registered Manager the RQIA is assured through the registration process that the person:

- Having regard to the size of the establishment or agency, the statement of purpose, and the number and needs of the patients, has the necessary qualifications, skills and experience necessary to manage the establishment or agency.

Where healthcare procedures are carried out, there must be a clinical lead.

The following are also required:

- A satisfactory employment history together with a written explanation of any gaps in employment;
- A pre-employment health assessment;
- Two satisfactory written references one of which is from the applicant's present or most recent employer;
- Confirmation of identity;
- Satisfactory AccessNI and police checks; and where appropriate
- Evidence of professional and vocational qualifications; and
- Evidence of registration with professional regulatory bodies.

In addition the RQIA is assured through the registration process that the person:

- Has knowledge and understanding of his or her legal responsibilities;
- Intends to carry on the establishment in accordance with legislative requirements, DHSSPS Minimum Standards and other standards set by professional bodies and standard setting organisations;
- Intends to undertake update training to ensure he or she has the necessary knowledge and skills; and
- Will adhere to the professional codes of conduct of the relevant regulatory bodies.

Suitability of Premises to be Registered

To determine the fitness of the proposed premises the following must be met:

- The design and construction of the building and grounds must comply with all relevant legislative requirements and guidance documents as set out in Health Building Notes, Health Technical Memoranda, Health Facilities Notes and design guides at the time of registration. Certificates and commissioning documents with regard to engineering services and plant, and approval letters and letters certifying completion of works from other agencies and authorities confirm this; and
- The premises are fully commissioned and operational.

APPENDIX 1 - Policies and Procedures

Independent health care providers must develop policies, procedures and protocols appropriate to the setting, for the following:

Absence of the Registered Manager
Admission
Advance Directives
Access to health records
Accidents and adverse incidents
Accounting, financial and auditing procedures
Advertising
Arrangements for admission, acceptance, transfer and discharge of patients and clients
Arrangements for assessment, diagnosis and treatment of patients and clients
Breaking bad news
Certification of death
Clinical procedures
Complaints
Completion of Clinical Records
Confidentiality
Consent
Consultation with patients and clients about treatment and care
Contracts and delivery of services
Death and bereavement care
Decontamination
Disclosure of patient information
Displaying legally required certificates and licences
Electro-convulsive Therapy (ECT)
Examination and treatment of children and young people
Fire precautions and fire safety policy and emergency fire action plan
First Aid
Fitness of the premises
Food Hygiene
Human Resources that include:

- Dealing with Alert letters issued by DHSSPS and professional regulatory bodies;
- Health clearance for health care staff;
- International recruitment;
- Job descriptions;
- Offers of gifts to staff;
- Organisational structure of the establishment;
- Practising privileges;

- Recruitment of staff and volunteers;
- Smoking;
- Staffing;
- Staff uniforms;
- Staff contracts;
- Staff supervision and appraisal;
- Staff records;
- Staff training and development;
- Using agency staff;
- Using AccessNI;
- Violence towards staff;
- Volunteers – roles and responsibilities;
- Whistle blowing; and
- Whole practice appraisal and information sharing with the HSC.

Infection prevention and control
Information provision to patients and clients
Inspections of the establishment
Insurance arrangements
Labeling of Material
Laundry
Maintenance of the premises and grounds
Maintenance of equipment, plant, premises and grounds
Management, control and monitoring of the establishment
Management of medical gases and cylinders
Management of medicines
Medical Devices and Equipment
Medical Emergencies
Moving and Handling
Missing items
Missing patients and clients
Monitoring the quality of services, clinical treatment and care
Monitoring the suitability of facilities and equipment
Observations
Operational policy
Out of hours cover for Allied Health Professionals
Out of hours medical cover
Palliative Care Services
Pathology services
Patient and clients' guide
Patient and clients' money and valuables
Patients on Leave
Pharmaceutical services during normal working hours and out of hours

Prevention of Suicide
Quality improvement
Records and information management
Referral arrangements to relevant health professionals
Reporting accidents, incidents, infectious diseases and deaths (including RIDDOR Arrangements)
Research
Restraint
Resuscitation
Risk assessment and management
Safe and healthy working practices
Safeguarding
Seculsion
Security of the establishment
Seeking the views of patients and clients, their carers and family members
Transport and administration of blood and blood products
Transfer and transportation of specimens
Using and operating equipment
Waste Management

Pre-Operative Procedures:
Assessing the patient's fitness for treatment
Counting and accounting for items such as swabs, needles, operative instruments and blades
Positioning the patient on the operating table
Pre-anaesthetic assessment.
Protection of patient from diathermy burns
Protection of patient from laser and radiation risks
Pre-operative check list

Operating Theatre Procedures:
Dental surgery under general anaesthesia
Minimising hazards from blood and body fluid
Planning peri-operative care
Preventing and managing surgical complications
Register of surgical procedures and operations

Recording Details Of Implanted Medical Devices:
Recording Tissue Sent For Laboratory Examination

Roles And Responsibilities Of Theatre Staff:
Day surgery
Scheduling of patients and clients
Servicing equipment

Surgical procedures

Post-operative procedures:
Bleeding
Care of the post-operative site
Critical care
Discharge from the recovery room
Pain relief
Post–operative instruction for patients and clients

Glossary of Terms

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 patient or member of staff.

Assessment

Collection and measurement of data to determine a patient's need for health, personal and social care and support services, undertaken with the individual, his/her relatives/representatives, and relevant professionals.

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.

Bad News

Any information which adversely and seriously affects an individual's view of his or her future or in situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life. Bad news situations can include, disease recurrence, spread of disease, or failure of treatment to affect disease progression, the presence of irreversible side effects, results of genetic tests, or raising the issue of palliative care and resuscitation.

Case Records

Records or documents containing information which has been created or maintained as evidence of patient/client care, treatment given, treatment planned.

Consultant

Medical practitioner who works independently without supervision.

Cosmetic Surgery

An operation or procedure that revises or changes the appearance, colour, texture, structure or position of bodily features, which most would consider otherwise to be within the broad range of ‘normal’ for that person.

Dedicated

Specific identified services, facilities, equipment and staff to meet the needs of particular groups of patients such as children.

Evidence-based (care/practices)

An approach to decision making where a health professional uses the best evidence available, in consultation with patients and other health care professionals to decide upon the option which suits each patient best.

General Medical Council (GMC)

The UK regulatory body that is responsible for registration, education, practice and conduct of doctors and dentists.

Holistic care

Care that meets social, psychological, emotional and physical and spiritual needs.

Intense Light Sources

An intense light, being broadband non-coherent light which is filtered to produce a specified range of wavelengths, such filtered radiation being delivered to the body with the aim of causing thermal, mechanical or chemical damage to structures such as hair follicles and skin blemishes while sparing surrounding tissues.

Nursing and Midwifery Council (NMC)

The UK regulatory body that is responsible for registration, education, practice and conduct of nurses and midwives.

Practising Privileges

The grant to a person who is not employed in the establishment, permission to practise in that establishment.

Records

Books, papers, maps, photographs, machine readable materials or other documentation created or maintained as evidence of a business activity, patient/ client care, treatment given, treatment planned.

Symptom control

The management of any/all symptoms a patient may experience in order to promote comfort and enhance the quality of life. Symptom control is much more than simply pain relief, although this is an important feature of symptom control.

Treatment and Care Plan

A document, which details the care and treatment that a patient receives and identifies who delivers the care and treatment.