

# ACSA 10<sup>th</sup> Anniversary event

**Dr Mike Swart**

ACSA Committee Chair and Clinical Lead

# Session 1

## 10 years of ACSA



# Anaesthesia Clinical Services Accreditation (ACSA)

## 10 years and counting – Where are we now?

Dr Rachel Smith FRCA  
Dr Kate Glennon FRCA  
ACSA Committee Vice-Chairs



**ACSA**  
Anaesthesia Clinical Services Accreditation

**A** Royal College of  
**Anaesthetists**

**ACCREDITATION**

# ACSA <sup>10<sup>th</sup></sup> ANNIVERSARY

Anaesthesia Clinical Services Accreditation

**RCOA**  
Royal College of Anaesthetists

**ACSA** <sup>10<sup>th</sup></sup>  
ANNIVERSARY  
Anaesthesia Clinical Services Accreditation

# Why ACSA?

“Requests have come from departments and employers for proactive and supportive professional advice about best practice in the organisation and provision of anaesthetic clinical services in the NHS environment”

# Where did it all begin?

- 2009 - 2011
- Dr Peter Venn & Mr Charlie McLaughlan
- Quality Management of Service Group



# What happened next?

- Radiology, psychiatry and pathology consulted on their own experience with accreditation
- Patient Liaison Group involved throughout
- AoMRC, NICE, CQC all provided support
- **Sept – December 2011**
  - First set of standards published (174)
  - 20 anaesthetic departments underwent self-assessment process (1<sup>st</sup> phase)
- **Jan 2012 – Oct 2014**
  - Standards refined after feedback and departments could then progress to a visit (2<sup>nd</sup> phase)

# First accreditation in 2014



# First accreditation in 2014



# ACSA – 10 years and counting.....

- A guide to the process 10 years on
- Highlights of the last 10 years
- Final thoughts...

# ACSA: The Process

- **Voluntary** scheme = Quality Improvement through **peer review**
- Department benchmarks their performance against a set of 151 standards taken from the Guidelines for the Provision of Anaesthetic Services (GPAS)
  - priority 1 (148) = must meet
  - priority 2 (2) = standard in development
  - priority 3 (1) = aspirational standard
- A team of trained reviewers are **invited** to visit the department to validate **the self-assessment of the organisation**
- When the organisation meets all the required standards their achievement is recognised by the College

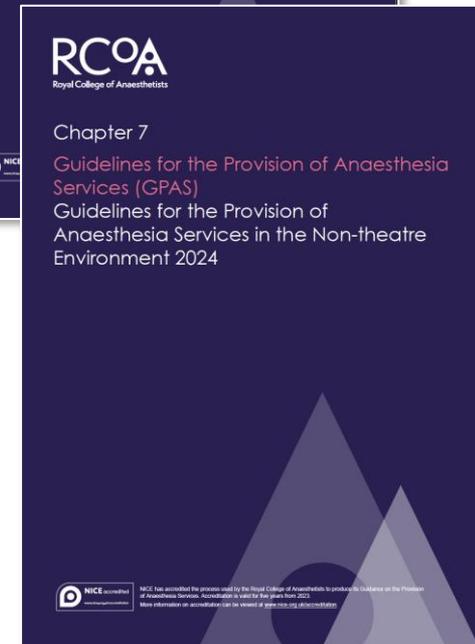
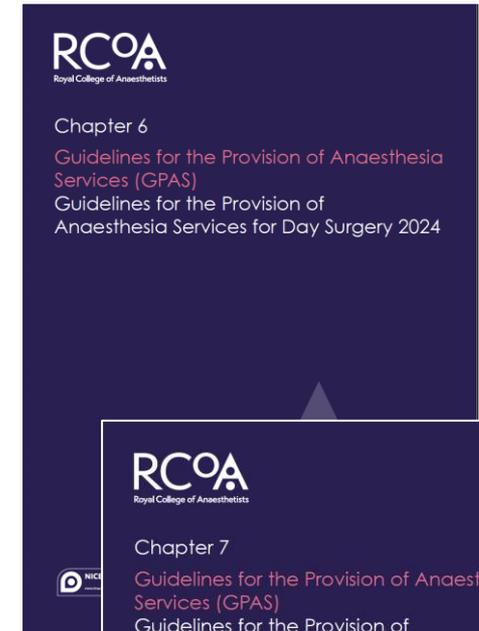
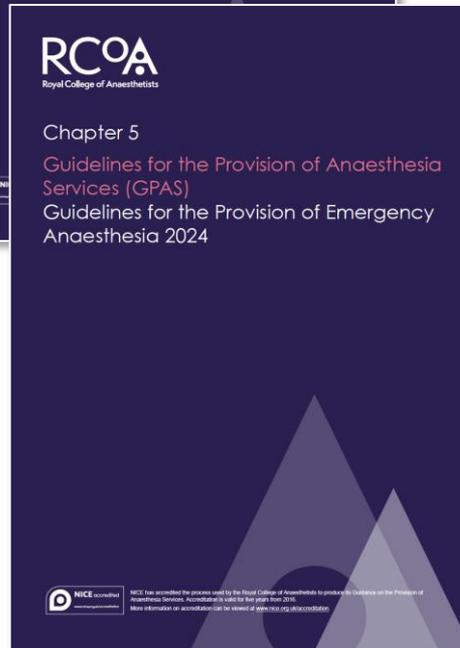
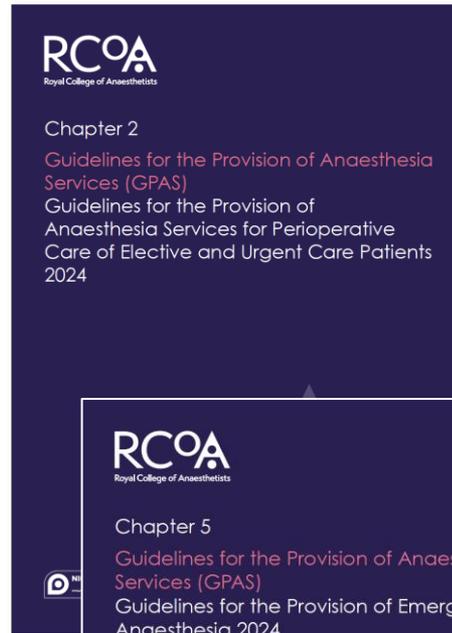
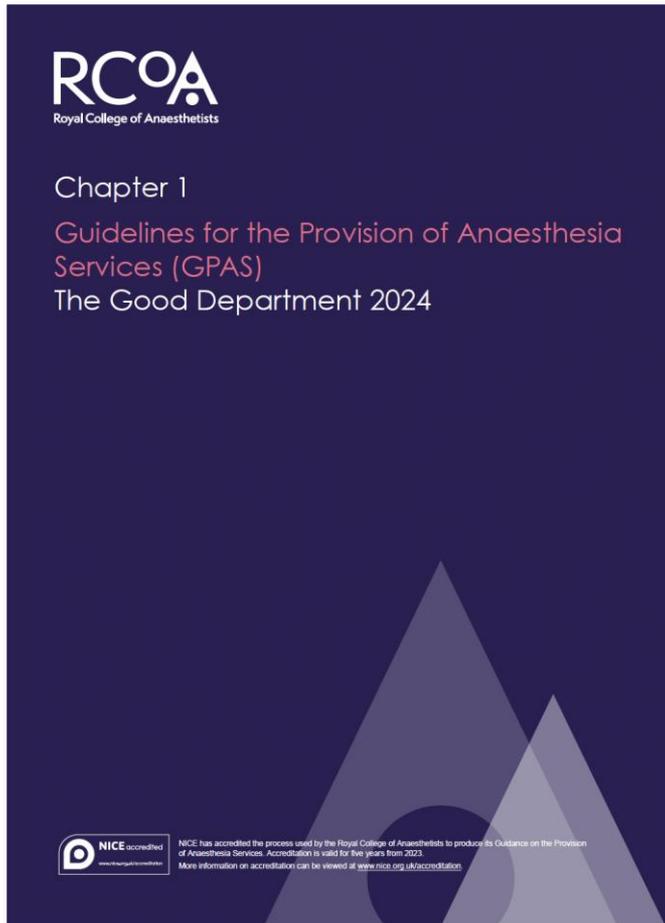
# Who is engaged with ACSA?

Percentage Trusts/Boards engaged



- 126 registered departments (78%)
- 77 departments are subscribed to ACSA
- 53 accredited departments (33%)

# The origin of the ACSA Standards



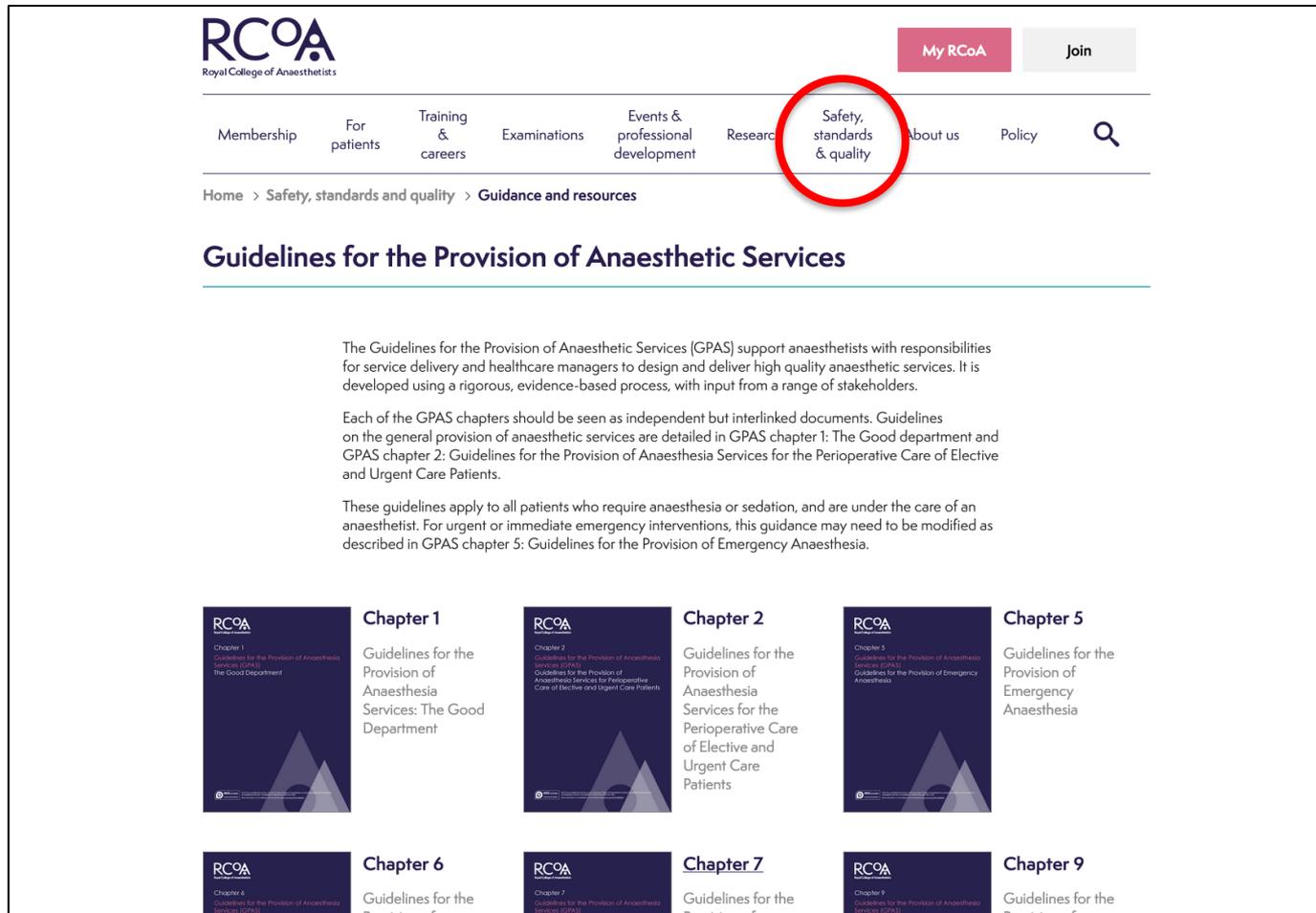
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# The ACSA Standards 2024 - GPAS

The screenshot shows the RCoA website interface. The RCoA logo is in the top left. Navigation links include 'My RCoA', 'Join', 'Membership', 'For patients', 'Training & careers', 'Examinations', 'Events & professional development', 'Research', 'Safety, standards & quality', 'About us', and 'Policy'. A search icon is also present. The 'Safety, standards & quality' dropdown menu is open, showing five categories: 'Anaesthesia Clinical Services Accreditation', 'Guidance and resources', 'Patient safety', 'Professional support', and 'Quality Improvement'. The 'Anaesthesia Clinical Services Accreditation' category is circled in red and contains the following links: 'ACSA Online Portal', 'The ACSA standards', 'The ACSA process', 'NHS Organisations' engagement', and 'ACSA resources and information'. The background of the screenshot shows a blurred image of a person in a hospital setting wearing a 'CRITICAL CARE UNIT' lanyard.

# The ACSA Standards 2024 - GPAS



The screenshot shows the RCoA website navigation menu. The 'Safety, standards & quality' menu item is circled in red. Below the navigation, the breadcrumb trail reads 'Home > Safety, standards and quality > Guidance and resources'. The main heading is 'Guidelines for the Provision of Anaesthetic Services'. The text explains that the GPAS guidelines support anaesthetists with responsibilities for service delivery and healthcare managers to design and deliver high quality anaesthetic services. It is developed using a rigorous, evidence-based process, with input from a range of stakeholders. Each of the GPAS chapters should be seen as independent but interlinked documents. Guidelines on the general provision of anaesthetic services are detailed in GPAS chapter 1: The Good department and GPAS chapter 2: Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients. These guidelines apply to all patients who require anaesthesia or sedation, and are under the care of an anaesthetist. For urgent or immediate emergency interventions, this guidance may need to be modified as described in GPAS chapter 5: Guidelines for the Provision of Emergency Anaesthesia.

**Chapter 1**  
Guidelines for the Provision of Anaesthesia Services: The Good Department

**Chapter 2**  
Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients

**Chapter 5**  
Guidelines for the Provision of Emergency Anaesthesia

**Chapter 6**  
Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients

**Chapter 7**  
Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients

**Chapter 9**  
Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients

# The ACSA Standards 2024: DOMAINS

1. The Care Pathway
2. Equipment, Facilities & Staffing
3. Patient Experience
4. Clinical Governance
5. Subspecialties (Cardiac, Neuro, Vascular, Ophthalmic)

# The ACSA Standards 2024: SUBDOMAINS

## 1. The Care Pathway

### 1.1 Policies

- General
- Non-theatre environment
- High Risk Patients

### 1.2 Before the procedure

- Pre-assessment
- Consent

### 1.3 On the day of the procedure

- Intraoperative period
- Services

### 1.4 Post Procedure

- Recovery
- Recovery Staff
- Escalation of care
- Review and Discharge
- Pain Management

### 1.5 Emergency Surgery

- Emergency Care Pathway

### 1.6 Paediatrics

- General
- Policies
- Critically Ill Children

### 1.7 Obstetrics

- Policies
- Staffing
- Facilities

## 2. Equipment, Facilities & Staffing

### 2.1 Equipment

### 2.2 Drugs, fluid and blood

### 2.3 Anaesthetic Records

### 2.4 Facilities

### 2.5 Staffing

## 3. Patient Experience

### 3.1 Patient Information

- Patient Decision Making
- Communication

### 3.2 Care of the individual

- Dignity
- Patients with Additional Needs

## 4. Clinical Governance

### 4.1 Departmental Management

- Planning
- Leadership
- Culture

### 4.2 Learning from Experience

- Incident reporting
- Audit and QI
- Outcome Measurement

### 4.3 Workforce

- Recruitment
- Induction

# THE STRUCTURE OF A STANDARD

The ACSA standard has **5 DOMAINS**:

- 1 The Care Pathway
- 2 Equipment, Facilities and Staffing
- 3 Patient Experience
- 4 Clinical Governance
- 5 Specialities

These are broken down further into **SUBDOMAINS** and **AREAS**

## KEY

DOMAIN

SUBDOMAIN

AREAS

STANDARD

The standard has to be a **definitive statement** which warrants a 'yes' or 'no', 'met' or 'unmet' response.

The ACSA standards have been mapped against the Care Quality Commission Key Lines of Enquiry, Health Inspectorate Wales and Health Improvement Scotland inspection domains

Guidelines for the Provision of Anaesthetic Services references.

## 1. The Care Pathway

### 1.1 General

#### 1.1.1 Policies

#### 1.1.1.1 All patients should have a named and documented supervisory anaesthetist who has overall responsibility for the care of the patient

This should be visible on the anaesthetic record, on the rota, on display in the department and visible in the obstetric area

### PRIORITY

### CQC KLoE, HIW and HIS Domains

### GPAS REFERENCES

### HELP NOTE

1

Safe  
Effective  
Well-led  
Safe & effective care  
Safe, effective and person-centred care delivery

3.4.6  
9.1.19, 9.1.20  
10.1.4

This additional wording has been produced to clarify the standard where possible and has been agreed by the ACSA Committee.

Each **STANDARD** has a number. If a standard is removed, the number is not re-used, so some numbers are missing where standards have been taken out during the editing process. The standards themselves are grouped into these areas so that the standards are categorised and easy to find.

The text underneath each standard describes the evidence required to determine whether or not that standard is met.

Standards are either listed as Priority 1, Priority 2 or Priority 3.

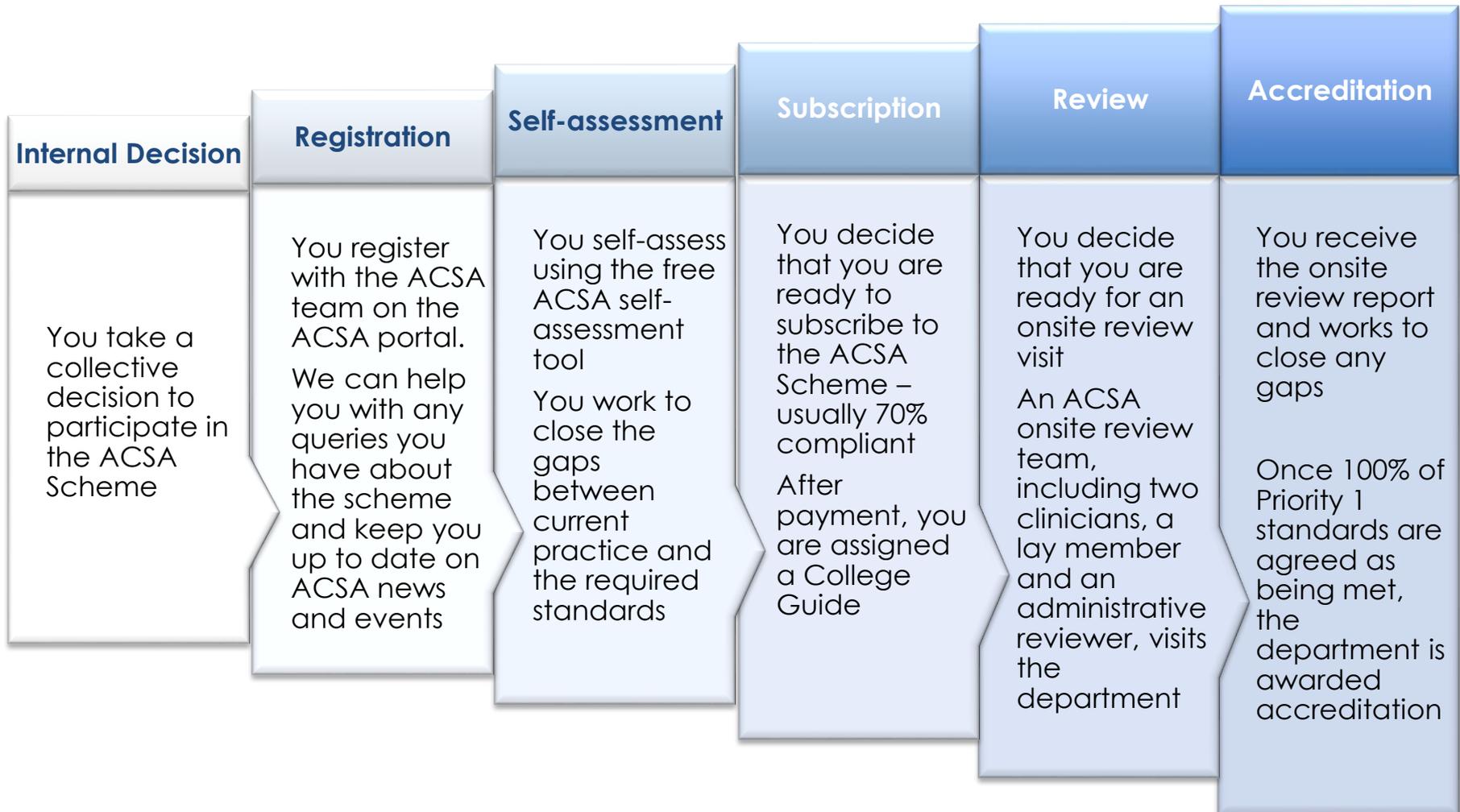
**Priority 1 standards must be achieved** in order for accreditation to be awarded.

**Priority 2 standards are aspirational**, but may not be achievable because of mitigating circumstances (e.g. resource or geography issues) and may form part of ongoing issues.

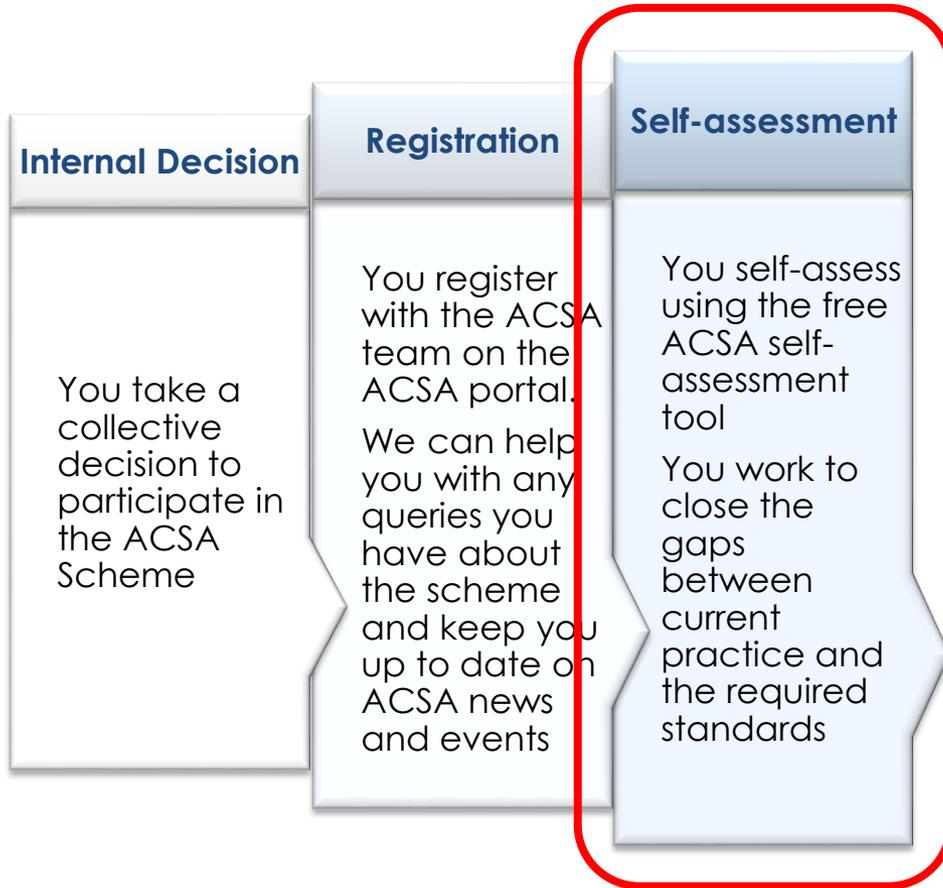
**Priority 3 standards provide targets** for the highest performing departments to achieve.

The standards all have one or more references to the GPAS document.

# ACSA: The Process



# ACSA: The Process



# Do you meet the ACSA Standard?

- 4 key questions.....

# Do you meet the ACSA Standard?

1. What does the standard require?
2. How should we rate ourselves & why?
3. What evidence can we provide to support our assessment?
4. Met, Not Met or Not applicable

# ACSA Wallpaper





THE CARE  
PATHWAY



THE PATIENT  
EXPERIENCE



EQUIPMENT  
FACILITIES &  
STAFFING



CLINICAL  
GOVERNANCE



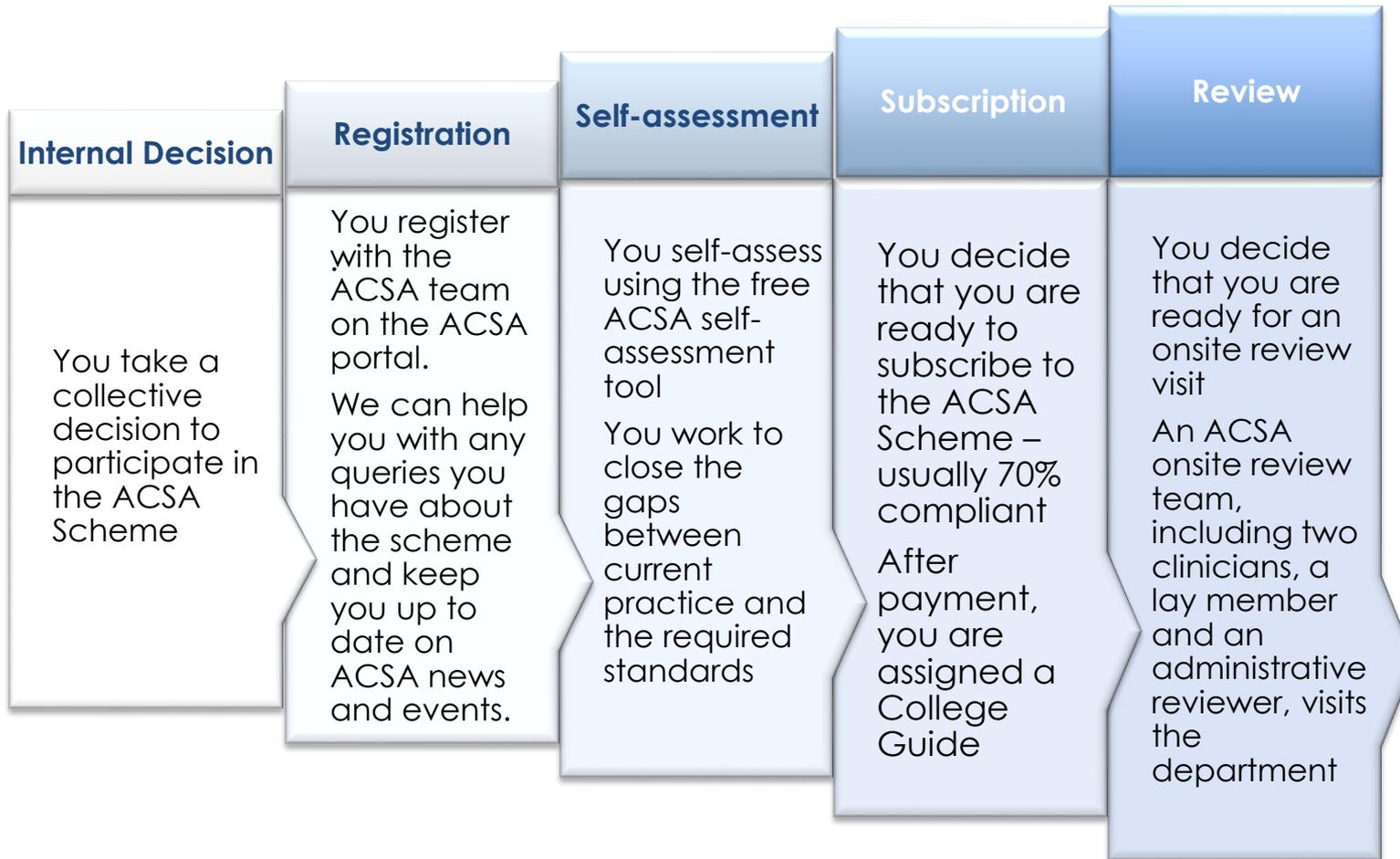
# ACSA Standards: Met, Un-met & Not Applicable

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
<b>2.2.3 Access to blood and blood conservation techniques (cell salvage or acute normovolaemic haemodilution)</b>						
<b>2.2.3.1 Blood storage facilities are in close proximity to emergency theatres and contain O rhesus negative blood</b>  Facilities should be seen	1	Safe Effective	<a href="#">5.4.18</a> , <a href="#">9.2.5</a>	X		
<b>2.2.3.2 Equipment for fluid and blood warming and rapid infusion is available</b>  Equipment should be seen	1	Safe Effective	<a href="#">7.3.2</a> , <a href="#">9.2.21</a> , <a href="#">9.2.7</a> , <a href="#">10.2.1</a> , <a href="#">10.2.6</a>		X	
<b>2.2.3.3 A cell salvage machine and trained staff are available for appropriate patients</b>  Equipment should be seen with evidence of ongoing training  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 this 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	1	Effective Responsive Well-led	<a href="#">5.4.9</a> , <a href="#">9.2.8</a>			X

# Where to start?

- Self-assessment against the ACSA standards
  - What are our strengths and weaknesses?
  - What is the size of the gap between current practice and meeting the ACSA standards?
- Communication with colleagues – clinical and non-clinical
  - Involving as many people as possible from the start will make it easier to identify problem areas
  - Share the load
  - Management support is essential
- Improvement – what and how can we improve?
  - Some improvements will be straight forward to implement, even before the department is formally engaged with ACSA
  - Other improvements will take more effort and the College will offer help from experienced clinicians and via examples of good practice

# ACSA: The Process



# Do you meet the ACSA Standard?

- Self-assessment against the ACSA standards
  - 80% of standards met
- Request On-site Review
- 2 or 3 day Review (Hybrid or all onsite)

# Do you meet the ACSA Standard?



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# Meeting the Team.....



# Do you meet the ACSA Standard?

- Self-assessment against the ACSA standards
  - 80% of standards met
- Request On-site Review and pay subscription....
- 2 Day Review
  - Departmental presentation
  - Classroom Session
  - Meeting with Consultants/Trainees/SAS/Managers/Senior staff
  - Walkabout
  - Initial Feedback BUT no decision on accreditation
- Report Produced & Accreditation Decision
  - Not pass/fail

# ACSA - 10 years and counting?

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**Anaesthesia Clinical Services Accreditation**

# ACSA - 10 years in numbers...

- 78% of trusts/boards registered
- 52 ACSA accredited departments
  - 26 departments re- accredited
  - 2 departments on 4<sup>th</sup> cycle of ACSA
- On average 91% of standards met at time of visit

# ACSA - 10 years in numbers...

- 124 review visits undertaken
  - 120 reviewers (clinical and lay)
  - 124 reports written
  - > 20,000 standards reviewed
- 4 ACSA Chairs guiding the way



# ACSA - 10 years in numbers...

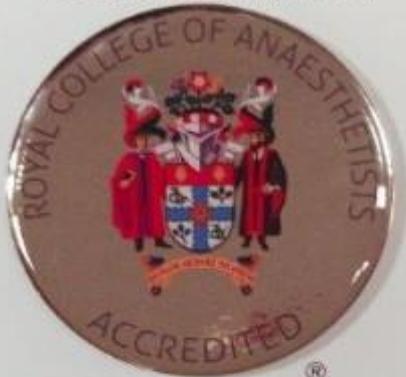
- As a result of their ACSA review:
  - 20 departments have increased the provision of capnography throughout the patient journey
  - 11 departments have improved preoperative assessment services, both adult and paediatric through increasing consultant sessions within the service
  - 9 departments have introduced or expanded a separately staffed elective theatre for their maternity services
  - Acute Pain Team overhaul

# Finally...

- Sharon Drake, Ruth Nichols, Hannah West (Carly Melbourne and Emily Basra)
- The Reviewers (Clinical & Lay)
- The Staff at RCoA
  - Ruth, Hannah, Daisy, Heather, Mohamoud, Owen and Ifarah
- The Departmental ACSA Leads
- The Departments who have engaged



Anaesthesia Clinical Services  
Accreditation (ACSA)



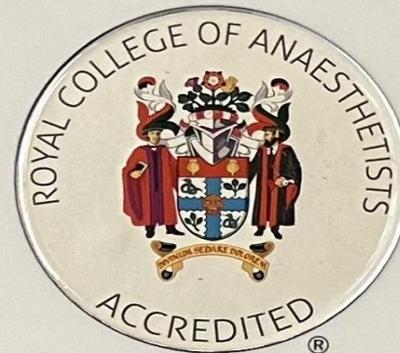
FEBRUARY 2016

Department of Anaesthetics,  
St Helens and Knowsley Teaching  
Hospitals NHS Trust

Dr L Brennan  
President  
The Royal College of Anaesthetists

Dr S Fletcher  
Chair, Quality Management of Service Group  
The Royal College of Anaesthetists

Anaesthesia Clinical Services  
Accreditation (ACSA)



September 2022

Dorset County Hospital  
NHS Foundation Trust

Dr Fiona Donald  
President  
Royal College of Anaesthetists

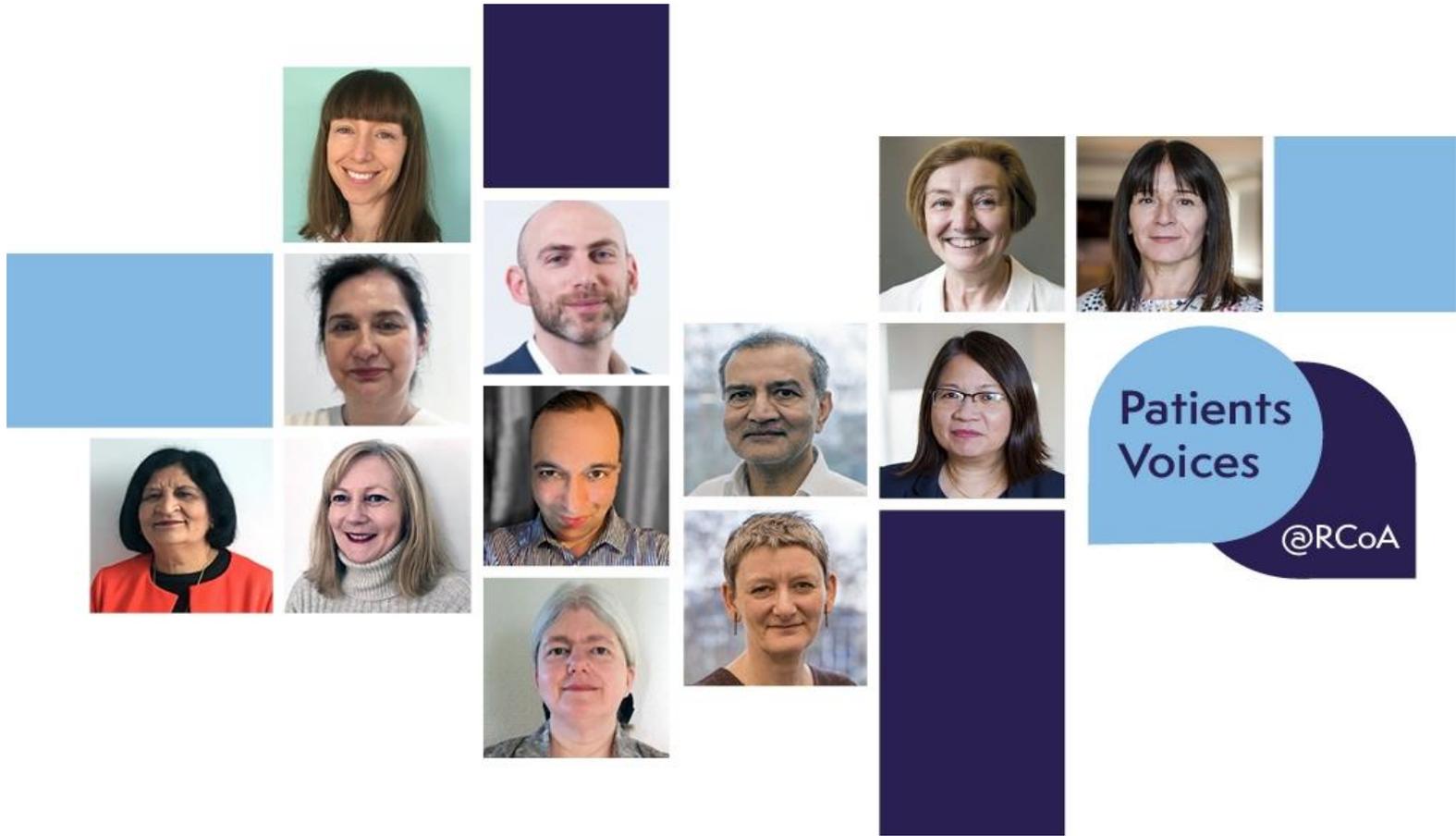
Dr R Perkins  
Chair, ACSA Committee  
Royal College of Anaesthetists

# Listening to patients' voices

**Pauline Elliott**  
PatientsVoices@RCoA

# Who are we?

PatientsVoices@RCOA is a group of diverse people who support, advise and influence the College by providing patients' perspectives on its activities.



# What do we do?

We help the College improve the delivery of safe, more effective, patient-centred care to enhance patients' experience of anaesthesia and perioperative care.

# What are our key objectives?

- Strengthening our voice.
- Improving how we communicate the view of patients internally and externally.
- Increasing our impact by developing effective ways of working.

# Patients' voices and ACSA

- We contribute the patient and public perspective to the review process.
- We understand the RCoA's objectives & values.
- We're open-minded & independent.

# Our focus in reviews

- Generally we observe the culture and environment, especially as it relates to patient and carer experience.
- Specifically we help assess the patient experience standards.

# Not within our remit

- We don't assess the technical, clinical or specialist standards.
- We may ask questions if we detect an issue which relates to patient and carer experience.

# Governance & development

- At least two members of PatientsVoices@RCOA sit on the ACSA Committee.
- Invited to review all ACSA reports.
- Contribute patients' perspective to debates, discussions & decisions.

# Summary

Patients' voices have a vital role in ensuring patients' and carers' experience are central to all aspects of the ACSA process.

# Celebrating 10 Years of ACSA Confessions of a Lay Reviewer

Bob Evans

ACSA Lay Reviewer



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# The Good Bits

- Lay Involvement designed into ACSA from the start – not an afterthought
- Lay Reviewers are engaged in GPAS reviews from which ACSA Standards derive – develops sound understanding and ownership
- Full member of the ACSA Review Team

# The Good Bits continued

- Lay involvement in Invited Reviews can bring a helpful insight into issues of management and working relationships.
- Lay people can sometimes help the Staff Reviewer with note taking, especially if the Review Team needs to split up
- Promote RCoA – eg encourage clinicians to become Reviewers, Examiners and engage in research projects (NELA, PQIP etc); and plug CPOC and the perioperative process.
- Can bring expertise on future plans

# Could Do Better

- Better training before we are let loose, especially on NHS roles, human factors and EDI
- 1-2-1 or small group training session with Staff reviewer or conversation with a Lay Reviewer
- Closer work on GPAS development – don't leave it all to a long single session
- Clearer template for consistent end of Review briefing

# Could Do Better continued

- Try to get a face-to-face preliminary meeting with the lead clinician and other team members if possible
- Improved technology at College helps but the Portal can be a bit difficult
- Eve of Review dinner and breakfast meeting with team is so important for team-building
- Possible Lay contact with a Trustee or Patient Rep to get a view on the Anaesthetic Dept?



*"When we want your opinion,  
we'll give it to you."*

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# It's Been Good...

- Very positive experience – hopefully made a difference
- Contributions always valued
- Good to be part of well-lead teams
- Great to work with RCoA staff and esteemed Clinicians





Anaesthetic?... or you could choose to spend half an hour on the phone with a Lay Reviewer...

# Break

**11:00 – 11:30**

Please join us for refreshments in the café

# Session 2

## Benefits and Challenges of the ACSA process

# Our ACSA Journey Keeping up momentum

Dr Jonathan Short  
Consultant Anaesthetist & ACSA Lead, Lewisham &  
Greenwich NHS Trust

# ACSA - Lewisham & Greenwich

- Several false starts over past decade
- Newly merged organization (now 10 years)
- Disparities between hospital sites
  - Guidelines/policies
  - Governance structures
  - Equipment
  - Departmental cultures

# Progression to decision to start

- Cross-site clinical leadership
- Gradual merger of processes, guidelines & policies
- Alignment of equipment
- Cross-site working
  
- Post-Covid environment
- Management support

# Initial gap analysis August 2022

- 32% Met, 48% in progress, 16% not met
- Funding agreed by execs (including job plan)
- Registration with ACSA team
- Department presentation
  
- “Just a lot of policy writing”
- “All these SOPs are useless without a culture shift”
- Why bother? What do we get out of this?
- It's too much work! Don't have time for this!

# Identify early tasks

- Those that take time, money, multiple meetings, or institutional resistance
  - Local examples include
    - LA drug cupboards; paediatric DAT; NC pumps
    - Procedural Sedation & Analgesia SOP
    - Multiple audit cycles
    - Patient information leaflets
    - Redesigning anaesthetic chart
    - Policies outside of Anaesthetics e.g. MI, TEP, safeguarding

# Building momentum

- Develop a cross-site team; early leads involvement; shared drive
- Excel spreadsheets
- Monthly updates (CG) to raise awareness and present guidelines
- Weekly breakfast meetings for audits

# Trainee Induction August 2023

- Induction handbooks for both sites
- Getting trainee engagement
- Previous trainee audits -repeat cycles
- Previous experience from other Trusts
- Identify tasks for senior trainees
  - Patient information
  - Simpler policies (PONV, latex)
  - Supporting CTs with audits

# Timescale to Review

- Hopelessly optimistic
- Subscribed July 2023
- Originally planned for Nov 2023 (15 months after initial launch)
- Delays in governance processes
- Deferment to March 2024
  - Balance between realistic timeframe and department weariness

# Final push

- Statements for each standard
- Department engagement & quiz
- Uploading evidence
  - Portal issues
- Shock deadline from ACSA
- Portal closure 8/52 in advance

# Review Visit March 2024

- Logistical planning for visit
  - Rooms, IT, food, packs, scrubs & shoes
  - Initial presentation
  - Availability of key staff (ODPs, PDNs, matrons, service manager, rota coordinator, trainees, SAS, key consultants & CD)
  - Notify theatres, PAC, maternity, ED of walkabout
- Agenda flexibility
- Smooth visit with excellent dept engagement

# Final Report 30/5/24

- Not Yet Accredited
- 148/150 standards Met, some with recommendations
- 2 remaining unmet standards
  - Procurement of nerve catheter pumps
  - Refurbishment of Lewisham on-call facilities

# Top tips

- Early senior clinical & management engagement
- Leads & PDNs involvement
- Identify and tackle time-consuming tasks first!
- Trainee engagement
- Monthly updates to department
- Early prep for visit for full engagement



# Reaccreditation – Our Experience

Dr Lucy McManamon – ACSA lead  
Dr Sue Moss - CD

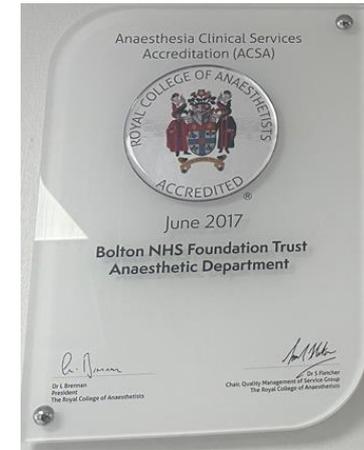
# Introduction

- Medium Acute DGH
- 622 beds and 4554 staff
- Royal Bolton Hospital integrated with community services - Bolton NHS Foundation Trust (2011)
- Centre of Excellence for Women & Children 2019
- High Acuity Centre for Paediatric Surgery
- High proportion (21%) population from BAME background
- High levels of deprivation



# Our ACSA journey

- 2015 - Appointed as ACSA lead
- Feb 2016 – Onsite 2 day visit
- June 2017 – ACSA accreditation-1<sup>st</sup> DGH in northwest
- Autumn 2019- both CD/ ACSA Lead became Clinical ACSA Reviewers
- Hybrid reaccreditation process due to COVID
- April 2021
  - Presentation
  - Classroom Standards
  - Interviews with staff groups- Managers, nurses, midwives
- Nov 2021
  - More Staff interviews- Consultants, AIT, SAS
  - Update on progress with unmet Standards
- March 2022
  - Onsite 1 day walk about and feedback
- Reaccreditation March 2023



# Improvements supported by 1<sup>st</sup> ACSA review

- Capnography – recovery
- Updated emergency buzzer system
- Standardised airway trolleys across all theatre areas
- All day paed's list in day care – met safeguarding/ improved efficiency
- Trust Sedation Committee
- LA cupboards

# Lessons Learnt as ACSA Lead

- Departmental awareness improved
  - Continuous process
- Maintain focus in between reviews
  - Volume of evidence to collate
  - Audits
  - Patient Satisfaction
  - Guidelines
- Delegation
  - Subspecialty leads to take ownership of standards
    - Accountability
    - Timelines
    - Tasks

# Lessons Learnt for Virtual/On site review

- Involve/inform wider team early
  - Theatre Staff (staff meetings/huddles)
  - Preop team
  - Pain team
  - Midwives
  - Managers (Division to Execs)
- Presentation for review
  - ACSA presentation
  - Included answers to classroom standards sent by ACSA team
    - Evidence
    - Updates
    - Presentation by subspecialty leads i.e preop/special needs/frailty pathways

# Challenging standards 1<sup>st</sup> vs 2<sup>nd</sup>

## 1<sup>st</sup> Review

- Creation of LA cupboards
- Training compliance non-anaesthetic staff
- ETCO<sub>2</sub> in Recovery
- Sedation Committee
- Cell Salvage
- Difficult airway equipment in remote sites

## 2<sup>nd</sup> Review

- LA in ED/ general non-compliance!
- Training compliance non-anaesthetic staff
- ETCO<sub>2</sub> for transfer
- Preop assessment off site
- Trainee awareness Trust Consent Policy
- Post procedural review ASA 3+
- Management vulnerable patient guideline

# Improvements supported by 2<sup>nd</sup> ACSA review

- Cross cover trainee rota
  - Improved Trainee experience
  - Safety
- Transfer Capnography equipment
- New Day Care build (supported)
- ED Difficult Airway trolley
- Reinstated midwife epidural/remiPCA training
- Obstetric on call room renovation
- Dedicated trainee office

# Role of the CD

- Support & collaborate with ACSA Lead
- Point of contact with wider organisation
  - Raising awareness
  - Operational and Clinical Strategy
- Support with BCs
- Support creation of Sedation Committee
- Important for CD to be aware of progress/ Governance/ Concerns

# Role of the CD

- Governance Oversight
  - Standard monthly governance agenda
  - Guidelines/policies
  - RAG rated Tracker for unmet standards
  - Updates from leads
- Early escalation of unmet/challenging standards through management structures
  - Equipment/Finance/BC

# Summary

- Awareness/Education
  - Profile of ACSA in Trust
  - Stakeholders
- Leadership
- Organisation
- Communication
- Teamwork
- Delegation

# Questions?



# Re-Accreditation post merger – A difficult journey

**Dr Michael McGovern**

Consultant Anaesthetist

Liverpool University Hospitals NHS Foundation Trust

# How it all began



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- Department started exploring in 2014
- Leadership team at time interested in exploring further and seeing how feasible it was
- What value would we get from it?
  - Other departments involved
  - Alignment with strategic objectives

- Attendance at engagement sessions held
- Decision to engage
  - Felt it would help support drive for change
  - Improve interdepartmental working
  - ‘Murmurs’ of hospital merger

# Fell into the trap



- Started as a consultant in 2014
- Said yes
- Hadn't looked into ACSA fully at that point and didn't appreciate exactly what was involved

# Long and lonely



- Felt at times to be very lonely
- Excellent support from college and college guide
- Library in infancy, available resources were more limited
- Department invited and audit presentation held to explain what it was
- At the time not lots of 'buy in' as:-
  - I was new
  - People didn't fully understand what it was
  - Few others had been through the process so what was the endgame?

# Reaching the end



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# First accreditation

- 2018
- Huge relief
- Still work to be done
  - Met with recommendations
  - Many areas we felt could be improved
  - Encouraged by addition of 'our' guidelines to library
- Continued departmental evolution

# Fork in road



- Trust merger
- And COVID
- And new build
- And service reconfiguration
- And CQC review



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# Trust Merger

- Trust shared policies
- Re-accredit singly or jointly
- Decisions around shared departmental policies and guidelines
- Lost guidelines
- Lost services
- Cross-site agreements
- Management and governance challenges

# COVID

- Similar impact across NHS organisations
- Non-clinical work stopped
- Adapting to new ways of working
- High underlying disease load
- High levels of deprivation
  - Significant acute and chronic workload increase
  - Above national average
- Slow to 'restart'

# New build

- Links in with service reconfiguration
- New build at sister site
  - Multiple delays
  - National coverage
  - Transfer of bed capacity
  - Loss of overall bed capacity
- Additional work required on both sites to improve service delivery

# Service reconfiguration

- Transfer of elective work out
  - Colorectal
  - Liver/HPB
  - Urology
  - Orthopaedics
- Transfer of vascular services in
- Acute workload increase
  - Orthopaedic trauma
  - Emergency surgery
  - Vascular
  - trauma
- Ongoing work

# CQC review

- Requires improvement
- Significant clinical and management pressures
- Executive board changes
  - Inertia in decision making
- Review visits and intervention

# Tough terrain



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214 Wainwright fells of the Lake District

# WAINWRIGHT FELLS



- |                 |                      |              |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |               |                |
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| 01 CAFFELL FELL | 02 BASSINTON BOG MAN | 03 BULL HEAD | 04 BARNBARROW | 05 BIRCH BUSH | 06 BIRCH BUSH | 07 BIRCH BUSH | 08 BIRCH BUSH | 09 BIRCH BUSH | 10 BIRCH BUSH | 11 BIRCH BUSH | 12 BIRCH BUSH | 13 BIRCH BUSH | 14 BIRCH BUSH | 15 BIRCH BUSH | 16 BIRCH BUSH | 17 BIRCH BUSH | 18 BIRCH BUSH | 19 BIRCH BUSH | 20 BIRCH BUSH | 21 BIRCH BUSH | 22 BIRCH BUSH | 23 BIRCH BUSH | 24 BIRCH BUSH | 25 BIRCH BUSH | 26 BIRCH BUSH | 27 BIRCH BUSH | 28 BIRCH BUSH | 29 BIRCH BUSH | 30 BIRCH BUSH | 31 BIRCH BUSH | 32 BIRCH BUSH | 33 BIRCH BUSH | 34 BIRCH BUSH | 35 BIRCH BUSH | 36 BIRCH BUSH | 37 BIRCH BUSH | 38 BIRCH BUSH | 39 BIRCH BUSH | 40 BIRCH BUSH | 41 BIRCH BUSH | 42 BIRCH BUSH | 43 BIRCH BUSH | 44 BIRCH BUSH | 45 BIRCH BUSH | 46 BIRCH BUSH | 47 BIRCH BUSH | 48 BIRCH BUSH | 49 BIRCH BUSH | 50 BIRCH BUSH | 51 BIRCH BUSH | 52 BIRCH BUSH | 53 BIRCH BUSH | 54 BIRCH BUSH | 55 BIRCH BUSH | 56 BIRCH BUSH | 57 BIRCH BUSH | 58 BIRCH BUSH | 59 BIRCH BUSH | 60 BIRCH BUSH | 61 BIRCH BUSH | 62 BIRCH BUSH | 63 BIRCH BUSH | 64 BIRCH BUSH | 65 BIRCH BUSH | 66 BIRCH BUSH | 67 BIRCH BUSH | 68 BIRCH BUSH | 69 BIRCH BUSH | 70 BIRCH BUSH | 71 BIRCH BUSH | 72 BIRCH BUSH | 73 BIRCH BUSH | 74 BIRCH BUSH | 75 BIRCH BUSH | 76 BIRCH BUSH | 77 BIRCH BUSH | 78 BIRCH BUSH | 79 BIRCH BUSH | 80 BIRCH BUSH | 81 BIRCH BUSH | 82 BIRCH BUSH | 83 BIRCH BUSH | 84 BIRCH BUSH | 85 BIRCH BUSH | 86 BIRCH BUSH | 87 BIRCH BUSH | 88 BIRCH BUSH | 89 BIRCH BUSH | 90 BIRCH BUSH | 91 BIRCH BUSH | 92 BIRCH BUSH | 93 BIRCH BUSH | 94 BIRCH BUSH | 95 BIRCH BUSH | 96 BIRCH BUSH | 97 BIRCH BUSH | 98 BIRCH BUSH | 99 BIRCH BUSH | 100 BIRCH BUSH |
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LAKE DISTRICT PARK PROJECT  
1961

Path blocked



# Navigation



# Navigation

- Back to basics
- Remained separated as departments
  - Long-term aim
  - Increased interdepartmental working
- Support from department
- Support from other departments
  - Shared goals and aims
- Executive support



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# Toughest part of journey



# The Visit.....

- College team are excellent
- Made clear it is a supportive aim
  - Appreciate the challenges
  - Keen to find positives
- Are there to help you
  - What do you need?
  - How can college help you get it?
- Friendly faces

# The Report

- Primary focus is positives
  - Evidence of good/exceptional practice
  - Developments from previous visit and review
  - Positives ACSA has made already
- Areas for improvement
  - Most unmet standards will be predicted
  - Every department has some areas they struggle with

Closing the gap



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# Use the report

- Specific areas that have been challenging
  - Motivation
  - Funding
  - Knowing where to start
- Executive engagement
  - Had been a challenge within our trust
  - Has been extremely helpful in closing gap and gaining funding



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# Accreditation



Thank you



# One merger, three sites and just a little pandemic

**Dr Jenny Illingworth**

Consultant Anaesthetist

Clinical Lead for Health Improvement ICHT

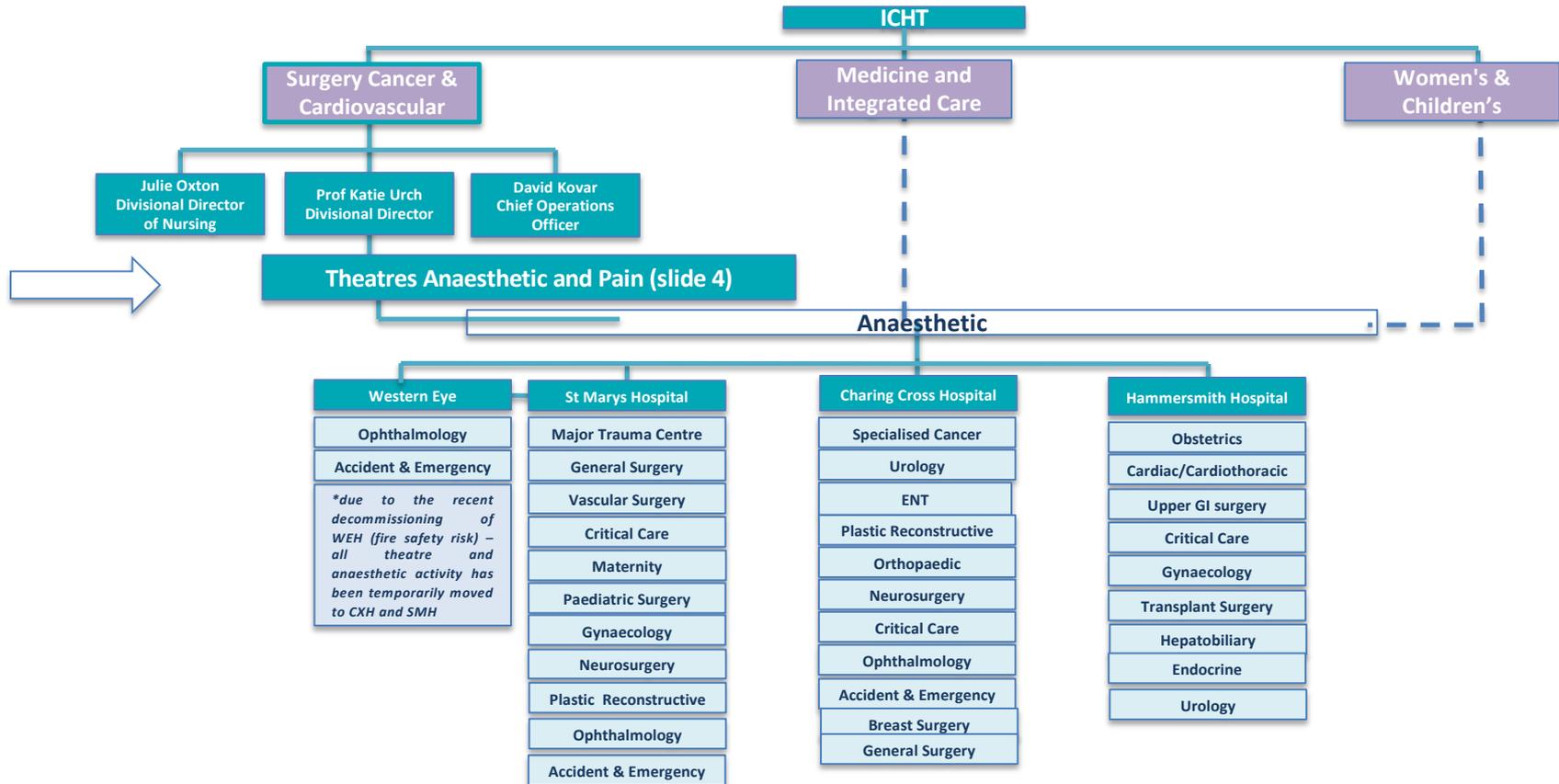
# Imperial College Healthcare



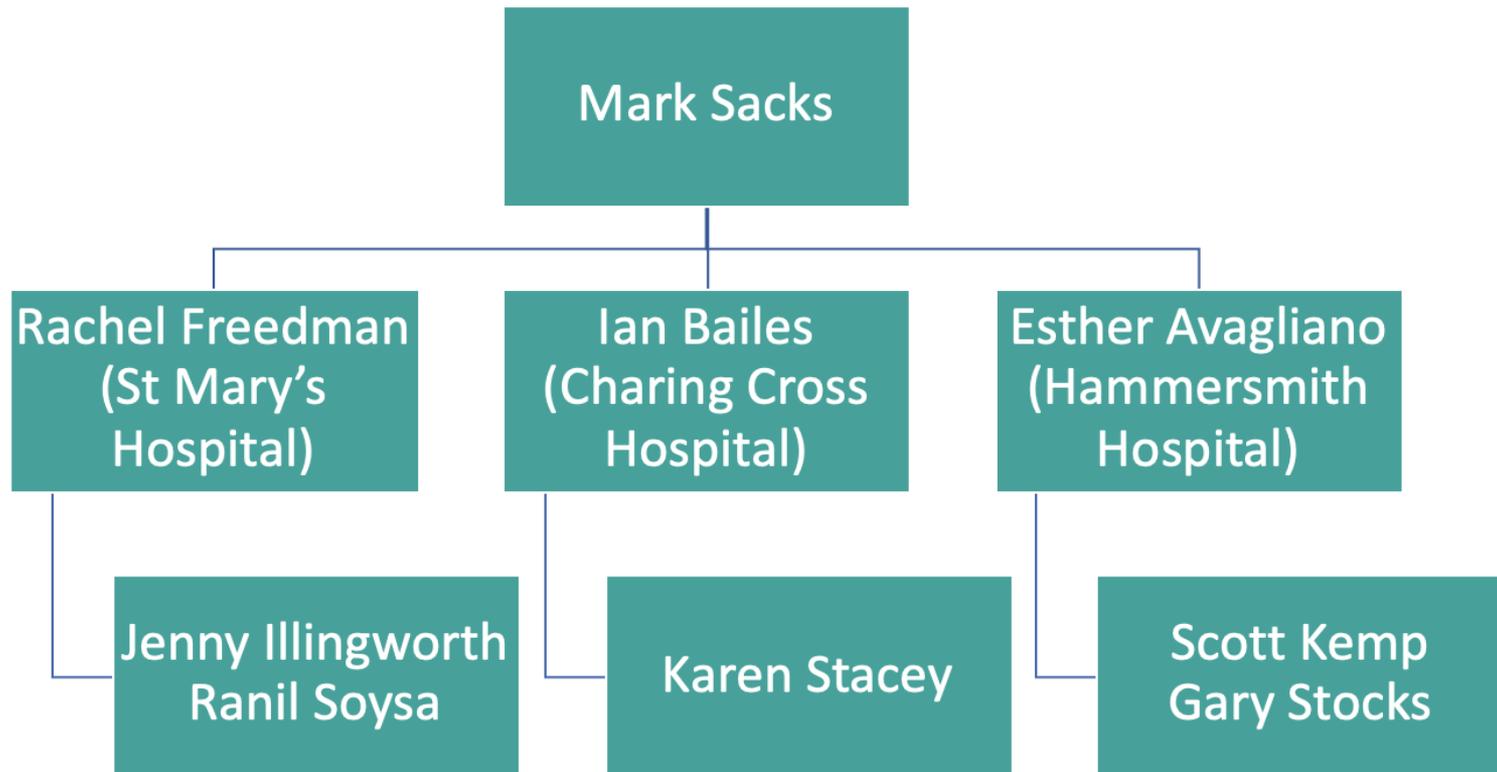
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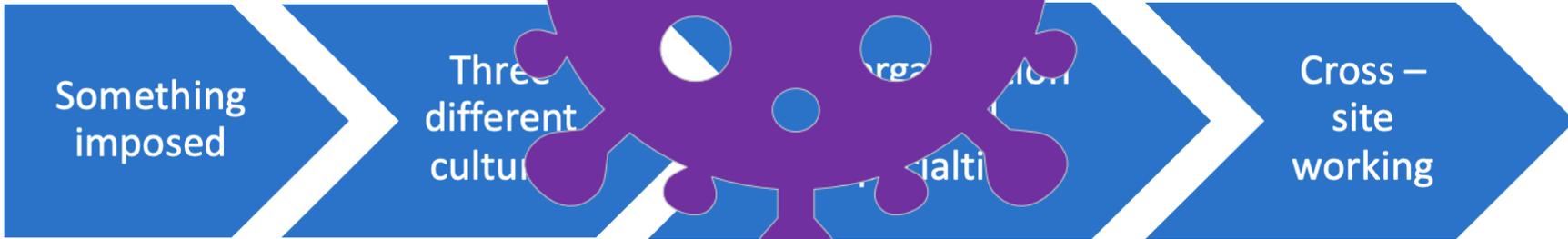
# Introduction to the organisation



# Imperial ACSA Team

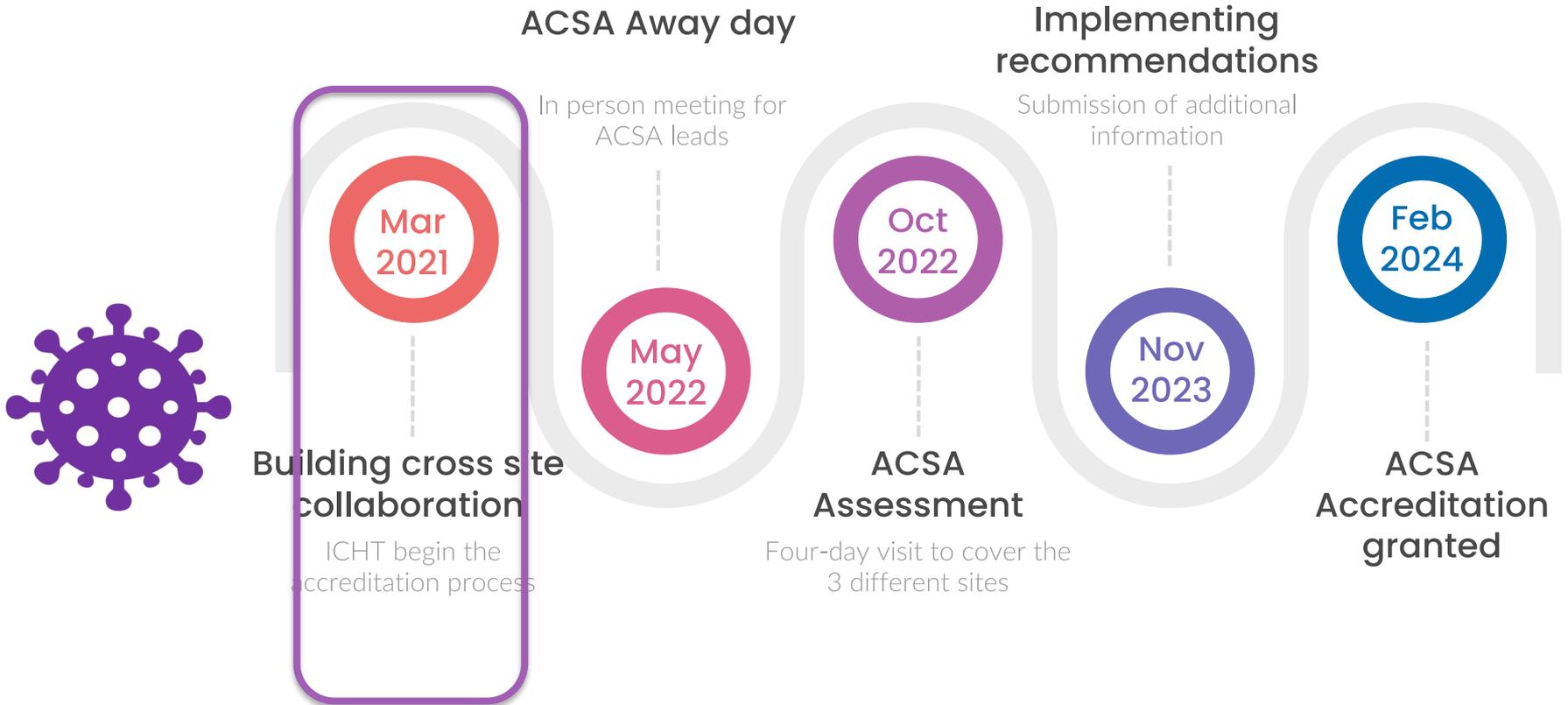


# Organisational Context



Impact of the merger & creation of Imperial College Healthcare NHS Trust

# Accreditation timeline



# First steps

Familiarisation  
with the  
standards

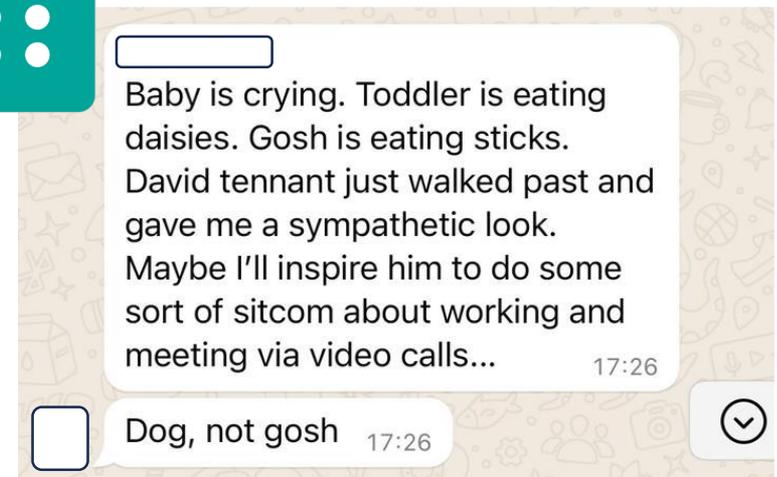
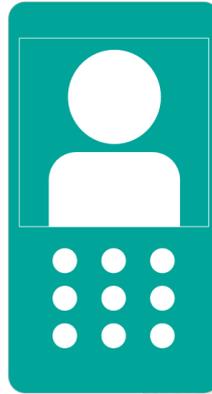
Learning how  
to collaborate  
together

Building local  
engagement

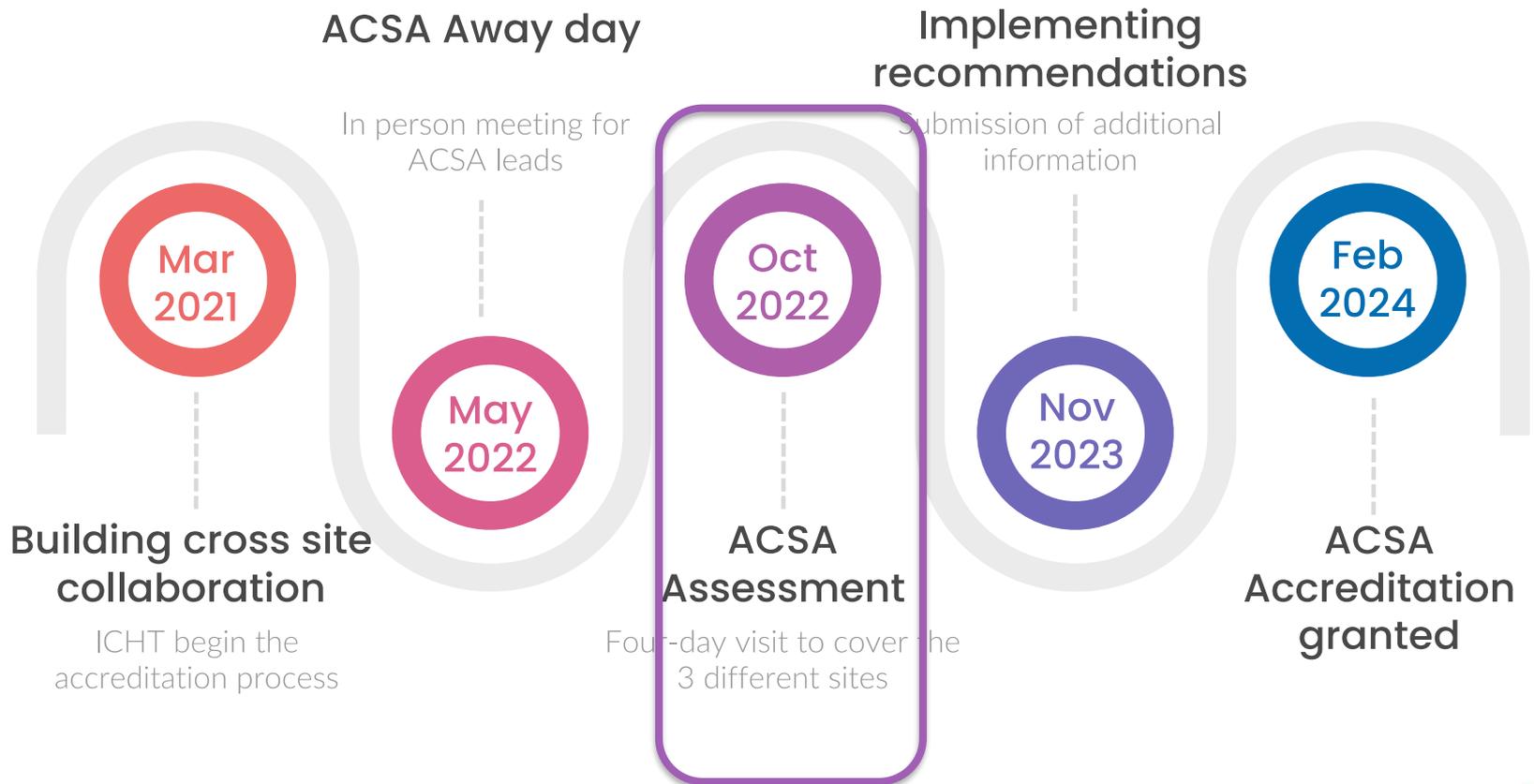
Collating  
existing  
policies

# Collaborating across sites

- Combination of zoom, WhatsApp & Microsoft Teams
- >12 months before meeting in person
- Most meetings after 5pm



# Accreditation timeline



# ACSA Assessment Visit Oct 22

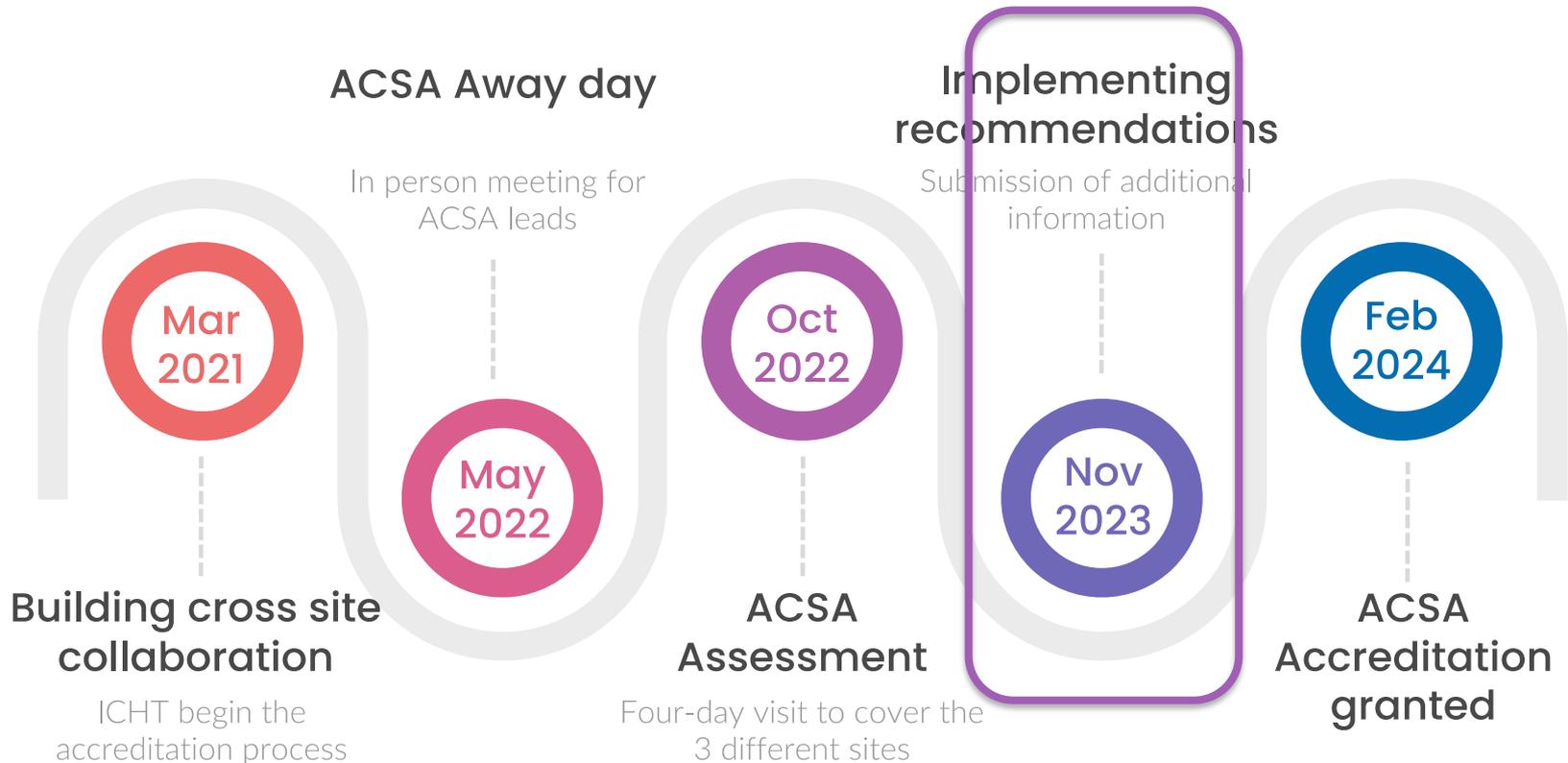


October's  
rain makes  
**little dent**  
in year's  
dryness

\*Provisional Met Office data

- Reviewers grounded in realities of delivering care.
- Good engagement from departments during visit
- Validation from having department & ethos reflected back

# Accreditation timeline

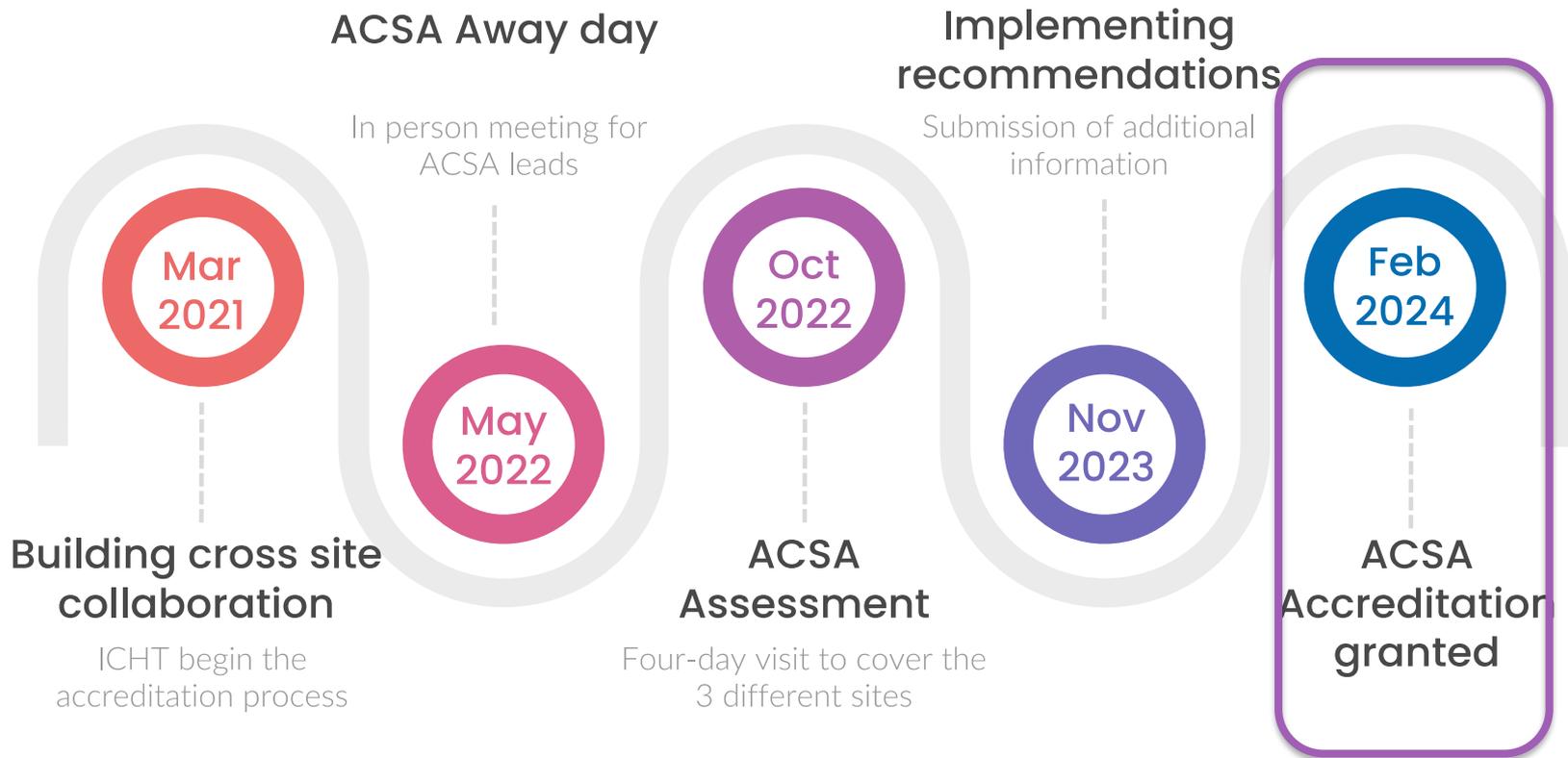


# Meeting recommendations



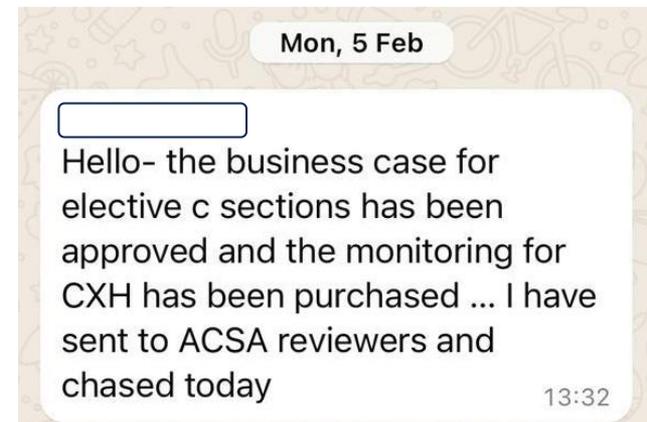
- Challenging to maintain momentum
- NHS procurement & business planning processes slow
- Shortening time between visit & report

# Accreditation timeline

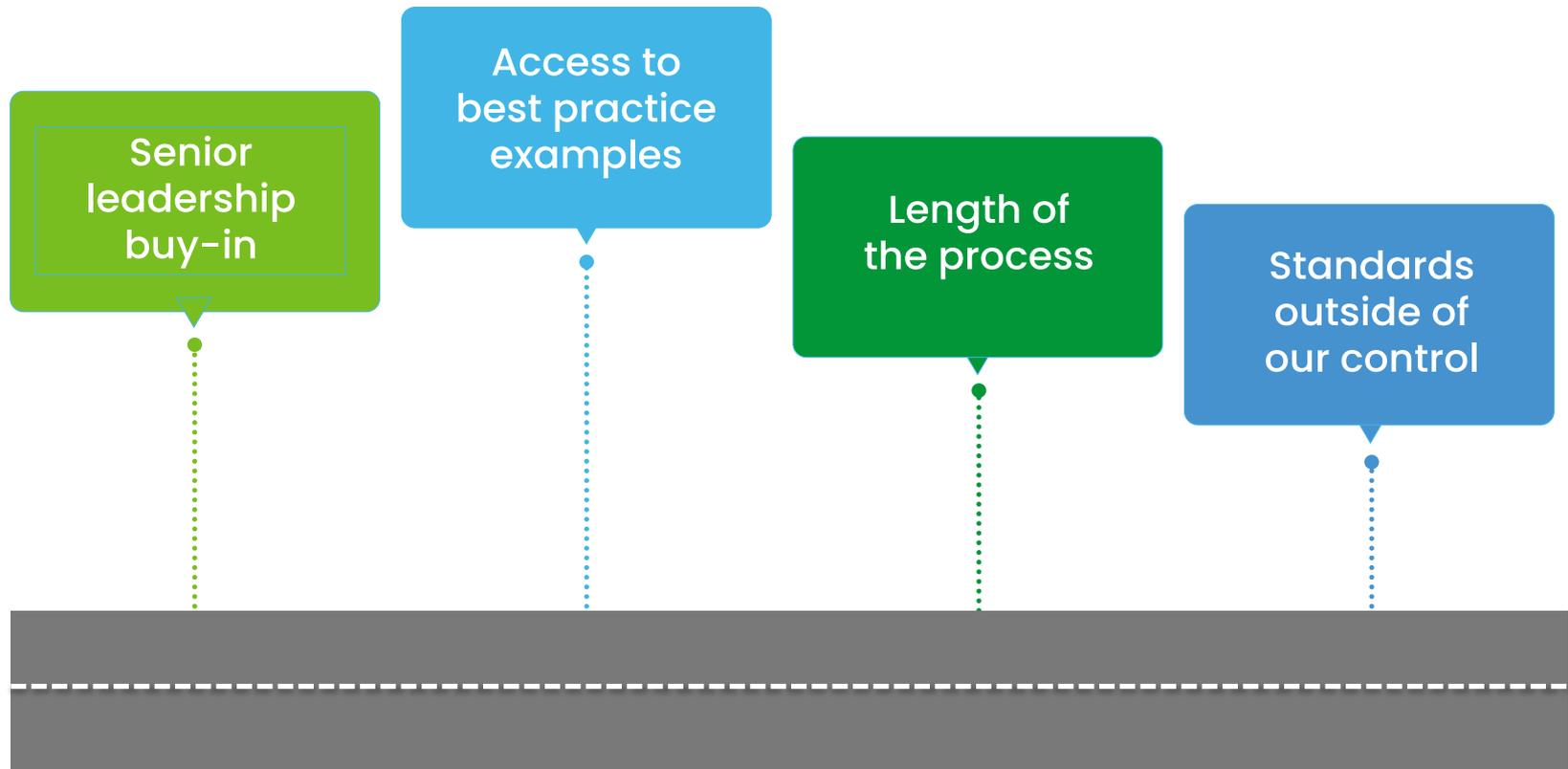


# Benefits of ACSA

- Unlocking capital projects
- Collation & updating of policies
- Opportunity to showcase what we do well
- Bringing the sites together



# Key challenges of ACSA



# If we had to do it all again...

Encourage communication with the college. They were most helpful with any question & quick responders

The more was done, the more momentum was built and that helped

Teams evolve but having an overall lead, site leads & deputies helped

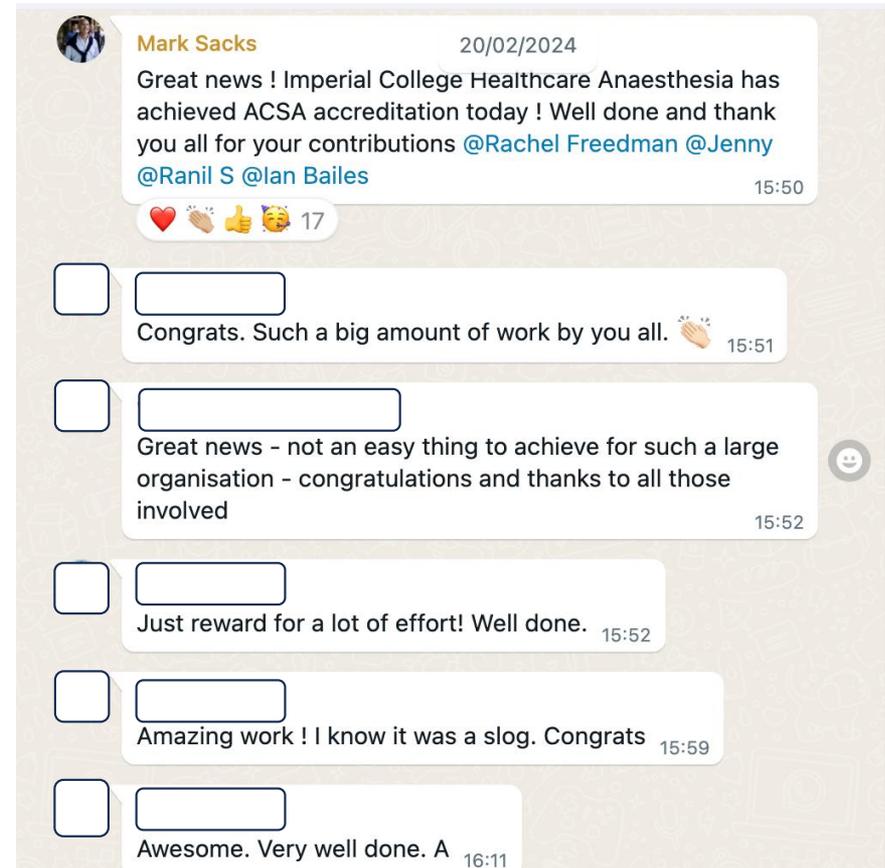
Make more use of evolving technology such as Sharepoint & Teams

Comms resources to easily describe what ACSA is

Hold launch events with CD & Heads of specialties

I would say ...not to feel overwhelmed, it's lots to do but feasible with great team working and support

# Achieving accreditation



Thank you

# Lunch break

**12:50 – 13:50**

Please join us for lunch in the café

# Session 3

## Meeting difficult standards

# ACSA: Meeting Difficult Standards

## Part One

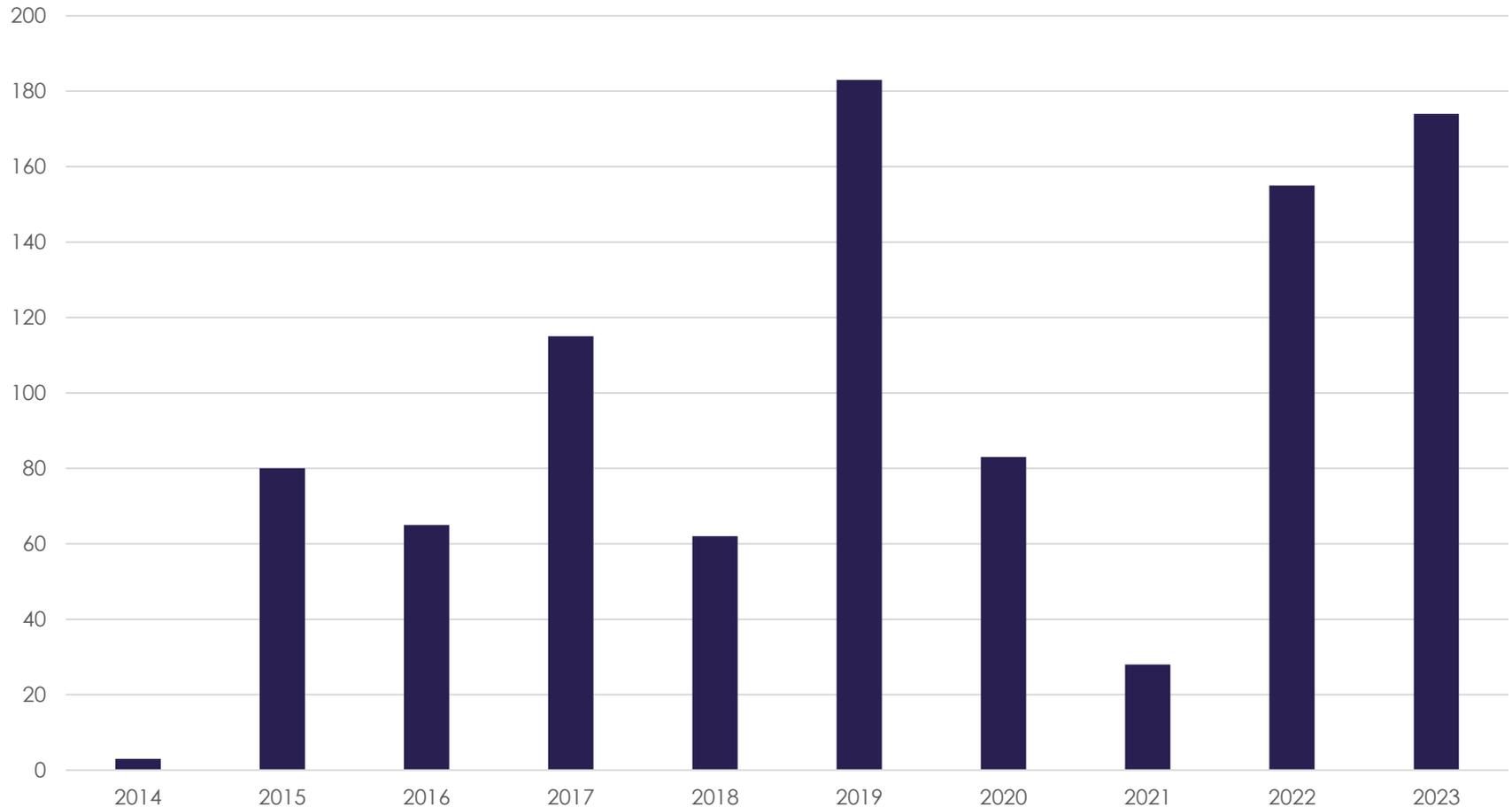
Adrian Jennings

Consultant Anaesthetist  
The Dudley Group NHSFT

# ACSA Outcomes

- Met
- Met with recommendations
- Unmet
- Further evidence required
- Not assessed

# Unmet standards



Based on 103 visits

# Averages per visit

- 9.2 unmet [0-22]
- 6.8 met with recommendations [0-17]

# The Top 5

Standard	Frequency
Local anaesthetic agent storage	49
Sedation committee	40
Post-procedural review policy	27
Emergency call bell system	25
Guidelines for the management of anaesthetic emergencies	24

## 2.2.1.2

*Local anaesthetic agents (ampoules and bags) must be stored separately from other drugs and intravenous fluids.*

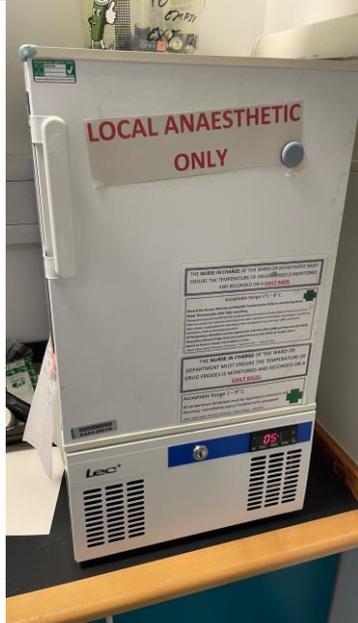
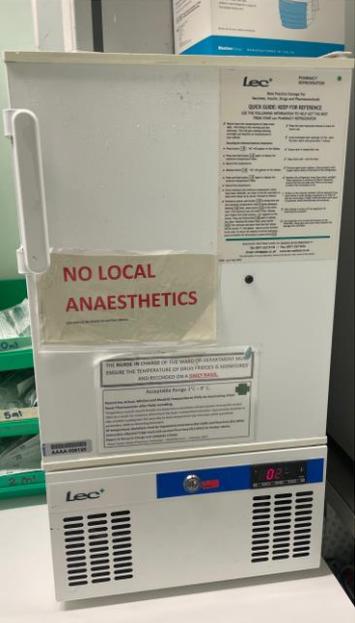
### **Help note**

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. A locked box may be permitted as an interim measure. Human factors should be considered to ensure there is a conscious separate action (e.g. opening a separate door) required to access local anaesthetic agents.





- ED
- Fridges
- Epidural trolleys
- Remote sites
- Eye theatre
- Recovery



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## 1.1.2.5

The trust/board Sedation Committee has anaesthetic representation.

### Help note

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.





February / 2021

# Safe sedation practice for healthcare procedures

## An update

# Terms of Reference

- Purpose
- Membership
- Frequency
- Quorum
- Reporting

Minutes

## 1.4.4.2

Appropriate pathways are in place for the post procedural review of patients.



All doctors working in the department including trainees are informed and can relay the process 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.

# Good practice

- Adequate provision within job plans
- ASA3+, epidurals, invasive monitoring...
- Somewhere to document

# Required

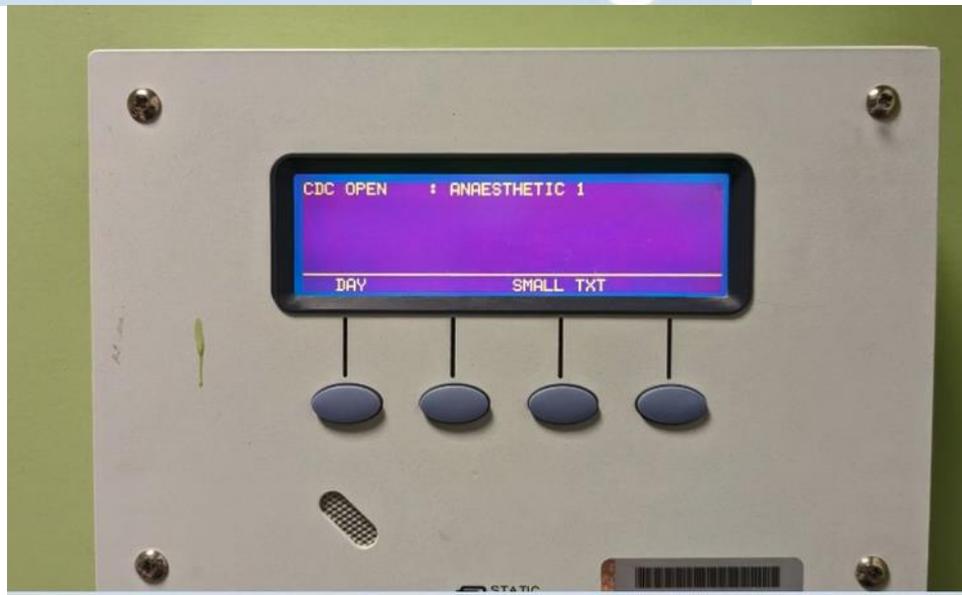
- Recovery period
- Difficult airway follow up
- Maternity

## 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.



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.



# Unmet....



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# Met



2222  
Anaesthetic  
code red



# 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.**

The intranet may not be adequate unless reliable and immediately available.



- Version control
- Locations
- Remote sites
- QR code
- Web app

**Location of emergency equipment and drugs**

**Cardiac arrest trolley**

**Pacing**

**Airway**

**Dantrolene**

**hypertension**

**Lipid normalisation**

**anaesthesia**

**Anaphylaxis**

**Rapid**

**Cell salvage equipment**

**Ultrasound machine**

**Videolaryngoscope**



From time to time ensure that the location of the equipment is updated. If the location of the equipment changes, the QR code should be updated. This is done by the following steps:

- 0-1 Check the location of the equipment
- 0-2 Check the location of the equipment
- 3-4 B Check the location of the equipment
- 3-10 L and S Check the location of the equipment

This is done by the following steps:

# Conclusion

## Standard

Local anaesthetic agent storage

Sedation committee

Post-procedural review policy

Emergency call bell system

Guidelines for the management of anaesthetic emergencies

# Thank you



# Tricky Standards

## Part 2

**Ritchie Marcus**

ACSA clinical reviewer

ACSA lead at Birmingham Children's Hospital

# 1.4.2.1 Trained Recovery

- **The recovery room staff, including those working in obstetrics, are appropriately trained, and updated in all relevant aspects of postoperative care.**
- 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.
- **CQC KIoE**
- Safe; Well-led
- Priority: **1**

# Obstetrics (9)

- Midwife only Recovery
  - 4 used midwives only 24/7
  - 2 OOH midwives only
  - 1 yes for GA, no for regionals
  - 1 yes, only if available
  - 1 shortage of midwives- can't release for training

# Outlying/Subspecialty Areas

- On site
  - Endoscopy Unit
  - Oncology day unit (paeds)
  - Eye unit (?LA only?)
- Cottage Hospitals
  - ODP and anaesthetist recover
  - Recovery yes, but not ALS trained
    - Needed as only 1 anaesthetist
- No paeds competencies OOH

# Solutions

- Co-location Obstetrics in Main theatres
  - Consider with new builds
- Business Cases for staff
  - Examples of success needed
- Training to theatre recovery standards

# 1.4.2.2 Recovery Staff ILS

- **All recovery staff should be trained to an appropriate level in life support and maintain their competencies.**
- 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.
- **CQC KIoE**
- Safe; Well-led
- **Priority: 1**

# Problems

- Trust Policy
  - BLS only/ILS only for team leaders
- Training availability
  - Not enough ILS courses
    - Theatres not Trust priority
    - ILS Recerts a challenge
  - Staff shortages
- Remote Sites
  - Obstetrics – midwives not ILS
  - Cottage Hospitals - lack of ALS

# Solutions

- Don't have to use branded courses
  - Can design and deliver in house
  - Cover relevant topics
- Cottage Hospitals
  - Need 2<sup>nd</sup> ALS provider
    - Send 2<sup>nd</sup> anaesthetist
  - Is service safe and sustainable there?

# 1.6.1.3 Paeds Competencies

- **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 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.
- **CQC KIoE**
- Safe
- Priority: **1**

# Resus Training main issue

- No/limited PLS trained ODP etc
- Limited elective workload but OOH ED
- Poor records
- No system to ensure PLS trained on shift
- Anaesthetist training: only assurance was appraisal

# Solutions

- Tailor training to workload
- Intelligent rostering
- Local MDT training
  - More appropriate than EPLS etc
  - Think about MEPA
  - Who needs training (separate rotas)

## 2.5.6.2 MDT Emergency Training

- **There is regular multidisciplinary team based training for emergency situations.**
- 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. 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.
- **CQC KIoE**
- Safe; Effective; Well-led
- Priority: **1**

# Issues

- Not in place
- Ad hoc only
- Not involving whole team
- Lack of venue
- Time/staffing/PA issues
  - Leadership
- We do PROMPT...go to ED scenarios

# Solutions

- Champion
- Get help from ED/Paed/Resus dept
- Start small/low cost....use audit time
  - Whole team and theatres available
  - Can be resus update for Consultants
- Use SI reports to show need
- Get positive feedback

## 2.1.2.2 New equipment

- **All anaesthetists and anaesthetic assistants receive systematic training in the use of new medical equipment and the training is documented.**
- Documentation of training should be provided.
- **CQC KIoE**
- Safe; Well-led
- **Priority: 1**

# About Record Keeping

- 16 no records or poor records
  - 4 equip. company has the records
- 4 up to individual to sign
- Issues with trainees and new starters

# Solutions

- Induction packages
  - Specific equipment training delivered
    - Trainees especially
- Don't release new equipment
  - Until evidence of x% trained
  - Need records
    - Even if equipment company trains

# 1.3.1.3 WHO/NATSIPPS process

- **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.**
- 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.
- **CQC KIoE**
- Safe; Effective; Well-led
- **Priority: 1**

# No surprises here

- 19 no or inconsistent debriefs
- 4 not adapted to specialist areas
  - 3 obstetrics, 1 radiology
- 4 lack of audit evidence
- 4 lack of engagement
  - 3 surgeons, 1 midwives

# My observations

- Pretty much universally done
  - Electronic collection of audit data on theatre systems
    - » will always be 100%
    - » Can't close case off if not completed
  - Audit via observation (secret if possible) best assurance
    - » details of odd non-compliance helps assurance
- Debriefs a real problem
  - ?do at sign out of last case or lose staff
    - But is anaesthetist distracted at this stage
  - Only useful if issues are addressed
  - Best I've seen is in single theatre day case unit
    - Done when last patient in recovery
    - Written up into electronic form
    - Good engagement of staff, all make suggestions
- Would like your examples of how you get reliable debrief

# Meeting Difficult Standards

## Part 3

Romesh Rasanayagam

ASCA Co-Opted Committee Member

Consultant Anaesthetist, University Hospitals Sussex

# My Experience

- ACSA Reviewer for 8 reviews to date
- Have assisted the Royal College of Obstetrics and Gynaecology on their invited review of Maternity Services
- A pragmatic approach, but the standards are there to maintain and improve the service, and to reduce the risk of errors.
- I would thoroughly recommend to you to apply to be an ACSA Reviewer for your own benefit, as well as to help the RCoA and the anaesthetic community

# 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.

# 1.1.1.2 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.
- Portal upload, Staff interviews and Walkabout

# 1.1.1.2 My Comments

- Laminated Prompt Card over each recovery bay. 5/6 points as Aide-Memoir
- Recovery instructions on back of anaesthetic charts
- Transfer form for patients going to ICU – Airway issues/Tracheostomies



# Standard 1.3.1.5

- Recommended standards of monitoring are met for each patient.

# 1.3.1.5 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
- Portal upload, Staff Interviews and Walkabout

# 1.3.1.5 My Comments

- a nerve stimulator when neuromuscular blocking drugs are used. (now qualitative – or plan to get there)
- depth of anaesthesia monitoring. (where case-mix requires)
- 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



# Standard 3.1.2.2

- Day surgery patients are given clear and concise written information on discharge including access to a 24/7 staffed telephone line for advice.

# 3.1.2.2 Evidence Required

- Information given to patients on discharge from the hospital include a telephone number for advice.
- 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 in case of immediate concerns for adults and children
- Portal upload, Walkabout

## 3.1.2.2 My Comments

- Good practice seen with leaflets of post neuroaxial blockade and post nerve block care.
- Common issue is change in ward/ telephone number and leaflets out of date
- Inappropriate for generic Call 111 for specific post surgical issues

# Standard 4.1.1.1

- The department has a live and annually reviewed operational plan in line with the wider organisational strategy

# 4.1.1.1 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

# 4.1.1.1 My Comments

- Evidence of discussions within Dept. management meetings.
- Evidence from Directorate/Divisional meetings/presentations and Business Plans.
- Can include Risk Register with plans to reduce or mitigate the items
- Can be a Word document with goals and aspirations of the department

# 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

## 2.3.1.2 Evidence Required

- Demonstration of the system and confirmation of back up arrangements.
- Priority 3
- Standards will be aspirational for most; however, they will provide targets for the highest performing departments to achieve.

## 2.3.1.2 My Comments

- So far, not seen in use on my reviews, however, 25% were in the process of starting in the next year
- Obviously the way to go, but it would be useful to have feedback from departments who have done it or about to.
- All departments need to be able to access the records easily.

# Final Thoughts

- As with most things in life, good preparation makes for a much better and smoother visit.
- Look at the standards set, and put something (evidence or narrative) down in each one. Do not miss anything out.
- It really is an excellent way to know what happens throughout your service and ensure consistently good practice everywhere.
- You are also holding up your department as a beacon of good practice locally and nationally.

# **Q&A with all speakers**

All speakers

chaired by Jon Chambers

ACSA committee vice-chair

# Closing comments

Dr Mike Swart

ACSA committee chair and clinical lead