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) Subspecialties

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

Guidance for the Provision of Anaesthetic Services References

4. Clinical Governance

4.6 Staff

4.6.1 Induction

		PRIORITY	CQC KLoE	GPAS REFERENCES	HELPNOTE
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	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.
	Documentation for anaesthetic department induction should be provided				

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

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 be **aspirational** for most, however they will provide targets for the highest performing departments to achieve. All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that.
Note 2	On the use of the term 'policies'	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'. Where the standard refers to both children and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.

		Priority	CQC KLoE	GPAS References	Helpnote
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 chart, on the rota and on display in the department	**1**	Safe Effective Well-led	1.1.10, 5.5.9, 9.1.15	
1.1.1.2	**A consultant paediatrician is available for advice for every paediatric patient undergoing anaesthesia** This should be a duty paediatrician or a local arrangement with a nearby hospital and staff should be able to provide a verbal account of the local policy. A hospital policy document should be available	**1**	Safe Effective Responsive	10.1.6	
1.1.1.3	**There is a resuscitation policy** A copy of the policy should be provided	**1**	Safe Caring Responsive	5.5.20, 6.2.7, 8.3.4, 8.6.1	
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** A copy of the policy should be provided	**1**	Safe Effective Caring	7.3.8, 10.2.17, 19.2.11, 19.3.29	**See Note 2 for an explanation of what is meant by the term 'policies'.**
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 the policy should be provided	**1**	Safe Well-led	4.1.4, 4.2.12	**See Note 2 for an explanation of what is meant by the term 'policies'.**
1.1.1.6	**There is a documented policy for the transfer of patients requiring anaesthetic supervision and care, including any additional requirements for transfers to another geographical site** A copy of the policy should be provided	**1**	Safe Well-led	7.3.3, 9.2.36, 9.2.37, 10.3.7	**See Note 2 for an explanation of what is meant by the term 'policies'.**
1.1.1.7	**Guidelines for the management of anaesthetic emergencies are displayed prominently 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 visibly displayed	**1**	Safe Effective	3.2.18, 5.5.24, 5.5.25, 10.2.12, 19.2.7	**If your department does not treat children, please refer to Note 3.**
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 needs, e.g. chronic pain, drug dependency** A copy of the policies should be provided	**1**	Caring Responsive Well-led	4.2.12, 10.2.13, 11.2.4, 11.3.2, 11.6.3	**See Note 2 for an explanation of what is meant by the term 'policies'.**
1.1.1.9	**There is a policy for the management of morbidly obese patients** A copy of the policy should be provided	**1**	Safe Responsive	5.4.5, 5.4.6, 9.2.12, 9.2.13	**See Note 2 for an explanation of what is meant by the term 'policies'.**
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	**2**	Safe Responsive Caring	4.1.9	**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.**
1.1.1.11	**There are multidisciplinary guidelines for care of the obstetric patient** Previous CNST, NHSLA or equivalent evidence should be provided	**1**	Safe Effective Well-led	9.2.43, 9.3.10, 9.3.11, 9.3.12	
1.1.1.12	**An appropriate Modified Early Warning Score (MEWS) is in use for all patients including emergencies and obstetric patients** MEWS and MEOWS should be visible on patient observation charts	**1**	Safe Effective	5.5.17, 9.3.12	
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	**1**	Caring Responsive Well-led	9.3.16	**See Note 2 for an explanation of what is meant by the term 'policies'.**

		Priority	CQC KLoE	GPAS References	Helpnote
1.1.1.14	**There is a locally agreed policy for the 24-hour cover of emergency surgery** The local arrangements should be verbally relayed by staff members	1	Safe Well-led	5.2.2	**See Note 2 for an explanation of what is meant by the term 'policies'.**
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 on-site e.g. paediatric care** The service level agreement should be relayed by staff members	1	Safe Effective Responsive Well-led	5.2.5, 10.2.8	**See Note 2 for an explanation of what is meant by the term 'policies'.**
1.1.1.17	**There is a documented policy to address unexpected death in the operating theatre** A copy of the policy should be provided	2 (This will change to Priority 1 in 2016)	Caring Well-led	5.5.21	**See Note 2 for an explanation of what is meant by the term 'policies' .** **Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
1.1.1.18	**There is a documented policy to address the airway management of patients in the emergency department** The policy should be provided, its location should be pointed out and should be easily accessible, staff should be able to relay the main points and what is expected of them verbally	1	Safe Well-led	7.3.2	**See Note 2 for an explanation of what is meant by the term 'policies'. Please also see the RCoA/RCEM joint position statement here: http://www.rcoa.ac.uk/node/21161**
1.1.1.19	**There are documented policies for the anaesthetic management of patients in radiology and MRI suites** A copy of the policy/policies should be provided	1	Safe Well-led	7.3.3	**See Note 2 for an explanation of what is meant by the term 'policies' .**
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	7.3.4	
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	1	Safe Effective Caring Well-led	10.3.4, 10.3.5	**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.**
1.2	**Pre-procedure**				
1.2.1	**Pre-assessment**				
1.2.1.1	**All patients undergoing anaesthesia or sedation have an appropriate preoperative assessment by an anaesthetist** 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)	1	Safe Effective Responsive	2.1.1, 5.5.10, 6.2.10, 9.2.17, 9.2.18, 10.2.10, 10.3.11, 10.6.6, 19.1.1, 19.3.8	**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.**
1.2.1.2	**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	2.1.3, 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 patients to level 2 and level 3 care	1	Safe Effective Well-led	2.2.9, 5.5.12, 5.5.13, 5.5.14, 5.5.15, 7.1.4, 7.3.6, 9.3.1, 10.2.10, 10.3.3	
1.2.1.4	**All patients 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	1	Safe Responsive	2.1.1, 2.2.1, 6.1.3, 6.2.14, 10.6.6, 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** A copy of the policy/policies should be provided and staff should give verbal confirmation that they are fit for purpose and followed	1	Safe Effective	2.2.4, 2.2.5, 2.2.12, 2.3.4, 2.3.5, 2.3.6, 2.3.7, 2.3.8, 3.2.23, 3.2.25, 6.2.11, 6.2.13, 9.2.19, 10.2.11	**See Note 2 for an explanation of what is meant by the term 'policies'.**

		Priority	CQC KLoE	GPAS References	Helpnote
1.2.1.6	**There is a designated area suitable for private communication with patients** The designated area should at least be a curtain around a bed and should be seen	1	Caring Responsive	6.2.4	
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	9.1.10	
1.2.2	**Consent**				
1.2.2.1	**Patients are given adequate information upon which to base their decision about informed consent** Leaflets are given and the anaesthetic chart (or an equivalent) shows a record that patients having epidurals or regional blocks have had risks explained to them. The system should be robust	1	Caring Responsive	2.7.1, 2.7.2, 2.7.3, 2.7.4, 2.7.5, 5.5.4, 6.7.4, 10.7.1, 11.7.1	
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 and include specification that consent is taken by a qualified person	1	Effective Well-led	2.7.6, 2.7.7, 2.7.8, 2.7.9, 10.7.4	
1.2.2.3	**There are written arrangements to cover consent for patients agreeing to participate in research studies** A copy of the policy should be provided	1	Safe Effective Well-led	2.7.10	
1.2.2.4	**Separate written arrangements for consent apply for children under sixteen** A copy of the national policy for consent for children should be provided	1	Effective Caring	2.7.9, 10.7.4. 10.7.5, 10.7.6	
1.2.3	**Access to investigations**				
1.2.3.1	**A process is in place to ensure that abnormal results of 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	2.2.2, 2.2.9, 2.6.7, 6.2.14	
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	**2 (This may change to Priority 1 in 2016)**	Safe	2.1.3	**Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
1.2.4	**List planning**				
1.2.4.1	**National policy for patient identification is followed** Evidence that patients are labelled, that labels are replaced and that patient name and number are both used at every stage of the WHO process (all checks) should be seen	1	Safe Well-led	2.2.10	
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	1	Caring Well-led	2.3.1, 2.3.2, 2.3.3, 5.5.22, 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, 10.2.18, 10.2.19, 10.2.20, 10.2.22, 10.2.23, 10.6.5, 11.1.2, 11.3.1	
1.2.4.3	**Arrangements are in place for the multidisciplinary management of patients with multiple co-morbidities** A copy of a policy should be provided The policy should include the involvement of physicians. Evidence that audit takes place, including audit data, should be provided	1	Safe Well-led	2.3.4, 2.3.5, 2.6.4	
1.2.4.4	**Any changes to lists are agreed by all relevant parties** Verbal confirmation should be given that protocols are in place and that they comply with the WHO Checklist	1	Safe Well-led	3.5.3	
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	

		Priority	CQC KLoE	GPAS References	Helpnote
1.2.4.6	**There are elective caesarean section lists with dedicated obstetric, anaesthesia, theatre and midwifery staff** A copy of rotas and lists showing dedicated theatre lists should be provided	1	Responsive Well-led	9.6.4	**In smaller units with less than 2500 deliveries the provision for caesarean section should not compromise the elective workload.**
1.2.4.7	**Arrangements are in place for the multidisciplinary management of vulnerable elderly patients** A copy of the policy should be provided. The policy should include the involvement of physicians. Evidence that audit takes place, including audit data, should be provided	1	Responsive Well-led	2.3.4, 2.3.5, 2.3.6, 2.3.7, 5.5.23	
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	3.1.4, 3.1.5, 5.3.2, 6.1.4, 7.1.1, 9.1.17, 9.1.18, 9.1.19, 9.4.9, 10.1.3, 19.1.3, 19.3.11	
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	1	Safe	3.2.5, 19.2.3	
1.3.2.2	**Devices for maintaining or raising the temperature of the patient are available including control of theatre temperature** Devices need to be seen and need to be in working order so that they can be used intra-operatively	1	Safe	3.2.10, 4.2.11, 5.4.8, 5.4.9, 10.2.1, 10.2.4	
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	
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	3.2.12, 3.2.13, 3.2.14, 3.2.15, 3.2.16, 5.4.10, 5.4.11, 6.2.6, 10.2.1, 10.2.4, 10.2.5, 10.2.6, 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	9.2.34	
1.3.5	**Access to pre procedural 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	2.1.3, 2.2.5, 2.2.12, 3.2.22, 6.2.15, 7.3.2, 9.2.20, 9.2.21, 9.2.22, 9.2.23, 9.2.24, 10.2.11	
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 DoH guidelines (e.g. oxygen, suction and monitoring)** The recovery area should be seen	1	Safe Responsive	4.2.1, 4.2.6, 4.2.7, 4.2.8, 4.2.9, 7.1.4, 19.1.4	
1.4.1.2	**An emergency call system is in place and understood by all relevant staff** Verbal confirmation of the system and how it is used should be given by any member of staff when asked	1	Safe	4.2.4	
1.4.1.3	**Devices for maintaining or raising the temperature of the patient are available** Devices should be seen	1	Safe	4.2.11	
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	1	Safe Responsive	4.3.1, 8.3.1, 10.1.4, 19.3.2	**If your department does not treat children, please refer to Note 3.**

		Priority	CQC KLoE	GPAS References	Helpnote
1.4.1.5	**Patients being discharged from the hospital following general, regional or local anaesthesia or sedation are accompanied by a responsible person** Discharge criteria on a form	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	9.1.20, 9.4.10, 11.1.7	
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	1	Safe	4.1.1, 6.1.4, 6.2.16, 6.2.17	
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	4.3.2	
1.4.2.5	**Whenever emergency surgery is undertaken, the recovery unit is open continuously and adequately staffed** Verbal confirmation should be given that there is one more staff member than there are patients at all times	1	Safe Effective	4.1.3	
1.4.2.6	**At any given time at least one member of recovery staff present is certified as an advanced life support provider or equivalent** Verbal confirmation should be given	2	Safe Well-led	4.4.2	**Be advised that 24 hour access to an anaesthetist is not the same as 'recovery staff present'.** **Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
1.4.3	**Escalation of level of care**				
1.4.3.1	**There is a recognised process in place for the referral of patients requiring inpatient admission to an appropriate facility** A written policy should be provided	1	Safe Well-led	6.2.18, 6.2.19, 7.2.7, 7.3.2	**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.**
1.4.3.2	**There is a recognised process in place for the referral of patients requiring critical care, including paediatric patients, to an appropriate facility** A written policy should be provided	1	Safe Responsive Well-led	7.3.2, 9.2.36, 10.2.7, 10.3.1, 10.3.6	**This refers specifically to unplanned intensive care admissions following surgery.**
1.4.4	**Pain management**				
1.4.4.1	**Methods of postoperative pain management are discussed with the patient** This should be visible on the anaesthetic chart. Written evidence that it is covered in induction should be given	1	Caring	2.1.2, 2.7.2, 2.7.3, 6.2.22, 10.7.5, 11.3.3	
1.4.4.2	**Pain management for day surgery patients includes prescription for pain relief medication after discharge** This should be visible on the anaesthetic chart and a written proforma or policy should be provided	1	Caring Effective	6.2.21, 11.3.3	
1.4.4.3	**Specialist acute pain management advice and intervention is available at all times** 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	1	Safe Effective Responsive	9.2.29, 10.2.13, 11.1.3, 11.1.6	
1.4.4.4	**There is a dedicated acute pain nurse specialist service** Verbal confirmation should be given	1	Effective Well-led	11.1.4	
1.4.4.5	**Multi-modal analgesia for children should be available in all settings** A policy document on analgesia in paediatrics should be available	1	Effective Caring	10.2.14	**If your department does not treat children, please refer to Note 3.**
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	1	Safe Effective	4.1.4	
1.4.5.2	**There is an agreed procedure for the removal of endotracheal tubes and supraglottic airways** A written policy should be provided	1	Safe	4.1.5, 4.1.6	

		Priority	CQC KLoE	GPAS References	Helpnote
1.4.5.3	**There are agreed criteria for discharge from recovery** A written policy should be provided	1	Safe Effective Well-led	4.2.12, 6.2.20	
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	4.1.8	
1.5	**Emergencies**				
1.5.0.1	**Fully resourced, dedicated daytime emergency and trauma lists are provided** Lists should be provided Half day NCEPOD lists are acceptable	1	Safe Responsive Well-led	3.5.2, 5.1.2, 5.1.3, 5.1.4, 5.1.5	
1.5.0.2	**There is access to all clinical areas for appropriate staff at all times e.g. with swipe cards** Evidence of this should be visible	1	Safe Well-led	9.2.31	
1.5.0.3	**There is clear method of communication between theatre teams (including midwives where appropriate) concerning the category of urgency of an emergency** Verbal confirmation should be given and must include a process for multidisciplinary communication	1	Safe Effective Well-led	9.3.10	
1.5.0.4	**There are clear guidelines available on whom to call if two emergencies occur simultaneously** Verbal confirmation should be given and evidence should be seen in the staff induction pack	1	Safe Effective	9.1.6, 9.3.1	
1.5.0.5	**There is adequate staffing of emergency areas to allow safe movement 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	1	Safe Effective	5.3.3, 7.3.2, 7.3.3	**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.**
1.5.0.6	**Patients have an anaesthetic risk assessment performed which informs the process of consent** Details of scoring system for emergencies must be provided	1	Caring	5.5.4	
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	1	Safe Well-led	5.5.6, 5.5.7	
1.6	**Management of Complications**				
1.6.0.1	**There is a policy for the management of complications of neuraxial blockade** A written policy should be provided	1	Safe Effective	11.3.4	**See Note 2 for an explanation of what is meant by the term 'policies'.**
1.7	**Resuscitation**				
1.7.0.1	**A person skilled in intubation is available to support the resuscitation team when requested** 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	

		Priority	CQC KLoE	GPAS References	Helpnote
1.7.0.2	**There is a trained resuscitation team for adults, children and neonates as appropriate** Verbal confirmation should be given	1	Safe Responsive Well-led	9.1.21, 10.1.4	**If your department does not treat children, please refer to Note 3.**
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** 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	1	Safe Effective Well-led	3.2.1, 3.2.12, 3.2.16, 5.4.1, 5.4.10, 5.4.11, 6.2.7, 7.2.1, 7.3.2, 8.2.2, 8.2.3, 8.2.4, 9.2.16, 10.2.1, 10.2.2	
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	7.3.5	
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	1	Safe Effective Responsive Well-led	3.2.2, 5.4.16, 6.2.8, 10.2.1	
2.1.1.6	**Ultrasound imaging equipment is available for the placement of central venous access and regional anaesthesia** Verbal confirmation should be given	1	Safe Effective Responsive Well-led	5.4.15, 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	1	Safe Effective Well-led	3.2.3, 5.4.13, 5.4.14, 9.2.10	
2.1.1.8	**There are scavenging systems that meet the Health & Safety Executive's occupational exposure standards for anaesthetic agents** Verbal confirmation should be given	1	Safe	3.2.20, 7.2.6	
2.1.1.10	**Appropriate equipment is available for all patient transfers** Portable ventilators and monitoring should be seen	1	Safe Effective Responsive Well-led	5.5.26, 8.2.5, 7.3.3, 10.3.2, 10.3.7	
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	1	Effective Caring Responsive	9.2.11, 11.2.1	
2.1.1.12	**There is equipment available to monitor and maintain patient temperature** Equipment should be seen	1	Effective	5.4.4	
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	1	Safe	7.2.2	
2.1.2	**Maintenance and replacement policies**				
2.1.2.1	**A named consultant oversees the provision of anaesthetic equipment** The name of this person should be given	1	Safe Well-led	3.2.8	

		Priority	CQC KLoE	GPAS References	Helpnote
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	3.2.9, 5.4.3, 9.2.35, 11.2.1	
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	3.2.6	
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	1	Safe Effective	3.2.19	**See Note 2 for an explanation of what is meant by the term 'policies'.**
2.2	**Drugs, fluids and blood**				
2.2.1	**Availability**				
2.2.1.1	**Access to the British National Formulary (BNF) and BNF for Children is available** Written copies or verbal evidence of a procedure to access the information by phone should be provided	1	Safe	10.2.12, 10.6.7	**If your department does not treat children, please refer to Note 3.**
2.2.1.3	**In every site where anaesthesia is given emergency drugs including intralipid, sugammadex and dantrolene are available and in-date supply is maintained** Drugs should be seen	1	Safe Effective	4.2.9, 7.2.4, 9.2.27	
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 in close proximity to emergency theatres and contain O rhesus negative blood** Facilities should be seen	1	Safe Effective	5.4.18, 9.2.5	
2.2.3.2	**Equipment for fluid and blood warming and rapid infusion is available** Equipment should be seen	1	Safe Effective	7.3.2, 9.2.21, 9.2.7, 10.2.1, 10.2.6	
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	1	Effective Responsive Well-led	5.4.9, 9.2.8	**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.**
2.2.4	**Storage and security**				
2.2.4.1	**Drugs intended for regional anaesthesia are stored separately from those intended for intravenous use** Separate areas should be seen	1	Safe	9.2.26,11.2.2	**Any part of the hospital where drugs for regional anaesthesia are kept for use by anaesthetic staff should be 'stored separately' - at the least this would be behind different doors which in practice means different cupboards.**

		Priority	CQC KLoE	GPAS References	Helpnote
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	7.3.2, 3.2.21, 19.2.8	
2.4	**Department accommodation**				
2.4.1	**Guidelines on space**				
2.4.1.1	**The anaesthetic room and operating theatre conform to Department of Health building standards**	2	Effective	3.2.24	**The link for the DoH building standards is here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pdf. Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
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	2	Well-led	9.2.38, 9.2.39, 11.2.3	**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. Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
2.4.2	**Hotel services**				
2.4.2.1	**Appropriate facilities for rest are available for on-call/on-duty staff** A quiet area with comfortable seating must be seen. Staff should report that they are satisfied	1	Safe	1.2.9, 9.2.40, 9.2.41, 9.2.42	
2.4.2.2	**Appropriate facilities for refreshments are available for on-call/on-duty staff**	2	Safe Well-led	9.2.43	**Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
2.4.3	**Teaching facilities**				
2.4.3.1	**Space is made available for resuscitation and theatre team training** Space for resuscitation and theatre team training should be seen	1	Safe	8.2.10	
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** Staff should report that they are satisfied	1	Well-led	6.6.1, 11.1.10	**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?**
2.5.2	**Adequacy of training**				
2.5.2.1	**There is evidence that there is whole team training for both technical and non-technical skills** Verbal confirmation should be given	2	Safe Effective Well-led	5.7.1	**Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
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** 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 availability of trained staff. Departments which have achieved CNST, NHSLA or equivalent automatically meet this standard	1	Safe Effective Well-led	9.3.3, 9.3.4, 9.4.11	

		Priority	CQC KLoE	GPAS References	Helpnote
2.6	**Medical Staff**				
2.6.1	**Rota Management**				
2.6.1.1	**Where transfer is necessary patients are always accompanied by appropriately trained staff** A written policy should be provided	1	Safe Effective Well-led	5.5.26, 7.3.2, 7.3.3, 10.3.7	
2.6.2	**Consultants**				
2.6.2.1	**There is a consultant clinical lead with responsibility in the following areas: Resuscitation, day surgery, acute pain management, obstetrics, emergency anaesthesia, remote sites (including the emergency department/trauma), ECT, paediatrics, ICM, anaesthetic, pre-operative assessment, simulator training (if available), airway management (to include difficult and awake intubation management protocols)** The names of individuals should be provided	1	Well-led	5.1.1, 5.3.1, 6.1.1, 7.1.5, 7.3.2, 7.3.3, 8.1.6, 9.1.8, 10.3.7, 10.4.5, 11.1.1	**A single consultant may cover more than one responsibility if required; for example, in smaller departments.**
2.6.3	**Career grade and specialty doctors**				
2.6.3.1	**Career grade and specialty doctors 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, 9.4.8, 10.1.2	
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	5.3.1, 5.5.9, 6.1.2, 9.1.2, 10.1.2	
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, 10.1.2, 19.4.1	
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	5.3.1, 5.5.9, 6.1.2, 9.1.2, 9.1.15, 10.1.2	
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, 9.1.5	
2.6.5.2	**A separate anaesthetist is allocated for elective obstetric work** A copy of the rota should be provided	1	Effective Well-led	9.1.14	**This additional anaesthetist is not necessarily at consultant level but could, for example, be at registrar level. As an example, the consultant anaesthetist runs planned electives in the morning, usually with someone who is doing an obstetric training block. Covering the ward would be an anaesthetist at registrar level.**
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	9.1.5, 9.1.6	
2.6.5.4	**Consultant led obstetric units have a minimum of ten consultant anaesthesia DCC PAs per week** A copy of the rota should be provided	1	Safe Well-led	9.1.9	**This may include elective section lists, providing that the consultant covering the list is not the only anaesthetist in the unit (at least one other anaesthetist is on the rota to cover the unit to meet 2.6.5.2).**

		Priority	CQC KLoE	GPAS References	Helpnote
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	9.3.14	
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	9.1.7	
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	2.1.2, 2.1.4, 2.2.1, 10.2.10, 19.7.1	
3.1.2.2	**Patients and their advocates understand the choices available and the relevant side effects of their anaesthetic procedure** Patient information and written feedback should be provided	1	Caring Responsive	2.7.3, 2.7.4, 2.7.5, 10.2.10	**This refers to an 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?**
3.1.2.3	**Patients and their advocates understand the risks and outcomes associated with their procedure** Patient information and feedback should be provided	1	Caring Responsive	2.7.5, 11.3.2, 11.7.2, 19.7.1	**The 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 such as POSSUM (the Physiological and Operative Severity Score for the enumeration of Mortality and morbidity), and should be documented and communicated to patients as part of the consent procedure if possible.** **An 'advocate' is an appropriate adult or relative**
3.1.2.4	**Alternatives are explained to patients and their advocates** Patient information and feedback should be provided	1	Caring Responsive	2.7.1	**This refers specifically to pre-operative assessment and should facilitate a conversation regarding treatment, rather than a one-way delivery of information to the patient, allowing them to feedback the information, and ask questions.** **An 'advocate' is an appropriate adult or relative**

		Priority	CQC KLoE	GPAS References	Helpnote
3.1.2.5	**Patients and/or their advocates are given information about the possible side effects of pain relief drugs** Patient information and feedback should be provided	1	Caring Responsive	2.7.2, 10.2.10	**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?**
3.2	**Care of the Individual**				
3.2.2	**Dignity**				
3.2.2.1.a	**There is an appropriate facility for privacy and confidentiality for pre-operative discussion about anaesthetic care** An area that where confidential discussions can take place should be seen	1	Caring Responsive	6.2.4, 6.2.14	**There should be a space available within every area where patients are pre-assessed that is private and reasonably soundproof (i.e. 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.**
3.2.2.1.b	**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	1	Caring Responsive	6.2.4, 6.2.14	
3.2.2.2	**There is support for patients with individual or special needs including children** Staff should report that they are satisfied	1	Caring Responsive	6.7.2, 11.3.1, 11.3.2, 10.6.8	**If your department does not treat children, please refer to Note 3.**
3.3	**Communication**				
3.3.1	**Patients**				
3.3.1.1	**Day surgery patients must have access to a 24-hour staffed telephone line for advice after discharge** Verbal confirmation should be given	1	Safe Caring Responsive	6.2.24	
3.3.1.2	**Day surgery patients should be given clear and concise written information prior to discharge** This information should include warning signs of serious complications and appropriate actions to take. The post-operative instructions facilitate ongoing self-care by the patient, and should include a help-line in case of concerns	1	Safe Responsive	6.7.1, 19.1.5	
3.3.2	**Language resources**				
3.3.2.1	**Alternative language leaflets are available appropriate to the needs of the local population** Copies of leaflets should be provided	2	Caring Responsive	3.6.2, 6.7.2, 9.7.2, 9.7.4, 11.7.2	**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.** **Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
3.3.2.2	**Patients and/or advocates have access to an interpreter** Verbal confirmation should be given	1	Caring Responsive	3.6.2, 9.7.4, 11.7.2	
3.3.3	**Patient information**				
3.3.3.1	**Verbal and written information given to patients and/or advocates includes what to expect in the anaesthetic room, operating theatre and recovery room** Verbal confirmation and copies of written information should be provided	1	Caring Responsive	4.6.1, 6.7.1, 10.2.10, 10.7.1	

		Priority	CQC KLoE	GPAS References	Helpnote
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	9.3.1, 9.7.1	
3.3.3.3	**Information on what to do, and what not to do, preoperatively and following discharge is provided verbally and in writing. This includes post-discharge analgesia protocols** These should include information for patients who have had neuraxial blockade as in-patients, especially late-complication of infection and haematoma	1	Safe Caring Responsive	6.2.23, 10.2.10, 10.3.11, 10.3.12	
3.3.3.4	**Patients and/or advocates are provided with information that is specific to their level of understanding** Simplified versions of leaflets and children's leaflets should be provided. Verbal confirmation of the discussion around the consent process should be given	1	Caring Responsive	3.6.3, 6.7.3, 10.7.2, 11.7.1	**Please be advised that 'information' does not necessarily have to be in the form of leaflets**
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	1	Effective Caring Responsive	16.7.11	**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.**
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	1	Caring Responsive	3.2.26, 9.7.6, 10.2.10, 10.6.8	**If your department does not treat children, please refer to Note 3.**
3.4	**End of Life Care**				
3.4.0.1	**Senior clinicians are involved in the discussion of end of life pathways** Written policy should be provided as well as a verbal account of discussions end of life pathways	1	Effective Caring Responsive Well-led	5.5.20	
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	
4.1.0.2	**The whole theatre and maternity team engage in, and document, the use of the WHO checklist in all settings where anaesthesia is administered** Records should be provided	1	Safe Effective Well-led	3.5.3, 7.2.6, 9.6.2, 9.3.10, 10.5.1	
4.1.0.3	**Up-to-date, clear and complete information about operating lists is immediately available. Any changes are agreed by all relevant parties** Written documentation should be provided and display should be seen	1	Safe Effective Well-led	3.5.3	
4.1.0.4	**Arrangements for the cover of obstetrics, ICM and general work are monitored with respect to the workload** Evidence of audit should be provided and verbal confirmation that there is a mechanism to recognise issues should be given	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	5.5.18, 9.1.7	
4.1.0.6	**The name and method of contact for the consultant on-call (e.g. bleep number) are prominently displayed in appropriate areas** Prominent display should be seen	1	Safe Well-led	9.1.15	
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	1	Safe Well-led	7.1.3	

		Priority	CQC KLoE	GPAS References	Helpnote
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 of critical incidents and near-misses** Verbal confirmation of should be given	**1**	Safe Effective Well-led	3.4.2, 11.5.2	
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	**1**	Safe Effective Well-led	1.4.4, 5.6.2, 5.6.3, 10.5.3, 10.5.4	
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' meetings** Minutes of meetings should be provided	**1**	Safe Effective Well-led	9.6.3, 9.6.5	
4.4.3	**Skills and drills**				
4.4.3.1	**A representative range of resuscitation equipment, matching that in use and including mannequins, is available for training purposes** Equipment should be shown by the resuscitation training officer	**1**	Safe Effective Well-led	8.2.6,	
4.4.3.2	**There is regular multidisciplinary training for emergency situations** Documentation should be provided	**2 (This may change to Priority 1 in 2016)**	Safe Effective Well-led	5.7.1, 9.4.13	**Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
4.5	**Audit**				
4.5.1	**Participation**				
4.5.1.1	**The department has evidence of engagement with national audit projects, including obstetrics** Written and verbal evidence should be provided	**1**	Effective Responsive Well-led	1.5.10, 5.6.1, 8.5.1, 9.1.16, 9.5.1, 9.5.2, 9.5.3, 10.5.2	**This can be achieved through engagement with the National Emergency Laparotomy Audit (NELA)**
4.5.1.2	**Regular audits of elective and emergency anaesthesia activities are undertaken** Written and verbal evidence should be provided	**1**	Safe Effective Responsive Well-led	1.5.10, 2.5.2, 3.4.1, 4.5.1, 5.6.1, 6.5.1, 7.1.5, 7.3.2, 9.1.6, 10.5.1, 11.5.1	
4.5.1.3	**The emergency surgery workload is continually monitored and reviewed** Verbal evidence should be given by the clinical director including seven-day, late night and fasting policies as well as examples of subsequent improvements	**1**	Safe Effective Caring Responsive Well-led	5.2.3, 5.6.1, 5.6.2	**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.**
4.5.1.4	**The department has evidence of implementation of appropriate local and national audit recommendations, e.g. NAP and NCEPOD** Written evidence should be provided	**1**	Safe Responsive Well-led	6.6.8, 1.5.10	**This can be achieved through engagement with the National Emergency Laparotomy Audit (NELA)**
4.6	**Staff**				
4.6.1	**Induction**				

		Priority	CQC KLoE	GPAS References	Helpnote
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	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	**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.**
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	1	Safe Well-led	3.2.7, 11.1.6, 11.2.1	**Self-certification is fine if consultants are keeping a record of their own training for appraisal purposes, again, this should be appropriately documented.**
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	2	Well-led	8.4.3	**Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
4.6.2.2	**There is a resuscitation officer responsible for coordinating and training of staff** The name of this person should be provided	1	Safe Well-led	8.2.7	
4.6.2.3	**All permanent members of staff should receive adequate time and support for all activities related to appraisal and revalidation** Examples of appraisal portfolios	2	Safe Well-led Effective	1.4.3	**Please note this is a 'priority 2' standard, see Note 1 for further explanation.**
4.6.3.1	**Resources are available for all staff to have up to date training, which is appropriately funded, in resuscitation relevant to their clinical practice including paediatric resuscitation and obstetrics where relevant** Records of funded training should be seen and the name of the person within the department with responsibility for ensuring all staff are up to date with mandatory training should be given	1	Safe Effective Well-led	6.2.7, 8.3.1, 8.4.1, 8.4.2, 9.4.11, 10.4.1, 10.4.4, 10.4.8, 10.4.9, 11.4.2	**If your department does not treat children, please refer to Note 3.**
4.6.3.2	**All staff have up to date training relevant to their clinical practice including emergency surgery** Records that the training has happened and rotas for emergency surgery lists should be provided	1	Safe Effective Well-led	5.7.2, 6.1.2, 6.4.1, 9.4.7, 9.4.8, 11.4.1, 11.4.2, 11.4.3, 11.4.4	**Records of statutory and mandatory training and a functional annual appraisal system (covered in interviews with medical staff and with the CD) are required.**
4.6.3.3	**All staff undertaking paediatric practice have evidence of maintaining their knowledge and skills through CPD, including child protection** Records of training should be seen and the name of the person within the department with responsibility for ensuring all staff are up to date with mandatory training should be given	1	Safe Effective Well-led	8.3.1, 10.1.1, 10.4.1, 10.4.6, 10.4.7	**If your department does not treat children, please refer to Note 3.**
4.6.4	**Supervision of Staff**				
4.6.4.1	**Non-consultant staff have unimpeded access, for advice, to a nominated consultant** 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	6.1.2, 10.1.2	
4.6.4.2	**Physicians' Assistant (Anaesthesia) 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	1	Safe Well-led	1.1.11	**If no PA(As) are employed by the department, this standard should be marked N/A.**
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	5.4.7, 7.2.6, 7.3.3	
4.7	**Research**				
4.7.0.1	**All research is R&D reviewed and REC reviewed** Written documentation from the ethics committee should be provided	1	Caring Well-led	9.5.4, 10.5.6	

		Priority	CQC KLoE	GPAS References	Helpnote
4.8	**Business planning**				
4.8.0.1	**The department has a business plan to ensure necessary resources for perioperative care** The Clinical Director should provide verbal confirmation	**1**	Safe Effective Well-led	2.6.2, 3.5.1	
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 verbal confirmation	**1**	Effective Caring Well-led	11.6.1, 11.6.2	**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.**
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	9.6.5	
4.8.0.4	**The department has a business plan in place for the delivery of safe emergency surgical workload** The Clinical Director should provide verbal confirmation	**1**	Safe Effective Caring Responsive Well-led	5.1.4	