The Regulation and Quality Improvement Authority

Inspection Framework
Core Indicators
for
Acute Hospitals

Contents Page

		Page No.
Inspection Details & Participants		**1**
The Inspection Framework		**3**
	Scoring	**6**
	General Information	**8**
	Staffing Information (Day 1)	**10**
Core Indicators		
	Leadership and Management of the Clinical Area	**13**
	Environmental Safety	**28**
	Infection Prevention and Control	**32**
	Patient Safety	**37**
	Medicines Management	**46**
	Nursing Care Records	**54**
	Medical Care Records	**58**
	Nutrition and Hydration	**67**
	Pain Management	**71**
	Pressure Ulcers	**74**
	Promotion of Continence and the Management of Incontinence	**77**
	Person Centred Care	**81**
	Communication	**86**
	End of Life Care	**90**

Results Tables	**91**
Appendix 1: Supporting Standards, Guidance and Legislation	**93**

Inspection Details and Participants

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

The Inspection Framework

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

Is Care Safe? Is Care Effective? Is Care Compassionate?

The inspection framework includes:

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

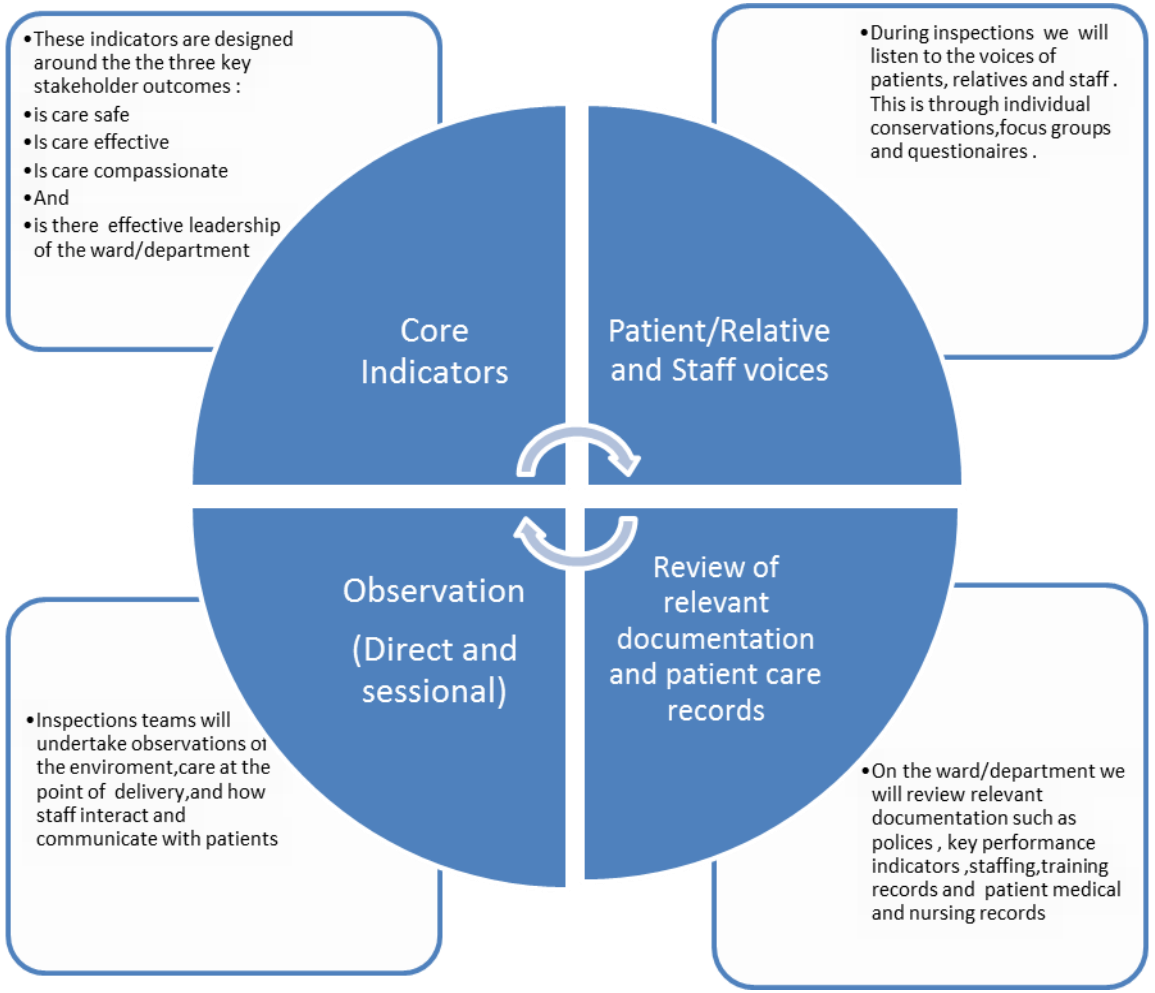
Supported by:

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

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

To enable the inspection team to reach a rounded conclusion as to the performance of the wards or departments all of the above will be used to determine an overall outcome assessment of the area subject inspection. The overall outcome assessment of the area inspection will be based on the decision matrix shown below:

Decision Matrix



Core Indicators

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

Is the ward/department/area well led? Leadership and Management of the Clinical Area

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

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

Scoring

- All criteria should be marked YES, NO or non-applicable.

It is not acceptable to enter a non-applicable response where an improvement may be achieved. For example where a regional/ national standard is not being met, a non-applicable must not be used. If a standard is not achievable because a facility is absent or a practice is not observed, the use of non-applicable is acceptable.

Comments should be written on the form for each of the criteria at the time of the inspection clearly identifying any issues of concern or areas of good practice. These comments can then be incorporated into the final report.

Weighting of criteria has not been carried out, this may be considered in future versions of this document. If inspectors identify areas of immediate risk within the core indicators, this will be reported to the ward sister in the first instance to allow immediate action to be taken.

Manual scoring can be carried out as follows: Add the total number of yes answers and divide by the total number of questions answered (including all yes and no answers); multiply by 100 to get the percentage.

$$\textbf{Formula:}\quad \frac{\textbf{Total number of yes answers}}{\textbf{Total number of questions answered}} \times 100 = \%$$

$$\textbf{For Example for Infection Control:}\quad \frac{13}{19} \times 100 = 68\ \%$$

Percentage scores are allocated to demonstrate a level of compliance. Each individual core indicator inspected will receive an individual score; the associated scores are then allocated as follows:

Compliance Scores	
95% or above	**Excellent Compliance**
85% to 94%	**Good Compliance**
76% to 84%	**Partial Compliance**
75% or below	**Minimal Compliance**

Each core indicator will receive an overall score. This will be calculated as follows:

$$\textbf{Formula:}\quad \frac{\textbf{Total scores from each core indicator}}{\textbf{No of core indicators assessed}} \times 100 = \%$$

Each of the four domains will receive an overall score. A combined overall score will not be given.

The final outcome of the inspection will be based on the decision matrix to enable the inspection team to reach a rounded conclusion as to the performance of the wards or departments inspected. This means that all of the aspects outlined in the decision matrix will be used to provide an overall outcome. For example if an area achieves an excellent score in the core indicator document but negative results or serious concerns are raised in the other areas, the team may determine that on this occasion the result would be reduced. The team may also, based on the same principles raise an overall score. The details and reasons for this decision will be clearly identified.

General Information

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

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

Additional Information

Staffing Information (Day One)

Number of staff on duty	AM			PM			EVENING			NIGHT DUTY		
	NIC	RN	HCA	NIC	RN	HCA	NIC	RN	HCA	NIC	RN	HCA
Nursing Staff Nurse in Charge Registered Nurse Healthcare Assistant												
Medical staff (dedicated to ward as well as those cross-covering)												
Medical rounds (number/timing)												
Allied Health Professionals e.g. Occupational Therapist, SALT, Dietician, Physiotherapists, Social Worker, Pharmacist												
Others e.g. Domestic staff Specialist nurse/nurse practitioner												
Administrative												

Additional Information

WELL LED

AREA FOR INSPECTION: Leadership and Management of the Clinical Area **OUTCOME: Effective leadership is displayed, the clinical area is managed and organised in a way that patients and staff feel safe, secure and supported. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
Governance					
1. The ward sister/nurse in charge is easily identifiable, visible and available to support ward activities.	Ask staff				
2. Staff have access to a range of policies and guidance documents at ward level.	Review Documentation *(Inspection Booklet)*				
3. There is a mechanism in place to ensure staff learn from ward complaints. Staff are aware of any complaints that are made and the learning following from these.	Ask staff				
4. There is appropriate recording of all verbal complaints to identify trends and patterns.	Ask staff Review Documentation				
5. Staff are aware of how to report SAIs, Incident and Near Misses (open and transparent culture/duty of candour).	Ask staff Review Documentation *(Inspection Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
6. SAIs, Incident and Near Miss reports are reviewed for trends or patterns. Results of investigations are disseminated to staff for learning and effecting change.	Ask staff Review Documentation *(Inspection Booklet)*				
7. Nursing staff attend Morbidity and Mortality meetings where information on HSMR (Hospital Standardised Mortality Ratio) is discussed and results are shared with ward staff for learning and feed into service improvement.	Ask staff Review Documentation *(Inspection Booklet)*				
8. The ward sister is aware of trust HCAI rates and targets in relation to HCAIs e.g. MRSA, CDI. Results are shared with ward staff for learning.	Ask staff Review Documentation *(Inspection Booklet)*				
9. The ward sister is aware of the trust cardiac arrest rates and, where appropriate, action is taken at ward level.	Ask staff Review Documentation				
10. Any issues identified on the ward that necessitated being placed onto the directorate/trust risk register are being actioned appropriately.	Ask staff Review Documentation *(Inspection Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Staffing & Supervision					
11. Nursing staffing levels on the ward do not compromise patient care. Check normative staffing range/ratio has been agreed	Review Documentation (Duty rota/Agreed staffing complement/use of bank/ agency staff)				
12. The ward displays information on the agreed and actual nursing staffing levels for each shift.	Observe Review Documentation				
13. Staffing levels are reviewed where required (e.g. increase in dependency levels, increase in number of patients, one to one care, decrease in staffing ratio).	Ask staff Review Documentation				
14. Staff retention is good.	Ask staff Review Documentation				
15. Absence/sickness levels are monitored and effectively managed (staff cover is easily accessible).	Ask staff Review Documentation				
16. Recruitment of staff is ongoing and vacancies are advertised promptly (appropriate action has been taken to reduce the use of bank and agency staff).	Ask staff Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
17. The ward sister* has sufficient time to undertake managerial duties and provide effective clinical leadership. (The aim is for the sister to be supernumerary) *Term ward sister denotes: Charge Nurse, Ward Sister and Ward Manager	Ask staff (named lead/staff) Review Documentation (Duty rota/Agreed staffing complement)				
18. Medical staffing levels on the ward do not compromise patient care (including out of hours and weekend cover).	Ask staff Review Documentation *(Medical Record Booklet)*				*Clinician to check
19. There is a system in place to ensure ward inliers/outliers are reviewed promptly by medical staff (including out of hours and weekend cover).	Ask staff Review Documentation *(Medical Record Booklet)*				*Clinician to check
20. Beds are not closed due to staff shortage.	Ask staff				
21. To support learners, the ward has sufficient number of nursing mentors and preceptors, with appropriate training.	Ask staff Review Documentation *(Inspection Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
22. AHP and support staff levels on the ward do not compromise patient care (including out of hours and weekend cover. Outline any difficulties in the time it takes for patients to seen by the MDT).	Ask staff Review Documentation (Whiteboards etc)				
23. Staff have received supervision and appraisal, in line with trust policy.	Review Documentation *(Inspection Booklet)*				
24. The ward sister ensures staff do not work outside their competency levels **(3).**	Ask staff				
25. Staff feel able to raise concerns* and appropriate support is provided by line management (positive organisational culture is apparent). **(3 & Focus Group)** *(including concerns about disrespectful, discriminatory, abusive behaviour or attitudes)	Ask staff Review Documentation Refer to focus group				
26. Trust security staff respond in a timely manner when required.	Ask staff				
Staff Training					
27. Staff have received induction training to meet the needs of their role.	Review Documentation *(Inspection Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
28. Staff have received ongoing mandatory training to meet the needs of their role.	Review Documentation *(Inspection Booklet)*				
29. Staff have received ongoing role-specific training.	Review Documentation *(Inspection Booklet)*				
30. Appropriate action is taken to address individual poor teamwork and practice.	Ask staff Review Documentation Focus Groups				
Patient Flow					
31. A Registered Nurse (preferably the ward sister) takes part in consultant ward rounds.	Observe Ask staff				
32. Ward rounds/ MDT whiteboard meeting are timed to facilitate early transfer or discharge (preferably as early in the morning as possible).	Observe Review Documentation *(Medical Record Booklet)*				*Clinician to check
33. Hospital and ward systems facilitate patient discharge*. *give comment on issues identified	Ask staff Review documentation *(Handover sheet)*				

	SOURCE	YES	NO	N/A	COMMENTS
34. A reablement project is in operation to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home.	Ask staff				
35. There is an effective system* in use for nursing handovers. *please describe/note the current system , check staff cover on ward during handover	Observe Ask staff				
36. There is an effective system* in use for medical handovers. *Please describe/note the current system	Observe Ask staff *(Medical Record Booklet)*				*Clinician to check
37. Communicating clinical concerns to colleagues within or between teams is carried out in an appropriate manner (discussion between the relevant medical staff, either in person or by telephone conversation).	Ask staff *(Medical Record Booklet)*				*Clinician to check

	SOURCE	YES	NO	N/A	COMMENTS
Communication					
38. There is evidence of effective communication and dissemination of information to staff. For example; • Safety brief/handovers ward meetings • Multi-professional meetings • Infection control link nurse meetings • Staff have a personal trust email account.	Ask staff Review Documentation (*Inspection Booklet)*				
39. All ward clinical staff have access to the Electronic Care Record (ECR).	Ask staff				
40. Audit/quality performance indicators undertaken in the ward are up to date (dependent on the ward).	Review Documentation *(Inspection Booklet)*				
41. Staff receive up to date feedback on results of audit.	Ask staff Review Documentation *(Inspection Booklet)*				
42. Audit action plans are being implemented to improve care/address suboptimal performance.	Ask staff Review Documentation *(Inspection Booklet)*				
43. The ward displays up to date results of safety/performance/patient experience audits for both patients and staff e.g. preventable pressure ulcers, cardiac arrests, HCAIs, falls, hand hygiene, environmental cleanliness.	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
44. Patient experience data is captured, recorded and routinely analysed and acted on.	Ask staff Review Documentation				
45. The trust board review of patient experience data is routinely disseminated to staff.	Ask staff				
Safeguarding					
46. There are arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements (this includes identification and management).	Review documentation Ask staff *(Inspection Booklet)*				
47. Staff are aware of the trust/directorate safeguarding lead	Ask staff				
48. In order to develop the most appropriate care plan, the ward sister is aware of the need to hold Best Interest Case Conferences for a patient who may lack capacity.	Review documentation Ask staff				
49. Staff receive feedback on the outcome of case conferences/MDT.**(3)**	Ask staff				
50. Staff are aware that in a case of suspected child abuse, the Consultant Paediatrician is called immediately and child protection procedures commenced (Clinical Standards for ED).	Review documentation Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
51. Staff are aware that additional safeguards are required for children including contribution to Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment. **(3)**	Review documentation Ask staff				

Additional for Emergency Department (ED)					
Clinical Quality Indicators ***** Inspector to ask for statistics relating to past year					
52. The percentage of patients, treated, discharged or admitted within 4 hours of arrival in the ED is in line with DHSSPS targets.	Review Documentation Ask staff				
53. Patients do not wait longer than 12 hours in ED to be treated, discharged or admitted.	Review Documentation Ask staff				
54. Patients are triaged in line with DHSSPS targets.	Review Documentation Ask staff Observe				
55. 95% of patients are seen by the decision making clinician within 60 minutes of arrival.	Review Documentation Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
56. The ED is achieving a monthly target of less than 5% patients who leave before treatment is complete. (A more in-depth analysis of the profile of these patients on a quarterly basis i.e. gender, age, post code, presenting complaint and to ascertain if they fall into what might be termed a "high risk" category such as mental health or children is undertaken).	Review Documentation Ask staff				
57. A target of between 1 - 5%, for unscheduled re-attenders is achieved.	Review Documentation Ask staff				
Governance, Staffing and Training					
58. An effective internal ED escalation policy is in place and links with overall trust policy (how often used).	Review Documentation Ask staff				
59. Emergency departments have an effective IT system for tracking patients, integrated with other communications.	Review Documentation Ask staff Observe				
60. Sufficient staff are available 24/7 to keep this system up to date.	Review Documentation Ask staff				
61. Dependant on the ED size, a designated nursing shift leader (Band 7) is present in the emergency department 24 hours a day, seven days a week.	Review Documentation Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
62. A consultant in emergency medicine is scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. (Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety).	Review Documentation *(Medical Record Booklet)* Ask staff				*Clinician/inspector to check
63. A trained and experienced doctor (e.g. ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week. This may be dependent on ED size.	Review Documentation *(Medical Record Booklet)* Ask staff				*Clinician/inspector to check
64. Sufficient trained reception staff are available 24/7 to accurately record patients into the ED.	Review Documentation Ask staff Observe				
65. Triage is provided by qualified healthcare staff. (Patient registration does not delay triage).	Review Documentation Ask staff Observe				
66. Emergency departments to have a process in place to access support services seven days a week including: a. Alcohol liaison b. Mental health c. Older people's care d. Safeguarding e. Social services	Review Documentation Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
67. Patient ED attendance record and discharge summaries are immediately available in case of re-attendance and monitored for data quality.	Review Documentation Ask staff				
68. There is timely access seven days a week to, and support from, physiotherapy and occupational therapy teams to support discharge from hospital.	Review Documentation Ask staff				
Score					
Percentage Achieved					

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

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

SAFE

AREA FOR INSPECTION: Environmental Safety **OUTCOME: The environment is safe for patients, staff and visitors (SAFE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. The ward* environment is free of trip and fall hazards. *Term ward denotes: department, unit, patient area	Observe				
2. Ward lighting is sufficient to provide access to patients, devices and equipment.	Observe				
3. Individual lighting is available at the bedside.	Observe				
4. Nursing staff maintain a level of visual contact with higher risk patients.	Observe				
5. Patient monitoring equipment alarms are audible (check ambient noise levels, layout of working areas).	Observe				
6. The resuscitation trolley is: easily accessible, clean and sealed*, equipment is maintained and replaced, checks are carried out on a daily basis (checking schedules should identify and record that daily checking procedures have been completed). *Check trust policy	Observe Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
7. The contact details for the resuscitation crash team are clearly displayed.	Observe				
8. Equipment and supplies are stored in areas only accessible to staff, not stored in public access areas.	Observe				
9. Fire alarms, break-glass points, fire extinguishers and emergency signage is in place.	Observe				
10. Patient emergency exits are clearly identified, kept closed and not blocked.	Observe				
11. Appropriate hazard notices/signage are displayed and removed when no longer required.	Observe				
12. The ward environment has been adapted to meet the needs of patients with dementia (large clocks, calendars, signage).	Observe				
13. The ward environment has been adapted to meet the needs of patients with a disability (hand rails, sanitary facilities etc).	Observe				
14. Known hazards in the ward environment have been risk assessed and preventive action has been implemented (view risk assessment).	Ask staff Review Documentation				

Additional for Emergency Department (ED)					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
15. Overcrowding/congestion in the area does not comprise patient safety (a timely response to emergency situation such as resuscitation, fire can be achieved).	Observe Ask staff				
16. Space constraints in the ED; do not comprise the use of patient equipment.	Observe Ask staff				
17. There is no unauthorised access to the area	Observe Ask staff				
18. Cubicles used as an overflow from the resuscitation area have appropriate equipment specification available.	Observe Ask staff				
19. The space in the ED is adequate to meet the current footfall of patients, and the available space is used effectively.	Observe Ask staff				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: Infection Prevention and Control **OUTCOME: Patients are cared for in an environment where the risk of cross infection is minimised. (SAFE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. The ward environment is clean, clutter free and in a good state of repair.	Observe				
2. Environmental cleanliness audits currently meet trust compliance levels	Observe Ask staff Review Documentation				
3. Alcohol rub is available at the ward entrance and directly accessible at the point of care/ treatment/ bed space.	Observe				
4. Hand washing sinks are clean, accessible, located near to the point of care and are in accordance with local and national policy. **(3)**	Observe				
5. Patient equipment is clean, free from damage and in good repair. **(3)**	Observe				
6. Clinical staff are compliant with the HSC trust dress code policy. **(3)**	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
7. A range of Personal Protective Equipment (PPE) is available on the ward and worn appropriately.	Observe				
8. Patients requiring isolation are in a single room or an appropriate cohort area with transmission based precautions in place and poster displayed.	Observe Ask staff				
9. Hand hygiene is performed at each of the WHO 5 moments of care using the 7 step technique. **(3)**	Observe Ask staff				
10. Hand hygiene audits currently meet trust compliance levels.	Observe Ask staff Review Documentation				
11. Staff are compliant with ANTT practices and can demonstrate when ANTT procedures are applied. **(3)** If ANTT practices are poor recommend ANTT competency training for staff	Observe Ask staff				
12. Invasive devices are managed in line with best practice guidance. **(3)**	Observe Ask staff Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
13. The appropriate care bundle/evidence based practice is used to prevent surgical site infections.	Review Documentation (*Inspection Booklet)*				
14. Clostridium *difficile* infection (CDI) bundle/care pathway is in place for appropriate patients. There is evidence of appropriate sampling, Bristol stool chart, daily review, timely administration of medications.	Review Documentation				
15. Methicillin Resistant Staphylococcus Aureus (MRSA) bundle/care pathway is in place for appropriate patients. There is evidence of appropriate sampling, daily review, timely administration of medications.	Review Documentation				
16. If blood cultures were taken there is documentation of date, time, site and clinical indication for taking. **(3)**	Review Documentation *(Medical Record Booklet)*				*Clinician to check
17. An IR1 form and RCA are completed as appropriate for example MRSA/CDI/cluster/outbreak.	Review Documentation				
18. Appropriate patient equipment cleaning schedules are available (nursing).	Review Documentation				
19. Appropriate ward cleaning schedules are available (domestic).	Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
20. The ward has an Infection Prevention Control Link Nurse.	Ask staff Review Documentation				

Additional for Emergency Department (ED)					
21. Lack of space or congestion does not compromise infection prevention and control procedures and practices.	Observe Ask staff				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: Patient Safety **OUTCOME: The delivery of patient care avoids, prevents and ameliorates outcomes or injuries stemming from healthcare. (SAFE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. All patients receiving treatment are wearing a clear, clean and accurately printed identity band which includes an identification number. **(3)**	Observe				
2. Staff are aware of the action to take if they discover that a patient's identification details are incorrect.	Ask staff				
3. There is a protocol outlining the steps taken by trust/hospital to provide a prompt, structured response and review of a deteriorating patient in line with NICE guideline The Acutely Ill Patient (CG50).	Review Documentation (*Inspection Booklet)*				
4. Patients Early Warning Score (EWS) are completed within the set timescales. **(3)**	Review Documentation *(Care Record Booklet)*				
5. As per best practice the nurse stays with the patient whilst undertaking observations.	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
6. There is an appropriate clinical response to EWS triggers. They are documented and discussed at handover as per algorithm*. Actions include referral to more senior or specialised staff when certain scores are reached. **(3)** *refer to Trust EWS chart	Ask staff Review Documentation *(Care Record Booklet)*				
7. A Sepsis bundle is in place for the recognition and timely management of sepsis (Sepsis 6 care bundle).	Review Documentation *(Inspection Booklet)*				
8. If a patient has been identified for Sepsis management the appropriate measures are in place or implemented in line with the care bundle.	Review Documentation *(Medical Record Booklet)*				*Clinician to check.
9. Inpatients have 24/7 access to key diagnostics.	Ask Staff *(Medical Record Booklet)*				*Clinician to check.
10. There is a falls safe bundle in place.	Review Documentation				
11. There is a ward system in place to monitor falls and figures are available at ward level.	Ask Staff Review documentation				

	SOURCE	YES	NO	N/A	COMMENTS
12. Patients and clients are involved in decision making in line with the DHSSPS guidance on consent. **(3)**	Review Documentation *(Care Record Booklet)*				
13. Consent forms are completed fully and appropriately (E.g. date, legible, signature). **(3)**	Review Documentation *(Care Record Booklet)*				
14. A WHO Surgical Safety Checklist has been completed if necessary. **(3)**	Review Documentation *(Care Record Booklet)*				
15. There is a VTE risk assessment completed for each patient on admission. **(3)**	Review Documentation *(Care Record Booklet)*				
16. If a patient has been identified as at risk, VTE prophylaxis has been commenced. **(3)**	Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
17. There is a ward system in place to monitor preventable pressure ulcers and figures are available at ward level.	Ask Staff Review documentation				
18. Staff are compliant with Blood Transfusion Competency Assessments. (For medical staff see Haemovigilance Practitioner)	Review documentation *(Inspection Booklet)*				
19. Staff are aware of their responsibility to complete the blood transfusion record sheet.	Ask staff Review Documentation				
20. Management act quickly when a safety concern is raised.	Ask staff				
21. Patient safety/medical device alerts are appropriately actioned, signed off and communicated to staff where relevant.	Review Documentation				
22. Appropriate equipment is available, maintained and replaced to meet the needs of the patient e.g. observation machines, oxygen points.	Observe Ask staff				
23. Safeguarding information/support is available on the ward for staff, patients, family/carers.	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
24. Vulnerable/at risk patients are identified in the ward safety briefings. **(3)**	Review Documentation Observe				

Additional for Emergency Department (ED)					
25. Consideration is given to patient placement, safety and vulnerability.	Observe Ask staff				
26. Patients brought in by ambulance are seen and assessed promptly by ED staff.	Observe Ask staff				
27. Patient status board is proactively updated in real time (check system for updating staff/ ED status etc).	Observe Ask staff Review Status Board				
28. Hourly safety rounds and four hourly patient reviews are carried out by the consultant and sister in charge.	Observe Ask staff				
29. There is safe and effective patient flow from ED to the ward.	Observe Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
30. There are self-harm protocols in place and interface between mental health services within the trust and the wider community (ask about training).	Review Documentation Ask staff				
31. Patients waiting for a bed have their nursing treatment plan commenced.	Review Documentation				
32. Patients have the appropriate nursing risk assessment completed if applicable.	Review Documentation				
33. All documentation is written legibly, with clear signatures, dated, timed and signed. (complete NIPEC guidelines). **(3)**	Review Documentation				
34. All older people are assessed in ED for the presence of frailty syndromes.	Review Documentation Ask staff				
35. Older people who present with self-harm are assessed for on-going risk of further self-harm, by the mental health team whilst in ED.	Review Documentation Ask staff				
36. An assessment tool is used to identify high risk older people e.g. Identification of Seniors At Risk tool (ISAR) or equivalent.	Review Documentation Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
37. Clinical Standards for the ED are being implemented.	Review documentation Ask staff				
38. The hospital is achieving the targets for treatment of Thrombolysis in acute stroke.	Review Documentation *(Medical Record Booklet)*				*Clinician/inspector to check
39. The following data is collected for Thrombolysis treatment in acute stroke. • Assessment by Stroke team within 30 minutes • CT scan within 45 minutes • Door to needle time 60 minutes • Onward transfer to acute stroke unit, or appropriate environment, within 90 minutes Are lessons learnt from non-compliance issues identified?	Review Documentation *(Medical Record Booklet)*				*Clinician/inspector to check
40. Patients have 24/7 access to the minimum key diagnostics: • X-ray: immediate access with formal report received by the ED within 24 hours of examination • CT: immediate access with formal report received by the ED within one hour of examination • Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination • Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken • Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken	Review Documentation Ask staff Observe *(Medical Record Booklet)*				*Clinician/inspector to check

	SOURCE	YES	NO	N/A	COMMENTS
41. When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	Review Documentation Ask staff *(Medical Record Booklet)*				*Clinician/inspector to check
42. Emergency department patients who have undergone an initial assessment and management by ED clinicians, who are referred to another team, have a medical management plan (including the decision to admit or discharge) within one hour from referral to that team.	Review Documentation Ask staff Observe *(Medical Record Booklet)*				*Clinician/inspector to check
Score					
Percentage Achieved					

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

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

	SOURCE	YES	NO	N/A	COMMENTS
7. IV medications are drawn up, checked and administered straightaway by two staff members who are both present at the bedside for administration. If there is more than one unlabelled syringe including flushes and it leaves the hand of the operator, it should be labelled.	Observe				
8. IV medications are not drawn up en masse.	Observe				
9. Medication is taken when administered and not left unattended on the bedside table/locker.	Observe				
10. Does observed medication administration meet good practice guidance e.g. NMC standards.	Observe				
11. Medication administered is recorded and in all cases where medicines have been delayed or omitted, the reason for the delay or omission has been documented. **(3)**	Review Documentation Kardex *(Care Record Booklet)*				
12. All patients have their allergy/medicine sensitivity status documented. **(3)**	Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
13. When insulin is prescribed blood glucose levels are monitored at the correct frequency or before administration of insulin. **(3)**	Review Documentation *(Care Record Booklet)*				
14. When outside the usual blood glucose range, appropriate action is taken. **(3)**	Review Documentation *(Care Record Booklet)*				
15. Self-administration of medication is in accordance with trust policy.	Ask staff				
16. The ward has access to pharmaceutical advice at all times.	Ask staff				
17. There is evidence of Integrated Medicines Management (IMM) service being implemented on the ward with pharmacy involvement in the completion of medicines reconciliation on admission. **(3)**	Observe Review Documentation Kardex *(Care Record Booklet)*				
18. There is evidence of IMM service being implemented on the ward with pharmacy involvement in the completion of medicines reconciliation during inpatient stay. **(3)**	Observe Review Documentation Kardex *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
19. There is evidence of IMM service being implemented on the ward with pharmacy involvement in the completion of medicines reconciliation on discharge **(3)**.	Observe Review Documentation Kardex *(Care Record Booklet)*				
20. In the absence of IMM service, there is reconciliation of the kardex and discharge prescription as part of the pharmacist clinical check at discharge.	Observe				
21. There is evidence that patients are involved in decisions about their medicines e.g. decision making regarding new or as required medicines and receive the information they need to take their medicines safely and effectively.**(3)** When patients are discharged, they should receive written and verbal information about their medicines and any changes.	Ask patients				
22. There is evidence that patients' concordance with prescribed medicines is assessed on admission and that systems are in place for the provision of appropriate support with medicines taking prior to discharge.	Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
23. There is evidence of compliance with best practice in the handling of critical medicines where timelines of administration is crucial. A list of critical medicines is available (includes, anti-infectives, insulin, resuscitation medicines, medicines for Parkinson's disease and any other high risk medications identified locally). Medication procedures should include guidance on timeliness issues and what to do if medication has been delayed or omitted. Staff show awareness of what a critical medication is and how to obtain a medicine that is not available	Ask staff Observe (poster/card on trolley) Review Documentation				
24. There is evidence of medication incidents being reported, investigated, learning identified and shared.	Review Documentation				
25. The ward has a stock of and uses enteral/oral syringes where a syringe is required for oral/enteral administration.	Observe Ask Staff				
26. Where oxygen is administered, it is prescribed and an administration record completed. **(3)**	Review Documentation Kardex *(Care Record Booklet)*				
27. Patient weight is measured on admission and recorded on the kardex. **(3)**	Review Documentation Kardex *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Additional for Emergency Department (ED)					
28. All EDs should have ready access to critical medicines where timeliness of administration is crucial.	Observe				
Score					
Percentage Achieved					

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

EFFECTIVE

AREA FOR INSPECTION: Nursing Care Records **OUTCOME: Scores to be backfilled from the care record template. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. On admission a comprehensive assessment* of the patient's needs has been undertaken. This has been updated as required (nursing assessment booklet) **(3)** *Ensure all older people are assessed for the presence of frailty syndromes (falls, immobility, incontinence, confusion).	Review Documentation *(Care Record Booklet)*				
2. Relevant risk assessments have been undertaken and within set timescales (as noted in the regional nursing booklet). **(3)**	Review Documentation *(Care Record Booklet)*				
3. A nursing care plan* is in place for patient needs identified in the nursing assessment and on observation (these are reviewed daily or within the set timescales). **(3)** *If applicable review care pathways	Review Documentation *(Care Record Booklet)*				
4. Care records demonstrate on-going assessment and evaluation of the daily care. **(3)**	Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
5. Patient movement between wards is based on clinical need. Rationale is documented. **(3)**	Review Documentation *(Care Record Booklet)*				
6. There is documented evidence that the patient has been involved in agreeing their own care plan. **(3)**	Review Documentation *(Care Record Booklet)*				
7. There is documented evidence that families have been involved in planning of all aspects of patient care as appropriate. **(3)**	Review Documentation *(Care Record Booklet)*				
8. When required appropriate MDT referrals have been carried out and clearly evidenced within documentation. **(3)**	Review Documentation *(Care Record Booklet)*				
9. There is documented evidence of MDT discharge planning (including an estimated date) for all patients. **(3)**	Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
10. All documentation is written legibly, with clear signatures, dated, timed and signed. (complete NIPEC guidelines, Booklet Page 7). **(3)**	Review Documentation *(Care Record Booklet)*				
11. All patient documentation includes the patient name, date of birth, healthcare number, ward and date. **(3)**	Review Documentation *(Care Record Booklet)*				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: Medical Care Records **OUTCOME: Scores to be backfilled from the care record template. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Does the ward have a standardised protocol for the organisation of documents within the health records?	Review Documentation *(Medical Record Booklet)*				
2. Do the notes in the record comply with the ward's standardised protocol for organisation of health records? **(3)**	Review Documentation *(Medical Record Booklet)*				
3. Does the ward have a standardised initial assessment proforma?	Review Documentation *(Medical Record Booklet)*				
4. Does the ward have a standardised discharge summary proforma ?	Review Documentation *(Medical Record Booklet)*				
5. Are the initial (admission) assessment and subsequent continuation notes filed in chronological order? **(3)**	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Within the CURRENT admission entry/inpatient episode is there:					
6. A documented patient length of stay **(days)? (3)**	Review Documentation *(Medical Record Booklet)*				
7. A record of the presenting problems? **(3)**	Review Documentation *(Medical Record Booklet)*				
8. A management plan? **(3)**	Review Documentation *(Medical Record Booklet)*				
9. The patient's name recorded on every page? **(3)**	Review Documentation *(Medical Record Booklet)*				
10. The patient's ID number recorded on every page? **(3)**	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
11. A date recorded at each entry? **(3)**	Review Documentation *(Medical Record Booklet)*				
12. A time recorded at each entry? **(3)**	Review Documentation *(Medical Record Booklet)*				
13. An entry author identified in block capitals? **(3)**	Review Documentation *(Medical Record Booklet)*				
14. A signature at all entries? **(3)**	Review Documentation *(Medical Record Booklet)*				
15. All entries completed legibly? **(3)**	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
16. Deletions or alterations are countersigned? **(3)**	Review Documentation *(Medical Record Booklet)*				
17. A date recorded at all deletions or alterations? **(3)**	Review Documentation *(Medical Record Booklet)*				
18. A time recorded at all deletions or alterations? **(3)**	Review Documentation *(Medical Record Booklet)*				
19. A timely entry in the medical notes commensurate with the clinical need of the patient. ? **(3)**	Review Documentation *(Medical Record Booklet)*				
20. On the occasions where this is a gap of more than the expected standard time period, has an explanation been provided? **(3)**	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
21. Evidence in the medical notes that a consultant reviews at least weekly and commensurate with the clinical need of the patient? **(3)**	Review Documentation *(Medical Record Booklet)*				
22. Evidence of investigation results recorded? **(3)**	Review Documentation *(Medical Record Booklet)*				
23. Is the most senior clinician present on the ward round documented? **(3)**	Review Documentation *(Medical Record Booklet)*				
24. A documented record of any change in the consultant/lead professional responsible for the patient's care? **(3)** Check if this occurs on a frequent basis, include the number of times	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
25. A date recorded at each change of responsible consultant/lead professional? **(3)**	Review Documentation *(Medical Record Booklet)*				
26. A time recorded at each change of responsible consultant/lead professional? **(3)**	Review Documentation *(Medical Record Booklet)*				
Within inpatient notes, is there evidence of information given to the patient or relative about:					
27. The diagnosis? **(3)**	Review Documentation *(Medical Record Booklet)*				
28. The management plan? **(3)**	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
Within the CURRENT discharge/transfer summary is there:					
29. ID of Clinician responsible for patient's care? **(3)**	Review Documentation *(Medical Record Booklet)*				
30. Name of author? **(3)**	Review Documentation *(Medical Record Booklet)*				
31. Admission Date? **(3)**	Review Documentation *(Medical Record Booklet)*				
32. Discharge date? **(3)**	Review Documentation *(Medical Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
33. List of current diagnoses with dates? **(3)**	Review Documentation *(Medical Record Booklet)*				
34. List of medications? **(3)**	Review Documentation *(Medical Record Booklet)*				
35. Follow-up arrangements? **(3)**	Review Documentation *(Medical Record Booklet)*				
Discharge Communication					
36. Is the discharge letter completed in a timely manner? **(3)** *Please comment on any lengths of delay	Review Documentation *(Medical Record Booklet)*				
Scores					
Percentage Achieved					

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

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

	SOURCE	YES	NO	N/A	COMMENTS
8. Food is appropriately placed in front of patients and assistance given in ensuring bedside/trolley tables are placed appropriately and with any food which requires opening/cutting.	Observe				
9. Patients have a drink* available and accessible at the bedside (fresh water is available for all patients, water in reach of patients, frequency of assistance to offer and encourage patients to drink). *Exceptions for NBM and restricted intake	Observe				
10. Appropriate tableware is available for all patients including those with reduced dexterity (crockery, cutlery, drinking cups).	Observe				
11. Patients who need help with meals are assisted in an appropriate manner (timely/staff not standing over patients).	Observe				
12. There are sufficient staff allocated to support and supervise those who need assistance.	Observe				
13. A mechanism is in place to identify/report patients' intake at mealtimes.	Observe Ask staff				

	SOURCE	YES	NO	N/A	COMMENTS
14. Where a meal is interrupted or missed a replacement meal can be accessed. Outline system	Observe Ask staff				
15. Nutritional supplements are prescribed and administered appropriately (not at mealtimes/as a substitute for meals). **(3)**	Observe Review Documentation *(Care Record Booklet)*				
16. Patients who are nil by mouth/fasting are not kept fasting for long periods (have been assessed for alternative methods of hydration). **(3)**	Review Documentation *(Care Record Booklet)*				
17. The regional fluid balance charts are completed appropriately (fully completed/reconciled daily/nurses report any significant abnormalities). **(3)**	Review Documentation *(Care Record Booklet)*				
18. Food charts are completed appropriately (fully completed daily/nurses report any significant abnormalities). **(3)**	Review Documentation *(Care Record Booklet)*				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: Pain Management **OUTCOME: Pain will be controlled to an acceptable level by the medical and nursing team. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Patients look comfortable and do not appear to be visibly in pain or distressed.	Observe				
2. There is adequate pain relieving measures available for patients i.e. simple comfort measures: pillows and repositioning.	Observe				
3. Staff respond promptly to patients' requests for pain relief. **(3)**	Observe Ask patient				
4. Pain assessment is carried out as part of routine practice including prior to wound dressings and movement (NEWS charts, body map and suitable method for patients unable to communication e.g. Abbey pain score). **(3)**	Review Documentation *(Care Record Booklet)*				
5. Pain medication is administered as prescribed in the medicine kardex.**(3)**	Observe Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
6. Pain relief prescribed is appropriate for the condition e.g. basic/intermediate/complex pain relief. **(3)**	Review Documentation *(Medical Record Booklet)*				*Clinician to check.
7. The effectiveness of pain medication is routinely reviewed. **(3)**	Review Documentation *(Medical Record Booklet)*				*Clinician to check.
8. A pain team is available for advice and support.	Observe Review documentation				

Additional for Emergency Department (ED)					
9. All patients are assessed for pain using an appropriate standardised pain score within 15 minutes of first contact.	Ask staff Observe Review documentation				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: Pressure Ulcers **OUTCOME: The condition of the patients skin will be maintained or improved. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Patients look comfortable and are appropriately positioned e.g. not on draw sheets, hoist slings.	Observe				
2. Pressure relieving equipment (including beds, cushions/seating) is available and used appropriately to meet individual patient needs.	Observe				
3. Pressure relieving equipment is ordered and is delivered promptly when required.	Ask staff Review documentation				
4. A validated classification tool and wound chart is in use to guide management e.g. International NPUAP-EPUAP (2009) Pressure Ulcer Classification System or similar.	Review documentation				
5. A SSKIN care bundle* is in place and evaluated to reflect the patient's ongoing care needs (surface, skin, keep moving, incontinence, nutrition). **(3)** *check Trust policies	Observe Review documentation *(Care Record Booklet)*				
6. Nutritional supplements are offered to adults at risk of, or who have pressure ulcers, or who have a nutritional deficiency. **(3)**	Observe Review documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
7. Pressure ulcers are photographed in line with trust policy.	Observe Ask staff				
8. Tissue viability services are contacted and have given advice/visited patients when required.	Observe Review documentation				
9. Incident forms (IR1) are completed for hospital acquired pressure ulcers (Grade 2 and above).	Review documentation Ask staff				
10. Root Cause Analysis (RCAs) are completed for hospital acquired pressure ulcers (Grade 3 & 4).	Review documentation				
11. Mattress audits are carried out on a regular basis (include opening covers after every patient discharge to check for signs of impermeability/damage/sunken).	Review documentation				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: Promotion Of Continence & Management of Incontinence **OUTCOME: Continence and incontinence will be appropriately managed by the medical and nursing team. (EFFECTIVE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. Patients are provided with appropriate assistance to promote continence. **(3)**	Observe Review Documentation *(Care Record Booklet)*				
2. Patients with incontinence have the appropriate care provided. **(3)**	Observe Review Documentation *(Care Record Booklet)*				
3. Patients have the opportunity for hand hygiene after toileting.	Observe				
4. The clinical indication(s) for catheterisation, date of insertion, expected duration, type of catheter and drainage system, and planned date of removal is documented within the patient records. **(3)**	Observe Review Documentation *(Care Record Booklet)*				
5. Stool charts are in place and reviewed as appropriate for condition. **(3)**	Review Documentation *(Care Record Booklet)*				

	SOURCE	YES	NO	N/A	COMMENTS
6. Staff have access to continence/stoma specialist services during in patient episodes and on discharge.	Observe Ask staff				
7. Stoma/continence aids (commode, bedpans etc.) are available on the ward if required.	Observe				
Score					
Percentage Achieved					

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

COMPASSIONATE

AREA FOR INSPECTION: Person Centred Care **OUTCOME: Every patient is treated as an individual, with compassion all of the time. (COMPASSIONATE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. The ward has an organised atmosphere.	Observe				
2. Is there evidence of De facto detention* *restriction of patient movement without consent e.g. unable to independently able to exit ward	Observe Ask Staff				
3. Patients are not bothered by noise or light. Auditory clutter is minimised, the environment is quiet and ward noise is kept to a safe level (noise levels do not disturb patients sleep, increase patient stress).	Observe				
4. A call bell system is in place, in working order and available in all patient areas e.g. bedside/sanitary facilities.	Observe				
5. Patient call bells are appropriately positioned, within easy reach (not unplugged).	Observe				
6. Staff respond promptly to call bells and patient requests for assistance e.g. general assistance, mobility, toileting (how long).	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
7. Patient privacy is maintained by the use of curtains, screens, and appropriate clothing. Curtains are fully closed (appropriate length/good state of repair).	Observe				
8. Patient dignity is maintained at all times (including moving between areas).	Observe				
9. There are adequate supplies of laundry to meet the needs of the ward/department.	Observe Ask staff				
10. Toileting is not carried out at the bedside during meal service (where appropriate, patients are taken to the toilet when others are eating).	Observe				
11. Patients' personal hygiene needs have been attended to as appropriate, comfortable and suitability clothed e.g. no stains on clothing, clean nails, shaved, dental care.	Observe				
12. Patients receive mouth care appropriate to their ongoing care needs.	Observe				
13. Staff advise/alert the patient before entering any private areas i.e. curtains, bathrooms, cubicles.	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
14. Where escalation beds are in use patients are risk assessed and patients' privacy and dignity is maintained (locker, call bell, seat, curtains, screens etc).	Observe				
15. Intentional Care Rounding or similar is in place and includes personal needs to ensure comfort **(3)**	Observe Review Documentation *(Care Record Booklet)*				
16. Personal items are available for patients to use and are easily accessible and e.g. glasses, hearing aid, dentures, mobility aids, bedside table.	Observe				
17. Bed bays are single sex and not mixed gender.	Observe				
18. Appropriate single sex sanitary facilities are available and accessible (which take account of individual preferences).	Observe				
19. A quiet room is available and used appropriately for private conversation & relaxation (includes patients/visitors/staff).	Observe				
20. Patients have access to public/ward telephones, as required.	Observe				

	SOURCE	YES	NO	N/A	COMMENTS
21. Extra staff are available if additional care interventions are required e.g. for patients with dementia & delirium (1:1 if required).	Observe Ask staff				
22. Patient personal details are displayed in a way that promotes patient dignity. Patient information is not easily viewed (except name) e.g. on boards/computer.	Observe				
23. Staff can access hospital chaplaincy services.	Ask staff				
24. Advocacy services are available.	Ask staff				
Score					
Percentage Achieved					

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

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

	SOURCE	YES	NO	N/A	COMMENTS
7. Before care is carried out, staff provide an easily understood explanation of the care for patients.	Observe				
8. Staff speak discretely e.g. patient's medical condition is not discussed within hearing of others.	Observe				
9. Communication aids are available e.g. picture cards/booklets/loop system.	Observe				
10. Patients, carers and relatives have access to appropriate information and leaflets within the ward area, both general and specific to that ward.	Observe				
11. Information is available in various formats (Braille, sign language, different languages etc) including access to interpreting services as and when required.	Observe				
12. Information regarding the Trust's complaints procedure and patient advice and liaison (PALS), and how to contact them, is available.	Observe				
13. The ward has systems in place to actively listen to patients and include them in the care they receive (patient questionnaires etc.). When necessary feedback to ward staff is given regularly and in a timely manner.	Ask staff Review Documentation				

	SOURCE	YES	NO	N/A	COMMENTS
14. Health care records are stored in a way that ensures confidentiality.	Observe				
Score					
Percentage Achieved					

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

AREA FOR INSPECTION: End of Life Care **OUTCOME: Patients have control over their own health care and promote independence. (COMPASSIONATE)**					
	SOURCE	**YES**	**NO**	**N/A**	**COMMENTS**
1. The use of tools or an integrated care pathway/care plan for the dying is used and embedded in practice (e.g. Gold Standards Framework.)	Review Documentation				
2. Information and support systems are available for patients and carers before and after a patient dies (including printed information: coping with dying, what to do after death, bereavement booklet).	Observe Ask staff				
3. Patients are cared for in a ward environment appropriate to end of life care (side room).	Observe				
4. Staff can access guidance on end of life care (includes information on care of the patient after death, different cultural practices).	Ask staff Review Documentation *(Inspection Booklet)*				
5. Following death, family/carers are able to view the patient in an appropriate setting that ensures dignity in death (check system in place, on ward, mortuary).	Ask staff Observe				

	SOURCE	YES	NO	N/A	COMMENTS
6. Family/carers have access to; car parking, washing/toilet/sleeping/dining facilities/spiritual guidance where appropriate.	Observe Ask staff				
7. The palliative care team is easily accessible and available 24/7.	Observe				
8. The nurse in charge is aware of whom to contact in the event that organ donation is expressed by patient/family.	Ask staff				
9. If the patient has been assessed as requiring a DNAR order, the order has been appropriately completed and signed by the doctor. Check that the order has been fully completed and a record made of either discussion with the patient or relatives. **(3)**	Review Documentation *(Medical Record Booklet)*				*clinician to check
10. When the patient is not the decision maker, the responsible person is clearly identified (e.g. lasting power of attorney). **(3)**	Review Documentation *(Medical Record Booklet)*				*clinician to check

	SOURCE	YES	NO	N/A	COMMENTS
11. Where there are statements in relation to Advance Directives, Consent or Cardio-Pulmonary Resuscitation, the decision maker has been clearly identified. **(3)**	Review Documentation *(Medical Record Booklet)*				*clinician to check
Score					
Percentage Achieved					

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

Results Table : For completion by RQIA inspectors

Overall Score (%)	
Well Led	
Safe	
Effective	
Compassionate	

Compliance Scores	
95 % or above	**Excellent Compliance**
85% to 94%	**Good Compliance**
76% to 84%	**Partial Compliance**
75% or below	**Minimal Compliance**

Is the ward/department/area well led?	**Score (%)**
Leadership and Management of the Clinical Area	

Is Care Safe?	**Score (%)**
Environmental Safety	
Infection Prevention and Control	
Patient Safety	
Medicines Management	
Total Score	

Is Care Effective?	**Score (%)**
Nursing Care Records	
Medical Care Records	
Nutrition and Hydration	
Pain Management	
Pressure Ulcers	
Promotion of Continence and the Management of Incontinence	
Total Score	

Is Care Compassionate?	**Score (%)**
Person Centred Care	
Communication	
End of Life Care	
Total Score	

Appendix 1: Supporting Standards, Guidance and Legislation

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

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

16. NMC Record Keeping. Guidance for Nurses and Midwives. http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf
17. DHSSPS Improving Dementia services in NI. A regional Strategy November 2011 http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-a-regional-strategy-november-2011.pdf
18. *Living Matters; Dying Matters (LMDM) Palliative and End of Life Care Strategy* (DHSSPS, 2010)
19. LMDM Strategy and other relevant guidance - including the Department's "*Strategy for Bereavement Care*" (2009)
20. HSS(MD) 21/2014 - Advice to Health And Social Care professionals for the care of the dying person in the final days and hours of life – phasing out of the Liverpool care pathway in Northern Ireland by 31 October 2014
21. Patient safety First "The how to guide for Reducing Harm from High Risk Medicines"
22. National Patient Safety Agency: Lessons from High Hazard Industries for Healthcare
23. NPSA, Rapid response report NPSA /2010/RRR009:Reducing harm from omitted and delayed medicines in hospitals
24. Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance (September 2006) http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf
25. The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007http://www.legislation.gov.uk/nisi/2007/1351/contents/made
26. Mental Health Order 1986 http://www.legislation.gov.uk/nisi/1986/595
27. DHSSPSNI, Area Child Protection Committees Regional Policies and Procedures, 2005 http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf
28. WHO definition of Elder Abuse http://www.who.int/aging/projects/elder_abuse/en/
29. DHSSPSNI, Adult Safeguarding in Northern Ireland. Regional and Local Partnership Arrangements. The NI Adult Safeguarding Partnership (NIASP 2010). http://www.dhsspsni.gov.uk/asva-_march_2010.pdf
30. Public Protection Arrangements NI (PPANI) http://www.publicprotectionni.com/
31. Domestic Violence advice available from http://www.nidirect.gov.uk/protecting-yourself-and-your-child-from-domestic-abuse-2
32. DHSSPSNI, 2005. Tackling Violence at Home. A Strategy for Addressing Domestic Violence and Abuse in Northern Ireland. http://www.dhsspsni.gov.uk/tackling_violence_strategy.pdf
33. SCIE, 2011. IMCA and paid relevant person's representative roles in the Mental Capacity Act Deprivation of Liberty Safeguards Available from http://www.scie.org.uk/publications/guides/guide41/files/guide41.pdf
34. British Geriatrics Society, 2011. Mental Capacity Act and Deprivation of Liberty Safeguards. http://www.bgs.org.uk/index.php/ethicslaw/1195-bpgmcaliberties15

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