Gloucestershire Hospitals NHS Foundation Trust

Accredited Clinical Environments (ACE)- Cycle 1- 2023/24
Lead Nurse for Accreditation Assessment Form

Date:
Ward Manager:
Area Matron:
Divisional Director of Quality and Nursing:
Assessment carried out by: Alan Dyke

Results following visit	
Percentage of standards achieved %	
Date Improvement Plan Due:	

Grading

Designation	% of standards met	Improvement action
White	Less than 60% - concern	To discuss immediately with Matron and DDQN
Bronze	61%- 80%	Action plan to be developed within 4 weeks
Silver	81%-90%	Action plan to be developed within 4 weeks
Gold	Over 91% complete action plan in place	Sustained level of achievement and improvement

For Gold to be achieved your Area requires a Shared Decision-Making Council represented at NAME Council (This can be area specific or part of a wider team). It must have 3 sets of Minutes in a 6-month period. Alternatively, a ward meeting that practises shared decision making.

Name of Council	

ACE

Delivering high quality and appropriate care to people who use our service is of paramount importance. The Trust overall must be accountable for the quality of care it delivers and that care should be evidence based and appropriate to the individual needs.

Measuring the quality of nursing care delivered by individuals and teams. This performance assessment framework considers both the Nursing Midwifery Council (NMC)- "Fundamentals of care" (2015 updated 2018).

The framework is separated into 5 parts.

1. Pre visit review of key information
2. Ward manager discussion
3. Staff discussions
4. Patient experience views
5. Ward Observations

Pre visit review of key information. Ward manager discussion. Staff discussions. Patient experience views. Ward Observations.

ACE recognises the important role our team plays and has questions relative to their health and wellbeing, as per the NHS Peoples Promise.

Assessment Process

1. The Lead Nurse for accreditation and regulation will select a day to assess the area arranged in conjunction with the ward manager as an announced visit.

2. The process begins away from the area where the Lead Nurse will undertake a review of key information pertaining to the area. Comparing key diagnostics and insight prior to the visit.

3. On Visiting the area, a three-step approach, Meeting and tour with the area manager, discussion with the Multidisciplinary Team, and patients alongside observation of practice.

4. The nursing, midwifery and AHP assessment will cover the following areas on the ward:

    - Observation of area environment and care contact episodes
    - Discussion with patients, visitors and staff members (including area manager or representative)
    - Health Records / EPR review (spot check of ten patient records, for paper records)

5. Where an indicator is not observed or not applicable, it will be noted as NA. The total number of yes (compliant) against the total number of statements applicable to an area gives the final area percentage.

6. Following the assessment, the Lead Nurse will provide verbal feedback to the Area Manager and write a report of findings to be shared with the Area Manager, Matron and Divisional Director of Quality and Nursing as well as identified Specialty Leads for relevant standards within 10 working days. Reports will be shared with the Chief Nurse, Deputy Director of Quality and Deputy Chief Nurse.

7. The Area Manager will be required to formulate an Improvement Plan for all indicators where “no” is answered. The Improvement Plan will be prepared on a standard template.

8. The Area Manager will be given 4 weeks to create their Improvement Plan (from date of receipt of the report) and will send a copy of the Improvement Plan to the Matron to approve and endorse in practice. Extensions to the 4-week timeframe may be given at the Lead Nurse/Area Matrons discretion.

9. The Improvement Plan should be returned to the Lead Nurse electronically.

10. Improvement Plans will then form part of every ward team meeting/Council and Area Manager/Matron “1-2-1” to track progress. Councils should be actively involved in finding shared solutions to identified issues.

	Effective leadership, and Safety of the Clinical Environment	Source	Yes	No	N/A	Feedback
1	Duty rotas are signed off as fully approved within the Trust E-roster deadline.	e-roster				
2	Staff appraisal compliance rate is equal to, or greater than 90%.	Compliance report				
3	Staff Mandatory Training rate is equal to or greater than 90%.	Compliance report				
4	Review of EPR Inpatient Care Report to ensure high standards of documentation- Highlight up to 3 areas for Improvement. If not available audit of ten sets of patient record admission.	EPR Inpatient Care Report				
5	Patients' admission documentation is fully completed greater than 95%.	EPR Inpatient Care Report				
6	All relevant care plans are in place and appropriately completed.	EPR Inpatient Care Report Observe				
7	Review Datix relevant to the area. Including Rate of response (number of days)	Datix system Area manager/Staff	For Information			
8	Review of FFT data for Clinical Environment.	FFT SharePoint	For information			
9	Health records are stored in a secure trolley / locked room and under direct supervision when not in use and in public.	Observe				
10	Computers are not left "logged in" and active allowing unsupervised access to patient information.	Observe				
11	Staff ID badges and Name badges are worn by all staff.	Observe staff				
12	Uniform Policy is adhered to by all staff. (If concerns discuss with area manager re possible management plans regarding staff)	Observe staff				

	Effective leadership, and Safety of the Clinical Environment	Source	Yes	No	N/A	Feedback
13	Magnetic designated bedspace signage has all the appropriate information needed.	Observe				
14	Designated bed space oxygen and suction points are accessible for all bed spaces and in good working order.	Observe				
15	Portable oxygen cylinders are in date with adequate amounts for emergency use and are stored appropriately.	Observe				
16	Patient privacy, dignity and modesty is maintained by the use of curtains, screens, and appropriate clothing and permission is obtained before entering these designated bed spaces.	Observe				
17	Equipment is cleaned in between patients (e.g., Dynamap, pulse oximeter, BM machines, thermometers).	Observe				
18	Patient Property is being managed in line with Policy -Check of snatch box and lost property.	Observe				
19	Beds are in a good state of repair evidence of a mattress Audit in area- spot check if able.	Observe				
20	Sharps bins are correctly assembled and signed according to policy, stored appropriately away from public access, clean and not overfilled.	Observe				
21	Safer sharps are used unless otherwise authorised.	Observe stocks. Ask staff/Area Manager				
22	All paper-based documentation has 3 pieces of personal Identifiable information- (if applicable).	Observe				
23	Evidence of Nurse in Charge of shift. Allocated on roster.	Observe Ask staff				
24	The multidisciplinary team have a positive experience of the nursing staff on the ward.	Ask Staff				
25	The ward has a “positive culture” (honesty, respect, transparency, civility).	Ask Staff				

	Effective leadership, and Safety of the Clinical Environment	Source	Yes	No	N/A	Feedback
26	Senior staff (Band 6 and 7- Band 5s who take charge) can clearly articulate the steps they would take if there was short notice staff absence.	Ask staff				
27	Staff are aware of the Trust's Complaints and PALS procedure and the importance of patient feedback.	Ask staff				
28	All staff can identify fire exits in their area of work and explain the evacuation procedure.	Ask Staff				
29	Staff are aware of correct procedure after sustaining a sharps injury.	Ask Staff				
30	Staff are aware of what the different coloured identity bands denote and staff can give examples of when they would check patient identification and actions to take in the event of a discrepancy.	Ask Staff				
31	Staff feel able to attend and participate in Area Council shared decisions.	Ask Staff				
32	There is evidence that staff are encouraged and are given the opportunity to pursue practice-based education and courses.	Area Manager				
33	There is evidence that staff are encouraged and permitted flexible working to meet service and individual needs.	Area Manager				
34	Discuss ward handover format- use of SBAR.	Area Manager Ask Staff				
35	There is evidence of learning from, and acting on patient experience feedback.	Area Manager				
36	Evidence of councils held and minutes.	Area Manager				
37	Patients and relevant visitors are informed of their clinical progress and discharge plans.	Ask Patient				
38	Patients are encouraged to be involved in their own care and contribute to care planning.	Ask Patient/Carer Ask Staff				
39	Visitors to the area (including patients) can access information pertinent to the ward regarding Ward Management structure, visiting times etc.	Ask Patient Observe				

	Effective leadership, and Safety of the Clinical Environment	Source	Yes	No	N/A	Feedback
40	Information is available to support patients and carers in giving feedback regarding their care. PALS Leaflets/poster. FFT information.	Ask patients				
41	The nurse call systems are within the patient's/carers reach.	Ask Patients Observe				
42	Patients are not bothered by unavoidable noise and light at night.	Ask Patients				
43	Patients, carers and relatives have access to appropriate information and leaflets within the ward area.	Ask Patients Observe				
44	Staff introduce themselves to patients and their relatives using "Hello, My Name Is…" and their role.	Ask patients Observe				
45	All patients wear a clear, clean and accurately printed identity band.	Ask Patients Observe				

	Safeguarding Patients	Source	Yes	No	N/A	Feedback
46	Patients have a safeguarding screening tool completed within 4 hours of arrival to ward.	EPR/Documentation				
47	Patients requiring Enhanced Care will have the relevant risk assessment completed.	EPR/Documentation				
48	All patients who have a safeguarding concern are identified at every safety huddle / handover.	Documentation. Ask staff/ Observe				
49	Staff can identify when and how to escalate safeguarding concerns.	Ask staff				
50	Staff are aware of the appropriate referral and assessment form to complete when an allegation of domestic abuse is disclosed.	Ask staff				
51	Staff are aware of when and how to contact the Safeguarding, Learning Disabilities and Mental Health Liaison teams.	Ask staff				
52	Staff have awareness of and can access policies and procedures relating to safeguarding, care of the carer, etc.	Ask staff				
53	Staff can describe how to identify a patient with a Management Plan and what they would do.	Ask staff				

54	The area manager is able to describe the steps to be taken if any safeguarding concerns are raised regarding a staff member.	Area manager				
55	Do patients feel safe in their clinical environment.	Ask Patients				

	Medicines Management	Source	Yes	No	Feedback
56	POPAM Audit results Reviewed- Action Plan in place if required.	Pharmacy pages			
57	In all cases where medicines have been omitted the reason for omission has been documented on drug chart/EPR.	Pre-Visit Observe			
58	All medicines are stored safely as per POPAM guidelines.	Observe			
59	Patients dispensed / prepared medication is not left unattended but seen to be given / taken immediately.	Observe			
60	Patient's ID and allergy status is checked (against wristband and verbally) prior to administration of medicines.	Observe			
61	The medication fridge is locked and has a current temperature log sheet which is completed daily (3 months or since last assessment) and relevant actions documented according to results.	Observe			
62	All IV infusions are stored in appropriately labelled drawers / containers or in their original boxes and potassium-containing solutions kept separately.	Observe Area			
63	There is a printed file of PGDs, each signed by those competent to administer that PGD. All PGDs are in-date and the most current published version is being used.	Area Manager			

	Infection control	Source	Yes	No	Feedback
64	Monthly Hand Hygiene Audit is completed and logged on Infection Control Share point (3 months or since last assessment).	IC SharePoint			
65	High impact Intervention Audits are completed in line with policy. (Review 3 months).	IC SharePoint			
66	Covid Assurance Framework: is completed and logged on the IC SharePoint in line with current policy.	IC SharePoint			
67	The 3 most recent Cleanliness Scores within Nursing Metrics are rated green/amber.	Audit record			
68	Alcohol rub is directly accessible at the point of care and are all working.	Observe			

69	Empty bed spaces and Equipment not in use (lockers/chairs/beds/overbed tables/Syringe pumps etc) are identified as being clean by appropriate signage- and is up to date within policy.	Observe			
70	All items within the Dirty Utility room are stored appropriately and where necessary have evidence of being cleaned (labels / stickers).	Observe			
71	There is an adequate supply of mouth care tools: toothbrush, denture pot, toothpaste (containing fluoride)	Observe			
72	All area cleaning rotas are evident and are completed (bed pulling, weekly / daily cleaning).	Ask staff			
73	Staff are able to demonstrate where IPC information resources can be found.	Ask staff			
74	The ward has an Infection Control Link Nurse.	Ask Area Manager			
75	Infection Control link meeting minutes and other pertinent information are disseminated to staff by the relevant Link Nurse / Champion.	Ask Area Manager Observe resource			

	CARE: Pain	Source	Yes	No	NA	Evidence/Outcome
76	There is an identified, pain link nurse for the clinical area with an available resource which contains up to date information.	Ask staff / Observe				
77	There are adequate simple comfort/pain-relieving measures available for patients e.g., pillows and repositioning.	Observe				
78	Staff are aware of when and how to contact the different specialist teams for Pain Management.	Ask staff				
79	Staff know how to access clinical guidelines for pain management.	Ask staff				
80	All staff have taken action to ensure optimisation of pain management. There is documented evidence of assessment and actions taken.	Ask patients. Documentation				

	CARE: Deteriorating patient	Source	Yes	No	N/A	Evidence/Outcome

81	There is documented evidence that the appropriate EWS score has no missing values and is correctly calculated.	EPR/Observe				
82	There is documented evidence that the appropriate EWS pathway is followed when escalation actions are required.	EPR/Observe				
83	Staff highlight any patients (using full name) with an Advanced Care Plan on safety huddles / all handover.	Observe safety huddle / discuss with staff				
84	The checklists for the Resuscitation Trolley and associated equipment are completed as per Trust policy.	Observe/ Compliance Report				
85	The resuscitation trolley and associated equipment is easily accessible, clean and staff know where to find it / them.	Observe Ask Staff				
86	Staff demonstrate knowledge of the SBAR communication tool.	Ask staff				

	CARE: Nutrition & Hydration	**Source**	**Yes**	**No**	**NA**	**Evidence Outcome**
87	Patients have weight recorded on admission.	EPR- 10 sets				
88	The patient's MUST score has been completed within 24 hours of admission. (4-hour standard)	EPR Inpatient Care Record				
89	MUST reassessments are completed on a weekly basis (where appropriate).	EPR PATIENT				
90	Kitchen Audit is completed and Action Plan in place.	Via GMS Area Manager				
91	Staff can identify the variety of available menus (i.e., cultural / modified texture etc.), and how to obtain them (including weekend and Bank Holidays provision).	Ask staff				
92	Staff clearly identify and record patients who are nil by mouth.	Ask staff Observe				
93	Staff can articulate the importance of mouth care, good oral health and the links to general health and wellbeing.	Ask staff				
94	Staff appropriately prepare the patient for mealtimes (remove obstacles, positioning, offer hand wipe).	Observe Ask patients Ask staff				

95	All efforts are made to ensure patients receive adequate nutrition and hydration in an appropriate manner. Patients report food is timely and warm on arrival if appropriate.	Patients				

	CARE: Tissue Viability	Source	Yes	No	N/A	Notes
96	On admission to the Clinical Environment a relevant risk assessment is correctly calculated and recorded. According to results, relevant documentation is commenced and completed appropriately.	EPR				
97	All patients needing referral to TVN service have had this done.	EPR/Documentation Ask staff				
98	If patients have a management plan put in place by Tissue Viability, is there evidence that this is being adhered to or evidence of review if not adhered to.	EPR/Documentation				
99	Mattresses, seats and pressure relieving aids are clean (with no evidence of inappropriate stickers, tape, etc.) and are fit for purpose.	Observe				
100	Pressure relieving equipment (including seating) is used appropriately to meet individual patient needs.	Observe area Ask staff				
101	All zipped items (mattress covers, seat cushions / covers etc.) are opened up after every patient discharge to check for signs of ingress / damage.	Ask staff observe				
102	Staff can describe the reporting process for patients with tissue damage.	Ask staff				
103	The area has a proactive Tissue Viability Link Nurse with evidence of feedback relating to TV matters to all staff. All staff are able to identify who this is.	Ask Manager				
104	Patients (or their carer) that are deemed high risk of tissue damage are given relevant information (both verbal and written).	Patients Observe				

	CARE: End of Life	Source	Yes	No	N/A	
105	Area has appropriate well stocked end of life resources in line with trust guidance.	Observe				
106	Area has a nominated End of Life/SWAN Ambassador who has attended an annual update, is aware of how to	Ask staff				

	replenish SWAN resources & demonstrates other initiatives to promote best practice in care of the dying.					
107	Syringe pump training rate is above 50% (Note target from 2024/25 75%)	Training Data				
108	Feather symbol displayed appropriately on EPR 95% of time when a dying patient is recognised.	BI Data				
109	On visit day patients with EPR feather symbol also have visual feather signage at bedside.	Observe				
110	Assessment of care of the dying and management of uncontrolled symptoms.	Observe Ask staff				
111	Staff are aware and able to follow correct procedures after death.	Observe Ask Staff				

	Elimination	**Source**	**Yes**	**No**	**N/A**	
112	Daily checks of the catheter care plan are fully completed. Staff are Monitoring how long the patient's urinary catheter has been in place.	Documentation/EPR (Observe)				
113	Patient's drainage bags are positioned appropriately and a catheter securing device is in place.	Observe Ask staff / patients				
114	The reason for an indwelling catheter insertion is documented on the catheter care plan.	Observe documentation				
115	Patients & carers have access to specific products and devices to assist in the management of bladder and bowel incontinence	Ask patient Observe				
116	When giving assistance to meet the elimination needs of patients, staff ensure that this is performed with consideration to the individual's need for privacy and dignity.	Ask patients				