

STANDARD

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

EVIDENCE REQUIRED

This should be visible on the anaesthetic record, on the rota, on display in the department, theatre suite and visible in the obstetric unit

PRIORITY

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CQC KLoEs

Safe Effective Well led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.4.6 All patients undergoing anaesthesia should be under the care of a consultant anaesthetist whose name is recorded as part of the anaesthetic record. A Staff Grade and Specialty (SAS) anaesthetist could be the named anaesthetist on the anaesthetic record if local governance arrangements have agreed in advance that, based on the training and experience of the individual doctor and the range and scope of their clinical practice, the SAS anaesthetist can take responsibility for patients themselves in those circumstances, without consultant supervision.

9.1.19 There should be a named consultant anaesthetist responsible for every elective Caesarean delivery operating list. This consultant should be immediately available. A suitably trained and experienced Staff Grade, Associate Specialist and Specialty (SAS) doctor could be the named anaesthetist on the anaesthetic record if local governance arrangements have agreed in advance that the individual doctor can take responsibility for patients in the particular circumstances, without consultant supervision.

9.1.20 Consultant support should be available and the response time should not be more than half an hour away from the delivery suite, maternity operating theatre or Accident and Emergency Department.

10.1.4 There should be a locally agreed policy on the level of consultant supervision required based on the age, complexity and comorbidities of the patient.

HELPNOTE

This is likely to be tested in the meetings with trainees, SAS doctors and consultants where they will be asked how it works in practice and who the consultants are supervising. The review team will need to be able to judge the evidence of implementation on the ground and assess if the level of supervision is adequate for the environment they are visiting.

STANDARD

1.1.1.2 When children are admitted for surgery there is timely access to a named consultant paediatrician

EVIDENCE REQUIRED

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

PRIORITY

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CQC KLoEs

Safe Effective Responsive

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

10.1.8 Wherever children undergo anaesthesia, there should be immediate access to a named consultant paediatrician with acute care responsibilities at all times. This includes a local agreement for those sites without inpatient paediatric beds.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.1.1.3 There is a trust resuscitation policy with specific reference to a do not resuscitate order for the perioperative period

EVIDENCE REQUIRED

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

PRIORITY

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CQC KLoEs

Safe Caring Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

5.5.36 Appropriate clinical policies and Standard Operating Procedures for operating theatres should be in place, and should be available at all times, including a resuscitation policy and major incident plans.

5.9.7 Hospitals should have a DNACPR guidance and documentation that complies with national requirements.

6.2.18 Full resuscitation equipment and drugs should be provided as outlined by the Resuscitation Council and hospital policy

8.3.4 Every hospital should have an ethical resuscitation policy. This is based usually on the document 'Decisions relating to cardiopulmonary resuscitation'. Anaesthetists/intensive care physicians usually make a significant contribution to the preparation of the local policy for ethical resuscitation.

8.6.1 The resuscitation services in a trust are co-ordinated by a resuscitation committee, which typically meets quarterly. The anaesthetic lead for resuscitation will be a key member of this committee and is often the chair. In large trusts this will represent a significant time commitment and should be recognised as supporting professional activities (SPA) activity in job planning. Much of the day-to-day resuscitation training will be delivered by resuscitation officers but more advanced training, especially for the rapid response systems, is often delivered by anaesthetists.

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

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

10.5.20 When infants and children undergo procedures under sedation alone, recommended published guidance for the conduct of paediatric sedation should be used.

HELPNOTE

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](#).

STANDARD

1.1.1.5 There are policies and documentation for the handover of care of patients from one team to another throughout the perioperative pathway

EVIDENCE REQUIRED

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

PRIORITY

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CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.5.21 Handover, including on moving to the post-operative care environment or to the intensive care unit, should always be to a member of staff who is competent to look after the patient at that time and clearly documented.

3.5.2.2 Handover should be structured to ensure continuity of care.

4.1.4 An anaesthetist should have overall responsibility for the transport of patients from theatre to the post-anaesthesia care unit.

4.5.1 All institutions should have protocols and the necessary facilities for managing post-operative care and should review and update these regularly.

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

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

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

This includes handover to critical care post operatively.

Standardisation of handover, using SBAR or other such systems is recommended. A suggested dataset for PACU/ICU handover is:

- patient name/age/occupation (if relevant)
- operation/procedure and intraoperative events of note

- ASA grade (relevant co-morbidities for NEWs scoring adjustment)
 - airway
 - breathing
 - circulatory
- drugs, allergies and intraoperative medication relevant to postoperative management plan
- postoperative analgesia, antiemetics and investigations
- tubes in and out (hydration, nutrition and elimination, catheter, NGT etc.)
- contact details for queries/problems
- hard copy of Anaesthetic record (if not routine)

STANDARD

1.1.1.8 There are 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

EVIDENCE REQUIRED

A copy of the policies should be provided

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CQC KLoEs

Caring Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

4.2.18 Protocols and equipment should be available for the postoperative management of various symptoms, signs and conditions deemed locally appropriate. Such examples include the management of postoperative nausea and vomiting, pain relief of patients with chronic pain, hypothermia, blood transfusion, fluid therapy, diabetes, acute coronary syndrome, the deteriorating and dying patient, delirium, respiratory diseases, hypotension, hypertension and vulnerable adults and children.

10.2.15 There should be a fully resourced acute pain service that covers the needs of children. In hospitals with a smaller paediatric caseload, this may be the adult acute pain service liaising with the paediatric anaesthetic team rather than a dedicated paediatric service.

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

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

STANDARD

1.1.1.10 There is a policy for the post-procedural review of all patients

EVIDENCE REQUIRED

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

PRIORITY

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CQC KLoEs

Safe Responsive Caring

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

4.1.11 Adequate provision should be made for a member of the anaesthetic team to visit the following groups of patients within 24 hours following their operation:

- those graded as 'American Society of Anesthesiologists (ASA) Physical Status 3, 4 or 5'
- those receiving epidural analgesia in a general ward
- those discharged from recovery with invasive monitoring in situ
- those for whom a request is made by other medical, nursing or other clinical colleagues
- those for whom there is any other appropriate need.

9.5.3 All women who have received regional analgesia/anaesthesia or general anaesthesia for labour and delivery should be reviewed following delivery. Women should fulfil locally agreed discharge criteria before going home.

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

The following groups of patients should be reviewed by a member of the anaesthetic team within 24 hours of their operation: those graded ASA 3, 4 or 5; those receiving epidural analgesia in a general ward, those discharged from recovery with invasive monitoring in situ, and those patients for whom there is any other appropriate need. Women who have received regional analgesia/anaesthesia or general anaesthesia for labour or delivery should be reviewed following delivery.

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.

STANDARD

1.1.1.11 There are multidisciplinary guidelines for care of the obstetric patient

EVIDENCE REQUIRED

Multidisciplinary guidelines should be provided

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CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

9.2.46 All obstetric departments should provide and regularly update multidisciplinary guidelines. A comprehensive list of recommended guidelines can be found in the OAA/AAGBI Guidelines for Obstetric Anaesthesia Services.

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

STANDARD

1.1.1.12 An appropriate early warning score is in use for all patients including emergencies, obstetric patients and children

EVIDENCE REQUIRED

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

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CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

5.2.11 All areas, including Accident and Emergency departments, admitting acutely ill patients should have early warning pathways. Acutely ill or deteriorating emergency surgical patients on a general surgical ward need prompt recognition and definitive care, so early-warning pathways should be established that automatically trigger an appropriate response. This should include policies for early medical review and early escalation to the responsible consultant surgeon or equivalent.

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

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

STANDARD

1.1.1.14 There should be 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

EVIDENCE REQUIRED

The local arrangements should be verbally relayed by staff members

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CQC KLoEs

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HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

5.5.18 The urgency of emergency cases should be clearly and unambiguously coded. There should be regular review of delays, to facilitate improved theatre access and to promote accurate urgency coding at booking. Prioritisation of cases based on their urgency is not the sole domain of any single specialty. It requires a team approach involving discussion between different surgical groups, anaesthetists and in some cases, critical care. Prioritisation should consider not only the surgical condition of the patient but also any pre-existing medical conditions such as cardiovascular or diabetic disease.

5.5.35 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 anaesthesia staff according to patient risk.

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

STANDARD

1.1.1.15 There is a policy for the provision of anaesthetic care, with or without transfer, for specialties not available onsite

EVIDENCE REQUIRED

Patient pathways should be relayed by staff members

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CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

5.5.42 There should be a documented policy for the transfer of patients requiring anaesthetic supervision and care, including any additional requirements for transfers to another geographical site.

10.5.13 Hospitals should engage with networks in order to develop agreed care pathways based on age, co-morbidity and complexity of procedure, as well as clinical urgency. Care pathways should relate to local service provision, staffing and geography.

10.5.18 In hospitals with no on-site paediatric high-dependency and critical care facilities, there should be the facilities and expertise to initiate intensive care prior to transfer/retrieval to a designated regional paediatric intensive care unit (PICU)/high-dependency unit (HDU) facility. This may involve short-term use of adult/general ICU facilities.

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

STANDARD

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

EVIDENCE REQUIRED

A copy of the policy should be provided which has specific reference to the pastoral care of the bereaved family and staff members involved

PRIORITY

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CQC KLoEs

Caring Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance; Partnerships and resources; Quality improvement-focussed leadership

GPAS REFERENCES

3.5.15 When members of the healthcare team are involved in a critical incident, the personal impact on individual team members can be significant. A team debriefing should take place after a significant critical incident. Critical incident stress debriefing by trained facilitators, with further psychological support, may assist individuals to recover from a traumatic event. After a significant critical incident, the clinical director should review the immediate clinical commitments of the staff concerned promptly.

3.5.16 Hospitals should have local guidelines for when a patient dies in theatre or recovery. This should include arrangements to maintain dignity for the patient and to give relatives the best support possible. It should also include arrangements to minimise the impact on other patients being treated in the theatre complex.

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

- guidelines for the management of anaesthetic emergencies displayed prominently in sites where anaesthesia and sedation are provided, including guidelines for children and difficult airway management; access to paperless guidelines through a readily accessed hospital intranet repository is encouraged
- infection control policies, including staff protection/ health and safety (HIV, hepatitis, chemical)/ antimicrobial prophylaxis and post-exposure prophylaxis guidelines
- an escalation plan for theatre capacity and staffing, including a locally agreed policy for the deferment of elective activity to accommodate emergency surgical activity when required
- clear guidelines on whom to call and what facilities can be utilised if two or more emergencies occur simultaneously
- a guideline to address death in the operating theatre
- a documented policy for the management of organ donation and retrieval

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

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CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

5.5.45 Hospitals should have policies for the management of the airway in emergency situations, which should include fasting times, pre-anaesthetic assessment of the airway, availability and maintenance of the equipment and training of staff.

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

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

7.3.11 The use of an emergency induction checklist is recommended.

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'. [Please also see the RCoA/RCEM joint position statement here](#)

STANDARD

1.1.1.19 There are policies for the anaesthetic management of adults and children in radiology and MRI suites

EVIDENCE REQUIRED

A copy of the policy/policies should be provided

PRIORITY

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CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

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

The radiology department

7.3.15 Exposure to ionising radiation should be kept to a minimum by the use of screens or lead gowns; remote slave monitors in screened viewing areas should be provided and staff should remain as distant from the imaging source as possible if they must remain in the X-ray environment

7.3.16 The anaesthetist accompanying transferred patients from the ED should be suitably skilled and experienced to manage all eventualities in an isolated environment and should be accompanied by a dedicated trained assistant

7.3.17 As not all radiology tables tilt into a head-down position, a tipping trolley should be available for patients who require general anaesthesia

Interventional Radiology

7.3.18 Procedure-specific agents, such as those required to manipulate coagulation, intracranial pressure or arterial blood pressure, should be available.

7.3.19 Interventional vascular radiology may involve treating unstable patients with severe haemorrhage. Such patients may include those with significant gastrointestinal bleeding or patients with post-partum haemorrhage. Equipment to deal with these patients should be immediately available. This includes that necessary to introduce and monitor a variety of intravascular catheters, rapid infusion devices, blood- and fluid-warming devices and patient-warming devices.

7.3.20 The hospital's protocol for major haemorrhage should be available and periodically rehearsed

Magnetic resonance imaging (MRI)

7.3.21 Anaesthetic equipment that is used in the MRI scanning room should be MR compatible.

7.3.22 Remote monitoring of the patient with slave screens should be available to allow the anaesthetic team to monitor the patient from outside of the magnetic field.

7.3.23 Particular consideration should be given to the problems of using infusion pumps. All non-essential pumps and equipment should be removed from the patient before entering the magnetic field. MRI-compatible infusion pumps should be available wherever anaesthesia is provided regularly. Infusions with extra long giving sets can be used when MRI-specific pumps are not available.

7.3.24 All staff involved with transferring a patient to the MRI scanner should understand the unique problems caused by monitoring and anaesthetic equipment in this environment. It is not acceptable for inexperienced staff unfamiliar with the MR environment to escort or manage a patient in this environment, particularly out of hours.

7.3.25 The patient and all staff should have an MRI safety and exclusion questionnaire completed before entering the magnetic field.

7.3.26 In the event of an adverse incident in the MRI scanning room, the patient should be removed from the scanning room without delay; immediate access to an anaesthetic preparation room or resuscitation area is essential

7.4.1 All anaesthetists should be fully familiarised with all remote areas of anaesthetic provision, e.g. as part of their induction process, prior to undertaking anaesthetic procedures in that location

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

STANDARD

1.1.1.20 Where ECT is provided the department has been accredited against the relevant national accreditation scheme

EVIDENCE REQUIRED

Documentation of the accreditation should be provided

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CQC KLoEs

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HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

7.3.27 Anaesthesia provided for ECT is frequently performed in remote locations. Ideally, a consultant or suitably experienced SAS doctor should provide general anaesthesia; the guidance provided for anaesthetic provision in remote sites should be followed.

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

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

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

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

7.3.32 Equipment for managing the airway, including the difficult airway, emergency drugs, resuscitation equipment and defibrillator should all be available.

7.3.33 Standards for monitoring and recovery are stipulated by the AAGBI and should be adhered to for all ECT cases

STANDARD

1.1.1.21 There is a policy for the interdisciplinary management of critically ill children including short term admission to a general ICU

EVIDENCE REQUIRED

The policy should be verbally relayed and should include retrieval policy and contact with paediatricians

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CQC KLoEs

Safe Effective Caring Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

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

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

10.3.19 There should be a nominated lead consultant and nurse within general critical care units who are responsible for the policies and procedures for babies and children when admitted.

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

HELPNOTE

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.

STANDARD

1.1.1.22 Care pathways and evidence of engagement with available regional paediatric (anaesthetic/surgical/critical care) networks, based on the complexity of procedure, age and co-morbidity of children, as well as clinical urgency and geography, are developed and agreed

EVIDENCE REQUIRED

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

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Safe and effective care; Management and leadership

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

GPAS REFERENCES

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

10.3.13 Staff without recent paediatric experience or training may be able to contribute transferable skills as part of the multidisciplinary team, e.g. expertise with ultrasound to assist line placement or echocardiography skills, and should be supported by local protocols.

10.5.14 In all emergency departments receiving infants and children, neonatal and paediatric resuscitation equipment, medications (including anaesthetic drugs) and fluids should be available to prepare an infant or child for PICU transfer.

10.5.15 There should be immediate access to protocols for management of acute life threatening conditions. These will often be agreed with the local PICU network or PIC transport team. Protocols should include acute respiratory, cardiovascular or neurological emergencies, trauma, poisoning and major burns.

10.5.16 Hospitals without a suitable PICU/NICU bed should obtain the advice of the local PICU transport team as soon as possible during the management of the sick or critically injured child or young person.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

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

EVIDENCE REQUIRED

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

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Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

10.5.2 Each hospital should have a multidisciplinary committee to formulate and review provision. This committee should involve anaesthetists, paediatricians, surgeons, emergency department representatives, senior children's nurses, managers and other professionals, e.g. paediatric pharmacists. In some hospitals, this will also include PICU physicians.

10.5.3 The multidisciplinary committee should be responsible for the overall management, governance and quality improvement of anaesthetic and surgical services for children and should report directly to the hospital board.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.1.1.26 There are clear criteria and standards for day surgery with regards to the patients attending, discharge pathway and also the environment and staff where it is delivered

EVIDENCE REQUIRED

Policies and guidelines (for adults and children) should be available, including comorbidities and common conditions, and appropriate staff rotas

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HIS Domains

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

GPAS REFERENCES

6.2.1 The minimum operating facility required is a dedicated operating session in a properly equipped operating theatre.

6.2.8 Each DSU should have a fully equipped recovery area, staffed by recovery personnel trained to defined standards.

6.2.9 Dedicated day surgery secondary recovery areas should be provided, which are not part of an inpatient ward area. This area should ideally be separated into male and female wards.

6.5.9 Protocols should be available to maximise the opportunity for patients with significant co-morbidities (e.g. diabetes, morbid obesity, sleep apnoea) to be safely managed via a day case pathway.

6.5.18 Locally agreed written discharge criteria should be established.

10.3.28 Infants, children and young people should have their day surgery delivered to the same standards as inpatient care, but with additional consideration of measures to promote early discharge. In particular younger infants should be scheduled early in the day to allow sufficient time for recovery and discharge on the same day.

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

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

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

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

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

EVIDENCE REQUIRED

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

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

GPAS REFERENCES

2.1.1 All patients should be assessed before anaesthesia or sedation for surgery by an appropriately trained doctor, nurse or physicians' assistant.

2.1.3 Anaesthetists need time to cover the following essential points in the more immediate pre-operative phase. The anaesthetic room is not usually an appropriate place for this except in an emergency.

Assessment

- Interview and medical case notes review to establish current diagnoses, current medicines and past medical and anaesthetic history.
- Examination, including airway assessment.
- Review of results of relevant investigations.
- The presence of any risk factors, including methicillin-resistant *Staphylococcus aureus* (MRSA) screening and risk of venous thromboembolism.
- The need for further tests to give the patient more information about their individual risk. This information also needs to be disseminated to the anaesthetist involved in the case as well as the extended perioperative team.

Preparation

- The patient's understanding of and consent to the procedure and a share in the decision-making process.
- An explanation of the options for anaesthesia, an opportunity to ask questions, and agreement to the anaesthetic technique proposed.
- Pre-operative fasting, the proposed pain relief method, expected sequelae, and possible major risks (where appropriate).
- The prescription and ordering of any pre-operative medication including carbohydrate drinks.
- A plan for the perioperative management of anticoagulant drugs, diabetic drugs and other current medications.
- A process of medicines reconciliation by a pharmacist or pharmacy technician should be in place pre-operatively.
- The documentation of details of any discussion in the anaesthetic record.

- Information that may be reinforced by attendance at communal sessions such as 'joint school' for hip and knee surgery at which there may be input from an anaesthetist, orthopaedic surgeon, occupational therapist, physiotherapist, acute pain specialists, pharmacists and ward nurse

2.5.1 Most patients undergoing elective surgery should attend a pre-operative preparation clinic. Healthy patients having minor day-case surgery can in certain circumstances have telephone or electronic-based assessments.

2.5.4 If the patient has not been seen in a pre-operative clinic, for example those admitted for emergency surgery, they should undergo an equivalent assessment and preparation process with the findings documented, before their final anaesthetic assessment. Most expedited emergency surgery patients should be able to have the same assessment and preparation as elective surgery patients.

2.5.23 High risk surgical patients should have their expected risk of death estimated and documented prior to intervention, with due adjustments made in planning the urgency of care, seniority of staff involved and postoperative care.

2.5.24 High-risk surgical patients should have their predicted 30-day mortality recorded pre-operatively. The National Confidential Enquiry into Patient Outcome and Death report on high-risk surgery recommended the assessment and recording of 30-day predicted mortality for high-risk surgery (defined as a greater than 5 per cent risk). The national emergency laparotomy audit and the national hip fracture database both recommend the recording of predicted 30-day mortality. There are validated prediction scores for 30-day mortality after hip fracture, elective abdominal aortic aneurysm surgery and all types of surgery. There are also validated prediction scores for longer-term mortality after surgery for hip fracture and elective surgery for abdominal aortic aneurysm

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

5.5.23 There should be a formalised integrated pathway for unscheduled adult general surgical care which should be patient centred and include:

- a clear diagnostic and management plan made on admission
- risk assessment and identification of the high-risk patient
- early identification of co-morbidities (including diabetes, pacemakers and internal cardiac defibrillators) and their management according to hospital guidelines
- medicine reconciliation to assess risk of existing medications (including anticoagulation), and to assess the risk of stopping long term medication
- pregnancy testing as appropriate
- an assessment of mortality risk that is made explicit to the patient and recorded clearly on the consent form and in the medical record
- communication of mortality risk to members of the multidisciplinary team; this allows early senior input, including senior members of the anaesthetic team, and allocation of resources commensurate to the patient's risk of death following surgery
- timely investigations and surgery
- a plan for post-operative care.

5.5.26 An anaesthetist should pre-operatively assess all patients undergoing emergency surgery who require anaesthesia. This should take place outside of the theatre complex if possible and adequate time should be available for this to occur as clinical urgency allows.

5.5.28 The experience and expertise of the anaesthetist assessing the patient pre-operatively should be appropriate for the complexity and level of risk of the patient.⁴⁶ The decision to operate on high-risk patients should be made at consultant level, involving surgeons and those who will provide intra- and post-operative care.

5.9.6 Consent should be seen as an important part of the process of discussion and decision-making, rather than as something that happens in isolation. Assessment of capacity must be time- and decision-specific; an individual's capacity to make particular decisions may fluctuate or be temporarily affected by factors such as pain, fear, confusion, the effects of medication or intoxication by alcohol or other drugs

6.3.14 Pre-operative assessment should, when possible, be provided to the same standard as that used for elective day surgery.

6.5.7 Effective pre-operative assessment and patient preparation, performed as early as possible in the planned patient pathway, is essential to the safety and success of day surgery.

6.5.8 Local pre-operative assessment guidelines and protocols should be established. These should be in line with current national recommendations from the Preoperative Association.

9.5.1 A system should be in place to ensure that women requiring antenatal referral to the anaesthetist are seen and assessed by an anaesthetist, normally a consultant, within a suitable time frame, preferably in early pregnancy. Ideally, this should be in the form of multidisciplinary team management of these high risk women.

9.5.2 All women requiring caesarean section should, except in extreme emergency, be visited and assessed by an anaesthetist before arrival in the operating theatre. This should be timed to allow women sufficient time to weigh up the information they have been given, in order to give informed consent for anaesthesia.

10.2.7 Children undergoing anaesthesia should be offered a pre-assessment service prior to the day of their procedure.

16.5.21 Isolated elective orthopaedic units performing major inpatient surgery should have 24/7 access to all support services including acute pain services and critical care. Local guidelines should be in place to provide safe anaesthesia care which includes pre-assessment screening for risk stratification, transfer criteria and postoperative care facilities

HELPNOTE

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. An on the day cancellation audit would be useful evidence to demonstrate this.

STANDARD

1.2.1.2 There is adequate time allowed for consultant input into the anaesthetic preoperative assessment service

EVIDENCE REQUIRED

Documented evidence should be provided, e.g. job plan or rota

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

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

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

- the review of results and concerns identified by nursing staff
- consultations with patients identified by a triage process to allow optimal delivery of pre-operative assessment resources
- cardiopulmonary exercise testing or other functional assessment of fitness on high risk patients and a subsequent consultation on the chance of harm or benefit
- the training and support of nursing and other staff
- the maintenance of close two-way links with primary care clinicians facilitating agreed evidence-based 'fitness for surgery' protocols between primary and secondary care. This arrangement also encourages general practitioners to develop a broader knowledge of remediable perioperative risk factors which can be optimised before surgery
- developing links with clinical commissioning groups
- the establishment of internal protocols for patients such as those with diabetes, obese patients or those on anticoagulant therapy.

6.1.5 Pre-operative assessment clinics should have a nominated consultant or SAS lead, and be delivered by a team specifically trained in pre-operative assessment and preparation for day surgery.

6.5.10 Consultant anaesthetic advice should be available to comment on an individual patient's suitability for day surgery and to assist with optimisation.

STANDARD

1.2.1.3 The appropriate level of postoperative care is planned and arranged preoperatively

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

2.1.6 Perioperative time should be allocated for the work the anaesthetist undertakes on the day of surgery for both pre-operative and postoperative care. The times allocated might vary per patient but for most theatre lists it approximates to one hour per four hours spent in the operating theatre suite or two hours per eight hours in the operating theatre suite.

2.5.29 As a result of the assessment, the appropriate level of post-operative care can be determined and booked in a day-surgery facility, ward, high-dependency unit (level 2 care), or critical care unit (level 3 care), enabling both optimum care and efficient planning.

5.5.43 There should be a clear process in place for the referral of patients requiring critical care, including paediatric patients, to an appropriate facility.

7.1.5 Patients recovering from anaesthesia or sedation in an isolated unit should receive the same standard of care as that required in an operating theatre post-anaesthetic care unit. For major vascular surgery, transfer to the main post-anaesthesia care unit by appropriately trained personnel may be required

7.2.6 A post-anaesthesia care unit or equivalent should be available for each patient at the end of the procedure.

9.3.3 All units should be able to escalate care to an appropriate level and critical care support should be provided to the woman as soon as required, regardless of location.

10.2.7 Children undergoing anaesthesia should be offered a pre-assessment service prior to the day of their procedure.

10.3.21 Infants and children who are likely to require intensive care following an operation should undergo their surgery in a hospital/unit with a designated PICU or NICU.

STANDARD

1.2.1.4 All patients, undergoing anaesthesia or sedation are seen by an anaesthetist after admission, prior to the procedure. Children should be seen with their carers

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

2.5.7 Following admission and prior to undergoing a procedure that requires general or regional anaesthesia, all patients should have a pre-operative visit by an anaesthetist or suitably trained assistant, ideally a person directly involved with the administration of the anaesthetic.⁶ This should be done to confirm earlier findings or, in the case of the emergency admission, initiate pre-operative anaesthetic assessment and care.

2.5.30 Patients should be admitted to a ward or alternative facility with sufficient time before the operating list on which they are scheduled. If an adequate pre-operative assessment has been performed, admission can be on the day of surgery but it remains essential that the anaesthetist who will be administering the anaesthetic is able to confirm the findings of the assessment and agree final details with the patient.

5.5.26 An anaesthetist should pre-operatively assess all patients undergoing emergency surgery who require anaesthesia. This should take place outside of the theatre complex if possible and adequate time should be available for this to occur as clinical urgency allows.

6.2.7 Adequate time and facilities should be provided within the DSU to enable the multidisciplinary clinical team to undertake all aspects of the admission process; including clinical assessment, further discussion about the procedure and delivery of information

10.2.7 Children undergoing anaesthesia should be offered a pre-assessment service prior to the day of their procedure.

STANDARD

1.2.1.5 There are agreed local policies for preoperative preparation of patients. Examples include fasting, investigations, cross-match, thromboprophylaxis, diabetes, latex-allergy, antacid prophylaxis and enhanced recovery after surgery (ERAS)

EVIDENCE REQUIRED

A copy of the policy/policies should be provided and staff should give verbal confirmation that they are fit for purpose and followed. In children, similar policies should be provided including fasting and pregnancy testing in adolescents

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

2.5.17 Each trust should have agreed written policies, protocols or guidelines, following national guidelines where these are available, covering:

- the time allocated for the anaesthetist to undertake pre-operative care in both out-patient clinic and ward settings. Job plans should recognise an adequate number of programmed activities
- pre-operative tests and investigations
- pre-operative blood ordering for potential transfusion
- management of anaemia including parenteral iron therapy to reduce the risk of allogenic blood transfusion
- management of diabetes and anticoagulant therapy, including newer anticoagulant drugs
- pre-operative fasting schedules and the administration of pre-operative carbohydrate drinks
- antacid prophylaxis
- latex and chlorhexidine allergies
- escalation of care in the event of perioperative complications to the intensive care unit
- continuation of regular medication
- locally agreed protocol for the administration of thromboprophylactic agents to patients undergoing surgery, including venous thromboembolism risk assessment, for identification of patients at low, moderate and high risk, and a recommended prophylactic method for each group (including timing of administration to patients undergoing regional anaesthesia)
- referral of patients from a nurse-led clinic to medical staff for further review
- pregnancy testing before surgery
- use of the WHO Surgical Safety Checklist
- management of acute pain in complex patients (e.g. opioid-tolerant patients)
- peri-operative management of pacemakers including implantable cardioverter defibrillators.

3.2.23 There should be policies in place for the safe and rational use of blood and blood products.

3.2.25 There must be policies and facilities in place to protect patients and staff who are hypersensitive to latex-containing products.

6.5.7 Effective pre-operative assessment and patient preparation, performed as early as possible in the planned patient pathway, is essential to the safety and success of day surgery.

6.5.8 Local pre-operative assessment guidelines and protocols should be established. These should be in line with current national recommendations from the Preoperative Association.

6.5.9 Protocols should be available to maximise the opportunity for patients with significant co-morbidities (e.g. diabetes, morbid obesity, sleep apnoea) to be safely managed via a day case pathway.

6.5.11 Clinical investigations rarely inform the suitability for day surgery or influence subsequent management or outcome. Those that are appropriate should be ordered at pre-assessment, according to a locally agreed protocol. A mechanism for review and interpretation of the results of tests ordered before the day of surgery should be developed.

9.2.17 There should be arrangements or standing orders for agreed pre-operative laboratory investigations. There should be a standard prescription or a local Patient Group Directive for pre-operative antacid prophylaxis.

10.3.31 Parents, carers, children and young people should be provided with good-quality pre-operative information, including information on fasting and on what to do if the child becomes unwell before the operation. Post-operative analgesia requirements should be anticipated, and discussed at the pre-assessment visit.

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

10.9.2 Information provided pre-operatively should include:

- anaesthetic technique, analgesia plan, including regional blockade, any additional procedures, e.g. invasive monitoring, blood transfusion, and planned post-operative care in a critical care environment.
- a statement that the ultimate decision-making will take place on the day of surgery, according to the needs and safety of the child and as judged by the attending anaesthetist. Planned resources, e.g. critical care beds, could be unexpectedly unavailable on the day and this may also be part of the decision-making.
- a description of generally common side effects, e.g. sore throat and post-operative nausea and vomiting and significant risks, e.g. allergic reactions. Also, any additional risks particular to the individual child and their co-morbidities.
- concerns raised in discussion with a child or young person or parents and carers, e.g. fear of needles, fear of facemasks, loss of control (which is common in teenagers), emergence delirium, awareness, post-operative pain, PONV, and the risk to the developing brain of anaesthesia in infants
- pre-operative fasting instruction should be given verbally and in writing. The timing should be appropriate to the proposed theatre list start time
- information on the use of unlicensed medicines and/ or licensed medicines for off-label indication.

HELPNOTE

See Note 2 for an explanation of what is meant by the term 'policies'.

STANDARD

1.2.1.7 There is adequate time allowed for consultant assessment of antenatal referrals

EVIDENCE REQUIRED

Verbal confirmation should be given that a system, which staff are satisfied allows enough time, is in place

PRIORITY

1

CQC KLoEs

Safe Caring Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

9.1.17 Additional consultant programmed activities should be allocated for:

- Elective Caesarean deliveries
- Antenatal anaesthetic clinics (or to review referrals if no formal clinic is in place).

STANDARD

1.2.2.1 Patients and their carers are given adequate information upon which to base their decision regarding anaesthesia, postoperative care and pain relief

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

2.9.1 Patients should be fully informed about the planned procedure and participate in a shared decision-making process. Consultation skills for shared-decision making should be used to prepare patients for anaesthesia and surgery. The patient should determine the information provided to obtain their consent for treatment. Patients should be informed of the increasing number of decision aids available at NHS Direct to help them with their choices

2.9.4 All patients undergoing elective procedures should be provided with easily understood information materials covering their operation, anaesthesia and post-operative pain relief, before admission to hospital. Provision of this information should be documented in the patient's notes

2.9.5 The anaesthetist should explain what the patient will experience before and after anaesthesia, and include any choices of anaesthetic technique and details of post-operative management.

2.9.6 The anaesthetist should invite and answer questions from the patient or, if appropriate, the patient's relatives.

6.5.12 Patients should be provided with written information outlining the day surgery pathway, planned procedure and anaesthetic, and expectation of postoperative recovery.

6.9.1 Patients will be provided with information specific to their condition/indication for surgery in addition to information about day surgery. Clear and concise information given to patients at the right time and in the correct format is essential to facilitate good day surgery practice. Much of this information may be given to patients at pre-operative assessment. Verbal information should always be reinforced with printed material. Alternative means of communication with patients, including the internet, email and text messaging, should be considered.

6.9.2 Diagrammatic representation of the patient journey through day surgery may help explain the process.

6.9.3 Information should be arranged in such a way that it is comprehensive and comprehensible, and should be available in a format suitable for the visually impaired and those with other difficulties understanding and considering the information. It may be necessary to provide information leaflets in a number of different languages to accommodate the needs of the local population.

6.9.4 Whatever form the information takes, it should be sufficient to allow informed consent and patients should have an opportunity to ask for further information or clarification.

6.9.5 At a minimum, information provided to patients should include:

- the date and time of admission to the unit,
- location of the unit, travel and parking instructions including information regarding parking costs
- details of the surgery to be undertaken, and any relevant pre-operative preparations required of the patient
- information on the anaesthetic to be provided, including clear instruction for pre-operative fasting, and the way in which patients will manage their medication
- requirement to arrange an escort home and a postoperative carer
- postoperative discharge information, including details of follow-up appointments, management of drugs, pain relief and dressings, and clear instructions on whom to contact in the event of postoperative problems.

6.9.6 Patients must also be made aware at the pre-operative assessment visit that conversion to inpatient care is always a possibility and that they should consider how this may impact on their home arrangements, including any dependent relatives.

9.9.1 Information should be made available to purchasers and to women in the early antenatal period about availability of neuraxial analgesia and anaesthetic services in their chosen location for delivery.

9.9.2 Information must be made available to women in the antenatal period about possible deviations from normal delivery and of emergencies that might arise in the peripartum period, in anticipation of constraints imposed by time and circumstances in the event of such situations arising.

10.9.2 Information provided pre-operatively should include:

- anaesthetic technique, analgesia plan, including regional blockade, any additional procedures, e.g. invasive monitoring, blood transfusion, and planned post-operative care in a critical care environment.
- a statement that the ultimate decision-making will take place on the day of surgery, according to the needs and safety of the child and as judged by the attending anaesthetist. Planned resources, e.g. critical care beds, could be unexpectedly unavailable on the day and this may also be part of the decision-making.
- a description of generally common side effects, e.g. sore throat and post-operative nausea and vomiting and significant risks, e.g. allergic reactions. Also, any additional risks particular to the individual child and their co-morbidities.
- concerns raised in discussion with a child or young person or parents and carers, e.g. fear of needles, fear of facemasks, loss of control (which is common in teenagers), emergence delirium, awareness, post-operative pain, PONV, and the risk to the developing brain of anaesthesia in infants
- pre-operative fasting instruction should be given verbally and in writing. The timing should be appropriate to the proposed theatre list start time
- information on the use of unlicensed medicines and/ or licensed medicines for off-label indication.

HELPNOTE

This can be demonstrated through an audit of patient satisfaction regarding the information received, as outlined in standard 3.1.2.2.

STANDARD

1.2.2.2 Staff have knowledge of national guidelines and the Trust/Board policy on informed consent

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

2.9.8 The competent patient has a fundamental right, under common law, to give, or to withhold, consent to examination, investigation and treatment.

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

10.9.11 Although separate written consent for anaesthesia is not mandatory in the UK, there should be a written record of all discussions with the child and/or parent/carers about methods of induction, and provision of post-operative pain relief (including the use of suppositories).

10.9.12 Where special techniques such as epidural blockade, invasive monitoring and blood transfusions, are anticipated, there should normally be written evidence that this has been discussed with the child or young person as appropriate and their parents or carers.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

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

2.5.27 Pre-operative care requires careful co-ordination and communication with individual surgeons, general practitioners, medical records, out-patient clinics and specialist services such as diabetes. The anaesthetic lead for the pre-operative preparation clinic should ensure adequate systems are in place, and be responsible for overseeing the adequacy of these processes

2.5.33 Anticipated difficulty with anaesthesia should be brought to the attention of the anaesthetist as early as possible before surgery. This includes planned admission to a critical care unit, the need for special skills, such as those of fibre optic intubation, obesity, complex pain problems or a known history of anaesthetic complications.

6.5.11 Clinical investigations rarely inform the suitability for day surgery or influence subsequent management or outcome. Those that are appropriate should be ordered at pre-assessment, according to a locally agreed protocol. A mechanism for review and interpretation of the results of tests ordered before the day of surgery should be developed.

HELPNOTE

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

STANDARD

1.2.3.3 A policy exists for the perioperative management (including regional anaesthesia) of patients with regard to anticoagulant therapy

EVIDENCE REQUIRED

A copy of the policy should be provided

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Policies, planning and governance

GPAS REFERENCES

2.5.17 Each trust should have agreed written policies, protocols or guidelines, following national guidelines where these are available, covering:

- the time allocated for the anaesthetist to undertake pre-operative care in both out-patient clinic and ward settings. Job plans should recognise an adequate number of programmed activities
- pre-operative tests and investigations
- pre-operative blood ordering for potential transfusion
- management of anaemia including parenteral iron therapy to reduce the risk of allogenic blood transfusion
- management of diabetes and anticoagulant therapy, including newer anticoagulant drugs
- pre-operative fasting schedules and the administration of pre-operative carbohydrate drinks
- antacid prophylaxis
- latex and chlorhexidine allergies
- escalation of care in the event of perioperative complications to the intensive care unit
- continuation of regular medication
- locally agreed protocol for the administration of thromboprophylactic agents to patients undergoing surgery, including venous thromboembolism risk assessment, for identification of patients at low, moderate and high risk, and a recommended prophylactic method for each group (including timing of administration to patients undergoing regional anaesthesia)
- referral of patients from a nurse-led clinic to medical staff for further review
- pregnancy testing before surgery
- use of the WHO Surgical Safety Checklist
- management of acute pain in complex patients (e.g. opioid-tolerant patients)
- peri-operative management of pacemakers including implantable cardioverter defibrillators

STANDARD

1.2.4.2 The specific needs of children are considered at all stages of perioperative care including emergencies and carers accommodation

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

2.3.1 The particular needs of children should be considered at all stages of perioperative care. They should ideally attend a pre-operative clinic staffed by nurses experienced in pre-assessing children. Children may benefit from a visit to the locality to which they will be admitted and familiarisation with the environment and personnel.¹⁵ There should be access to play specialists.

2.3.4 Parents and carers should be enabled to remain as close to their child as possible during the process of anaesthesia and recovery. There should be a space available within close proximity to theatres, where they can wait and be contacted.

2.3.9 Children should be separated from, and not managed directly alongside adults throughout the patient pathway including in waiting rooms, pre-assessment clinic rooms and theatre areas, including anaesthetic and recovery areas, as far as possible. These areas should be child-friendly.

4.3.2 A designated separate recovery area for children and young people should be available in the paediatric anaesthesia location. This should have sufficient capacity for children to recover, be child friendly and staffed by suitably trained and qualified recovery practitioners to look after babies, children and young people.¹

4.3.3 If this is not available, in the absence a dedicated post-anaesthesia care unit for children, a discrete segregated area in the general post-anaesthesia care unit should be available. The environment should be made as child-friendly as possible.

4.3.4 Children should never be left unattended in the recovery area.

4.3.5 A designated area for parents/guardians should be located in an area close to theatre, where they can be contacted or wait until they are invited by the clinical staff to the recovery area to be reunited with their child as soon as they are awake.

6.3.1 The lower age limit for day surgery depends on the facilities and experience of staff and the medical condition of the infant. Ex-preterm neonates should not be considered for day surgery unless medically fit and beyond 60 weeks post-conceptual age.

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

6.3.3 Infants with a history of chronic lung disease or apnoeas should be managed in a centre equipped with facilities for post-operative ventilation.

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

6.3.5 Nursing staff caring for children should be skilled in paediatric and day surgical care and trained in child protection.

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

6.3.7 A pre-admission programme for children should be considered, to decrease the impact and stress of admission to the DSU on the day of surgery

7.3.1 Children should always be managed in accordance with RCoA and Association of Paediatric Anaesthetists recommendations.

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

7.3.3 The paediatric anaesthetist should consider the patient age, physical capacity, complexity of the procedure and the status of the surgical facility before administering anaesthesia.

7.3.4 The standard of care provided to children during sedation or anaesthesia outside of theatre should be delivered to the same standards of care as applied to procedures performed in theatre.

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

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

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

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

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

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

10.2.21 Arrangements should be in place to enable at least one parent or carer to stay with children who require overnight admission to hospital.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.2.4.3 Arrangements are in place for the multidisciplinary management of patients with significant co-morbidities

EVIDENCE REQUIRED

A brief presentation of an example scenario which may be requested at your ACSA review visit

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

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

2.5.12 High-risk patients should be discussed in regular specialty multidisciplinary team (MDT) meetings with anaesthetic representation. Such an arrangement facilitates robust team decision-making with regard to patient care while minimising delays in the surgical pathway. Clinical time should be agreed in consultant job plans to reflect this commitment. There should be an anaesthetic MDT led by anaesthetists including cardiologists, respiratory physicians, surgeons, haematologists to discuss high-risk surgical patients, do quick in-house referrals and make plans for pre-surgery optimisation and post-operative management.

16.1.13 Elderly patients presenting for elective surgery frequently have pre-existing comorbidities that require careful review and peri-operative planning. As such, the pre-assessment service for elective patients should be consultant led, by anaesthetists with an interest in, and appropriate experience in, delivering anaesthetic care to orthopaedic patients

16.1.4 Anaesthetists should be involved alongside surgical colleagues and orthogeriatricians, in discussions on pre-operative planning, timing of surgery, and postoperative care, especially for high risk patients.

16.5.14 Elective patients with major comorbidities or those undergoing complex or prolonged surgery should be scheduled earlier in the day, to allow time for postoperative stabilisation.

STANDARD

1.2.4.5 There are dedicated arrangements for day surgery

EVIDENCE REQUIRED

Appropriately placed operating lists should be seen to allocate the first slots of the list to day case patients

PRIORITY

1

CQC KLoEs

Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

6.2.1 The minimum operating facility required is a dedicated operating session in a properly equipped operating theatre.

6.2.3 A viable alternative is for patients to be admitted to and discharged from a dedicated day surgery ward, with surgery undertaken in the main theatre suite. This arrangement may be more flexible for complex work and avoids duplicating theatre skills and equipment.

6.2.4 Every effort should be made to avoid mixing day cases and in-patients on the same operating list, and day case patients should never be managed through in-patient wards, as this greatly increases their chance of an unnecessary overnight stay.

6.5.15 Day case patients should ideally be managed on dedicated day case ward areas, to ensure safe and timely discharge

10.3.28 Infants, children and young people should have their day surgery delivered to the same standards as inpatient care, but with additional consideration of measures to promote early discharge. In particular younger infants should be scheduled early in the day to allow sufficient time for recovery and discharge on the same day.

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

STANDARD

1.2.4.6 Where there are elective caesarean section lists, there are dedicated obstetric, anaesthesia, theatre and midwifery staff

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

9.1.2 There should be a duty anaesthetist immediately available for the obstetric unit 24 hours a day. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The role should not include undertaking elective work during the duty period.

9.1.17 Additional consultant programmed activities should be allocated for:

- Elective Caesarean deliveries
- Antenatal anaesthetic clinics (or to review referrals if no formal clinic is in place)

9.5.22 Units with high Caesarean delivery rates should have elective Caesarean delivery lists to minimise disruption due to emergency work. Any elective Caesarean delivery list should have dedicated obstetric, anaesthetic and theatre staff.

HELPNOTE

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

STANDARD

1.2.4.7 Arrangements are in place for the multidisciplinary management of older patients

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

2.3.16 Pre-operative assessment, optimisation and shared decision-making in older patients with multiple comorbidities, frailty or cognitive impairment require a cross-specialty approach involving anaesthetists, surgeons, geriatricians, pharmacists and allied health professionals. Liaison with a clinical pharmacist to support older patients with polypharmacy in the peri-operative period will enable optimisation of medicines and improved management of the patient's non-surgical co-morbidities during this time. The development of such teams requires time and resources. These should be recognised and provided.

2.3.17 Patients with frailty are at increased risk of adverse postoperative outcome. Older patients undergoing intermediate and high-risk surgery should be assessed for frailty using an established tool or scoring system. Pathways of care providing proactive pre-operative interventions for frailty, involving therapy services, social services and geriatricians, should be developed. Older patients should have access to a consultant geriatrician. Opportunities for joint geriatric and surgical clinical governance should be considered.

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

5.3.3 The outcomes following emergency surgery for elderly patients (particularly patients who are either partially or wholly dependent) are considerably worse than for younger patients. Consequently, planning of care and decisions to operate require very careful consideration at a consultant level. This should include discussion of issues around risk versus benefit, futility and realistic longer-term outcomes, e.g. requirement for nursing home care. This should also involve the multidisciplinary team, ideally with the patient, families and carers.

16.1.14 Anaesthetists should be involved alongside surgical colleagues and orthogeriatricians, in discussions on pre-operative planning, timing of surgery, and postoperative care, especially for high risk patients.

16.3.14 The majority of hip fracture patients are aged > 65 years and often have multiple comorbidities, some of which may be undiagnosed. Decisions on their treatment should ideally be made using a multidisciplinary team that involves senior anaesthetists, peri-operative physicians, orthopaedic surgeons and orthogeriatricians, all with a specific interest in this patient population.

HELPNOTE

Orthogeriatrician input is considered an excellent way to demonstrate compliance with this standard

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Effective Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

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

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

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

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

HELPNOTE

The ideal is complete separation of adults and children in recovery using solid building construction while permitting immediate assistance and observation. In many situations this may not be possible and pragmatic solutions which achieve demonstrably acceptable results may be used. If your department does not treat children, please refer to Note 3.

STANDARD

1.2.4.9 Services and facilities take account of the physical and emotional needs of adolescents, where these are different from those of children and adults.

EVIDENCE REQUIRED

Demonstrate appropriate information on anaesthesia and surgery, provision of privacy and policy on consent

PRIORITY

2

CQC KLoEs

Responsive

GPAS REFERENCES

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

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

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

Transitional care

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

HELPNOTE

Please note this is a 'priority 2' standard, see Note 1 for further explanation.

STANDARD

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

EVIDENCE REQUIRED

A written policy should be provided and verbal confirmation should be given that it is used for 100 per cent of anaesthetic procedures in all areas at all times including out of hours and emergencies

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

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

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

7.1.2 A dedicated, skilled anaesthetic assistant should be available in all locations outside the operating theatre where anaesthesia is undertaken.

7.1.3 If sedation is administered by an anaesthetist, then a suitably trained individual should be present to assist the anaesthetist.

9.1.24 The anaesthetist should have a competent trained assistant immediately available for the duration of any anaesthetic intervention and this practitioner should not have any other duties.

9.1.25 All theatre staff acting as anaesthetic assistants should comply fully with current national qualification standards and be deemed to have attained and maintained the relevant competencies to perform the role (an example of these competencies is referenced).

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

9.1.27 Anaesthetists and anaesthetic assistants working without direct supervision in obstetric theatres, and on the delivery suite, should be familiar with the environment and working practices of that unit and work there on a frequent basis to maintain that familiarity.

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

STANDARD

1.3.1.2 When a child undergoes anaesthesia, all staff (operating department practitioners/assistants/anaesthetic nurses/recovery) have paediatric competencies and experience

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

10.1.1 Anaesthetists who care for children should have received appropriate training and must ensure that their competency in anaesthesia and resuscitation is adequate for the management of the children they serve.

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

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

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.3.2.1 All anaesthetic equipment is checked before use according to AAGBI published guidelines and the checks are documented

EVIDENCE REQUIRED

A copy of documented checks should be provided

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.2.24 All anaesthetic equipment should be checked before use according to the AAGBI published guidelines. Anaesthetic machine checks should be recorded in a log and on the anaesthetic chart.

HELPNOTE

Example of evidence would be an audit of anaesthetic records showing a completion of checklist and any copies or examples of data. A completed machine self-check only covers part of the AAGBI checklist and this check should be recorded.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.2.20 Appropriate equipment should be available to minimise heat loss by the patient and to provide active warming.

3.2.21 A fluid warmer allowing the warmed transfusion of blood products and intravenous fluids should be available.

3.2.30 The following equipment should be available:

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

5.2.23 There must be an adequate ventilation system within theatres to minimise infection and to provide the capacity for effective temperature control of the operating theatre environment.

5.2.32 All necessary equipment should be available to ensure normothermia can be maintained throughout the perioperative period. Policies should be in place to facilitate and monitor the maintenance of normothermia. Devices for patient warming should be readily available for use pre-theatre and in the anaesthetic room, operating theatre, recovery unit, critical care areas and emergency department.

5.2.42 Patient temperature monitoring should be available.

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

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

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

10.3.4 The theatre should have the capacity to reach a temperature of 28°C.

16.2.4 Warming devices for patients should be available for use in the anaesthetic room, operating theatre, recovery unit and ED.

16.2.5 Elective orthopaedic and planned trauma cases should have their temperature checked pre-operatively on the ward. Active warming devices should be available for patients prior to coming to theatre.

16.2.6 A rapid infusor allowing the infusion of warmed intravenous fluids and blood products should be available.

HELPNOTE

The ACSA review team will check that there is adequate provision to support this.

STANDARD

1.3.2.3 Equipment must be available to administer oxygen to all patients undergoing procedures under sedation by an anaesthetist. There must be the ability to monitor continuous CO₂ output

EVIDENCE REQUIRED

Equipment must be seen

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.3 Environments in which patients receive anaesthesia or sedation should have full facilities for resuscitation available, including a defibrillator, suction, oxygen, airway devices and a means of providing ventilation

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

STANDARD

1.3.3.1 Recommended standards of monitoring are met for each patient

EVIDENCE REQUIRED

The anaesthetic record in use should contain all elements of the current AAGBI 'Recommendations for standards of monitoring during anaesthesia and recovery' dataset

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

3.2.29 The recommended standards of monitoring, instrumental or otherwise, should be met for every patient.

3.2.30 The following equipment should be available:

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

3.2.31 Some patients may require additional monitoring equipment. The following should be considered:

- invasive pressure monitoring
- cardiac output monitors
- depth of anaesthesia monitoring.

3.2.32 All monitors should be fitted with audible alarms.

5.2.39 Routine monitoring for anaesthesia according to AAGBI standards of monitoring should be available for all areas where anaesthesia is undertaken. Departments should follow national clinical guidelines for the use of monitoring equipment, or local guidelines when national guidelines are not available.

6.2.17 The recommended AAGBI standards of anaesthetic monitoring should be met for every patient.

7.2.9 Equipment for monitoring should be available at all sites where patients receive anaesthesia or sedation.¹⁰ For patients receiving conscious sedation, this should include pulse oximetry

7.3.19 Interventional vascular radiology may involve treating unstable patients with severe haemorrhage. Such patients may include those with significant gastrointestinal bleeding or patients with post-partum haemorrhage. Equipment to deal with these patients should be immediately available. This includes that necessary to introduce and monitor a variety of intravascular catheters, rapid infusion devices, blood- and fluid-warming devices and patient-warming devices.

7.3.22 Remote monitoring of the patient with slave screens should be available to allow the anaesthetic team to monitor the patient from outside of the magnetic field.

7.3.33 Standards for monitoring and recovery are stipulated by the AAGBI and should be adhered to for all ECT cases

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

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

HELPNOTE

Use of continuous monitoring (e.g. the transition from theatre to recovery) is a recent addition to the AAGBI's [Recommendations for standards of monitoring during anaesthesia and recovery guidelines](#). If this is not currently available, there should be a plan for the next cycle of equipment renewal to ensure that this is in place.

STANDARD

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

EVIDENCE REQUIRED

Verbal confirmation 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

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

9.2.33 There should be at least one fully equipped obstetric theatre within the delivery suite, or immediately adjacent to it. The number of operating theatres required should depend on the number of deliveries and operative risk profile of the women delivering in the unit.

STANDARD

1.3.5.1 Timely access to the following services are available: haematology, blood transfusion, chemical pathology, blood gas analysis, radiology, electrocardiography and appropriate cardiopulmonary assessment including for emergencies

EVIDENCE REQUIRED

Verbal confirmation of how services would be accessed during a procedure should be given

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

2.2.4 There should be equipment and facilities for blood tests and urine analysis.

3.2.10 Services should be available for:

- blood transfusion
- radiology
- haematology
- clinical pathology
- electrocardiography.

5.2.27 Near-patient testing for haemoglobin, blood gases, lactate, blood sugar and ketones should be readily available for theatres.

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

6.2.22 Support services including radiology, pharmacy and investigative laboratories should be available.

6.2.23 The facility to perform a 12-lead electrocardiogram and other point-of-care tests, such as international normalised ratio, should be available within the DSU itself

9.2.18 Haematology and biochemistry services should be available to provide analysis of blood and other body fluids 24 hours a day.

9.2.19 A local policy should be established with the haematology department to ensure blood and blood products once available are able to be transferred to delivery suite rapidly for the management of major haemorrhage

9.2.20 O-negative blood should be immediately available, ideally stored on the delivery suite.

9.2.21 There should be rapid availability of radiology services.

9.2.22 In tertiary referral centres, there should be 24-hour access to interventional radiology services.

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

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

STANDARD

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)

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

4.2.1 In the main operating theatre complex, a dedicated post-anaesthesia care unit is required. This should be located in the operating theatre department and be separate from the department's admission area and with a separate access for transfer of patients to the ward.

4.2.2 The size, design and facilities of the post-anaesthesia care unit must meet the Department of Health guidelines.

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

4.2.11 Clinical observations should be supplemented by pulse oximetry and non-invasive blood pressure monitoring until the patient is fully recovered from anaesthesia. An electrocardiograph, nerve stimulator, thermometer, glucometer and capnograph should also be readily available.

7.1.5 Patients recovering from anaesthesia or sedation in an isolated unit should receive the same standard of care as that required in an operating theatre post-anaesthetic care unit. For major vascular surgery, transfer to the main post-anaesthesia care unit by appropriately trained personnel may be required.

7.2.27 Patients should be appropriately monitored during their recovery

7.3.33 Standards for monitoring and recovery are stipulated by the AAGBI and should be adhered to for all ECT cases

STANDARD

1.4.1.4 Particular provision is made for the care of children including nurses/ODPs trained in paediatric resuscitation

EVIDENCE REQUIRED

Verbal confirmation should be sought from staff in the recovery area, including the qualifications of individuals in that area

PRIORITY

1

CQC KLoEs

Safe Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

4.3.2 A designated separate recovery area for children and young people should be available in the paediatric anaesthesia location. This should have sufficient capacity for children to recover, be child friendly and staffed by suitably trained and qualified recovery practitioners to look after babies, children and young people.

4.3.10 All staff working in paediatric recovery should be trained and competent in protocols, and familiar with the relevant procedures and personnel if there are safeguarding or child protection concerns that arise while the child is in theatre.

10.1.1 Anaesthetists who care for children should have received appropriate training, and must ensure that their competency in anaesthesia and resuscitation is adequate for the management of the children in their care

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

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

10.3.14 In all emergency departments receiving infants and children, neonatal and paediatric resuscitation equipment, medications (including anaesthetic drugs) and fluids should be available to prepare an infant or child for PICU transfer.

10.4.2 All anaesthetists who provide elective or emergency care for children should have advanced training in life support for children, and should maintain these competencies by annual training that ideally is multidisciplinary and scenario based

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.4.1.5 Patients being discharged from the hospital following anaesthesia or sedation should be discharged into the care of a responsible adult

EVIDENCE REQUIRED

Discharge criteria on a form for adults and children

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

6.5.25 Following procedures performed under general or regional anaesthesia, a responsible adult should escort the patient home and provide support for the first 24 hours after surgery. A carer at home may not be essential if there has been good recovery after brief or non-invasive procedures and where any postoperative haemorrhage is likely to be obvious and controllable with simple pressure.

7.5.9 Patients meeting discharge criteria following anaesthesia or sedation who are to be discharged home should be discharged into the care of a responsible third party. Verbal and written instructions for post-procedural care should be provided if a procedure has been performed

HELPNOTE

This does not apply to surgically administered local anaesthetic.

STANDARD

1.4.2.1 The recovery room staff are appropriately trained and updated in all relevant aspects of postoperative care

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

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

9.1.28 All women requiring postoperative recovery care should receive the same standard of care as the non-obstetric postoperative population.

9.1.29 All theatre and post-anaesthetic recovery staff looking after the obstetric population should be familiar with the area for recovery of obstetric patients and be experienced in the use of the different early warning scoring systems for obstetric patients. They should have been trained to the same standard as for all recovery nurses, maintained these skills through regular work on the theatre recovery unit, and undergone a supernumerary preceptorship in this environment before undertaking unsupervised work.

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

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

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

4.1.5 The anaesthetist/anaesthetic department should retain overall responsibility for the patient during the recovery period and should be readily available for consultation until the patient is able to maintain their own airway, has regained respiratory and cardiovascular stability and is able to communicate.

4.1.6 The patients' anaesthetist should retain overall responsibility for the patient during the recovery period and should be readily available for consultation until the patient is able to maintain their own airway, has regained respiratory and cardiovascular stability and is able to communicate, unless this care has been handed over to another named anaesthetist

4.1.7 Until the patient is able to maintain their own airway, has regained respiratory and cardiovascular stability and is able to communicate, continuous individual observation and care of each patient should be performed on a one-to-one basis. All post-anaesthesia care units should be staffed to a level that allows this to be routine practice (this could be assessed using queuing theory or other models of staffing) and the recovery staff should not have any other duties during this time.

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

6.1.6 The secondary recovery area in the day surgery unit should be staffed to match patients' needs and consideration should be given to the skill-mix as well as numbers of staff

6.2.8 Each DSU should have a fully equipped recovery area, staffed by recovery personnel trained to defined standards

STANDARD

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

EVIDENCE REQUIRED

A written policy should be provided and this should be seen in the recovery area

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

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

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

STANDARD

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

EVIDENCE REQUIRED

Verbal confirmation should be given

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

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

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

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

STANDARD

1.4.3.1 There is a recognised process for the referral of day-case patients requiring inpatient admission to an appropriate facility

EVIDENCE REQUIRED

A written policy should be provided for adults and children

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

6.5.17 If day surgery is being undertaken in an isolated site, protocols should define finding an inpatient bed and mechanism of transport for a patient requiring an overnight stay.

6.3.20 There should be agreed pathways for patients who require admission to hospital following their day surgery procedure

6.5.16 There should be agreed protocols for the management of patients who require unplanned hospital admission following their day case procedure

7.2.5 It should also be possible to arrange transfer of a patient from the procedure room to other areas within the institution if necessary.

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

7.5.5 In remote off-site locations, such as psychiatric hospitals where anaesthesia is provided for ECT, advanced plans should be made to manage patient transfer if required

HELPNOTE

This refers specifically to day surgery under the escalation of level of care, such as in day surgery when the patient subsequently requires an overnight stay.

STANDARD

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

EVIDENCE REQUIRED

A written policy should be provided for adults and children

PRIORITY

1

CQC KLoEs

Safe Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

7.1.5 Patients recovering from anaesthesia or sedation in an isolated unit should receive the same standard of care as that required in an operating theatre post-anaesthetic care unit. For major vascular surgery, transfer to the main post-anaesthesia care unit by appropriately trained personnel may be required.

7.3.13 Transfer of patients within the hospital to ICU, radiology or the operating theatre is not without risk and will require the use of a tipping transfer trolley, oxygen cylinders, suction, a transport ventilator, infusion pumps, monitor with adequate battery life and a portable defibrillator if appropriate. Local guidelines along with use of a formal 'Intra Hospital Transfer Form' should be considered to mitigate procedure specific issues.

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

9.3.3 All units should be able to escalate care to an appropriate level and critical care support should be provided to the woman as soon as required, regardless of location.

9.3.4 Whenever possible, escalation in care should not lead to the separation of mother and baby.

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

10.5.1 Hospitals should define the extent of elective and emergency surgical provision for children, and the thresholds for transfer to other centres.

10.5.13 Hospitals should engage with networks in order to develop agreed care pathways based on age, co-morbidity and complexity of procedure, as well as clinical urgency. Care pathways should relate to local service provision, staffing and geography.

HELPNOTE

This refers specifically to unplanned intensive care admissions following surgery.

STANDARD

1.4.4.1 Methods of postoperative pain management are discussed with and written information given to the patient

EVIDENCE REQUIRED

This should be visible on the anaesthetic record. Written evidence that it is covered in induction should be given

PRIORITY

1

CQC KLoEs

Caring

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

2.9.4 All patients undergoing elective procedures should be provided with easily understood information materials covering their operation, anaesthesia and post-operative pain relief, before admission to hospital. Provision of this information should be documented in the patient's notes

6.5.21 Locally agreed policies should be in place for the management of postoperative pain after day surgery. This should include pain scoring systems in recovery and a supply of pain relief medication on discharge, with written and verbal instructions on how to take medications and what to take when the medications have finished.

6.5.22 Patients may be discharged home with residual sensory or motor effects after nerve blocks or regional anaesthesia.²⁵ The duration of the effects should be explained and the patient should receive written instructions as to their conduct until normal sensation returns

6.9.5 At a minimum, information provided to patients should include:

- the date and time of admission to the unit
- location of the unit, travel and parking instructions including information regarding parking costs
- details of the surgery to be undertaken, and any relevant pre-operative preparations required of the patient
- information on the anaesthetic to be provided, including clear instruction for pre-operative fasting, and the way in which patients will manage their medication
- requirement to arrange an escort home and a postoperative carer
- postoperative discharge information, including details of follow-up appointments, management of drugs, pain relief and dressings, and clear instructions on whom to contact in the event of postoperative.

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

11.7.1 Patient information leaflets should be made available to cover analgesia in general and specific to individual surgical interventions such as arthroplasty. Leaflets should also explain pain management after discharge.

STANDARD

1.4.4.2 Pain management for day surgery patients includes prescription for pain relief medication after discharge

EVIDENCE REQUIRED

A written proforma or policy should be provided

PRIORITY

1

CQC KLoEs

Caring Effective

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

6.5.21 Locally agreed policies should be in place for the management of postoperative pain after day surgery. This should include pain scoring systems in recovery and a supply of pain relief medication on discharge, with written and verbal instructions on how to take medications and what to take when the medications have finished.

11.3.6 Day case surgery perioperative care should include patient advice on pain management after discharge.

STANDARD

1.4.4.3 Specialist acute pain management advice and intervention is available at all times including escalation plans

EVIDENCE REQUIRED

A system by which anaesthetists can be called at any time for advice should be relayed verbally by any member of staff, including nursing staff, for adults and children

PRIORITY

1

CQC KLoEs

Safe Effective Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

10.2.15 There should be a fully resourced acute pain service that covers the needs of children. In hospitals with a smaller paediatric caseload, this may be the adult acute pain service liaising with the paediatric anaesthetic team rather than a dedicated paediatric service.

11.1.1 Acute pain services should be multidisciplinary teams led by appropriately trained consultant or SAS anaesthetists. The minimum training requirement for new appointments to APS lead roles is Royal College of Anaesthetists higher pain training. Advanced pain training, or its equivalent, should be considered optimal. Consultants or other leads already in post need to demonstrate an ongoing significant interest in acute pain management by involvement in CME and job planning.

11.1.4 Specialist advice should be available at all times, with adequate cover to maintain this service when individuals are on leave.

11.1.6 Outside working hours arrangements for cover of the acute pain service, including appropriate expert advice, should be made available. This may be via suitably qualified senior anaesthetic trainees.

STANDARD

1.4.4.4 There is a dedicated acute pain nurse specialist service which also covers the needs of children and obstetric patients

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Effective Well-led

GPAS REFERENCES

10.2.15 There should be a fully resourced acute pain service that covers the needs of children. In hospitals with a smaller paediatric caseload, this may be the adult acute pain service liaising with the paediatric anaesthetic team rather than a dedicated paediatric service.

11.1.5 An adequate number of clinical nurse specialists in pain medicine should be available to fulfil the following roles within working hours:

- provide advice to ward staff and other medical teams regarding all aspects of pain management
- review patients in pain with appropriate frequency to provide a safe and effective service
- provide education for ward staff; this must include basic pain assessment and treatment, as well as training in specialist pain management techniques as appropriate
- provide education for other staff, such as post anaesthetic care unit (PACU) staff or junior doctors
- liaise with the clinical lead in pain medicine to highlight complex or systematic problems.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.4.5.2 There is an agreed procedure for the removal of supraglottic airways

EVIDENCE REQUIRED

A written policy should be provided which includes reference to the use of capnography

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

4.1.2 On many occasions, patients will be handed over to the recovery practitioner with a laryngeal mask airway or other supraglottic airway device in place. The person taking over direct clinical care should be specifically trained in the management of these patients and in the safe removal of the airway device.

4.1.3 If a patient is transferred to the post-anaesthesia care unit with a tracheal tube in place, the anaesthetist remains responsible for the removal of the tube but may delegate its removal. Delegation should be to an appropriately trained member of the PACU staff who is prepared to accept this delegated responsibility.

4.2.12 Capnography has the potential to aid early detection of airway obstruction and should be available in recovery and used in high-risk cases. If patients remain intubated or they have their airways maintained with a supraglottic or other similar airway device, continuous capnography should be used.

HELPNOTE

Where there is nurse led extubation, evidence of training, an SOP and rolling audit of practice must be available.

STANDARD

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

EVIDENCE REQUIRED

A written policy should be provided for adults and children

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

4.2.17 Locally devised protocols should be available for discharge criteria.

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

6.5.18 Locally agreed written discharge criteria should be established.

HELPNOTE

Where patients are discharged home directly from recovery it is accepted that they would not need to be accompanied by a member of staff.

A checklist is useful to demonstrate this.

STANDARD

1.5.0.1 Fully resourced, dedicated daytime emergency and trauma lists are provided appropriate to local demand

EVIDENCE REQUIRED

Lists should be provided. Half day NCEPOD lists are acceptable

PRIORITY

1

CQC KLoEs

Safe Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.5.12 Emergency and elective work should be separated (whenever practically feasible), to improve clinical care for patients.

5.5.20 Adequate emergency theatre time should be provided throughout the day, to minimise delays and avoid emergency surgery being unnecessarily undertaken out of hours when the hospital may have reduced staffing to care for complex post-operative patients. Consideration should be given to consultant staffing of 'twilight' or evening emergency theatre sessions. Job plans may have to be reviewed to achieve this, depending upon local circumstances.

5.5.21 Dedicated emergency lists for some individual surgical services (e.g. paediatrics) may be an effective use of resources and improve patient flow and care.

HELPNOTE

Audit of emergency workload after 10pm would be useful to demonstrate this.

STANDARD

1.5.0.2 Clinical areas should be secure for the protection of patients and staff but appropriate access when required (ie for emergency teams) must always be available

EVIDENCE REQUIRED

Evidence of this should be visible

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.2.10 Access to theatres and associated clinical areas should be appropriately restricted.

9.2.31 There should be easy and safe access to the delivery suite from the main hospital at all times of the day.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

5.5.18 The urgency of emergency cases should be clearly and unambiguously coded. There should be regular review of delays, to facilitate improved theatre access and to promote accurate urgency coding at booking. Prioritisation of cases based on their urgency is not the sole domain of any single specialty. It requires a team approach involving discussion between different surgical groups, anaesthetists and, in some cases, critical care. Prioritisation should consider not only the surgical condition of the patient but also any pre-existing medical conditions such as cardiovascular or diabetic disease.

9.5.13 There should be a clear line of communication between the duty anaesthetist, theatre staff and anaesthetic assistant once a decision is made to undertake an emergency Caesarean delivery.

STANDARD

1.5.0.4 There are clear escalation processes should two emergencies occur simultaneously

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

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

- guidelines for the management of anaesthetic emergencies displayed prominently in sites where anaesthesia and sedation are provided, including guidelines for children and difficult airway management; access to paperless guidelines through a readily accessed hospital intranet repository is encouraged
- infection control policies, including staff protection/health and safety (HIV, hepatitis, chemical)/antimicrobial prophylaxis and post-exposure prophylaxis guidelines
- an escalation plan for theatre capacity and staffing, including a locally agreed policy for the deferment of elective activity to accommodate emergency surgical activity when required
- clear guidelines on whom to call and what facilities can be utilised if two or more emergencies occur simultaneously
- a guideline to address death in the operating theatre
- a documented policy for the management of organ donation and retrieval.

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

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

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

3.1.3 In exceptional circumstances, anaesthetists working single-handedly may be called on briefly to assist with or perform a life-saving procedure nearby. This is a matter for individual judgement and the dedicated anaesthetic assistant should be present to monitor the unattended patient

3.1.4 Anaesthesia departments should have a nominated anaesthetist immediately available to provide cover in clinical emergencies, as well as advice and support to other anaesthetists

5.2.13 Staffing needs to be of a level that emergency theatre activity and HDU/ICU patient care are not compromised when intra- and inter-hospital transfers are undertaken.

The emergency department (ED)

7.3.8 In a designated Major Trauma Centre the receiving Trauma Team should include an anaesthetist, and, where possible this should be an appropriately experienced consultant.

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

7.3.12 Many of these patients will require inter-hospital transfer to the regional trauma centre and local and national guidelines for transfer should be followed.

7.3.13 Transfer of patients within the hospital to ICU, radiology or the operating theatre is not without risk and will require the use of a tipping transfer trolley, oxygen cylinders, suction, a transport ventilator, infusion pumps, monitor with adequate battery life and a portable defibrillator if appropriate. Local guidelines along with use of a formal 'Intra Hospital Transfer Form' should be considered to mitigate procedure specific issues.

HELPNOTE

The aim of this standard is to find out whether there are sufficient staff to allow 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.

STANDARD

1.5.0.7 Patients designated as high risk are managed either directly or under the immediate supervision of a consultant anaesthetist

EVIDENCE REQUIRED

Evidence should be seen on the anaesthetic record for adults and children

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Impact on patients, service users, carers and families; Safe, effective and person-centred care delivery; Quality improvement-focussed leadership

GPAS REFERENCES

2.5.23 High risk surgical patients should have their expected risk of death estimated and documented prior to intervention, with due adjustments made in planning the urgency of care, seniority of staff involved and postoperative care

5.3.22 To facilitate optimal care of high-risk patients, systems should be in place to ensure:

- timely surgical review (typically at a consultant level), and access to diagnostic imaging and urgent reporting
- documented evaluation of mortality and relevant morbidity risk prior to surgery
- communication of risk to the multidisciplinary clinical team, to allow appropriate pre-operative review and allocation of resources according to risk
- patient assessment for the presence of sepsis and severe sepsis; hospitals should have in place policies for the management of sepsis, in particular the early administration of antibiotics – ‘The Sepsis Six’ is a pragmatic approach to this
- timely access to appropriate care (including resuscitation, antibiotics, interventional radiology or surgery)
- the presence of a consultant surgeon and anaesthetist in the operating theatre for patients with an estimated mortality >5 per cent (a national recommendation); in the UK 74 per cent of emergency laparotomies have a consultant anaesthetist present in the operating theatre
- anaesthesia for emergency surgery is delivered by a competent individual, with appropriate supervision; the level of supervision should reflect the severity of the case and the seniority of the individual; local supervision policies should be reviewed, taking into consideration national recommendations and new evidence as it arises
- trainees are given the appropriate level of responsibility, in order to gain the experience of emergency anaesthesia to be able to function as a consultant later in their career; however, trainees must be appropriately supervised at all times – rotas and staffing arrangements should be in place to facilitate this
- The recommendation that all high-risk patients are considered for critical care is followed; as a minimum, patients with an estimated risk of death of ≥ 10 per cent should be admitted to a critical care location (unless there is a contraindication).⁴ The threshold of 10 per cent for risk of death is historical and should be perceived as an absolute minimum standard. The exact percentage mortality risk that warrants critical care admission is unknown, and probably varies from condition to condition. There should be locally agreed protocols for postoperative intensive care admission. The efficacy and compliance of local intensive care admission protocols should be audited.

5.5.23 There should be a formalised integrated pathway for unscheduled adult general surgical care which should be patient centred and include:

- a clear diagnostic and management plan made on admission
- risk assessment and identification of the high-risk patient
- early identification of co-morbidities (including diabetes, pacemakers and internal cardiac defibrillators) and their management according to hospital guidelines
- medicine reconciliation to assess risk of existing medications (including anticoagulation), and to assess the risk of stopping long term medication
- pregnancy testing as appropriate
- an assessment of mortality risk that is made explicit to the patient and recorded clearly on the consent form and in the medical record
- communication of mortality risk to members of the multidisciplinary team; this allows early senior input, including senior members of the anaesthetic team, and allocation of resources commensurate to the patient's risk of death following surgery
- timely investigations and surgery
- a plan for post-operative care.

HELPNOTE

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 per cent, ASA 3 and 4 or those designated high risk by local policy.

STANDARD

1.5.0.8 The specific needs of critically ill children are considered

EVIDENCE REQUIRED

Paediatric early warning scores should be visible on all age-specific observation charts. Verbal confirmation should be given as to whom would provide anaesthetic support to the multidisciplinary team caring for a critically ill child

PRIORITY

2

CQC KLoEs

Safe Responsive

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

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

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

10.3.11 Hospitals should have clear operational policies regarding the care of young people aged 16-18 years of age and for pre-term babies who have been discharged from neonatal units.

STANDARD

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

EVIDENCE REQUIRED

Network and local policies, evidence of multidisciplinary working, named lead consultant

PRIORITY

1

CQC KLoEs

Safe Responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

10.3.16 Hospitals without a suitable PICU/NICU bed should obtain the advice of the local PICU transport team as soon as possible during the management of the sick or critically injured child or young person.

10.3.23 There should be a designated consultant with responsibility for transfers who provides and updates a written policy for emergency transfers of intubated children.

STANDARD

1.5.1.0 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

EVIDENCE REQUIRED

Confirmation of the system and how it is used should be given by any member of staff when asked. The review team may request a demonstration of the system at the review visit. In remote areas, other robust call systems may be appropriate. Generally an appropriate system will have both audible and visual elements

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.2.2 There should be provision of an emergency call system, including an audible alarm. A visible indication of where the emergency is should also be considered.

4.2.6 An emergency audible and visible call system should be in place, checked regularly to maintain functionality and understood by all staff.

STANDARD

1.6.0.1 There are policies for the management of immediate and delayed complications of neuraxial blockade

EVIDENCE REQUIRED

Written policies should be provided

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

9.5.6 Units should have local guidelines on the recognition and management of complications of neuraxial analgesia that include training on the recognition of complications and access to appropriate imaging facilities when neurological injury is suspected.

11.6.8 Monitoring requirements should be standardised for advanced analgesic techniques. This includes safety checks for rare serious complications of neuraxial and regional analgesia.

11.6.12 Staff caring for patients with neuraxial or regional analgesic techniques should be aware of the potential complications and able to assess for their occurrence. In particular, the potential for neurological injury and local anaesthetic toxicity should be noted.

STANDARD

1.7.0.2 There is a trained resuscitation team for adults, including pregnant women, children and neonates as appropriate

EVIDENCE REQUIRED

Verbal confirmation should be given. Evidence of appropriate mandatory training for age range of patients

PRIORITY

1

CQC KLoEs

Safe Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

9.1.30 An adult resuscitation team trained in resuscitation of the pregnant patient should be immediately available.

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

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

1.7.0.3 The trust/board Sedation Committee has anaesthetic representation.

EVIDENCE REQUIRED

List of Sedation Committee members

PRIORITY

2

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

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

STANDARD

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. In areas that treat children, this must include equipment specifically designed for children

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

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

3.2.29 The recommended standards of monitoring, instrumental or otherwise, should be met for every patient.

3.2.30 The following equipment should be available:

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

3.2.31 Some patients may require additional monitoring equipment. The following should be considered:

- invasive pressure monitoring
- cardiac output monitors
- depth of anaesthesia monitoring.

3.2.32 All monitors should be fitted with audible alarms.

5.2.39 Routine monitoring for anaesthesia according to AAGBI standards of monitoring should be available for all areas where anaesthesia is undertaken. Departments should follow national clinical guidelines for the use of monitoring equipment, or local guidelines when national guidelines are not available.

6.2.18 Full resuscitation equipment and drugs should be provided as outlined by the Resuscitation Council and hospital policy

7.2.3 Environments in which patients receive anaesthesia or sedation should have full facilities for resuscitation available, including a defibrillator, suction, oxygen, airway devices and a means of providing ventilation

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

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

7.2.27 Patients should be appropriately monitored during their recovery

7.3.19 Interventional vascular radiology may involve treating unstable patients with severe haemorrhage. Such patients may include those with significant gastrointestinal bleeding or patients with post-partum haemorrhage. Equipment to deal with these patients should be immediately available. This includes that necessary to introduce and monitor a variety of intravascular catheters, rapid infusion devices, blood- and fluid-warming devices and patient-warming devices.

MRI: 7.3.22 Remote monitoring of the patient with slave screens should be available to allow the anaesthetic team to monitor the patient from outside of the magnetic field.

ECT

7.3.32 Equipment for managing the airway, including the difficult airway, emergency drugs, resuscitation equipment and defibrillator should all be available.

7.3.33 Standards for monitoring and recovery are stipulated by the AAGBI and should be adhered to for all ECT cases

9.2.16 Resuscitation equipment including an automated defibrillator should be available on the delivery suite and should be checked regularly.

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

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

HELPNOTE

This specifically includes all situations where a patient will be intubated, including the ward, in accordance with never event 16: 'Undetected oesophageal intubation'.

If your department does not treat children, please refer to Note 3.

STANDARD

2.1.1.3 Facilities for external cardiac pacing are available

EVIDENCE REQUIRED

Defibrillators should be checked to ensure they include pacing mode

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.2.18 The following ancillary anaesthetic equipment is required for the safe delivery of anaesthesia, and should also be available at all sites where patients are anaesthetised:

- oxygen supply
- self-inflating bag
- facemasks
- suction
- airways (nasopharyngeal and oropharyngeal)
- laryngoscopes including videolaryngoscopes and fiberoptic scopes
- appropriate range of tracheal tubes and connectors
- intubation aids (bougies, forceps, etc)
- supraglottic airways
- heat-moisture exchange filters
- defibrillators and equipment for external cardiac pacing
- trolley/bed/operating table that can be tilted head-down rapidly
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc)
- ultrasound imaging equipment for vascular access
- equipment for administering a volatile-free anaesthetic, including infusion pumps or volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines.

7.3.34 Precautions prior to embarking on DC cardioversion should include the immediate availability of emergency anaesthetic drugs, resuscitation and external pacing equipment.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.2.23 Equipment for placement and monitoring of local and regional blocks should be available where necessary.

5.2.35 Ultrasound scanning, nerve stimulators and all equipment and drugs necessary for local and regional techniques should be available.

6.2.19 Peripheral nerve blocks, spinal/epidural blocks and intravenous regional anaesthesia often provide excellent conditions for day surgery. Equipment to facilitate these techniques, such as nerve stimulators and ultrasound, should be available.

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

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

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

2.1.1.6 Ultrasound imaging equipment is available to assist with vascular access and regional anaesthesia

EVIDENCE REQUIRED

Verbal confirmation should be given for adults and children

PRIORITY

1

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.2.17 The following ancillary anaesthetic equipment is required for the safe delivery of anaesthesia and should also be available at all sites where patients are anaesthetised:

- oxygen supply
- self-inflating bag
- facemasks
- suction
- airways (nasopharyngeal and oropharyngeal)
- laryngoscopes
- appropriate range of tracheal tubes and connectors
- intubation aids (bougies, forceps, etc.)
- supraglottic airways
- heat-moisture exchange filters
- trolley/bed/operating table that can be tilted head-down rapidly
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc.)
- ultrasound imaging equipment for vascular access
- equipment for administering a volatile free anaesthetic including infusion pumps or volatile free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines.

3.2.23 Equipment for placement and monitoring of local and regional blocks should be available where necessary.

5.2.35 Ultrasound scanning, nerve stimulators and all equipment and drugs necessary for local and regional techniques should be available.

9.2.14 Ultrasound imaging equipment should be available for invasive procedures including central vascular access, transversus abdominis plane (TAP) blocks and the provision of central neuraxial blockade.

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

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

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

2.1.1.7 There is standardised and specialised equipment for the management of difficult airways reliably available within 5 minutes in every area where anaesthesia is given

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

3.2.18 The following ancillary anaesthetic equipment is required for the safe delivery of anaesthesia, and should also be available at all sites where patients are anaesthetised:

- oxygen supply
- self-inflating bag
- facemasks
- suction
- airways (nasopharyngeal and oropharyngeal)
- laryngoscopes including videolaryngoscopes and fibreoptic scopes
- appropriate range of tracheal tubes and connectors
- intubation aids (bougies, forceps, etc)
- supraglottic airways
- heat-moisture exchange filters
- defibrillators and equipment for external cardiac pacing
- trolley/bed/operating table that can be tilted head-down rapidly
- positioning equipment (stirrups for lithotomy, arm boards, head rest for prone positions, bariatric supports etc)
- ultrasound imaging equipment for vascular access
- equipment for administering a volatile-free anaesthetic, including infusion pumps or volatile-free anaesthetic machine and/or activated charcoal filters
- adequate numbers and types of infusion pumps and syringe drivers available for high risk medicines.

3.2.19 There should be at least one readily available portable storage unit with specialised equipment for management of the difficult airway in every theatre suite. In addition, a fiberoptic laryngoscope should also be readily available.

5.2.30 A difficult airway trolley, including the equipment necessary for failed intubation and surgical airway access, should be available in all areas in which tracheal intubation may be required.

7.2.3 Environments in which patients receive anaesthesia or sedation should have full facilities for resuscitation available, including a defibrillator, suction, oxygen, airway devices and a means of providing ventilation.

9.2.10 There should be at least one readily available portable storage unit with specialised equipment for management of the difficult airway in every theatre suite. In addition, a fiberoptic laryngoscope should also be readily available.

HELPNOTE

Ideally there should be a difficult airway trolley available on every floor. There must be a robust process for obtaining assistance in remote sites. If your department does not treat children, please refer to Note 3.

STANDARD

2.1.1.10 Appropriate equipment is available and used for all intra and inter hospital patient transfers

EVIDENCE REQUIRED

Portable ventilators and monitoring should be seen for adults and children. Transfer audit forms should be demonstrable

PRIORITY

1

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

4.2.13 A brief interruption of monitoring during transfer of the patient from theatre is only acceptable if the recovery area is immediately adjacent to the operating theatre. Otherwise monitoring should be continued during transfer to the same degree as any other intra- or inter-hospital transfer

5.2.14 All necessary equipment to facilitate safe transport of the patient should be available at all times.

5.2.25 There must be appropriate equipment available for transfer of the patient within the theatre, together with the appropriate staff trained to use it safely.

7.2.1 Access to lifts for easy trolley transfer should be available.

7.3.13 Transfer of patients within the hospital to ICU, radiology or the operating theatre is not without risk and will require the use of a tipping transfer trolley, oxygen cylinders, suction, a transport ventilator, infusion pumps, monitor with adequate battery life and a portable defibrillator if appropriate. Local guidelines along with use of a formal 'Intra Hospital Transfer Form' should be considered to mitigate procedure specific issues.

10.3.24 There should be portable monitors, transfer equipment (including a portable ventilator) and drugs readily available to transfer critically ill children.

HELPNOTE

Use of continuous monitoring (e.g. the transition from theatre to recovery) is a recent addition to the AAGBI's [Recommendations for standards of monitoring during anaesthesia and recovery guidelines](#).

If this is not currently available, there should be a plan for the next cycle of equipment renewal to ensure that this is in place.

If your department does not treat children, please refer to Note 3.

STANDARD

2.1.1.11 There is specialised equipment for the management of postoperative pain

EVIDENCE REQUIRED

An adequate number of PCAs and epidural pumps and the arrangements for their use should be available for the services being provided for adults and children. Staff spoken to should agree that numbers are sufficient. An audit would be an additional way demonstrate the number is sufficient

PRIORITY

1

CQC KLoEs

Effective Caring Responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

9.2.11 Patient controlled analgesia (PCA) equipment should be available for post-operative pain relief and staff operating it should be trained in its use and how to look after women with PCA.

11.2.1 There should be an adequate supply of:

- infusion pumps for neuraxial analgesia (epidural infusion/patient-controlled epidural infusion (PCEA) and potentially intrathecal infusion)
- infusion pumps for use with continuous regional analgesia catheters
- patient-controlled analgesia (PCA) infusion pumps
- infusion pumps for other analgesic drugs, e.g. ketamine, lidocaine.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.3 Environments in which patients receive anaesthesia or sedation should have full facilities for resuscitation available, including a defibrillator, suction, oxygen, airway devices and a means of providing ventilation.

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

7.2.12 Where piped oxygen is available, back-up cylinders should always be available and appropriately stored.

STANDARD

2.1.2.2 There is a planned maintenance and replacement programme for all anaesthetic equipment as required

EVIDENCE REQUIRED

The age of the oldest equipment should be given and written evidence of the replacement programme should be provided

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.2.28 There should be a planned maintenance and replacement programme for all anaesthetic equipment.

11.2.3 Rolling equipment replacement and maintenance of equipment should be provided.

HELPNOTE

Use of continuous monitoring (e.g. the transition from theatre to recovery) is a recent addition to the AAGBI's [Recommendations for standards of monitoring during anaesthesia and recovery guidelines](#).

If this is not currently available, there should be a plan for the next cycle of equipment renewal to ensure that this is in place.

STANDARD

2.1.2.3 No anaesthetic machine is able to supply a hypoxic gas mixture

EVIDENCE REQUIRED

Equipment, especially in remote locations including A&E, should be checked to ensure this

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.2.18 Anaesthetic machines should never be able to supply a hypoxic gas mixture.

STANDARD

2.2.1.3 In every site where anaesthesia is given emergency drugs including intralipid, sugammadex and dantrolene are readily available and in-date supply is maintained

EVIDENCE REQUIRED

Drugs should be seen

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.18 Wherever anaesthesia or sedation is undertaken, a full range of emergency drugs including specific reversal agents such as naloxone, sugammadex and flumazenil should be made available.

7.2.19 In remote locations where anaesthesia is undertaken, drugs to treat rare situations, such as dantrolene for malignant hyperthermia, or intralipid for local anaesthetic toxicity should be immediately available and located in a designated area.

7.2.21 Robust systems should be in place to ensure reliable medicines management, including storage facilities, stock review, supply, expiry checks, and access to appropriately trained pharmacy staff to manage any drug shortages

9.2.29 Emergency medicines for rare but life-threatening anaesthetic emergencies, in particular Intralipid, sugammadex and dantrolene, should be kept on the delivery suite and their location should be clearly identified. There should be a clear local agreement on the responsibility for maintenance of these emergency medicines, ie regular checks of stock levels, integrity, expiry dates.

STANDARD

2.2.1.4 In every site where sedation is given emergency drugs including naloxone and flumazenil are available and in-date supply is maintained

EVIDENCE REQUIRED

Drugs should be seen in sites where sedation procedures are undertaken by an anaesthetist

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

7.2.18 Wherever anaesthesia or sedation is undertaken, a full range of emergency drugs including specific reversal agents such as naloxone, sugammadex and flumazenil should be made available.

7.2.21 Robust systems should be in place to ensure reliable medicines management, including storage facilities, stock review, supply, expiry checks, and access to appropriately trained pharmacy staff to manage any drug shortages.

STANDARD

2.2.3.1 Blood storage facilities are immediately available to emergency theatres (including obstetrics) and contain O rhesus negative blood

EVIDENCE REQUIRED

Facilities should be seen

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

5.2.4 Appropriate blood storage facilities should be in close proximity to the emergency operating theatre and clearly identifiable. Satellite storage facilities or a clear process for preservation of the cold chain should be in place, to enable resuscitation at additional sites such as interventional radiology.

9.2.20 O-negative blood should be immediately available, ideally stored on the delivery suite.

STANDARD

2.2.3.2 Equipment for fluid and blood warming and where appropriate rapid infusion is available

EVIDENCE REQUIRED

Equipment should be seen for adults and children

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.2.21 A fluid warmer allowing the warmed transfusion of blood products and intravenous fluids should be available.

3.2.22 A rapid infusion device should be available for the management of major haemorrhage.

7.2.26 Appropriate equipment should be available to minimise heat loss by the patient and to provide active warming.

7.3.19 Interventional vascular radiology may involve treating unstable patients with severe haemorrhage. Such patients may include those with significant gastrointestinal bleeding or patients with post-partum haemorrhage. Equipment to deal with these patients should be immediately available. This includes that necessary to introduce and monitor a variety of intravascular catheters, rapid infusion devices, blood- and fluid-warming devices and patient-warming devices.

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

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

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

2.2.3.3 A cell salvage machine and trained staff are available for appropriate patients

EVIDENCE REQUIRED

Equipment should be seen with evidence of ongoing training appropriate to case-mix

PRIORITY

1

CQC KLoEs

Effective Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

5.2.34 Availability of a cell salvage system should be considered for procedures associated with a risk of blood loss exceeding 1.5 litres.

9.2.9 Cell salvage may be considered for women who refuse blood products or where massive obstetric haemorrhage (MOH) is anticipated. Women should be informed of the risks and benefits of its use and staff who operate this equipment should receive training in how to operate it, and use it frequently to maintain their skills

HELPNOTE

Hospitals that do not treat 'appropriate patients' should choose the 'not applicable' option. The site would need to justify to the reviewers who visit why the standard is not applicable to their service. If patients who require this machine are seen rarely, and only in planned surgery, an SLA with an appropriate provider to hire the machine and staff required on demand is a fair alternative to purchase.

STANDARD

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

EVIDENCE REQUIRED

Separate areas should be seen

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.2.37 All local anaesthetic solutions should be stored separately from intravenous infusion solutions, to reduce the risk of accidental intravenous administration of such drugs

9.2.28 Local anaesthetic solutions intended for epidural infusion should be stored separately from intravenous infusion solutions, to minimise the risk of accidental intravenous administration of such drugs.

11.2.7 There should be a store of these drugs available to all clinical areas at all times, potentially stored within a PACU.

HELPNOTE

Any part of the hospital where local anaesthetic agents are kept for use by anaesthetic staff these must be 'stored separately' from other drugs and intravenous fluids - at the least this would be behind different doors which in practice means different cupboards. A locked box may be permitted as an interim measure.

STANDARD

2.3.1.1 All records for anaesthesia and sedation contain the relevant portion of the recommended anaesthetic data set and are kept as a permanent document in the patient's record

EVIDENCE REQUIRED

Anaesthetic records and case notes should be seen

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.5.6 All anaesthetic records should contain the relevant portion of the recommended anaesthetic data set for every anaesthetic and be kept as a permanent document in the patient's medical record.

STANDARD

2.3.1.2 An appropriate electronic anaesthetic record system capable of providing a hard copy is in use

EVIDENCE REQUIRED

A hard copy print out

PRIORITY

3

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

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

STANDARD

2.4.1.2 Appropriate office facilities are provided for all aspects of the anaesthesia service

EVIDENCE REQUIRED

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 to specialist reference material and local multidisciplinary evidence-based guidelines and policies.

PRIORITY

2

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

9.2.40 An anaesthetic office, within five minutes from the delivery suite, should be available to the duty anaesthetic team. The room should have a computer with intra/internet access for access to specialist reference material and local multidisciplinary evidence-based guidelines and policies. The office space, facilities and furniture should comply with the standards recommended by the AAGBI guidelines. This office could also be used to allow teaching, assessment and appraisal.

11.2.9 There should be adequate office space and IT support for the APS.

HELPNOTE

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.

STANDARD

2.4.2.1 Appropriate facilities for rest are available for anaesthetic staff working at night, as described in the new contract

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe and effective care

HIS Domains

Policies, planning and governance

GPAS REFERENCES

3.2.8 Appropriate facilities for rest breaks should be provided according to defined norms.

9.2.43 All hospitals should ensure the availability of areas that allow those doctors working night shifts to take rest breaks essential for the reduction of fatigue and improve safety. These areas should not be used by more than one person at a time and allow the doctor to fully recline.

9.2.44 Standards of accommodation for doctors in training should be adhered to. Where a consultant is required to be resident, on-call accommodation should be provided.

HELPNOTE

The RCoA and AAGBI have produced an [educational resource pack](#) which includes standards for rest facilities that departments should use to inform this standard.

STANDARD

2.4.2.2 Appropriate facilities for refreshments are available for on-call/on-duty staff

EVIDENCE REQUIRED

Verbal confirmation and viewing area where staff can make and drink tea/coffee

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Impact on staff; Policies, planning and governance; Workforce management and support

GPAS REFERENCES

9.2.45 Hotel services should provide suitable on-call facilities including housekeeping for resident and non-resident anaesthetic staff. Refreshments should be available throughout the 24-hour period.

STANDARD

2.5.1.1 There are sufficient administrative staff to support all aspects of the anaesthesia service

EVIDENCE REQUIRED

Majority of permanent staff should report that they are satisfied

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Impact on staff; Workforce management and support

GPAS REFERENCES

6.1.10 The day surgery unit should have appropriate administrative support.

6.5.1 Each DSU should have a clinical director or specialty lead. This will often, but not always, be an anaesthetist with some management experience. The role of the clinical director is to champion the cause of day surgery and ensure that best practice is followed. This role may involve the development of local policies, guidelines and clinical governance and should be recognised by adequate programmed activity allocation and provided with appropriate administrative support.

11.1.13 There should be adequate administration and clerical staff to support the APS in the roles listed above.

HELPNOTE

Answers to the following types of questions could reflect the level of staff satisfaction:

- is the rota produced in timely way?
- are queries and alterations made appropriately?
- is the general administrative support function adequate?

STANDARD

2.5.2.2 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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Impact on staff; Workforce management and support

GPAS REFERENCES

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

STANDARD

2.6.2.1 There are anaesthetic clinical leads with responsibility in the following areas: pre-operative assessment, emergency anaesthesia, remote sites, paediatrics, obstetrics, day surgery, acute pain management, perioperative medicine, resuscitation, ICM, anaesthetic equipment, governance, simulation/human factors training, ECT (if available), research, airway management, staff welfare and safety and others as appropriate. This list is not exhaustive

EVIDENCE REQUIRED

The names of individuals should be provided

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Impact on staff; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

3.2.25 A named consultant should oversee the provision and management of anaesthetic equipment.

5.1.3 The emergency anaesthesia team should be led by a consultant anaesthetist and include all medical and other healthcare professionals involved in the delivery of anaesthesia for emergency surgery. Part of this role should include liaison with non-anaesthetic departments such as radiology, medicine and Accident and Emergency.

6.1.1 Day surgery should be a consultant-led service (surgical and anaesthetic) with a dedicated clinical lead or clinical director who has programmed activities allocated to the role within their job plan.

7.1.1 A clinical lead for anaesthesia in the non-theatre environment (ANTE) should be appointed with adequate time provided within their job plan. They should be involved in developing the service, training and revalidation of staff, and ensuring that safety standards and audit are appropriate

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

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

9.1.11 Every obstetric unit should have a designated lead anaesthetist, who should be a consultant with specific programmed activities allocated for this role.

10.5.6 In all centres admitting children, one consultant should be appointed as lead consultant for paediatric anaesthesia. Typically, they might undertake at least one paediatric list each week and will be responsible for co-ordinating and overseeing anaesthetic services for children, with particular reference to teaching and training, audit, equipment, guidelines, pain management, sedation and resuscitation.

11.1.1 Acute pain services should be multidisciplinary teams led by appropriately trained consultant or SAS anaesthetists. The minimum training requirement for new appointments to APS lead roles is Royal College of Anaesthetists higher pain training. Advanced pain training, or its equivalent, should be considered optimal. Consultants or other leads already in post need to demonstrate an ongoing significant interest in acute pain management by involvement in CME and job planning.

16.1.1 Each unit should have a designated consultant anaesthetist who is the lead for anaesthesia services for trauma and a designated lead for anaesthesia services for orthopaedic surgery. This should be recognised in their job plan and they should be involved in multidisciplinary service planning and governance within the unit

Recommended leads from specialist societies:

[Airway lead](#)

[ICM lead – GPICs 1.1.4](#)

[POM leads](#)

HELPNOTE

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.

STANDARD

2.6.2.2 There is documented and verbal evidence that the appropriate recruitment methods are routinely implemented for consultant and SAS anaesthetic staff

EVIDENCE REQUIRED

Documentation should be provided indicating the trust/board/hospital follows the RCoA's Advisory Appointments Committee (AAC) process

PRIORITY

2

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

11.1.1 Acute pain services should be multidisciplinary teams led by appropriately trained consultant or SAS anaesthetists. The minimum training requirement for new appointments to APS lead roles is Royal College of Anaesthetists higher pain training. Advanced pain training, or its equivalent, should be considered optimal. Consultants or other leads already in post need to demonstrate an ongoing significant interest in acute pain management by involvement in CME and job planning.

STANDARD

2.6.3.1 Staff Grade, Associate Specialist and Specialty (SAS) Doctors and Trust grade anaesthetists have specific training and demonstrated competence in relevant areas before working with distant supervision

EVIDENCE REQUIRED

Specific groups should be interviewed about their practices and training

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

3.4.7 Departments of anaesthesia should ensure that a named supervisory consultant is available to all non-consultant anaesthetists, except those SAS anaesthetists that local governance arrangements have agreed in advance are able to work in those circumstances without consultant supervision, based on the training and experience of the individual doctor and the range and scope of their clinical practice. Where an anaesthetist is supervised by a consultant, they should be aware of their supervisor's identity, location and how to contact them.

6.1.2 High quality anaesthesia is pivotal to achieving successful outcomes following day surgery. The majority of anaesthesia for day surgery should be delivered by consultant anaesthetists. Staff or associate specialist (SAS) grade doctors and experienced trainee anaesthetists may also provide anaesthesia for day surgery. However, these doctors should be suitably experienced and skilled in techniques appropriate to the practice of day surgery, and have undertaken appropriate training in the provision of anaesthesia for day surgery

9.4.9 Any non-trainee anaesthetist who undertakes anaesthetic duties in the labour ward should have been assessed as competent to perform these duties in accordance with OAA and RCoA guidelines. Such a doctor should work regularly in the labour ward but should also regularly undertake non-obstetric anaesthetic work to ensure maintenance of a broad range of anaesthetic skills.

10.1.3 There should be an identified consultant anaesthetist with overall responsibility for supervision of anaesthetic trainees and, where necessary, anaesthetists who are neither consultants nor trainees.

HELPNOTE

See note 4. The College's guidance on the supervision of SAS and other non-consultant anaesthetists should be followed

STANDARD

2.6.3.2 Staff Grade, Associate Specialist and Specialty (SAS) Doctors and Trust grade anaesthetists have unimpeded access to a nominated consultant for advice and supervision at all times

EVIDENCE REQUIRED

Written policies should be provided and specific groups should be able to relay how they would know who to contact. For example; names are displayed or on the rota

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

3.4.7 Departments of anaesthesia should ensure that a named supervisory consultant is available to all non-consultant anaesthetists, except those SAS anaesthetists that local governance arrangements have agreed in advance are able to work in those circumstances without consultant supervision, based on the training and experience of the individual doctor and the range and scope of their clinical practice. Where an anaesthetist is supervised by a consultant, they should be aware of their supervisor's identity, location and how to contact them.

5.4.11 All patients undergoing anaesthesia should be under the care of a consultant anaesthetist, whose name is recorded as part of the anaesthetic record. A non-consultant non-trainee anaesthetist, e.g. Staff Grade, Associate Specialist and Specialty Doctors, could be the named anaesthetist on the anaesthetic record if local governance arrangements have agreed in advance that, based on the training and experience of the individual doctor and the range and scope of their clinical practice, the non-consultant non-trainee anaesthetist can take responsibility for patients themselves in those circumstances, without consultant supervision.

9.1.5 The duty anaesthetist should have a clear line of communication to the supervising consultant at all times.

10.1.3 There should be an identified consultant anaesthetist with overall responsibility for supervision of anaesthetic trainees and, where necessary, anaesthetists who are neither consultants nor trainees.

10.1.4 There should be a locally agreed policy on the level of consultant supervision required based on the age, complexity and comorbidities of the patient.

HELPNOTE

See note 4. The College's guidance on the supervision of SAS and other non-consultant anaesthetists should be followed

STANDARD

2.6.4.1 Trainees have specific training and demonstrated competence in relevant areas before working with distant supervision

EVIDENCE REQUIRED

Specific groups should be interviewed about their practices and training

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

6.1.2 High quality anaesthesia is pivotal to achieving successful outcomes following day surgery. The majority of anaesthesia for day surgery should be delivered by consultant anaesthetists. Staff or associate specialist (SAS) grade doctors and experienced trainee anaesthetists may also provide anaesthesia for day surgery. However, these doctors should be suitably experienced and skilled in techniques appropriate to the practice of day surgery, and have undertaken appropriate training in the provision of anaesthesia for day surgery

7.4.5 Sedation techniques are frequently used in the non-theatre environment along with anaesthetic techniques. Sedation is regarded as a core competency for anaesthetic practice and training/exposure should be provided to current standards at basic, intermediate and higher levels.

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

10.1.3 There should be an identified consultant anaesthetist with overall responsibility for supervision of anaesthetic trainees and, where necessary, anaesthetists who are neither consultants nor trainees.

10.1.4 There should be a locally agreed policy on the level of consultant supervision required based on the age, complexity and comorbidities of the patient.

STANDARD

2.6.4.2 Trainees have unimpeded access to a nominated consultant for advice and supervision at all times

EVIDENCE REQUIRED

Written policies should be provided and specific groups should be able to relay how they would know who to contact. For example; names are displayed or on the rota

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

3.4.5 All trainees must be appropriately clinically supervised at all times.

5.4.10 All trainees must be appropriately clinically supervised at all times.

6.1.2 High quality anaesthesia is pivotal to achieving successful outcomes following day surgery. The majority of anaesthesia for day surgery should be delivered by consultant anaesthetists. Staff or associate specialist (SAS) grade doctors and experienced trainee anaesthetists may also provide anaesthesia for day surgery. However, these doctors should be suitably experienced and skilled in techniques appropriate to the practice of day surgery and have undertaken appropriate training in the provision of anaesthesia for day surgery.

9.1.5 The duty anaesthetist should have a clear line of communication to the supervising consultant at all times.

9.1.20 Consultant support should be available and the response time should not be more than half an hour away from the delivery suite, maternity operating theatre or Accident and Emergency Department.

10.1.3 There should be an identified consultant anaesthetist with overall responsibility for supervision of anaesthetic trainees and, where necessary, anaesthetists who are neither consultants nor trainees.

10.1.4 There should be a locally agreed policy on the level of consultant supervision required based on the age, complexity and comorbidities of the patient.

STANDARD

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 immediately available to the delivery suite

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

9.1.2 There should be a duty anaesthetist immediately available for the obstetric unit 24 hours per day. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention; the role should not include undertaking elective work during the duty period.

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

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

STANDARD

2.6.5.2 A separate anaesthetist is allocated for elective obstetric work

EVIDENCE REQUIRED

A copy of the rota should be provided

PRIORITY

1

CQC KLoEs

Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

9.1.2 There should be a duty anaesthetist immediately available for the obstetric unit 24 hours per day. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention; the role should not include undertaking elective work during the duty period.

9.1.15 As a basic minimum for any obstetric unit, a consultant anaesthetist should be allocated to ensure consultant cover for the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed). This is to provide urgent and emergency care, not to undertake elective work.

9.1.17 Additional consultant programmed activities should be allocated for:

- Elective Caesarean deliveries
- Antenatal anaesthetic clinics (or to review referrals if no formal clinic is in place)

9.1.19 There should be a named consultant anaesthetist responsible for every elective Caesarean delivery operating list. This consultant should be immediately available. A suitably trained and experienced Staff Grade, Associate Specialist and Specialty (SAS) doctor could be the named anaesthetist on the anaesthetic record if local governance arrangements have agreed in advance that the individual doctor can take responsibility for patients in the particular circumstances, without consultant supervision.

9.5.22 Units with high Caesarean delivery rates should have elective Caesarean delivery lists to minimise disruption due to emergency work. Any elective Caesarean delivery list should have dedicated obstetric, anaesthetic and theatre staff.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

9.1.2 There should be a duty anaesthetist immediately available for the obstetric unit 24 hours per day. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention; the role should not include undertaking elective work during the duty period.

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

STANDARD

2.6.5.4 Obstetric units have, as a minimum, consultant cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)

EVIDENCE REQUIRED

A copy of the rota should be provided

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

9.1.15 As a basic minimum for any obstetric unit, a consultant anaesthetist should be allocated to ensure consultant cover for the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed). This is to provide urgent and emergency care, not to undertake elective work.

9.1.16 In busier units, increased levels of consultant cover should be considered, reflecting the level of consultant obstetrician staffing in the unit. This may involve extending the working day to include consultant presence into the evening session and/or increasing consultant numbers.

STANDARD

2.6.5.5 There is a named consultant anaesthetist or intensivist (dependent on location) responsible for all level two maternal critical care patients

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Effective

HIW Domains

Safe and effective care

HIS Domains

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

GPAS REFERENCES

9.3.6 There should be a named consultant anaesthetist and obstetrician responsible for all women requiring a higher level of care 24 hours a day.

HELPNOTE

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

STANDARD

2.6.5.6 The duty anaesthetist for obstetrics should participate in delivery suite ward rounds

EVIDENCE REQUIRED

A copy of the rota to demonstrate duty consultant availability at a time when delivery suite ward rounds are taking place

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery; Quality improvement-focussed leadership

GPAS REFERENCES

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

STANDARD

3.1.2.1 The time allocated for preoperative assessment is adequate to allow the patient to discuss and understand the information they are given

EVIDENCE REQUIRED

Verbal confirmation should be given that adequate time to allow understanding is allocated and clinic lists should provide additional evidence of this. An audit of patient satisfaction will provide further evidence

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.9.2 Information should be provided with enough time for the patient to consider and reflect on before anaesthesia and surgery take place.

5.9.3 Organisations should have clear guidance, policies and training for all staff taking consent, which is in accordance with GMC guidance. Anaesthetists must work in partnership with patients and other healthcare professionals, to ensure good care guided by the principles listed next.

- Healthcare professionals should assume patients have capacity to make decisions until assessed and proven otherwise. Clinicians must support patient autonomy in reaching decisions and should enable patients to reach decisions supported by medical advice and, where feasible, include their chosen supporter(s) or relatives
- Every effort should be made to allocate adequate time for pre-operative assessment, to allow patients to consider and reflect upon the information they are given, and adequate facility for privacy and confidentiality to be maintained, within the time constraints of delivering urgent or immediate care. Departments should include these considerations when assessing staffing requirements and development of facilities.
- Reasonable care should be taken to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternatives or varied treatments.
- The information shared must be in accordance with patients' wishes, in proportion to the nature of their condition, the complexity of the proposed investigation or treatment, and the seriousness of any potential side effects, complications or other risks.
- A competent adult patient has the right to refuse treatment and their refusal of treatment must ultimately be respected, even if it will result in their death or perceived harm.
- The scope of the authority that has been given by an adult patient should not be exceeded, except in an emergency. In an emergency clinical situation, where it is not possible to find out a patient's wishes, a patient must be treated without their consent, provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition. The treatment provided should be the least restrictive of the patient's future choices.

- Doctors are under no legal or ethical obligation to agree to a patient's request for treatment if they consider the treatment is not in the patient's best interests. In an emergency, the doctor must make decisions that they view to be in the best interests of the patient, using whatever information is available.

7.9.4 Information regarding planned procedures outside of the operating theatre and the requirement for sedation or anaesthesia should be given to the patient in advance of their admission. Details on fasting times and medications to continue or omit should be included. The patient needs to be aware that they require a competent adult to escort them home after receiving sedation

10.2.7 Children undergoing anaesthesia should be offered a pre-assessment service prior to the day of their procedure.

10.9.2 Information provided pre-operatively should include:

- anaesthetic technique, analgesia plan, including regional blockade, any additional procedures, e.g. invasive monitoring, blood transfusion, and planned post-operative care in a critical care environment.
- a statement that the ultimate decision-making will take place on the day of surgery, according to the needs and safety of the child and as judged by the attending anaesthetist. Planned resources, e.g. critical care beds, could be unexpectedly unavailable on the day and this may also be part of the decision-making.
- a description of generally common side effects, e.g. sore throat and post-operative nausea and vomiting and significant risks, e.g. allergic reactions. Also, any additional risks particular to the individual child and their co-morbidities.
- concerns raised in discussion with a child or young person or parents and carers, e.g. fear of needles, fear of facemasks, loss of control (which is common in teenagers), emergence delirium, awareness, post-operative pain, PONV, and the risk to the developing brain of anaesthesia in infants
- pre-operative fasting instruction should be given verbally and in writing. The timing should be appropriate to the proposed theatre list start time
- information on the use of unlicensed medicines and/ or licensed medicines for off-label indication.

STANDARD

3.1.2.2 Patients and their advocates understand the choices available and the associated risks and side effects of their anaesthetic procedure, including pain relief

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.9.1 Patients should be fully informed about the planned procedure and participate in a shared decision-making process. Consultation skills for shared-decision making should be used to prepare patients for anaesthesia and surgery. The patient should determine the information provided to obtain their consent for treatment. Patients should be informed of the increasing number of decision aids available at NHS Direct to help them with their choices

2.9.4 All patients undergoing elective procedures should be provided with easily understood information materials covering their operation, anaesthesia and post-operative pain relief, before admission to hospital. Provision of this information should be documented in the patient's notes.

2.9.5 The anaesthetist should explain what the patient will experience before and after anaesthesia, and include any choices of anaesthetic technique and details of post-operative management.

2.9.6 The anaesthetist should invite and answer questions from the patient or, if appropriate, the patient's relatives.

2.9.12 A recent judgement of the UK Supreme Court in the case of Montgomery v Lanarkshire Health Board clarifies some aspects of consent to medical treatment. Consent is a process and it should be viewed as an opportunity for a dialogue and not a one-way flow of information. The doctor must find out which risks are relevant to each 'particular patient' and tailor the consent process accordingly. The doctor must not, by fear of no-disclosure, 'bombard the patient' with technical information. This is more likely to promote confusion. The GMC states: 'The test of materiality is whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it.'

2.9.13 The patient must be made aware of alternative treatment options, or the option for no treatment at all. It is acceptable to recommend one of the alternatives but, as the GMC states: 'The doctor may recommend a particular option which they believe to be best for the patient, but may not put any pressure onto the patient to accept their advice.'

10.2.7 Children undergoing anaesthesia should be offered a pre-assessment service prior to the day of their procedure.

10.9.1 Families should be provided with written or web-based resources that provide information specific to anaesthesia before the planned surgery/procedure, and contact details for the pre-assessment team should be provided in case they have further questions or need to speak directly with their anaesthetist. The 'Information for teenagers, children and parents' available from the [RCoA website](#) and the [Association of Paediatric Anaesthetists of Great Britain and Ireland \(APAGBI\)](#) provides examples of leaflets and other patient, parent and carer information resources.

10.9.2 Information provided pre-operatively should include:

- anaesthetic technique, analgesia plan, including regional blockade, any additional procedures, e.g. invasive monitoring, blood transfusion, and planned post-operative care in a critical care environment.
- a statement that the ultimate decision-making will take place on the day of surgery, according to the needs and safety of the child and as judged by the attending anaesthetist. Planned resources, e.g. critical care beds, could be unexpectedly unavailable on the day and this may also be part of the decision-making.
- a description of generally common side effects, e.g. sore throat and post-operative nausea and vomiting and significant risks, e.g. allergic reactions. Also, any additional risks particular to the individual child and their co-morbidities.
- concerns raised in discussion with a child or young person or parents and carers, e.g. fear of needles, fear of facemasks, loss of control (which is common in teenagers), emergence delirium, awareness, post-operative pain, PONV, and the risk to the developing brain of anaesthesia in infants
- pre-operative fasting instruction should be given verbally and in writing. The timing should be appropriate to the proposed theatre list start time
- information on the use of unlicensed medicines and/ or licensed medicines for off-label indication.

11.7.4 Patient education regarding expectation of pain and analgesia after surgery should be given to all patients in the pre-operative period.

HELPNOTE

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

STANDARD

3.2.2.1.b Adequate rooms are available for multiple patients to have private conversations at the same time, according to needs

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

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

GPAS REFERENCES

6.2.6 Facilities for privacy and confidentiality during pre-operative discussion and examination should be provided. Pre-operative discussions with patients in crowded waiting rooms should be avoided

6.2.7 Adequate time and facilities should be provided within the DSU to enable the multidisciplinary clinical team to undertake all aspects of the admission process; including clinical assessment, further discussion about the procedure and delivery of information

HELPNOTE

There should be a space available within every area where patients are pre-assessed that is private and reasonably soundproof (ie 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.

STANDARD

3.2.2.2 There is support for patients with individual or special requirements including children

EVIDENCE REQUIRED

Staff should report that they are satisfied with the support for adults and children with particular requirements, for example learning disabilities. An audit of patient satisfaction will provide further evidence for this standard

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.3.31 In patients with learning disabilities or special needs, there should be close co-operation with other specialists. A learning disability liaison nurse could be available to support patients and carers while attending the hospital for either out-patients, day surgery or as in-patients. If patients lack capacity and are un-befriended then the involvement of an Independent Mental Capacity Advocate (IMCA) should be sought.

6.9.1 Patients will be provided with information specific to their condition/indication for surgery in addition to information about day surgery. Clear and concise information given to patients at the right time and in the correct format is essential to facilitate good day surgery practice. Much of this information may be given to patients at pre-operative assessment. Verbal information should always be reinforced with printed material. Alternative means of communication with patients, including the internet, email and text messaging, should be considered.

6.9.2 Diagrammatic representation of the patient journey through day surgery may help explain the process.

6.9.3 Information should be arranged in such a way that it is comprehensive and comprehensible, and should be available in a format suitable for the visually impaired and those with other difficulties understanding and considering the information. It may be necessary to provide information leaflets in a number of different languages to accommodate the needs of the local population.

10.2.8 Children undergoing anaesthesia, and their families should be offered input from play specialists to help prepare the child for anaesthesia

10.9.5 Children should receive information before admission that is appropriate to their age and level of understanding. Information can be provided at face-to-face meetings by nurses and play therapists and enhanced with booklets, web links or videos.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Safe Caring Responsive

HIW Domains

Quality of patient experience; Safe and effective care

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.1.3 Anaesthetists need time to cover the following essential points in the more immediate pre-operative phase. The anaesthetic room is not usually an appropriate place for this except in an emergency.

Assessment

- Interview and medical case notes review to establish current diagnoses, current medicines and past medical and anaesthetic history.
- Examination, including airway assessment.
- Review of results of relevant investigations.
- The presence of any risk factors, including methicillin-resistant *Staphylococcus aureus* (MRSA) screening and risk of venous thromboembolism.
- The need for further tests to give the patient more information about their individual risk. This information also needs to be disseminated to the anaesthetist involved in the case as well as the extended perioperative team.

Preparation

- The patient's understanding of and consent to the procedure and a share in the decision- making process.
- An explanation of the options for anaesthesia, an opportunity to ask questions, and agreement to the anaesthetic technique proposed.
- Pre-operative fasting, the proposed pain relief method, expected sequelae, and possible major risks (where appropriate).
- The prescription and ordering of any pre-operative medication including carbohydrate drinks.
- A plan for the perioperative management of anticoagulant drugs, diabetic drugs and other current medications.
- A process of medicines reconciliation by a pharmacist or pharmacy technician should be in place pre-operatively.
- The documentation of details of any discussion in the anaesthetic record.

- Information that may be reinforced by attendance at communal sessions such as 'joint school' for hip and knee surgery at which there may be input from an anaesthetist, orthopaedic surgeon, occupational therapist, physiotherapist, acute pain specialists, pharmacists and ward nurse.

2.9.5 The anaesthetist should explain what the patient will experience before and after anaesthesia, and include any choices of anaesthetic technique and details of post-operative management.

4.9.3 Patient information regarding post-operative and post-discharge care, including contact details and protocols if complications arise, should be provided.

6.5.22 Patients may be discharged home with residual sensory or motor effects after nerve blocks or regional anaesthesia. The duration of the effects should be explained and the patient should receive written instructions as to their conduct until normal sensation returns.

6.5.23 Postoperative short term memory loss may prevent verbal information being assimilated by the patient. If postoperative analgesia has been provided, clear, written instructions on how and when to take medication should be provided. Other important information should also be provided in writing.

6.5.24 A 24-hour telephone number should be supplied so that every patient knows whom to contact in case of postoperative complications. This should ideally be to an acute surgical area and should not be an answer phone.

6.5.29 All patients should receive a copy of their discharge summary in case emergency treatment is needed overnight.

6.9.5 At a minimum, information provided to patients should include:

- the date and time of admission to the unit,
- location of the unit, travel and parking instructions including information regarding parking costs
- details of the surgery to be undertaken, and any relevant pre-operative preparations required of the patient
- information on the anaesthetic to be provided, including clear instruction for pre-operative fasting, and the way in which patients will manage their medication
- requirement to arrange an escort home and a postoperative carer
- postoperative discharge information, including details of follow-up appointments, management of drugs, pain relief and dressings, and clear instructions on whom to contact in the event of postoperative problems.

10.3.31 Parents, carers, children and young people should be provided with good-quality pre-operative information, including information on fasting and on what to do if the child becomes unwell before the operation. Post-operative analgesia requirements should be anticipated, and discussed at the pre-assessment visit.

10.3.34 Discharge advice should be detailed and carefully worded to facilitate on-going care by parents or carers.

HELPNOTE

The phone number should ideally be an acute surgical area and should not be an answer phone. A number for A+E/111/GP out of hours would not be considered acceptable.

STANDARD

3.3.2.2 Patients and/or advocates have access to adequate interpretation services according to their needs or protected characteristics

EVIDENCE REQUIRED

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 and patient feedback should be available to highlight satisfaction

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.3.2 The child should be helped to understand events that are happening or will happen, with the use of age-specific and developmentally appropriate explanation and materials. There are specific issues around consent for children that need to be understood, including the particular requirements for children who are not under the care of their parents.

2.3.33 Translators or interpreters should be available for patients who do not speak or understand English and those who use sign language. Written information also needs to be available in different languages.

2.9.3 Information can be provided in a range of formats, including through written leaflets and on the internet. Details of websites that provide reliable, impartial and evidence-based information should be made available to patients where appropriate. Where possible formats should include large print, Braille and audio. Information should conform to the 'Accessible Information' standard set by the Department of Health for those with disabilities.

3.9.2 Patients from non-English speaking groups may need interpreters. Hospitals should have arrangements in place to provide language support, including interpretation and translation (including sign language and Braille). This information should comply with the NHS England 'Accessible information Standard'. Patients with learning and other difficulties may need special assistance and consideration.

4.9.2 Some patients, both adults and children, may need interpreters, parents or other members of their family to be with them. This need is best determined at pre-assessment, so that sensitivities can be taken into account in the operative process.

6.9.3 Information should be arranged in such a way that it is comprehensive and comprehensible and should be available in a format suitable for the visually impaired and those with other difficulties understanding and considering the information. It may be necessary to provide information leaflets in a number of different languages to accommodate the needs of the local population.

9.9.3 Information should be made available to non-English speaking women in their native languages.

9.9.4 Units should consider local demographics, such as the prevalence of particular languages, when designing information or commissioning interpreting services.

9.9.5 Hospitals should ensure that the mother's need for information in other languages should be assessed and recorded during ante natal care so that interpreting services can be planned for.

9.9.6 Interpreting services should be made available for non-English speaking women, with particular attention paid to how quickly such services can be mobilised and their availability out of hours.

9.9.7 Face to face interpreting services should be considered as most suitable, given the practical requirements for women in labour. However, telephone-based services may be able to serve a greater number of languages and be more quickly mobilised, particularly out of hours.

9.9.8 The use of family members to interpret or translate should be avoided unless absolutely necessary or if the woman specifically declines an independent interpreter. It should be a rare occurrence that there is no alternative translation method available.

HELPNOTE

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.

STANDARD

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

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.9.4 All patients undergoing elective procedures should be provided with easily understood information materials covering their operation, anaesthesia and post-operative pain relief, before admission to hospital. Provision of this information should be documented in the patient's notes.

2.9.7 The anaesthetist should document in the patient's case notes that all of the above have been properly performed.

4.9.1 The written and verbal information given to patients before their admission to hospital should explain the purpose and nature of their recovery and the recovery department. *You and your anaesthetic*, published by the Royal College of Anaesthetists and the AAGBI is an example of this. Further details on information to be given pre-operatively can be found in the [GPAS Chapter for pre-operative assessment and preparation](#).

6.9.1 Patients will be provided with information specific to their condition/indication for surgery in addition to information about day surgery. Clear and concise information given to patients at the right time and in the correct format is essential to facilitate good day surgery practice. Much of this information may be given to patients at pre-operative assessment. Verbal information should always be reinforced with printed material. Alternative means of communication with patients, including the internet, email and text messaging, should be considered.

6.9.2 Diagrammatic representation of the patient journey through day surgery may help explain the process.

10.2.7 Children undergoing anaesthesia should be offered a pre-assessment service prior to the day of their procedure.

10.9.1 Families should be provided with written or web-based resources that provide information specific to anaesthesia before the planned surgery/procedure, and contact details for the pre-assessment team should be provided in case they have further questions or need to speak directly with

their anaesthetist. The 'Information for teenagers, children and parents' available from the [RCoA website](#) and the [Association of Paediatric Anaesthetists of Great Britain and Ireland \(APAGBI\)](#) provides examples of leaflets and other patient, parent and carer information resources

STANDARD

3.3.3.2 Patients and/or advocates are informed of what anaesthesia services are available in the obstetrics department, including whether a 24 hours epidural service is available

EVIDENCE REQUIRED

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

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

9.9.1 Information should be made available to purchasers and women in the early ante-natal period about availability of neuraxial analgesia and anaesthetic services in their chosen location for delivery.

STANDARD

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

EVIDENCE REQUIRED

This process, as well as the information given, should be described. Evidence could be audit data of compliance with DNR via the resuscitation group

PRIORITY

1

CQC KLoEs

Effective Caring Responsive

HIW Domains

Quality of patient experience; Safe and effective care

HIS Domains

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

GPAS REFERENCES

5.9.7 Hospitals should have a DNACPR guidance and documentation that complies with national requirements.

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

16.9.6 When it is considered appropriate for an order not to attempt resuscitation in the event of a cardiopulmonary arrest (DNACPR), it should be discussed with competent patients, including those who have expressed their own wish not to be resuscitated. In patients not competent to consent, every attempt should be made to discuss this with the close family (or an independent mental capacity advocate), according to local trust guidelines.

HELPNOTE

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.

STANDARD

3.3.4.1 A system is in place to enable the presence of carers and/or advocates at induction of anaesthesia in children or patients with special requirements

EVIDENCE REQUIRED

A copy of a written policy on the presence of carers in the anaesthetic room and recovery should be provided

PRIORITY

1

CQC KLoEs

Caring Responsive

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

2.3.3 A parent or legal guardian should ideally be with the child up to the point of moving into the operating theatre.

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

10.5.11 All children and young people should be assessed before their operations by an anaesthetist. Parents and carers, as well as the child, should be given the opportunity to ask questions and to be involved in the physical and psychological preparation for surgery.

10.5.12 Parents and carers should be involved throughout the care process. With the agreement of the anaesthetist in charge of the case on the day, they should be able to accompany children to the anaesthetic room, remain present for induction of anaesthesia and be able to gain easy access to the recovery area. In special circumstances, such as some small neonates and in anticipated difficult intubation, this may not be possible.

HELPNOTE

If your department does not treat children, please refer to Note 3.

STANDARD

3.4.0.1 Senior clinicians are involved in breaking bad news and discussions around fertility and end of life decisions

EVIDENCE REQUIRED

The end of life policy should be provided as well as a verbal account of discussions about end of life pathways

PRIORITY

1

CQC KLoEs

Effective Caring Responsive Well-led

HIW Domains

Quality of patient experience; Safe and effective care; Management and leadership

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

5.9.11 A team approach should be considered for breaking bad news and discussions around fertility and end-of-life decisions with patients and relatives.

HELPNOTE

Trainees may be asked about this at the review and this will be triangulated in other forums during the visit.

STANDARD

4.1.0.1 If appropriate resources are not available, the level of clinical activity is limited to ensure a safe provision of care

EVIDENCE REQUIRED

Clearly defined written lines of escalation with management. Verbal confirmation of managerial support should be given and staff should relay anecdotal evidence of times that this has been handled well

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance

GPAS REFERENCES

3.5.1 If appropriate resources are not available, the level of clinical activity should be limited to ensure safe provision of intra-operative care.

HELPNOTE

The final decision should be clinically based and the lines of responsibility within the department and the Trust's management structure should be clear.

STANDARD

4.1.0.2 The whole theatre 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

EVIDENCE REQUIRED

Verbal confirmation from staff. Records of annual audits should be provided

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.5.2 The theatre team should all engage in the use of the WHO surgical safety process, commencing with a team brief, and concluding the list with a team debrief. Debrief should highlight things done well and also identify areas requiring a room for improvement. Teams should consider including the declaration of emergency call procedures specific to the location as part of the team brief.

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

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

7.7.4 Compliance with agreed guidelines should be audited including WHO checklists, team brief, and post anaesthesia discharge checklist

9.5.20 A WHO checklist adapted for maternity should be used in theatre

10.5.8 A World Health Organization checklist should be performed before and during all procedures and investigations under anaesthesia and sedation, if provided by the anaesthetic department. Appropriate checklists should include issues particularly pertinent to the paediatric age group, e.g. flushing of IV cannulae prior to discharge to the recovery/post anaesthesia care unit.

STANDARD

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

EVIDENCE REQUIRED

Written documentation should be provided and display should be seen

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

2.5.36 The whole operating team should agree to any change to a published operating list. This list should be rewritten or reprinted, including a date and time of the update. After a change in the theatre list a further team brief should take place.

3.5.3 Up-to-date, clear and complete information about operating lists should be available to the pre-operative area, theatre and recovery.

3.5.4 The language in all communications relating to the scheduling and listing of procedures should be unambiguous. Laterality should always be written in full, ie 'left' or 'right'.

3.5.5 Any changes to the list should be agreed by all relevant parties, to ensure that the correct operation is performed on the correct side (if relevant) of the correct patient. List amendments should be clear and unambiguous. The list should be rewritten or reprinted, including the date and time of the update.

STANDARD

4.1.0.4 Where relevant there must be adequate doctors available to simultaneously cover commitments in obstetrics, critical care and emergency theatres

EVIDENCE REQUIRED

Verbal confirmation that there is a mechanism to recognise issues should be given. Example of scenario at review visit if requested

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

5.1.5 The level of staffing should be sufficient for the consultant leading the emergency anaesthesia team to be able to provide a continuous emergency anaesthesia service in the theatre complex without interruption. Other service requirements, e.g. remote sites, trauma calls and advice should be anticipated and managed through local arrangements.³¹ Anaesthetists assigned to provide cover for emergency lists should not also be assigned to elective work; neither should anaesthetists be assigned to undertake emergency work while also assigned to Supporting Professional Activities.

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

STANDARD

4.1.0.5 There is a structured handover process between shifts, multidisciplinary where appropriate

EVIDENCE REQUIRED

Rotas should be provided and include the allocation of time and place as well as which staff should be present at handover

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

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

GPAS REFERENCES

3.5.21 Handover, including on moving to the post-operative care environment or to the intensive care unit, should always be to a member of staff who is competent to look after the patient at that time, and this should be clearly documented.

5.22 Handover should be structured to ensure continuity of care.

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

STANDARD

4.1.0.6 The consultant on call name and contact details are prominently displayed in appropriate areas

EVIDENCE REQUIRED

Prominent display should be seen

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Workforce management and support; Quality improvement-focused leadership

GPAS REFERENCES

3.1.4 Anaesthesia departments should have a nominated anaesthetist immediately available to provide cover in clinical emergencies, as well as advice and support to other anaesthetists.

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

9.1.21 Staff working in the maternity unit should know how to contact the anaesthetic consultant; the name(s) of the consultant(s) covering the delivery suite should be easily seen by all staff and contact numbers readily available.

STANDARD

4.1.0.7 If anaesthesia or sedation is given in an isolated/single specialty unit there is appropriate medical cover and nursing cover

EVIDENCE REQUIRED

Either a written policy or verbal confirmation, as well as rota evidence, should be provided and show that there is assistance for the anaesthetist and specific arrangements for remote sites

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

7.1.5 Patients recovering from anaesthesia or sedation in an isolated unit should receive the same standard of care as that required in an operating theatre post-anaesthetic care unit. For major vascular surgery, transfer to the main post-anaesthesia care unit by appropriately trained personnel may be required

7.3.16 The anaesthetist accompanying transferred patients from the ED should be suitably skilled and experienced to manage all eventualities in an isolated environment and should be accompanied by a dedicated trained assistant

HELPNOTE

This standard applies to isolated sites within a hospital and equally to single specialty units such as 'cold' orthopaedic units operating within an adjoining unit or small hospital nearby under the auspices of the department.

STANDARD

4.2.1.1 There is a system in place to allow reporting and regular audit, with demonstrated learning and improved outcomes, from complaints, critical and untoward incidents and near-misses

EVIDENCE REQUIRED

Verbal confirmation should be given. Minutes of governance meetings, morbidity and mortality reviews and risk register should be seen. There should be evidence of actions taken. Copies of an incident reporting form and information provided on induction should be seen. Major airway incident data should be available, along with how this has been followed up. 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.

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe & effective care, Management & leadership

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance; Quality improvement-focussed leadership

GPAS REFERENCES

3.5.23 A system for reporting and regular audit of critical incidents and near-misses is an essential part of a well led safety structure and so should be in place and be multi-professional. The methodology must be explicit and identify underlying relevant factors to inform learning and development of safe systems. All staff must recognise the duty of candour and foster a culture for reporting incidents and concerns.

3.5.24 All critical incidents should be reported.

3.5.25 Hospitals should have systems in place to facilitate multidisciplinary Morbidity and Mortality meetings.

4.7.3 Nurturing a safety culture, learning from mistakes, preventing harm and working as part of a team are all part of the discipline of safety. To this end, shared learning and quality improvement that contribute towards improvements in safety, such as critical incident reporting with thematic analysis, and communication through morbidity and mortality meetings, could be undertaken.

5.5.63 A system for reporting and regular audit of critical incidents and near-misses should be in place and be multiprofessional. The methodology should be explicit and identify underlying relevant factors to inform learning and development of safe systems. All staff must recognise the duty of candour and foster a culture for reporting incidents and concerns.

5.5.64 There must be systematic measures in place to respond to serious incidents. These measures must protect patients and ensure that robust investigations are carried out by trained safety leads. When an incident occurs, it must be reported to all relevant bodies within and without the hospital.

5.5.67 Hospitals should have systems in place to facilitate multidisciplinary Morbidity and Mortality meetings.

5.7.1 National-level audit of emergency surgical activity and outcome is essential, and all hospitals delivering emergency surgical care must contribute to the recognised national or other major audits of safe practice and critical incident reporting systems

10.7.5 Multidisciplinary audit and morbidity and mortality meetings relating to paediatric anaesthesia and procedures including resuscitation should be held regularly. Peri-operative death in infants and children is rare. When a death occurs within 30 days of surgery, a multidisciplinary meeting should be convened and a note made in the clinical record. In the event of any unexpected child death, whether related to surgery or not this must be reported to the local Child Death Overview Panel (CDOP). This will usually be the responsibility of the local designated paediatrician and the process for notification of a child death must be followed.

11.5.5 The acute pain service should engage with critical incident reporting and engage with root cause analysis and mortality and morbidity meeting reporting of adverse events.

STANDARD

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

EVIDENCE REQUIRED

Minutes of meetings and multidisciplinary reviews, completed reports and local audits

PRIORITY

1

CQC KLoEs

Responsive Safe

HIW Domains

Safe and effective care

HIS Domains

Key organisational outcomes; Safe, effective and person-centred care delivery; Policies, planning and governance; Partnerships and resources

GPAS REFERENCES

10.7.5 Multidisciplinary audit and morbidity and mortality meetings relating to paediatric anaesthesia and procedures including resuscitation should be held regularly. Peri-operative death in infants and children is rare. When a death occurs within 30 days of surgery, a multidisciplinary meeting should be convened and a note made in the clinical record. In the event of any unexpected child death, whether related to surgery or not this must be reported to the local Child Death Overview Panel (CDOP). This will usually be the responsibility of the local designated paediatrician and the process for notification of a child death must be followed.

STANDARD

4.4.1.1 An obstetric anaesthetist takes part in regular multidisciplinary 'labour ward forum' or equivalent meetings

EVIDENCE REQUIRED

Minutes of meetings and record of attendance should be provided

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management & leadership

HIS Domains

Impact on staff; Workforce management and support

GPAS REFERENCES

9.1.13 The lead consultant obstetric anaesthetist should ensure representation of the anaesthetic department at multidisciplinary meetings for service planning, e.g. Labour Ward Forum.

9.5.24 Anaesthesia should be represented on all committees responsible for maternity services (e.g. the Maternity Services Liaison Committee, Delivery Suite Forum, Obstetric Multidisciplinary Guidelines Committee, Obstetric Risk Management Committee).

STANDARD

4.4.3.2 There is regular multidisciplinary team training for emergency situations

EVIDENCE REQUIRED

Documentation should be provided. Space for resuscitation and theatre team training should be seen. Verbal evidence should be provided that team training has occurred incorporating human factors

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

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

GPAS REFERENCES

3.4.2 Theatre teams should undergo regular, multidisciplinary training that promotes teamwork, with a focus on human factors, effective communication and openness.

4.4.7 Wherever possible, training should be multidisciplinary.

5.4.2 Multidisciplinary procedural teams that work together should train together. Teams should undergo regular, multidisciplinary training that promotes teamwork, with a focus on human factors, effective communication and openness.

5.4.5 Teams should train for and practise their Standard Operating Procedures for serious, complex and rare emergencies, as well as major incidents. There should be regular multidisciplinary training for emergency situations, and simulation training should be considered.

7.4.4 Difficult tracheal intubation equipment, waveform capnography and training for the management of the emergency airway should be available.

9.4.12 Anaesthetists should help organise and participate in regular multidisciplinary courses and 'skills drills' of emergency situations.

HELPNOTE

It is established that benefits of simulation training decrease over time and are almost entirely gone after one year. For this reason multidisciplinary team training should be available on a monthly basis. Individuals should attend at least annually.

STANDARD

4.5.1.1 The department has evidence of engagement with, and implementation of national audit projects and quality improvement programmes, including obstetrics

EVIDENCE REQUIRED

Written and verbal evidence should be provided

PRIORITY

1

CQC KLoEs

Effective Responsive Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Key organisational outcomes; Safe, effective and person-centred care delivery

GPAS REFERENCES

5.7.1 National-level audit of emergency surgical activity and outcome is essential, and all hospitals delivering emergency surgical care must contribute to the recognised national or other major audits of safe practice and critical incident reporting systems.

9.7.2 There should be regular audits of the quality of clinical governance, with particular attention being paid to provision and updating of local guidelines, reviews of adverse events, and record-keeping.

9.7.6 All cases of maternal death, significant permanent neurological deficit, failed intubation or awareness (AAGA) should undergo case review, with learning shared locally and/or nationally.

9.7.9 As well as the specific topics detailed above, a regular audit programme should encompass national audit recipes and standards.

10.7.2 Regional networks could provide agreed quality standards for the peri-operative care of infants and children and young people, and units could be encouraged to participate in regular collation of data relating to these standards. Participation in national audit should also be encouraged.

10.7.3 Quality-improvement projects in relevant areas of paediatric anaesthetic practice should be agreed and implemented.

16.7.3 All hospitals treating patients with hip fractures should participate in national audits, e.g. National Hip Fracture Database, national joint registry to monitor its performance against national benchmarks and quality standards. Outcomes from these audits should be distributed to anaesthetic staff.

HELPNOTE

Examples of suitable audits to demonstrate compliance with this standard are SNAP, NAP, maternal mortality audits and NELA. This is not an exhaustive list and the review team will acknowledge regional variations in participation with national audits in their assessment.

STANDARD

4.5.1.2 Continuous measurements of the outcome of elective and emergency anaesthesia is undertaken

EVIDENCE REQUIRED

Written evidence should be provided

PRIORITY

1

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

3.7.1 There should be a multidisciplinary programme for auditing intra-operative care.

5.5.62 Robust data collection underpins much of the success in documenting and learning from experiences. All institutions providing anaesthesia care to emergency surgery patients should collect the required data to be able to produce an annual report on a variety of relevant patient morbidity and mortality metrics, including return to theatre within 24 hours. This report should be reviewed regularly and used for organisational learning.

5.7.2 Outcomes for types of emergency surgery not covered by national audits should be audited via Hospital Episode Statistics for benchmarking purposes.

6.5.6 Each unit should have a multidisciplinary operational group that oversees the day to day running of the unit, agrees policies and timetables, reviews operational problems and organises audit strategies.

6.5.30 For commissioning purposes, suggested indicators of quality of a DSU include:

- day surgery existing as a separate and 'ring-fenced' administrative care pathway
- a senior manager directly responsible for day surgery
- pre-operative assessment undertaken by staff familiar with the day surgery pathway
- provision of timely written information
- appropriate staffing levels
- nurse-led discharge
- provision for appropriate postoperative support including follow-up and outreach after home discharge
- involvement and feedback from patients, the public and community practitioners.

This list, however, is not exhaustive and other factors – such as theatre utilisation, levels of unplanned overnight admissions after day surgery, management of pain relief and postoperative nausea and vomiting, and complication and readmission rates – are also important quality indicators that should be audited regularly.

6.7.1 Each DSU should have a system in place for the routine audit of important basic parameters such as unexpected admissions following surgery, non-attendance (DNA) rates, patients cancelled on the day of operation, postoperative symptoms (e.g. pain and PONV) and patient satisfaction. The Royal College of Anaesthetists has also issued guidance for audits in day surgery.

6.7.2 Current practice in day surgery includes more complex procedures and more elderly patients. Audit of complications related to wound healing process and impaired mobility based on risk scores can help improve the safe delivery of day surgery service.

7.3.9 The safe management of unstable patients depends on close liaison between emergency physicians and anaesthetists, 33, 34 to ensure that clear guidelines are in place, emergency department support staff are trained to assist with tracheal intubation, and audit and discussion of complications is undertaken regularly.

7.5.3 Hospitals should have a system for multidisciplinary involvement in reporting and regular audit of critical incidents and near-misses.

7.7.1 There should be a multidisciplinary programme for auditing anaesthesia and sedation in the non-theatre environment

7.7.2 Audit should be under regular review by a clinical lead and those relating to sedation should be co-ordinated by a hospital sedation committee.

9.7.1 The lead obstetric anaesthetist should audit and monitor the duty anaesthetist workload to ensure that there is sufficient provision for the busyness of the unit.

10.7.1 Quality indicators, such as unplanned inpatient admission following day case surgery, readmission within 28 days or unanticipated admission to PICU following surgery, should be measured, collated and analysed and can be compared within regional networks. A number of suggested audit topics, specifically relating to paediatric anaesthesia are set out in the RCoA document *Raising the standard: a compendium of audit recipes*.

HELPNOTE

These audits could include ICNARC, recovery data such as postoperative nausea and vomiting, fractured neck of femur, pain or patient satisfaction surveys. This list is not exhaustive.

STANDARD

4.5.1.3 The emergency surgery workload is continually monitored and reviewed and is used to plan future demand

EVIDENCE REQUIRED

Rolling audit data should be available. The clinical director should be able to provide examples of how this data has been used to inform business planning

PRIORITY

1

CQC KLoEs

Safe Effective Caring Responsive Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Key organisational outcomes; Safe, effective and person-centred care delivery

GPAS REFERENCES

5.5.3 The hospital business plan should address the predicted growth in surgical emergencies, ageing population and any changes as a result of regional specialisation. Future planning should be based on accurate and timely data. Mathematical modelling for matching theatre demand and capacity could be beneficial.

HELPNOTE

In addition to looking at the policy, reviewers will look for evidence that rotas are reviewed regularly and whether the department runs local audits to measure availability of theatres and staff for emergency surgery, differences in clinical outcome measures - comparing day and late night, weekend and weekday etc. We will also be looking for subsequent interventions to improve following results of the audits.

STANDARD

4.6.1.1 There is documentary evidence that all anaesthetists and anaesthetic assistants, including locum, agency and trust grade staff, have undergone an appropriate induction process to the anaesthetic department

EVIDENCE REQUIRED

Documentation for anaesthetic department induction should be provided

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

3.4.8 There should be induction programmes for all new members of staff, including locums. Induction for a locum doctor should include familiarisation with; the layout of the hospital; location of emergency equipment and drugs; access to guidelines and protocols; information of how to summon support/assistance; and assurance that the locum is capable of using the equipment in that hospital. All inductions should be documented.

5.4.6 When new members join teams, particular care should be taken to introduce them to the teams and to ensure that their care is harmonised with that of other team members and teams.

5.4.9 Anaesthetists must be given support and time to familiarise themselves with non-theatre locations and local working arrangements (e.g. during induction sessions).

7.4.1 All anaesthetists should be fully familiarised with all remote areas of anaesthetic provision, e.g. as part of their induction process, prior to undertaking anaesthetic procedures in that location

9.4.7 There should be induction programmes for all new members of staff, including locums. Induction for a locum doctor should include familiarisation with: the layout of the labour ward; location of emergency equipment and drugs (e.g. MOH trolley/intralipid/dantrolene); access to guidelines and protocols; information of how to summon support/assistance; and assurance that the locum is capable of using the equipment in that obstetric unit. All inductions should be documented.

HELPNOTE

Some members of the anaesthesia team will go through a different process of induction compared to the anaesthetists, but the anaesthetic department should have some input into that process, e.g. by providing information about departmental policies that relate to anaesthesia; anaesthetic machine

inductions etc. What this input consists of and how it is managed will need to be described to the review team, including how changes to documentation and policies are communicated.

STANDARD

4.6.1.2 All anaesthetists and anaesthetic assistants receive systematic training in the use of new medical equipment and the training is documented

EVIDENCE REQUIRED

Documentation of training should be provided

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

3.2.26 All anaesthetists and anaesthetic assistants should receive systematic training in the use of new equipment. This should be documented.

5.2.22 Hospitals should ensure that staff are trained and competent to use the equipment provided. Equipment should be properly maintained and replaced in a timely and planned fashion.

HELPNOTE

Self-certification is fine if consultants are keeping a record of their own training for appraisal purposes; again, this should be appropriately documented.

STANDARD

4.6.2.1 Staff with specific training commitments, including resuscitation and life support courses and simulation/human factors training have appropriate support

EVIDENCE REQUIRED

Staff with specific training commitments in these areas should give verbal confirmation that they are supported

PRIORITY

1

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

8.4.3 Anaesthetists frequently teach on these life support courses – this represents a considerable workload for the average anaesthetic department and must be taken into account when planning requirements for permanent staff.

HELPNOTE

Those providing the training should be supported in their job plans

STANDARD

4.6.2.3 All permanent members of staff should receive adequate time, resources and support for all activities related to appraisal and revalidation

EVIDENCE REQUIRED

Examples of appraisal process. Verbal confirmation from department lead appraiser and consultants

PRIORITY

1

CQC KLoEs

Safe Well-led Effective

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Impact on staff; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

3.4.3 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical practice, including annual mandatory training such as basic life support.

5.4.4 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical practice, including resuscitation training.

9.4.10 All staff working on the delivery suite should have annual resuscitation training, including the specific challenges of pregnant women.

10.4.4 Specialist and non-specialist paediatric anaesthetists should have advanced training in life support for children, and should maintain these competencies by regular annual training that is ideally multidisciplinary and scenario based.

10.4.6 Anaesthetists who do not have regular children's lists but have both daytime and out-of-hours responsibility to provide care for children requiring emergency surgery should maintain appropriate clinical skills. There should be arrangements for undertaking regular supernumerary attachments to lists or secondments to specialist centres. The Certificate of Fitness for Honorary Practice may facilitate such placements and provides a relatively simple system for updates in specialist centres. Paediatric simulation work may also be useful in helping to maintain paediatric knowledge and skills. There should be evidence of appropriate and relevant paediatric CPD in the five-year revalidation cycle.

10.4.7 There should be funding and arrangements for study leave such that all consultants and career grade staff who have any responsibility to provide anaesthesia for children are able to participate in relevant CPD that relates to paediatric anaesthesia and resuscitation, and to their level of specialty practice. Individual CPD requirements should be jointly agreed during the appraisal process.

STANDARD

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 REQUIRED

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

PRIORITY

2

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Impact on staff; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

10.4.1 Consultants with a substantial commitment to paediatric anaesthesia should have satisfied the higher and advanced-level competency-based training requirements in paediatric anaesthesia of the RCoA or equivalent. It is recognised that anaesthetists involved in highly specialised areas such as paediatric cardiac and neurosurgery will require additional training that is individually tailored to their needs.

10.4.2 All anaesthetists who provide elective or emergency care for children should have advanced training in life support for children, and should maintain these competencies by annual training that ideally is multidisciplinary and scenario based.

10.4.4 All anaesthetists must undertake at least level 2 training in safeguarding/child protection and must maintain this level of competence by annual updates of current policy and practice and case discussion.

10.4.5 At least one consultant in each department should take the lead in safeguarding/child protection and undertake training and maintain core level 3 competencies. The lead anaesthetist for safeguarding/child protection should advise on and co-ordinate training within their department, but will not have responsibility to decide upon management of individual clinical cases.

10.4.6 Anaesthetists who do not have regular children's lists but have both daytime and out-of-hours responsibility to provide care for children requiring emergency surgery should maintain appropriate clinical skills. There should be arrangements for undertaking regular supernumerary attachments to lists or secondments to specialist centres. The Certificate of Fitness for Honorary Practice may facilitate such placements and provides a relatively simple system for updates in specialist centres. Paediatric simulation work may also be useful in helping to maintain paediatric knowledge and skills. There should be evidence of appropriate and relevant paediatric CPD in the five-year revalidation cycle.

10.4.7 There should be funding and arrangements for study leave such that all consultants and career grade staff who have any responsibility to provide anaesthesia for children are able to participate in relevant CPD that relates to paediatric anaesthesia and resuscitation, and to their level of specialty practice. Individual CPD requirements should be jointly agreed during the appraisal process.

HELPNOTE

The safeguarding training aspect of this standard is applicable to those who only treat patients who are 16-18 years old

STANDARD

4.6.2.5 Staff with commitments to national work undertaken for the wider benefit of the public and health services across the UK have appropriate support

EVIDENCE REQUIRED

Staff with commitments in these areas, as defined as 'External Duties' in the [NHS Consultant contract](#), should give verbal confirmation that they are supported

PRIORITY

2

CQC KLoEs

Well-led

HIW Domains

Management and leadership

HIS Domains

Workforce management and support

REFERENCES

[Letter to all NHS employers from GMC and Chief Medical Officers, 23/06/17](#)

STANDARD

4.6.4.2 Physician's Assistants (Anaesthesia) work under the supervision of a consultant at all times when administering general anaesthesia or sedation

EVIDENCE REQUIRED

A copy of the rota should be provided showing allocation of PA(A)s to lists should be seen. Verbal evidence should be provided

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

3.1.6 The PA(A) should work at all times within an anaesthesia team led by a consultant anaesthetist who has overall responsibility for anaesthesia care of the patient and whose name should be recorded in the individual patient's medical notes.

3.1.7 The consultant anaesthetist should be easily contactable and should be available to attend within two minutes of being requested by the PA(A).

3.1.8 The supervising consultant anaesthetist should not be responsible for more than two anaesthetised patients simultaneously, where one involves supervision of a PA(A).

5.1.7 Consideration may be given to Physicians' Assistants (Anaesthesia) or PA(A)s working as part of a team-based approach to deliver anaesthesia. The ratio of two PA(A)s to one consultant anaesthetist has been suggested and should remain the maximum, and each PA(A) working in this way should have their own qualified assistance.⁴⁶ In some emergency situations, a ratio of 1:1 may be more appropriate, in view of the high incidence of comorbidities, complications and mortality.

HELPNOTE

If no PA(As) are employed by the department, this standard should be marked N/A.

STANDARD

4.6.5.1 There is adequate protection from environmental hazards provided for staff

EVIDENCE REQUIRED

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 and be able to explain how radiation exposure is monitored. A scavenging system that meet the Health and Safety Executive's occupational exposure standards for anaesthetic agents should be seen

PRIORITY

1

CQC KLoEs

Safe Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Workforce management and support

GPAS REFERENCES

3.2.4 Anaesthetic sites must have scavenging systems that meet the Health and Safety Executive's occupational exposure standards for anaesthetic agents.

5.2.26 There must be full provision of personal protective equipment and shields from blood spray, radiation and hazardous substances for all staff working in the operating theatre, and guidance on its usage.

7.3.15 Exposure to ionising radiation should be kept to a minimum by the use of screens or lead gowns; remote slave monitors in screened viewing areas should be provided and staff should remain as distant from the imaging source as possible if they must remain in the X-ray environment.

7.5.4 Environmental hazards such as radiation exposure, magnetic resonance (MR) fields and lack of scavenging should be considered by staff before the start of each list. Volatile agent scavenging canisters, air-oxygen mixtures and avoidance of nitrous oxide can mitigate environmental risks. Pregnant personnel may be particularly at risk in these environments and should follow local occupational health policy.

STANDARD

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

EVIDENCE REQUIRED

The clinical director should provide a copy of the document

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Policies, planning and governance; Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

2.6.1 Business planning by trusts and anaesthetic departments should ensure that the necessary time and resources are directly targeted towards pre-operative preparation.

5.5.3 The hospital business plan should address the predicted growth in surgical emergencies, ageing population and any changes as a result of regional specialisation. Future planning should be based on accurate and timely data. Mathematical modelling for matching theatre demand and capacity could be beneficial.

STANDARD

4.8.0.3 Anaesthesia is represented as part of the planning of maternity services

EVIDENCE REQUIRED

The names of the representatives should be given

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Policies, planning and governance

GPAS REFERENCES

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

STANDARD

4.8.0.5 The department has a plan in the event of a major incident

EVIDENCE REQUIRED

A written policy. Staff should be aware of their role in the event of a major incident

PRIORITY

1

CQC KLoEs

Safe Effective Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Policies, planning and governance; Workforce management and support

GPAS REFERENCES

5.5.36 Appropriate clinical policies and Standard Operating Procedures for operating theatres should be in place, and should be available at all times, including a resuscitation policy and major incident plans.

5.4.5 Teams should train for and practise their Standard Operating Procedures for serious, complex and rare emergencies, as well as major incidents. There should be regular multidisciplinary training for emergency situations, and simulation training should be considered.

16.5.10 All acute hospitals should have a defined major incident plan. The plan should be built around the network of MTCs, TUs and LEHs. A pre-hospital triage tool should be used to determine where patients should be taken

STANDARD

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.

EVIDENCE REQUIRED

The clinical director should provide written evidence

PRIORITY

2

CQC KLoEs

Safe Effective Responsive Well-led

HIW Domains

Safe and effective care; Management and leadership;

HIS Domains

Quality-improvement focussed leadership

REFERENCES

Royal College of Anaesthetists statement on training, revalidation and accreditation in the Independent Sector July 2014

NHS Constitution 2009

The new Equality Act 2006

2003 Scottish Consultant Contract

HELPNOTE

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.



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