Royal College of Anaesthetists | ACSA Anaesthesia Clinical Services Accreditation

ACCREDITATION STANDARDS 2025

Notes to Provide Clarification of ACSA Standards

Note 0	On GPAS references	The Guidelines for the Provision of Anaesthetic Services (GPAS) provides the evidence base for ACSA standards and GPAS recommendations are themselves developed through a rigorous evidence-based process. GPAS recommendations also provided added detail and can help departments gain a more thorough understanding of the standard; however, not every GPAS recommendation cited in a standard will be relevant to the services provided at a particular hospital. GPAS is broken into chapters, which include sub-specialist services, and the chapter numbers are listed below: Chapter 1: The Good Department Chapter 2: The Perioperative Care of Elective and Urgent Care Patients Chapter 5: Emergency Anaesthesia Services Chapter 6: Day Surgery Chapter 7: Anaesthesia in the Non-theatre Environment Chapter 8: Regional Anaesthesia Chapter 9: Anaesthesia Services for an obstetric population Chapter 10: Paediatric Anaesthesia Chapter 11: Inpatient Pain Management Chapter 12: ENT, Oral Maxillofacial and Dental surgery Chapter 13: Ophthalmic Anaesthesia Chapter 14: Neuroanaesthesia Chapter 15: Vascular Procedures Chapter 16: Trauma and Orthopaedic surgery Chapter 17: Burns and Plastic surgery Chapter 18: Cardiac Procedures Chapter 19: Thoracic Procedures
Note 1	On the prioritisation of standards	Every ACSA standard has been assigned a priority. Standards are assigned priority 1 if they **must** be achieved in order for accreditation to be awarded if they are applicable to the department. Priority 2 standards **should** be achievable by most departments. Priority 3 standards will be **aspirational** for most; however, they will provide targets for the highest performing departments to achieve.
		All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that.
Note 2	On the use of the term 'policies'	"Policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such

		as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction.
		Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available.
		Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.
Note 3	For hospitals that do not provide services for patients under 18 years of age (or, in Scotland, under 16 years of age).	If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
		If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.
Note 4	On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee').	The diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the RCoA Guidance on Supervision arrangements for anaesthetists.
Note 5	On terminology	Please use the following definitions and explanation to facilitate your understanding of the ACSA standards: **Appropriately trained** This refers to someone who has been assessed as competent to undertake their designated role. **Autonomously practising anaesthetists** are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks. **Immediate** Without any appreciable delay, within a matter of seconds or minutes. Unless otherwise specified, this should be no

		more than five minutes. **Locally-employed Doctors (LEDs)** are anaesthetists on local, employer-based contracts, commonly based on a current or historical version of the resident doctor contract. Examples of these roles include Trust Doctors, Clinical Fellows, and Medical Training Initiative doctors. **Multidisciplinary** This will have different meaning in respect of which healthcare professionals are referred to according to context and clinical situation. It is referred to as an integral part of perioperative care; 'the practice of patient-centred, multidisciplinary and integrated clinical care for patients from contemplation of surgery until full recovery.' **Remote sites** A remote site is any location where general or regional anaesthesia or sedation is administered away from the main theatre suite and/or anaesthetic department. This may be within or away from the base hospital. Common examples include MR or CT scanners, maternity units or dental sedation suites. Please be advised that areas that do not have any anaesthetic input, such as midwife-led maternity units, will not be assessed during the onsite review visit. **SAS Doctors** are anaesthetists on the national Speciality Doctor or Specialist Doctor contract and any anaesthetists on closed SAS contracts, such as the Associate Specialist contract. **Sedation** Unless otherwise specified, sedation refers to sedation delivered by an anaesthetist.

STANDARD

1.1.1.1 All patients should have a named and documented supervisory consultant or autonomously practising anaesthetist who has overall responsibility for the care of the patient.

EVIDENCE REQUIRED

A written policy should be provided describing the department's supervisory arrangements. The name of the supervisory consultant or autonomously practising anaesthetist should be observable on the anaesthetic record, on the rota, on display in the department, theatre suite and visible in the obstetric unit. Their name and contact details should be visible and accessible to the rest of the theatre team. Audit data based on the Cappuccini Test should be used to provide evidence for this standard, as well as for standards 2.4.1.3, 2.5.2.2 and 2.5.3.2.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.13.10 All patients undergoing anaesthesia should be under the overall care of a consultant or other autonomously practising anaesthetist whose name is recorded as part of the anaesthetic record.

9.1.18 There should be a named consultant or other autonomously practising anaesthetist responsible for every elective caesarean delivery list. This anaesthetist should be immediately available. The named person should have no other concurrent clinical responsibilities.

9.1.19 Consultant or other autonomously practising anaesthetist support should be contactable at all times and have a response time for attendance on site of not more than half an hour to attend the delivery suite and maternity operating theatre. The supervising anaesthetist should not therefore be responsible for two or more geographically separate obstetric units.

HELPNOTE

This is likely to be tested in the meetings with anaesthetists in training, SAS doctors and consultants when they will be asked how supervision works in practice in order to judge the evidence of implementation on the ground and assess if the level of supervision is adequate for the environment. There needs to be a rigorous process in place to make sure: firstly that the whole theatre/procedural team is aware of the name and way of contacting the supervisory anaesthetist, for

example inclusion in the team brief, and secondly that the supervisor is aware of their supervisees and what they are doing.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.4 Anaesthetic record keeping*, *3.7 Recovery discharge protocols*, *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

Note 4: The diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the RCoA Guidance on Supervision arrangements for anaesthetists.

Note 5: On terminology, autonomously practising anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks.

STANDARD

1.1.1.2 There are policies and documentation for the structured handover of care of patients from one clinical team to another throughout the perioperative pathway including intraoperative handover.

EVIDENCE REQUIRED

A copy of policies and protocols should be provided. Handovers should be visible on the anaesthetic record. A rolling audit of handover quality against the agreed system would be useful to demonstrate compliance with this standard.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.9.4 An anaesthetist should have overall responsibility for the transport of patients from theatre to the recovery unit.

2.9.5 Anaesthetists or a delegated AA should formally handover the patient, and should remain in the recovery unit if their input is required. They should leave the patient in a stable condition.

2.11.6 Handover, including on moving to the postoperative care environment or to the ICU, should always be to a member of staff who is competent to care for the patient at that time, and this should be clearly documented.

2.11.7 All handovers should be structured to ensure continuity of care.

2.11.8 Staff should complete urgent tasks before information transfer, limiting conversations while performing these tasks adopting a 'sterile cockpit' approach.

2.11.9 If responsibility for care is transferred from one anaesthetist to another, a 'handover protocol' should be followed, during which all relevant information concerning the patient's medical history, medical condition, anaesthetic status, and plan should be communicated.

2.11.10 Standardisation of the handover process can improve patient care by ensuring information completeness, accuracy and efficiency (the use of checklists should be considered). Staff should comply with the local standardised handover processes.

HELPNOTE
This standard includes handover to critical care post operatively; please note handover between shifts is covered in standard 1.1.1.3.

Standardisation of handover, using SBAR, I-PASS or other such systems is recommended.

A suggested dataset for PACU/ICU handover is:
- patient name/age/occupation (if relevant)
- operation/procedure and intraoperative events of note
- ASA grade (relevant comorbidities for NEWS2 scoring adjustment)
  - airway
  - breathing
  - circulatory
- drugs, allergies and intraoperative medication relevant to postoperative management plan, including controlled drugs
- postoperative analgesia, antiemetics and investigations
- tubes in and out (hydration, nutrition and elimination, catheter, NGT etc.)
- contact details for queries/problems
- hard copy of Anaesthetic record (if not routine).

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.12 Intraoperative patient handover*, *3.2 Patient handover in the post-anaesthesia care unit*, *3.7 Recovery discharge protocols*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.1.1.3 There is a structured handover process between shifts; multidisciplinary where appropriate.

EVIDENCE REQUIRED

Rotas should be provided and include the allocation of time and place as well as which staff should be present at handover. Time for handover should be included in job plans and rotas and accounted for in work shift planning.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

2.11.7 All handovers should be structured to ensure continuity of care.

5.1.55 There should be appropriate overlap between shift changes, to ensure adequate time for handover. Time for handover should be included in job plans and rotas and accounted for in work shift planning.

9.1.7 Adequate time for formal multidisciplinary team (MDT) handovers between shifts should be built into the timetable. In the case of the anaesthetist being otherwise engaged with work at the time of the MDT labour ward handover, a briefing from the midwifery and obstetric team should be sought at the earliest opportunity to facilitate a shared mental model of the existing workload/potential patients

9.1.8 A structured tool should be considered for handover between shifts and its formal documentation.

9.1.9 The duty anaesthetist should participate in MDT delivery suite handovers and ward rounds.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.12 intraoperative patient handover*.

STANDARD

1.1.1.4 There is a policy for the provision of anaesthetic care for specialties and services not available onsite within a clinically appropriate timeframe. This may involve transfer out of the hospital or specialists coming in.

EVIDENCE REQUIRED

Patient pathways should be relayed by staff members. Copies of relevant policies should be provided.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; partnerships and resources

GPAS REFERENCES

5.1.48 Departments should have local guidelines for intrahospital transfers.

5.1.49 Where transfers between hospitals are foreseeable (e.g. transfers to major trauma, neurosurgical or paediatric centres) local arrangements should be in place to ensure safe and timely transfer, which may involve a retrieval service.

5.1.51 Hospitals should collect data on inter and intrahospital transfers, including the effects on the emergency theatre and critical patient care. The transfer arrangements should not result in the interruption of a busy emergency list.

10.5.1 Hospitals should define the extent of elective and emergency surgical provision for children, and the thresholds for transfer to other centres as part of an ODN for children's surgery

10.5.18 Units without inpatient paediatric beds should have a formal arrangement with a neighbouring unit, to ensure that practical assistance is available should a child require transfer. Protocols should be in place for the rapid assessment and transfer of patients to the local specialist unit within the network.

16.2.29 In MTCs and TUs there should be a rapidly accessible imaging suite for patients with major trauma, with immediate access to specialised equipment for the management of difficult airways including physiological and gas monitoring. In addition, the room design should allow visual and technical monitoring of the patient by the anaesthetic staff.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.7 Transfer of the critically ill patient*, *6.1 Anaesthesia in the accident and emergency department*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.1.1.5 There is a trust/board resuscitation policy with specific reference to the perioperative period. There is guidance to assist anaesthetists to implement advanced care plans in the perioperative period.

EVIDENCE REQUIRED

A copy of the policy should be provided. Policy should include provision for review of 'not for resuscitation' orders prior to surgery.

PRIORITY

1

CQC KLoEs

Safe; caring; responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

5.1.57 Appropriate clinical policies and standard operating procedures for operating theatres should be in place and available at all times, including a resuscitation policy and major incident plans.

5.5.16 Hospitals should have a treatment escalation plan and/or do not attempt cardiopulmonary resuscitation (DNACPR) guidance and documentation that complies with national requirements.

5.5.17 Patients who may require surgical procedures with DNACPR decisions in place should have senior members of the anaesthesia and surgical team review the condition of the patient and the DNACPR status. Where feasible, a discussion should take place with the patient and their next of kin. It may be appropriate to suspend components of a DNACPR decision (e.g. tracheal intubation) to allow surgery to proceed safely.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.10 Prevention of unexpected cardiac arrest*.

The department may follow the ReSPECT process, which creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

'Implementing advance care plans in the perioperative period, including plans for cardiopulmonary resuscitation: Association of Anaesthetists clinical practice

guideline,' Association of Anaesthetists February 2022 replaces 'Do Not Attempt Resuscitation (DNAR) Decisions in the Peri-operative Period, 2009'.

STANDARD

1.1.1.6 There is a policy to address patient death in the operating theatre.

EVIDENCE REQUIRED

A copy of the policy should be provided detailing the processes which should take place and, which has specific reference to the pastoral care of the bereaved family and the review of the immediate clinical commitments of the staff concerned.

PRIORITY

1

CQC KLoEs

Caring; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; partnerships and resources; quality improvement-focused leadership

GPAS REFERENCES

2.1.12 When members of the healthcare team are involved in a critical incident, the personal impact on individual team members can be significant. Following a significant critical incident, the clinical director or appropriate individual (head of service) should promptly review the immediate clinical commitments of the staff concerned. Relevant support for staff following a critical incident is outlined in GPAS chapter 1: Guidelines for the Provision of a Good Department.

2.1.14 Generic policies covering the entire perioperative period should be held and easily accessible. These include but are not limited to:

- support for patients and staff of diverse religious beliefs and cultural backgrounds
- infection control, including personal protective equipment
- implementation of enhanced perioperative care
- management of death in the perioperative period

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.13 Management of death in theatre*. Staff wellbeing and support is considered in standard 4.1.3.1.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review

date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.1.1.7 There are policies for the management of immediate and delayed complications of neuraxial blockade. This should include out of hours access to MRI.

EVIDENCE REQUIRED

Written policies should be provided, which include provision for access to MRI, with or without transfer, 24/7. Policies should include day surgery and obstetric settings if appropriate.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.11.4 The following protocols should be held and easily accessible for:

- management of postoperative nausea and vomiting
- pain relief for patients with chronic pain
- hypothermia
- blood transfusion
- fluid therapy
- acute coronary syndrome
- respiratory diseases
- hypotension
- hypertension
- monitoring following central and peripheral neuraxial blockade
- escalation to higher levels of postoperative care (e.g. to a critical care unit) should the patient develop perioperative complications.

9.5.13 Units should have local guidelines on the recognition and management of complications of regional analgesia that include training on the recognition of complications and access to appropriate imaging facilities when neurological injury is suspected. The patient's general practitioner should be informed in the event of any of these complications.

11.2.10 Clinical areas caring for patients receiving analgesic techniques which may result in cardiovascular, respiratory or neurological impairment should have appropriate facilities and adequately trained staff to provide appropriate monitoring.

11.2.11 Drugs and equipment for the management of the complications associated with analgesic techniques should be readily available.

HELPNOTE
Policies should refer to guidance from the safety guideline: Neurological monitoring associated with obstetric neuraxial block 2020

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *5.5 How effective is your daycase spinal service?, 7.10 Postnatal obstetric anaesthetic adverse effects and complications, 10.1 Assessment and documentation in acute pain management, 10.4 Managing epidural analgesia*.

STANDARD

1.1.1.8 There are clear escalation processes should emergencies occur simultaneously.

EVIDENCE REQUIRED

Verbal confirmation should be given, and evidence should be seen in the staff induction pack.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

1.2.38 Departments should consider having flexibility in the day-to-day rota so that there are more anaesthetists working in a clinical area, such as a theatre suite, than there are procedures being carried out to ensure that this cover is always immediately available. The size of the additional staffing resource is dependent on the number of anaesthetic procedures underway simultaneously and the local geography.

5.1.56 Emergency theatres should ensure that policies on the following areas are readily available:

- management and running of the emergency theatre, including an escalation plan for emergency theatre capacity and staffing
- management of anaesthetic emergencies, including guidelines for children
- difficult airway management, including the 'can't ventilate, can't oxygenate' scenario, fasting times, preanaesthetic assessment of the airway, availability and maintenance of the equipment and training of staff
- major haemorrhage protocol, including clinical, laboratory and logistic responses
- blood transfusion policy, including transfusion for inter- and intrahospital transfers
- safe extubation of patients following emergency anaesthesia
- management of the deteriorating patient
- whom to call and what facilities can be used if two or more emergencies occur simultaneously
- a policy for the management of organ donation and retrieval
- a policy for managing delirium in the perioperative period
- a policy for the management of airborne and bloodborne infections.

9.1.6 It is recognised that, in smaller units, the workload may not justify having an anaesthetist exclusively dedicated to the delivery unit. If the duty

anaesthetist does have other responsibilities, these should be of a nature that would allow the activity to be immediately delayed or interrupted should obstetric work arise. Under these circumstances, the duty anaesthetist should be able to delegate care of their non-obstetric patient to be able to respond immediately to a request for care of obstetric patients. They would therefore, for example, not simultaneously be able to be a member of the on-call resuscitation team. If the duty anaesthetist covers general theatres, another anaesthetist should be ready to take over immediately should they be needed to care for obstetric patients.

9.5.22 There should be clear arrangements in contingency plans and an escalation policy should two emergencies occur simultaneously, including whom to call.

STANDARD

1.1.1.9 There are clear criteria and standards for day surgery, particularly in regard to the range of patients, the admission and discharge pathways and the environment and staffing structure where it is delivered.

EVIDENCE REQUIRED

Policies and guidelines (for adults and children) should be available, including comorbidities and common conditions, and appropriate staff rotas. Audit data should be provided to demonstrate appropriate provision. This could include data for on the day cancellations, unplanned overnight admission, unplanned return or readmission to day surgery unit or hospital, and patient experience. This should include the principles highlighted in the GIRFT National Day Surgery Delivery Pack (2024).

PRIORITY

1

CQC KLoEs

Safe; Caring

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

6.1.9 Protocols should be available to maximise the opportunity for patients with significant comorbidities (e.g. diabetes, morbid obesity, sleep apnoea) to be safely managed via a day case pathway. Preoperative assessment should be inclusive and not exclusive.

6.1.15 If it is occasionally necessary to undertake daycase surgery on inpatient operating lists, the day cases should be prioritised at the beginning of the list to allow time for postoperative recovery and discharge. Starting the list with a daycase patient may improve efficiency (no delay to starting list) in times of bed pressures.

6.1.16 Daycase patients should ideally be cared for in dedicated day surgery ward areas, to ensure safe and timely discharge.

6.3.8 The secondary recovery area in the day surgery unit (day surgery ward) should be staffed to match patients' needs. Consideration should be given to the skill mix as well as numbers of staff.

6.3.10 When children are present on the unit, there should be a registered paediatric nurse present at all times. The Royal College of Nursing standards recommend two registered paediatric nurses at all times.

6. 4.6 The minimum operating facility required is a dedicated operating session in a properly equipped operating theatre to the same standards as an inpatient theatre.

6.4.2 A viable alternative is for patients to be admitted to and discharged from a dedicated day surgery ward, with surgery undertaken in the main theatre suite. This arrangement may be more flexible for complex work and avoids duplicating theatre skills and equipment. Day surgery patients should be prioritised as first on the main theatre list to allow recovery time for successful day surgery discharge.

6.4.20 Each day surgery unit should have a fully equipped recovery area, staffed by recovery personnel trained to defined standards.

10.3.37 The lower age limit for day surgery will depend on the facilities and experience of staff and the medical condition of the infant. Significantly ex-preterm infants should generally not be considered for day surgery unless they are medically fit and have reached a corrected age of 60 weeks. Risks should be discussed with parents and carers on an individual basis.

10.3.40 There should be clear, documented discharge criteria following day case surgery.

HELPNOTE
The department should demonstrate that they utilise current guidelines from the British Association of Day Surgery and the Association of Anaesthetists in their criteria. This should include the principles highlighted in the GIRFT National Day Surgery Delivery Pack (2024).

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *5.1 Optimising your daycase rates*, *5.2 Minimising day surgery cancellations/failure to attend*, *5.3 Day surgery within the main theatre setting*, *5.4 Performing emergency ambulatory surgery*, *5.5 How effective is your daycase spinal service*, *5.6 Pain relief after day surgery*, *5.9 Evaluating your day surgery pathway*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.1.2.1 There are policies for the anaesthetic management, including preoperative assessment, of adults and children in remote sites e.g. radiology, MRI suites, endoscopy.

EVIDENCE REQUIRED

A copy of the policy/policies should be provided and include reference to how help will be summoned in an emergency according to the location. Verbal confirmation of understanding by the whole team and those nominated for assistance should be provided. The modified Five Steps to Safer Surgery/WHO process for each remote area should be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

7.1.1 A clinical lead(s) for anaesthesia in the non-theatre environment should be appointed with adequate time provided within their job plan to develop the service, train staff, and ensure that safety standards are upheld. The anaesthesia clinical lead for the non-theatre environment should create local consensus guidelines for the staffing of each non-theatre area where anaesthesia is delivered.

7.1.2 An escalation policy should be in place and should be understood by all medical, healthcare professional and managerial staff. This should include the names and method of contact, which should be prominently displayed in appropriate areas. Internal hospital telephone switchboards should have ready access to rotas and methods of contacts.

7.3.5 Equipment available in remote sites should mirror equipment available in the main paediatric facility.

7.4.1 Patient safety is, as always, of paramount importance. Particular attention should be paid to teamwork, communication, the use of checklists and procedure brief when working in less familiar environments. At the team briefing, an explicit plan should be agreed for requesting help if required, recognising the risk of, and preparing adequately for, high blood loss, and life-threatening loss of the airway or respiratory function.

7.4.2 Many patients undergoing elective procedures outside the operating theatre can be managed as day cases and should be assessed accordingly in conjunction with local guidelines. All patients should undergo an appropriate risk assessment and level of preoperative assessment in line with the GPAS

recommendations in *Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients*.

HELPNOTE
Remote sites should meet minimum standards, including, but not limited to team briefing, equipment (including monitoring), emergency call systems and immediate access to emergency drugs.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.1 WHO surgical checklist*, *6.2 Remote site anaesthesia*, *6.4 Sedation and anaesthesia in endoscopy*, *6.6 Sedation and anaesthesia in radiology*, *6.8 Provision of anaesthesia in MRI*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

Note 5: On terminology, a remote site is any location where general or regional anaesthesia or sedation is administered away from the main theatre suite and/or anaesthetic department. This may be within or away from the base hospital. Common examples include MR or CT scanners, maternity units or dental sedation suites. Please be advised that areas that do not have any anaesthetic input, such as midwife-led maternity units, will not be assessed during the onsite review visit.

STANDARD

1.1.2.2 There is a policy to address the airway management of adults and children in the emergency department.

EVIDENCE REQUIRED

The policy should be provided, its location should be pointed out and should be easily accessible, consistent with other areas, and staff should be able to relay the main points and what is expected of them verbally.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

7.3.9 The safe management of unstable patients depends on close liaison between emergency physicians and anaesthetists, to ensure that clear guidelines are in place, emergency department support staff are trained to assist with tracheal intubation, and audit and discussion of complications is undertaken regularly.

7.3.10 Emergency airway management in the ED should follow the joint guidance from the RCoA and Royal College of Emergency Medicine (RCEM).

7.3.11 The use of an emergency induction checklist is recommended.

12.5.2 Airway management should be guided by local protocols, including formal adoption of national guidelines such as Difficult Airway Society awake tracheal intubation, extubation, paediatric and obstetric guidelines. These protocols should be reviewed and amended when an increased risk of infectivity during aerosol generating procedures is identified to ensure the safety of patients as well as their healthcare providers.

HELPNOTE

Please also see the RCoA/RCEM joint position statement here.

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.1 Anaesthesia in the accident and emergency department*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review

date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.1.2.3 Where ECT is provided, the department has been accredited against the relevant national accreditation scheme.

EVIDENCE REQUIRED

Documentation of the accreditation should be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

7.3.43 Anaesthesia for ECT is frequently performed in remote locations. Ideally, a consultant or an autonomously practising anaesthetist should provide general anaesthesia. Appropriately trained recovery and operating department staff should be provided, and the guidance provided for anaesthetic provision in remote sites should be followed.

7.3.44 The ECT clinic should adhere to the ECT Accreditation Service (ECTAS) or Scottish ECT Accreditation Network (SEAN) standards for administration of ECT and have been assessed and accredited by ECTAS or SEAN.

7.3.45 There should be a clinical lead for ECT who is responsible for provision of the service in each anaesthetic department. The named consultant should be responsible for determining the optimal location for provision of anaesthesia for patients of American Society of Anesthesiologists classification III or above. Contingency plans for transfer to an acute care facility should also be in place.

7.3.46 The ECT clinical lead should streamline the preassessment and consent processes for all ECT patients by setting up a collaborative system with ECT clinics and experienced anaesthetists. The mental capacity issues that affect informed consent should be acknowledged.

7.3.47 Anaesthetists should have specialised knowledge of the effect of concurrent medications, anaesthetic agents, anaesthetic techniques and equipment on the conduct and efficacy of ECT, as well as the specific anaesthetic contraindications.

7.3.48 Standards specific to ECT clinics should be available, including a minimum of four rooms: a waiting room, treatment room, recovery area and post-ECT waiting area. The clinic should have a reliable source of oxygen supplied either by pipeline or cylinder with a reserve supply immediately available.

7.3.49 Recommendations for standards of monitoring during anaesthesia and recovery are stipulated by the Association of Anaesthetists and should be adhered to for all patients undergoing ECT.

STANDARD

1.1.2.4 Where sedation is provided by the anaesthetic department there is a policy for the provision of this service in all subspecialty areas including paediatrics. The specifications of the facilities provided in standalone sites should be clearly outlined in any such policies.

EVIDENCE REQUIRED

A copy of the policy should be provided.

PRIORITY

1

CQC KLoEs

Safe; effective; caring

HIW Domains

Safe and effective care

HIS Domains

Policies, planning and governance

GPAS REFERENCES

7.1.4 A dedicated, appropriately trained anaesthetic assistant, who is familiar with that specific environment, should be available in all non-theatre environments where anaesthesia or deep sedation is undertaken by an anaesthetist.

7.2.3 Environments in which patients receive anaesthesia or sedation should have full facilities for resuscitation available, including a defibrillator, suction, oxygen, airway devices, an escalating plan of airway intervention equipment, including equipment required to manage a difficult airway and a means of providing ventilation.

7.2.9 Equipment for the minimum standards of monitoring should be available at all sites where patients receive anaesthesia or sedation. For patients receiving conscious sedation, this should include pulse oximetry.

7.2.10 Continuous waveform capnography should be available for all patients undergoing general anaesthesia and moderate or deep sedation.

7.3.2 Each facility should develop written policies, designating the types of paediatric operative diagnostic and therapeutic procedures requiring anaesthesia.

7.3.4 Irrespective of the site of care delivery (theatre or non-theatre), children should receive the same standard of anaesthetic care or sedation as applied to procedures performed in theatre.

7.3.6 Guidance for paediatric sedation should be developed for the local context, by a multidisciplinary team.

7.3.7 Paediatric sedation should be managed in accordance with recognised national guidelines.

7.4.3 Hospitals should have a system for multidisciplinary involvement in reporting and regular audit of critical incidents and near misses. A risk register should be maintained for all remote locations in the hospital.

10.5.22 When infants and children undergo procedures under sedation alone, recommended published guidance for the conduct of paediatric sedation should be used for example guidance published by the National Institute for Health and Care excellence (NICE) and the Academy of Medical Royal Colleges.

HELPNOTE
Please refer to the recommended published guidance for the conduct of paediatric sedation and the recommended published guidance for safe sedation practice.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.3 Sedation competency*, *8.3 Paediatric sedation*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.1.2.5 The trust/board has a sedation committee or similar appropriate governance committee with anaesthetic representation.

EVIDENCE REQUIRED

Terms of reference, recent example of minutes and a list of sedation committee members.

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Quality improvement-focused leadership

GPAS REFERENCES

7.4.9 A named anaesthetist should be responsible for liaising with consultants in other departments who have responsibility for sedation, to establish local guidelines and training for the provision of safe sedation by non-anaesthetists.

7.4.10 All institutions where sedation is practised should have a sedation committee. This committee should include key clinical teams using procedural sedation and there should be a nominated clinical lead for sedation. In most institutions, the sedation committee should include an anaesthetist, at least in an advisory capacity.

7.4.11 Each facility should develop written policies, designating the types of operative, diagnostic and therapeutic procedures requiring anaesthesia or sedation.

HELPNOTE

Hospitals that provide sedation should appoint a sedation committee in line with the recommendations from the Academy of Medical Royal Colleges. There should be anaesthetic representation on this committee. If sedation is only provided by anaesthetists then this standard may be considered non-applicable.

STANDARD

1.1.3.1 Arrangements are in place for the multidisciplinary management of patients with significant co-morbidities for both elective and emergency surgery which includes direct involvement of a consultant or autonomously practising anaesthetist.

EVIDENCE REQUIRED

A brief presentation of an example scenario may be requested at your ACSA review visit. The department should identify ways in which the care and experience of patients with significant comorbidities can be improved and demonstrate how these improvements have been integrated into relevant clinical pathways and protocols for both planned and non-planned care. National audit data should also be provided to evidence benchmarking. Specific examples of management of patients in subspecialties in your hospital may be requested. Documentary evidence of consultant or autonomously practising anaesthetist supervision regularly occurring should be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families; policies, planning and governance

GPAS REFERENCES

2.4.9 Agreed internal referral pathways to other specialties should be in place for the minority of cases where this may be required to expedite further investigation and patient optimisation. This should be done in close collaboration between the preoperative assessment lead and nominated representatives from appropriate specialties (e.g. cardiology, diabetes, renal, respiratory and geriatric medicine).

2.4.10 Where the risk of an adverse patient outcome associated with surgery is identified as being high, the preoperative assessment consultation should facilitate a shared patient discussion, which may result in a well-informed individual opting for non-surgical management. Under such circumstances the decision-making process should be endorsed through close collaborative discussion with surgical colleagues – this is ideally conducted and documented within a preoperative multidisciplinary team (MDT) meeting.

5.1.40 There should be a formalised integrated pathway for non-elective adult general surgical care which should be patient centred and should include risk assessment and identification of the high-risk patient. The integrated pathway should include risk assessment and identification of the high-risk patient.

5.1.41 There should be locally agreed guidelines for risk assessment and documentation. A number of risk prediction tools such as the Physiological and Operative Severity Score for the enumeration of Mortality and morbidity (POSSUM), Surgical Outcome Risk Tool (SORT), American College of Surgeons-National Surgical Quality Improvement Program (ACS-NSQIP), National Emergency Laparotomy Audit (NELA) are commonly used. Mortality risk should be assessed preoperatively and documented on the consent form.

9.5.2 An anaesthetist should be included in the MDT antenatal management planning for those with complex medical needs. Planning should be in the form of shared decision making and include consideration of the woman's wishes and preferences.

15.3.1 Risk stratification based on clinical history may help guide management. However, determination of a patient's functional capacity may be difficult if exercise tolerance is limited by peripheral vascular insufficiency, respiratory or other disease. Clinical guidelines should be developed for further investigation, referral, optimisation, and management according to local facilities and expertise.

15.3.2 To guide clinical decision-making, cardiopulmonary exercise testing should be considered for patients undergoing aortic surgery to establish functional capacity and the presence and severity of cardiopulmonary disease. Test results may also be helpful in guiding collaborative decision-making as to the most appropriate treatment option for patients.

16.3.2 Hospitals providing surgical treatment for hip fractures should have a formal pathway including prompt provision of analgesia (including nerve blocks) and hydration, preoperative assessment of high-risk patients by the anaesthetic team. In addition, orthogeriatrician input should be prioritised on orthopaedic trauma lists.

16.4.2 The anaesthetist should contribute in the multidisciplinary perioperative care process which focuses on preoptimisation, patient education, standardised enhanced recovery pathways of care aimed at delivering early mobility, discharge, and early return to normal life. The option of doing nothing should be considered where relevant.

16.4.3 There should be multidisciplinary input for the preoperative assessment of high risk patients such as patients with cognitive disorders, chronic kidney disease, diabetes mellitus and ischaemic heart disease. The anaesthetist should be involved in preoperative optimisation and prehabilitation plans.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.8 Managing frailty in the perioperative period*, *1.11 Perioperative neurocognitive disorders*, *2.10 Think kidneys*, *4.4 Emergency anaesthesia for the elderly patient*, *4.5 Anaesthesia for fractured neck of femur surgery*, *7.9 Timely anaesthetic involvement in the care of high-risk and critically ill women*.

STANDARD

1.1.3.2 Arrangements are in place for the multidisciplinary management of patients with frailty.

EVIDENCE REQUIRED

A copy of the policy should be provided. Such a policy should include the involvement of physicians and a formal system for assessing and recording frailty and the cognitive status of patients during preoperative assessment.

PRIORITY

1

CQC KLoEs

Responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

2.12.29 Preoperative assessment, optimisation and shared decision making in patients with multiple comorbidities, frailty or cognitive impairment require a cross specialty approach involving anaesthetists, surgeons, geriatricians, pharmacists and allied health professionals. Liaison with a clinical pharmacist in the perioperative period will enable optimisation of medicines and improved management of the patients' non-surgical comorbidities during this time. The development of such teams requires time and resources. These should be recognised and provided.

2.12.30 Care of the frail and older surgical patient starts at the contemplation of surgery and continues through the hospital stay and beyond. Models of care for frail and older patients should include multidisciplinary management between surgical teams, physicians with expertise in the assessment and management of frailty/delirium and allied health professionals providing consistent hands-on medical care, direction of rehabilitation goal setting and discharge planning until discharge at which point signposting to community services will occur.

2.12.31 Models of care could include comprehensive geriatric assessment which may have potential to improve outcomes.

2.12.32 Patients with frailty are at increased risk of adverse postoperative outcome. Older patients undergoing intermediate and high-risk surgery should be assessed for frailty using an established tool or scoring system.

2.12.33 Pathways of care providing proactive preoperative interventions for frailty, involving therapy services, social services, discharge teams and geriatricians or physicians with expertise in the assessment and management of frailty/ delirium should be developed.

2.12.34 Older patients should have access to a consultant or other autonomously practising anaesthetist experienced in the management of the older surgical patient to support shared decision making, patient optimisation and perioperative care. Opportunities for joint geriatric and surgical clinical governance should be considered as this model of care is superior to that delivered without this expert support

2.12.35 The risk of postoperative functional decline and complex discharge related issues should be considered. Procedures should be in place to identify complex patients at pre-assessment and complex discharge planning should begin then. This will require a multi-disciplinary team approach. Guidelines should be developed for the prevention, recognition and management of common postoperative geriatric complications and/or syndromes, including delirium, falls, functional decline and pressure area care.

2.12.37 There is a high prevalence of recognised and unrecognised cognitive impairment amongst older surgical patients. This has implications for shared decision making, the consent process and perioperative management. Older patients should have preoperative cognitive assessment using established screening or diagnostic tools.

5.6.2 All older patients who require emergency surgery should be routinely assessed for multimorbidity, frailty, cognition and polypharmacy.

5.6.3 Planning of care and decisions to operate should reflect the outcomes for older patients who are having emergency surgery, and should include discussion of issues around risks and benefits, clinical benefit and realistic longer-term outcomes (e.g. a requirement for nursing home care). This discussion should involve the multidisciplinary team as well as the patient, families and carers where possible.

16.3.2 Anaesthetists should be involved alongside surgical colleagues and orthogeriatricians, in discussions on preoperative planning, timing of surgery, and postoperative care, especially for high risk patients. Hospitals providing surgical treatment for hip fractures should have a formal pathway including prompt provision of analgesia (including nerve blocks) and hydration, preoperative assessment of high-risk patients by the anaesthetic team. In addition, orthogeriatrician input should be prioritised on orthopaedic trauma lists.

16.4.4 In patients aged over 65, frailty screening using an appropriate validated screening tool should be performed and documented early in the preassessment pathway. A screening tool used in combination with direct questioning should also be adopted to help identify patients with cognitive impairment and therefore increased risk of delirium.

16.6.9 Older patients who are admitted following trauma should have a comprehensive geriatric assessment. The use of frailty screening tools may facilitate more informed early decision making in older trauma patients.

16.6.10 Protocols for end of life care should be in place to manage older patients with frailty who are unlikely to survive. The multidisciplinary team and patient's family or next of kin should be involved in these decisions.

HELPNOTE

Orthogeriatrician input, frailty scoring, cognitive assessments and having a lead anaesthetist available for the older patient in the anaesthetic department are examples of ways to demonstrate compliance with this standard. In 2021, the Centre for Perioperative Care and the British Geriatric Society published "Guidelines for the perioperative care for People Living with Frailty undergoing elective and emergency surgery"; departments should be working towards implementation of these recommendations.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.8 Managing frailty in the perioperative period*, *1.11 Perioperative neurocognitive disorders*, *4.4 Emergency anaesthesia for the elderly patient*, *4.5 Anaesthesia for fractured neck of femur surgery*.

STANDARD

1.1.3.4 There is a policy for the management of patients with obesity.

EVIDENCE REQUIRED

A copy of the policy should be provided. The policy should outline local processes and equipment available for the treatment of patients with a BMI classification of morbid obesity, in line with national guidance. Appropriate equipment should be seen on the walkabout.

PRIORITY

1

CQC KLoEs

Safe; responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.12.44 Medical records should include the patient's weight and body mass index (BMI).

2.12.45 Ideally, patients with morbid obesity should undergo preassessment by a senior anaesthetist.

2.12.49 The safe movement and positioning of patients with obesity may require additional staff and specialised equipment. An operating table, hoists, beds, position aids (including for induction of anaesthesia) and transfer equipment appropriate for the care of patients with obesity should be available in appropriate quantities for the caseload, and staff should be trained in its use. Additional members of staff should be available where necessary, and manual handling should be minimised where possible.

2.12.50 Operating lists should include the patients' weight and BMI to highlight additional or alternative equipment requirements. Equipment and manual handling issues should be highlighted at the team brief element of the WHO *Surgical safety checklist*.

2.12.51 In view of the increased technical and clinical risks posed by patient with morbid obesity, senior anaesthetic and surgical staff should manage these patients.

2.12.52 In the postoperative period, the safety of patients with obesity may be improved by the use of supplemental oxygen, non-invasive ventilation (continuous positive airway pressure), monitoring of sedation, and ideally continuous pulse oximetry.

2.12.53 Patients with obstructive sleep apnoea have a higher incidence of postoperative complications including hypoxia, renal failure, unplanned critical care stay, and delayed discharge. Therefore, consideration should be given to monitoring such patients in a critical

care environment postoperatively.

5.6.15 An operating table in the emergency area, hoists, beds, positioning aids and transfer equipment appropriate for patients with obesity should be available and staff should be trained in its use and their limitations.

5.6.16 Specialist positioning equipment for the induction of anaesthesia and intubation in the patient with obesity should be available in the emergency area.

5.6.17 Patients with morbid obesity who require emergency surgery should have experienced anaesthetists and surgeons available (typically, but not exclusively, at consultant level) to minimise operative time. A surgical team familiar with emergency surgery in patients with morbid obesity and the complications associated with laparoscopic surgery should be available.

9.3.11 There should be a system in place for antenatal anaesthetic review by a senior anaesthetist for women who are morbidly obese. Assessment should be arranged to ensure that timely delivery planning can take place.

9.3.12 The duty anaesthetist should be informed as soon as a woman with a BMI above a locally agreed threshold is admitted.

9.3.13 Equipment to facilitate the care of women with morbidly obesity (including specialised electrically operated beds, operating tables with suitable width extensions and positioning aids, such as commercially produced ramping pillows, extra-long spinal and epidural needles, weighing scales, sliding sheets and hover mattresses or hoists) should be readily available. Staff should receive training on how to use the specialised equipment. The maximum weight that the operating table can support should be known and alternative provision made for women who exceed this weight.

HELPNOTE
The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.12 Management of obesity in the perioperative period*, *7.2 Anaesthetic care for women who are obese during pregnancy*, *7.9 Timely anaesthetic involvement in the care of high-risk and critically ill women*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.1.3.5 The department has a policy for the perioperative management of patients with complex pain needs including; those at risk of severe pain postoperatively, chronic post-surgical pain and persistent post-operative opioid use. This should also include a policy on responsible opioid stewardship and planning post discharge.

EVIDENCE REQUIRED

A copy of the policy is provided and includes how high-risk patients are identified preoperatively e.g. patients with pre-existing chronic pain and high dose opioid use (including a recording of their Oral Morphine Equivalent (OME) Dose per 24hrs) and how their care is planned perioperatively. It may include referral of patients with complex pain needs to specialist outpatient pain services to optimise their pain management and consider, where appropriate, opioid optimisation. Verbal explanation should be given of how responsible opioid stewardship is ensured, including providing patients with information on safe opioid use, storage, and disposal.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; workforce management and support

GPAS REFERENCES

11.3.9 Responsible opioid stewardship should be practiced as described by the Faculty of Pain Medicine Opioids Aware guidelines and Surgery and Opioid: Best Practice Guidelines 2021. Patient information material about opioids should be available for patients.

11.3.11 Patients taking high-dose opioids during pregnancy should be identified and involved in a review in an antenatal obstetric anaesthesia clinic, with referral to specialist pain services as required.

11.3.13 Discharge prescriptions for opioids should be for a maximum of five days to reduce the risk of persistent postoperative opioid use.

11.3.18 Patients at high risk of developing pain complications should be identified preoperatively e.g., patients with preexisting chronic pain and high-dose opioid use (including a recording of their Oral Morphine Equivalent dose per 24 hours). The perioperative care of these patients should be planned in advance.

11.3.24 Specific arrangements and guidelines should be available, where applicable, for the management of subgroups of vulnerable adult patients, including:

- critically ill patients
- elderly and/or frail patients

- non-native English speakers
- patients with chronic pain
- patients with coexisting mental health problems
- patients with dementia
- patients with multiple trauma or significant blunt chest wall trauma
- patients with opioid tolerance
- patients with physical or learning disability
- patients with problem drug and alcohol use
- patients with significant organ dysfunction
- pregnant and breastfeeding patients.

11.6.1 Clear lines of communication and close working with other services such as surgical and medical colleagues, outpatient (chronic) pain, palliative care, emergency medicine and primary care should be in place.

HELPNOTE
Best practice guidelines for the management of opioids in surgery are available from the Faculty of Pain Medicine here: Surgery and Opiods: Best Practice Guidelines (2021)

The British Pain Society has a 'Managing pain after surgery' patient leaflet which includes patient information on safe opioid use, storage and disposal: https://www.britishpainsociety.org/static/uploads/resources/files/pain_management_after_surgery_English.pdf

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.16. The full references can be found here: Core Standards for Pain Management Services in the UK

The MHRA guidelines can be viewed here: Prolonged-release opioids: Removal of indication for relief of post-operative pain - GOV.UK

STANDARD

1.2.1.1 All patients undergoing anaesthesia or sedation have an appropriate preoperative assessment.

EVIDENCE REQUIRED

Verbal explanation should be given to demonstrate that an appropriate individualised risk assessment is undertaken and of the procedure for triage of patients. Evidence should include preassessment records, data for on the day cancellations, patient information and patient satisfaction audits.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.2.1 All patients should be assessed prior to anaesthesia or anaesthesia led sedation. This could be conducted face to face in a clinic or virtually (any interaction that does not take place face to face). The majority of preoperative assessment will be nurse led and delivered (in association with allied health professionals and pharmacy staff) using locally agreed and developed protocols.

2.2.2 An anaesthetic preoperative assessment service should involve consultant anaesthetists and staff grade, specialty and associate specialist (SAS) doctors. Dedicated anaesthetic presence in the preoperative assessment and preparation clinic is required for:

- the review of results and concerns identified by preoperative staff
- consultations with patients identified using a triage process to allow optimal delivery of preoperative assessment resources
- consultation, including shared decision making, on the risks and benefits of anaesthesia and surgery in high risk patients, including arranging and interpretation of functional assessments of fitness. This should also include identifying modifiable risk factors and motivational interviewing (see Glossary), empowering patients to improve outcomes from proposed surgery.

2.4.1 Objective assessment of risk should be routine and the identification of increased risk should trigger advanced planning specific to that patient. Each hospital should have a consistent and where possible evidence based system in place to identify high risk surgical patients who require additional assessment. This assessment should be based on:

- age
- comorbidity
- medication history and allergy status
- type of surgery including risk of severe postsurgical pain
- dementia and cognitive dysfunction
- frailty
- nutritional status

- lifestyle factors (i.e. smoking behaviour, excess alcohol consumption, drug use, obesity)
- psychological factors and anxiety
- functional status
- chronic pain.

2.4.3 There are validated general risk prediction tools available that assess the risk of 30-day mortality (and morbidity) following surgery, as well as procedure specific risk prediction tools for elective aortic aneurysm surgery. There is also a wide variety of other screening and risk assessment tools that are useful in estimating the specific or additional risks accrued through the factors listed in recommendation 4.1. The focus is upon improving quality of outcomes through improved perioperative planning based on individual hospital case mix. Where possible, risk quantification tools should be used to facilitate shared decision-making conversations and to enable informed anaesthetic consent consistent with GMC requirements. Quality improvement outcomes should be assessed through national and local audit. Appropriate tools for risk prediction in perioperative care can be found at www.CPOC.org.uk.

2.4.4 Preoperative assessment should occur as early as possible in the patient's care pathway. Greater than two weeks preoperatively is recommended as good practice and preferably as close to the point of contemplation of surgery as possible to allow for the optimisation of chronic health conditions and health behaviours, so that all essential resources and obstacles can be anticipated prior to the day of procedure, including discharge arrangements. If there are delays to surgery and a significant period of time has elapsed between preassessment and the date of surgery, a repeat preoperative assessment should be undertaken to ensure there are no changes to the patient's co-morbidities.

2.4.8 The secondary care preoperative service should liaise closely with primary care, other secondary care professionals and commissioners to promote a 'fitness for referral' process in line with best practice.

2.4.9 Agreed internal referral pathways to other specialties should be in place for the minority of cases in which this may be required to expedite further investigation and patient optimisation. This should be done in close collaboration between the preoperative assessment lead and nominated representatives from appropriate specialties (e.g. cardiology, diabetes, renal, respiratory and geriatric medicine).

2.8.3 If the patient has not been seen in a preoperative clinic, (e.g. those admitted for urgent surgery), they should undergo an equivalent assessment and preparation process with the findings documented before their final anaesthetic assessment. Most patients for expedited urgent surgery should have the same assessment and preparation as for elective surgery.

2.12.37 There is a high prevalence of recognised and unrecognised cognitive impairment amongst older surgical patients. This has implications for shared decision-making, the consent process and perioperative management. Older patients should have preoperative cognitive assessment using established screening or diagnostic tools.

5.1.28 Some aspects of pre-anaesthetic assessment and preparation of the emergency patient differ from those of the elective patient. These include severity of illness, fluctuating condition of the patient and the 24/7 nature of emergency work. Staffing levels and seniority of anaesthetists should be adequate to enable pre-anaesthetic planning and assessment that is appropriate to the patient's risks associated with surgery. This should be informed by a formal assessment of risk of mortality and morbidity.

5.1.31 An anaesthetist, anaesthesia associate or advanced nurse practitioner should preoperatively assess all patients undergoing emergency surgery who require anaesthesia. Adequate time should be available for this assessment to occur as clinical urgency allows

5.1.33 The experience and expertise of the anaesthetist assessing the patient preoperatively should be appropriate for the complexity and level of risk of the patient. The decision to operate on high-risk patients should be made at a senior level, involving surgeons and those who will provide intra and postoperative care.

10.2.7 All children and young people should expect to have a preassessment prior to the day of their procedure that meets the medical, physical and emotional needs of that family. The Best Practice Guidance: Preassessment Services for Children undergoing Surgery or Procedures describes the establishment and delivery of a paediatric preassessment service in any hospital where children aged 0-18 years of age undergo surgery or other procedures under anaesthetic, and the functions it should deliver.

HELPNOTE
Ideally, all patients should have a formal preoperative assessment, often nurse led, where potential issues are sought for and relevant information flagged. An anaesthetist will then review after admission, before surgery. This may not always be logistically possible or necessary in fit patients for minor surgery. Where no formal preoperative assessment has been conducted, a more rigorous assessment will be necessary on admission.

Appointments can be delivered face to face or virtually where appropriate but the preassessment pathway must include the opportunity for physical examination and baseline observations to be completed prior to the procedure. Clinical, socioeconomic and geographical factors should be considered in determining the optimal preassessment pathway for each patient and patient choice should be factored into these decisions. The timing of preassessment should occur prior to the day of the procedure with sufficient time, according to the complexity of the patient or procedure, to complete any assessments, investigations or optimisation needed beforehand.

Best practice guidelines for the preoperative assessment and optimisation of adult patients is available here: Preoperative Assessment and Optimisation for Adult Surgery.

Best practice guidelines for the preassessment of children aged 0-18 years are available here: Best Practice Guidance: Preassessment Services for Children undergoing Surgery or Procedures.

Assessment should include a formal system in place for assessing and recording the cognitive status of patients where appropriate, which ought to be conducted according to local policy (e.g. all patients aged 75 and over; please see an example of a screening pathway https://www.hweclinicalguidance.nhs.uk).

The Preoperative Assessment and Optimisation for Adult Surgery has information on mental health and cognition assessment and preparation.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.2 Perioperative risk prediction*, *1.4 Consent in anaesthesia*, *1.11 Perioperative neurocognitive disorders*, *5.1 Optimising your daycase rates*, *5.9 Evaluating your day surgery pathway*, *11.4 Cancellation of surgery*.

STANDARD

1.2.1.2 The preoperative assessment service meets the needs of the patient population.

EVIDENCE REQUIRED

Documented evidence should be provided, e.g. job plan or rota. This will be triangulated with staff. Anaesthetists should report that they have adequate time allowed for input into the anaesthetic preoperative assessment service. Data, such as cancellation on the day of surgery due to medical reasons, should be provided. Where appropriate, specific pathways for patients undergoing major specialist surgery should be provided (e.g. cardiac, neuro, vascular and ophthalmic surgery).

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

2.2.2 An anaesthetic preoperative assessment service should involve consultant anaesthetists and staff grade, specialty and associate specialist (SAS) doctors. Dedicated anaesthetic presence in the preoperative assessment and preparation clinic is required for:

- the review of results and concerns identified by preoperative staff
- consultations with patients identified using a triage process to allow optimal delivery of preoperative assessment resources
- consultation, including shared decision making, on the risks and benefits of anaesthesia and surgery in high risk patients, including arranging and interpretation of functional assessments of fitness. This should also include identifying modifiable risk factors and motivational interviewing (see Glossary), empowering patients to improve outcomes from proposed surgery.

2.2.3 An appropriate level of staffing and suitable facilities should be available to deliver a good quality preoperative service. Non-anaesthetist health professionals, such as, specialist nurses, pharmacy staff, allied health professionals and Anaesthesia Associates (AAs) add considerable value to the service.

2.2.4 The time allocation for staffing of the preoperative service with nurses, AAs, operating department practitioners (ODPs), healthcare assistants and pharmacy staff should be based on local data that reflect surgical case mix, acuity of patients and high risk daycase workload.

2.2.5 There should be a designated lead anaesthetist for this service with specific programmed activities for this role within their job plan. The lead anaesthetist is responsible for:

- the training and support of nursing, ODPs and other staff

- the maintenance of close two-way links with primary care clinicians facilitating agreed evidence based 'fitness for surgery' protocols between primary and secondary care. This arrangement also encourages general practitioners to develop a broader knowledge of remediable perioperative risk factors which can be optimised prior to surgery
- developing links with clinical commissioning groups
- the establishment of internal protocols for patients such as those with diabetes, obesity or those receiving anticoagulant therapy
- audit, research, teaching, protocol development and relevant information technology development.

2.2.7 The preassessment clinic should be predominantly led by suitably trained nurses or other extended role practitioners using agreed protocols and with support from an anaesthetist.

15.1.7 The preoperative assessment and decisions regarding the risks of vascular surgery are often complex and time consuming, and require detailed discussions with the patient and other colleagues. Patients undergoing major vascular surgery should ideally be assessed by a vascular anaesthetist. Regular sessional time and programmed activities should be made available for anaesthetists to fulfil these requirements.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *5.9 Evaluating your day surgery pathway*.

STANDARD

1.2.1.3 The appropriate level of postoperative care is planned and arranged preoperatively. This planning of care is based on individualised risk assessment.

EVIDENCE REQUIRED

A verbal explanation should be provided regarding: how patients are individually risk assessed and ranked in urgency when there is pressure on beds, how patients are recovered when anaesthetised remotely (outside main theatres), what plans are in place for booking enhanced or critical care and the access of obstetric and paediatric patients to critical care.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.4.1 Objective assessment of risk should be routine and the identification of increased risk should trigger advanced planning specific to that patient. Each hospital should have a consistent and where possible evidence based system in place to identify high risk surgical patients who require additional assessment. This assessment should be based on:

- age
- comorbidity
- medication history and allergy status
- type of surgery including risk of severe postsurgical pain
- dementia and cognitive dysfunction
- frailty
- nutritional status
- lifestyle factors (i.e. smoking behaviour, excess alcohol consumption, drug use, obesity)
- psychological factors and anxiety
- functional status
- chronic pain.

2.4.2 As a minimum, all ASA 3–5 patients and those undergoing high risk surgery should have their expected risk of morbidity and mortality estimated and documented prior to an intervention, with adjustments made in accordance with national guidelines in planning the urgency of care, seniority of staff involved and postoperative care.

2.4.6 Each hospital should have agreed written preoperative policies or guidelines, following national guidelines where available, including but not limited to:

- preoperative tests and investigations
- preoperative ordering for potential blood transfusion

- preoperative fasting schedules and the administration of preoperative carbohydrate drinks
- default to day surgery for suitable procedures
- optimisation and continuation/ cessation of regular medication, including on the day of surgery, and including adjustments to monitored dosage systems
- referral of patients from a nurse led clinic to anaesthetic staff for further review
- pregnancy testing prior to surgery
- breastfeeding guidelines

5.1.43 Preoperative risk stratification should inform the decision-making process for critical care admission.

7.1.5 Patients recovering from anaesthesia or all depths of sedation including mild sedation in a non-theatre environment should receive the same standard of care as that required in an operating theatre.

9.3.3 All units should be able to escalate care to an appropriate level; critical care support should be provided if required, regardless of location.

10.3.26 Neonates, infants and children who are likely to require critical care following an operation should undergo their surgery in a hospital/unit with a designated PICU or NICU.

HELPNOTE
Individualised risk assessment, e.g. using Surgical Outcome Risk Tool (SORT)-clinical judgement models as described by the RCoA-endorsed Preoperative assessment and optimisation for adult surgery guidance or PQIP individualised risk assessment: why and how guide, should be used.

Please refer to the guidance on establishing and delivering enhanced perioperative care services.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.2 Perioperative risk prediction*, *1.11 Perioperative neurocognitive disorders*, *3.7 Recovery discharge protocols*, *3.9 Unplanned critical care admission after elective work*, *4.11 Admission to HDU and ICU after emergency surgery*, *5.6 Pain relief after day surgery*, *7.9 Timely anaesthetic involvement in the care of high-risk and critically ill women*.

STANDARD

1.2.1.4 There are agreed local policies for preoperative preparation of patients.

EVIDENCE REQUIRED

A copy of the policy/policies should be provided, and staff should give verbal confirmation that they are fit for purpose and followed. Examples include fasting, preoperative tests and investigations and management of comorbidities. In children, similar policies should be provided including fasting and pregnancy testing in adolescents. Where there is specific support for patients to prepare for a procedure, details should be provided (e.g. 'Surgery Schools').

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.4.6 Each hospital should have agreed written preoperative policies or guidelines, following national guidelines where available, including but not limited to:

- preoperative tests and investigations
- preoperative ordering for potential blood transfusion
- preoperative fasting schedules and the administration of preoperative carbohydrate drinks
- default to day surgery for suitable procedures
- optimisation and continuation/ cessation of regular medication, including on the day of surgery, and including adjustments to monitored dosage systems
- referral of patients from a nurse led clinic to anaesthetic staff for further review
- pregnancy testing prior to surgery
- breastfeeding guidelines

2.4.7 Each hospital should have agreed protocols, following national guidance where available, including, but not limited to:

- management of anaemia including parenteral iron therapy to reduce the risk of allogenic blood transfusion
- antacid prophylaxis
- preoperative nutritional screening

2.4.12 Consideration should be given to the use of formal prehabilitation pathways as well as services for nutritional assessment, smoking cessation, alcohol / drug addiction services and psychological support.

2.4.17 Where inpatient care is necessary, an enhanced recovery pathway should be followed as this is now considered to provide optimum perioperative care. The preoperative service should ensure that patients are clear about their own responsibilities and expected length of stay to support enhanced

recovery pathways.

6.1.9 Protocols should be available to maximise the opportunity for patients with significant comorbidities (e.g. diabetes, morbid obesity, sleep apnoea) to be safely managed via a day case pathway. Preoperative assessment should be inclusive not exclusive.

10.5.21 There should be ready access to evidence-based guidelines that are appropriate for children on the following topics:

- management of pain, nausea and vomiting
- fluid fasting
- intravenous fluid management
- prevention of perioperative venous thromboembolism
- death of the child in theatre
- protocols for anaesthetic emergencies, including:
    - anaphylaxis
    - malignant hyperthermia
    - difficult airway management
    - airway obstruction
    - resuscitation
    - local anaesthetic toxicity
    - major haemorrhage
    - emergency paediatric tracheostomy management.

10.5.23 Guidance on pre-procedure pregnancy testing in female patients should be followed.

15.3.1 Risk stratification based on clinical history may help guide management. However, determination of a patient's functional capacity may be difficult if exercise tolerance is limited by peripheral vascular insufficiency, respiratory or other disease. Clinical guidelines should be developed for further investigation, referral, optimisation, and management according to local facilities and expertise.

15.3.2 To guide clinical decision-making, cardiopulmonary exercise testing should be considered for patients undergoing aortic surgery to establish functional capacity and the presence and severity of cardiopulmonary disease. Test results may also be helpful in guiding collaborative decision-making as to the most appropriate treatment option for patients.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.3 Prehabilitation before surgery*, *1.6 Preoperative fasting*, *1.7 Perioperative management: diabetes*, *1.9 Management of preoperative anaemia*, *1.11 Perioperative neurocognitive disorders*, *1.13 Enhanced recovery after surgery*, *2.5 Awareness under anaesthesia*, *3.6 Drinking, eating and mobilising after surgery*, *6.7 Cardioversion*, *11.4 Cancellation of surgery*.

CPOC has useful resources: SipTilSend | Centre for Perioperative Care

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use

and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.2.1.5 A process is in place to ensure that abnormal results of tests and investigations are flagged to the relevant person within a clinically appropriate timeframe.

EVIDENCE REQUIRED

Verbal or written confirmation that test results reach the right person should be provided as well as confirmation that staff are satisfied that information can be found if it is looked for. Staff should be able to describe a system by which lists can be amended or planned days and/or weeks before based on the results of investigations. Departments should be able to demonstrate that patients are listed, allowing enough time for abnormal results to be actioned.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

2.4.6 Each hospital should have agreed written preoperative policies or guidelines, following national guidelines where available, including but not limited to:

- preoperative tests and investigations
- preoperative ordering for potential blood transfusion
- preoperative fasting schedules and the administration of preoperative carbohydrate drinks
- default to day surgery for suitable procedures
- optimisation and continuation/ cessation of regular medication, including on the day of surgery, and including adjustments to monitored dosage systems
- referral of patients from a nurse led clinic to anaesthetic staff for further review
- pregnancy testing prior to surgery
- breastfeeding guidelines

2.4.7 Each hospital should have agreed protocols, following national guidance where available, including, but not limited to:

- management of anaemia including parenteral iron therapy to reduce the risk of allogenic blood transfusion
- antacid prophylaxis
- preoperative nutritional screening

2.4.8 The secondary care preoperative service should liaise closely with primary care, other secondary care professionals and commissioners to promote a 'fitness for referral' process in line with best practice.

2.4.9 Agreed internal referral pathways to other specialties should be in place for the minority of cases in which this may be required to expedite further investigation and patient optimisation. This should be done in close collaboration between the preoperative assessment lead and nominated representatives from appropriate specialties (e.g. cardiology, diabetes, renal, respiratory and geriatric medicine).

2.4.13 Documentation and communication of information on preoperative preparation are essential. Electronic systems should be considered to enable the capture and sharing of information, support risk identification and allow data to be collected and available for audit and research purposes.

2.4.15 A preoperative blood ordering schedule should be agreed with the local blood transfusion service for each procedure and appropriate system should be in place to facilitate timely provision of blood products.

2.4.16 Anticipated difficulty with anaesthesia should be brought to the attention of the anaesthetist as early as possible before surgery. This includes planned admission to a critical care unit, the potential need for special skills such as fibre optic intubation, obesity, complex pain problems, a known history of anaesthetic complications or patients with learning disabilities who may require additional resources or theatre time. Local groups such as critical care MDTs or high-risk MDTs could facilitate perioperative planning of patients where high risk is identified.

6.1.10 Appropriate investigation should be ordered at preassessment, according to a locally agreed protocol. A mechanism for review and interpretation of the results of tests ordered before the day of surgery should be in place.

HELPNOTE
This may be assessed in the classroom session where examples can be requested of how this works in practice.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.9 Management of preoperative anaemia*, *2.10 Think kidneys*, *4.4 Emergency anaesthesia for the elderly patient*, *11.4 Cancellation of surgery*.

STANDARD

1.2.1.6 A policy exists for the perioperative management (including regional anaesthesia) of patients receiving anticoagulant therapy.

EVIDENCE REQUIRED

A copy of the policy should be provided and verbal confirmation from staff that it is in use.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Policies, planning and governance

GPAS REFERENCES

2.1.15 The following policies covering the entire perioperative period should be held and easily accessible for the management of patients with additional clinical requirements including, but not limited to:

- patients with obesity
- obstructive sleep apnoea
- allergies, including perioperative management of latex and chlorhexidine allergies
- management of complex cardiovascular disease including patients with cardiac pacemakers and implantable cardioversion defibrillators
- management of significant respiratory impairment including severe chronic obstructive pulmonary disease
- blood/component management for patients who refuse transfusion of blood or blood components
- thromboprophylaxis including the management of patients receiving any anticoagulant therapy
- diabetes management
- patients with sickle cell disease.

2.4.6 Each hospital should have agreed written preoperative policies or guidelines, following national guidelines where available, including but not limited to:

- preoperative tests and investigations
- preoperative ordering for potential blood transfusion
- preoperative fasting schedules and the administration of preoperative carbohydrate drinks
- default to day surgery for suitable procedures
- optimisation and continuation/ cessation of regular medication, including on the day of surgery, and including adjustments to monitored dosage systems
- referral of patients from a nurse led clinic to anaesthetic staff for further review
- pregnancy testing prior to surgery
- breastfeeding guidelines

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.9 Management of preoperative anaemia.*

STANDARD

1.2.1.7 Where appropriate, anaesthetists contribute to MDT discussions within relevant patient pathways.

EVIDENCE REQUIRED

Mechanisms for input to MDT meetings. Anaesthetists who are required to attend MDT meetings confirm that this is recognised in their job plans. Local clinical pathway/policies show evidence of multidisciplinary input where appropriate. Evidence of shared learning from relevant specialty M&M and audit meetings.

PRIORITY

2

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Management & leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

14.5.8 Hospitals should have systems in place to facilitate multidisciplinary meetings for neuroscience services.

15.5.4 Programmed time should be available in job plans to support appropriate attendance at multidisciplinary team meetings and preoperative assessment clinics.

15.5.5 Participation in morbidity and mortality and governance meetings, and participation in audit and development of local protocols, should be supported in the job plans.

15.7.1 All departments undertaking major vascular surgical cases should organise regular multidisciplinary audit meetings with vascular surgeons and radiologists. These should occur in addition to departmental clinical governance meetings. Regular audit or evaluation of the following aspects of vascular patient care may include:

- survival of and complications in patients undergoing surgery, including review of unexpected outcomes
- survival in patients treated non-surgically, e.g. abdominal aortic aneurysm including cause of death, where appropriate
- compliance with recommended national guidance timeframes, e.g. VSQIP, including reasons for delay or cancellations of major elective cases
- techniques and quality of perioperative pain management for elective and emergency cases
- utilisation of intraoperative blood conservation strategies and impact on blood component usage
- impact of MDT process on clinical decision-making in patient management
- patient-reported outcome and experience measures with the vascular service.

15.7.2 It is recommended that individual vascular anaesthetists register with, and contribute to, the UK national audit database (National Vascular Registry), which incorporates a section dedicated to 'anaesthesia' as developed between the Vascular Anaesthesia Society of Great Britain and Ireland and partnership organisations. The systems needed to provide the necessary data should be available and supported.

18.1.3 The complexity of some procedures may necessitate anaesthetic involvement in multidisciplinary team meetings and this activity should be reflected in job plans.

18.3.5 Specialist anaesthetists should be involved in the discussion of referrals and planning when conducted in the setting of a multidisciplinary team. This involvement should be recognised in job plans. Anaesthesia for complex adult congenital heart procedures should be undertaken by suitably trained adult congenital anaesthetists. Appropriate support from ACHD cardiologists and other cardiologists with suitable expertise in ACHD is necessary.

18.3.14 A multidisciplinary team should agree and document plans for the peripartum management of patients with known congenital or acquired cardiac disease in advance. Staff and facilities should be available for monitored or operative delivery, and for managing acute decompensation.

18.5.2 There should be a forum for discussion of matters relevant to both surgeons and anaesthetists, for example protocol development and critical incidents.

18.5.5 Hospitals should have systems in place to facilitate multidisciplinary meetings for discussion of high-risk and complex cardiac procedures to allow for adequate planning of service provision.

18.7.4 All cardiac units should have regular multidisciplinary morbidity and mortality meetings. These should have a list of patients to discuss in advance, an attendance register, and minutes with learning points. Consultant or autonomously practising anaesthetists should attend these meetings and, where possible, inclusion in job plans should be considered. Trainees should be encouraged to attend during their attachments.

19.1.3 The complexity of some procedures necessitates anaesthetic involvement in multidisciplinary team meetings and this activity should be reflected in job plans.

19.3.10 Where thoracic surgery is scheduled to occur immediately after Caesarean section, there should be early involvement of obstetricians, specialist obstetric anaesthetists, neonatal paediatricians and midwifery services.

19.5.5 Hospitals should have systems in place to facilitate multidisciplinary meetings for thoracic services.

19.5.2 There should be a forum for discussion of matters relevant to both surgeons and anaesthetists, for example protocol development and critical incidents.

19.7.3 All thoracic units should have regular morbidity and mortality meetings. These meetings should be provided with a list of patients to discuss in advance, an attendance register, and minutes with learning points. Consultants or autonomously practising anaesthetists should attend these meetings and they should be included in job plans. Trainees should be encouraged to attend during their attachments.

STANDARD

1.2.1.8 Guidelines are in place for the prevention and management of postoperative cognitive dysfunction and postoperative delirium.

EVIDENCE REQUIRED

Copy of guidelines provided. Verbal confirmation from staff that guidelines are followed.

PRIORITY

2

CQC KLoEs

Safe, Effective, Responsive, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

2.12.15 Children have an increased incidence of postoperative delirium. Recovery staff should have an increased awareness and there should be local protocols for the management of this condition.

2.12.28 Multidisciplinary care improves outcomes. Protocol driven integrated pathways guide care effectively, but should be individualised to suit each patient, with emphasis on management of postoperative pain and avoidance of postoperative delirium.

2.12.35 The risk of postoperative functional decline and complex discharge related issues should be considered. Procedures should be in place to identify complex patients at pre-assessment and complex discharge planning should begin then. This will require a multi-disciplinary team approach. Guidelines should be developed for the prevention, recognition and management of common postoperative geriatric complications and/or syndromes, including delirium, falls, functional decline and pressure area care.

HELPNOTE

CPOC has useful resources: Perioperative Care of People Living with Frailty | Centre for Perioperative Care, and information on postoperative delirium can be found here: Evidence-based strategies to reduce the incidence of postoperative delirium: a narrative review

The National Hip Fracture Database can be referenced: The National Hip Fracture Database

STANDARD

1.2.1.9 Policies are in place for the management of perioperative allergy, including referrals to allergy clinics where appropriate.

EVIDENCE REQUIRED

Copy of policy provided. The policy should include processes for patients who suffer suspected perioperative allergic reactions and pathways for patients who meet the criteria to be referred to a specialist allergy clinic for investigation. Clinical governance arrangements for suspected perioperative allergic reactions should be specified. Verbal confirmation from staff that policies are followed.

PRIORITY

2

CQC KLoEs

Safe, Effective, Responsive, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

2.1.15 The following policies covering the entire perioperative period should be held and easily accessible for the management of patients with additional clinical requirements including, but not limited to:

- patients with obesity
- obstructive sleep apnoea
- allergies, including perioperative management of latex and chlorhexidine allergies
- management of complex cardiovascular disease including patients with cardiac pacemakers and implantable cardioversion defibrillators
- management of significant respiratory impairment including severe chronic obstructive pulmonary disease
- blood/component management for patients who refuse transfusion of blood or blood components
- thromboprophylaxis including the management of patients receiving any anticoagulant therapy
- diabetes management
- patients with sickle cell disease.

2.4.1 Objective assessment of risk should be routine and the identification of increased risk should trigger advanced planning specific to that patient. Each hospital should have a consistent and where possible evidence based system in place to identify high risk surgical patients who require additional assessment. This assessment should be based on:

- age
- comorbidity
- medication history and allergy status
- type of surgery including risk of severe postsurgical pain

- dementia and cognitive dysfunction
- frailty
- nutritional status
- lifestyle factors (i.e. smoking behaviour, excess alcohol consumption, drug use, obesity)
- psychological factors and anxiety
- functional status
- chronic pain.

2.4.9 Agreed internal referral pathways to other specialties should be in place for the minority of cases in which this may be required to expedite further investigation and patient optimisation. This should be done in close collaboration between the preoperative assessment lead and nominated representatives from appropriate specialties (e.g. cardiology, diabetes, renal, respiratory and geriatric medicine).

2.4.16 Anticipated difficulty with anaesthesia should be brought to the attention of the anaesthetist as early as possible before surgery. This includes planned admission to a critical care unit, the potential need for special skills such as fibre optic intubation, obesity, complex pain problems, a known history of anaesthetic complications or patients with learning disabilities who may require additional resources or theatre time. Local groups such as critical care MDTs or high risk MDTs could facilitate perioperative planning of patients where high risk is identified.

2.8.11 The following policies should be immediately and reliably available at sites where anaesthesia and sedation are provided:
- guidelines for the checking of anaesthetic machines
- guidelines for the management of anaesthetic emergencies, including anaphylaxis, malignant hyperpyrexia and major haemorrhage
- periarrest and cardiac arrest algorithms
- difficult airway management, including the 'can't ventilate, can't oxygenate' scenario.

2.11.11 There should be an established policy to ensure clear communication of continuing requirements at discharge (e.g. analgesia) to include communication with primary care. This should include written information about common concerns (restarting medication, driving, etc.) and how to contact the hospital when required post discharge. Surgical teams will ordinarily be responsible for most of this process.

HELPNOTE
The 6th National Audit project: Anaesthesia, Surgery and Life-threatening allergic reactions provided tools to improvement perioperative allergy treatment, which are available here: https://www.rcoa.ac.uk/research/research-projects/national-audit-projects-naps/nap6-report-tools-publications

A chlorhexidine-free box should be provided for patients with known or suspected chlorhexidine allergy, containing products used in the department's local area and identify safe, viable alternatives. When looking for whether a product contains chlorhexidine, the initials CHG and CHX are both used.

The following resource can be used to consider which patients should be referred to allergy clinics: Perioperative-Allergy-Network-recommendations-on-referral_partner-logos-added.pdf

STANDARD

1.2.2.2 Staff have knowledge of national guidelines and trust/board policy on informed consent.

EVIDENCE REQUIRED

A copy of the trust/board policy and evidence of regular training should be provided. For staff taking consent for paediatric anaesthesia this should include practice guidance involving rights of the child, parental responsibility as applied to consent. Consent is taken by a trained person. All practitioners must follow the practices outlined in the GMC *Decision making and consent* guidance.

PRIORITY

1

CQC KLoEs

Effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

2.5.8 The Mental Capacity Act, Adults with Incapacity (Scotland) Act or the Mental Capacity Act (Northern Ireland) must be complied with. Staff should have regular training in the application of the Mental Capacity Act and have defined access to patient advocates. This is a rapidly changing area, and clinicians should have access to expert advice if required. All NHS trusts are now nationally mandated to have a named safe guarding lead for adults and this individual should be used as appropriate.

2.5.10 All practitioners must follow the practices outlined in the GMC *Decision making and consent* guidance. Documentation of the risks discussed or the dialogue leading to a decision is required in accordance with paragraphs 50–55. Equally, completion of a consent form is not a substitute for a meaningful dialogue tailored to the individual patient's needs.

2.5.11 Ideally, as part of shared decision making, consent for surgical and anaesthetic procedures should be obtained prior to the day of surgery, allowing sufficient time for the patient to reflect on their consent discussion. The competent patient has a fundamental right, under common law, to give, or to withhold, consent to examination, investigation and treatment.

10.9.9 Anaesthetists treating children and young people must ensure that they understand the requirements for consent in the part of the UK in which they are working

STANDARD

1.3.1.1 All patients, undergoing anaesthesia or sedation are seen by an anaesthetist after admission, prior to the procedure. Children should be seen with their parent(s)/carer(s).

EVIDENCE REQUIRED

Patient records should have evidence that patients have been seen. Staff should be able to give verbal confirmation that the assessment happens privately. Audit of patient and/or parental feedback and satisfaction.

PRIORITY

1

CQC KLoEs

Safe; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

2.6.1 Perioperative time should be allocated for the work the anaesthetist undertakes on the day of procedure for both pre and postoperative care. The time required for pre and postoperative care will vary and should be accounted for in individual job plans.

2.8.1 Following admission and prior to undergoing a procedure that requires general or regional anaesthesia, all patients should have a preoperative visit by an anaesthetist, ideally a person directly involved with the administration of the anaesthetic. This should be done to confirm earlier findings or, in the case of emergency admission, initiate preoperative anaesthetic assessment and care.

5.1.31 An anaesthetist, anaesthesia associate or advanced nurse practitioner should preoperatively assess all patients undergoing emergency surgery who require anaesthesia. Adequate time should be available for this assessment to occur as clinical urgency allows.

9.5.3 All pregnant women requiring caesarean birth should, except in an extreme emergency, be visited and assessed by an anaesthetist before arrival in the operating theatre. This should allow sufficient time to weigh up the information to give informed consent for anaesthesia.

STANDARD

1.3.1.2 A dedicated and appropriately trained anaesthetic assistant is present throughout the entire anaesthetic procedure, including sedation given by an anaesthetist.

EVIDENCE REQUIRED

A written policy should be provided, and verbal confirmation should be given that this is standard practice for anaesthetic procedures in all areas at all times (including out of hours and emergencies).

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

2.6.8 There should be a dedicated trained assistant (i.e. an ODP, anaesthetic nurse or equivalent) who holds a valid registration with the appropriate regulatory body, immediately available in every location in which anaesthesia care is being delivered, whether this is by an anaesthetist or an AA.

2.6.9 Staff assigned to the role of anaesthetic assistant should not have any other duties that would prevent them from providing dedicated assistance to the anaesthetist during anaesthesia.

7.1.4 A dedicated, appropriately trained anaesthetic assistant, who is familiar with that specific environment, should be available in all non-theatre environments where anaesthesia or deep sedation is undertaken by an anaesthetist.

9.1.24 Anaesthetic assistants who cover obstetrics should demonstrate additional knowledge and skills specific to the care of pregnant women.

10.1.9 When a child undergoes anaesthesia or an anaesthetic department provides sedation services, there should be a dedicated trained assistant (i.e. an operating department practitioner or equivalent) who has had paediatric experience and maintained their paediatric competencies.

STANDARD

1.3.1.3 The whole theatre team engage in the relevant sequential steps from the National Safety Standards for Invasive Procedures in any situation where anaesthesia or sedation is administered by an anaesthetist.

EVIDENCE REQUIRED

Verbal confirmation from staff. Records of annual audits should be provided including any action plans and recommendations to improve safety. All procedures should be compliant with the current National Safety Standards for Invasive Procedures. Staff should confirm adherence to "Prep stop block" protocol where appropriate.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

2.8.8 The theatre team should all engage in the use of the sequential steps from the National Safety Standards for Invasive Procedures commencing with a consent and procedural verification, and concluding the list with a team debrief or handover. Debrief should highlight things done well and also identify areas requiring improvement. Teams should consider including the declaration of emergency call procedures specific to the location as part of the team brief.

7.2.17 All procedures should be compliant with National Safety Standards for Invasive Procedures (NatSSIPs) and the Safe Surgery Checklist. An appropriate 'prelist check' of the anaesthesia systems, facilities, equipment, supplies and resuscitation equipment should be performed prior to the start of each list.

10.5.8 A WHO checklist should be completed before and during all procedures and investigations under anaesthesia and sedation, if provided by the anaesthetic department. A pre-procedure team safety brief should be undertaken as per the national safety standards for invasive procedures.

HELPNOTE

In every setting where anaesthesia or sedation is administered by an anaesthetist the current National Safety Standards for Invasive Procedures should be followed. The sequential standards or steps are, as they suggest, performed in sequence for every patient in their invasive procedure pathway. They form the basis of an 'enhanced local standard' WHO checklist or specialty specific checklists in some settings. Further details on 'the NatSSIPs 8' (2023) can be found here: The NatSSIPs Eight'.

Procedures that are performed in a dedicated area are suited to a specific checklist which is proportionate to the risks and processes in that area. Based on the risk within that specialty and procedure, particular checks may be more or less applicable.

To aid compliance with standard 1.1.1.1, names and contact details of the supervisor where necessary could be included in the team brief.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.1 WHO surgical checklist*, *4.4 Emergency anaesthesia for the elderly patient*, *6.2 Remote site anaesthesia*, *6.4 Sedation and anaesthesia in endoscopy*, *6.6 Anaesthesia and sedation in radiology*, *6.7 Cardioversion*, *6.8 Provision of anaesthesia in MRI*, *6.9 Provision of anaesthesia for cardiac catheterisation*.

STANDARD

1.3.1.4 Accurate, contemporaneous, clear and complete information about operating lists are published and any changes to lists are agreed and all relevant parties notified.

EVIDENCE REQUIRED

The process should be described and seen by the review team. Patient confidentiality should be observed where such information is displayed in an area where other patients, carers etc. may have access.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

2.8.4 Up to date, clear and complete information about operating lists should be available to the admissions area, theatre and recovery area. Operating lists should be made available to the anaesthetist before the list starts.

2.8.5 The language in all communications relating to the scheduling and listing of procedures should be unambiguous. Operating lists should include details of the patient's operation, date of birth, hospital identification number, any alerts and the ward in which they are located. Laterality should always be written in full (i.e. 'left' or 'right').

2.8.6 The whole operating team should agree to any change to a published operating list. This list should be rewritten or reprinted, including a date and time of the update and should be clearly identifiable as a changed list. Following a change in the theatre list, a further team brief should take place and the admissions area and recovery units should be informed.

HELPNOTE

If lists are printed, there ought to be ways of differentiating versions to ensure that only the latest copy is in use, and all other copies destroyed. Colour coding of versions could be used, for example.

STANDARD

1.3.1.5 Recommended standards of monitoring are met for each patient.

EVIDENCE REQUIRED

The anaesthetic record in use should contain all elements of the 2021 Association of Anaesthetists 'Recommendations for standards of monitoring during anaesthesia and recovery' dataset.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.4 The recommended standards of monitoring, by instrument or otherwise, should be met for every patient. All monitors should be fitted with audible alarms, with preset but adjustable limits. The following equipment should be available at all sites where anaesthesia is administered:

- oxygen analyser
- device to display airway pressure whenever positive pressure ventilation is used, with alarms that warn if the airway pressure is too high or too low
- vapour analyser whenever a volatile anaesthetic agent is in use
- capnography
- pulse oximeter
- non-invasive blood pressure monitor
- electrocardiograph
- a means of measuring the patient's body temperature
- a nerve stimulator when neuromuscular blocking drugs are used.

2.7.8 Some patients may require additional monitoring equipment. The following should be considered based on case mix and workload:

- invasive cardiovascular pressure monitoring
- Point of Care coagulation testing
- cardiac output monitors
- depth of anaesthesia monitoring.

5.3.19 The standards of monitoring provided in all locations where emergency procedures are performed, including non-theatre locations, should be the same as those provided in theatres. This includes temperature and end tidal CO_2 in recovery.

7.2.9 Equipment for the minimum standards of monitoring should be available at all sites where patients receive anaesthesia or sedation. For patients receiving conscious sedation, this should include pulse oximetry

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages, including:

- equipment for airway management and monitoring airway patency, including video laryngoscopy and capnography in an easily accessible

location. A standardised paediatric difficult airway trolley should be located in areas of the hospital where paediatric airway management is required including the operating theatres, emergency department and critical care units

- paediatric breathing systems
- invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- total intravenous anaesthesia (TIVA) pumps with paediatric algorithms
- ultrasound devices with a dedicated paediatric probe (for central venous and nerve identification
- equipment on the ward for recording weight and height.

HELPNOTE

Use of continuous monitoring (e.g. the transition from theatre to recovery) is part of the Association of Anaesthetists Recommendations for standards of monitoring during anaesthesia and recovery guidelines. If an airway device (supraglottic airway or tracheal tube) remains in place, this should include waveform capnography. Quantitative neuromuscular monitoring is a new addition to the 2021 version of the guidance. If this is not currently available, there should be a plan of equipment renewal to ensure that this is in place in the future, and it should be included on the trust risk register.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.2 Conduct of regional anaesthesia, 2.4 Anaesthetic record keeping, 2.6 Perioperative temperature management*, *2.8 Intravenous anaesthesia and target-controlled infusions, 3.4 Record keeping in recovery*, *6.5 Use of capnography outside operating theatres*, *7.8 Monitoring of obstetric patients in recovery and receiving enhanced maternity care*.

STANDARD

1.3.1.6 Current guidelines for the management of anaesthetic emergencies (including paediatric and obstetric) are appropriately displayed and immediately and reliably available in sites where anaesthesia and sedation are provided.

EVIDENCE REQUIRED

Copies of policies which are required for emergencies that may occur (based on the services being provided) should be appropriately displayed and immediately and reliably available and compatible with human factors use.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.8.11 The following policies should be immediately and reliably available at sites where anaesthesia and sedation are provided:

- guidelines for the checking of anaesthetic machines
- guidelines for the management of anaesthetic emergencies, including anaphylaxis, malignant hyperpyrexia and major haemorrhage
- periarrest and cardiac arrest algorithms

2.8.12 The following policies should be held and easily accessible for:

- WHO checklist, including time out
- 'Stop Before You Block'
- 'Do not attempt cardiopulmonary resuscitation'
- death in the operating theatre
- major incident procedures
- infection control (including antibiotic prophylaxis, staff protection and post exposure prophylaxis)
- prevention of hypothermia
- major haemorrhage
- blood and blood products administration
- handover and continuity of clinical care
- medicines management
- local anaesthetic toxicity
- perioperative care for breastfeeding mothers.

5.1.56 The following policies should be immediately and reliably available at sites where emergency anaesthesia and sedation are provided:

- management and running of the emergency theatre, including an escalation plan for emergency theatre capacity and staffing[5]
- management of anaesthetic emergencies, including guidelines for children
- difficult airway management, including the 'can't ventilate, can't oxygenate' scenario, fasting times, preanaesthetic assessment of the airway, availability and maintenance of the equipment and training of staff
- major haemorrhage protocol, including clinical, laboratory and logistic responses
- blood transfusion policy, including transfusion for inter- and intrahospital transfers
- safe extubation of patients following emergency anaesthesia
- management of the deteriorating patient
- whom to call and what facilities can be used if two or more emergencies occur simultaneously
- a policy for the management of organ donation and retrieval
- a policy for managing delirium in the perioperative period
- a policy for the management of airborne and bloodborne infections.

10.5.21 There should be ready access to evidence-based guidelines that are appropriate for children on the following topics:

- management of pain, nausea and vomiting
- fluid fasting
- intravenous fluid management
- prevention of perioperative venous thromboembolism
- death of the child in theatre
- protocols for anaesthetic emergencies, including:
  - anaphylaxis
  - malignant hyperthermia
  - difficult airway management
  - airway obstruction
  - resuscitation
  - local anaesthetic toxicity
  - major haemorrhage
  - emergency paediatric tracheostomy management.

HELPNOTE

The Association of Anaesthetists Quick Reference Handbook would be considered an acceptable example. The department will need to demonstrate guidelines are readily accessible. The intranet may not be adequate unless reliable and immediately available.

The Obstetric Anaesthetists' Association Quick Reference Handbook for Obstetric Emergencies can be viewed here: https://www.oaa-anaes.ac.uk/oaa-quick-reference-handbook/qrh.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.8 Initial management of the adult patient with major trauma*, *6.1 Anaesthesia in the accident and emergency department*, *11.8 Anaphylaxis and the anaesthetist*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may

disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case. If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.3.1.7 Appropriate early warning score pathways are in use within the organisation for all patients including emergencies, obstetric patients, paediatric patients and acutely ill or deteriorating emergency surgical patients on a general surgical ward. This should include policies for early medical review and early escalation to the responsible consultant surgeon or equivalent.

EVIDENCE REQUIRED

Early warning scores, in accordance with NEWS2, should be visible on patient observation charts. Paediatric early warning scores should be visible on all age specific observation charts. Charts should be modified for the obstetric patient.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

5.1.44 All areas, including emergency departments, admitting acutely ill patients should have early warning pathways to ensure prompt recognition of a deteriorating patient to trigger an appropriate response. This should include policies for early medical review and early escalation to the responsible consultant surgeon or equivalent

9.3.2 An early warning score system, modified for use in obstetrics, with a graded response system should be used for all obstetric patients to aid early recognition and treatment of the acutely ill woman.

10.3.14 Paediatric early warning scores should be used to help identify the deteriorating or critically ill child.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.8 Monitoring of obstetric patients in recovery and receiving enhanced maternity care*.

STANDARD

1.3.2.1 Access to the following services is available within a clinically appropriate timeframe including out of hours: haematology, blood transfusion, biochemistry, blood gas analysis, radiology, electrocardiography and appropriate cardiopulmonary assessment.

EVIDENCE REQUIRED

Verbal confirmation of how services would be accessed during a procedure should be given and should be appropriate to the services provided by the hospital.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

2.7.12 As a minimum, services should be available for:

- blood transfusion
- radiological investigations
- haematology
- clinical pathology
- electrocardiography.

2.7.13 There should be equipment and facilities for near patient testing and laboratory blood tests and urine analysis.

2.7.14 Near patient testing for haemoglobin, blood gases, lactate, ketones and coagulation measurements should be considered, particularly in areas where major blood loss is likely. If near patient testing is not available, laboratory testing should be readily and promptly available.

5.1.64 Hospitals must have audited policies and procedures for the administration of blood and blood components that comply with standards set out by the National Blood Transfusion Committee. Hospitals should have systems in place to ensure that blood can be crossmatched, issued and supplied in a timely manner.

9.2.23 Echocardiography services should be available at all times in units that routinely deal with cardiac patients.

10.2.10 Blood transfusion and diagnostic services should meet the requirements of neonates, infants, and children. A massive transfusion protocol, including provision for children, should be in place.

14.2.12 Neuroradiology support should be available 24/7 for interpretation of neuroimaging.

14.2.14 Online imaging results from referring hospitals and within the neuroscience centre should be available locally, and consideration should be given to the provision of remote access for all consultants who provide cover to neuroanaesthesia out of hours.

14.5.1 Much of neurosurgery involves acute work with a high degree of urgency. The provision of associated services should recognise this need and inappropriate delay should not be allowed to occur as a result of lack of key personnel or facilities. Laboratory services, neuroradiology, availability of operating theatre time and sufficient Level 1–3 bed provision should all be organised to cope with these demands.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.9 Management of preoperative anaemia*, *2.10 Think kidneys*, *6.9 Provision of anaesthesia for cardiac catheterisation*.

STANDARD

1.4.1.1 After general or regional anaesthesia, or sedation, patients recover in a specially designated area, which meets Association of Anaesthetists and DH guidelines (e.g., oxygen, suction and monitoring).

EVIDENCE REQUIRED

The recovery area should be seen. Monitoring to include the provision for (and use of) waveform capnography when appropriate.

PRIORITY

1

CQC KLoEs

Safe; Responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.10.2 Operating theatre complexes require a dedicated recovery unit. This unit should be located in the operating theatre department and should be separate from the department's admission area. It should have a separate access for transfer of patients to the ward.

2.10.3 The size, design and facilities of the recovery unit must meet the Department of Health and Social Care guidelines.

2.10.5 Oxygen and suction should be present in every recovery bay and ideally delivered by pipeline.

2.10.12 Capnography, pulse oximetry and non-invasive blood pressure monitoring should be available until the patient is fully recovered from general anaesthesia. An electrocardiograph, nerve stimulator, thermometer and glucometer should also be readily available.

7.1.5 Patients recovering from anaesthesia or all depths of sedation including mild sedation in a non-theatre environment should receive the same standard of care as that required in an operating theatre.

9.1.26 Those requiring postoperative recovery care should receive the same standard of care as the non-obstetric postoperative population.

HELPNOTE

Department of Health guidelines on recovery areas are available in the Health Building Note HBN 26, which is available here: https://www.england.nhs.uk/estates/health-building-notes/

The Association of Anaesthetists' guidelines on immediate post-anaesthesia recovery are available here: https://anaesthetists.org/Home/Resources-

publications/Guidelines/Immediate-post-anaesthesia-recovery

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.1 Recovery room staffing and monitoring*, *6.5 Use of capnography outside operating theatres*, *7.8 Monitoring of obstetric patients in recovery and receiving enhanced maternity care*.

It should be exceptional practice that the recovery area is used for any patient other than post-operative.

STANDARD

1.4.1.2 There are policies for the management of acute pain and postoperative nausea and vomiting, including for those patients with special requirements.

EVIDENCE REQUIRED

A copy of the policies should be provided.

PRIORITY

1

CQC KLoEs

Caring; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.11.3 All institutions should have protocols and the necessary facilities for managing postoperative care and should review and update these regularly.

2.12.38 Multicomponent interventions which reduce the incidence of delirium in elderly patients undergoing surgery should be considered. These include early mobilisation, avoidance of dehydration and avoidance of delirium triggering medications.

2.12.39 Provisions should be made for the assessment and management of pain in older people, and more specifically in those with dementia.

10.5.21 There should be ready access to evidence-based guidelines that are appropriate for children on the following topics:

- management of pain, nausea and vomiting
- fluid fasting
- intravenous fluid management
- prevention of perioperative venous thromboembolism
- death of the child in theatre
- protocols for anaesthetic emergencies including:
    - anaphylaxis
    - malignant hyperthermia
    - difficult airway management
    - airway obstruction
    - resuscitation
    - local anaesthetic toxicity
    - major haemorrhage
    - emergency paediatric tracheostomy management

11.3.24 Specific arrangements and guidelines should be available, where applicable, for the care of subgroups of patients with additional complexities, including but not limited to:

- patients with acute exacerbations of chronic pain
- patients with opioid tolerance
- patients with multiple trauma or significant blunt chest wall trauma
- critically ill patients
- patients with significant organ dysfunction
- pregnant and breastfeeding patients
- older and/or frail patients
- patients with dementia
- patients with physical or learning disability
- patients with problem drug and alcohol use
- patients with coexisting mental health problemsD
- patients who do not speak English.

11.6.5 Analgesia guidelines, including those for specific analgesic techniques, should be widely disseminated and easily accessible.

11.6.7 Guidelines for the management of specific patient groups (as listed in recommendation 3.25) should be available.

HELPNOTE
Specific arrangements and guidelines should be available, where applicable, for the management of subgroups of vulnerable patients as listed in GPAS reference 11.3.24.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.14 Individualised perioperative pain management*, *3.3 Postop nausea and vomiting beyond recovery*, *5.6 Pain relief after day surgery, 7.7 Pain relief after caesarean section, 8.5 Postoperative vomiting in children*, *10.1 Assessment and documentation in acute pain management*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.14. The full references can be found here; https://fpm.ac.uk/sites/fpm/files/documents/2021-07/FPM-Core-Standards-2021_1.pdf

STANDARD

1.4.1.3 There is an agreed procedure for the removal of airway devices.

EVIDENCE REQUIRED

A written policy which includes reference to the use of waveform capnography.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.9.2 On occasions, patients may be handed over to the recovery practitioner with a supraglottic airway device in place. The person taking over direct clinical care of such a patient should be specifically trained in the management and safe removal of the airway device.

2.10.12 Capnography, pulse oximetry and non-invasive blood pressure monitoring should be available until the patient is fully recovered from general anaesthesia. An electrocardiograph, nerve stimulator, thermometer and glucometer should also be readily available.

HELPNOTE

Where removal of supraglottic airway devices is undertaken by non-anaesthetists, there is evidence of training, and an agreed SOP.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.1 Recovery room staffing and monitoring*, *3.7 Recovery discharge protocols*.

STANDARD

1.4.1.4 Patients who have had a tracheostomy are cared for by adequate levels of appropriately trained staff skilled in the care of the surgical airway.

EVIDENCE REQUIRED

A written policy should be provided. This should include reference to the staff who care for these patients and where.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

12.1.7 Patients who have had a recent tracheostomy or airway surgery returning to a general ward, should be cared for by adequate levels of nursing staff who are skilled in the care of the surgical airway and aware of the specific risks involved.

12.1.10 Nursing and theatre staff trained to manage patients with a tracheostomy should be available in recovery areas of hospitals.

12.4.5 All hospitals providing care to tracheostomy patients should have trained staff (medical and nursing) available to care for these patients. Training should be regularly updated.

STANDARD

1.4.2.1 The recovery room staff, including those working in obstetrics, are appropriately trained, and updated in all relevant aspects of postoperative care.

EVIDENCE REQUIRED

A written policy should be provided describing which members of staff, based on their qualifications, should be present in recovery for each of the procedures being undertaken.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

2.9.1 Patient care should be transferred to staff who have been specially trained in recovery procedures and reached locally or nationally agreed prescribed competencies, such as the UK National Core Competencies for Post-Anaesthesia Care 2013.

2.12.40 All staff managing patients in the postoperative period must be familiar with the arrangements determining mental capacity in the part of the UK in which they are working and pathways of care for patients with dementia.

9.1.26 Those requiring postoperative recovery care should receive the same standard of care as the non-obstetric postoperative population.

9.1.27 All staff caring for the obstetric population following anaesthesia should be familiar with the area for recovery of obstetric patients and be experienced in the use of the different early warning scoring systems for obstetric patients. They should have been trained to the same standard as for all recovery practitioners working in other areas of general surgical work, should maintain their skills through regular work on the theatre recovery unit and should have undergone a supernumerary preceptorship in this environment before undertaking unsupervised work.

11.4.2 All staff providing acute pain management should be trained to an adequate level. Specific skills should include:

- competency in pain assessment using locally agreed and standardised tools
- an awareness of all appropriate treatment options
- the ability to recognise and manage common side effects and other problems.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.1 Recovery room staffing and monitoring*.

STANDARD

1.4.2.2 All recovery staff should be trained to an appropriate level in life support and maintain their competencies.

EVIDENCE REQUIRED

Evidence such as training records to show all recovery staff maintain competency equivalent to at least ILS should be provided. Arrangements to ensure that at least one advanced life support provider or an anaesthetist is always immediately available should be described.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

2.13.15 Members of clinical staff working within the recovery area should be certified to a standard equivalent to immediate life support providers, and training should be provided.

2.13.16 At all times, an anaesthetist or at least one other advanced life support provider should be immediately available.

2.13.17 For children, a staff member with an advanced paediatric life support qualification or an anaesthetist with paediatric competencies should be immediately available.

HELPNOTE

Your own internal training rather than an external course would suffice as 'equivalent' to ILS if the content is considered satisfactory by the trust resuscitation training officer.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.1 Recovery room staffing and monitoring*, *7.8 Monitoring of obstetric patients in recovery and receiving enhanced maternity care*.

Note 5: On terminology, unless otherwise specified, immediately means within five minutes.

STANDARD

1.4.2.3 Until patients can maintain their airway, breathing and circulation they are cared for on a one-to-one basis by an appropriately trained member of staff, with an additional member of staff available at all times.

EVIDENCE REQUIRED

Verbal confirmation that this is met for 100 per cent of anaesthetic procedures should be given, along with a named consultant anaesthetist or autonomously practising anaesthetist or intensivist who is responsible for the patient.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.9.6 The patient's anaesthetist should retain overall responsibility for the patient during the recovery period and should be readily available for consultation until the patient is able to maintain their own airway, has regained respiratory and cardiovascular stability and is able to communicate, unless this care has been handed over to another named anaesthetist. Where the patient's anaesthetist is not the named consultant or other autonomously practising anaesthetist for that patient (e.g. out of hours, when the consultant or other autonomously practising anaesthetist is non-resident or distantly supervising a trainee), the consultant or other autonomously practising anaesthetist should be immediately contactable for advice and guidance at all times, but the resident anaesthetist maintains immediate responsibility for postoperative care of the patient.

2.9.7 The care of an individual patient should be delivered on a one-to-one basis until the patient is able to maintain their own airway, has respiratory and cardiovascular stability and is able to communicate appropriately. All recovery units should be staffed to a level that allows this to be routine practice and the recovery staff should not have any other duties during this time.

2.9.8 A minimum of two members of staff should be present (of whom at least one should be a registered practitioner) when there is a patient in the recovery unit who does not fulfil the criteria for discharge to the ward. If this level of staffing cannot be assured, an anaesthetist should stay with the patient until satisfied that the patient fulfils discharge criteria.

5.2.15 Whenever emergency surgery is undertaken, the recovery unit should be open continuously and adequately staffed. Until patients can maintain their own airway, breathing and circulation, they should be cared for on a one-to-one basis, with an additional member of staff available at all times.

STANDARD

1.4.2.4 Critically ill patients in the recovery area are cared for by appropriately trained staff and have appropriate monitoring and support.

EVIDENCE REQUIRED

A written policy and training records should be provided.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

2.12.54 Critically ill patients should only be held in the recovery area because of a lack of availability of appropriate facilities elsewhere if recovery staff are appropriately trained, and the recovery unit is appropriately equipped to enable monitoring and treatment to the standard of a level 3 intensive care unit (ICU). In some circumstances, such as a viral pandemic or a major incident involving mass casualties, this may not be possible because of a huge surge in demand. This situation should be seen as exceptional rather than the accepted norm. Non-critical transfer to another hospital should be considered where necessary. It cannot be assumed that it is safe to use the recovery facility as an extension of ICU, and local policies and procedures should govern this issue.

2.12.55 Where postoperative care is delivered outside of a main ICU (e.g. a level 2 high dependency unit (HDU) or specifically developed PACU), nurse-led, protocol driven care of frequently occurring problems for high risk surgical patients (such as pain, fluid imbalance, nutrition and mild cardiorespiratory compromise) can ensure good patient outcomes. Protocols and policies should be agreed between nursing staff, critical care, surgeons and anaesthetists.

2.12.56 Where the postoperative destination is not a main ICU (e.g. a level 2 HDU or specifically developed PACU), the patient should remain in PACU until they are stable and are no longer likely to require immediate support from an anaesthetist. This is of particular importance when transferring patients from recovery to level 2 critical care units that are not staffed by doctors skilled in airway management.

2.12.57 All hospitals should have a clear policy describing the safe triage of surgical patients considered to require postoperative critical care, with guidance on which patients should be admitted immediately to ICU, and which can wait in a standard recovery area for a short period while an ICU bed becomes available. Staff in critical care and recovery units should develop procedures to ensure safe and effective patient care during this transition. While the patient remains in the recovery unit, their care should be the primary responsibility of the staff and doctors working in that location.

14.1.14 Where departments use post-anaesthetic recovery units for extended recovery, the post-anaesthetic recovery staff caring for those patients should have a registered nurse or operating department practitioner: patient ratio of 1:2, as in a level 2 critical care unit. However, the care of an individual patient should be delivered on a one to one basis until the patient is able to maintain their own airway, has respiratory and cardiovascular stability and is able to communicate (where applicable). Departments should have procedures in place to demonstrate the adequacy of medical cover for such extended recovery units.

HELPNOTE

The remit of this standard is the ad hoc care of critically ill patients in the recovery area due to short term pressures on ICU.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.1 Recovery room staffing and monitoring*, *4.7 Transfer of the critically ill patient*, *7.8 Monitoring of obstetric patients in recovery and receiving enhanced maternity care*.

STANDARD

1.4.3.1 Where day surgery is provided in a standalone unit, there is a recognised process for the referral of day case patients requiring inpatient admission.

EVIDENCE REQUIRED

A written policy should be provided for adults and children.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

6.1.19 There should be agreed protocols for the management of patients who require unplanned hospital admission following their daycase procedure.

6.5.41 Where day surgery is performed in isolated units, practice should comply with the RCoA guidelines on anaesthetic services in remote sites.

7.2.6 Transfer of a patient from the procedure room to other areas within the institution should be possible to arrange if necessary.

7.4.5 In remote offsite locations, such as psychiatric hospitals where anaesthesia is provided for ECT, advanced plans should be made to manage patient transfer if required.

HELPNOTE

This refers specifically to escalation of care in day surgery, e.g. when the patient subsequently requires an overnight stay.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.9 Unplanned critical care admission after elective work*, *5.1 Optimising your daycase rates*, *5.5 How effective is your daycase spinal service*, *5.7 The need for a carer at home after day surgery*, *5.8 Unplanned admission after day surgery*.

STANDARD

1.4.3.2 There is a recognised process for the referral of patients requiring critical care, including paediatric and obstetric patients, to an appropriate facility.

EVIDENCE REQUIRED

A written policy should be provided for adults and children.

PRIORITY

1

CQC KLoEs

Safe; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

2.12.57 All hospitals should have a clear policy describing the safe triage of surgical patients considered to require postoperative critical care, with guidance on which patients should be admitted immediately to ICU, and which can wait in a standard recovery area for a short period while an ICU bed becomes available. Staff in critical care and recovery units should develop procedures to ensure safe and effective patient care during this transition. While the patient remains in the recovery unit, their care should be the primary responsibility of the staff and doctors working in that location.

9.3.3 All units should be able to escalate care to an appropriate level; critical care support should be provided if required, regardless of location.

9.3.4 Whenever possible, escalation in care should not lead to the separation of mother and baby. When separation is unavoidable, the duration should be minimised.

10.5.20 In hospitals with no onsite paediatric high-dependency and critical-care facilities, there should be the facilities and expertise to initiate critical care prior to transfer/retrieval to a designated regional PICU/high-dependency facility. This may involve short-term use of adult/general intensive care facilities and clear pathways of communication and referral.

HELPNOTE

This refers specifically to unplanned intensive care admissions following surgery.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.9 Unplanned critical care admission after elective work*, *4.7 Transfer of the critically ill patient*, *6.1 Anaesthesia in the accident and emergency department*.

STANDARD

1.4.4.1 There are agreed criteria for discharge from recovery. After these criteria have been met, an appropriately trained member of staff accompanies patients during transfer.

EVIDENCE REQUIRED

A written policy should be provided for adults and children.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

2.11.5 Patients should be transferred to the ward, the postoperative care environment or the critical care unit accompanied by two members of staff, at least one of whom should be suitably trained to locally agreed standards. The anaesthetic record, recovery and prescription charts together with the postoperative plan, should accompany the patient and be clearly communicated to the receiving ward nurse.

HELPNOTE

Where patients are discharged home directly from recovery after a general anaesthetic they should be accompanied by a competent adult carer. A checklist is useful to demonstrate discharge criteria.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *3.6 Drinking, eating and mobilising after surgery*, *3.7 Recovery discharge protocols*, *4.7 Transfer of the critically ill patient*.

STANDARD

1.4.4.2 Appropriate pathways and systems are in place for the post procedural review of patients

EVIDENCE REQUIRED

Members of the MDT can relay the pathway for post procedural review for different groups of patients, including how patients are reviewed up until the point of discharge from anaesthetic care. How this information is shared with new staff members should be relayed. Discharge criteria for both adults and children should be seen. Audit data may be useful to demonstrate compliance with this standard.

PRIORITY

1

CQC KLoEs

Safe; responsive; caring.

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

2.9.6 The patient's anaesthetist should retain overall responsibility for the patient during the recovery period and should be readily available for consultation until the patient is able to maintain their own airway, has regained respiratory and cardiovascular stability and is able to communicate, unless this care has been handed over to another named anaesthetist. Where the patient's anaesthetist is not the named consultant or other autonomously practising anaesthetist for that patient (e.g. out of hours, when the consultant or other autonomously practising anaesthetist is non-resident or distantly supervising a trainee), the consultant or other autonomously practising anaesthetist should be immediately contactable for advice and guidance at all times, but the resident anaesthetist maintains immediate responsibility for postoperative care of the patient.

9.5.5 All women who have received an anaesthetic intervention for labour and/or delivery should be reviewed postnatally. Locally agreed discharge criteria should be met before they go home and written information should be provided.

12.8.1 As part of a difficult airway follow-up, patients should be informed in writing about any significant airway problem encountered, and be advised to bring it to the attention of anaesthetists during any future preoperative assessment.

HELPNOTE

What constitutes an appropriate review will depend on the patient, type of surgery and surgical location. In some circumstances, an appropriate review may be carried out by a member of the MDT rather than directly by an anaesthetist e.g. pain nurse, critical care team. All members of the team should be aware of departmental responsibilities and arrangements for post procedural review.

Post procedural review should be used for quality improvement and as a learning opportunity for anaesthetists. Data from post procedural reviews can provide supporting evidence to standard 4.2.3.1.

Patients should be informed about any significant airway problem encountered, and be advised to bring it to the attention of anaesthetists during any future preoperative assessments. The Difficult Airway Society (DAS) has a national registry to allow clinicians to access details of previous difficult airway episodes in patients issued with a difficult airway card. Further information on this can be found here: DAS Difficult Airway Registry - Difficult Airway Society

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.5 Awareness under anaesthesia*, *3.5 Postoperative visiting*, *3.6 Drinking, eating and mobilising after surgery*, *3.7 Recovery discharge protocols*, *5.7 The need for a carer at home after day surgery*, *7.7 Pain relief after caesarean section*, *10.1 Assessment and documentation in acute pain management*.

STANDARD

1.4.5.1 Methods of postoperative pain management are recorded and discussed with the patient, and information given to the patient.

EVIDENCE REQUIRED

This should be recorded on the anaesthetic record. When opioids are prescribed, this must include guidance on opioid management such as a step down analgesic plan, how further supplies of medicine can be obtained, the need to avoid harm from long term strong opioid use and clear advice on the impact of analgesics on driving. Written evidence that it is covered in staff induction should be given.

PRIORITY

1

CQC KLoEs

Caring

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; impact on patients, service users, carers and families

GPAS REFERENCES

2.5.1 All patients undergoing elective procedures should be provided, prior to admission with information on their intended treatment pathway (day surgery or enhanced recovery) that is easy to understand. This should include information on the operation, anaesthesia, recovery and postoperative pain relief. Provision of this information should be documented in the patient's notes. The written and verbal information given to patients before their admission to hospital should explain the purpose and nature of their recovery and the recovery department. The Fitter Better Sooner resources published by the Royal College of Anaesthetists and the 'You and your anaesthetic' leaflet, published by the Royal College of Anaesthetists and the Association of Anaesthetists are examples.

6.1.18 Locally agreed policies should be in place for the management of postoperative pain after day surgery. This should include pain scoring systems in recovery and a supply of pain relief medication on discharge, with written and verbal instructions on how to take medications and what to take when the medications have finished. Information on over-the-counter analgesics to have at home should be given at preoperative assessment.

6.1.20 Patients may be discharged home with residual sensory or motor effects after peripheral nerve or plexus blocks (not after neuraxial anaesthesia). Duration of the effects should be explained, and the patient should receive written instructions as to how to care for their numb limb until normal sensation returns.

10.9.4 Information provided postoperatively should include the safe use of analgesia after surgery and discharge from hospital, and what to do and who to contact in the event of a problem or concern. This should include telephone numbers where advice may be sought 24 hours a day.

11.3.9 Responsible opioid stewardship should be practiced as described by the Faculty of Pain Medicine Opioids Aware guidelines and Surgery and Opioid: Best Practice Guidelines 2021. Patient information material about opioids should be available for patients.

11.7.1 Patient information should be available in a range of formats that take into account the information needs of patients with additional complexities as listed in recommendation 3.25 and they should be accessible electronically.

11.7.3 Leaflets should explain pain management after discharge, including a step-down analgesic plan and how further supplies of medicine can be obtained. Patient information should emphasise the need to avoid harm from long-term opioid use and should give clear advice on the impact of analgesics on driving, acknowledging the current Driver and Vehicle Licensing Agency guidance.

11.7.5 Patient education regarding expectation of pain and analgesia after surgery should be given to all patients in the preoperative period.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.4 Anaesthetic record keeping, 5.6 Pain relief after day surgery, 8.7 Postoperative pain management in children, 10.1 Assessment and documentation in acute pain management, 10.3 Non-medical prescribing for pain management*.

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.10, 3.6.11, 3.6.12 and 3.6.20. The full references can be found here: Core Standards for Pain Management Services in the UK.

STANDARD

1.4.5.3 Specialist pain management advice and intervention is available at all times including escalation plans.

EVIDENCE REQUIRED

Verbal confirmation should be given of arrangements for specialist pain management to be provided, including out of hours. Adult and paediatric guidelines should be available, such as those for multi-modal analgesia, and include use of age-appropriate pain tools. This should include functional pain scoring. Records should show regular pain scores being taken and audits of pain management should be provided.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; workforce management and support

GPAS REFERENCES

10.2.15 There should be a fully resourced children's inpatient pain service. The service should be delivered by an appropriately trained and experienced multidisciplinary team (MDT), with specific skills in children's pain management. The team may include clinical nurse specialists, anaesthetists, paediatricians, surgeons, pharmacists, child psychologists and physiotherapists. In hospitals with a smaller paediatric caseload, and non-complex surgical procedures children's inpatient pain management may be provided by the adult inpatient pain service liaising with the paediatric anaesthetic team. Detailed recommendations for pain management can be found in Chapter 11: Guidelines for the Provision of Anaesthesia Services for Inpatient Pain Management.

11.1.4 Adequate staffing and systems should be in place to provide timely pain management to all inpatients. Out of usual working hours, this may be delivered by appropriately trained IPS nursing staff or anaesthetic staff. A clear point of contact for expert advice should be available at all times.

11.1.5 Patients under the care of an IPS should be reviewed by the IPS regularly, with patients receiving epidural analgesia or other continuous local anaesthetic infusions being seen at least once daily (including weekends).

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.6 Major lower limb amputation*, *8.7 Postoperative pain management in children*, *13.6 Pain control in thoracic surgery*, *13.7 Acute pain management after cardiac surgery*.

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.8 and 3.6.9. The full references can be found here; https://fpm.ac.uk/sites/fpm/files/documents/2021-07/FPM-Core-Standards-2021_1.pdf

STANDARD

1.4.5.4 There is a dedicated, specialist pain service for inpatients, which also covers the needs of all patients within the hospital.

EVIDENCE REQUIRED

Verbal confirmation should be given of pain service and staffing, which should be appropriate for the surgical services provided. Audits of pain management and adult and paediatric guidelines available, such as those for multi-modal analgesia. Demonstrate use of age-appropriate pain tools. Records showing regular pain scores being taken.

PRIORITY

1

CQC KLoEs

Effective; well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

10.2.15 There should be a fully resourced children's inpatient pain service. The service should be delivered by an appropriately trained and experienced multidisciplinary team (MDT), with specific skills in children's pain management. The team may include clinical nurse specialists, anaesthetists, paediatricians, surgeons, pharmacists, child psychologists and physiotherapists. In hospitals with a smaller paediatric caseload, and non-complex surgical procedures children's inpatient pain management may be provided by the adult inpatient pain service liaising with the paediatric anaesthetic team. Detailed recommendations for pain management can be found in Chapter 11: Guidelines for the Provision of Anaesthesia Services for Inpatient Pain Management.

11.1.1 IPS should be staffed by multidisciplinary teams (MDTs) led by appropriately trained autonomously practising anaesthetists. The minimum training requirement for new appointments to IPS lead roles is stage 3 Special Interest Area Pain Medicine training.

11.1.6 Adequate numbers of clinical nurses in pain medicine should be available to fulfil the following roles within working hours:

- review of patients in pain with appropriate frequency to provide a safe and effective service
- provision of advice to ward staff and other healthcare teams regarding all aspects of pain management
- liaison with an appropriate pain medicine specialist to highlight clinical or systematic problems
- ensuring that systems are in place to support non specialist healthcare staff to safely and effectively manage acute pain overnight and at weekends if the IPS is not immediately available
- ensuring that systems are in place to support advance pain management techniques for acute pain management.

14.5.17 The 24/7 acute pain service should be available for neurosurgical patients and staff should be trained to address the specific needs of neurosurgical patients, such as those with impaired communication.

14.5.18 Pain is a useful outcome measure for audit. The utility of specific local and regional techniques for neurosurgical patients is established and pain teams should be aware of these techniques.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.7 Pain relief after caesarean section*, *8.7 Postoperative pain management in children*, *13.6 Pain control in thoracic surgery*, *13.7 Acute pain management after cardiac surgery*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.8, 3.6.15, .3.6.16, and 3.6.17. The full references can be found here; Core Standards for Pain Management Services in the UK.

STANDARD

1.5.1.1 There should be policies for 24/7 cover of emergency surgery appropriate to local demand, prioritisation of emergency cases according to clinical urgency, and seniority of clinical staff according to patient risk.

EVIDENCE REQUIRED

Copy of the local policy and the local arrangements should be verbally relayed by staff members. Audits of patient wait times and theatre activity should be provided including lists. An audit of emergency workload after 2200 is recommended to demonstrate arrangements meet demand requirements

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

5.1.14 Adequate emergency theatre time should be provided throughout the day to minimise delays and avoid emergency surgery being unnecessarily undertaken out of hours when the hospital may have reduced staffing to care for complex postoperative patients. Consideration should be given to staffing of additional evening (twilight) emergency sessions with autonomously practising anaesthetists.

5.1.19 Local systems should be in place to triage patients with surgical emergencies. NELA reports a proportion of patients for laparotomy arriving in theatre within three separate time frames (< 2 hours; 2–6 hours; 6–18 hours). The World Society of Emergency Surgery study group proposed a classification to triage patients for surgical emergencies. These timeframes could be used as a guide and adapted to design local triage systems.

5.1.21 There should be a locally agreed policy that explains prioritisation of non-elective cases according to clinical urgency.

16.2.11 There should be a flexible approach to trauma list planning and management to accommodate emergency cases that need priority treatment. There should be a system in place to alert the theatre team of the arrival of an unstable patient with major trauma. Appropriately trained staff and facilities should be available to receive these patients at short notice.

HELPNOTE

Audit of emergency workload after 2200h would be useful to demonstrate this.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.1 Risk assessment and preparation for emergency surgery*, *4.3 Emergency laparotomy*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up

to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

1.5.1.3 There is clear method of communication within the theatre team about the category of urgency of an emergency including emergency deliveries in obstetrics.

EVIDENCE REQUIRED

Verbal confirmation should be given and must include a process for multidisciplinary communication.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

5.1.21 There should be a locally agreed policy that explains prioritisation of non-elective cases according to clinical urgency.

5.1.24 The urgency of emergency cases should be clearly and unambiguously coded.

9.5.20 The anaesthetist should be informed about the category of urgency of caesarean birth and the indication for surgery at the earliest opportunity.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.1 Risk assessment and preparation for emergency surgery*, *4.3 Emergency laparotomy, 4.6 Major lower limb amputation*, *4.8 Initial management of the adult patient with major trauma*, *7.3 Response times for the provision of intrapartum analgesia and anaesthesia*, *7.6 Caesarean section anaesthesia: technique and failure rate*.

STANDARD

1.5.1.4 There is appropriate staffing to allow immediate stabilisation and transfer of emergency patients.

EVIDENCE REQUIRED

A written policy should be provided. Verbal confirmation should be given that staff know where appropriate help will come from in order to assist the movement of patients requiring urgent transfer either within the hospital (to scanning facilities or theatres) or another site if required.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

5.1.46 Staffing should be provided at a level such that emergency theatre activity and critical patient care are not compromised when intra and inter hospital transfers are undertaken.

5.1.48 Departments should have local guidelines for intrahospital transfers.

5.1.50 Transfers should be carried out by appropriately trained and competent staff. Arrangements should be in place for insurance (personal and medical indemnity), crash test compliant equipment, ambulance booking procedures, procedures for receiving patients, communication between medical teams and families, documentation, and procedures for repatriation of staff and equipment.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.7 Transfer of the critically ill patient*.

STANDARD

1.6.1.1 The specific needs of children are considered at all stages of perioperative care including in emergencies.

EVIDENCE REQUIRED

Evidence should include documentation of special considerations in patient notes and preassessment records, patient information and patient satisfaction audits. Arrangements for parent's/carer's accommodation should be described. Children undergoing anaesthesia and their families should be offered input from play specialists to help to prepare the child for anaesthesia.

PRIORITY

1

CQC KLoEs

Caring; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.12.1 The particular needs of children should be considered at all stages of perioperative care. Children should receive an appropriate preassessment from staff with appropriate paediatric experience.

2.12.4 Consideration should be given to appropriate strategies for recognising and managing anxiety of children particularly at induction e.g. play specialists, counselling, psychological support and anaesthetic training around managing preoperative anxiety.

2.12.9 Preoperative fasting should be minimised as much as possible, especially for infants and younger children.

6.5.1 The lower age limit for day surgery depends on the facilities and experience of staff and the medical condition of the infant and proposed surgery. Not less than 60 weeks post-conceptual age are not normally considered unless medically fit and the unit has the appropriate expertise. Risks should be discussed with parents and carers on an individual basis.

7.3.4 Irrespective of the site of care delivery (theatre or non-theatre), children should receive the same standard of anaesthetic care or sedation as applied to procedures performed in theatre.

10.2.19 Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a solution.

10.2.20 The appearance of the anaesthetic induction and recovery areas should take into account the emotional and physical needs of children.

10.2.21 Parents and carers should be allowed timely access to the recovery area or, if this is not feasible, children should be reunited with their parents or carers as soon as possible

HELPNOTE
The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *8.2 Premedication and anxiolysis in children*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.1.2 When children are admitted for surgery, there is access to a named paediatrician within a clinically appropriate timeframe.

EVIDENCE REQUIRED

Show clear arrangements/written guidance for access to a paediatrician proportionate to the service delivered.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

6.3.6 There should be access to a paediatrician. Where the DSU does not have inpatient paediatric services, robust arrangements should be in place for access to a paediatrician and transfer to a paediatric unit if necessary.

10.1.8 All paediatric patients undergoing anaesthesia should have immediate access to a consultant paediatrician either in person or via telephone/videocall.

HELPNOTE

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.1.3 When a child undergoes anaesthesia, all staff (operating department practitioners/assistants/anaesthetic nurses/recovery) involved in the care of that child have appropriate paediatric competencies and experience.

EVIDENCE REQUIRED

Evidence of staff experience, regular training, rotas or policy. A lead paediatric nurse should be directly involved with the organisation of the service and training of staff.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

10.1.6 In the period immediately after anaesthesia, the child should be managed in a recovery area, staffed on a one-to-one basis at least until the child can manage their own airway. The staff in this area should have paediatric experience and current paediatric competencies, including resuscitation. An extra member of staff in the recovery area can be extremely useful in the event of an emergency arising.

10.1.9 When a child undergoes anaesthesia or an anaesthetic department provides sedation services, there should be a dedicated trained assistant (i.e. an operating department practitioner or equivalent) who has had paediatric experience and maintained their paediatric competencies.

HELPNOTE

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.1.4 Particular provision is made for the care of children including anaesthetists, nurses and ODPs trained in paediatric resuscitation.

EVIDENCE REQUIRED

Verbal confirmation should be sought from staff groups, including those in the recovery area, including the qualifications of individuals in that area. Training records/confirmation from managers should be provided. All anaesthetists who provide elective or emergency care for infants, children or young adults should have advanced training in life support that covers their expected range of clinical practice and responsibilities.

PRIORITY

1

CQC KLoEs

Safe; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

10.1.6 In the period immediately after anaesthesia, the child should be managed in a recovery area, staffed on a one-to-one basis at least until the child can manage their own airway. The staff in this area should have paediatric experience and current paediatric competencies, including resuscitation. An extra member of staff in the recovery area can be extremely useful in the event of an emergency arising.

10.1.7 An additional member of staff with advanced training in life support for children should always be available to assist where required.

10.4.2 All anaesthetists who provide elective or emergency care for infants, children or young adults should have training in advanced life support that covers their expected range of clinical practice and responsibilities. These competencies should be maintained by annual training that are ideally multidisciplinary and scenario based

HELPNOTE

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.1.5 Children are separated from adult patients throughout their care pathway, including theatres, recovery, inpatient wards and day ward. These areas should be safe and where appropriate accessible to parents and carers.

EVIDENCE REQUIRED

Demonstrate separate pathway and environment – during 'walkabout' session at onsite ACSA review visit. Prioritisation on mixed lists.

PRIORITY

1

CQC KLoEs

Caring; effective; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

6.3.4 Infants, children and young people should, where possible, be managed in a dedicated paediatric unit, or have specific time allocated in a mixed adult/paediatric unit, where they are separated from adult patients.

10.2.19 Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a solution.

10.2.21 Parents and carers should be allowed timely access to the recovery area or, if this is not feasible, children should be reunited with their parents or carers as soon as possible.

HELPNOTE

The ideal is complete separation of adults and children in recovery using solid building construction while permitting immediate assistance and observation. In many situations this may not be possible and pragmatic solutions which achieve demonstrably acceptable results may be used.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.1.6 Services and facilities take into account the physical and emotional needs of adolescents where these are different from those of children and adults, including particular consideration of adolescents transitioning from paediatric to adult services.

EVIDENCE REQUIRED

The decision on the most appropriate pathway for adolescents should be made on an individual basis and take their preference into account. Demonstrate appropriate information on anaesthesia and surgery, provision of privacy and policy on consent.

PRIORITY

1

CQC KLoEs

Responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; partnerships and resources

GPAS REFERENCES

10.2.21 Services and facilities should take account of the specific needs of adolescents, where these are different from those of children and adults.

10.3.43 The decision on the most appropriate place for the treatment of a teenager or young person should be made on an individual basis, balancing the expertise of the clinician in the patient's condition against any effort to fully separate adult patients from teenagers. Local operating policies should be in place to support this decision.

10.3.44 Where treatment is carried out in facilities normally used by adult patients, such as obstetric units or for patients requiring electroconvulsive therapy treatment, guidelines should be in place for staff training and organisation of services.

10.3.45 Where children are transferring from paediatric to adult services there should be the opportunity to advise them about possible changes in anaesthesia management. Examples may include the use of sedation for some procedures that previously would have been managed with general anaesthesia, or the use of alternatives to topical anaesthesia.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *8.1 Preoperative information for children and their families*.

STANDARD

1.6.2.1 An anaesthetist participates in the multidisciplinary committee that formulates and reviews policies for children's surgical services.

EVIDENCE REQUIRED

Demonstrate committee overseeing services for children (minutes of meeting) and hospital engagement in regional network (agenda, minutes).

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

10.5.2 Non-specialist tertiary paediatric centres should have a multidisciplinary committee for paediatric care to formulate and review provision. This committee should involve anaesthetists, paediatricians, surgeons, emergency department representatives, senior children's nurses, managers and other professionals, such as paediatric pharmacists. In some hospitals, this will also include critical care physicians.

10.5.3 In non-specialist tertiary paediatric centres a multidisciplinary committee should be responsible for the overall management, governance and quality improvement of anaesthetic and surgical services for children and should report directly to the hospital board.

HELPNOTE

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.2.2 There is evidence of engagement with regional and supraregional paediatric (anaesthetic/surgical/critical care) networks, based on the complexity of procedure, age and comorbidity of children.

EVIDENCE REQUIRED

Local and regional network standards, care pathways and relevant policies including a policy clearly defining local surgical provision for children. Evidence of attendance at regional network meetings and use of regional guidelines or involvement in network audits.

PRIORITY

1

CQC KLoEs

Safe; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

10.3.13 Hospitals admitting children should be part of a fully funded critical care network.

10.5.13 Hospitals should engage with networks to develop agreed standard patient care pathways based on age, comorbidity and complexity of procedure, as well as clinical urgency. There should be multidirectional flow of patients within the care pathways as part of the ODN determined by patient needs to local service provision, staffing and geography.

10.5.14 The ODN and the hospitals within the network should work in partnership in providing a framework for CPD education and training, audit and standards for clinical care to meet the needs of individual clinicians within the network and the local service provision.

10.5.16 Surgical and anaesthetic ODNs should work with existing paediatric critically ill networks to ensure links between departments of paediatrics, surgery, anaesthesia and critical care in non-specialist paediatric tertiary centres and the corresponding specialist tertiary paediatric centres.

HELPNOTE

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.6.3.1 The specific needs of critically ill children, including transfer, are considered.

EVIDENCE REQUIRED

Paediatric early warning scores should be visible on all age specific observation charts. Verbal confirmation should be given as to whom would provide anaesthetic support to the multidisciplinary team caring for a critically ill child. The policy for interdisciplinary management should be submitted and verbally relayed and should include retrieval policy, where the critically ill child will be treated while awaiting retrieval or admission to PICU and contact with paediatricians. Network and local policies, evidence of multidisciplinary working, and a named lead anaesthetist should be provided.

PRIORITY

1

CQC KLoEs

Safe; responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; partnerships and resources

GPAS REFERENCES

10.3.14 Paediatric early warning scores should be used to help identify the deteriorating or critically ill child.

10.3.15 There should be local hospital protocols in place that are clear on the roles and responsibilities of the MDT in caring for the critically ill child. Individual hospitals will have different personnel providing anaesthetic support to these teams.

10.3.13 Hospitals admitting children should be part of a fully funded critical care network.

10.3.15 There should be local hospital protocols in place that are clear on the roles and responsibilities of the MDT in caring for the critically ill child. Individual hospitals will have different personnel providing anaesthetic support to these teams.

10.3.21 Hospitals without a suitable paediatric or neonatal intensive care bed should obtain the advice of the local PICU transport team as soon as possible during the management of the sick or critically injured child or young person.

10.3.25 In the event of unusual circumstances (e.g. pandemic flu) adult critical care units should have a contingency plan for longer periods of paediatric critical care delivery.

14.3.3 Paediatric and neuroscience centres should consider partnering to help each maintain expertise of the other area.

14.3.4 In a true emergency situation involving a child requiring urgent neurosurgery for a deteriorating condition admitted to an 'adult-only' neurosurgical service, the most appropriate surgeon, anaesthetist and intensivist available would be expected to provide lifesaving care, including emergency resuscitation and surgery.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.7 Transfer of the critically ill patient.*

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

1.7.1.1 There are multidisciplinary guidelines for care of the obstetric patient.

EVIDENCE REQUIRED

Multidisciplinary guidelines should be provided.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

9.2.42 Guidelines containing standards about the following subjects should be held and easily accessible:

- provision of information to patients
- conditions requiring antenatal referral to the anaesthetist
- antacid prophylaxis for labour and delivery and oral intake in labour
- regional analgesia for labour
- management of regional techniques in patients with coagulopathy or receiving thromboprophylaxis
- management of the complications of regional analgesia and anaesthesia, including:
    - management of failed or inadequate regional block
    - accidental dural puncture
    - post-dural puncture headache
    - prolonged neuroaxial block
    - epidural haematoma
    - management of severe local anaesthetic toxicity
    - management of high regional block
- intravenous opioid patient controlled anaesthesia (including remifentanil)
- caesarean section anaesthesia, including:
    - fasting and antacid prophylaxis before elective and emergency obstetric procedures
    - regional anaesthesia for caesarean section (emergency and elective)
    - general anaesthesia for caesarean section (including avoiding awareness under general anaesthesia)
    - management of difficult or failed intubation in obstetrics
    - management of failed regional anaesthesia, including pain during caesarean section
    - antibiotic and thromboprophylaxis for caesarean section
    - recovery following general and regional anaesthesia

    - post caesarean section analgesia
- care of the obstetric patient with an elevated BMI
- anaesthetic management of major obstetric haemorrhage
- anaesthetic management of pre-eclampsia and eclampsia
- modified obstetric early warning score use
- higher levels of care for the critically ill obstetric patient
- resuscitation of the pregnant patient
- intrauterine fetal resuscitation
- sickle cell disease
- anaesthesia for non-caesarean section obstetric procedures.
- escalation policy to summon support for the Duty Anaesthetist
- staffing and supervision

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.2 Anaesthetic care for women who are obese during pregnancy*, *7.7 Pain relief after caesarean section*.

STANDARD

1.7.1.3 Anaesthesia is represented as part of the planning of maternity services. This should include the lead obstetric anaesthetist, or a deputy, taking part in regular multidisciplinary 'labour ward forum' or equivalent meetings.

EVIDENCE REQUIRED

The names of the representatives should be given. Minutes of meetings and record of attendance should be provided.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

9.1.12 The lead obstetric anaesthetist should ensure representation of the anaesthetic department at multidisciplinary meetings for service planning and governance purposes, including labour ward forum, risk management groups and incident reviews.

9.5.24 If any major restructuring of the provision of local maternity services are planned, the lead obstetric anaesthetist should be involved in that process.

9.5.25 Anaesthesia should be represented on all committees responsible for maternity services (e.g. the maternity services liaison committee, delivery suite forum, obstetric multidisciplinary guidelines committee, obstetric risk management committee).

STANDARD

1.7.2.1 A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

EVIDENCE REQUIRED

The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. Maternity Incentive Scheme (MIS) or equivalent evidence and audits should also be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

9.1.1 To act as the duty anaesthetist without direct supervision from a consultant or autonomously practising anaesthetist, the duty anaesthetist should meet the basic training specifications and have attained the RCoA's Initial Assessment of Competence in Obstetric Anaesthesia.

9.1.2 There should be a duty anaesthetist immediately available for the obstetric unit 24/7. As their primary responsibility is to provide care to those in labour or who require medical or surgical interventions, ante or peripartum, the role should not include undertaking elective work during the duty period.

9.1.4 In units offering a 24-hour regional analgesia service, the duty anaesthetist should be resident on the hospital site where the regional analgesia is provided (not at a nearby hospital).

9.1.6 It is recognised that, in smaller units, the workload may not justify having an anaesthetist exclusively dedicated to the delivery unit. If the duty anaesthetist does have other responsibilities, these should be of a nature that would allow the activity to be immediately delayed or interrupted should obstetric work arise. Under these circumstances, the duty anaesthetist should be able to delegate care of their non-obstetric patient to be able to respond immediately to a request for care of obstetric patients. They would therefore, for example, not simultaneously be able to be a member of the on-call resuscitation team. If the duty anaesthetist covers general theatres, another anaesthetist should be ready to take over immediately should they be needed to care for obstetric patients.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.3 Response times for provision of intrapartum analgesia and anaesthesia*

Note 5: On terminology, unless otherwise specified, immediately means within five minutes.

STANDARD

1.7.2.2 Obstetric units have, as a minimum, a consultant or an autonomously practising anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed) and there are arrangements in place to cover leave.

EVIDENCE REQUIRED

A copy of the rota should be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

9.1.14 As a basic minimum for any obstetric unit, a consultant or other autonomously practising anaesthetist should be allocated to ensure senior cover for the full daytime working week; that is, ensuring that Monday to Friday morning and afternoon sessions (see Glossary), are staffed. This cover is to provide urgent and emergency care, not to undertake elective work.

9.1.15 In busier units, increased levels of consultant or other autonomously practising anaesthetist cover may be necessary and should reflect the level of consultant obstetrician staffing in the unit. This may involve extending the working day to include senior presence into the evening session and/or increasing numbers of autonomously practising anaesthetists.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.3 Response times for provision of intrapartum analgesia and anaesthesia*.

Note 5: On terminology, autonomously practising anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks.

STANDARD

1.7.2.3 A system is in place to ensure women requiring antenatal and postnatal anaesthetic referral are seen by an obstetric anaesthetist within an appropriate timeframe.

EVIDENCE REQUIRED

Verbal confirmation should be given that a system, which staff are satisfied allows enough time, is in place. Women who wish to discuss previous difficult experiences with obstetric anaesthesia and analgesia should be able to do so, even if events were some time in the past.

PRIORITY

1

CQC KLoEs

Safe; caring; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

9.1.16 Additional programmed activities for consultant or autonomously practising anaesthetists should be allocated for elective caesarean birth lists and antenatal anaesthetic clinics (or to review referrals if no formal clinic is in place). Time is required to identify and follow up potential anaesthetic morbidity and to arrange continuing investigation and referral.

9.5.1 A system should be in place to ensure that those requiring antenatal and postnatal anaesthetic referral are seen and assessed by a senior obstetric anaesthetist, usually an autonomously practising anaesthetist, within a suitable time frame. Where the workload is high, consideration should be given to risk stratification so that not all women are required to attend in person, by using targeted telemedicine and/or distribution of relevant literature.

HELPNOTE

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal follow-up must be available as per recommendations from the Ockenden review – https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.9 Timely anaesthetic involvement in the care of high-risk and critically ill women*.

Note 5: On terminology, autonomously practising anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks.

STANDARD

1.7.2.4 There is a named consultant anaesthetist or other autonomously practising anaesthetist or intensivist (dependent on location) responsible for all critically ill maternal patients.

EVIDENCE REQUIRED

Verbal confirmation that there is a system in place to make sure critically ill patients on a labour ward are cared for by a consultant or other autonomously practising anaesthetist/intensivist.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

9.3.6 There should be a named consultant or other autonomously practising anaesthetist and obstetrician responsible 24/7 for all women requiring a higher level of care.

HELPNOTE

If level two maternal critical care patients are managed on the labour ward, then the named doctor will be an anaesthetist. If they are managed in a general critical care area, then the named doctor may be an intensivist.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.8 Monitoring of obstetric patients in recovery and receiving enhanced maternity care*, *7.9 Timely anaesthetic involvement in the care of high-risk and critically ill women*, *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

Note 5: On terminology, autonomously practising anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks.

STANDARD

1.7.2.5 Any elective caesarean section lists should have dedicated obstetric, anaesthesia, theatre and midwifery staff.

EVIDENCE REQUIRED

A copy of rotas and lists showing dedicated theatre lists with a named consultant or autonomously practising anaesthetist with no other clinical commitment should be provided. An audit demonstrating minimal delays to elective procedures and rapidness of emergencies to support local arrangements.

PRIORITY

1

CQC KLoEs

Responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

9.1.18 There should be a named consultant or other autonomously practising anaesthetist responsible for every elective caesarean delivery list. This anaesthetist should be immediately available. The named person should have no other concurrent clinical responsibilities.

9.5.27 Units with high numbers of caesarean births should have specific lists to minimise disruption due to emergency work. Any elective caesarean delivery list should have dedicated obstetric, anaesthetic and theatre staff and should take place in a separate theatre to where emergency cases are undertaken.

HELPNOTE

The provision of emergency care and regional analgesia should not compromise the elective obstetric workload.

Note 5: On terminology, autonomously practising anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance frameworks.

STANDARD

1.7.2.6 The duty anaesthetist for obstetrics should participate in delivery suite ward rounds including multidisciplinary handovers.

EVIDENCE REQUIRED

A copy of the rota to demonstrate duty anaesthetist availability at a time when delivery suite ward rounds are taking place. Attendance records of ward rounds should also be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; quality improvement-focused leadership

GPAS REFERENCES

9.1.7 Adequate time for formal multidisciplinary team (MDT) handovers between shifts should be built into the timetable. In the case of the anaesthetist being otherwise engaged with work at the time of the MDT labour ward handover, a briefing from the midwifery and obstetric team should be sought at the earliest opportunity to facilitate a shared mental model of the existing workload/potential patients.

9.1.8 A structured tool should be considered for handover between shifts and its formal documentation.

9.1.9 The duty anaesthetist should participate in MDT delivery suite handovers and ward rounds.

STANDARD

1.7.2.7 Midwives trained to an agreed local standard in the management of regional analgesia are available before an obstetric epidural block is established. An appropriate number of midwives trained to an agreed standard are available for the case mix of patients with regional analgesia.

EVIDENCE REQUIRED

Staff working in obstetric anaesthesia should report that they are satisfied with local arrangements and that epidurals are not denied to patients due to the non-availability of trained staff. The local standard should be agreed with the anaesthetic department. Audit data may be useful to support staff assurances.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on staff; workforce management and support

GPAS REFERENCES

9.5.12 Midwifery care of a pregnant woman receiving regional analgesia in labour should comply with local guidelines that have been agreed with the anaesthetic department. Local guidelines should include required competencies, maintenance of those competencies and frequency of training. If the level of midwifery staffing is considered inadequate, regional analgesia should not be provided.

STANDARD

1.7.2.8 Where a remifentanil PCA service is provided then a midwife trained to an agreed local standard must provide continuous supervision of any woman using this form of labour analgesia, throughout the entire duration of use.

EVIDENCE REQUIRED

The policy should be provided and evidence of training. This should outline the appropriate staffing levels to meet patient need. Staff should give verbal confirmation that the policy is fit for purpose and followed.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

9.5.18 Units that provide remifentanil patient controlled anaesthesia for labour analgesia should have policies and processes in place to ensure that it is used safely, that midwives who care for women using it are familiar with its use and have received specific training. Unit staffing levels should permit continuous midwifery supervision of its use.

HELPNOTE

Where Remifentanil PCAs are not provided then this standard can be marked as 'not applicable'.

STANDARD

1.7.3.1 There is either a fully equipped obstetric theatre in the delivery suite or an adjacent theatre that is always available for this purpose.

EVIDENCE REQUIRED

Verbal confirmation of the plan of action if all theatres are occupied should be given. This should include knowledge of a policy allowing inclusion on an existing theatre list or use of the first available theatre.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

9.2.32 There should be at least one fully equipped obstetric theatre within the delivery suite or immediately adjacent to it. Appropriately trained staff should be available to allow emergency operative deliveries to be undertaken without delay. The number of operating theatres available for obstetric procedures will depend on the number of deliveries and the operative risk profile of the women delivering in the unit.

STANDARD

2.1.1.1 All anaesthetic equipment is checked before use according to the Association of Anaesthetists published guidelines and the checks are recorded.

EVIDENCE REQUIRED

A copy of documented checks should be provided.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.5 All anaesthetic equipment should be checked prior to use in accordance with the Association of Anaesthetists' published guidelines. Anaesthetic machine checks should be recorded in a log and on each patient's anaesthetic chart.

HELPNOTE

Example of evidence would be an audit of anaesthetic records showing a completion of checklist and any copies or examples of data. A completed machine self-check only covers part of the Association of Anaesthetists checklist, and this check should be recorded. It is the responsibility of the anaesthetist to make sure that these checks have been performed, and the anaesthetist must be satisfied that they have been carried out correctly.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.3 Management of the difficult airway*, *11.6 Training on, maintenance and purchase of anaesthetic equipment*.

STANDARD

2.1.1.2 Equipment must be available to administer oxygen to all patients undergoing procedures under sedation by an anaesthetist. There must be the facility to monitor continuous CO_2 output.

EVIDENCE REQUIRED

Equipment must be seen.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.3 Environments in which patients receive anaesthesia or sedation should have full facilities for resuscitation available, including a defibrillator, suction, oxygen, airway devices, an escalating plan of airway intervention equipment, including equipment required to manage a difficult airway and a means of providing ventilation.

7.2.11 The anaesthetist should ensure that an adequate supply of oxygen is available before starting any procedure. Many of the sites where anaesthesia is provided outside the main operating theatres do not have piped oxygen; if anaesthesia is provided frequently in such a location, the use of the location should be reviewed or piped oxygen provided.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.5 Use of capnography outside operating theatres*.

STANDARD

2.1.1.4 Where piped oxygen is not available, there is an adequate supply from cylinders which are checked regularly. Oxygen and air cylinders are stored separately.

EVIDENCE REQUIRED

Cylinders should be seen, and paper records of checks should be provided along with an operational policy for backup oxygen provision. Oxygen and air cylinders are seen to be stored separately in accordance with never event 15: Unintentional connection of a patient requiring oxygen to an air flowmeter.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.11 The anaesthetist should ensure that an adequate supply of oxygen is available before starting any procedure. Many of the sites where anaesthesia is provided outside the main operating theatres do not have piped oxygen; if anaesthesia is provided frequently in such a location, the use of the location should be reviewed, or piped oxygen provided.

7.2.12 Where piped oxygen is available, backup cylinders should always be available and appropriately stored.

STANDARD

2.1.1.5 Equipment for monitoring, including waveform capnography, ventilation of patients' lungs and resuscitation including defibrillation is available at all sites where patients are anaesthetised or sedated and on the delivery suite. In areas that treat children, this must include equipment specifically designed for children.

EVIDENCE REQUIRED

Bags, masks and waveform capnography should be seen, including in remote locations. Staff should be asked if they encounter any difficulties with equipment in any sites.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.7.1 Facilities for maintaining anaesthesia, monitoring, ventilation of patients' lungs and resuscitation, including defibrillation, should be available at all sites where patients are anaesthetised.

2.7.4 The recommended standards of monitoring, by instrument or otherwise, should be met for every patient. All monitors should be fitted with audible alarms, with preset but adjustable limits. The following equipment should be available at all sites where anaesthesia is administered:

- oxygen analyser
- device to display airway pressure whenever positive pressure ventilation is used, with alarms that warn if the airway pressure is too high or too low
- vapour analyser whenever a volatile anaesthetic agent is in use
- capnography
- pulse oximeter
- non-invasive blood pressure monitor
- electrocardiograph
- a means of measuring the patient's body temperature
- a nerve stimulator when neuromuscular blocking drugs are used.

2.7.8 Some patients may require additional monitoring equipment. The following should be considered based on case mix and workload: 114

- invasive cardiovascular pressure monitoring
- Point of Care coagulation testing
- cardiac output monitors
- depth of anaesthesia monitoring.

5.3.19 The standards of monitoring provided in all locations where emergency procedures are performed, including non-theatre locations, should be the same as those provided in theatres. This includes temperature and end tidal CO_2 in recovery.

6.4.15 Full resuscitation equipment and drugs should be provided as outlined by the Resuscitation Council UK and local policy. A cardiac arrest trolley and defibrillator should be provided in the first-stage recovery area.

7.2.9 Equipment for monitoring should be available at all sites where patients receive anaesthesia or sedation. For patients receiving conscious sedation, this should include pulse oximetry.

7.2.10 Continuous waveform capnography should be available for all patients undergoing general anaesthesia and moderate or deep sedation.

9.2.18 Resuscitation equipment as described by the Resuscitation Council UK should be available on the delivery suite and should be checked regularly. A resuscitative hysterotomy pack containing a scalpel, surgical gloves and cord clamp should be available on all resuscitation trolleys in the Maternity Unit and areas admitting pregnant women e.g. emergency departments. A range of sizes of endotracheal tubes of 7 mm internal diameter or less should also be kept on the resuscitation trolleys.

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages, including:

- equipment for airway management and monitoring airway patency, including video laryngoscopy and capnography in an easily accessible location. A standardised paediatric difficult airway trolley should be located in areas of the hospital where paediatric airway management is required including the operating theatres, emergency department and critical care units
- paediatric breathing systems
- invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- total intravenous anaesthesia (TIVA) pumps with paediatric algorithms
- ultrasound devices with a dedicated paediatric probe (for central venous and nerve identification
- equipment on the ward for recording weight and height.

HELPNOTE

Use of continuous monitoring (e.g. the transition from theatre to recovery) is part of the Association of Anaesthetists Recommendations for standards of monitoring during anaesthesia and recovery guidelines. If an airway device (supraglottic airway or tracheal tube) remains in place, this should include waveform capnography. Quantitative neuromuscular monitoring is a new addition to the 2021 version of the guidance. If this is not currently available, there should be a plan of equipment renewal to ensure that this is in place in the future and it should be included on the trust risk register.

Waveform capnography should be used to prevent unrecognised oesophageal intubation as described in 'Preventing unrecognised oesophageal intubation consensus guidelines'.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.3 Management of the difficult airway*, *8.3 Paediatric sedation*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

2.1.1.6 Equipment for external cardiac pacing is available.

EVIDENCE REQUIRED

Defibrillators should be checked to ensure they include pacing mode.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes
- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device.

STANDARD

2.1.1.7 Equipment to provide a full range of local and regional blocks is available.

EVIDENCE REQUIRED

Staff should be asked whether the range of equipment for local and regional blocks is sufficient based on the procedures they undertake for adults and children.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes
- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device.

2.7.7 All equipment used for regional anaesthesia and analgesia should have NRfit connections.

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages, including:

- equipment for airway management and monitoring airway patency, including video laryngoscopy and capnography in an easily accessible location. A standardised paediatric difficult airway trolley should be located in areas of the hospital where paediatric airway management is required including the operating theatres, emergency department and critical care units

- paediatric breathing systems
- invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- total intravenous anaesthesia (TIVA) pumps with paediatric algorithms
- ultrasound devices with a dedicated paediatric probe (for central venous and nerve identification
- equipment on the ward for recording weight and height.

HELPNOTE
The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *10.4 Managing epidural analgesia*

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

2.1.1.8 Ultrasound imaging equipment is available to assist with vascular access and regional anaesthesia, in all areas where this is required.

EVIDENCE REQUIRED

Verbal confirmation should be given for adults and children.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes
- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device

9.2.12 Ultrasound imaging equipment should be available to anaesthetists trained in its use for central vascular access and transversus abdominis plane blocks. Where staff have the relevant competencies, ultrasound may also be useful for other tasks.

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages, including:

- equipment for airway management and monitoring airway patency, including video laryngoscopy and capnography in an easily accessible location. A standardised paediatric difficult airway trolley should be located in areas of the hospital where paediatric airway management is required including the operating theatres, emergency department and critical care units
- paediatric breathing systems

- invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- total intravenous anaesthesia (TIVA) pumps with paediatric algorithms
- ultrasound devices with a dedicated paediatric probe (for central venous and nerve identification
- equipment on the ward for recording weight and height.

HELPNOTE
The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.6 Training on, maintenance and purchase of anaesthetic equipment*, *11.7 Availability of ultrasound equipment in anaesthetic areas*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

2.1.1.9 Devices for monitoring and maintaining or raising the temperature of the patient are available throughout the perioperative pathway including control of theatre temperature.

EVIDENCE REQUIRED

Devices, including those suitable for use on children, should be seen and need to be in working order so that they can be used intraoperatively.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.4 The recommended standards of monitoring, by instrument or otherwise, should be met for every patient.114 All monitors should be fitted with audible alarms, with preset but adjustable limits.114, The following equipment should be available at all sites where anaesthesia is administered:

- oxygen analyser
- device to display airway pressure whenever positive pressure ventilation is used, with alarms that warn if the airway pressure is too high or too low
- vapour analyser whenever a volatile anaesthetic agent is in use
- capnography
- pulse oximeter
- non-invasive blood pressure monitor
- electrocardiograph
- a means of measuring the patient's body temperature
- a nerve stimulator when neuromuscular blocking drugs are used.

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes

- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device.

9.2.9 Devices such as warming mattresses and forced air warmers should be available to prevent and treat hypothermia.

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages, including:

- equipment for airway management and monitoring airway patency, including video laryngoscopy and capnography in an easily accessible location. A standardised paediatric difficult airway trolley should be located in areas of the hospital where paediatric airway management is required including the operating theatres, emergency department and critical care units
- paediatric breathing systems
- invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- total intravenous anaesthesia (TIVA) pumps with paediatric algorithms
- ultrasound devices with a dedicated paediatric probe (for central venous and nerve identification
- equipment on the ward for recording weight and height.

10.2.6 Theatre temperature should be capable of regulation to at least 23°C, and up to 28°C where neonatal surgery is performed. There should be accurate thermostatic controls that permit rapid change in temperature.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.6 Perioperative temperature management*, *8.4 Perioperative temperature control in children*.

STANDARD

2.1.1.10 Equipment for fluid and blood warming, and where appropriate, rapid infusion is available.

EVIDENCE REQUIRED

Equipment should be seen for adults and children.

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high-risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes
- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device.

5.3.16 A rapid infuser allowing the infusion of warmed intravenous fluids and blood products should be available in the emergency theatre. Staff should undergo regular training in its use and they should be able to troubleshoot common problems.

9.2.6 A fluid warming device allowing rapid infusion of blood products and intravenous fluids should be immediately available to the delivery suite.

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages and includes:

- equipment for airway management and monitoring, including capnography and invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- TIVA pumps with paediatric algorithms
- ultrasound devices (for central venous and nerve identification)
- equipment for recording weight on the ward.

HELPNOTE
The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.10 Patient blood management in perioperative care*

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

2.1.1.11 There is standardised and specialised equipment for the management of difficult airways immediately available in every area where anaesthesia is given.

EVIDENCE REQUIRED

The airway rescue trolley should be seen and the equipment on it should be checked. It should have a standard layout that is identical to trolleys in other parts of the trust/board. All members of staff should be able to confirm its location for adults and children.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes
- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device.

9.2.10 A difficult intubation trolley with a variety of laryngoscopes including video laryngoscopes, tracheal tubes (size 7 and smaller), second-generation supraglottic airway devices, equipment for emergency front of neck and other aids for difficult airway management should be available in theatre. The difficult intubation trolley should have a standard layout that is identical to trolleys in other parts of the hospital so that users will find the same equipment and layout in all sites. The Obstetric Anaesthetists Association/Difficult Airway Society difficult and failed tracheal intubation algorithms should be

displayed.

10.2.1 Equipment should be available and maintained that is appropriate for use in neonates, infants and children of all sizes and ages, including:

- equipment for airway management and monitoring airway patency, including video laryngoscopy and capnography in an easily accessible location. A standardised paediatric difficult airway trolley should be located in areas of the hospital where paediatric airway management is required including the operating theatres, emergency department and critical care units
- paediatric breathing systems
- invasive haemodynamic monitoring
- pulse oximetry sensors and blood pressure cuffs
- vascular access equipment, including intraosseous needles
- devices to allow rapid and accurate fluid and drug delivery
- equipment for warming fluids
- patient warming devices
- equipment for measuring patient temperature
- total intravenous anaesthesia (TIVA) pumps with paediatric algorithms
- ultrasound devices with a dedicated paediatric probe (for central venous and nerve identification
- equipment on the ward for recording weight and height.

HELPNOTE
Ideally, there should be a difficult airway trolley available on every floor. There must be a robust process for obtaining assistance in remote sites.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.3 Management of the difficult airway*, *6.2 Remote site anaesthesia*, *7.5 Airway and intubation problems during obstetric general anaesthesia*, *11.6 Training on, maintenance and purchase of anaesthetic equipment*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

Note 5: On terminology, unless otherwise specified, immediately means within five minutes.

STANDARD

2.1.1.12 There should be a full range of equipment relating to the management of the anticipated difficult airway available within the theatre suite. This should include equipment for videolaryngoscopy, fibreoptic intubation, high-flow nasal oxygen therapy (HFNO).

EVIDENCE REQUIRED

Verbal confirmation should be provided, and the equipment should be seen.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

12.2.1 Many patients with intraoral malignancy, craniofacial disorders and traumatic facial injuries present with a predicted difficult intubation. There should be a full range of equipment relating to the management of the anticipated difficult airway available within the theatre suite. This should include equipment for videolaryngoscopy, fibreoptic intubation, high-flow nasal oxygen therapy (HFNO), and equipment to perform front of neck access (FONA).

12.6.1 Specialist airway equipment, for example videolaryngoscopes, high frequency jet ventilators, transnasal high-flow humidified oxygen delivery devices and portable ultrasound machines should be included in annual budget planning and procurement processes.

HELPNOTE

This equipment may be held in a central store, which can be made available in theatres when anticipated difficult airway is planned.

STANDARD

2.1.1.13 Appropriate equipment is available and used for all intra and inter hospital patient transfers.

EVIDENCE REQUIRED

Portable ventilators and monitoring should be seen for adults and children. Transfer audit forms should be demonstrable.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.10.14 A brief interruption of monitoring during transfer of the patient from theatre is only acceptable if the recovery area is immediately adjacent to the operating theatre. Otherwise, monitoring should be continued during transfer to the same degree as any other intra or inter-hospital transfer.

5.1.47 All necessary equipment to facilitate safe transport of the patient should be available at all times. Standardisation of transfer bags should be considered.

7.3.13 Transfer of patients within the hospital to ICU, radiology or the operating theatre is not without risk and will require the use of a tipping transfer trolley, oxygen cylinders, suction, a transport ventilator, infusion pumps, monitor with adequate battery life and a portable defibrillator if appropriate. Local guidelines along with use of a formal 'intra hospital transfer form' should be considered to mitigate procedure specific issues.

10.3.19 In all emergency departments receiving infants and children, neonatal and paediatric resuscitation equipment (including airway equipment), medications (including anaesthetic drugs) and fluids should be available to prepare an infant or child for transfer to the paediatric intensive care unit (PICU).

HELPNOTE

Use of continuous monitoring (e.g. the transition from theatre to recovery) is part of the Association of Anaesthetists Recommendations for standards of monitoring during anaesthesia and recovery guidelines. If this is not currently available, there should be a plan for the next cycle of equipment renewal to ensure that this is in place.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.7 Transfer of the critically ill patient*, *6.1 Anaesthesia in the accident and emergency department*.

Note 3: If your department does not treat patients under 18 years of age routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet

that standard for adult care, or 'not met' if that isn't the case. If you have an emergency department but do not routinely treat patients under 18 years of age or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

2.1.1.14 There is specialised equipment for the management of postoperative pain.

EVIDENCE REQUIRED

An adequate number of PCAs and epidural pumps, LA infusion devices, local anaesthetic catheter infusion systems and the arrangements for their use should be available for the services being provided for adults and children. Staff spoken to should confirm that numbers are sufficient. An audit would be an additional way to demonstrate this.

PRIORITY

1

CQC KLoEs

Effective; caring; responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

9.2.11 Patient controlled analgesia equipment should be available for postoperative pain relief, and staff should be trained in its use and how to look after women using the equipment.

11.2.1 All equipment and disposables must be compliant with local and national safety policies. There should be an adequate supply of the following:

- infusion pumps for neuraxial analgesia (epidural infusion/patient-controlled epidural analgesia and potentially intrathecal infusions)
- infusion pumps for use with continuous regional analgesia catheters
- patient-controlled analgesia infusion pumps
- infusion pumps for other analgesic drugs
- disposables for the above, including neuraxial and regional block devices e.g. NRFit.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.7 Pain relief after caesarean section, 10.4 Managing epidural analgesia*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.18, 3.6.21 and 3.6.22. The full references can be found here; https://fpm.ac.uk/sites/fpm/files/documents/2021-07/FPM-Core-Standards-2021_1.pdf

STANDARD

2.1.1.15 There is adequate protection from environmental and infectious hazards provided for staff and sufficient supplies available.

EVIDENCE REQUIRED

The staff member with responsibility for safety of X-ray, Control of Substances Hazardous to Health and infection control should be named. Staff should be asked if they have any concerns and be able to explain how exposure, for example to nitrous oxide and other volatiles, is monitored. A scavenging system that meets the Health and Safety Executive's occupational exposure standards for anaesthetic agents should be seen. There should be written guidance on the appropriate levels of personal protective equipment.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

2.7.28 Anaesthetic sites must have scavenging systems that meet the Health and Safety Executive's occupational exposure standards for anaesthetic agents.

5.3.4 Emergency theatres should be equipped with an appropriate ventilation system. Details of ventilation and air change times should be known and factored into list management in all areas where an aerosol generating procedure may be performed during emergency anaesthesia.

5.3.11 There must be full provision of personal protective equipment and shielding from blood spray, radiation and hazardous substances for all staff working in the operating theatre. Guidance should be provided on its use.

7.3.15 Exposure to ionising radiation should be kept to a minimum by the use of screens or lead gowns; remote slave monitors in screened viewing areas should be provided and staff should remain as distant from the imaging source as possible if they must remain in the x-ray environment.

7.4.4 Environmental hazards such as radiation exposure, magnetic resonance (MR) fields and lack of scavenging should be considered by staff before the start of each list. Volatile agent scavenging canisters, air-oxygen mixtures and avoidance of nitrous oxide can mitigate environmental risks. Pregnant personnel may be particularly at risk in these environments and should follow local occupational health policy.

9.2.4 Delivery suite rooms must comply with Control of Substances Hazardous to Health Regulations 2002 and guidelines on workplace exposure limits on waste gas pollution.

HELPNOTE

Department of Health guidelines on theatres, including protective measures such as scavenging systems, are available in the Health Building Note HBN 26, which

is available here: https://www.england.nhs.uk/estates/health-building-notes/

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.8 Provision of anaesthesia in MRI*, *11.1 Focus on sustainability: reducing our carbon footprint through inhalational agents*, *11.6 Training on, maintenance and purchase of anaesthetic equipment*.

STANDARD

2.1.1.16 Any clinical area caring for patients with a tracheostomy should have the recommended bedside equipment and the locally immediately available emergency equipment, as indicated in the UK National Tracheostomy Safety Project Guide.

EVIDENCE REQUIRED

Verbal confirmation should be provided, and the equipment should be seen.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

12.2.2 An adequate range of tracheostomy tubes, including adjustable flange tubes with inner tubes, should be stocked and standardised within the hospital.

12.2.7 Any clinical area caring for patients with a tracheostomy should provide the recommended bedside equipment and the locally 'immediately available' emergency equipment, as indicated in the UK National Tracheostomy Safety Project Guide.

HELPNOTE

See the UK National Tracheostomy Safety Project Guide for more information.

Note 5: On terminology, unless otherwise specified, immediately means within five minutes.

STANDARD

2.1.1.17 The department has a plan to address the environmental sustainability of their anaesthetic practice.

EVIDENCE REQUIRED

There should be a regularly reviewed plan for increasing environmental sustainability in the department. A lead should be named. This does not have to be an anaesthetist and could be a member of the wider anaesthetic team.

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

1.1.12 The department should aim for sustainability in all that it does, in the clinical context, its management and administration and in other activities. The department should contribute to initiatives to improve the environmental sustainability of the system.

HELPNOTE

On 1 July 2022 the NHS became the first health system to embed net zero into legislation and the Delivering a Net Zero National Health Service report is now issued as statutory guidance: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf

Departments will address their environmental impact in different ways relevant to their local practice and linked to sustainability initiatives in the wider organisation. The Global consensus statement from the World Federation of Societies of Anaesthesiologists on "the principles of environmental sustainable anaesthesia" was published in Anaesthesia in November 2021 and is available here: https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15598

The Royal College of Anaesthetists, UK and Ireland Surgical Colleges, the Association of Anaesthetists and the Association for Perioperative Practice have published the Intercollegiate Green Theatre Checklist. The checklist contains a list of recommendations to reduce the environmental impact of operating theatres with specific detail on anaesthesia, preparing for surgery, intraoperative and the post-operative stages.

The RCoA is committed to embedding environmental sustainability into everything we do; the RCoA sustainability strategy and further information about sustainability and anaesthesia is available here: https://www.rcoa.ac.uk/about-college/strategy-vision/environment-sustainability

STANDARD

2.1.1.18 Specialised monitoring and equipment appropriate to the surgery undertaken is available with staff who are trained and competent to use it. This is adequately maintained.

EVIDENCE REQUIRED

Presence of equipment appropriate to anaesthetic services provided. Staff should confirm that they are trained and competent in its use.

PRIORITY

2

CQC KLoEs

Safe, effective, well-led, responsive

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES

2.7.6 The following equipment is required for the safe delivery of anaesthesia and should be available at all sites where patients are anaesthetised in sufficient quantities for the case mix and workload:

- defibrillators and equipment for external cardiac pacing
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access and regional anaesthesia
- equipment required for the administration of a volatile-free anaesthetic, including infusion pumps, volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines
- at least one readily available portable storage unit with specialised equipment for the management of patients with a difficult airway in every theatre suite including video laryngoscopes and fibre-optic scopes
- active patient warming devices
- fluid warming devices, allowing the transfusion of body temperature blood products and intravenous fluids of body temperature
- rapid infusion device for the management of major haemorrhage
- regional anaesthesia equipment, including ultrasound and regional anaesthesia nerve stimulators
- cuff pressure monitors
- blood glucose measuring device

13.2.13 Optimal patient positioning is critical to the safe conduct of ophthalmic surgery and for patient comfort. Adjustable trolleys/operating tables that permit correct positioning should be available.

13.2.14 Some patients, for example those with restricted mobility, may require specific equipment such as hoists to position them. Preoperative planning should ensure that such equipment is available, and allow for the extra time and staff needed to position these patients safely.

15.2.4 Transesophageal echocardiography (TOE) may be useful in the identification of thoracic aortic pathology, successful deployment of thoracic stent grafts and detection of early complications. When required, TOE should be performed by certified practitioners with expertise in its use and interpretation.

15.2.8 Equipment should be immediately available for rapid blood gas analysis, near patient tests of coagulation, e.g. thromboelastograph and activated clotting time, and the measurement of haemoglobin and blood glucose.

18.2.3 During the transfer of the patient at the end of surgery to the postoperative care unit there should be access to electrocardiogram (ECG), invasive blood pressure monitoring, pulse oximetry, disconnection alarm for any mechanical ventilation system, fractional inspired oxygen concentration, and end-tidal carbon dioxide.

18.2.4 Access to cardiac output monitoring should be available for high-risk cardiac cases perioperatively.

18.2.11 Transoesophageal echocardiography should be immediately available.

18.2.12 Patients with complex conditions may require additional monitoring, such as pulmonary arterial pressure monitoring and measurement of cardiac output. Facilities for on-bypass haemofiltration should be available, which may include cytokine haemadsorption filters in patients with higher inflammatory burden.

18.2.14 Monitoring during cardiopulmonary bypass should conform to the standards recommended by the joint working group of the Society of Clinical Perfusion Scientists of Great Britain and Ireland, ACTACC, the Society for Cardiothoracic Surgery in Great Britain and Ireland and the European Guidelines on Cardiopulmonary Bypass in Adult Cardiac Surgery.

18.2.20 Where possible, point of care or near-patient testing should be used for blood gas analysis, measurement of electrolytes and blood sugar, haemoglobin, lactate and coagulation. This testing should include platelet function, thromboelastography or rotational thromboelastometry and early acute kidney injury urinary markers. The need for direct oral anticoagulant analysis at point of care should be carefully considered·

18.2.27 For cardiac patients, dedicated echocardiography equipment, including transoesophageal echo should be immediately available in the operating suite and postoperative care areas. Those who deliver intraoperative echocardiography services should be trained to the level of competence defined by specialist bodies.

18.3.21 Where revision of rhythm management devices is considered to pose a high risk of requiring emergency surgical intervention, cardiopulmonary bypass equipment and a plan for surgery should be available at the start of the procedure.

19.2.8 Flexible fibreoptic bronchoscopy should be immediately available for all patients where lung isolation is used.

19.2.9 A range of equipment to facilitate lung isolation should be available. This may include left and right double-lumen tracheal tubes, bronchial blockers, dual lumen tracheostomy tubes, and airway exchange catheters.

19.2.15 Dedicated equipment for jet ventilation should be available for interventional airway procedures. Appropriate fittings should be checked and available for connection to rigid bronchoscopes. It should include an ultrasound machine for nerve blocks

19.3.14 The use of extracorporeal membrane oxygenation (ECMO) for the management of adults with severe respiratory failure is currently is centralised in a number of cardiothoracic centres. Anaesthetists often institute ECMO and support retrieval of patients from non-specialist hospitals. Anaesthetists providing ECMO should be suitably trained.

HELPNOTE

This may include appropriate equipment to adjust patient position to ensure maximum comfort and optimum surgical access. Staff should be trained to use the equipment to safely help patients on and off operating tables with care and dignity.

STANDARD

2.1.2.1 There is a planned maintenance and replacement programme for all anaesthetic equipment as required.

EVIDENCE REQUIRED

The age of the oldest equipment should be given, and written evidence of the replacement programme should be provided. There should be a section in the annual plan for anaesthetic services showing approval, budgeting and procurement arrangements for equipment replacement.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

2.7.11 There should be a planned maintenance and replacement programme for all anaesthetic equipment.

12.6.1 Specialist airway equipment, for example videolaryngoscopes, high frequency jet ventilators, transnasal high-flow humidified oxygen delivery devices and portable ultrasound machines should be included in annual budget planning and procurement processes.

HELPNOTE

The plan should include:

- A timetable to implement the agreed facilities.
- Equipment purchase and replacement that includes both planned objectives for the immediate year and outline plans for 2 to 5 years.

It should also be taken into consideration with reference to the department's strategic plan as described in standard 4.1.1.1.

Use of continuous monitoring (e.g. the transition from theatre to recovery) is a recent addition to the Association of Anaesthetists Recommendations for standards of monitoring during anaesthesia and recovery guidelines.

If this is not currently available, there should be a plan for the next cycle of equipment renewal to ensure that this is in place.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.6 Training on, maintenance and purchase of anaesthetic equipment*, *11.7 Availability of ultrasound equipment in anaesthetic areas*

STANDARD

2.1.2.2 All anaesthetists and anaesthetic assistants receive systematic training in the use of new medical equipment and the training is documented.

EVIDENCE REQUIRED

Documentation of training should be provided.

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

1.5.13 Hospitals must ensure that all members of the anaesthetic team including locums are trained and competent to use the relevant equipment provided.

1.5.14 All staff should be provided with opportunities to familiarise themselves with all equipment by way of documented formal training sessions.

2.7.9 All anaesthetists, AAs and anaesthetic assistants should receive systematic training in the use of new equipment. This should be clearly documented. Anaesthetists should not use equipment unless they have been trained to use it and are competent to do so. The NHS Clinical Negligence Scheme for trusts and Healthcare Improvement Scotland require that hospitals ensure all personnel are trained to use and to check relevant equipment. This may take place at induction for new staff or at the introduction of new equipment. A record of training should be kept. The use of routine checks and associated checklists is an important part of training in anaesthesia and is part of the RCoA's competency-based training.

HELPNOTE

Self-certification is sufficient if anaesthetists are keeping a record of their own training for appraisal purposes; again, this should be appropriately documented.

STANDARD

2.2.1.1 All departments should have a policy for the safe and secure handling of medicines that follows "Safe drug management in anaesthetic practice 2020".

EVIDENCE REQUIRED

Copy of written policy. ACSA review team will confirm on walkabout and with staff groups that policy is routinely followed.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW DOMAINS

Safe and effective care

HIS DOMAINS

Safe, effective and person-centred care delivery**;** policies, planning and governance

REFERENCES

2.7.35 All staff involved in the prescribing, dispensing, preparing, administering and monitoring of medicines must be appropriately trained.

2.7.36 All theatre staff involved in any aspects of the use of medicines should have access to up to date resources on safe preparation and administration of medicines, and access to a pharmacy service for advice.

2.7.37 There must be a system for ordering, storage, recording and auditing of controlled medicines in all areas where they are used, in accordance with legislation.

2.7.39 Robust systems should be in place to ensure reliable medicines management, including accurate medication history taking and documentation on admission, medication storage facilities, stock review and management, supply, expiry checks, and access to appropriately trained pharmacy staff to manage any medicine shortages.

2.7.40 All local anaesthetic solutions should be stored in a separate storage unit from intravenous infusion solutions, to reduce the risk of accidental intravenous administration of such medication.

2.7.41 All medication containing infusions and syringes should be clearly labelled and ideally colour coded in accordance with the anaesthesia recommended scheme.

HELPNOTE

The policy should be formulated with particular reference to Appendix C of the Royal Pharmaceutical Society's Safe and Secure Handling of Medicines guidance and the RCoA and Association of Anaesthetists' Safe Management of Drugs in Anaesthetic Practice guidance

STANDARD

2.2.1.2 Local anaesthetic agents (ampoules and bags) must be stored separately from other drugs and intravenous fluids.

EVIDENCE REQUIRED

Separate areas should be seen in any part of the hospital where local anaesthetic agents are kept for use by anaesthetic staff. See helpnote for further detail.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.40 All local anaesthetic solutions should be stored in a separate storage unit from intravenous infusion solutions, to reduce the risk of accidental intravenous administration of such medication.

HELPNOTE

Any part of the hospital where local anaesthetic agents are kept for use by anaesthetic staff these must be 'stored separately' from other drugs and intravenous fluids – at the least this would be behind different doors which in practice means different cupboards. Human factors should be considered to ensure there is a conscious separate action (e.g. opening a separate door, a box with a lid within a drawer/cupboard) required to access local anaesthetic agents.

STANDARD

2.2.1.3 In every site where anaesthesia is given emergency drugs including intralipid, sugammadex and dantrolene are readily available and in date supply is maintained.

EVIDENCE REQUIRED

Drugs should be seen.

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.38 All drugs required for safe delivery of anaesthesia including emergency drugs, should be available. Some drugs such as dantrolene or intralipid may be held centrally rather than immediately to hand.

7.2.18 Wherever anaesthesia or sedation is undertaken, a full range of emergency drugs including specific reversal agents such as naloxone, sugammadex and flumazenil should be made available.

7.2.19 In remote locations where anaesthesia is undertaken, drugs to treat rare situations, such as dantrolene for malignant hyperthermia, or intralipid for local anaesthetic toxicity should be immediately available and located in a designated area.

7.2.21 Robust systems should be in place to ensure reliable medicines management, including storage facilities, stock review, supply, expiry checks, and access to appropriately trained pharmacy staff to manage any drug shortages

9.2.28 Medication for life threatening anaesthetic emergencies should be immediately available to the delivery suite and their location should be clearly identified. There should be a clear local agreement on the responsibility for maintenance of these emergency medicines (i.e. regular checks of stock levels, integrity and expiry dates).

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.1 Anaesthesia in the accident and emergency department, 6.2 Remote site anaesthesia*.

STANDARD

2.2.1.4 In every site where sedation is given emergency drugs including naloxone and flumazenil are available and in date supply is maintained.

EVIDENCE REQUIRED

Drugs should be seen in sites where sedation procedures are undertaken by an anaesthetist.

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.20 A standardised list of anaesthesia medications should be available wherever anaesthesia or sedation is undertaken. A full range of emergency medications, including specific reversal agents such as naloxone, sugammadex and flumazenil, should be available.

7.2.23 Robust systems should be in place to ensure reliable medicines management, including storage facilities, stock review, supply, expiry checks, and access to appropriately trained pharmacy staff to manage any drug shortages.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.1 Anaesthesia in the ED, 6.2 Remote site anaesthesia*, *6.3 Sedation competency*.

STANDARD

2.2.2.1 Blood storage facilities are immediately available to emergency theatres (including obstetrics). O rhesus negative blood should be immediately available in emergency theatres and on delivery suite.

EVIDENCE REQUIRED

Facilities should be seen.

PRIORITY

1

CQC KLoEs

Safe; effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance

GPAS REFERENCES

5.3.6 Appropriate blood storage facilities should be in close proximity to the emergency operating theatre and should be clearly identifiable. Satellite storage facilities or a clear process for preservation of the cold chain should be in place to enable resuscitation to be effectively performed in appropriate non-theatre locations such as interventional radiology suites.

9.2.20 Group O Rhesus negative blood should be immediately (see Glossary) available. To enable immediate availability, most units will require a blood fridge located within the delivery suite.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.10 Patient blood management in perioperative care*.

Note 5: On terminology, unless otherwise specified, immediately means within five minutes.

STANDARD

2.2.2.2 A cell salvage machine and trained staff are available for appropriate patients.

EVIDENCE REQUIRED

Equipment should be seen with evidence of ongoing training appropriate to case mix. Audit data should be provided to demonstrate the extent of cases where massive blood loss is anticipated.

PRIORITY

1

CQC KLoEs

Effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

5.3.17 A cell salvage service should be available for cases where massive blood loss is anticipated. Staff who operate this equipment should receive training in how to operate it and should use it with sufficient frequency to maintain their skills.

9.2.8 Cell salvage may be considered for women who refuse blood products or where massive obstetric haemorrhage is anticipated but it should not be used routinely for caesarean birth. When cell salvage is required, staff who operate this equipment should have received training and should maintain the appropriate skills to continue to do so.

HELPNOTE

Hospitals that do not treat 'appropriate patients' should choose the 'not applicable' option. The site would need to justify to the reviewers who visit why the standard is not applicable to their service. If patients who require this machine are seen rarely, and only in planned surgery, an SLA with an appropriate provider to hire the machine and staff required on demand is a fair alternative to purchase.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: 1.10 Patient blood management in perioperative care.

STANDARD

2.3.1.1 All records for anaesthesia and sedation contain the relevant portion of the recommended anaesthetic data set and are kept as a permanent document in the patient's record.

EVIDENCE REQUIRED

Anaesthetic records and case notes should be seen. Audit, at least annually, of a random selection of user records for adherence to national standards, validation of clinical content and accuracy of clinical coding.

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

1.4.12 Relevant patient information should be recorded and kept up to date.

1.4.13 All anaesthetic records should contain the relevant portion of the recommended anaesthetic data set for every anaesthetic and should be kept as a permanent document in the patient's medical record.

1.4.14 The use of electronic anaesthetic records in the perioperative period should be considered. Departments that currently do not have access to electronic anaesthetic records should link with wider hospital plans for the development of electronic patient records.

1.4.15 If electronic health records are in use there should be a clearly labelled anaesthetic record section so that documentation can be easily accessed.

2.1.3 All anaesthetic records (paper and electronic) must contain the relevant portion of the recommended anaesthetic data set for every anaesthetic and must be kept as a permanent document in the patient's medical record.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.4 Anaesthetic record keeping*, *3.4 Record keeping in recovery*.

STANDARD

2.3.1.2 An appropriate electronic anaesthetic record system linked to an electronic health record using recognised health informatics standards, controlled terminology and capable of providing a hard copy is in use.

EVIDENCE REQUIRED

Demonstration of the system and confirmation of back up arrangements.

PRIORITY

3

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

1.4.14 The use of electronic anaesthetic records in the perioperative period should be considered. Departments that currently do not have access to electronic anaesthetic records should link with wider hospital plans for the development of electronic patient records.

1.4.15 If electronic health records are in use there should be a clearly labelled anaesthetic record section so that documentation can be easily accessed.

2.4.13 Documentation and communication of information on preoperative preparation are essential. Electronic systems should be considered to enable the capture and sharing of information, support risk identification and allow data to be collected and available for audit and research purposes.

HELPNOTE

The system should support patient safety, semantic interoperability and sharing. Recognised informatics standards include HL7 and OpenEHR. The recognised health terminology standard for the UK is SNOMED-CT.

STANDARD

2.4.1.1 Access to clinical areas should be appropriately restricted for the protection of patients and staff.

EVIDENCE REQUIRED

Evidence of this should be visible.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.34 Access to theatres and associated clinical areas should be appropriately restricted.

9.2.30 There should be easy and safe access to the delivery suite from the main hospital at all times.

STANDARD

2.4.1.2 An emergency call system is in place and understood by all relevant staff. Where there are multiple locations the system must clearly indicate in which location the emergency is occurring.

EVIDENCE REQUIRED

Confirmation of the system and how it is used should be given by any member of staff when asked. The review team may request a demonstration of the system at the review visit. In remote areas, other robust call systems may be appropriate. Generally, an appropriate system will have both audible and visual elements. Audit data demonstrating routine rehearsal and response times may also be requested.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.7.26 There should be provision of an emergency call system, including an audible alarm. A visible indication of the location of the emergency should also be considered.

2.8.8 The theatre team should all engage in the use of the WHO surgical safety process, including the 'Five Steps to Safe Surgery' commencing with a team brief, and concluding the list with a team debrief. Debrief should highlight things done well and also identify areas requiring improvement. Teams should consider including the declaration of emergency call procedures specific to the location as part of the team brief.

HELPNOTE

This standard pertains to being able to summon anaesthetic assistance in an emergency and the review team will consider the appropriateness of any local solution for specific local circumstances with this aim in mind, particularly in remote areas.

STANDARD

2.4.1.3 There should be a nominated consultant or autonomously practising anaesthetist immediately available with capacity to provide cover in clinical emergencies, as well as advice and support to other anaesthetists. These details should be immediately accessible.

EVIDENCE REQUIRED

Prominent display should be seen. All staff groups report immediate access to the named anaesthetist and their contact details and a departmental culture that supports asking for assistance when needed.

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

2.6.2 Anaesthesia departments should have a nominated anaesthetist immediately available (see Glossary) and free from direct clinical responsibilities to provide cover in clinical emergencies, as well as providing advice and support to other anaesthetists.

5.1.59 An escalation policy should be in place for all medical, healthcare professional and managerial staff. An emergency protocol should be in place and understood by all relevant staff. This should include the names and method of contact, which should be prominently displayed in appropriate areas. Internal hospital telephone switchboards should have ready access to rotas and methods of contacts.

9.1.5 The duty anaesthetist should have an effective and rapid means of communication with their supervisor at all times. Staff working in the maternity unit should be aware of their supervisor's identity, location and how to contact them. The name(s) of the autonomously practising anaesthetist(s) covering the delivery suite and how to contact them should be clearly displayed and easily visible to all staff.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

The RCoA and Association of Anaesthetists' joint publication on the safer staffing for the delivery of anaesthesia services can be referenced for staffing guidance: Safer Staffing for the Delivery of Anaesthesia Services

Note 5: On terminology, unless otherwise specified, immediately means within five minutes.

STANDARD

2.4.2.1 Appropriate facilities for rest and refreshment are available for anaesthetic staff working at night

EVIDENCE REQUIRED

A quiet and dark area with ability for horizontal rest must be seen and resident staff should report that they are aware of and satisfied with the available facilities for rest and refreshment. The guardian for safe working should be available to speak with the review team.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Policies, planning and governance

GPAS REFERENCES

1.2.66 Facilities should be provided for regular rest breaks and refreshments as well as quiet facilities for sleep during and after shifts for anaesthetists working overnight.

2.7.32 Appropriate facilities for rest breaks should be provided according to defined norms.

9.2.39 All hospitals should ensure the availability of areas that allow those doctors working night shifts to take rest breaks, which are essential for the reduction of fatigue and improve safety. These areas should not be used by more than one person at a time and should allow the doctor to fully recline.

9.2.40 Standards of accommodation for doctors in training should be adhered to. Where a consultant or other autonomously practising anaesthetist is required to be resident, on-call accommodation should be provided.

9.2.41 Hotel services should provide suitable on-call facilities, including housekeeping services for resident and non-resident anaesthetic staff. Refreshments should be available 24/7.

HELPNOTE

The RCoA and Association of Anaesthetists have produced an educational resource pack, which includes standards for rest facilities that departments should use to inform this standard.

The following resources can be utilised: Minimising the impact of rotational training within the anaesthetic training programme | The Royal College of Anaesthetists and Fight Fatigue resources | Association of Anaesthetists

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.12 Professional compliance analysis tool for improving the working environment and rotas*, *11.13 Wellbeing*, *11.14 Fatigue and the anaesthetist*.

STANDARD

2.4.2.4 Departments should ensure that their working practices support safer staffing. This should also include providing appropriate support for teams providing long and complex procedures.

EVIDENCE REQUIRED

Departments should be able to describe practice in this area including how breaks are given and rest accounted for after being on call. Examples of the rota should be provided. Verbal confirmation from staff that the minimum period for rest is respected.

PRIORITY

2

CQC KLoEs

Safe; effective; responsive; well-led

HIW DOMAINS

Safe and effective care; management and leadership

HIS DOMAINS

Impact on staff; workforce management and support

GPAS REFERENCES

1.2.19 Job plans and rotas should be constructed to ensure reasonable rest periods and should be regularly reviewed taking into consideration out of hours work frequency, duration of out of hour's periods and availability of recovery time after being on call.

1.2.20 Where 'group job plans 'are the norm, there may be specific requirements for individual variation including susceptibility to fatigue. This includes consideration of work intensity before and after out of hours commitments and discussion of strategies to minimise impact.

1.2.23 Scheduled lists that are planned to take longer than three sessions (e.g. where a patient requires prolonged time in theatre) must be staffed appropriately to ensure that no single anaesthetist works longer than three elective sessions. Adequate rest periods during sessions must be provided.

1.2.30 Scheduled lists that are planned to take longer than three sessions (e.g. where a patient requires prolonged time in theatre) must be staffed appropriately to ensure that no single anaesthetist works longer than three elective sessions. Adequate rest periods during sessions must be provided.

1.2.33 Departments should ensure that their anaesthetic rotas are working time regulation (WTR) compliant, achieving the minimum 11 hours rest between consecutive periods of work (both direct clinical care and supporting professional activities (SPA). This rest time should be unambiguous, so that clinicians are neither required to self-assess fatigue levels, nor be influenced by the clinical needs of the department. It should be recognised that travelling to and from work is not rest, so should not count in the 11-hour rest period.

14.1.6 Hospitals should have well integrated arrangements that ensure anaesthetists covering long neurosurgical procedures or overrunning lists are regularly relieved by an appropriate colleague for refreshment and comfort breaks. If a case is expected to run over three sessions, consideration should be given to organising a second anaesthetist.

REFERENCES

Further information on the working time directive is available from The British Medical Association (BMA). Doctors and the European Working Time Directive

STANDARD

2.4.3.1 Appropriate office facilities are provided for all aspects of the anaesthesia service.

EVIDENCE REQUIRED

A space should be available to the duty anaesthetic team, in proximity to emergency theatres and the delivery suite as appropriate. The room should have computers with intra/internet access for to specialist reference material and local multidisciplinary evidence-based guidelines and policies.

PRIORITY

2

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Policies, planning and governance; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.5.1 An anaesthetic office space located in close proximity to relevant departments (e.g. theatres, ICU and labour ward) should be available to allow local supervision of trainees. The size of this space should be proportionate to the size of the department.

1.5.2 Private office spaces should also be available for CPD, to conduct assessments and for confidential meetings such as appraisals.

2.7.31 Facilities to allow access to online information, such as electronic patient records, local guidelines and clinical decision aids, in the theatre suite should be available.

9.2.36 An anaesthetic office, located within five minutes' walk of the delivery suite, should be available to the duty anaesthetic team. The room should have a computer with intra/internet access to specialist reference material and local multidisciplinary evidence based guidelines and policies. The office space, facilities and furniture should comply with the Association of Anaesthetists' standards.80 This office could also be used to allow teaching, assessment and appraisal.

11.2.14 There should be proportionate office space to the size of the IPS and adequate informatics and administrative staff to support all areas of the IPS.

HELPNOTE

This should be regarded as acceptable to a significant majority of the anaesthetic staff.

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.13 Wellbeing*.

STANDARD

2.5.1.1 Where relevant there must be sufficient doctors available to simultaneously cover commitments to obstetrics, critical care and emergency theatres.

EVIDENCE REQUIRED

Verbal confirmation that there is a mechanism to recognise issues should be given. Example of scenario at review visit if requested.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

5.2.2 The level of staffing should be sufficient to provide a continuous emergency anaesthesia service in the theatre complex without interruption. Other service requirements (e.g. remote sites, trauma calls and advice) should be anticipated and managed through local arrangements. Such service requirements should not result in interruption of busy emergency lists.

5.2.9 Anaesthetists assigned to provide cover for emergency lists should not also be assigned to undertake other activities such as elective work or supporting professional activities or independent practice.

9.1.6 It is recognised that, in smaller units, the workload may not justify having an anaesthetist exclusively dedicated to the delivery unit. If the duty anaesthetist does have other responsibilities, these should be of a nature that would allow the activity to be immediately delayed or interrupted should obstetric work arise. Under these circumstances, the duty anaesthetist should be able to delegate care of their non-obstetric patient to be able to respond immediately to a request for care of obstetric patients. They would therefore, for example, not simultaneously be able to be a member of the on-call resuscitation team. If the duty anaesthetist covers general theatres, another anaesthetist should be ready to take over immediately should they be needed to care for obstetric patients.

18.1.6 An appropriately trained consultant or autonomously practising cardiac anaesthetist should be wholly and exclusively available at all times, through a formal on-call rota. The out of hours duties of the on-call consultant or autonomously practising cardiac theatre anaesthetist should cover only cardiac emergencies, as they can arise and escalate very rapidly, particularly in tertiary referral units. On-call cardiac intensive care consultants or autonomously practising anaesthetists should be trained in and provide support and cover for critical care emergencies such as out of hours diagnostic transoesophageal echocardiography.

18.1.10 Interventional cardiology services increasingly require anaesthesia, critical care and nursing resources depending on procedural complexity and patient morbidity. General anaesthesia may be needed to facilitate complex interventions or required in an emergency for invasive cardiological procedures. Both eventualities require that appropriate anaesthetic staffing, skilled assistance, equipment and monitoring should be available.

19.1.6 An appropriately trained consultant or autonomously practising anaesthetist should be available at all times, through a formal thoracic or cardiothoracic anaesthetic on-call rota, particularly if lung transplantation is performed.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.3 Response times for provision of intrapartum analgesia and anaesthesia*.

The RCoA and Association of Anaesthetists' joint publication on the safer staffing for the delivery of anaesthesia services can be referenced for staffing guidance: Safer Staffing for the Delivery of Anaesthesia Services.

STANDARD

2.5.1.2 There is a trained resuscitation team for all patients including obstetric, paediatric and neonates as appropriate.

EVIDENCE REQUIRED

Verbal confirmation should be given. Evidence of appropriate mandatory training for age range of patients.

PRIORITY

1

CQC KLoEs

Safe; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

9.1.28 An adult resuscitation team trained in resuscitation of the pregnant patient should be immediately available.

10.1.7 An additional member of staff with advanced training in life support for children should always be available to assist where required.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.10 Prevention of unexpected cardiac arrest*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

2.5.1.3 If anaesthesia or sedation is given in an isolated/single specialty unit there is appropriate medical and nursing staffing.

EVIDENCE REQUIRED

Either a written policy or verbal confirmation, as well as rota evidence, should be provided and show that there is assistance for the anaesthetist and specific arrangements for remote sites.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

7.1.5 Patients recovering from anaesthesia or all depths of sedation including mild sedation in a non-theatre environment should receive the same standard of care as that required in an operating theatre.

7.1.8 Anaesthesia for non-theatre environment should be delivered by a competent individual with appropriate supervision; the level of supervision should reflect the severity of the case and the seniority of the individual in accordance with the RCoA's Guidance on Supervision Arrangements for Anaesthetists.

7.2.29 The care of the patient should remain the responsibility of the anaesthetist up to discharge for ambulatory procedures or ward transfer for inpatient procedures.

HELPNOTE

This standard applies to isolated sites within a hospital and equally to single specialty units such as 'cold' orthopaedic units operating within an adjoining unit or small hospital nearby under the auspices of the department.

Note 5:
A remote site is any location where general or regional anaesthesia or sedation is administered away from the main theatre suite and/or anaesthetic department. This may be within or away from the base hospital. Common examples include MR or CT scanners, maternity units or dental sedation suites. Please be advised that areas that do not have any anaesthetic input, such as midwife-led maternity units, will not be assessed during the onsite review visit.

On terminology, unless otherwise specified, sedation refers to sedation delivered by an anaesthetist.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.7 Remote site anaesthesia, 6.3 Sedation competency*, *8.3 Paediatric sedation*.

STANDARD

2.5.2.1 SAS doctors and Locally-Employed Doctors (LEDs) have specific training and demonstrated competence in relevant areas before working with distant supervision.

EVIDENCE REQUIRED

Specific groups should be interviewed about their practices and training.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.3.3 The induction should be documented. It should ensure competency in the use of equipment and should act as an opportunity to identify those who require additional support in certain skills or areas of practice.

1.3.5 Anaesthetists should be given support and time to familiarise themselves with non-theatre locations and different environments prior to solo sessions and out of hours work. This may include undertaking operating lists with a colleague.

2.13.11 Departments of anaesthesia should ensure that a named supervisory consultant or other autonomously practising anaesthetist is available to all non-autonomously practising anaesthetists based on the training and experience of the individual doctor and the range and scope of their clinical practice. Where an anaesthetist is supervised by a consultant or other autonomously practising anaesthetist, they should be aware of their supervisor's identity, location and how to contact them.

9.4.3 A process should be in place for the formal assessment of anaesthetists before allowing them to join the on-call rota for obstetric anaesthesia with distant supervision.

9.4.8 Any non-trainee anaesthetist who undertakes anaesthetic duties in the labour ward should have been assessed as competent to perform these duties in accordance with RCoA guidelines.

HELPNOTE
The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

Note 4: On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee'); the diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the RCoA Guidance on Supervision arrangements for anaesthetists.

Note 5: The 'Guidance on supervision arrangements for anaesthetists' comprehensively outlines arrangements for supervision and the different levels of supervision. Audit data based on the Cappuccini Test should be used to provide evidence for supervision arrangements.

On terminology, SAS Doctors are anaesthetists on the national Speciality Doctor or Specialist Doctor contract and any anaesthetists on closed SAS contracts, such as the Associate Specialist contract. Locally-employed Doctors (LEDs) are anaesthetists on local, employer-based contracts, commonly based on a current or historical version of the resident doctor contract. Examples of these roles include Trust Doctors, Clinical Fellows, and Medical Training Initiative doctors.

STANDARD

2.5.2.2 SAS doctors and Locally-Employed Doctors (LEDs) have unimpeded access to a nominated consultant or other autonomously practising anaesthetist for advice and supervision at all times.

EVIDENCE REQUIRED

Written policies should be provided, and specific groups should be able to relay how they would know who to contact. For example, names are displayed in the department or shown on the rota. Audit data based on the Cappuccini Test should be used to provide evidence for this standard, as well as for standards 1.1.1.1, 2.4.1.3 and 2.5.3.2.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Quality improvement-focused leadership

GPAS REFERENCES

1.2.43 At all times SAS anaesthetists who are not autonomously practising anaesthetists should be supervised at an appropriate level(1-4) of sessional supervision, varying depending on both their level, including their previous experience and capability, and the case or cases for which they are being supervised doing.

1.2.45 Where an anaesthetist is supervised by a sessional supervisor, the individual should be aware of their supervisor's identity, location and how to contact them.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

Note 4: On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee'); the diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the 2021 RCoA 'Guidance on supervision arrangements for anaesthetists'.

Note 5: On terminology, the 'Guidance on supervision arrangements for anaesthetists' comprehensively outlines arrangements for supervision and the different levels of supervision. Audit data based on the Cappuccini Test should be used to provide evidence for supervision arrangements.

On terminology, SAS Doctors are anaesthetists on the national Speciality Doctor or Specialist Doctor contract and any anaesthetists on closed SAS contracts, such as the Associate Specialist contract. Locally-employed Doctors (LEDs) are anaesthetists on local, employer-based contracts, commonly based on a current or historical version of the resident doctor contract. Examples of these roles include Trust Doctors, Clinical Fellows, and Medical Training Initiative doctors.

STANDARD

2.5.3.1 Anaesthetists in training have specific training and demonstrated competence in relevant areas before working with distant supervision.

EVIDENCE REQUIRED

Specific groups should be interviewed about their practices and training.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

1.3.3 The induction should be documented. It should ensure competency in the use of equipment and should act as an opportunity to identify those who require additional support in certain skills or areas of practice.

1.3.5 Anaesthetists should be given support and time to familiarise themselves with non-theatre locations and different environments prior to solo sessions and out of hours work. This may include undertaking operating lists with a colleague.

9.1.1 To act as the duty anaesthetist without direct supervision from a consultant or autonomously practising anaesthetist, the duty anaesthetist should meet the basic training specifications and have attained the RCoA's Initial Assessment of Competence in Obstetric Anaesthesia.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

Note 5: On terminology, the 'Guidance on supervision arrangements for anaesthetists' comprehensively outlines arrangements for supervision and the different levels of supervision. Audit data based on the Cappuccini Test should be used to provide evidence for supervision arrangements.

STANDARD

2.5.3.2 Anaesthetists in training have unimpeded access to a nominated consultant or other autonomously practising anaesthetist for advice and supervision at all times.

EVIDENCE REQUIRED

Written policies should be provided, and specific groups should be able to relay how they would know who to contact. For example, names are displayed in the department or show on the rota. Audit data based on the Cappuccini Test should be used to provide evidence for this standard, as well as for standards 1.1.1.1, 2.4.1.3 and 2.5.2.2.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Quality improvement-focused leadership

GPAS REFERENCES

1.2.42 At all times trainees should be supervised at an appropriate level (1-4) of sessional supervision, which varies depending on both the level of the trainee, including their stage of training, their previous experience and capability, and the case or cases for which they are being supervised.

1.2.45 Where an anaesthetist is supervised by a sessional supervisor, the individual should be aware of their supervisor's identity, location and how to contact them.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.10 The Cappuccini test: effective clinical supervision to ensure safe delivery of anaesthetic services*.

Note 5: On terminology, the 'Guidance on supervision arrangements for anaesthetists' comprehensively outlines arrangements for supervision and the different levels of supervision. Audit data based on the Cappuccini Test should be used to provide evidence for supervision arrangements.

STANDARD

2.5.4.1 Anaesthesia Associates (AAs) work under the supervision of a consultant or other autonomously practising anaesthetist at all times when administering anaesthesia or sedation. The level of clinical activity and supervision should be as outlined within the scope of practice published by the RCoA.

EVIDENCE REQUIRED

A copy of the rota should be provided showing allocation of AAs to lists should be seen. Verbal evidence should be provided confirming AAs are supervised according to the current scope of practice.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

1.2.44 AAs should be supervised in accordance with the scope of practice published by the RCoA.

2.6.4 Anaesthesia associates should work within the scope of practice and levels of supervision defined by the RCoA.

2.6.5 AAs should always work within an anaesthesia team led by a consultant or other autonomously practising anaesthetist who has overall responsibility for the anaesthesia care provided for the patient and whose name should be recorded in the individual patient's medical notes.

2.6.6 Anaesthetists providing supervision to other anaesthetists or AA's should be easily contactable, able to provide the level of supervision required by individual supervisees and free to attend in an appropriate timeframe.

2.6.7 Clinical governance of AAs should follow the same principles as that applied to medically qualified staff. This should include training that is appropriately focused and resourced, supervision and support in keeping with practitioners' needs and practice responsibilities, and practice centred audit and review processes.

HELPNOTE

If no AAs are employed by the department, this standard should be marked N/A. AAs should be supervised in accordance with the latest guidance from the RCoA, available here: https://www.rcoa.ac.uk/training-careers/working-anaesthesia/anaesthesia-associates.

STANDARD

2.5.5.1 There are sufficient administrative staff to support all aspects of the anaesthesia service.

EVIDENCE REQUIRED
Majority of permanent staff should report that they are satisfied.

PRIORITY
1

CQC KLoEs
Well-led

HIW Domains
Management and leadership

HIS Domains
Impact on staff; workforce management and support

GPAS REFERENCES
1.5.6 There should be sufficient administrative staff and facilities to support all aspects of the anaesthesia service to enable it to perform its duties safely and efficiently.

HELPNOTE
Answers to the following types of questions could reflect the level of staff satisfaction:
- is the rota produced in timely way?
- are queries and alterations made appropriately?
- is the general administrative support function adequate?

STANDARD

2.5.6.2 There is regular multidisciplinary team based training for emergency situations.

EVIDENCE REQUIRED

Multidisciplinary theatre teams that work together should train together. Teams should undergo regular, multidisciplinary training that promotes teamwork, with a focus on human factors. Evidence should be provided that team training occurs in different areas. Multidisciplinary team training should be available regularly enough to allow all individuals to attend at least annually.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Safe, effective and person-centred care delivery; workforce management and support

GPAS REFERENCES

1.3.18 Teamwork is fundamental to the safe delivery of patient care. Organisations should ensure, as far as possible, that theatre teams are consistent and coherent, familiar with the procedure and therefore able to provide a consistent standard of care safely and efficiently.

1.3.19 Multidisciplinary theatre teams that work together should train together. Teams should undergo regular, multidisciplinary training that promotes teamwork, with a focus on human factors, effective communication and a flattened hierarchy in which supportive challenging is normalised for patient safety.

1.3.20 When new members join teams, particular care should be taken to introduce them to the team and to support them both to integrate and work with the team and bring their fresh insights to the team.

1.3.21 Regular, simple, in situ, multidisciplinary team training should form part of everyday practice. As well as enabling the rehearsal of standard operating procedures (SOPs) for serious, complex and rare emergencies, of untoward events and new processes, such training can help to identify system process gaps, leading to longer term improvements in safety and efficiency.

1.3.22 Multidisciplinary teams should have regular, more in-depth simulation exercises, moving the focus to the understanding of human factors and effective communication.

1.3.23 Simulation based learning techniques should be used to assist the department and organisation to identify areas of existing positive practice and areas requiring improvement, as well as supporting the development of technical and non-technical skills.

1.3.24 Simple and more in-depth team training exercises should include structured feedback.

1.3.25 The outcomes of these team training exercises should lead to change in practice where needed.

1.3.26 The anaesthetic department should have a lead for multidisciplinary team training and simulation.

1.3.27 The department should have access to the resources to support a comprehensive system of multidisciplinary team training in all clinical settings to achieve enhanced patient care.

HELPNOTE
It is established that benefits of simulation training decrease over time and are almost entirely gone after one year. For this reason, multidisciplinary team training should be available on a monthly basis. Individuals should attend at least annually.

The RCoA, Association of Anaesthetists and the Difficult Airway Society have produced specific resources, including short flashcard scenarios for multidisciplinary team training, to support the use of waveform capnography to prevent unrecognised oesophageal intubation, which are available here: https://www.rcoa.ac.uk/safety-standards-quality/patient-safety/prevention-future-deaths.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.3 Management of the difficult airway*, *6.1 Anaesthesia in the accident and emergency department*, *7.5 Airway and intubation problems during obstetric general anaesthesia*, *13.5 Simulation in cardiothoracic anaesthesia*.

STANDARD

3.1.1.1 Patients and, where appropriate, their family member, friend, parent or chosen advocate are involved in shared and supported decision making and they are given adequate information (including about their individualised risk assessment) upon which to base their decision regarding their anaesthetic care, postoperative care and pain relief.

EVIDENCE REQUIRED

There is a record that patients have been provided with information describing the options, risks and benefits of the proposed procedures, including the risk of rare events e.g. mortality. A discussion should take place based on the principles of shared decision making and this should be documented e.g. on the preoperative assessment notes and on the anaesthetic record. It should be confirmed that all letters concerning the patient have been copied to them.

PRIORITY

1

CQC KLoEs

Caring; responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

2.5.1 All patients undergoing elective procedures should be provided, prior to admission with information on their intended treatment pathway (day surgery or enhanced recovery) that is easy to understand. This should include information on the operation, anaesthesia, recovery and postoperative pain relief. Provision of this information should be documented in the patient's notes. The written and verbal information given to patients before their admission to hospital should explain the purpose and nature of their recovery and the recovery department. The Fitter Better Sooner resources published by the Royal College of Anaesthetists and the You and your anaesthetic leaflet, published by the Royal College of Anaesthetists and the Association of Anaesthetists are examples.

2.5.4 Consultation skills for shared decision making should be used to prepare patients for anaesthesia, surgery and analgesia. Patients should also be informed of the increasing number of decision aids available from NHS Direct to help them with their choices. The use of shared decision making tools such as 'Benefits, Risks, Alternatives, Nothing' and 'Ask 3 questions' should be considered.

2.5.10 Ideally, as part of shared decision making, consent for surgical and anaesthetic procedures should be obtained prior to the day of surgery (see recommendation 4.3), allowing sufficient time for the patient to reflect on their consent discussion. The competent patient has a fundamental right, under common law, to give, or to withhold, consent to examination, investigation and treatment.

2.5.11 Where a patient is seen prior to the day of surgery and shared decision making and discussion of anaesthetic conduct has taken place, the anaesthetist on the day of surgery has a responsibility to ensure the patient still understands and agrees with the perioperative plan.

9.7.1 Early on in the antenatal period women should be informed of the analgesic options available in their planned delivery location, so that they can make informed decision about their place of birth.

9.7.2 Every unit should provide, in early pregnancy, advice about pain relief and anaesthesia during labour and delivery. An anaesthetist should be involved in preparing this information and should approve the final version.

9.7.3 Pregnant women should have access to information about the differing modes of delivery during the antenatal period and should be offered the opportunity to speak to an anaesthetist if they wish to discuss how this might affect their choices around analgesia and anaesthesia.

10.9.2 Information provided preoperatively should include:

- anaesthetic technique; analgesia plan, including regional blockade; any additional procedures (e.g. invasive monitoring, blood transfusion); and planned postoperative care in a critical care environment
- a statement that the ultimate decision making will take place on the day of surgery, according to the needs and safety of the child and as judged by the attending anaesthetist; and that planned resources, e.g. critical care beds, could be unexpectedly unavailable on the day and this may also be part of the decision making
- a description of generally common adverse effects, e.g. sore throat and postoperative nausea and vomiting, and significant risks, e.g. allergic reactions; and any additional risks particular to the individual child and their comorbidities
- concerns raised in discussion with a child or young person or parents and carers, such as a fear of needles, fear of facemasks, loss of control (which is common in teenagers), emergence delirium, awareness, postoperative pain, postoperative nausea and vomiting, and the risk to the developing brain of anaesthesia in young children[90,91]
- preoperative fasting instruction should be given verbally and in writing; the timing should be appropriate to the proposed theatre list start time[92]
- information on the use of unlicensed medicines and/or licensed medicines for off-label indication if requested.

15.9.2 It is important to engage in a shared decision-making process with patients to discuss the risks and benefits of scheduled or elective major vascular surgery. Details should be explained to the patient in an appropriate setting and in language they can understand. Patient information materials should be made available to support the patient's decision with regard to choices on anaesthesia and analgesia.

15.9.3 These discussions should occur well in advance of planned surgery to allow reflection and informed decision-making. All such discussions should be documented, although it is still necessary to give relevant explanations at the time of the procedure.

15.9.4 Options for anaesthesia and all aspects of perioperative care, including risks and benefits, should be discussed with the patient by the responsible anaesthetist.

HELPNOTE

This can be demonstrated through an audit of shared decision making using a validated questionnaire such as Elwyn et al.'s collaborate tool (http://www.glynelwyn.com/collaborate.html) or Härter and Scholl's 9 item Shared Decision Making questionnaire (http://www.patient-als-partner.de/index.php?article_id=20&clang=2).

Using a framework to support the process of making decisions, such as the one developed by Choosing Wisely UK, helps support conversations where decisions need to be made – both in preparation for an appointment and during the appointment. 'BRAN' (Benefits, Risks, Alternatives and doing Nothing) has been endorsed by Choosing Wisely. The Centre for Perioperative Care has dedicated webpages with additional resources on shared decision making, including a

shared decision making animation: 'Peter's Journey: An Example of Shared Decision Making'.

Individualised risk assessment, e.g. using Surgical Outcome Risk Tool (SORT)-clinical judgement models as described by the RCoA-endorsed Preoperative assessment and optimisation for adult surgery guidance, should be used to discuss risks with patients.

This standard has been mapped to the following Core Standards for Pain Management Services (CSPMS): 3.6.19 and 3.6.20. The full references can be found here; https://fpm.ac.uk/sites/fpm/files/documents/2021-07/FPM-Core-Standards-2021_1.pdf

The Royal College of Anaesthetists has several information resources on risk, including patient information leaflets, which can be accessed here.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.1 Patient information for anaesthesia*, *1.2 Perioperative risk prediction*, *1.11 Perioperative neurocognitive disorders*, *1.14 Individualised perioperative pain management*, *5.6 Pain relief after day surgery*, *7.7 Pain relief after caesarean section*, *10.1 Assessment and documentation in acute pain management*.

STANDARD

3.1.1.2 Patients should have adequate time to discuss information about their procedure with the anaesthetist prior to arriving in the anaesthetic room to ensure valid, informed consent for anaesthesia.

EVIDENCE REQUIRED

Verbal confirmation should be given that adequate time is allocated and that there is an opportunity to discuss concerns with an anaesthetist. The department should have a transparent process for patients to access additional advice, e.g. after their preoperative assessment appointment, when required. An audit of patient satisfaction will provide further evidence.

PRIORITY

1

CQC KLoEs

Caring; responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

1.5.7 The department should have a process in place to deal with ad-hoc patient queries about their treatment. Patients should be advised how to access this process.

2.5.5 Information should be provided sufficiently far in advance to allow the patient to consider and reflect on this information prior to anaesthesia and surgery.

2.5.10 Ideally, as part of shared decision making, consent for surgical and anaesthetic procedures should be obtained prior to the day of surgery, allowing sufficient time for the patient to reflect on their consent discussion. The competent patient has a fundamental right, under common law, to give, or to withhold, consent to examination, investigation and treatment.

5.5.5 Informed consent should take into account the benefits and risks of the procedure, alternative options available and the option of doing nothing. Consent should be given at the earliest possible opportunity in view of limited time available for the patients having emergency surgery to consider the information. All discussions should be clearly documented.

7.9.4 Information regarding planned procedures outside of the operating theatre and the requirement for sedation or anaesthesia should be given to the patient in advance of their admission. Details on fasting times and medications to continue or omit should be included. The patient needs to be aware that they require a competent adult to escort them home after receiving sedation.

9.7.2 Every unit should provide, in early pregnancy, advice about pain relief and anaesthesia during labour and delivery. An anaesthetist should be involved in preparing this information and should approve the final version.

9.7.3 Pregnant women should have access to information about the differing modes of delivery during the antenatal period and should be offered the opportunity to speak to an anaesthetist if they wish to discuss how this might affect their choices around analgesia and anaesthesia.

10.9.7 Young people have additional needs and may wish to speak to the anaesthetist or another member of staff without direct parental presence. Anaesthetists should make it clear that they are willing to speak with young people on their own, on request.

10.9.9 Anaesthetists treating children and young people must ensure that they understand the arrangements for consent in the part of the UK in which they are working.

HELPNOTE

Following the Montgomery ruling it is incumbent on medical staff (including anaesthetists) to ensure that patients have adequate information upon which to base their decisions during consent. This requires time, even when patients have received comprehensive written information about anaesthesia and its potential risks. The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.4 Consent in anaesthesia*, *1.5 Shared decision making in perioperative care*, *2.5 Awareness under anaesthesia*.

STANDARD

3.1.1.3 A process is in place to ensure that clinicians and patients and/or where appropriate, their family member, friend, parent or chosen advocate have a preoperative discussion to ensure a shared understanding about which perioperative treatments, including cardiopulmonary resuscitation, would be appropriate and in line with patient's wishes.

EVIDENCE REQUIRED

This process, as well as the information given, should be described. Useful evidence includes the DNACPR or resuscitation policy, a description of how the process is implemented, audit data via the resuscitation group, and clinical pathways for emergency laparotomy and fractured neck of femur patients. The department should comply with guidance on advance care planning.

PRIORITY

1

CQC KLoEs

Effective; caring; responsive

HIW Domains

Quality of patient experience; safe and effective care

HIS Domains

Impact on patients, service users, carers and families; safe, effective and person-centred care delivery

GPAS REFERENCES

5.5.16 Hospitals should have a treatment escalation plan and/or do not attempt cardiopulmonary resuscitation (DNACPR) guidance and documentation that complies with national requirements.

5.5.17 Patients who may require surgical procedures with DNACPR decisions in place should have senior members of the anaesthesia and surgical team review the condition of the patient and the DNACPR status. Where feasible, a discussion should take place with the patient and their next of kin. It may be appropriate to suspend components of a DNACPR decision (e.g. tracheal intubation) to allow surgery to proceed safely.

16.6.7 A patient-centred approach is preferred for documenting advanced care plans, which include overall treatment goals including resuscitation status. It should include discussing and planning treatments that should be considered, not just those that should be withheld.

HELPNOTE

The process should be in accordance with the Association of Anaesthetists clinical practice guideline "Implementing advance care plans in the peri-operative period, including plans for cardiopulmonary resuscitation 2022".

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.5 Shared decision making in perioperative care*, *4.10 Prevention of unexpected cardiac arrest*.

STANDARD

3.1.1.4 A team approach, with support from senior colleagues is taken for discussions about clinical benefit and end of life decisions prior to surgery.

EVIDENCE REQUIRED

Verbal confirmation from all staff groups. Pathways for surgery with elevated mortality risk scores (e.g. emergency laparotomy) or surgery undertaken for palliative reasons (e.g. fractured neck of femur) should be described.

PRIORITY

1

CQC KLoEs

Effective; caring; responsive; well-led

HIW Domains

Quality of patient experience; safe and effective care; management and leadership

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

5.5.8 Interventions that are unlikely to alter outcomes and may add to patient distress should be recognised and communicated with the patient and their relatives or supporters at the earliest opportunity.

5.5.9 A team approach should be considered for breaking bad news and discussions around clinical benefit and end-of-life decisions with patients and relatives.

5.5.10 Discussion and reasons behind decisions taken, as well as the information given to the patient and relatives, should be clearly recorded.

STANDARD

3.1.2.1 Information given to patients and/or where appropriate, their family member, friend, parent or chosen advocate about the patient's intended treatment pathway includes the operation, anaesthesia, what to expect in the anaesthetic room, operating theatre, recovery room, obstetrics department and after discharge, as appropriate.

EVIDENCE REQUIRED

Details of the information and materials should be provided. Information should include confirmation of whether a 24/7 epidural service is available.

PRIORITY

1

CQC KLoEs

Caring; responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.5.1 All patients undergoing elective procedures should be provided, prior to admission with information on their intended treatment pathway (day surgery or enhanced recovery) that is easy to understand. This should include information on the operation, anaesthesia, recovery and postoperative pain relief. Provision of this information should be documented in the patient's notes. The written and verbal information given to patients before their admission to hospital should explain the purpose and nature of their recovery and the recovery department. The *Fitter Better Sooner* resources published by the Royal College of Anaesthetists and the *You and your anaesthetic* leaflet, published by the Royal College of Anaesthetists and the Association of Anaesthetists are examples.

2.5.2 The information provided for patients should include information on what will happen to them in the anaesthetic room in the operating theatre and after discharge.

2.5.8 Some patients, both adults and children, may need parents or other members of their family to be with them. This need is best determined at the preassessment clinic visit, so that sensitivities can be taken into account in the operative process.

2.12.2 The child should be helped to understand events that are happening or will happen, with the use of age-specific and developmentally appropriate explanation and materials. There are specific issues around consent for children that need to be understood, including the particular requirements for children who are not under the care of their parents.

6.9.2 Diagrammatic representation of the patient journey through day surgery may help explain the process.

9.7.1 Early on in the antenatal period women should be informed of the analgesic options available in their planned delivery location, so that they can make informed decision about their place of birth.

10.9.1 Families should be provided with written or web-based resources that provide information specific to anaesthesia before the planned surgery/procedure, and contact details for the preassessment team should be provided in case they have further questions or need to speak directly with their anaesthetist. The leaflet 'Information for Teenagers, Children and Parents' is available from the RCoA website, and other leaflets there and on the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) website provide other patient, parent and carer information resources.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.1 Patient information for anaesthesia*, *7.1 Information for mothers about analgesia and anaesthesia during delivery*, *8.1 Preoperative information for children and their families*.

STANDARD

3.1.2.2 Day surgery patients are given clear and concise written information on discharge including access to a 24/7 hospital-based staffed telephone line for advice.

EVIDENCE REQUIRED

Information given to patients on discharge from the hospital includes a telephone number for advice. The phone number should ideally be an inpatient surgical area of the appropriate surgical specialty and should not be an answer phone. A number for A+E/111/GP out of hours would not be considered acceptable. The information should include warning signs of serious complications specific to the type of anaesthesia received, e.g. neuraxial block, and appropriate actions to take. There should also be information on what to do, and what not to do, following discharge including post discharge analgesia protocols. The postoperative instructions facilitate ongoing self-care by the patient and should include staffed telephone line 24/7 in case of immediate concerns for adults and children.

PRIORITY

1

CQC KLoEs

Safe; caring; responsive

HIW Domains

Quality of patient experience; safe and effective care

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.5.2 The information provided for patients should include information on what will happen to them in the anaesthetic room in the operating theatre and after discharge.

6.1.20 Patients may be discharged home with residual sensory or motor effects after peripheral or plexus nerve blocks (not after neuraxial anaesthesia). Duration of the effects should be explained, and the patient should receive written instructions as to how to care for their numb until limb normal sensation returns.

6.1.22 Postoperative short term memory loss may prevent verbal information being assimilated by the patient. If postoperative analgesia has been provided, clear, written instructions on how and when to take medication should be provided. Other important information should also be provided in writing.

6.1.23 A 24-hour telephone number should be supplied so that every patient knows whom to contact in case of postoperative complications. This should ideally be to an inpatient surgical area of the appropriate specialty and should not be an answer phone.

6.1.28 All patients should receive a copy of their discharge summary in case emergency treatment is needed overnight.

6.2.5 In additional to clinical information, patients should be provided with:

- the date and time of admission to the unit,
- location of the unit, travel and parking instructions, including information regarding parking costs, if relevant

- any relevant preoperative preparation instructions required of the patient
- information on the anaesthetic to be provided including clear instruction for preoperative fasting and hydration, and the way in which patients will manage their medication
- requirement to arrange an escort home and a postoperative carer if indicated
- postoperative discharge information, including details of follow-up appointments, management of drugs, pain relief and dressings, and clear instructions on whom to contact in the event of postoperative problems.

10.9.4 Information provided postoperatively should include the safe use of analgesia after surgery and discharge from hospital, and what to do and who to contact in the event of a problem or concern. This should include telephone numbers where advice may be sought 24 hours a day.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *5.6 Pain relief after day surgery*.

STANDARD

3.2.1.1 Sufficient, appropriate facilities are available preoperatively. This should allow for multiple patients to have confidential and dignified consultations, according to their wishes and include space to wait prior to surgery.

EVIDENCE REQUIRED

Sufficiency is assessed on the size of the department and the number of anaesthetists working at the same time who may need use of a private and confidential area. Appropriateness of type of room is assessed to ensure that the room is sufficient for the needs of the conversation. Patients should be made aware of the available rooms to be able to request access.

PRIORITY

1

CQC KLoEs

Caring; responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families; Policies, planning and governance

GPAS REFERENCES

6.2.6 Facilities for privacy and confidentiality during preoperative discussion and examination should be provided. Preoperative discussions with patients in crowded waiting rooms should be avoided

6.4.5 Adequate time and facilities should be provided within the DSU to enable the multidisciplinary clinical team to undertake all aspects of the admission process; including clinical assessment, further discussion about the procedure and delivery of information.

HELPNOTE

There should be a space available within every preoperative area, that is private and reasonably soundproof (i.e. a room with a door). Patients and anaesthetists should be aware that such a space is available should they require it.

STANDARD

3.2.2.1 There is support for patients tailored to their individual needs.

EVIDENCE REQUIRED

Written policies should be provided and staff should describe local policies for supporting patients tailored to their individual needs and/or protected characteristics and should confirm that they are in place and effective. An audit of patient satisfaction will provide further evidence for this standard.

PRIORITY

1

CQC KLoEs

Caring; Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.5.8 The Mental Capacity Act, Adults with Incapacity (Scotland) Act or the Mental Capacity Act (Northern Ireland) must be complied with. Staff should have regular training in the application of the Mental Capacity Act and have defined access to patient advocates. This is a rapidly changing area, and clinicians should have access to expert advice if required. All NHS trusts are now nationally mandated to have a named safe guarding lead for adults and this individual should be used as appropriate.

2.12.16 Children with learning disabilities should ideally be recovered in an area with lower levels of noise and lighting and a familiar presence, such as a parent or their carer.

2.12.17 The presence of learning disability practitioners in recovery when a patient with learning disability is being recovered should be considered.

2.12.27 There is a high prevalence of recognised and unrecognised cognitive impairment amongst older surgical patients. This has implications for shared decision making, the consent process and perioperative management. Older patients should have preoperative cognitive assessment using established screening or diagnostic tools.

2.12.39 Provisions should be made for the assessment and management of pain in older people, and more specifically in those with dementia.

2.12.67 In patients with learning disabilities or special needs, there should be close co-operation with other specialists. A learning disability liaison nurse could be available to support patients and carers while attending the hospital either for outpatients, day surgery or as inpatients. If patients lack capacity and are unaccompanied, then the involvement of an independent mental capacity advocate (IMCA) should be sought.

2.12.68 Departments should have a policy on how to care for patients with additional needs including those covered under the Equality Act and consider appointing an assigned lead anaesthetist with time in their job plan for the role. The policy should incorporate preassessment, deprivation of liberty assessment, consent, pathways to minimise anxiety and considerations for analgesia and discharge planning.

5.5.2 Consideration should be given to assessing a patient's understanding of information given. At the end of an explanation, patients should be asked if they have any questions. Any such questions should be addressed fully and details recorded. If urgency allows, this is better undertaken in the presence of patient's relative(s) and/or carer(s). When this is not feasible in an emergency situation communicating the decisions to the next of kin should be considered. If there is no next of kin, independent medical advice or a second opinion should be sought.

5.6.47 Hospitals must have local policies in place for the identification, support and safeguarding of vulnerable adults.

10.3.7 Staff should take into consideration the needs of patients who have a hospital passport. A copy of the hospital passport should be kept in the patients notes and should be referred to throughout the perioperative pathway.

10.3.8 Children with learning disabilities should ideally be recovered in an area with lower levels of noise and lighting and a familiar presence, such as a parent or their carer.

10.3.11 Staff should liaise with a trust lead for patients with learning difficulties.

HELPNOTE
The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *8.1 Preoperative information for children and their families.*

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

3.2.2.2 A system is in place to enable the presence of, where appropriate, their family member, friend, parent or chosen advocate at induction of anaesthesia in children or patients with individual needs.

EVIDENCE REQUIRED

A copy of a written policy on the presence of family member, friend, parent or chosen advocate in the anaesthetic room and recovery should be provided. This includes play specialists where appropriate.

PRIORITY

1

CQC KLoEs

Caring; Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.5.8 Some patients, both adults and children, may need parents or other members of their family to be with them. This need is best determined at the preassessment clinic visit, so that sensitivities can be taken into account in the operative process.

2.12.3 A parent or legal guardian should ideally be with the child up to the point of moving into the operating theatre.

2.12.4 Consideration should be given to appropriate strategies for recognising and managing anxiety of children particularly at induction e.g. play specialists, counselling, psychological support and anaesthetic training around managing preoperative anxiety.

10.2.8 Children undergoing anaesthesia and their families should be offered input from play specialists to help to prepare the child for anaesthesia.

10.2.21 Parents and carers should be allowed timely access to the recovery area or, if this is not feasible, children should be reunited with their parents or carers as soon as possible.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *8.1 Preoperative information for children and their families*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat

patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

3.2.2.3 Patients have access to adequate information services according to their individual needs.

EVIDENCE REQUIRED

Patient information should be provided in a wide range of formats and styles relevant to the patient population, e.g. large print, Braille, easy-reading, QR codes, videos or other media. Patient feedback should be available to demonstrate levels of patient satisfaction.

PRIORITY

1

CQC KLoEs

Caring; Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.5.2 The information provided for patients should include information on what will happen to them in the anaesthetic room in the operating theatre and after discharge.

2.5.4 Information should be provided in a range of formats, including written leaflets or electronic material. Details of websites that provide reliable, impartial and evidence-based information should be made available to patients when appropriate. Where possible this should include large print, Braille and audio formats. Information should conform to the 'accessible information' standard set by the Department of Health for those with disabilities.

2.12.2 The child should be helped to understand events that are happening or will happen, with the use of age-specific and developmentally appropriate explanation and materials. There are specific issues around consent for children that need to be understood, including the particular requirements for children who are not under the care of their parents.

10.9.6 Children should receive information before admission that is appropriate to their age and level of understanding. Information can be provided at face-to-face meetings by nurses and play therapists, and can be enhanced with booklets, web links, online apps or videos.

HELPNOTE

Patients with disabilities should be considered including those with learning, vision and hearing disabilities.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.1 Patient information for anaesthesia*, *7.1 Information for mothers about analgesia and anaesthesia during delivery*.

STANDARD

3.2.2.4 All information for patients should be available in a language they can comprehend. Appropriate translation services should be available.

EVIDENCE REQUIRED

The hospital policy should be provided. Verbal confirmation should be given that access to interpretation services is available for patients who require them, and patient feedback should be available to demonstrate levels of patient satisfaction.

PRIORITY

1

CQC KLoEs

Caring; Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.5.7 Patients from non-English speaking groups may require interpreters. Wherever possible, this need should be identified in advance. Hospitals should have arrangements in place to provide language support, including interpretation and translation services (including sign language and Braille). Patients with learning and other difficulties may require special assistance and consideration.

6.2.3 Information should be arranged in such in way that it is comprehensive and comprehensible and should be available in a format suitable for the visually impaired and those with other difficulties understanding and considering the information. It may be necessary to provide information leaflets in a number of different languages to accommodate the needs of the local population.

9.7.4 Information should be made available to non-English speaking women in their native languages.

9.7.5 Units should consider local demographics, such as the prevalence of particular languages, when designing information or commissioning interpreting services.

9.7.6 Hospitals should ensure that the individual need for information in other languages should be assessed and recorded during antenatal care so that interpreting services can be planned for.

9.7.7 Interpreting services should be made available for non-English speaking women, with particular attention paid to how quickly such services can be mobilised and their availability out of hours.

9.7.8 Face to face interpreting services should be considered as most suitable, given the practical requirements for women in labour. However, telephone based services may be able to serve a greater number of languages and be more quickly mobilised, particularly out of hours.

9.7.9 The use of family members to interpret or translate should be avoided unless absolutely necessary or an independent interpreter is specifically declined. It should be a rare occurrence that there is no alternative translation method available.

HELPNOTE
A telephone line that interprets information for the patient is an alternative to foreign language leaflets where these are not available or where the level of linguistic diversity in the patient population means that the costs, in terms of space and finances, of keeping leaflets in all of these languages would be prohibitive.

The RCoA, working in partnership with the international translation charity Translators without Borders (TwB) has provided translations of our most popular patient information leaflets in the 20 most common languages used in the UK, including Welsh.

STANDARD

4.1.1.1 The department has a live and annually reviewed operational plan in line with the wider organisational strategy.

EVIDENCE REQUIRED

A written copy of the current operational plan should be provided, describing operational goals for service changes, estate developments, workforce developments (including wellbeing and inclusion), information technology developments (including electronic patient records) and other relevant improvements or changes. Verbal confirmation from staff that all permanent members of the department are involved in its formulation and annual review.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.1.1 Departments should have a clear and explicit strategy for developing a strong and supportive patient-centred safety culture. The departments strategy should emphasise using a systems based approach where safety systems are put in place that usually prevent accidents from occurring and develop systems that positively improve patient and staff safety.

1.1.2 Communication within organisations should promote an inclusive culture by promoting two-way communication, promoting the flattening of hierarchies across the organisation and ensuring that all staff feel listened to and valued. An organisation with such a culture uses the ideas of staff to shape the development of the organisation.

1.1.6 The department should create a culture that promotes high quality care, quality improvement and improved outcomes.

1.1.7 The anaesthetic team should be empowered to shape their working environment to enhance safety and quality of care.

1.1.9 The department should establish and support a culture that promotes the health and wellbeing of staff members.

1.1.10 The department must establish and maintain a culture of proactively thinking about and questioning equality, diversity and inclusion in all that it does, including recruitment, training, opportunities for extended roles and responsibilities.

1.1.15 The department should have a live, regularly reviewed annual plan describing service changes, estates developments, workforce developments and wellbeing, working conditions, capacity demand modelling and other relevant operational improvements. This will ensure that the department is responsive to requests for additional resources across all areas of activity.

1.2.1 Departments should have a workforce plan in line with their overall strategy and annual business plan that includes recruitment, opportunities for flexible working and staff retention. The plan should ensure a level of staffing and skill mix that meets current service and educational requirements with sufficient flexibility to ensure staff are not overstretched. It should be reviewed regularly and consider integrated care systems and other regional strategic developments, and the work life balance needs of anaesthetists and other staff as they age and at all stages of their career.

HELPNOTE
The annual plan for the anaesthetic department should be a living document that is developed collaboratively within the department and has clear links to the overall hospital plan.

The Annual Operating Plan should describe:

- the ethos, culture and values of the service
- the service
- the workforce, including a workforce development plan which includes succession planning to meet the needs of the department
- leadership of the service, including roles and responsibilities
- the roles and responsibilities for all staff members
- key relationships with other departments and organisations
- measurable objectives, KPIs, and metrics for the department based on national standards and local needs and procedure for collecting, monitoring, reviewing and analysing quantitative and qualitative data and feedback
- the services objectives, priorities and improvement plans
- plans for development, including strategies for the development of the department to meet the needs of the local population across the perioperative pathway
- the procedure for engaging with stakeholders in planning and communicating the department's operating plans results and outcomes to stakeholders.

Progress against the plan should be reviewed regularly and the plan updated in light of changing circumstances.

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.3 Theatre use and efficiency*.

STANDARD

4.1.1.3 Department should have a process to manage their risks. They should review their operational & clinical risks regularly, keep the risk register updated, take adequate steps to mitigate risks and have an effective process to escalate those risks that cannot be managed at a departmental level.

EVIDENCE REQUIRED

A copy of the risk register should be provided along with minutes of meeting(s) in which the risk register is discussed.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

1.4.66 The anaesthetic department should review clinical and operational risk on a regular basis. This should be done by using information obtained from other sources (e.g. literature and lessons learned from other clinical services) as well as communicating and discussing information they have identified to staff members and other clinical services.

1.4.67 The anaesthetic department should identify and agree plans to address and mitigate those risks identified in their risk register. The risk register should be a dynamic and responsive document that is regularly reviewed to ensure that all risks are being actively managed and should be disseminated appropriately. Members of the anaesthetic department should be educated in the benefits of using a risk register proactively to improve patient safety.

1.4.68 The anaesthetic department should escalate those risks that are identified as being beyond the control of the clinical service to those charged with overall hospital/trust risk management. The department should receive a response and regular update if the risk is not satisfactorily mitigated against.

STANDARD

4.1.1.4 If appropriate resources are not available, the level of clinical activity is limited to ensure a safe provision of care.

EVIDENCE REQUIRED

Clearly defined written lines of escalation with management. Verbal confirmation of managerial support should be given, and staff should relay anecdotal evidence of times that this has been handled appropriately.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

2.1.2 If appropriate resources are not available, the level of clinical activity pertaining to those resources should be limited, to ensure safe provision of perioperative care. The hospital policy for determining, communicating and documenting this process should have input from the anaesthetic department.

HELPNOTE

The final decision should be clinically based and the lines of responsibility within the department and the trust's/board's management structure should be clear.

The RCoA and Association of Anaesthetists' joint publication on the safer staffing for the delivery of anaesthesia services can be referenced for staffing guidance: Safer Staffing for the Delivery of Anaesthesia Services

STANDARD

4.1.1.5 The department has a plan in the event of a major incident.

EVIDENCE REQUIRED

A written policy. Staff should be aware of their role in the event of a major incident.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

16.2.7 All acute hospitals should have a defined major incident plan. The plan should be built around the regional network of MTCs, TUs and local emergency hospitals (LEHs).

16.7.17 Major incident training exercises should take place at regular intervals.

HELPNOTE

This standard is still applicable even if your hospital is not part of a major incident protocol. It applies to business continuity so could also refer to a hospital wide emergency rather than an external one (e.g. an IT shortage, data breach, fire) and how services would be managed under these circumstances.

STANDARD

4.1.2.1 The department has an agreed leadership structure, with clearly defined role and responsibilities.

EVIDENCE REQUIRED

The leadership structure should be provided, along with roles and responsibilities for each role. Verbal confirmation of the process for reviewing the structure and performance of the leadership team as a whole. Staff feedback that leadership development is available, and opportunities follow a transparent recruitment process.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Impact on staff; policies, planning and governance; workforce management and support

GPAS REFERENCES

1.1.14 Clinical leaders within anaesthetic services should be an integral part of system planning including how to deliver planned care and emergency care. They should have influence in all areas in which anaesthetists contribute to service delivery.

1.1.16 Clinical leadership roles should be designed to be desirable and exciting opportunities for anaesthetists. Appointment processes to clinical leadership roles should be open and transparent.

1.1.17 The department should have a clinical leader for the whole department. The clinical lead should be part of the wider overall hospital management structure. They should lead with compassion and foster a learning culture within the service they manage

1.1.19 The department should collaboratively review the structure and performance of the leadership team as a whole on an agreed schedule to ensure that it remains effective and fit for purpose. Clinical leaders should have annual reviews of performance in leadership and management duties. The annual review should by conducted by someone competent to do so with an understanding of the challenges of dual roles.

1.1.20 The department should have adequate remunerated time allocated to all clinical leaders to perform their roles in integrated governance, which recognises the breadth and depth of their roles within the department and wider hospital management structures. Adequate remunerated time may be facilitated through diarising time spent on a role and reviewing this as part of the job planning process.

1.1.23 Appropriate training and development should be offered across all aspects of a leadership role and identified in personal development plans (PDPs) as part of whole practice appraisal.

1.1.24 Departments should encourage the development of new leaders at all stages during an anaesthetic career.

1.1.25 Opportunities should be made available for shadowing leaders, coaching and mentorship.

1.1.26 SAS doctors and trainees should be encouraged to engage in leadership opportunities.

STANDARD

4.1.2.2 There are anaesthetic clinical leads with responsibility in the following areas: preoperative assessment, emergency anaesthesia, remote sites, day surgery, inpatient pain management, perioperative medicine, resuscitation, anaesthetic equipment, governance, simulation/human factors training, research, airway management, staff wellbeing, allergy, relevant sub-specialty areas and others as appropriate. This list is not exhaustive.

EVIDENCE REQUIRED

The names of individuals should be provided and the documented roles and responsibilities.

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Impact on staff; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.1.18 There should be anaesthetic clinical leads with clear and agreed responsibilities for different areas or specialties. The number of leads will depend on the size of the anaesthetic department, their areas of specialisation, workload and any ongoing areas of special focus. The list below is not exhaustive and not applicable to all departments:

- preoperative assessment
- perioperative medicine
- emergency anaesthesia
- remote sites
- paediatrics
- obstetrics
- day surgery
- acute pain management
- resuscitation
- airway management
- regional
- critical care (as appropriate)
- SAS
- locally employed doctors'
- procurement
- governance roles including safety, complaints, audit and quality improvement
- equality, diversity and inclusion

- multidisciplinary team training and simulation
- research
- wellbeing
- environmental
- electroconvulsive therapy (if available)

2.7.9 A named anaesthetist with time assigned in their job plan should oversee the provision and management of anaesthetic equipment.

HELPNOTE
Further details on the role of particular leads are available here: Airway lead; ICM lead – GPICs; POM leads; Regional safety lead; anaphylaxis lead.

A single anaesthetist may cover more than one responsibility if required; for example, in smaller departments. SAS doctors undertaking lead roles should be autonomously practising doctors who have competence, experience and communication skills in the specialist area equivalent to consultant colleagues. They should usually have experience in teaching and education relevant to the role and they should participate in Quality Improvement and CPD activities. Individuals should be fully supported by their Clinical Director and be provided with adequate time and resources to allow them to effectively undertake the lead role.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *6.2 Remote site anaesthesia*, *11.13 Wellbeing*.

Note 3: If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case. If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

STANDARD

4.1.3.1 The department promotes the health and wellbeing of staff members.

EVIDENCE REQUIRED

Verbal confirmation from staff groups regarding services that the organisation has in place to promote the health and wellbeing of staff. This should include particular welfare provision for staff involved in, and affected by, high volume and complex work. Evidence that wellbeing is considered in all departmental activities, e.g. designing the rota to reduce fatigue, providing sufficient notice of the rota and any changes to the rota and including a paragraph in job descriptions about the wellbeing services offered.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Impact on staff; policies, planning and governance; workforce management and support

GPAS REFERENCES

1.2.48 There should be a health and wellbeing policy in place for all staff.

1.2.49 Departments should consider having a health and wellbeing lead who has access to adequate expertise and resources.

1.2.50 To promote high job satisfaction departments should strive to achieve good working conditions, strong inter departmental relationships and appropriate resources.

1.2.52 Departments should promote a caring and supportive culture, in which every effort is made to identify and support those who may be in difficulty and have a means of offering appropriate support.

1.2.53 Poor teamwork can impact on the wellbeing of all staff and can lead to lower job satisfaction. Departments should consider providing team-based training to promote cohesiveness and collaboration.

1.2.56 The department should have a policy on providing breaks for anaesthetists working solo which might include discussing breaks as part of the theatre team brief and providing a 'floating' anaesthetist to help with breaks in the theatre suite. If breaks are unavailable, then this should be formally recorded and included in the organisation's risk register.

HELPNOTE
The RCoA and Association of Anaesthetists have produced an educational resource pack, which includes guidance that departments should use to inform this standard.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.12 Professional compliance analysis tool for improving the working environment and rotas*, *11.13 Wellbeing*, *11.14 Fatigue and the anaesthetist*.

STANDARD

4.1.3.2 Departments should have a photo board (real or virtual) of permanent staff and rotational doctors in training which includes their preferred term of address by colleagues.

EVIDENCE REQUIRED

Evidence of an up-to-date photo board that is accessible by new and permanent staff in the department. Labelled with their formal name and preferred term of address by colleagues. This allows colleagues working together for the first time to identify each other easily and address them in their preferred way.

PRIORITY

1

CQC KLoEs

Effective; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Workforce management and support; impact on staff

GPAS REFERENCES

1.1.2 Communication within organisations should promote an inclusive culture by promoting two-way communication, promoting the flattening of hierarchies across the organisation and ensuring that all staff feel listened to and valued. An organisation with such a culture uses the ideas of staff to shape the development of the organisation.

1.1.5 A culture of collaboration should be encouraged by ensuring opportunities for clear, open, respectful and non-judgemental communication within the department where staff, irrespective of seniority or role, feel free to comment and challenge to improve care and reduce errors.

1.2.45 Where an anaesthetist is supervised by a sessional supervisor, the individual should be aware of their supervisor's identity, location and how to contact them.

1.2.50 To promote high job satisfaction departments should strive to achieve good working conditions, strong inter departmental relationships and appropriate resources.

1.3.20 When new members join teams, particular care should be taken to introduce them to the team and to support them both to integrate and work with the team and bring their fresh insights to the team.

HELPNOTE

Compliance with this standard does not require 100% of the department to be on the photo board at the point of the review visit; it is sufficient for the majority of the department to be included and a process for updating the board to be in place.

STANDARD

4.2.1.1 There is a system in place to allow reporting and review of critical incidents and other anaesthesia related untoward incidents and near misses within a positive, supportive, no blame culture, which includes demonstrated learning.

EVIDENCE REQUIRED

Minutes of morbidity and mortality reviews and risk register should be seen including agenda, attendance and evidence of actions taken. Copies of an incident reporting form and information provided on induction should be seen. Understanding of and engagement with the current national reporting systems (NRLS) and its planned replacement (LFPSE) should be confirmed. Verbal confirmation should be given from all staff groups that they are aware of the reporting mechanisms in place and that the department communicates learning on a regular basis.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; quality improvement-focused leadership

GPAS REFERENCES

1.4.19 The department should have a system for reporting, investigating, sharing learning and regular audit of critical incidents. The methodology should be explicit and should identify underlying relevant factors to inform learning and development of safe systems, as well as enabling thematic analysis, continuous monitoring and evaluation.

1.4.20 The department should have a process to disseminate learning from incidents widely, both within the department and elsewhere in the organisation where appropriate.

1.4.21 Within the process for dealing with critical incidents, positive feedback should be emphasised and changes made to avoid recurrence.

1.4.22 It is the organisation's responsibility to ensure that patient safety concerns are addressed. An organisation with an effective safety culture should engage the team involved with working out where improvements might come rather than investigating at a distance and recommending the introduction of a change to be implemented by others.

1.4.23 It is important that local reporting systems should feed into national reporting systems, where relevant. Anaesthetists should contribute data as required, with the support of their Trust.

1.4.24 There should be multi-professional involvement in the review of critical incidents and near misses and in reviewing and learning from clinical excellence

1.4.25 Colleagues involved in reviewing significant adverse events should have appropriate education and training which includes an understanding of human factors and the complexity of healthcare systems

1.4.26 All staff should recognise and act upon their duty of candour and should foster a culture for reporting incidents and concerns with confidence that the focus of the organisation is on learning and improvement rather than blame. Adequate information sharing and feedback, as well as avoidance of blame, are essential to encouraging staff to value and therefore engage with the system.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.12 Structured morbidity and mortality reviews*, *7.5 Airway and intubation problems during obstetric general anaesthesia*, *7.10 Postnatal obstetric anaesthetic adverse effects and complications*, *11.5 Sharing, improving and learning from critical incidents*.

STANDARD

4.2.1.2 There is a system in place to facilitate and share learning in a positive and supportive environment in response to feedback, compliments and complaints from staff, patients, family members, friends, parents/carers or a chosen advocate.

EVIDENCE REQUIRED

Mechanisms for eliciting and collecting feedback and complaints from staff, patients, family member, friend, parent or chosen advocate should be described including escalation procedures. The review team may request an example of how a complaint has been dealt with and learned from. Confirmation from staff that actions taken in response to patient feedback are disseminated regularly.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; quality improvement-focused leadership

GPAS REFERENCES

1.4.6 The departmental ethos should foster an open safety culture in all aspects of the service.

1.4.16 Departments should have a culture of capturing learning and sharing it within and beyond the department to support further improvement in the future, building a robust system to ensure that learning is embedded in clinical practice.

1.4.18 Learning from negative episodes should be promoted within an ethos of support and avoidance of blame. This approach should be embedded throughout the department and the organisation as a whole.

1.4.52 Feedback including concerns, complaints and compliments should be captured, recorded and reviewed.

1.4.53 The anaesthetic department should have confidential procedures in place that enable patients to feed back their views on their experience within the clinical service

1.4.54 The anaesthetic service should collaborate with the hospital governance team to collate patient feedback.

1.4.56 All complaints should be acknowledged and appropriately reviewed in a timely fashion in line with local policy.

1.4.60 Those who have made a complaint should be informed about changes made as a result of their complaint, and if appropriate, should form part of the review process.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *7.11 New beginnings: A case study using patient experience-based co-design to improve services*, *11.12 Professional compliance analysis tool for improving the working environment and rotas*.

STANDARD

4.2.1.4 There is a process in place to ensure a team debriefing takes place after a patient safety or critical incident and there is a policy which appropriately addresses the pastoral care of staff members involved.

Evidence required
Written evidence should be provided and verbally confirmed by staff.

PRIORITY
1

CQC KLoEs
Caring; Safe; well-led; effective

HIW Domains
Safe and effective care; management and leadership

HIS Domains
Impact on staff; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.4.27 Departments should consider having a means of identifying those colleagues who have been involved in a patient safety incident and providing an opportunity for them to talk about what has happened and the impact it has had on them in a confidential and supportive environment.

1.4.28 Departments should have a clear and readily available plan accessible to all members of the anaesthetic team to manage adverse events both for a patient and beyond for a colleague/s or the department. This might include exploring the possibilities of interdepartmental peer support groups, and strategies to reduce the emotional burden on staff after adverse events.

1.4.29 The department should provide training and education in dealing with adverse events including: what to do after an adverse incident, potential problems, appropriate communication skills, the law surrounding adverse incidents and where to find expert support.

1.4.30 Following an adverse event, those involved should be supported appropriately. Expert support services should be signposted and made easy to access, and there should be a regular 'check in' from a trusted senior colleague known to and accepted by the anaesthetist or staff affected

HELPNOTE
The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *2.13 Management of death in theatre*.

Note 2: On the use of the term 'policies', "policy" is used as an umbrella term within the standards to describe a locally agreed process; other formats such as guidelines, standard operating procedures and processes embedded in IT systems are all included within this term. A "policy" should be an easily accessible, up to date reference point for staff members that is embedded into practice and used during staff induction. Review teams will assess whether the policy is in use and understood by relevant staff members, as well as any documentation available. Any documentation should be standardised in format, have a clear review date and, where applicable, be ratified in accordance with trust/board policies.

STANDARD

4.2.2.1 The department has a managed process of audit and quality improvement which includes regular presentation and information sharing of demonstrated learning and improvement planning.

EVIDENCE REQUIRED

Minutes of governance meetings should be seen, including agenda, attendance and evidence of actions taken. Verbal confirmation should be given from all staff groups that this takes place, and that the relevant information is disseminated.

PRIORITY

1

CQC KLoEs

Safe; effective; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; quality improvement-focused leadership

GPAS REFERENCES

1.4.40 The anaesthetic department should develop and document a quality improvement (QI) plan in accordance with operational aims and objectives and in consultation with staff members. The QI plan should include all potential areas for improvement and adoption of innovation.

1.4.41 The anaesthetic department should have a comprehensive and collaborative programme of engagement with QI initiatives locally, including audit of local guidelines and SOPs and improvements made following learning from incidents or near misses.

1.4.42 The anaesthetic department should have a comprehensive and collaborative programme of engagement with QI initiatives at national level, for example ACSA, the RCoA Raising the standards : QI Compendium, national audit projects such as NELA, PQIP, SNAP and GIRFT. This should include embedding learning and improvement from these national initiatives.

HELPNOTE

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.12 Structured morbidity and mortality reviews*, *7.3 Response times for the provision of intrapartum analgesia and anaesthesia*, *7.4 Regional analgesia during labour*, *8.6 Implementing thromboprophylaxis in paediatric surgical patients*, *11.12 Professional compliance analysis tool for improving the working environment and rotas*.

STANDARD

4.2.2.2 The department has evidence of engagement with, and implementation of, national audit projects and quality improvement programmes.

EVIDENCE REQUIRED

Written and verbal evidence should be provided, including for obstetrics.

PRIORITY

1

CQC KLoEs

Effective; responsive; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Key organisational outcomes; safe, effective and person-centred care delivery

GPAS REFERENCES

1.4.42 The anaesthetic department should have a comprehensive and collaborative programme of engagement with QI initiatives at national level, for example ACSA, the RCoA Raising the standards : QI Compendium, national audit projects such as NELA, PQIP, SNAP and GIRFT. This should include embedding learning and improvement from these national initiatives.

5.8.4 National level audit of emergency surgical activity and outcome is essential; all hospitals delivering emergency surgical care must contribute to the recognised national or other major audits of safe practice and critical incident reporting systems.

9.6.4 All cases of maternal death, significant permanent neurological deficit, failed intubation or awareness during general anaesthesia should undergo case review, with learning from this shared locally and/or nationally (by reporting to MBRRACE).

10.7.2 Regional ODNs could provide agreed quality standards for the perioperative care of infants, children and young people, and units should be encouraged to participate in regular collation of data relating to these standards. Participation in national audit should also be encouraged.

14.7.1 Departments of neuroanaesthesia should be encouraged to develop research interests, even if not part of an academic department. Research collaboration with other neuroscience disciplines is good practice. Taking part in national anaesthesia and critical care projects is to be encouraged.

15.7.2 It is recommended that individual vascular anaesthetists register with, and contribute to, the UK national audit database (National Vascular Registry), which incorporates a section dedicated to 'anaesthesia' as developed between the Vascular Anaesthesia Society of Great Britain and Ireland and partnership organisations. The systems needed to provide the necessary data should be available and supported.

16.8.6 All hospitals treating patients with hip fractures should participate in national audits, e.g., National Hip Fracture Database or the National Joint Registry to monitor its performance against national benchmarks, quality standards, and contribute to research. Outcomes from these audits should be discussed at

governance meetings and distributed to anaesthetic staff.

18.7.3 Centres should consider contributing to multidisciplinary national benchmarking audits such as the National Institute for Cardiovascular Outcomes Research, Getting It Right First Time and the National Cardiac Benchmarking Collaborative.

HELPNOTE
Examples of suitable audits/programmes to demonstrate compliance with this standard include SNAP, NAP, NELA, maternal mortality audits and PQIP. This is not an exhaustive list and the review team will acknowledge regional variations in participation with national audits in their assessment.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.15 Patient experience and outcome measures, 4.3 Emergency laparotomy, 4.12 Structured morbidity and mortality reviews*.

STANDARD

4.2.3.1 Measurements of relevant clinical outcomes of elective and emergency anaesthesia are collected and plans put in place to act on the findings.

EVIDENCE REQUIRED

Written evidence should be provided. These measures should be relevant to the scope of practice.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

2.15.1 There should be a multidisciplinary and cross specialty programme for auditing intraoperative care.

5.8.5 Outcomes for types of emergency surgery not covered by national audits should be audited via hospital episode statistics for benchmarking purposes.

6.8.1 The Royal College of Anaesthetists has published guidance for audits and quality improvement projects in day surgery. Each day surgery unit should have a system in place for the routine audit of important basic parameters such as:

- clinical: unplanned inpatient/overnightadmissions following surgery, postoperative symptoms (e.g. pain, nausea, and vomiting)
- organisational: non-attendance rates, patients cancelled on the day of operation.

10.7.1 Quality indicators, such as unplanned inpatient admission following day case surgery, readmission within 28 days, or unanticipated admission to PICU following surgery, should be measured, collated and analysed, and can be compared within regional networks. A number of suggested audit topics specifically relating to paediatric anaesthesia are set out in the RCoA document, *Raising the Standard: A compendium of audit recipes*.

HELPNOTE

These audits could include ICNARC, recovery data such as postoperative nausea and vomiting, fractured neck of femur, pain or patient satisfaction surveys. This list is not exhaustive. Data collection can be incorporated into post procedural reviews, as outlined in 1.4.4.2, to contribute to compliance with this standard.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.15 Patient experience and outcome measures*, *2.5 Awareness under anaesthesia*, *3.3 Postop nausea and vomiting beyond recovery*, *3.4 Record keeping in recovery*, *4.1 Risk assessment and preparation for emergency surgery*, *4.2 Theatre provision for emergency surgery*, *4,4 Emergency anaesthesia for the elderly patient*, *4.5*

Anaesthesia for fractured NOF surgery, *4.6 Major lower limb amputation, 5.8 Unplanned hospital admission after day surgery*, *5.9 Evaluating your day surgery pathway*.

STANDARD

4.2.3.2 The emergency surgery workload is monitored, reviewed, and used to plan future capacity.

EVIDENCE REQUIRED

Rolling audit data should be available. The clinical director should be able to provide examples of how this data has been used to inform business planning.

PRIORITY

1

CQC KLoEs

Safe; effective; caring; responsive; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Key organisational outcomes; safe, effective and person-centred care delivery

GPAS REFERENCES

5.1.3 The hospital business plan should address the predicted growth in surgical emergencies, ageing population and any changes as a result of regional specialisation. Future planning should be based on accurate and timely data. Mathematical modelling for matching theatre demand and capacity could be beneficial.

HELPNOTE

In addition to looking at the policy, reviewers will look for evidence that rotas are reviewed regularly and whether the department runs local audits to measure availability of theatres and staff for emergency surgery, differences in clinical outcome measures - comparing day and late night, weekend and weekday etc. They will also be looking for subsequent interventions to improve following results of the audits to evidence continuous quality improvement.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *1.15 Patient experience and outcome measure*, *4.1 Risk assessment and preparation for emergency surgery*, *4.2 Theatre provision for emergency surgery*, *4.1 Risk assessment and preparation for emergency surgery*, *4.5 Anaesthesia for fractured NOF surgery*, *4.6 Major lower limb amputation*, *5.1 Optimising your daycase rates*, *11.3 Theatre use and efficiency*, *11.4 Cancellation of surgery*.

STANDARD

4.3.1.1 There is documented and verbal evidence that the appropriate recruitment methods are routinely implemented for all anaesthetic appointments.

EVIDENCE REQUIRED

Evidence that the trust/board/hospital follows a transparent and equitable appointments process. This could include the RCoA's Advisory Appointments Committee (AAC) process.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

1.1.10 The department must establish and maintain a culture of proactively thinking about and questioning equality, diversity and inclusion in all that it does, including recruitment, training, opportunities for extended roles and responsibilities.

1.2.1 Departments should have a workforce plan in line with their overall strategy and annual business plan that includes recruitment, opportunities for flexible working and staff retention. The plan should ensure a level of staffing and skill mix that meets current service and educational requirements with sufficient flexibility to ensure staff are not overstretched. It should be reviewed regularly and consider integrated care systems and other regional strategic developments, and the work life balance needs of anaesthetists and other staff as they age and at all stages of their career.

STANDARD

4.3.2.1 There is documentary evidence that all members of the theatre team, including locum and agency staff, have undergone an appropriate induction process to the anaesthetic working environment.

EVIDENCE REQUIRED

Documentation for anaesthetic department induction and evidence of completion should be provided.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe & effective care; management & leadership

HIS Domains

Policies, planning and governance; workforce management and support

GPAS REFERENCES

1.3.1 An induction should be provided for all staff whether permanent or locum/agency staff starting in the department.

1.3.2 Inductions should be conducted during normal working hours at times convenient to all concerned.

1.3.3 The induction should be documented. It should ensure competency in the use of equipment and should act as an opportunity to identify those who require additional support in certain skills or areas of practice.

1.3.4 Induction for a short-term locum doctor should include as a minimum familiarisation with the layout of the hospital and the location of emergency equipment and drugs, access to guidelines and protocols, information on how to summon support/assistance, and assurance that the locum is capable of using the equipment and IT systems in that hospital.

1.3.5 Anaesthetists should be given support and time to familiarise themselves with non-theatre locations and different environments prior to solo sessions and out of hours work. This may include undertaking operating lists with a colleague.

1.3.6 Departments should include requirements for PPE into the induction process including fit testing where appropriate and the appropriate and safe use of PPE.

1.3.7 Departments should have specific processes in place to support IMGs starting work in the UK for the first time. Medical training initiative trainees and other IMGs, should undergo hospital and department induction, specifically tailored for them. This may include information and orientation about working in the NHS, accommodation facilities, city, banking etc.

1.3.20 When new members join teams, particular care should be taken to introduce them to the team and to support them both to integrate and work with the team and bring their fresh insights to the team.

HELPNOTE
Some members of the anaesthesia team will go through a different process of induction compared to the anaesthetists, but the anaesthetic department should have some input into that process, e.g. by providing information about departmental policies that relate to anaesthesia; anaesthetic machine inductions etc. What this input consists of and how it is managed will need to be described to the review team, including how changes to documentation and policies are communicated.

Feedback from staff on the effectiveness of induction should be collected and used to improve future induction processes.

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *11.12 Professional compliance analysis tool for improving the working environment and rotas*.

STANDARD

4.3.2.2 Departments should have regular protected clinical governance time where educational and clinical governance activity can take place. This should support sharing learning, promoting strong communication and a shared community of practice.

EVIDENCE REQUIRED

Attendance list and minutes from meetings should be provided and action tracker or progress plan to demonstrate output. Verbal confirmation from staff that this meets the needs of the service.

PRIORITY

1

CQC KLoEs

Safe; well-led; effective

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on staff; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.3.10 Departments should have regular clinical governance time where educational activity and clinical governance activity can take place. Clinical activity should be reduced during clinical governance time to maximise attendance, which should ideally occur monthly.

1.3.13 The department should have a structured educational training programme for anaesthetists covering updates on new techniques and practice developments.

1.3.16 All anaesthetists should receive non-clinical training and education, which should be reflected in job plans and job planning. The list of topics should be agreed by the department according to local need, but is likely to cover management, education, EDI and communication skills.

STANDARD

4.3.3.1 All members of staff should receive adequate time, resources and support for all activities related to appraisal and revalidation, including access to continued professional development.

EVIDENCE REQUIRED

Examples of appraisal process. Verbal confirmation from all permanent members of the department. Details of training provided on new techniques and practice developments.

PRIORITY

1

CQC KLoEs

Safe; well-led; effective

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on staff; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.3.9 Departments should commit to providing the time and resources to educate those who provide anaesthetic care for patients by facilitating access to education and training. Continuing professional development (CPD) and education should be balanced between the individual's clinical and other areas of responsibility.

1.3.12 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical and non-clinical practice, including annual mandatory training.

1.3.13 The department should have a structured educational training programme for anaesthetists covering updates on new techniques and practice developments.

1.3.15 Anaesthetists who provide out of hours cover to areas of practice that they do not provide in working hours, should be able to demonstrate the maintenance of appropriate skills and knowledge through regular clinical involvement and CPD. This should be facilitated during working hours where possible.

HELPNOTE

Any time, resources and support related to education, wellbeing and risk mitigation would be useful evidence here in addition to routine appraisal and revalidation activity.

The following quality improvement recipes from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *10.8 Continuing professional development and practice improvement for pain medicine anaesthetists*, *11.12 Professional compliance analysis tool for improving the working environment and rotas*.

STANDARD

4.3.3.2 All anaesthetic staff should complete training in adult and paediatric life support, safeguarding and consent, appropriate to their clinical practice and case load (emergency as well as elective), and as deemed appropriate by the employing organisation in line with prescribed mandatory training. Knowledge and skills in these domains should be maintained through CPD and planned as part of annual appraisal and personal development plans (PDP). Resources must be available to ensure compliance.

EVIDENCE REQUIRED

Evidence of departmental compliance with appraisal, for all non-trainee members of staff. Name of anaesthetic lead for child protection within the department and evidence of their level 3 training. Verbal confirmation that all other anaesthetic staff are appropriately trained to at least level 2. Evidence of policies for dealing with vulnerable adults.

PRIORITY

1

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Impact on staff; workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

2.13.8 All members of the anaesthetic team should receive non-clinical training and education, which should be reflected in job plans and job planning. This might include a locally arranged list of topics (e.g. fire safety, consent, infection control, blood product administration, mental capacity, safeguarding children and vulnerable adults, communication skills). Some of this training will be mandatory under the legislation for health and safety at work.

5.6.48 Staff should have regular training in the application of the legislation determining mental capacity in the part of the UK in which they are working and should have defined access to patient advocates. This is a rapidly changing area and clinicians should have access to expert advice.

10.4.2 All anaesthetists who provide elective or emergency care for infants, children or young adults should have training in advanced life support that covers their expected range of clinical practice and responsibilities. These competencies should be maintained by annual training that are ideally multidisciplinary and scenario based.

10.4.4 All anaesthetists must undertake at least level 2 training in safeguarding/child protection, and must maintain this level of competence by annual updates of current policy and practice and case discussion. Safeguarding resources to support learning can be found on the RCoA website (www.rcoa.ac.uk/safeguardingplus).

10.4.5 At least one consultant in each department should take the lead in safeguarding/child protection and undertake training and maintain core level 3 competencies. The lead anaesthetist for safeguarding/child protection should advise on and co-ordinate training within their department but will not

have responsibility for deciding on management of individual clinical cases.

HELPNOTE
The child safeguarding training aspect of this standard is applicable to both those who only treat patients who are 16-18 years old and those who treat younger children.

STANDARD

4.3.3.3 Staff with specific training commitments, including resuscitation and life support courses and simulation/human factors training have appropriate support.

EVIDENCE REQUIRED

Staff with specific training commitments in these areas should give verbal confirmation that they are supported, including within their job plans.

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Workforce management and support; quality improvement-focused leadership

GPAS REFERENCES

1.2.5 The workforce plan should include the minimum number of staff to maintain the service without compromising safety, quality, education and training and wellbeing.

1.3.9 Departments should commit to providing the time and resources to educate those who provide anaesthetic care for patients by facilitating access to education and training. Continuing professional development (CPD) and education should be balanced between the individual's clinical and other areas of responsibility.

HELPNOTE

The following quality improvement recipe from the RCoA's Quality Improvement Compendium may help departments to meet this standard: *4.10 Prevention of unexpected cardiac arrest*.

STANDARD

4.3.3.4 Staff with commitments to external work undertaken for the wider benefit of the public and health services across the UK have appropriate support.

EVIDENCE REQUIRED

Staff with commitments in these areas, for example, those defined as 'External Duties' in the NHS Consultant contract, should give verbal confirmation that they are supported.

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

1.2.24 Anaesthetists with commitments to regional and national work should have appropriate support through job planning. Departments should take into consideration both the impact this has on the rest of the department, as well as the considerable benefits local departments gain from having staff undertake anaesthetic regional and national roles.

REFERENCES

NHS England » Appropriate release of medical colleagues for the purposes for carrying out work for the wider health system

STANDARD

4.3.3.5 All individuals in clinical leadership roles should be well supported and given appropriate remuneration for their role.

EVIDENCE REQUIRED

Verbal confirmation from individuals in clinical leadership roles in the department. This includes roles such as Clinical Director and Clinical Lead.

PRIORITY

1

CQC KLoEs

Safe; effective; responsive; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Quality-improvement focused leadership

GPAS REFERENCES

1.1.16 Clinical leadership roles should be designed to be desirable and exciting opportunities for anaesthetists. Appointment processes to clinical leadership roles should be open and transparent.

1.1.20 The department should have adequate remunerated time allocated to all clinical leaders to perform their roles in integrated governance, which recognises the breadth and depth of their roles within the department and wider hospital management structures. Adequate remunerated time may be facilitated through diarising time spent on a role and reviewing this as part of the job planning process.

STANDARD

4.3.3.6 Anaesthetic provision for elective sub-specialist surgery is delivered by a group of consultant or autonomously practising anaesthetists who maintain current competency in that subspecialty area.

EVIDENCE REQUIRED

Staff should confirm that they have appropriate opportunities for sub-specialty CPD.

PRIORITY

2

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.1.4 There should be an identified group of senior anaesthetists who manage and deliver a comprehensive ophthalmic anaesthesia service, including the use of orbital regional anaesthetic techniques.

14.1.2 There should be a specified and therefore identifiable group of neuroanaesthetists who cover the neuroanaesthesia service and have sufficient programmed activities to deliver the elective and emergency service.

14.1.5 Adequate anaesthetic cover should be available to provide general anaesthesia and sedation for diagnostic neuroradiology sessions (i.e. brain and spine imaging) sessions, including computed tomography (CT) and MRI.

14.4.1 Any autonomously practising anaesthetist working in neuroanaesthesia must undertake continuing professional development (CPD) in neuroanaesthesia and must have sufficient regular programmed activities within this field to ensure that their specific skills and experience are maintained.

14.4.4 Elective neuroanaesthesia for highly specialised procedures that have limited case numbers (e.g. craniofacial procedures, awake neurosurgery, and deep brain stimulation) should be provided by a dedicated subgroup of neuroanaesthetists within the department to ensure that they are able to treat sufficient numbers in order to maintain their competence in these areas.

14.5.2 There should be sufficient numbers of clinical programmed activities in consultants' job plans to provide cover for all elective neurosurgical operating lists and to provide adequate emergency cover.

15.1.2 Anaesthesia for all patients undergoing major vascular surgery should be provided by or directly supervised by an anaesthetist suitably qualified, trained and experienced in vascular anaesthesia. This will be a consultant or other autonomously practising vascular anaesthetist, who has overall responsibility for the patient's care.

15.1.3 It is recognised that staff involved in providing care for out-of-hours vascular emergencies may differ from those involved in routine daytime care. It is essential that all staff who might potentially be involved in perioperative care of the emergency vascular surgical patient are trained and competent in the aspects of care for which they are responsible. There should be provision for such staff to attend and assist in the daytime care of routine major vascular cases to update their skills and knowledge, with appropriate recognition in their respective job plans.

15.1.4 Where possible, urgent and emergency vascular cases should be performed on daytime theatre lists by appropriately trained staff. There is evidence that the outcome after lower limb amputation is better when surgery is undertaken within normal working hours.

18.4.5 Consultant or autonomously practising anaesthetists intending to undertake anaesthesia for cardiac surgery should have received training to a higher level in cardiac anaesthesia for a minimum of one year in recognised training centres. Those providing critical care for cardiothoracic surgical patients should have received training as described by the Faculty of Intensive Care Medicine (see Cardiothoracic Critical Care, Guidelines for the Provision of Intensive Care Services). This should include training in transoesophageal echocardiography.

19.1.6 An appropriately trained consultant or autonomously practising anaesthetist should be available at all times, through a formal thoracic or cardiothoracic anaesthetic on-call rota, particularly if lung transplantation is performed.

HELPNOTE
The RCoA and Association of Anaesthetists' joint publication on the safer staffing for the delivery of anaesthesia services can be referenced for staffing guidance: https://www.rcoa.ac.uk/sites/default/files/documents/2025-05/SSDASvFinal.pdf

STANDARD

4.3.3.7 Those consultants or autonomously practising anaesthetists who provide emergency cover to sub-specialty clinical areas but who do not undertake regular anaesthetic practice in that sub-specialty have time to attend appropriate CPD and attend sub-specialty surgery lists in a supernumerary capacity.

EVIDENCE REQUIRED

Verbal confirmation from those who deliver emergency sub-specialty anaesthesia out of hours.

PRIORITY

2

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES

9.4.7 Any autonomously practising anaesthetist providing cover for the labour ward regularly or on an ad hoc basis must undertake continuing professional development (CPD) in obstetric anaesthesia and must have enough exposure to obstetric patients to maintain appropriate skills. This could be achieved through allocation of supernumerary sessions on the labour ward or in elective caesarean lists while reviewing appropriate CPD during the appraisal process.

15.1.3 It is recognised that staff involved in providing care for out-of-hours vascular emergencies may differ from those involved in routine daytime care. It is essential that all staff who might potentially be involved in perioperative care of the emergency vascular surgical patient are trained and competent in the aspects of care for which they are responsible. There should be provision for such staff to attend and assist in the daytime care of routine major vascular cases to update their skills and knowledge, with appropriate recognition in their respective job plans.

15.4.1 Anaesthetists with an appropriate level of training should manage patients undergoing major elective vascular surgery.

15.4.4 Some anaesthetists may have responsibility for management of major vascular surgical cases on an occasional or out-of-hours basis. Departments of anaesthesia should ensure that opportunities are made available for these anaesthetists to maintain appropriate skills and knowledge. Notwithstanding this, all anaesthetists must recognise and work within the limits of their professional competence.

15.4.5 A local training module should be provided for anaesthetists in training according to their grade, supervised by a nominated educational lead. This programme should develop understanding of the widespread nature of cardiovascular disease, optimisation and risk stratification, as well as perioperative management. The RCoA revised training curriculum (2010) provides explicit detail of the requirements.

STANDARD

4.3.3.8 The department has processes in place to regularly review Specialist, Specialty, Locally Employed Doctor and Fellow posts, to ensure that they best support the individual and contribute to career progression.

EVIDENCE REQUIRED

Verbal confirmation of processes from Clinical Director and relevant staff groups.

PRIORITY

2

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

1.1.10 The department must establish and maintain a culture of proactively thinking about and questioning equality, diversity and inclusion in all that it does, including recruitment, training, opportunities for extended roles and responsibilities.

1.2.1 Departments should have a workforce plan in line with their overall strategy and annual business plan that includes recruitment, opportunities for flexible working and staff retention. The plan should ensure a level of staffing and skill mix that meets current service and educational requirements with sufficient flexibility to ensure staff are not overstretched. It should be reviewed regularly and consider integrated care systems and other regional strategic developments, and the work life balance needs of anaesthetists and other staff as they age and at all stages of their career

1.2.2 Departments should ensure that they have the appropriate skill mix for their various clinical activities and that this mix is maintained through appropriate developmental opportunities for their staff.

1.2.6 Senior and experienced SAS doctors should be given the opportunity to take on additional roles within the department.

1.2.14 Departments should review the responsibilities of anaesthetists as part of job planning. This includes out of hours commitments and the scope of the individual's practice, as well as any additional roles and responsibilities.

1.2.15 Anaesthetists should be supported in maintaining the scope of their clinical practice as required for their clinical role, including their out of hours and flexible clinical commitments.

1.2.22 Departments should encourage flexibility when reviewing job plans to support the changing needs of colleagues over the course of their career. Colleagues should be supported in tailoring their career over time. The impact of change on the rest of the department should be considered.

HELPNOTE

The following resources may be useful: https://www.rcoa.ac.uk/training-careers/working-anaesthesia/sas-specialty-doctors

Note 4: On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee'); the diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the RCoA Guidance on Supervision arrangements for anaesthetists.

Note 5: On terminology, SAS Doctors are anaesthetists on the national Speciality Doctor or Specialist Doctor contract and any anaesthetists on closed SAS contracts, such as the Associate Specialist contract. Locally-employed Doctors (LEDs) are anaesthetists on local, employer-based contracts, commonly based on a current or historical version of the resident doctor contract. Examples of these roles include Trust Doctors, Clinical Fellows, and Medical Training Initiative doctors.

STANDARD

4.3.3.9 All anaesthetists within the department (including Specialists, Specialty, Locally Employed Doctors and Fellows) should be provided with the support to enable career development. This should include, but is not limited to, educational supervision, pastoral care and access to study leave.

EVIDENCE REQUIRED

Evidence of opportunities for education supervision, opportunities for leadership and educational roles, and mentorship programmes (if available) should be provided. Specific groups should be interviewed about their practices and training.

PRIORITY

2

CQC KLoEs

Safe; well-led

HIW Domains

Safe and effective care; management and leadership

HIS Domains

Safe, effective and person-centred care delivery; policies, planning and governance; workforce management and support

GPAS REFERENCES

1.1.10 The department must establish and maintain a culture of proactively thinking about and questioning equality, diversity and inclusion in all that it does, including recruitment, training, opportunities for extended roles and responsibilities.

1.1.16 Clinical leadership roles should be designed to be desirable and exciting opportunities for anaesthetists. Appointment processes to clinical leadership roles should be open and transparent.

1.1.18 There should be anaesthetic clinical leads with clear and agreed responsibilities for different areas or specialties. The number of leads will depend on the size of the anaesthetic department, their areas of specialisation, workload and any ongoing areas of special focus. This should include an SAS lead.

1.1.24 Departments should encourage the development of new leaders at all stages during an anaesthetic career.

1.1.25 Opportunities should be made available for shadowing leaders, coaching and mentorship.

1.1.26 SAS doctors and trainees should be encouraged to engage in leadership opportunities.

1.2.2 Departments should ensure that they have the appropriate skill mix for their various clinical activities and that this mix is maintained through appropriate developmental opportunities for their staff.

1.2.4 Opportunities for clinical colleagues to develop skills in non-clinical areas including teaching, mentoring and coaching, examining, research, audit and quality improvement, committee work and leadership and management should be supported, transparent, equitably balanced across the department and incorporated into departmental plans.

1.2.6 Senior and experienced SAS doctors should be given the opportunity to take on additional roles within the department.

1.2.7 The hospital should have mechanisms in place to support SAS doctors who aspire to achieve a Certificate of Eligibility for Special Registration (CESR), or advance their career in other ways, for example an educational supervisor who has knowledge of the necessary processes. SAS doctors who are preparing for CESR should have this recognised in their job plans and departments should, consider making adjustments to their job plan to assist them.

1.2.16 Anaesthetists should be provided with adequate time in their job plans, resources and support to help them to complete annual appraisals and achieve revalidation.

1. 2.17 Where possible departments should empower employees to make decisions concerning their jobs, regarding task variety and options to develop and learn new tasks.

1. 2.22 Departments should encourage flexibility when reviewing job plans to support the changing needs of colleagues over the course of their career. Colleagues should be supported in tailoring their career over time. The impact of change on the rest of the department should be considered.

1.2.23 Anaesthetists appointed to organisation wide, non-clinical roles should be adequately supported with sufficient time and resources to undertake the role.

1.2.24 Anaesthetists with commitments to regional and national work should have appropriate support through job planning. Departments should take into consideration both the impact this has on the rest of the department, as well as the considerable benefits local departments gain from having staff undertake anaesthetic regional and national roles.

1.2.40 Every department should have a named trained SAS mentor who has the responsibility to oversee the wellbeing, career needs, educational and professional needs of the SAS doctors in the department.

1.2.50 To promote high job satisfaction departments should strive to achieve good working conditions, strong inter departmental relationships and appropriate resources.

1.2.51 Departments should promote working conditions known to provide job satisfaction, including varied work, input into individual anaesthetist's job plans and opportunities for colleagues to contribute their ideas and skills to the department.

1.2.54 Departments should encourage a voluntary local mentorship programme with properly trained mentors and informed mentees who know what to expect, and should encourage staff engagement with national mentorship schemes.[15,43,50,51]

1.2.55 Departments should offer newly appointed consultants and SAS doctors the opportunity to work with a trained mentor to facilitate their development in their new role as well as at key transition points in a consultant's career.

1.3.9 Departments should commit to providing the time and resources to educate those who provide anaesthetic care for patients by facilitating access to education and training. Continuing professional development (CPD) and education should be balanced between the individual's clinical and other areas of responsibility.

1.3.12 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical and non-clinical practice, including annual mandatory training.

HELPNOTE

Guidance on the best practice for educational support for SAS and Locally Employed Doctors can be found here https://rcoa.ac.uk/media/39936.

The SAS Charter details what SAS doctors can expect from their employers and what employers can expect of them: SAS charter | NHS Employers.

Note 4: On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee'); the diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the RCoA Guidance on Supervision arrangements for anaesthetists.

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