



Royal College of General Practitioners
Northern Ireland
and
Irish College of General Practitioners

# Out of Hours Accreditation Programme

Guidance Booklet
2015

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# Introduction

The Royal College of General Practitioners (RCGP) was founded in 1952 as an academic body to represent General Practice with the following objective:

*"To encourage, foster and maintain the highest possible standards in general medical practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same."*

In 1994 a Working Party was established to develop standards and criteria for a new programme of team based practice. Subsequently, Out of Hours Accreditation has developed in Northern Ireland from past experience, initiatives and available evidence.

This Accreditation Programme is based on the operating standards and criteria which were developed and piloted by The Royal College of General Practitioners for the Out of Hours Accreditation Programme in Northern Ireland. Out of Hours providers who have completed the accreditation programme have shown tangible quality improvements. Because of an interest in the programme in the Republic of Ireland, RCGP Northern Ireland and the Irish College of General Practitioners, assisted by expert working groups, have adapted them for suitability both to the North and Republic of Ireland settings. The programme also includes references to the HIQA Safer Better Healthcare Standards which are applicable in ROI.

The criteria has been drawn from a variety of sources, including the 'Terms and Conditions of Service for Doctors in General Practice', the UK GP Contract and a number of RCGP Accreditation Programmes.

The Out of Hours Accreditation Programme is intended to measure the practice's performance against 73 criteria set at three levels: -

**E – Essential Practice Criteria (59)**
**Practices/co-operatives must meet all essential criteria, if these criteria are not in place:**

- Legal and/or professional requirements will not be met
- There will be a potential risk to patients or staff or the public
- The clinical governance agenda will not be met when applicable.

**G – Good Practice Criteria (10)**
Standard good practice that is expected to be in place.

**Q – Quality Practice Criteria (4)**
High quality practice which may not yet be standard.

At least 5 of any of the Good and Quality Practice Criteria combined must be met.

# Foreword

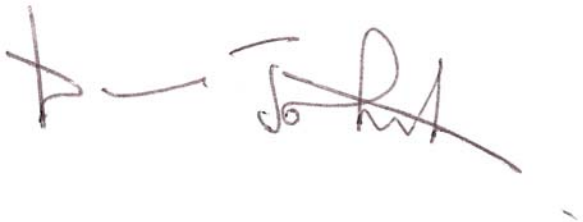
The Royal College of General Practitioners Northern Ireland (RCGPNI) developed a Quality programme to accredit Out of Hours Service Providers in Northern Ireland. The programme enables providers to ensure that they are moving in the right direction in their development and that they have the proper procedures in place to deliver a quality service to their patients. It is a source of tremendous professional satisfaction to be able to demonstrate to others that a high quality service is being provided.

In an effort to support the development of cross-border Out of Hours services, jointly RCGP Northern Ireland and the Irish College of General Practitioners reviewed the programme to make it applicable to Out of Hours service providers in both the North and the Republic of Ireland.

Out of Hours Accreditation adheres to the principles of Clinical Governance and will support General Practitioners in their recognition of quality and the identification of resource and development needs of primary care teams.

The essential features of the programme are that it is professionally led and multidisciplinary in nature. It focuses on the activities of the whole out of hour's team and the service it delivers to patients. There is an external peer review process to ensure that all the components are in place. The ethos is very definitely formative, educative and supportive.

We acknowledge the input and support of the Northern Ireland and ICGP working group members, the ROI RCGP Faculty and Dr Mike Turner of NoWDOC in helping to make this accreditation programme applicable to both the Northern and Republic of Ireland Out of Hours services.



Dr. David Johnston
Out of Hours Lead
Royal College of General Practitioners' Northern Ireland

# Process

Having decided to apply to undertake the RCGP Northern Ireland/ ICGP Out of Hours Quality assessment, the provider should follow the procedure below: -

1. Apply to the RCGP Northern Ireland Regional/ICGP office to submit for the award.

2. Complete the Self Assessment Checklist on pages 15-17, indicating on this which criteria are to be assessed. The checklist should be completed carefully by a member of the organisation/OOH team and signed by one of the doctor principals/medical directors. The signatory will be responsible for ensuring the provider can meet the criteria and subsequently have this verified on the assessment visit.

3. Submit copies of the checklist along with any available or required written evidence proving that criteria have been achieved, in triplicate, to the RCGP NI/ICGP office, as appropriate. This should be presented in a loose leaf file and clearly labelled as to which criteria they refer.

4. Agree timetable with assessors.

5. Accept that the assessors' decision as final.

6. Upon successful completion the Out-of-Hours Quality marker is awarded, which is valid for 3 years.

**Application for Visit**

**Royal College of General Practitioners, NI**

**Irish College of General Practitioners, ROI**

**Out of Hours Quality Assessment**

**Organisation**

Name:…….….

Address:……..…….…….……..

……..…….

Post Code:……...Tel:…….

Email: ……Fax:…….

NUMBER OF SITES …….

**Site/Property 1**

Organisation Manager:……..……

List Size:…….

No. of GP members:(State: FT / PT) ……....

No. of nursing staff:(State: Practice Nurse / Treatment Room, etc..)

……

……

No. of administrative staff:(State: Manager / Receptionist, etc..)

……..

……..……..……

**Site/Property 2 (if applicable)**

Organisation Manager:……..……

List Size:…….

No. of GP members:(State: FT / PT) ……....

No. of nursing staff:(State: Practice Nurse / Treatment Room, etc..)

……

……

No. of administrative staff:(State: Manager / Receptionist, etc..)

……..

……..……..……

**Site/Property 3 (if applicable)**

Organisation Manager:……..……

List Size:…….

No. of GP members:(State: FT / PT) ……....

No. of nursing staff:(State: Practice Nurse / Treatment Room, etc..)

……

……

No of administrative staff:(State: Manager / Receptionist, etc..)

……..

……..……..……

**Site/Property 4 (if applicable)**

Organisation Manager:……..……

List Size:…….

No. of GP members:(State: FT / PT) ……....

No. of nursing staff:(State: Practice Nurse / Treatment Room, etc..)

……

……

No. of administrative staff:(State: Manager / Receptionist, etc..)

……..

……..……..……

**Site/Property 5 (if applicable)**

Organisation Manager:……..……

List Size:…….

No. of GP members:(State: FT / PT) ……....

No. of nursing staff:(State: Practice Nurse / Treatment Room, etc..)

……

……

No. of administrative staff:(State: Manager / Receptionist, etc..)

……..

……..……..……

We confirm our application for quality assessment of our organisation.

Signed …….. Date …….

**Significant Event Analysis**

Users Guide for Practices

Significant Event Analysis was first known as critical event monitoring and provides structure to an activity that has been happening between health care professionals informally on an ongoing basis.. It is the discussion of cases and events and the learning obtained by doing that. It is an extension of audit which is also contained in Accreditation. Discussion of specific events can provoke emotions that can be harnessed to change. For it to be effective, it needs to be practised in a culture that avoids blame allocation and involves all disciplines within the practice/GP co-operative.

The following steps are useful in introducing significant event analyses to a practice/co-operative.

1. Multidisciplinary meeting to explain concept that can be analysed.

2. Consideration of events which should be important to practice/co-operative life but need not imply criticism of the practice/co-operative. The practice/co-operative can construct a core list which need not be slavishly followed or it can use the one published in the RCGP occasional paper, some of the examples from this are below:

| | |
|---|---|
| Preventative Care: | Measles |
| | Unplanned Pregnancy |
| | Non-Accidental Injury |
| | Squint Diagnosed by Ophthalmologist |
| Acute Care: | Sudden Unexplained Death |
| | Suicide Attempt |
| | All New Cancer Diagnosis |
| | Myocardial Infarction |
| Chronic Disease: | Diabetic Hypoglycaemia |
| | Leg Ulcer or Amputation |
| | Asthma – Hospitalisation |
| | Epilepsy – Status Epilepticus |
| Organisation: | Investigation received but not acted upon |
| | Break of confidentiality |
| | Any patient complaints |
| | Upset staff |

3. Mechanism for identification of events.

4. Significant event meetings. These need to be multidisciplinary, chaired and notes taken. Each attendee should be asked to take along at least one significant event. Those in attendance choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached. This can be:

a) Celebration of excellent care

b) No change

c) Audit required

d) Immediate change required

Follow-up of these decisions should be arranged and this may be at the next significant event analysis meeting.

Accreditation requires a minimum of six written reports of significant event analyses carried out within the three years prior to submission. These reports should contain the following elements:

1) Description of event. This should be brief and can be in note form.

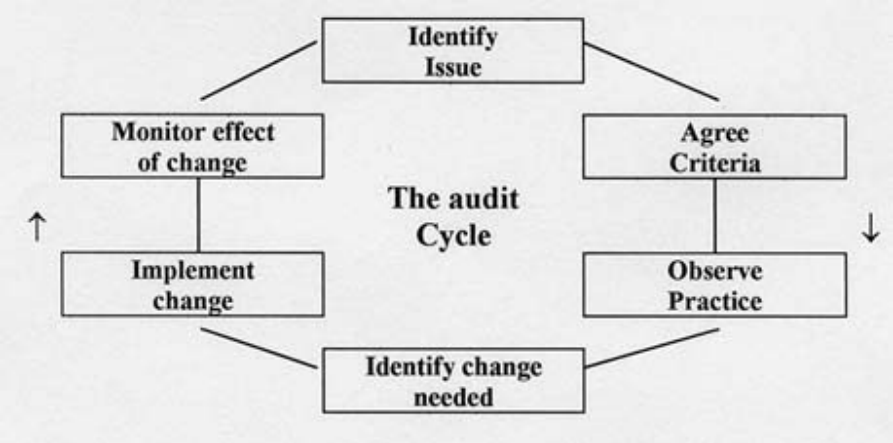
2) Summary of decisions. This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why it occurred.

3) The decisions(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned by the discussion.

**Audit**

**The Audit Cycle**

The process of identifying areas of care to be audited, implementing any necessary changes, and then periodically reviewing the same issues is known as the audit cycle. Although there can be many variations as to what constitutes the 'audit cycle', diagrammatically it is usually represented as similar to Figure 1:




After identifying the topic(s) to be audited, criteria will need to be agreed to decide what constitutes an acceptable standard of care. Current practice is then observed to compare the care which is being delivered against the standards that have been set. Once any changes have been made, their effects can be measured to see if they have the desired outcome.

## Health and Safety

Health and Safety Checklist for assessment visits

1. **Health and Safety Policy** □

   The organisation should have a written outline of their general policy for health and safety (e.g. An A4 statement clearly visible to staff), when employing five people or more.

2. **Health and Safety at Work Act** □

   The organisation should have the current version of the above clearly displayed for staff.

3. **Named Person Responsible for Health and Safety** □

   There should be a named person responsible for Health and Safety (detailed on the above poster).

4. **Employer's Liability Certificate** □

   This should be current and clearly displayed for staff.

5. **Fire**

   - Fire Action Notices – should be clearly displayed. □
   - All Fire equipment should be maintained annually. □
   - Fire Exits – should be clearly marked and unobstructed. □
   - Fire instruction – staff should receive fire training (which is updated) and participate in an annual fire drill. □

6. **Equipment** □

   Electrical equipment should be checked annually.

7. **Hazardous Substances**

   - Clinical waste should be correctly bagged/stored and disposed of through a suitably registered contractor. □
   - Check for other hazardous substances – gases, liquids, cleaning fluids, etc… Are they stored safely and securely? □

8. **Staff** □

   All relevant staff (doctors, nurses and receptionists as a minimum) should be offered immunisation against Hep. B and Rubella. There should be a system to ensure this is reviewed.

9. **Storage of Drugs, Needles and Prescriptions**

   - Storage of drugs should be secure. □
   - Needles should be carefully stored. □
   - Prescriptions should be regarded as secure stationery and treated as such. □

10. **Staff Training** □

    Health and Safety training occurs on recruitment and when being exposed to new or increased risks.

11. **Risk Assessment** □

    A risk assessment has been carried out when employing five people or more.

## Equipment List

A. Clinical staff should have access to the following:

(i) sphygmomanometer

(ii) stethoscope

(iii) otoscope/ophthalmoscope

(iv) tendon hammer

(v) peak flow meter (adult)

(vi) peak flow meter (paediatric)

(vii) tape measure

(viii) adult weight scales

(ix) height measure

B. It will be expected that the following equipment will be available within the surgery building, unless otherwise stated and reasons given:

(i) blood sugar testing sticks

(ii) doppler

(iii) urine testing sticks

(iv) thermoscan

(v) de-fibrillator

(vi) emergency Bag

(vii) nebuliser

(viii) emergency equipment

(ix) pregnancy Tests

(x) ECG machine (applicable to ROI only)

**Patient Satisfaction Survey**

This or equivalent questionnaire should be completed by a sample population of patients (no less than 50) their responses should then form the basis of service improvement plans.

ID:_____

**You recently requested medical help or advice when your doctor's surgery/treatment centre was closed. Please answer the following questions about your experiences. If you have used the service more than once recently, please tell us about your most recent experience.**

**About the patient**

If you requested medical help for yourself, please give your own details here. If you were seeking help for someone else - such as your child - please give details of the other person.

1. What age is the patient? _____ years

2. Is the patient Male □ Female □

**About the service you received**

When you telephoned the out-of-hours service, did you… (Please tick as many boxes as apply)

3. Receive advice over the telephone? □

4. Travel to the surgery or medical centre to be seen? □

5. Receive a visit in your home? □

6. Were you happy with the way your call was handled?
   - Yes □
   - No, I should have been invited to a medical centre □
   - No, I should have been given advice on the phone □
   - No, I should have had a home visit □

| How satisfied are you with the following: | VERY DISSATISFIED | DISSATISFIED | NEUTRAL | SATISFIED | VERY SATISFIED |
|---|---|---|---|---|---|
| 7. Getting through on the telephone | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. The way your initial phone call was handled | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. The time you had to wait before you saw or spoke to a doctor or nurse | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. The manner of the doctor or nurse | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. The explanation the doctor or nurse gave you about your problem | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. The treatment or advice you were given | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Overall, how satisfied were you with the service you received | ☐ | ☐ | ☐ | ☐ | ☐ |

**Draft Organisation Visit Timetable**

| Timescale | GP Assessor | Non-GP Primary Care Professional Assessor | Service User Representative Assessor |
|---|---|---|---|
| **1.00pm – 1.30pm** | Assessors agree visit arrangements and meet with organisation management, GPs and available staff. | | |
| **1.30pm – 2.15pm** | Tour of premises | | |
| **2.15pm – 3.00pm** | Interview reception staff and inspect survey of records, investigating sections 1, 7 and 9. | | Vehicle inspection and interview available drivers, investigating section 12. |
| **3.00pm – 4.15pm** | Interview GPs, investigating sections 4 and 17. | Interview organisation management, investigating sections 3, 10, 11, 12, 13 and 16. | |
| **4.15pm – 5.00pm** | Assessors meeting – check criteria – coffee. | | |
| **5.00pm – 6.15pm** | Interview management and GPs, investigating sections 2, 5, 6, 8, 14 and 15. | | |
| **6.15pm – 6.45pm** | Assessors meeting – check criteria. | | |
| **6.45pm – 7.15pm** | Verbal feedback to practice agreed. | | |
| **7.15pm – 7.30pm** | Verbal feedback to practice delivered. | | |
| **8.00pm** | Assessors debrief. | | |

**Self Assessment Checklist**

Name ……

Organisation ……

Address ……

……

……

I certify that we have achieved all the criteria which have been ticked.

Signed …… Date ……..

(GP Principal/Medical Director)

(Please tick where appropriate)

| **Section** | **Area of responsibility** | **Criteria number** | **Criteria met** | **Criteria not met** | **Data source or evidence supplied** |
|---|---|---|---|---|---|
| Patient | Responsiveness | 1.1 E | | | |
| | | 1.2 E | | | |
| | | 1.3 E | | | |
| | | 1.4 E | | | |
| | | 1.5 E | | | |
| | | 1.6 E | | | |
| | Communication | 2.1 E | | | |
| | | 2.2 E | | | |
| | Annual Review | 3.1 E | | | |
| | | 3.2 E | | | |
| | | 3.3 E | | | |
| | | 3.4 G | | | |

| Section | Area of responsibility | Criteria number | Criteria met | Criteria not met | Data source or evidence supplied |
|---|---|---|---|---|---|
| Clinical | Clinical | 4.1 E | | | |
| | | 4.2 E | | | |
| | | 4.3 G | | | |
| | | 4.4 Q | | | |
| | | 4.5 Q | | | |
| | | 4.6 E | | | |
| | | 4.7 E | | | |
| | | 4.8 E | | | |
| | | 4.9 G | | | |
| | | 4.10 G | | | |
| Organisation | External Relationships | 5.1 G | | | |
| | | 5.2 E | | | |
| | | 5.3 G | | | |
| | | 5.4 Q | | | |
| | | 5.5 E | | | |
| | | 5.6 G | | | |
| | Quality of Administrative performance | 6.1 E | | | |
| | | 6.2 E | | | |
| | | 6.3 E | | | |
| | | 6.4 E | | | |
| | | 6.5 E | | | |
| | Information | 7.1 E | | | |
| | | 7.2 E | | | |
| | | 7.3 E | | | |
| | | 7.4 E | | | |

| Section | Area of responsibility | Criteria number | Criteria met | Criteria not met | Data source or evidence supplied |
|---|---|---|---|---|---|
| | | 7.5 E | | | |
| | | 7.6 E | | | |
| | Information Technology | 8.1 E | | | |
| | | 8.2 E | | | |
| | | 8.3 E | | | |
| | Premises | 9.1 E | | | |
| | | 9.2 E | | | |
| | | 9.3 E | | | |
| | | 9.4 Q | | | |
| | Finance | 10.1 E | | | |
| | | 10.2 E | | | |
| | Health & Safety | 11.1 E | | | |
| | | 11.2 E | | | |
| | Clinician Transport | 12.1 E | | | |
| | | 12.2 E | | | |
| | | 12.3 E | | | |
| | | 12.4 E | | | |
| | | 12.5 E | | | |
| | | 12.6 E | | | |
| | | 12.7 E | | | |
| Staff | Employment Practice | 13.1 E | | | |
| | | 13.2 E | | | |
| | | 13.3 E | | | |
| | | 13.4 E | | | |
| | | 13.5 E | | | |

| Section | Area of responsibility | Criteria number | Criteria met | Criteria not met | Data source or evidence supplied |
|---|---|---|---|---|---|
| | Training & Development | 14.1 E | | | |
| | | 14.2 G | | | |
| | | 14.3 E | | | |
| | | 14.4 G | | | |
| | | 14.5 E | | | |
| | | 14.6 G | | | |
| | Working Patterns | 15.1 E | | | |
| | | 15.2 E | | | |
| | | 15.3 E | | | |
| | Team working | 16.1 E | | | |
| | Protecting Patients | 17.1 E | | | |

| Section A - The Patient (Patient-Centred Care and Support) | | | | |
|---|---|---|---|---|
| **Standard Statement** | **Criteria Code*** | **Reference to HIQA Safer Better Healthcare Standards (ROI ONLY)** | **Criteria** | **Options For Data Source/Evidence** |
| **RESPONSIVENESS** The service is accessible to patients. | 1.1 E | S 2.1.1, 2.1.6 | A patient should be required to make no more than two telephone calls to contact the service, ie one to GP answering machine and one to the OOH service. | Published evidence to patients and guidelines to doctors. Patient survey. |
| | 1.2 E | S 2.1.1, 2.1.6 | A standard call handling policy is implemented by the service. | Written protocol. Expert call management system reports, where available. |
| | 1.3 E | S 2.1.1, 2.1.6 | There are sufficient telephone lines and staff to meet the usual demand. | Survey of calls handled in a Time period, noting number of lines and number of staff.<br><br>Complaints received in this area in the past year. |
| | 1.4 E | S 1.2.2, 1.3,2 | All patients are treated equally and no group is favoured at the expense of | Survey of complaints procedure taking into account the demography of the area. |

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|---|---|---|---|---|
| | | | others. | Question may be included in patient survey (as identified n 1.5) about awareness of complaints procedure. |
| | 1.5 E | S 1.1.7 | A regular audit must be carried out to assess patient satisfaction, by looking at a random sample of patient experiences. The results of these surveys should be included in the Coops annual reports. | Patient satisfaction survey. |
| | 1.6 E | S 1 | If an answering machine is used as part of the access system to the service then the message must be clear and the contact number must be repeated at least twice. The service should routinely check that the answering service is functioning. | Contacting practice/co-operative. |
| **COMMUNICATION** The service communicates openly with | 2.1 E | S 5.3 | There is a broad communication strategy to inform patients about the service including how to | Practice/Service Leaflet. The Out of Hours providers may also have an up to date website. |

| | | | | |
|---|---|---|---|---|
| patients. | | | access it. | |
| | 2.2 E | S 1.6 | There is a protocol ensuring confidentiality which is applicable to all service staff. | Written protocol and confidentiality is included in the employee contract. |
| **ANNUAL REVIEW** The service reviews itself. | 3.1 E | S 5.8 | An annual report is produced which contains information on workload, proportion of calls dealt with in different ways, analysis of patient response and feedback. | Annual report. |
| | 3.2 E | S 1.8 | All complaints are to be monitored and audited in relation to individual staff, locum doctors and doctors working with the organisation as independent contractors. The quarterly report will identify the number and nature of complaints, which should be categorised into clinical, access and organisational, or | Statement of Complaints Procedure. |

| | | | | |
|---|---|---|---|---|
| | | | other. Providers must operate a complaints procedure that is consistent with the principles of the HPSS/HSE complaints procedure. All complaints are to be audited so that appropriate action can be taken where necessary. | |
| | 3.3 E | S 3.1, 3.2 | A regular audit of a sample of patient experiences must be carried out and appropriate action taken. The results of these should form part of the co-ops annual report. | Results of the audit. |
| | 3.4 G | S 2.6.4, 5.4, 5.5 and T7 | A development plan is created containing details of the way forward for the organisation, where applicable. | A written development plan or details included in the annual report. |

| SECTION B - CLINICAL CARE | | | | |
|---|---|---|---|---|
| **Standard Statement** | **Criteria Code*** | **Reference to HIQA Safer Better Healthcare Standards (ROI ONLY)** | **Criteria** | **Options For Data Source/Evidence** |
| **CLINICAL**<br>The service provides a good standard of clinical care. | 4.1 E | S 2.1 | There is a protocol for non-clinical staff training for answering, prioritising and handling all calls. | Written protocol and observation at visit. |
| | 4.2 E | S 2 | There are appropriate protocols for nurse telephone triage if nurses are employed. | Electronic based guidelines/protocols where available. Written protocol. |
| | 4.3 G | S 2 | There are appropriate protocols for doctor/nurse telephone triage.v | Written/electronic protocol. It is suggested that an electronic tick box list would be used for telephone triage and include details on time of call, who took the call, who the call was from (patient, parent, minder etc), urgency assigned. |

| | | | | |
|---|---|---|---|---|
| | 4.4 Q | S 2 | Any protocols in use should be readily available and regularly audited. | Written/electronic (where available) protocols and audit. |
| | 4.5 Q | S 2.3 | There is a system in place for reflective learning, sharing of best practice and service improvement. | Description of at least one service improvement resulting from complaint, significant event analysis, critical event analysis or risk assessment process. |
| | 4.6 E | S 3.1 | There is up to date emergency equipment and drugs, which are readily accessible to all doctors. | Up to date inspection of drugs and equipment. |
| | 4.7 E | S 3.1.5 | There is a system for maintaining drugs and equipment. | Examination of system. |
| | 4.8 E | S 3.1 | There is a minimum list of drugs used in emergencies and this list is agreed with relevant authorities. | Examination of list. |
| | 4.9 G | S 3.1 | There is a locally agreed drug formulary in use. | Examination of the Drug Formulary. |

| | | | | |
|---|---|---|---|---|
| | 4.10 G | S 2.3 | There is a mechanism to effectively pass on information between shifts where relevant. | Description of mechanism, e.g. handover sheet/direct input into patient record. |

| Section C - Organisation | | | | |
|---|---|---|---|---|
| **Standard Statement** | **Criteria Code*** | **Reference to HIQA Safer Better Healthcare Standards (ROI ONLY)** | **Criteria** | **Options For Data Source/Evidence** |
| **EXTERNAL RELATIONSHIPS** The service establishes productive joint working arrangements. | 5.1 G | S 2.2, 2.3 | There is an agreed procedure defining inter-referral between A&E and the service and vice versa. | Written procedure. |
| | 5.2 E | S 2.2, 2.3 | Where ancillary services are available, there is knowledge of how contact is made between the service and out-of-hours community nurses, mental health teams, social work departments and ambulance services. | Statement of how contact is made with respective services. |
| | 5.3 G | S 2.2, 2.3 | There are working links with acute hospitals, out-of-hours community public health nurses/doctors, | Evidence of discussions between managers of respective services. |

| | | | | |
|---|---|---|---|---|
| | | | mental health retrieval teams, social work departments and ambulance services. | |
| | 5.4 Q | S 2. | The OOH service needs to market and communicate the services they offer with the intent of better informing the public and broader health service/professionals. | Evidence of meetings with appropriate user groups. |
| | 5.5 E | S 2 | There are agreed referral guidelines to general dental services, where available. | Guidelines. |
| | 5.6 G | S 5 | The organisation has strategies in place to mitigate major organisational risks | A written strategic plan that covers disaster planning and to include IT failure, major staff loss/illness, major epidemic (inc. influenza), and major fire and flood damage. |
| **QUALITY OF ADMINISTRATIVE PERFORMANCE** The service is well | 6.1 E | S 2.1.1 | Call Handling: Providers should have a policy for telephone call handling. This should include | Written Standards. Audit. |

| | | | | |
|---|---|---|---|---|
| administered. | | | engaged and abandoned calls. All calls should be answered within 150 seconds from the end of an introductory message. | |
| | 6.2 E | S1.2.3, 1.4.1 | A robust system for identifying all immediate life threatening conditions must be in place. For these cases a call must be placed with ambulance service within 3 minutes. | Written Standards. Audit |
| | 6.3 E | S 2.1 | The following must be achieved to reach the standards for telephone clinical assessment and disposal where reasonable:<br>Urgent calls:<br>• 90% within 30 minutes (where nurse triage is fully operational)<br>• All complete within 60 minutes. | Written Standards.<br><br>Audit. |

| | | | | |
|---|---|---|---|---|
| | 6.4 E | S 2.1.1, 2.2.3<br>Access S 1 | Face to face consultations (in centre or patients place of residence) must be completed as follows:<br>1) Very Urgent - as soon as feasible and practicable with early involvement of the Emergency services where clinically indicated.<br>2) Urgent - Within two hours after completion of Triage (90%)<br>3) Routine - Minor illness/Injury - within 6 hours after completion of triage (90%) | Written Standards.<br>Audit. |
| | 6.5 E | S1 | Patients should be given an appointment time to be seen in the centre and an indication of the waiting time if need to be seen at home. If the doctor is going to be longer than expected, patients will be updated of this (by telephone for home visits). | Written Standards. |

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| **INFORMATION** Good clear, accurate and contemporaneous patient records are kept and information flows to the right people at the right place and time. | 7.1 | E | S2.5 | Records are kept for all contacts including telephone consultations for a minimum of 7 years. | Inspection of call log and records. |
| | 7.2 | E | S 2.5 | If telephone calls are recorded then this information should be highlighted on all publicity material to patients. | Publicity material. |
| | 7.3 | E | S 2.5.1, 2.6.3 | Providers must be able to supply clinical details to the patients own GP by the start of the next working day | System describes the method of transferring information during the next working day. |
| | 7.4 | E | S 2.5.3 | Entries in the records are appropriate, accurate, legible and attributable. | Survey of records by your organisation. Minimum standard: 90% of cases will be attributable. Of these, 80% will show appropriateness, accuracy and legibility. |
| | 7.5 | E | S 3.1.4 | All the medication that is dispensed and/or prescribed must be clearly documented in the patient record in all cases. | Survey of records by your organisation.<br>Emergency dispensing procedure policy.<br>Minimum standard: 80% of relevant records show dosage, |

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| | | | | directions and amount stated. |
| | 7.6 E | S 8.2.9 | Patients have access to their records on request in accordance with Data Protection and Freedom of Information Acts. | Questioning of staff. There is information to give out to patients on relevant Acts. |
| **INFORMATION TECHNOLOGY**<br>Information Technology is managed to comply with statutory requirements and improve the quality of the service.<br>. | 8.1 E | S 8.3.2 | If the service uses a computer it is registered under and conforms to the provisions of the Data Protection Act. | Copy of registration document. |
| | 8.2 E | S 8.2 | There is a written policy regarding:<br>a) Levels of access<br>b) Backing up data<br>c) Storage | Written policy. |
| | 8.3 E | S 8.2.7 | The system includes a secure trail to prevent data erasure and to guard the data, time and author of data entries and alterations. | Description of system. |
| **PREMISES**<br>The service has appropriate accommodation. | 9.1 E | S 2.7 | The Out of Hours Provider has made every effort to ensure that premises are accessible to disabled | Description of accessibility for disabled people and inspection of premises. |

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| . | | | people. | |
| | 9.2 E | S 2.7 | Examinations at the service's premises allow for the patient's privacy and dignity. | Inspection of premises that show individual consultation rooms with curtained area or room for examinations. |
| | 9.3 E | S 1 | Adequate privacy is provided for incoming and transferring calls, so that information is not overheard. | Inspection of services. |
| | 9.4 Q | S 1 | Patients unable to communicate effectively in English will be provided with an interpretation service, where available, within 30 minutes of initial contact. Providers must also make appropriate provision for patients with impaired hearing or impaired sight. | Description of service. |
| **FINANCE**<br>The finances of the service are well managed. | 10.1 E | S 5.5.1, 7.1 | The service has a policy to ensure financial accountability. | Annual audited accounts and standard financial procedures and controls. |

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| | 10.2 E | S 5.5.1 | The financial management of the services include:<br>• An annual budget<br>• Regular reports of income, expenditure and cash flow. | Description of financial management. |
| **HEALTH AND SAFETY**<br>The service adheres to the statutory requirements of health and safety. | 11.1 E | S 5.10 | The service will meet the statutory requirement of the Health and Safety at Work Act. | Inspection of premises. |
| | 11.2 E | S 3.1.1, 5.11 | The service will have carried out a risk assessment. | Written risk assessment. |
| **CLINICIAN TRANSPORT**<br>If vehicles are provided for the doctors by the service, they are appropriate. (These sections only apply to organisations where transport is provided.) | 12.1 E | S 7 | The vehicles supplied are appropriately maintained and suitable for attending urgent home visits. | Inspection of car services and vehicles meet legal requirements. |
| | 12.2 E | S 7 | There is a reliable method of communication with the doctor while in the car. | Inspection of system of communication. |
| | 12.3 E | S 7 | The licences of drivers employed are inspected. | Inspection of personnel file. |

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| | 12.4 E | S 7 | Drivers employed will fulfil current legal requirements. | Clean drivers licence. |
| | 12.5 E | S 7 | There are contingency plans to deal with vehicle breakdown. | Inspection of plan. |
| | 12.6 E | S 7 | Adequate insurance is provided for the vehicles and occupants. | Inspection of the vehicle papers. |
| | 12.7 E | S 7 | All drivers must inform their manager in writing of any changes in their circumstances which would effect their employment. | Inspection of personnel file. |

| SECTION D – STAFF (WORKFORCE) | | | | |
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| **Standard Statement** | **Criteria Code*** | **Reference to HIQA Safer Better Healthcare Standards (ROI ONLY)** | **Criteria** | **Options For Data Source/Evidence** |
| **EMPLOYMENT PRACTICE**<br>The service fulfils its statutory obligations as an employer. | 13.1a E<br><br>13.1b | S 6.2 | A system is in place to check that locum or new doctors are assessed as suitably trained as defined by the GP principle/medical director, is registered and in good standing with the relevant regulatory body and fulfils all relevant professional requirements.<br><br>Trainees can only work under the appropriate supervision as designated by the requirements of the appropriate body. | Description of system.<br>Description of arrangements for Registrars. |
| | 13.2 E | S 6.2 | A system is in place to ensure that all employed nurses are registered with | Inspection of Personnel File and questioning of nurses. |

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| | | | the relevant regulatory authority.<br><br>Any staff dealing with children and vulnerable adults are have undergone appropriate checks. | |
| | 13.3 E | S 6.4 | All statutory regulations in relation to staff employment (e.g. Equal Opportunities, National Insurance, Staff contracts, PAYE, Statutory Sick Pay) are adhered to and personnel records kept. | Description of selection and remuneration systems. |
| | 13.4 E | S 6.4.6 | There is an agreed disciplinary procedure that adheres to statutory requirements. | Copy of disciplinary procedure. |
| | 13.5 E | S 6.3.1 | All staff and independent contractors (clinical and non-clinical), including locum doctors, receive an induction, any necessary training and a job | Inspection of job descriptions and questioning of staff. |

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| | | | description.<br>Independent contractors to provide relevant insurance documents | |
| **TRAINING AND DEVELOPMENT**<br>The training needs of all staff are met. | 14.1 E | S 6.1.2 | The introduction, use and any change in any protocol are backed up with appropriate training. | Description of training and questioning of staff. |
| | 14.2 G | S 6.3.5 | Clinical staff are offered training on giving telephone advice on a regular basis. | Description of training and questioning of staff. |
| | 14.3 E | S 6.3.2 | All clinical staff should have up to date CPR training, including use of defibrillator, on a routine basis. GPs may provide proof of attending training elsewhere, e.g. in Practice. | Description of training and record of attendees. |
| | 14.4 G | S 3.1 | Providers must carry out an investigation and review of significant events in keeping with HPSS/HSE guidelines. | Written anonymous reports on significant event analyses. |
| | 14.5 E | S 6 | There is a regularly updated and accessible standard operating procedures manual. | Inspection of procedures manual. |

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| | 14.6 G | S 6.3.6 | All employed staff are regularly assessed and training needs identified. | Inspection of staff appraisal system. |
| **WORKING PATTERNS** Working patterns of staff are scrutinised. | 15.1 E | S 6 | A protocol is in place for calling additional clinical staff. | Written protocol. |
| | 15.2 E | S 6 | A policy is in place to state in contracts that no more than 16 hours can be worked in any given 24 hour period. This applies across the services not just in one service to ensure that the quality of care is not compromised by doctors or staff suffering from fatigue. | Written policy. |
| | 15.3 E | S 6 | Workload is periodically reviewed to ensure sufficient staffing levels and vice versa. | Evidence of review. |
| **TEAM WORKING** The service promotes effective communication and teamwork. | 16.1 E | S 1.1 | There are regular multi-disciplinary meetings to discuss clinical and administration issues, including meetings with | Board meetings. Staff/practice meetings. Inspection of diary entry and questioning staff. |

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| | | | other providers. | |
| **PROTECTING PATIENTS**<br>Patients are protected when a doctor's health or performance puts them at risk. | 17.1 E | S 1, 6.4.7 | There is a system of reporting to the appropriate body if anyone's performance, conduct or health might be putting patients at risk. | The complaints procedure needs to filter complaints accordingly as per the standard complaints mechanism including the degree of risk and the action that needs to be taken and by whom. |


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