NHS
Gateshead Health
NHS Foundation Trust

Appendix 1a
Care quality accreditation framework: standards with measures

March 2019

Key ambition 1: High quality care every time

1.1	Culture of compassionate care				Suggested evidence	KLOE
1.1.1	All nursing, HCA and ward support staff demonstrate care and compassion, and are polite and respectful in their interactions with patients	No	Partial	Yes	Patient experience questionnaires and comments, patient interviews, observation in practice	C
1.1.2	Patient privacy and dignity is maintained	No	Partial	Yes	Patient experience questionnaires and comments, patient interviews, observation in practice – bed curtains closed, privacy curtains used. Environment meets the required standards	C
1.1.3	There is clear evidence that the principle of 'Hello My Name Is' is embedded in daily practice	No	Partial	Yes	Observation in practice – nursing teams and ward support staff are seen to introduce themselves to patients and carers Name badges are worn and promotional materials are used in the area	C
1.1.4	The integrated rounding charts demonstrate that patients' fundamental care needs are addressed over a 24-hour period	<70%	70–79%	80%	Observation in practice – evidence of full completion of charts, and clearly identified exclusions	C, R
1.1.5	Staff respond promptly to the patient call bell	No	Partial	Yes	Observation in practice, patient experience data Patients say staff respond promptly when called	C, R

1.2	Nutrition and hydration				Suggested evidence	KLOE
1.2.1	MUST tool is completed on the day of admission and reviewed within given timescales	<70%	70–79%	80%	Review of nursing records – risk assessment including height and weight	E
1.2.2	Appropriate action is taken in response to risk assessment	<70%	70–79%	80%	Review of nursing records – care plans ± dietetics referral Staff can articulate how to obtain specialist advice	E
1.2.3	Patient care plans address individual needs and preferences	<70%	70–79%	80%	Review of nursing records – assessment and care planning For example, a variety of foods and dietary requirements are available, food can be provided outside of normal mealtimes if required	E
1.2.4	Adapted crockery/cutlery is readily available if required	No		Yes	Observation, question staff	E
1.2.5	Patient's food and drinks are within easy reach	No		Yes	Observation, question staff	E
1.2.6	Pictorial menus are readily available if required	No		Yes	Observation, question staff	E
1.2.7	Red placemats and jugs are used where monitoring of nutrition and hydration is required	No		Yes	Observation	E
1.2.8	Food charts are completed accurately following each meal	No		Yes	Observation of nursing records	E
1.2.9	Fluid charts are completed accurately after each meal and at each bedside nursing round or as the patient's condition dictates	No		Yes	Observation of nursing records	E

1.2.10	Protected mealtimes for patients are maintained	No		Yes	Observation, patient interviews. Only essential care or interventions are undertaken during mealtimes	E
1.2.11	Patients receive help and support with food and fluids	<70%	70–79%	80%	Patient experience data, patient interviews Observe how the team work together at mealtimes to ensure prompt meal distribution and assist those patients who require support Carers are encouraged to support at mealtimes if they so wish.	
1.2.12	Patients are offered snacks and drink between meals	No		Yes	Observation in practice – snacks and drinks are available throughout the day	E
1.3	**End of life care**				**Suggested evidence**	**KLOE**
1.3.1	All nursing/HCA staff have completed level 2 and level 3 end of life care training	<70%	70–79%	80%	Training records	E, C
1.3.2	When a patient is at the end of life there is documentary evidence that the five priorities of care have been considered and that the care delivered has been evaluated	<70%	70–79%	80%	Nursing records, staff interviews	E, C
1.3.3	The family voice diary is offered when appropriate in the last days of life	No	Partial	Yes	Staff interviews – awareness/examples from practice NB may not yet be available in all areas	E, C
1.4	**Pain management**				**Suggested evidence**	**KLOE**
1.4.1	There is evidence in nursing assessment that acute and chronic/established pain needs have been explored	<70%	70–79%	80%	Review nursing assessment documentation.	E

1.4.2	Staff respond promptly to the needs of patients who are in pain	No	Partial	Yes	Patients say that their pain needs are met, patient experience data	R, C
1.4.3	Nursing staff are aware of where to obtain specialist pain advice	No	Partial	Yes	Staff can say how specialist advice is obtained	E
1.5	**Dementia care**				**Suggested evidence**	**KLOE**
1.5.1	All nursing/HCA staff have completed mandatory training in dementia	<70%	70–79%	80%	Training records show compliance with trust standards for the service	S, C
1.5.2	Each ward/department has an identified dementia champion	No	Partial	Yes	Staff interviews, evidence of outcomes from role	E, WL
1.5.3	A forget-me-not document is completed for any patient who cannot express their needs	<70%	70–79%	80%	Observation in practice, nursing records	E, C, R
1.5.4	The principles of John's campaign are embedded in the clinical area	No		Yes	Carers passports, use of promotional materials, observation, patient and carer feedback	E, C, R
1.6	**Communication and MDT working**				**Observations/comments**	**KLOE**
1.6.1	As a minimum there is a daily MDT board round with nursing representation	No		Yes	Observation of board round – MDT members, key focus of discussion around deteriorating patients and discharge plans	E, WL
1.6.2	There is an identified nurse in charge on duty	No		Yes	Staff can identify the nurse in charge over a span of duty	E,
1.6.3	Regular communication observed between nursing and MDT members	No	Partial	Yes	Observation in practice	E, WL
1.6.4	Nursing staff are aware of patients who have a DNACPR	No		Yes	Staff can identify those patients for whom a DNACPR is in place	E

1.6.5	Nursing handovers use an SBAR framework	No	Partial	Yes	Observation in practice. Staff can explain the principles of the SBAR framework	E
1.7	**Discharge planning**				**Suggested evidence**	**KLOE**
1.7.1	Potential discharges are discussed at daily MDT board round	No		Yes	Observation in practice	R
1.7.2	There is an expected date of discharge identified for each patient	No	Partial	Yes	Displayed on white board and recorded Medway	E
1.7.3	Where appropriate there is evidence of liaison with other agencies to ensure seamless transfers of care	<70%	70–79%	80%	Review of nursing records including previous day's discharges, may need to review previous days discharges	S, E
1.7.4	Appropriate information, advice and contact numbers are given to patients on discharge	<70%	70–79%	80%	Review nursing records, discharge checklist, patient records from previous day's discharges. Patient and carer feedback	S
1.8	**Documentation and record keeping**				**Suggested evidence**	**KLOE**
1.8.1	A secondary nursing assessment has been undertaken on arrival at the base ward	<70%	70–79%	80%	Review of nursing documentation	E, S
1.8.2	Nursing records demonstrate that care is planned, implemented and evaluated	<70%	70–79%	80%	Review of nursing documentation	E, S
1.8.3	Nursing records document any sudden/acute changes in a patient's condition	<70%	70–79%	80%	Review of nursing documentation and National Early Warning Score data	E, R
1.8.4	There is documented evidence that patients and carers have been given information about ongoing care and progress/deterioration	<70%	70–79%	80%	Review of nursing documentation, patient and carer feedback, patient experience data	E, R
1.8.5	Nursing entries are signed in accordance with NMC guidelines	<70%	70–79%	80%	Review of nursing documentation: printed name, signature, date, time, band/position, black pen	E, S

Key ambition 2: Putting patients first

2.1	Meeting people's individual needs				Suggested evidence	KLOE
2.1.1	Staff can identify cultural and religious needs and adjust care plans accordingly	No	Partial	Yes	Review of nursing documentation. Staff can discuss give examples from practice of how religious and cultural needs have been met	C, R
2.1.2	Staff can identify and use the patient's preferred name	No	Partial	Yes	Observation in practice, nursing records, bed boards	C
2.1.3	Staff are aware of how to access interpreters, signers	No	Partial	Yes	Staff can say how appropriate support can be accessed	C
2.1.4	Where appropriate, there is evidence that the needs and wishes of patients with a physical/ learning disability or who lack capacity are assessed and reasonable adjustments made to meet those needs	No	Partial	Yes	Review of nursing documentation – assessment and care plans. Staff can discuss how assessment is undertaken and how relatives or carers can be involved	C, R
2.1.5	Staff recognise the importance of parity of esteem, valuing mental health equally with physical health	No	Partial	Yes	Staff interviews, questioning staff on duty	R
2.1.6	Patients and carers are kept up to date about ongoing care and progress	No	Partial	Yes	Review of nursing documentation, patient and carer feedback and patient experience data	C, R, E
2.2	**Family/carer information**				**Suggested evidence**	**KLOE**
2.2.1	Visiting times and ward contact information for patients and relatives is clearly displayed/ available	No	Partial	Yes	Environmental observation	R

2.2.2	Relevant information leaflets are on display and up to date	No	Partial	Yes	Environmental observation	C
2.2.3	Notice boards are well maintained and provide relevant information	No		Yes	Environmental observation	R
2.2.4	PALs/complaints information is visible and accessible to patients and relatives	No	Partial	Yes	Environmental observation	R

2.3	**Listening and learning from feedback and complaints**				**Suggested evidence**	**KLOE**
2.3.1	Patient experience feedback is shared with the ward team	No		Yes	Staff interviews, minutes of ward meetings, staff notice boards	R
2.3.2	Staff can discuss learning/change in response to incidents and feedback	No		Yes	Staff can give examples from practice. Evidence from RCAs, complaints and associated action plans	R
2.3.3	Staff are aware of service improvements that have been implemented in the ward/ department to improve patient experience	No	Partial	Yes	Staff can give examples from practice	E, R
2.3.4	Patients would recommend the ward/department to a friend or family member	<70%	70–79%	80%	Friends and Family Test results	E, R

Key ambition 3: Driving excellence in patient safety

3.1	Infection prevention and control				Suggested evidence	KLOE
3.1.1	PPE is easily accessible and used appropriately	No	Partial	Yes	Observation in practice	S
3.1.2	Appropriate signage is used to identify isolation/barrier nursing areas	No	Partial	Yes	Observation in practice	S
3.1.3	Relevant information about infection prevention and control (IPC) is available for patients and visitors	No	Partial	Yes	Observation in practice	S
3.1.4	There is hand hygiene compliance within the clinical area	<85%	85–89%	90%	Audit information, observation in practice	S
3.1.5	Urinary catheter surveillance demonstrates safe practice	<85%	85–89%	90%	Audit information, observation in practice	S
3.1.6	IPC audits are up to date and displayed	No		Yes	Observation in practice	WL
3.1.7	Results of DAMP compliance audits are shared with the team and actioned where required	No	Partial	Yes	Minutes of ward meetings, staff notice boards, evidence of actions/learning	S, WL
3.1.8	The team can demonstrate learning in response to feedback from IPC-related RCAs	No	Partial	Yes	Staff can give examples from practice, evidence of actions/learning	S, WL
3.1.9	Clinical equipment is clean and dust free	No	Partial	Yes	Equipment including commodes, infusion pumps, DINAMAP, trolleys	S
3.1.10	All patient areas are tidy, uncluttered and clean	No	Partial	Yes	Observation, information from environmental audits, matron walkabouts	S

3.2	Falls prevention				Suggested evidence	KLOE
3.2.1	All patients have a multifactorial falls risk assessment on admission, which is reviewed weekly or when change in condition dictates	<70%	70–79%	80%	Review of nursing documentation	S, R
3.2.2	The multifactorial falls assessment documentation demonstrates daily evaluation for patients identified as at risk	<70%	70–79%	80%	Review of nursing documentation	S,
3.2.3	Integrated rounding chart demonstrates preventative measures are in place for all patients (FOCUS bundle)	<70%	70–79%	80%	Review of nursing documentation	S
3.2.4	Falling stars are used to identify patients who are at risk	<70%	70–79%	80%	Observation in practice	S
3.2.5	Information is readily available for patients and carers on falls prevention	No		Yes	Evidence of written information/leaflets, promotional information such as falls information board	S, R
3.3	**Pressure damage prevention**				**Suggested evidence**	**KLOE**
3.3.1	All patients have a risk assessment undertaken on admission and this is reviewed weekly or if change in condition dictates	<70%	70–79%	80%	Review of nursing documentation	S
3.3.2	There is evidence in nursing records of planned care in response to risk assessment, and appropriate evaluation	<70%	70–79%	80%	Review of nursing documentation – assessment and care planning	S
3.3.3	In response to risk assessment, appropriate aids and equipment are in place	<70%	70–79%	80%	Review of nursing documentation, observation in practice	S

3.3.4	Integrated rounding chart demonstrates preventative measures are in place for all patients (SKIN bundle)	<70%	70–79%	80%	Review of nursing documentation	S
3.3.5	Incidence of pressure damage is reported using the Datix reporting system	Yes		No	Review of Datix reports against nursing records, review of the safety cross-visual tool	S, R

3.4	**Deteriorating patient**				**Suggested evidence**	**KLOE**
3.4.1	All nursing staff and HCAs have completed the NEWS competency-based assessment	<70%	70–79%	80%	Training records	S, WL
3.4.2	Vital signs are recorded on time as per protocol	<80%	80–89%	90%	Vital Pac data	S
3.4.3	An appropriate response to deteriorating NEWS score is implemented and recorded in the nursing record	<70%	70–79%	80%	Nursing records	S
3.4.4	Where there is a NEWS of 5 or above and/or any clinical concern, the sepsis screening tool has been completed and escalation to the medical team initiated	<70%	70–79%	90%	Nursing records	S
3.4.5	There is evidence that the sepsis ward-based training package has been delivered to the nursing and health care assistant staff.	<70%	70–89%	90%	Training records	S, WL
3.4.6	All registered staff have completed sepsis competency-based assessment	<70%	70–79%	80%	Training records	S, WL

3.5	Medicines management				Suggested evidence	KLOE
3.5.1	All medicines storage areas are secure	No		Yes	Inspection of treatment room, cupboards, medicines lockers, drug fridge	S
3.5.2	Controlled drugs (CD) keys are held as per trust policy	No		Yes	Observation in practice. Nursing staff can articulate policy requirements	S
3.5.3	There is evidence that weekly controlled checks are undertaken	No	Partial	Yes	Review of CD register, pharmacy audits	S
3.5.4	Patients have medicine allergies identified and recorded and are wearing a red wrist band	<70%	70–79%	80%	JAC reports, nursing records, observation	S
3.5.5	Staff can articulate the process for obtaining unavailable medicines to minimise missed doses	No		Yes	Staff interviews	S, E
3.5.6	Moderate/severe medicine errors are reported and investigated within 28 working days	No		Yes	Review of Datix reports.	S
3.5.7	There is evidence of learning from medicine errors	No		Yes	Action plans, improvements in practice as per Datix, minutes of staff meetings	S, R
3.5.8	Medicines for administration are not left at the patient's bedside	No		Yes	Observation in practice	S
3.5.9	Fridge temperatures are recorded daily	No		Yes	Observation of records/Omnicell reports	S
3.6	**Staffing**				**Suggested evidence**	**KLOE**
3.6.1	Off duty is compliant with effective rostering guidance: • off duty is available six weeks in advance • matron's checklist is complete	60%		80%	Rostering information (KPIs), matron's check list Consider holidays, study leave, sickness and absence	S, WL

	• skill mix aligns to safe staffing guidance • staff work within agreed shift patterns • the 21% headroom is managed appropriately					
3.6.2.	Planned and actual staffing levels are displayed in a public area	No		Yes	Observation	S, WL
3.6.3	Staff can explain the process of escalation when staffing levels are not as planned	No	Partial	Yes	Staff interviews	S, WL
3.6.4	The electronic staffing tool is complete and reflects current staffing levels	No		Yes	Observation	S, WL
3.6.5	If staffing levels are of concern, the appropriate escalation/documentation is completed	No		Yes	Report to matron, Datix reports, staff interviews	S, WL
3.6.6	Processes are in place to effectively manage sickness and absence	>6% No	5.9–3.9% Partial	4% Yes	Adherence to policy, % short-term sickness Evidence of appropriate management in line with attendance at work policy	WL
3.6.7	Exit interviews are undertaken when staff leave the trust	No	Partial	Yes	Discussion	WL
3.7	**Minimising risk**				**Suggested evidence**	**KLOE**
3.7.1	COSHH file is up to date	No		Yes	Observation	S
3.7.2	Information is readily available to staff about their local major incident plan	No		Yes	Observation, staff can say where information can be accessed Action cards are clearly visible to the team	S
3.7.3	Staff are up to date with the trust's medical devices training and competency assessment process	<80%	80–94%	95%	Training records	S

3.7.4	Staff have completed blood transfusion competencies	<80%	80–94%	95%	Training records, core skills dashboard	S
3.7.5	Fire safety checks are undertaken in accordance with trust policy	No	Partial	Yes	Evidence from file	S
3.7.6	Fire exits are kept clear	No		Yes	Environmental observation	S
3.7.7	Resuscitation trolley is checked daily and weekly as per trust requirement and there are no gaps (checked for previous 12 weeks)	>70%	70–89%	90%	Observation of records	S
3.7.8	Staff understand the Datix incident reporting process	No	Partial	Yes	Staff interviews – staff can give examples of where/when they would report	S
3.7.9	Staff are able to give examples of changes made to improve patient safety in response to feeback/lessons learnt	No	Partial	Yes	Staff interviews	R
3.7.10	Staff understand the principles of duty of candour	No	Partial	Yes	Staff interviews	R, WL
3.7.11	Nursing staff take an active role in MDT mortality reviews	No	Partial	Yes	Mortality review records, staff interviews	WL, S
3.7.12	Staff are aware of the procedures to follow in relation to safegaurding vulnerable adults	No	Partial	Yes	Staff interviews	S
3.7.13	Clinical records are kept confidential/stored appropriately/not left unattended	No	Partial	Yes	Observation, staff interviews	S, E

Key ambition 4: Shaping the future workforce

4.1	**Developing staff skills, knowledge and competence**				**Suggested evidence**	**KLOE**
4.1.1	Team members have an annual appraisal and PDP	<80%	80–89%	90%	Report from trust dashboard	WL
4.1.2	All new staff complete a local induction in line with trust policy	<80%	80–89%	90%	Staff records	WL
4.1.3	Staff access training and development relevant to their role/specialty	No	Partial	Yes	Training records, staff interviews Care certificate, academic study	WL
4.1.4	There is evidence that relevant competency-based assessments have been completed by nurses and HCAs	<80%	80–89%	90%	Training records	WL
4.1.5	All newly registered nurses complete the trust's preceptorship process	<80%	80–89%	90%	Staff records	WL
4.1.6	There is evidence of clinical supervision	No	Partial	Yes	Staff interviews, supervision records	WL
4.2	**Learning environment**				**Suggested evidence**	**KLOE**
4.2.1	Students have a positive learning experience	No	Partial	Yes	Student placement evaluations ARC feedback Q21	WL
4.2.2	The ward/department provides an environment that supports the delivery of the preregistration curriculum	No	Partial	Yes	Review Educational Audit of Practice (EAP) report.	WL

4.2.3	All mentors understand the requirements of the preregistration curriculum	<80%	80–94%	95%	ARC Pep reports – all mentors have accessed yearly curriculum updates	WL
4.2.4	Mentors have supervised at least two students in the previous three years	<80%	80–94%	95%	Documentary evidence of triannual review	WL
4.3	**Leadership**				**Observations/comments**	**KLOE**
4.3.1	Staff feel that managers/leaders are visible and approachable	No	Partial	Yes	Staff feedback	WL
4.3.2	Staff feel supported in their role	No	Partial	Yes	Staff feedback	WL
4.3.3	Staff feel valued and appreciated by managers and colleagues	No	Partial	Yes	Staff feedback	WL
4.3.4	Systems are in place to facilitate effective two-way communication between the ward sister and staff	No	Partial	Yes	Evidence of bimonthly staff meetings Attendance, dissemination of minutes Staff notice boards, communication books	WL, E
4.3.5	Band 7 and 6 ward sisters have undertaken a leadership development programme	No	Partial	Yes	Training records Staff feedback	WL
4.4	**Professionalism and culture**				**Observations/comments**	**KLOE**
4.4.1	Staff feel able to raise concerns when they feel patient care and safety are compromised	No	Partial	Yes	Staff interviews	WL
4.4.2	Staff are observed being polite and respectful in their interactions with colleagues	No	Partial	Yes	Observation in practice	WL
4.4.3	Staff feel positive and proud to work in the clinical area	No	Partial	Yes	Staff interviews	WL
4.4.4	Staff adhere to the trust's uniform policy	>85%	85–89%	90%	Audit information, observation in practice.	WL