ACSA
Anaesthesia Clinical Services Accreditation
Royal College of Anaesthetists
ACCREDITATION

ACCREDITATION STANDARDS 2017

The ACSA standard has **5 DOMAINS:**

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

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

KEY

DOMAIN | SUBDOMAIN | AREAS | STANDARD

The Care Quality Commission has released the **Key Lines of Enquiry** which the ACSA team maps against ACSA Standards.

Guidelines for the Provision of Anaesthetic Services references.

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

1. The Care Pathway

1.1 General

1.1.1 Policies

		PRIORITY	CQC KLoE	GPAS REFERENCES	HELP NOTE
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	1	Safe Well-led	1.1.11, 3.1.1, 4.2.4, 7.3.3, 9.4.6, 11.1.6, 11.2.1	This has been written by the ACSA Team and agreed by the Quality Management of Service Group as useful additional wording to help clarify the standard further where possible.

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.

These Key Lines of Enquiry are:

1 Safe
2 Effective
3 Caring
4 Responsive
5 Well-led

The KLoEs applicable to the standard are mentioned.

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

ACCREDITATION STANDARDS 2017

NOTES TO PROVIDE CLARIFICATION OF ACSA STANDARDS

Please be advised that:

Only certain parts of the cited GPAS reference text may be applicable to the ACSA Standard.
The term 'appropriately trained' refers to someone who has had specific training in the knowledge and skills required to undertake their designated role.
Areas that do not have any anaesthetic input will not be assessed during the onsite review visit.

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. Priority 2 standards should be achievable by most departments. Priority 3 standards will 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'	Whilst the ACSA standards utilises the term 'policies', it should be noted that the term is used as an umbrella term to refer to some sort of process that is maintained, kept up-to-date (reviewed every three years), can be used as a reference and is used during induction. This could be in the form of a policy document, practice document or even a piece of software that fulfils the function of the standard. The important criteria is that everyone knows the reference point exists and where to find it, and that the reference point is kept up to date in accordance with the trust policies.
Note 3	For hospitals that do not provide services for children	If your department does not treat children it is acceptable to mark child specific standards as 'N/A'.

For each standard you decide is 'unmet' you may want to identify the following (your findings can be recorded in the textbox of the self-assessment document or in the excel spreadsheet):

- What is the standard number and what domain is it in
- What are the actions required (current situation and possible solutions)
- Who is the implementation lead
- What are the resource requirements (financial, human or time)

All of these actions should be SMART (i.e. Specific, Measurable, Agreed, Realistic, Time-bound) and should have a review date and/or deadline.

For each standard you decide is 'unmet' you may want to consider the following barriers to change:

- Lack of awareness and knowledge
- Poor motivation
- Non-acceptance and counter beliefs
- Lack of skills
- Practicalities
- Barriers beyond our control e.g. your building layout

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
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	1	Safe Effective Well-led	3.4.6 5.1.4 9.1.19, 9.1.20 10.1.4			
1.1.1.2	**When children are admitted for surgery there is immediate access to a named consultant paediatrician** Indicate clear arrangements/written guidance for access to paediatrician If your department does not treat children, please refer to Note 3.	1	Safe Effective Responsive	10.1.8			
1.1.1.3	**There is a trust resuscitation policy with specific reference to a do not resuscitate order for the perioperative period** A copy of the policy should be provided. Policy should include provision for review of 'not for resuscitation' orders prior to surgery	1	Safe Caring Responsive	5.5.36 6.2.7 8.3.4, 8.6.1			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.1.1.4 **Where sedation is provided by an anaesthetist there is a policy for the provision of this service including all subspecialty areas and the specifications of the facilities provided, including paediatrics** A copy of the policy should be provided See Note 2 for an explanation of what is meant by the term 'policies'. Please refer to the recommended published guidance for the conduct of paediatric sedation	1	Safe Effective Caring	7.3.26, 7.3.27, 7.3.28 10.5.20 19.2.11, 19.3.29			
1.1.1.5 **There are documented and agreed policies and documentation for the handover of care of patients from one team to another throughout the perioperative pathway** A copy of policies and protocols should be provided See Note 2 for an explanation of what is meant by the term 'policies'. This includes handover to critical care post operatively.	1	Safe Well-led	3.5.21, 3.5.2.2 4.5.1, 4.5.4, 4.5.6			
1.1.1.7 **Guidelines for the management of anaesthetic emergencies are appropriately displayed and immediately and reliably available in sites where anaesthesia and sedation is provided and include guidelines for children** 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 If your department does not treat children, please refer to Note 3. The department will need to prove it is available. The intranet is not adequate unless reliable and immediately available	1	Safe Effective	3.5.18 5.5.44 10.5.19 19.2.7			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.1.1.8 There are documented policies for the management of acute pain and post-operative nausea and vomiting, including for those with special requirements e.g. chronic pain, drug dependency A copy of the policies should be provided See Note 2 for an explanation of what is meant by the term 'policies'	1	Caring Responsive Well-led	4.2.18 10.2.15, 10.5.19			
1.1.1.9 There is a policy for the management of morbidly obese patients A copy of the policy should be provided See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Responsive	3.3.3, 3.3.4, 3.3.5, 3.3.6, 3.3.7 9.3.7, 9.3.8, 9.3.9			
1.1.1.10 There is a policy for the post-procedural review of all patients All doctors working in the department including trainees are informed and can relay the post-procedural review for different groups of patients. How this information is shared with new staff members should be relayed See Note 2 for an explanation of what is meant by the term 'policies'. What constitutes an appropriate review will depend on the patient, type of surgery and surgical location. Review and discharge is often nurse led in the day procedure unit. What is important is that all, including trainees, are aware of departmental responsibilities and learning opportunities and that they are safe and appropriate	1	Safe Responsive Caring	4.1.11 9.5.3			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.1.1.11 There are multidisciplinary guidelines for care of the obstetric patient Multidisciplinary guidelines should be provided	1	Safe Effective Well-led	9.2.46, 9.5.18			
1.1.1.12 An appropriate early warning score is in use for all patients including emergencies, obstetric patients and children Early warning scores 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	1	Safe Effective	5.2.11 9.3.2 10.3.9			
1.1.1.13 There is a policy in place for the handling of complaints A copy of the policy and evidence of its use in practice should be provided See Note 2 for an explanation of what is meant by the term 'policies'	1	Caring Responsive Well-led	5.5.65 9.9.12, 9.9.13, 9.9.14			
1.1.1.14 There should be locally agreed policies for the 24-hour cover of emergency surgery, prioritisation of emergency cases according to clinical urgency, and seniority of clinical staff according to patient risk The local arrangements should be verbally relayed by staff members See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Well-led	5.5.18, 5.5.35			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.1.1.15 There is a locally agreed and documented policy for the provision of anaesthetic care, with or without transfer, for specialties not available onsite e.g. paediatrics Patient pathways should be relayed by staff members See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Effective Responsive Well-led	5.5.42 10.5.13, 10.5.18			
1.1.1.17 There is a policy to address patient death in the operating theatre A copy of the policy should be provided which has specific reference to the pastoral care of the bereaved family and staff members involved See Note 2 for an explanation of what is meant by the term 'policies'	1	Caring Well-led	3.5.15, 3.5.16 5.5.44			
1.1.1.18 There is a policy to address the airway management of adults and children in the emergency department The policy should be provided, its location should be pointed out and should be easily accessible and staff should be able to relay the main points and what is expected of them verbally See Note 2 for an explanation of what is meant by the term 'policies'. Please also see the RCoA/RCEM joint position statement	1	Safe Well-led	5.5.45 7.3.3, 7.3.4			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.1.1.19 There are documented policies for the anaesthetic management of adults and children in radiology and MRI suites A copy of the policy/policies should be provided See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Well-led	7.3.6, 7.3.7, 7.3.8, 7.3.9, 7.3.10, 7.3.11, 7.3.12			
1.1.1.20 Where ECT is performed the department has been accredited against the relevant national accreditation scheme Documentation of the accreditation should be provided	1	Safe Well-led	7.3.13, 7.3.14, 7.3.15, 7.3.16, 7.3.1.7			
1.1.1.21 There is a documented policy for the interdisciplinary management of critically ill children including short term admission to a general ICU The policy should be verbally relayed and should include retrieval policy and contact with paediatricians See Note 2 for an explanation of what is meant by the term 'policies'. If your department does not treat children, please refer to Note 3	1	Safe Effective Caring Well-led	10.3.8, 10.3.10, 10.3.19, 10.3.20			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.1.1.22 Care pathways and evidence of engagement with regional networks for paediatric anaesthesia and surgery, based on the complexity of procedure, age and co-morbidity of children, as well as clinical urgency and geography, are developed and agreed Local standard, care pathways and policies available. Evidence of attendance at regional network meetings and use of regional guidelines or involvement in network audits If your department does not treat children, please refer to Note 3	1	Safe Responsive Well-led	10.3.8, 10.3.13, 10.5.14, 10.5.15, 10.5.16			
1.1.1.25 Policies for children's surgical services are formulated and reviewed by a multidisciplinary team including leads from the following specialities; paediatrics, anaesthesia, surgery and nursing Demonstrate committee overseeing services for children (minutes of meeting) and hospital engagement in regional network (agenda, minutes) If your department does not treat children, please refer to Note 3	1	Safe Effective Responsive Well-led	10.5.2, 10.5.3			
1.1.1.26 There are clear criteria and standards for paediatric day surgery with regards the children attending, discharge pathway and also the environment and staff where it is delivered Policies and guidelines available including comorbidities and common conditions, appropriate staff rotas See Note 2 for an explanation of what is meant by the term 'policies'. If your department does not treat children, please refer to Note 3	1	Safe Caring	10.3.28, 10.3.29, 10.3.30, 10.3.33			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.2	**Pre-procedure**						
1.2.1	**Pre-assessment**						
1.2.1.1	**All patients, including parents and children, undergoing anaesthesia or sedation have an appropriate preoperative assessment** Verbal explanation should be given of the procedure for triage of patients including how test results and potential problems are flagged in a timely manner to aid list planning (Refer to reference 2.2.2 and 2.2.9 in particular) Ideally all patients should have a formal pre-operative 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 had been conducted a more rigorous assessment will be necessary on admission	1	Safe Effective Responsive	2.1.1, 2.1.3, 2.5.1, 2.5.4 5.5.22, 5.5.23, 5.5.26, 5.5.28, 5.9.6 6.2.10 9.5.1, 9.5.2 10.2.7 19.1.1			
1.2.1.2	**There is a consultant anaesthetist with responsibility to lead the anaesthetic preoperative assessment service, and this is factored into their job plan. Additional consultant anaesthetic input is available as required** Documented evidence should be provided, e.g. job plan or rota	1	Safe Well-led	2.5.14, 2.5.16 6.1.5, 6.2.11, 6.2.12			
1.2.1.3	**The appropriate level of postoperative care is planned and arranged preoperatively** A verbal explanation should be provided regarding how patients are ranked in urgency when there is competition for beds, how patients are recovered when anaesthetised remotely (outside main theatres), what plans are in place for booking level 2 and level 3 care and the access of obstetric and paediatric patients to level 2 and level 3 care	1	Safe Effective Well-led	2.5.29 5.5.43 7.3.22, 7.3.23 9.3.3 10.2.7, 10.3.21			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.2.1.4 **All patients, including children andtheir carers, undergoing anaesthesia or sedation are seen by an anaesthetist after admission, prior to the procedure** Patient charts should have evidence that patients have been seen. Staff should be able to give verbal confirmation that the assessment happens privately. Audit of parental feedback and satisfaction	1	Safe Responsive	2.5.7, 2.5.30 5.5.26 6.1.3, 6.2.15 10.2.7 19.1.2			
1.2.1.5 **There are agreed local policies for preoperative preparation as listed; fasting, investigations, cross-match, thromboprophylaxis, diabetes, latex-allergy, antacid prophylaxis and others where appropriate** A copy of the policy/policies should be provided and staff should give verbal confirmation that they are fit for purpose and followed. In children, similar policies should be provided including fasting and pregnancy testing in adolescents See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Effective	2.5.17 3.2.23, 3.2.25 6.2.11, 6.2.13 9.2.17 10.3.31, 10.5.21, 10.9.2			
1.2.1.7 **There is adequate time allowed for consultant assessment of antenatal referrals** Verbal confirmation should be given that a system which staff are satisfied allows enough time is in place	1	Safe Caring Well-led	9.1.17			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.2.2	**Consent**						
1.2.2.1	**Patients and their carers are given adequate information upon which to base their decision regarding anaesthesia, post operative care and pain relief** There is a record that patients have received information describing the options, risks and benefits of the proposed procedures. Documentation of discussion of procedures and risk e.g. on the anaesthetic record. Adequate information in the appropriate format should be accessible	1	Caring Responsive	2.9.1, 2.9.4, 2.9.5, 2.9.6 6.7.4, 6.7.5 9.9.1, 9.9.2 10.9.2			
1.2.2.2	**Staff have documented knowledge of national guidelines and the Trust/Board policy on informed consent** A copy of the staff induction pack should be provided. Staff taking consent for paediatric anaesthesia have documented knowledge of legislation and good practice guidance involving rights of the child, child protection processes and consent. Consent is taken by a qualified person	1	Effective Well-led	2.9.8 10.9.8, 10.9.11, 10.9.12			
1.2.3	**Access to investigations**						
1.2.3.1	**A process is in place to ensure that abnormal results of pertinent investigations are flagged to the relevant person in a timely manner** 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	1	Safe	2.5.26, 2.5.27, 2.5.33 6.2.15			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.2.3.3 **A written policy exists for the perioperative management (including regional anaesthesia) of patients for the use of anticoagulants** A copy of the policy should be provided	1	Safe	2.5.17			
1.2.4 **List planning**						
1.2.4.2 **The specific needs of children are considered at all stages of peri-operative care including emergencies and parental accommodation** Evidence should include sight of a separate area in recovery for children, documentation of special considerations in patient notes and pre-assessment records, patient information and patient satisfaction audits If your department does not treat children, please refer to Note 3	1	Caring Well-led	2.3.1, 2.3.4, 2.3.9 4.3.2, 4.3.3, 4.3.4, 4.3.5 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.3.5, 6.3.6, 6.3.7, 6.3.8, 6.3.9, 6.3.10, 6.3.11 7.3.1 10.2.12, 10.2.18, 10.2.19, 10.2.21			
1.2.4.3 **Arrangements are in place for the multidisciplinary management of patients with multiple co-morbidities** Brief presentation of an example scenario which may be requested at your ACSA review visit	1	Safe Well-led	2.5.11, 2.5.12 16.6.3			
1.2.4.5 **There are dedicated arrangements for day surgery** Operating lists should be seen to allocate the first slots of the list to day-case patients	1	Responsive Well-led	6.2.1, 6.2.3 10.3.28, 10.3.29			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.2.4.6 **Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff** A copy of rotas and lists showing dedicated theatre lists with a named consultant with no other clinical commitment should be provided. An audit demonstrating minimal delays to elective procedures and rapidness of emergencies to support local arrangements In smaller units with fewer than 2500 deliveries the provision of emergency care and regional analgesia should not compromise the elective obstetric workload	1	Responsive Well-led	9.1.2, 9.1.17, 9.5.22			
1.2.4.7 **Arrangements are in place for the multidisciplinary management of vulnerable older patients** A copy of the policy should be provided. The policy should include the involvement of physicians. Frailty scoring is a useful example as is having a named consultant available for the older patient in the anaesthetic department	1	Responsive Well-led	2.3.16, 2.3.17 3.3.2 5.3.3			
1.2.4.8 **Children are separated from adult patients throughout their care pathway, including theatres, recovery, inpatient wards, day ward and critical care unit. These areas should be safe and accessible to parents and carers** Demonstrate separate pathway and environment - seen at 'walkabout' session during ACSA review visit. Prioritisation on mixed lists Children need to be separated in the recovery area; a curtain is not considered to be adequate separation but a mobile screen is. If your department does not treat children, please refer to Note 3	1	Caring Effective Responsive	10.2.17, 10.2.19			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.2.4.9 **Services and facilities take account of the specific needs of adolescents, where these are different from those of children and adults** Demonstrate appropriate information on anaesthesia and surgery, provision of privacy and policy on consent Please note this is a 'priority 2' standard, see Note 1 for further explanation	2	Responsive	10.2.20, 10.3.36, 10.3.37, 10.3.38			
1.3.1 **Assistance for medical staff**						
1.3.1.1 **A dedicated and appropriately trained anaesthetic assistant is present throughout the entire anaesthetic procedure, including sedation** A written policy should be provided and verbal confirmation should be given that it is used for 100% of anaesthetic procedures in all areas at all times including out of hours and emergencies	1	Safe Well-led	3.1.11, 3.1.12 5.1.6 6.1.4 7.1.1 9.1.23, 9.1.24, 9.1.25, 9.1.26, 9.1.27 10.1.5 19.1.3, 19.3.11			
1.3.1.2 **When a child undergoes anaesthesia, all staff (operating department practitioners/ assistants/anaesthetic nurses) have paediatric training and experience** Evidence of staff experience, regular training, rotas or policy Please note this is a 'priority 2' standard, see Note 1 for further explanation. If your department does not treat children, please refer to Note 3	2	Safe	10.1.1, 10.1.5, 10.1.6			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.3.2	**Equipment**						
1.3.2.1	**All anaesthetic equipment is checked before use according to AAGBI published guidelines and the checks are documented** A copy of documented checks should be provided Example of evidence would be an audit of anaesthetic records showing a completion of checklist and any copies or examples of data	1	Safe	3.2.24 19.2.3			
1.3.2.2	**Devices for monitoring and maintaining or raising the temperature of the patient are available throughout the perioperative pathway including control of theatre temperature** Devices, including those suitable for use on children, should be seen and need to be in working order so that they can be used intra-operatively The ACSA review team will check that there is adequate provision to support this	1	Safe	3.2.20, 3.2.21, 3.2.30 5.2.23, 5.2.32, 5.2.42 10.2.1, 10.2.6, 10.3.4			
1.3.2.3	**Equipment is available to administer oxygen to all patients undergoing procedures under sedation by an anaesthetist** Equipment must be sighted	1	Safe	19.2.5			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.3.3	**Monitoring**						
1.3.3.1	**Recommended standards of monitoring are met for each patient** This should be visible on the anaesthetic chart	1	Safe	3.2.29, 3.2.30, 3.2.31, 3.2.32 5.2.32, 5.2.39 6.2.6 10.2.1 19.2.1, 19.2.2, 19.2.3, 19.2.4			
1.3.4	**Theatre access**						
1.3.4.1	**There is either a fully equipped obstetric theatre in the delivery suite or facilities for rapid transfer from the delivery suite to a theatre** Verbal confirmation regarding what happens 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	1	Safe Well-led	9.2.33			
1.3.5	**Access to preprocedural investigations**						
1.3.5.1	**Timely access to the following services are available for: haematology, blood transfusion, chemical pathology, blood gas analysis, radiology, electrocardiography and appropriate cardiopulmonary assessment including for emergencies** Verbal confirmation of how services would be accessed during a procedure should be given	1	Safe	2.2.4 3.2.10 5.2.27, 5.5.51 6.2.15 7.3.5 9.2.18, 9.2.19, 9.2.20, 9.2.21, 9.2.22, 9.2.23 10.2.20			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.4	**Post procedure**						
1.4.1	**Recovery facilities**						
1.4.1.1	**After general or regional anaesthesia, or sedation, all patients recover in a specially designated area which meets AAGBI and DH guidelines (e.g. oxygen, suction and monitoring)** The recovery area should be seen. Monitoring to include the provision for (and use of) capnography when appropriate	1	Safe Responsive	4.2.1, 4.2.2, 4.2.5, 4.2.11 7.1.4 19.1.4			
1.4.1.2	**An emergency call system is in place and understood by all relevant staff. In situations where there are several locations, including remote areas, this must be both audible and visible** Verbal 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	1	Safe	3.2.2 4.2.6			
1.4.1.4	**Particular provision is made for the care of children including nurses/ODPs trained in paediatric resuscitation** Verbal confirmation should be sought from staff in relevant areas, including the qualifications of individuals in that area If your department does not treat children, please refer to Note 3	1	Safe Responsive	4.3.2, 4.3.10 8.3.1 10.1.6 19.3.2			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.4.1.5	**Patients being discharged from the hospital following general or regional anaesthesia or sedation must be discharged into the care of a responsible adult** Discharge criteria on a form for adults and children This does not apply to surgically administered local anaesthetic	1	Safe	19.1.5			
1.4.2	**Staffing**						
1.4.2.1	**The recovery room staff are appropriately trained in all relevant aspects of post-operative 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	1	Safe Well-led	4.1.1 9.1.28, 9.1.29 11.4.2			
1.4.2.2	**Until patients can maintain their airway, breathing and circulation they are cared for on a one-to-one basis with an additional member of staff available at all times** Verbal confirmation that this is met for 100% of anaesthetic procedures should be given, along with a named consultant anaesthetist or intensivist who is responsible for the patient	1	Safe	4.1.5, 4.1.6, 4.1.7 5.1.11 6.1.4, 6.2.17, 6.2.18			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.4.2.4	**Critically ill patients in the recovery area are cared for by appropriately trained staff and have appropriate monitoring and support** A written policy should be provided and this should be seen in the recovery area	1	Safe Effective	4.3.26			
1.4.2.5	**Whenever emergency surgery is undertaken, the recovery unit is adequately staffed** Verbal confirmation should be given that there is one more staff member than there are patients at all times	1	Safe Effective	5.1.11			
1.4.2.6	**At any given time at least one member of recovery staff present is certified at an appropriate level in life support e.g. ILS or equivalent** Verbal confirmation should be given	1	Safe Well-led	4.4.3, 4.4.4, 4.4.5			
1.4.3	**Escalation of level of care**						
1.4.3.1	**There is a recognised process for the referral of day-case patients requiring inpatient admission to an appropriate facility** A written policy should be provided for adults and children This refers specifically to day-surgery under the escalation of level of care, such as in day surgery when the patient subsequently requires an overnight stay	1	Safe Well-led	6.2.19, 6.2.20 7.2.7			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.4.3.2	**There is a recognised process in place for the referral of patients requiring critical care, including paediatric and obstetric patients, to an appropriate facility** A written policy should be provided for adults and children This refers specifically to unplanned intensive care admissions following surgery	1	Safe Responsive Well-led	7.3.5 9.3.3, 9.3.4 10.3.8, 10.5.1, 10.5.13			
1.4.4	**Pain managements**						
1.4.4.1	**Methods of postoperative pain management are discussed with and written information given to the patient** This should be visible on the anaesthetic record. Written evidence that it is covered in induction should be given	1	Caring	2.9.4 6.2.23 10.9.3 11.7.1			
1.4.4.2	**Pain management for day surgery patients includes prescription for pain relief medication after discharge** A written proforma or policy should be provided	1	Caring Effective	6.2.22 11.3.6			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.4.4.3 Specialist acute pain management advice and intervention is available at all times including escalation plans A system by which anaesthetic trainees can be called at any time for advice should be relayed verbally by any member of staff, including nursing staff, for adults and children	1	Safe Effective Responsive	10.2.15 11.1.1, 11.1.4, 11.1.6			
1.4.4.4 There is a dedicated acute pain nurse specialist service which also covers the needs of children Verbal confirmation should be given of pain service and staffing. Audits of pain management and guidelines available, such as those for multi-modal analgesia. Records showing regular pain scores being taken If your department does not treat children, please refer to Note 3	1	Effective Well-led	10.2.15 11.1.5			
1.4.5 Handover						
1.4.5.1 The anaesthetist carries out handover of the patient to the recovery room staff This should be visible on the anaesthetic chart Checklists are useful to evidence this standard	1	Safe Effective	3.5.21, 3.5.22 4.1.4, 4.5.4			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.4.5.2	**There is an agreed procedure for the removal of endotracheal tubes and supraglottic airways** A written policy should be provided which includes reference to the use of capnography	1	Safe	4.1.2, 4.1.3, 4.2.12			
1.4.5.3	**There are agreed criteria for discharge from recovery** A written policy should be provided for adults and children	1	Safe Effective Well-led	4.2.17 6.2.21			
1.4.5.4	**After agreed criteria for discharge have been met, an appropriately trained member of staff accompanies patients during transfer** This should be included as part of the policy provided for standard 1.4.5.3	1	Safe Well-led	4.5.7			
1.5	**Emergencies**						
1.5.0.1	**Fully resourced, dedicated daytime emergency and trauma lists are provided appropriate to local demand** Lists should be provided Half day NCEPOD lists are acceptable	1	Safe Responsive Well-led	3.5.12 5.5.20, 5.2.21			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.5.0.2	**Clinical areas should be secure for the protection of patients and staff but appropriate access when required (i.e. for emergency teams) must always be available** Evidence of this should be visible	1	Safe Well-led	9.2.31			
1.5.0.3	**There is clear method of communication within the theatre team about the category of urgency of an emergency including emergency deliveries in obstetrics** Verbal confirmation should be given and must include a process for multidisciplinary communication	1	Safe Effective Well-led	5.5.18 9.5.13			
1.5.0.4	**There are clear escalation processes should two emergencies occur simultaneously** Verbal confirmation should be given and evidence should be seen in the staff induction pack	1	Safe Effective	5.5.45 9.1.6, 9.5.18			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.5.0.5 There is appropriate staffing of emergency areas to allow immediate stabilisation and transfer of emergency patients Verbal confirmation should be given that staff are aware where additional staff will come from in an emergency hospital-wide, as well as departmental policies, should be provided verbally The aim of this standard is to find out whether there are sufficient staff to allow critically ill patients who need to be moved urgently (either within the hospital e.g. to scanning facilities or theatres; or transferred to another site) to be accompanied by an appropriate member of staff during their transfer. During the review visit, the reviewers will check that this is the case by looking at the policy (if you have one) and asking various members of staff whether they are aware of whom to call in an emergency to help accompany a patient	1	Safe Effective	5.2.13 7.3.2, 7.3.3, 7.3.5, 7.3.7, 7.3.9			
1.5.0.6 Patients have an anaesthetic risk assessment performed which informs the process of consent Details of scoring system for emergencies must be provided P-POSSUM or equivalent risk assessment	1	Caring	5.5.22, 5.5.23, 5.9.6			
1.5.0.7 High risk patients are managed either directly or under the immediate supervision of a consultant anaesthetist Evidence should be seen on the anaesthetic record for adults and children See Note 2 for an explanation of what is meant by the term 'policies'. High risk patients are those regarded as surgical P-POSSUM score of greater than 5% or ASA 3 and 4	1	Safe Well-led	5.3.22, 5.5.23			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.5.0.8	**The specific needs of critically ill children are considered** 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	2	Safe Responsive	10.3.9, 10.3.10, 10.3.11			
1.5.0.9	**Hospitals have arrangements within their network for the transfer of sick infants and children to the regional specialist centre including time critical transfers** Network and local policies, evidence of multidisciplinary working, named lead consutlant	2	Safe Responsive	10.3.16, 10.3.23			
1.6	**Management of complications**						
1.6.0.1	**There are policies for the management of immediate and delayed complications of neuraxial blockade** Written policies should be provided See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Effective	11.6.12, 11.6.8			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
1.7	**Resuscitation**						
1.7.0.1	**A person skilled in intubation is onsite to support the resuscitation team** Either verbal confirmation that the resuscitation either includes an anaesthetist, or a written policy that there is anaesthetic support for the team, should be provided	1	Safe Effective Well-led	8.1.1			
1.7.0.2	**There is a trained resuscitation team for adults, including pregnant women, children and neonates as appropriate** Verbal confirmation should be given. Evidence of appropriate mandatory training for age range of patients If your department does not treat children, please refer to Note 3	1	Safe Responsive Well-led	9.1.30 10.1.7			
1.7.0.3	**The trust/board Sedation Committee has anaesthetic representation** List of Sedation Committee members	2	Well led	Chapter 19 summary, 19.3.29			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2	**Equipment, Facilities and Staffing**						
2.1	**Anaesthetic equipment and monitoring**						
2.1.1	**Range available**						
2.1.1.2	**Equipment for monitoring, including 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. This includes equipment specifically designed for children** Defibrillators, bag and masks and capnography should be seen, including in remote locations. Staff should be asked if they encounter any difficulties with equipment in any sites If your department does not treat children, please refer to Note 3	1	Safe Effective Well-led	3.2.16, 3.2.29, 3.2.31 5.2.39 6.2.7 7.2.1 8.2.2, 8.2.3, 8.2.4 9.2.16 10.2.1			
2.1.1.3	**Facilities for external cardiac pacing are available** Defibrillators should be checked to ensure they include pacing mode	1	Safe Effective Well-led	7.3.19 8.2.4			
2.1.1.5	**Equipment to provide a full range of local and regional blocks is available** Staff should be asked what range of local and regional blocks they feel is lacking based on the procedures they undertake for adults and children If your department does not treat children, please refer to Note 3	1	Safe Effective Responsive Well-led	3.2.23 5.2.35 6.2.8 10.2.1			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.1.1.6 Ultrasound imaging equipment is available to assist with vascular access and regional anaesthesia Verbal confirmation should be given for adults and children If your department does not treat children, please refer to Note 3	1	Safe Effective Responsive Well-led	3.2.17, 3.2.23 5.2.35 9.2.14 10.2.1			
2.1.1.7 There is specialised equipment for the management of difficult airways available in every area where anaesthesia is given The difficult airway trolley should be seen and the equipment on it should be checked. All members of staff should be able to confirm its location for adults and children If your department does not treat children, please refer to Note 3	1	Safe Effective Well-led	3.2.19 5.2.30 9.2.10			
2.1.1.8 There are scavenging systems that meet the Health & Safety Executive's occupational exposure standards for anaesthetic agents Evidence of the Control of Substances Hazardous to Human Health (COSHH) data COSHH recommends that: 'Exposure should be controlled to a level to which nearly all the population can be exposed day after day without adverse effect on health'	1	Safe	3.2.4			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.1.1.10 Appropriate equipment is available for all patient transfers Portable ventilators and monitoring should be seen for adults and children If your department does not treat children, please refer to Note 3	1	Safe Effective Responsive Well-led	5.2.14, 5.2.25 7.3.7 8.2.5 10.3.24			
2.1.1.11 There is specialised equipment for the management of post-operative pain An adequate number of PCAs epidural pumps and the arrangements for their use should be available for the services being provided for adults and children If your department does not treat children, please refer to Note 3	1	Effective Caring Responsive	9.2.11 11.2.1			
2.1.1.13 Where piped oxygen is not available there is an adequate supply from cylinders which are checked regularly Cylinders should be seen and paper records of checks should be provided along with an operational policy for backup oxygen provision	1	Safe	7.2.2			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.1.2	**Maintenance and replacement policies**						
2.1.2.2	**There is a planned maintenance and replacement programme for all anaesthetic equipment as required** The age of the oldest equipment should be given and written evidence of the replacement programme should be provided	1	Safe Effective Well-led	3.2.28 11.2.3			
2.1.2.3	**No anaesthetic machine is able to supply a hypoxic gas mixture** Equipment, especially in remote locations including A&E, should be checked to ensure this	1	Safe Well-led	3.2.18			
2.1.3	**Storage, cleaning and sterilisation**						
2.1.3.1	**Policies and equipment are in place to protect patients and staff from cross-infection** Written policies, including those regarding sterilisation procedures and gloves, should be provided See Note 2 for an explanation of what is meant by the term 'policies'	1	Safe Effective	3.2.14 5.2.26			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.2	**Drugs, fluids and blood**						
2.2.1	**Availability**						
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** Drugs should be seen	1	Safe Effective	7.2.4 9.2.29			
2.2.1.4	**In every site where sedation is given emergency drugs including naloxone and flumazanil are available and in-date supply is maintained** Drugs should be seen in sites where sedation procedures are undertaken by an anaesthetist	1	Safe Effective	7.2.4			
2.2.3	**Access to blood and blood conservation techniques (cell salvage or acute normovolaemic haemodilution)**						
2.2.3.1	**Blood storage facilities are immediately available to emergency theatres and contain O-rhesus negative blood** Facilities should be seen	1	Safe Effective	5.2.4 9.2.20			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.2.3.2 Equipment for fluid and blood warming and rapid infusion is available Equipment should be seen for adults and children If your department does not treat children, please refer to Note 3	1	Safe Effective	3.2.21, 3.2.22 7.3.5 10.2.1			
2.2.3.3 A cell salvage machine and trained staff are available for appropriate patients Equipment should be seen with evidence of ongoing training for adults and children 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 If your department does not treat children, please refer to Note 3	1	Effective Responsive Well-led	5.2.34 9.2.8			
2.2.4 Storage and security						
2.2.4.1 Local anaesthetic agents (ampoules and bags) must be stored separately from other drugs and intravenous fluids Separate areas should be seen 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	1	Safe	3.2.37 9.2.28 11.2.7			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.3	**Anaesthetic records**						
2.3.1	**Documentation**						
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** Anaesthetic records and case notes should be seen	1	Well-led	3.5.6 19.2.8			
2.4	**Department accommodation**						
2.4.1	**Guidelines on space**						
2.4.1.2	**Appropriate office space is provided for all aspects of the anaesthesia service** An anaesthetic office should be available to the duty anaesthetic team, including in proximity to the delivery suite. The room should have a computer with intra/internet access for accessing emails and e-learning facilities, and access to up-to-date information. A library of specialist reference books and/or journals and local multidisciplinary evidence-based guidelines must be available in anaesthesia and acute pain medicine In addition to this, there should be a separate anaesthetic consultant's office available to allow teaching, assessment and appraisal and it should comply with AAGBI guidelines. There should be storage space for PCAS devices, pumps and educational materials. This should be regarded as acceptable to a significant majority of the anaesthetic staff. Please note this is a 'priority 2' standard, see Note 1 for further explanation.	2	Well-led	9.2.40 11.2.9			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.4.2	**Hotel services**						
2.4.2.1	**Appropriate facilities for rest are available for anaesthetic staff working at night, as described in the new contract** A quiet and dark area with ability for horizontal rest must be seen and resident staff should report that they are satisfied. The guardian for safe working should provide exception reports. Evidence from an induction pack for trainees regarding advice about facilities available for rest prior to travelling home after finishing their night shift should be seen	1	Safe	3.2.8 9.2.43, 9.2.44			
2.4.2.2	**Appropriate facilities for refreshments are available for on-call/on-duty staff** Verbal confirmation and viewing area where staff can make tea/coffee	1	Safe Well-led	9.2.45			
2.4.3	**Teaching facilities**						
2.4.3.1	**Time, space and equipment is made available for resuscitation and theatre team training** Space for resuscitation and theatre team training should be seen. Verbal evidence should be provided that team training has occurred with recognition of human factors	1	Safe	3.4.2, 3.4.3 8.2.6, 8.2.10			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.5	**Non-medical staff**						
2.5.1	**Staffing numbers**						
2.5.1.1	**There are sufficient administrative staff to support all aspects of the anaesthesia service** Majority of permanent staff should report that they are satisfied 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?	1	Well-led	6.6.1 11.1.13			
2.5.2	**Adequacy of training**						
2.5.2.2	**Midwives trained to an agreed 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** Staff working in obstetric anaesthesia should report that they are satisfied with local arrangements and that epidurals are not being denied to patients due to the non-availability of trained staff. Audit data may be useful to support staff assurances	1	Safe Effective Well-led	9.5.5			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.6	**Medical staff**						
2.6.2	**Consultants**						
2.6.2.1	**There are anaesthetic clinical leads with responsibility in the following areas: resuscitation, day surgery, acute pain management, perioperative medicine, obstetrics, emergency anaesthesia, remote sites (including the emergency department/trauma), ECT (if available), research, paediatrics, ICM, anaesthetic equipment, pre-operative assessment, simulator training (if available), airway management (to include difficult and awake intubation management protocols)** The names of individuals should be provided. Identified paediatric lead, evidence of wider delivery of surgical / anaesthetic services for children e.g. training, guidelines, peer meetings A single consultant may cover more than one responsibility if required; for example, in smaller departments. If your department does not treat children, please refer to Note 3	1	Well-led	3.2.25 5.1.3 6.1.1 7.1.5, 7.3.3 8.1.6 9.1.11 10.5.6 11.1.1			
2.6.2.2	**There is documented and verbal evidence that the appropriate recruitment methods are routinely implemented for consultant and SAS anaesthetic staff** Documentation should be provided indicating the trust/board/hospital follows the RCoA's Advisory Appointments Committee (AAC) process	2	Safe	11.1.1			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.6.3	**Career grade and specialty doctors**	Well led"	11.1.1				
2.6.3.1	**Career grade and specialty doctors have specific training and demonstrated competence in relevant areas before working with distant supervision** Specific groups should be interviewed about their practices and training You could demonstrate competence by targeted multispecialty 360 degree feedback	1	Safe Well-led	3.4.7 6.1.2 9.4.9 10.1.3			
2.6.3.2	**Career grade and specialty doctors have unimpeded access to a nominated consultant for advice and supervision at all times** 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 or on the rota	1	Safe Well-led	3.4.7 5.4.11 6.1.2 9.1.5 10.1.3, 10.1.4			
2.6.4	**Trainees**						
2.6.4.1	**Trainees have specific training and demonstrated competence in relevant areas before working solo** Specific groups should be interviewed about their practices and training	1	Safe Well-led	6.1.2 9.1.1 10.1.3, 10.1.4 19.4.1			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.6.4.2	**Trainees have unimpeded access to a nominated consultant for advice and supervision at all times** 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 or on the rota	1	Safe Well-led	3.4.5 5.4.10 6.1.2 9.1.5, 9.1.20 10.1.3, 10.1.4			
2.6.5	**Obstetrics**						
2.6.5.1	**A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident** If this service is offered, rotas should be provided as evidence. If this service is not provided, patient information should be seen which relays exactly what services can be offered	1	Safe Well-led	9.1.2, 9.1.4, 9.1.6			
2.6.5.2	**A separate anaesthetist is allocated for elective obstetric work** A copy of the rota should be provided There is an expectation that elective work is undertaken by a Consultant anaesthetist. We recognise that, particularly in smaller units, this is not always the case at present. We accept that a non-consultant doctor, suitably trained, reviewed under local governance arrangements and supported by a consultant, may undertake this work. Units will be assessed on an individual basis with the delivery of a high quality and safe service remaining the requirement	1	Effective Well-led	9.1.2, 9.1.15, 9.1.17, 9.1.19, 9.5.22			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.6.5.3 **Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies** 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 at night and junior staff should provide verbal confirmation that they have been inducted in this way. CNST, NHSLA or equivalent evidence and audits should also be provided	1	Safe Well-led	9.1.2, 9.1.6			
2.6.5.4 **Medically led obstetric units have, as a minimum, consultant cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)** A copy of the rota should be provided Intelligent rostering is required and will be considered by the review team and Quality Management of Service Group (QMSG)	1	Safe Well-led	9.1.15, 9.1.16			
2.6.5.5 **There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients** Verbal confirmation that there is a system in place to make sure level 2 patients on a labour ward are cared for by a Consultant Anaesthetist/Intensivist	1	Safe Effective	9.3.6			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
2.6.5.6	**The duty anaesthetist for obstetrics should participate in delivery suite ward rounds** A copy of the rota to demonstrate duty consultant availability at a time when delivery suite ward rounds are taking place	1	Safe Well-led	9.1.9			
2.6.5.7	**Automated electronic anaesthetic record system capable of providing a hard copy is in use** A hard copy print out	3	Well led	2.5.26			
3	**Patient Experience**						
3.1	**Preoperative assessment**						
3.1.2	**Patient decision making**						
3.1.2.1	**The time allocated for preoperative assessment is adequate to allow the patients to understand the information they are given** Verbal confirmation should be given that adequate time to allow understanding is allocated and clinic lists should provide additional evidence of this	1	Caring Responsive	2.9.2 5.9.3 10.2.7, 10.9.2 19.7.1			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
3.1.2.2 Patients and their advocates understand the choices available and the relevant side effects of their anaesthetic procedure, including pain relief Patient information and feedback should be provided for adults and children; good communication via available leaflets; leaflets that set out risks and benefits of particular procedure; anaesthetic record shows that patients received this This standard refers specifically to the anaesthesia consent procedure (rather than the general surgery procedure). There should be a formalised pre-operative risk assessment, preferably using a scoring system, and should be documented and communicated to patients as part of the consent procedure if possible. There should be opportunity provided to the patient to contact the department if necessary e.g. a feedback section in patient leaflets. An 'advocate' is an appropriate adult or relative. The evidence of this standard would be met in the form of a very short audit from the hospital where patients were asked the following specific questions: Did your anaesthetist explain, in a manner that you felt you fully understood: **(a)** The anaesthetic choices available to you? **(b)** The relevant side effects of your anaesthetic procedure? **(c)** The side effects of your pain relief drugs? **(d)** The risks associated with your anaesthetic procedure	1	Caring Responsive	2.9.1, 2.9.4, 2.9.5, 2.9.6, 2.9.12, 2.9.13 10.2.7, 10.9.1, 10.9.2 11.7.4			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
3.2	**Care of the Individual**						
3.2.2	**Dignity**						
3.2.2.1b	**Adequate rooms are available for multiple patients to have private conversations at the same time, according to needs** Appropriateness of size is assessed on the size of the department and the number of consultants 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 There should be a space available within every area where patients are pre-assessed that is private and reasonably soundproof (e.g. a room with a door) and available to patients and anaesthetists for confidential discussion if required. Patients and anaesthetists should be aware that such as space is available should they require it	1	Caring Responsive	6.2.4, 6.2.15			
3.2.2.2	**There is support for patients with individual or special needs including children** Staff should report that they are satisfied with the support for adults and children with particular requirements, for example learning disabilities If your department does not treat children, please refer to Note 3	1	Caring Responsive	2.3.31 9.7.2 10.2.8, 10.9.5			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
3.3	**Communication**						
3.3.1	**Patients**						
3.3.1.1	**Day surgery patients are given clear and concise written information after discharge including access to a 24-hour staffed telephone line for advice** Leaflets given to patients on discharge from the hospital include a telephone number for advice. The information on the leaflets should include warning signs of serious complications 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 post-operative instructions facilitate ongoing self-care by the patient, and should include a help-line in case of concerns for adults and children	1	Safe Caring Responsive	2.1.3, 2.9.5 4.9.3 6.2.24, 6.7.1 10.3.31, 10.3.34 19.1.5			
3.3.2	**Language resources**						
3.3.2.2	**Patients and/or advocates have access to adequate interpretation services according to their needs or protected characteristics** Leaflets should be provided that cover a range of patient groups. Verbal confirmation should be given that access to interpretation services is available for patients who do not understand English Patients with disabilities should be considered including those with learning, vision and hearing disabilities. 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	1	Caring Responsive	2.3.2, 2.3.33, 2.9.3 3.9.2 4.9.2 6.7.2 9.9.3, 9.9.4, 9.9.5, 9.9.6, 9.9.7, 9.9.8			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
3.3.3	**Patient information**						
3.3.3.1	**Information given to patients and/or advocates includes what to expect in the anaesthetic room, operating theatre and recovery room and obstetrics department, as appropriate** Copies of written information should be provided. Leaflets that cover a variety of ages and levels of understanding appropriate to the patient, including confirmation of whether a 24 hour epidural service is available	1	Caring Responsive	2.9.4, 2.9.7 4.9.1 6.7.1 10.2.7, 10.9.1			
3.3.3.2	**Patients and/or advocates are informed of what anaesthesia services are available in the obstetrics department, including whether a 24-hour epidural service is available** A copy of a patient induction pack, particularly if a 24 hour epidural service is not provided, should be given or shown to be available online	1	Caring Responsive	9.9.1			
3.3.3.5	**Patients and/or advocates are fully informed regarding the hospital's written resuscitation policy where appropriate. This includes any decision not to resuscitate where appropriate and the information provided to each patient is regularly reviewed according to their circumstances** This process, as well as the information given, should be described. Evidence could be audit data of compliance with DNR via the resuscitation group A Do Not Resuscitate (DNR) or resuscitation policy should be provided as evidence and for patients to be aware of such policies when appropriate. It should be a case by case discussion with patients	1	Effective Caring Responsive	5.9.7, 5.9.18 16.7.11			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
3.3.4	**Advocates**						
3.3.4.1	**A system is in place to enable the presence of parents and/or advocates at induction of anaesthesia in children or patients with special needs** A copy of a written policy on the presence of parents in the anaesthetic room and recovery should be provided If your department does not treat children, please refer to Note 3	1	Caring Responsive	2.3.3 10.2.19, 10.5.11, 10.5.12			
3.4	**End of life care**						
3.4.0.1	**Senior clinicians are involved in breaking bad news and discussions around futility and end of life decisions** The end of life policy should be provided as well as a verbal account of discussions about end of life pathways	1	Effective Caring Responsive Well-led	5.9.11			
4	**Clinical governance**						
4.1	**Patient safety**						
4.1.0.1	**If appropriate resources are not available, the level of clinical activity is limited to ensure a safe provision of care** Verbal confirmation of managerial support should be given. Staff should relay anecdotal evidence of times that this has been handled well	1	Safe Well-led	3.5.1			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.1.0.2	**The whole theatre and maternity team engage in the use of the WHO process including team brief and debrief in all settings where anaesthesia is administered. The full five steps of surgical safety are included** Verbal confirmation from staff. Records should be provided	1	Safe Effective Well-led	3.5.2 7.2.6 10.5.8			
4.1.0.3	**Accurate, contemporaneous , clear and complete information about operating lists is printed and displayed and any changes to lists are agreed by all relevant parties** Written documentation should be provided and display should be seen	1	Safe Effective Well-led	2.5.36 3.5.3, 3.5.4, 3.5.5			
4.1.0.4	**Where relevant there must be adequate doctors available to simultaneously cover commitments in obstetrics, critical care and emergency theatres** Verbal confirmation that there is a mechanism to recognise issues should be given. Example of scenario at review visit if requested	1	Safe Effective Well-led	9.1.6			
4.1.0.5	**There is a formal handover process between shifts, multidisciplinary where appropriate** Rotas should be provided and include the allocation of time and place as well as which staff should be present at handover	1	Safe Effective Well-led	3.5.21, 3.5.22 5.5.59			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.1.0.6	**The consultant on call name and contact details are prominently displayed in appropriate areas** Prominent display should be seen	1	Safe Well-led	3.1.4 5.5.39 9.1.21			
4.1.0.7	**If anaesthesia or sedation is given in an isolated/single specialty unit there is no difference in the requirements for medical and nursing cover** 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 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	1	Safe Well-led	7.1.3			
4.2	**Critical incidents**						
4.2.1	**Reporting incidents**						
4.2.1.1	**There is a system in place to allow reporting and regular audit, with demonstrated learning and improved outcomes, of critical incidents and near-misses** Verbal confirmation should be given. Minutes of governance meetings and risk register should be seen	1	Safe Effective Well-led	3.5.23, 3.5.24 4.7.3 5.7.1 11.5.5			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.3	**Morbidity and mortality**						
4.3.1	**Outcome measurements**						
4.3.1.1	**There is documentary evidence of morbidity and mortality reviews of all anaesthetic activity and all untoward incidents** Copies of an incident reporting form and information provided on induction should be seen. Knowledge of College feedback mechanisms and use of the SALG Patient Safety Update in M&M meeting should be demonstrated verbally. Percentage attendance at departmental clinical governance meetings should be available. The agenda, actions and learning outcomes should be circulated to the anaesthetic department. The number of meetings per year should be clearly documented Meetings should be multidisciplinary where appropriate e.g. meetings relating to paediatric surgery and anaesthesia requires the involvement of paediatricians, surgeons and anaesthetists to discuss and review the services	1	Safe Effective Well-led	3.5.25 4.7.3 5.5.63, 5.5.64, 5.5.67 10.7.5			
4.3.1.2	**There are specific systems in place for review of the following relating to babies and children; perioperative deaths within 30 days of surgery, serious untoward incidents, untoward incidents and transfers of children for surgery elsewhere. These are reported to the relevant national agency** Minutes of meetings and multidisciplinary reviews, completed reports and local audits	1	Responsive Safe	10.7.5			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.4	**Learning from experience**						
4.4.1	**Quality improvement**						
4.4.1.1	**An obstetric anaesthetist takes part in regular multidisciplinary 'labour ward forum' or equivalent meetings** Minutes of meetings and record of attendance should be provided	1	Safe Effective Well-led	9.1.13, 9.5.24			
4.4.3	**Skills and drills**						
4.4.3.2	**There is regular multidisciplinary team training for emergency situations** Documentation should be provided This multidisciplinary team training should be at least on a monthly basis	1	Safe Effective Well-led	3.4.2 4.4.7 5.4.2, 5.4.5 9.4.12			
4.5	**Audit**						
4.5.1	**Participation**						
4.5.1.1	**The department has evidence of engagement with, and implementation of national audit projects and quality improvement programmes, including obstetrics** Written and verbal evidence should be provided	1	Effective Responsive Well-led	5.7.1 8.5.1 9.7.2, 9.7.6, 9.7.9 10.7.2, 10.7.3			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.5.1.2 Regular audits of elective and emergency anaesthesia activities are undertaken Written and verbal evidence should be provided This should be continuous	1	Safe Effective Responsive Well-led	3.7.1 5.5.62, 5.7.2 6.5.1 7.1.5, 7.3.5 9.7.1 10.7.1			
4.5.1.3 The emergency surgery workload is continually monitored and reviewed and is used to plan future workload Verbal evidence should be given by the clinical director including seven-day, late night and fasting policies as well as examples of subsequent improvements 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. We will also be looking for subsequent interventions to improve following results of the audits	1	Safe Effective Caring Responsive Well-led	5.5.3			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.6	**Staff**						
4.6.1	**Induction**						
4.6.1.1	**There is documented evidence that all anaesthetists and anaesthetic assistants, including locum, agency and trust grade staff, have undergone an appropriate induction process to the anaesthetic department** Documentation for anaesthetic department induction should be provided 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	1	Safe Well-led	3.4.8 5.4.6, 5.4.9 7.3.9, 7.3.10 9.4.7			
4.6.1.2	**All anaesthetists and anaesthetic assistants receive systematic training in the use of new equipment and the training is documented** Documentation of training should be provided Self-certification is fine if consultants are keeping a record of their own training for appraisal purposes, again, this should be appropriately documented	1	Safe Well-led	3.2.6 5.2.22			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.6.2	**Job plan and review**						
4.6.2.1	**Staff with specific training commitments to resuscitation and life support courses have appropriate support** Staff with specific training commitments in these areas should give verbal confirmation that they are supported	1	Well-led	8.4.3			
4.6.2.3	**All permanent member of staff should receive adequate time, resources and support for all activities related to appraisal and revalidation** Examples of appraisal process and verbal confirmation from department lead appraiser and consultants	1	Safe Well-led Effective	3.4.3 5.4.4 8.4.1, 8.4.2 9.4.10 10.4.4, 10.4.6, 10.4.7			
4.6.2.4	**All staff undertaking paediatric practice have evidence of maintaining their knowledge and skills through CPD, including resuscitation and safeguarding/child protection (level 2)** Evidence of appraisal for paediatric anaesthesia, appropriate supervision of trainees/non-training grades, training records. Named leads for training, including safeguarding lead with level 3 competencies	2	Safe Well-led	10.4.1, 10.4.2, 10.4.4, 10.4.5, 10.4.6, 10.4.7			

		Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.6.4	**Supervision of Staff**						
4.6.4.2	**Physicians' Assistant (Anaesthesia) [PA(A)] must work under the supervision of a consultant at all times when administering general anaesthesia or sedation** A copy of the rota should be provided showing allocation of PA(A)s to lists should be seen If no PA(A)s are employed by the department, this standard should be marked N/A	1	Safe Well-led	3.1.6, 3.1.7, 3.1.8 5.1.7			
4.6.5	**Staff safety**						
4.6.5.1	**There is adequate protection provided for staff in hazardous situations** The staff member with responsibility for safety of X-ray, chemicals and infection control should be named. Staff should be asked if they have any concerns	1	Safe Well-led	5.2.26 7.2.7, 7.3.6, 7.3.10, 7.3.12			
4.8	**Business planning**						
4.8.0.1	**The department has developed an annual plan or equivalent highlighting operational, strategic and workforce developments to ensure developing and responsive resources for perioperative care and the safe delivery of emergency surgical and non-theatre workload** The clinical director should provide a copy of the document	1	Safe Effective Well-led	2.6.1 5.5.3			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.8.0.2 **The department has developed a funded and staffed acute pain service or this is in development and agreed as part of the annual plan process** The clinical director should provide written evidence The review team would consult with staff and the CD as to whether your current provision is appropriate to meet demand (which will depend on local factors). If you have audit or patient satisfaction data to confirm this, it would be helpful	1	Effective Caring Well-led	11.1.2			
4.8.0.3 **Anaesthesia is represented as part of the planning of maternity services** The names of the representatives should be given	1	Safe Effective Well-led	9.5.23			
4.8.0.5 **The department has a plan in the event of a major incident** A written policy. Staff should be aware of their role in the event of a major incident	1	Safe Effective Well-led	5.5.36, 5.4.5 16.6.20, 16.6.21			

	Priority	CQC KLoE	GPAS Reference(s)	Met	Not Met	Not Applicable
4.8.0.6 In connection with all NHS work performed in your hospital (in both contracted and non-contracted hours) there is a policy to ensure that Consultant Anaesthetists and Surgeons are paid an equal hourly rate for performing it The clinical director should provide written evidence The review team will consult with staff and the CD as to whether this applies for all NHS work in both contracted and non-contracted hours.	2	Safe Effective Responsive Well led				

Name of Department:

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