Jersey Care Commission

Jersey Care Commission
Care Standards
Service Specific Requirements
Medical Care

Safe
Effective
Caring
Responsive
Well-led

SAFE

Standard 2. Learning Culture

We have a positive and proactive culture of safety based on openness and honesty. We listen to safety concerns, investigate and report safety events thoroughly, and learn from them to improve and embed good practices.

What this means to people:
I can voice safety concerns and the service takes these concerns seriously, investigates thoroughly, and learns from any safety incidents to improve practices.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 17 Workers
Regulation 22 Complaints and representations
Regulation 71 Requirements in respect of complaints procedure

2.2 Service Specific Requirements

2.2.1 The service assures itself that it is following best practice and using validated tools, such as NICE guidance, for the prevention and management of neutropenic sepsis.

2.2.2 The service has robustly reported safeguarding incidents, maintaining an audit trail of evidence and actions taken. Notifications have been appropriately made to the Commission, and relevant agencies.

2.2.3 The service monitors the incidence of pressure ulcers, falls, catheters and urinary tract infections (UTIs), and venous thromboembolism (VTE) for medical inpatients. Appropriate action is taken as a result of the findings to address and mitigate these issues.

SAFE

Standard 3. Safe systems, pathways and transitions

We work with people and our partners to establish and maintain secure care systems. We manage, monitor, and ensure safety. We make sure that care is continuous, even when people move between different services.

What this means to people:

- I know what to do and who I can contact when I realise that things might be at risk of going wrong, or my health condition may be worsening.
- When I move between services, settings or areas, there is a plan for what happens next, who will do what, and all the practical arrangements are in place.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 15 Shared responsibilities

3.2 Service Specific Requirements

3.2.1 The service assures itself against and implements NICE standards on things such as falls assessment.

3.2.2 Urgent or unplanned medical admissions are seen and assessed by a relevant consultant within 12 hours of admission or within 14 hours of arrival at the hospital, as per Society for Acute Medicine: Quality Standards. Before this, admissions are assessed by a suitably qualified medical practitioner within 30 minutes of arrival.

3.2.3 All people admitted acutely are continually assessed and monitored using the National Early Warning System (NEWS) 2, and the NEWS2 competency-based escalation trigger protocol is used for all people who use the service.

3.2.4 There is a hospital-wide standardised approach to the detection of patients whose conditions is deteriorating and a clearly documented escalation response. This includes during out-of-hours, with clear pathways and processes for the assessment of clinically unwell patients within endoscopy service, radiology departments, acute oncology unit, dialysis unit and day case patients who require hospital admission.

3.2.5 There is evidence of the use of a sepsis care bundle for the management of patients with presumed/confirmed sepsis, including an escalation policy for patients who require immediate review.

3.2.6 Treatment is delivered to patients with presumed sepsis within the recommended sepsis pathway timelines, such as antibiotics within an hour (Sepsis 6), and sepsis patients receive prompt assessment when escalated to a multi-professional team.

3.2.7 Leaders ensure that employees involved in the performance of invasive procedures develop shared understanding and are educated in good safety practice, including the development of local Safety Standards for Invasive Procedures using national guidelines.

3.2.8 Processes are in place to escalate patients who are in need of a higher level of care.

3.2.9 Staff have access to 24/7 mental health liaison and/or other specialist mental health support if they are concerned about risks associated with a patient's mental health, know how to make an urgent referral to them, and receive a timely response. Additionally, staff are provided with debriefing or other support after involvement in aggressive or violent incidents.

3.2.10 The service has an acute oncology service in line with the recommendations of the national recommendations.

3.2.11 Risk assessments, including those for pressure areas, are appropriately completed, especially for patients in the department for over 6 hours.

3.2.12 When people are prescribed an antimicrobial, the clinical indication, dose, and duration of treatment are accurately documented in their clinical record.

3.2.13 If a patient has been seen by a member of the mental health liaison team, their mental health assessment, care plan, and risk assessment are accessible to staff on the ward/clinic.

3.2.14 The staff team receives advice from mental health liaison about what to do if the patient attempts to discharge themselves, refuses treatment, or encounters other contingencies.

3.2.15 When relevant, staff have access to patient-specific information such as care plans, positive behaviour support plans, health passports, and communication aids, and they use or refer to them as needed.

3.2.16 The service ensures timely transfer of information between multiple IT systems, such as Electronic Patient Records and a separate cancer information system.

3.2.17 Patient records include all multi-disciplinary team staff involved in the patient's treatment, with a clear MDT plan, including other services, to support the patient through the pathway.

3.2.18 The service shares comprehensive discharge summaries with patients and their GPs, care home or home care staff, and anyone with power attorney including details of any surgery, implants, or medication changes to ensure effective continuity of care in the community.

Standard 4. Safeguarding

We work with people to understand what safety means to them and with our partners to make it happen. We focus on improving people's lives while protecting their right to live safely, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure that we share concerns quickly and appropriately.

What this means to people:
I am listened to, respected and know that my identity and personal safety matters. Care providers and partners work together to make sure I am kept safe from harm, bullying, and discrimination.

Relevant regulatory requirements

Regulation 9A Need for consent
Regulation 8 Person-centred care
Regulation 11 Safeguarding

4.2 Service Specific Requirement

4.2.1 If a patient is assessed to be at risk of suicide or self-harm, arrangements are put in place to enable them to remain safe.

4.2.2 Staff know how to identify, and report suspected abuse and/or neglect.

4.2.3 There is individualised and effective multi-agency follow-up, and leaflets with support contact details are available and offered.

4.2.4 There is an “abduction policy” and staff is aware of it.

4.2.5 There are policies and procedures in place for extra observation or supervision, lawful restraint, and, if needed, rapid tranquilisation.

Standard 7. Safe and effective staffing

We make sure there are enough qualified, skilled, and experienced staff who are well supported and receive effective supervision and development. They work together effectively to provide safe care that meets people's individual needs.

What this means to people:

- I always receive safe care and treatment delivered by competent staff
- Staffing levels and skills are planned and reviewed to provide safe care
- I know who my named nurse or key worker is and know how to contact them

Relevant regulatory requirements

Regulation 2 Fitness criteria
Regulation 8 Person-centred care
Regulation 17 Workers

7.2 Service Specific Requirements

7.2.1 There is a policy for sepsis management, and staff are aware of it.

7.2.2 Staff have received training to make them aware of the potential needs of people with mental health conditions, learning disabilities, autism, and dementia.

7.2.3 Where appropriate, staffing is based on national guidance set out in The National Quality Board's publication for AHPs and non-medical professionals.

7.2.4 A consultant trained in General Internal Medicine or Acute Internal Medicine, or with equivalent experience, is on call at all times and is able to reach the unit within 30 minutes.

7.2.5 Staffing skill mixes and distribution of staff grades are made in accordance with the national standards (such as standards set in the Society for Acute Medicine and the West Midlands Quality Review Service publication, Quality Standards in the Acute Medical Unit).

7.2.6 A doctor trained in the specialty of General Internal Medicine or Acute Internal Medicine, or a registered healthcare professional with equivalent competencies, is immediately available at all times. They must have up-to-date competencies in Advanced Life Support (ALS).

7.2.7 There is appropriate access to Clinical Nurse Specialist staffing or other appropriate care coordinators for all cancer patients.

Standard 9. Medicines optimisation

We make sure that medicines and treatments are safe and meet people's needs, capacities, and choices. We involve people in planning their care, even when things change.

What this means to people:

- I feel safe and am supported to understand and manage any risks.
- I know what to do and who I can contact when I realise that things might be at risk of going wrong, or my health condition may be worsening.
- If my treatment, including medication, has to change, I know why and am involved in the decision.
- I have considerate support delivered by competent people.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 14 Management of medicines

9.2 Service Specific Requirements

9.2.1 When someone dependent on alcohol or illegal drugs is admitted, the service offers medicines to assist with their withdrawal and associated side-effects.

9.2.2 The individuals and teams responsible for antimicrobial stewardship actively monitor data and provide constructive feedback on prescribing practices at both prescriber and team levels, fostering continuous improvement in antimicrobial use.

9.2.3 When individuals are prescribed an antimicrobial, the service ensures that a microbiological sample is taken, and their treatment is systematically reviewed when results become available.

9.2.4 When people are discharged, their medicines are explained to them and their carers, and they are informed about what to do with their previous medicines.

9.2.5 Systems are in place to identify, report, and learn from medicines related safety incidents and alerts.

9.2.6 When people are prescribed psychotropic medicines for challenging behaviour, it is in line with local protocols and national guidance, and the rationale and duration are documented with timely review.

EFFECTIVE

Standard 11. Delivering evidence-based care and treatment

We work with people to plan and provide care and treatment, considering what matters to them. Our approach aligns with the law and follows the latest evidence-based best practices and standards.

What this means to people:

- I am involved in the planning of my treatment and care.
- I am able to influence important decisions about my treatment and care.
- I can give or withhold my consent freely.
- The care I receive is personalised to my preferences and supported by best practice.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 12 Cleanliness and infection control
Regulation 13 Nutrition and hydration
Regulation 14 Management of medicines
Regulation 16 Control and restraint

11.2 Service Specific Requirements

11.2.1 The service has adapted guidance on quality standards for medical conditions published by NICE. Processes and mechanisms are in place to meet these standards for conditions such as chronic heart failure, chronic kidney disease, diabetes in adults, acute coronary syndromes, acute kidney injury, and acute upper gastrointestinal bleeding.

11.2.2 All people on the Acute Medical Unit are seen and reviewed by a consultant twice daily to ensure continuity of care, with consultants often working multiple day blocks to maximise continuity of care.

11.2.3 Once transferred from the acute area of the hospital to a general ward, people are reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless determined otherwise by the patient's care pathway.

11.2.4 Staff follow best practice for assessing and monitoring the physical health of people with severe mental illness, including appropriate health screening and falls risk assessment.

11.2.5 Patients suspected to be experiencing depression are referred for a mental health assessment.

11.2.6 Staff handovers routinely refer to the psychological and emotional needs of patients and their relatives/carers.

11.2.7 Relevant staff are trained to deal with violence and aggression appropriately.

11.2.8 Older people who may be frail or vulnerable receive a comprehensive assessment of their physical, mental, and social needs as a result of their contact with the service.

11.2.9 Healthy food and drink choices are available within the department for the well-being and satisfaction of patients and their accompanying individuals.

11.2.10 The service has effectively implemented, those standards, within the Faculty of Pain Medicine’s Core Standards for Pain Management, which can be met by a non-NHS organisation.

EFFECTIVE

Standard 12. How staff, teams and services work together

We collaborate well between teams and services to help people. We ensure that people who use services only have to tell their story once, by sharing their needs assessment when they move between different services.

What this means to people:

- I only have to tell my story once, and the care I receive is based on teams working together, even when I move between services
- I can expect that all information provided will be treated confidentially and held securely
- My care records will be shared appropriately with my knowledge and consent and on a need to know basis.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 15 Shared Responsibilities

12.2 Service Specific Requirements

12.2.1 People with complex needs receive prompt screening by a multi-professional team, including physiotherapy, occupational therapy, nursing, pharmacy, medical staff, and social services. A clear MDT assessment is undertaken within 14 hours, with a treatment or management plan in place within 24 hours of admission.

12.2.2 There are regular MDT meetings for people with complex needs, and social services attend as appropriate.

12.2.3 There is evidence of multi-disciplinary/interagency working when required, facilitating comprehensive care for patients with complex needs.

12.2.4 Pathways exist for referral between specialties within the hospital and with organisation for specialist advice. Staff effectiveness in utilising these pathways is evaluated.

12.2.5 All team members are aware of who has overall responsibility for each individual's care.

12.2.6 Established links exist with mental health services, learning disability services, autism services, and dementia services.

12.2.7 There is evidence of multi-disciplinary/interagency working when required, facilitating comprehensive care for patients with complex needs.

12.2.8 Cancer MDT Terms of Reference include links with other MDTs and services, ensuring access to specialised care for teenagers and young adults (TYA) with solid tumours.

12.2.9 Regular clinical discussions support effective protocol management of non-complex cancer patients, with a focus on incorporating patients' views and wishes into their care plans.

12.2.10 The service supports delivery of the Recovery Package of interventions, including Holistic Needs Assessments and Treatment Summaries, to improve communication between cancer services, patients, and primary care.

EFFECTIVE

Standard 14. Monitoring and improving outcomes

We routinely monitor people's care and treatment to continuously improve outcomes. We ensure that outcomes are positive and consistent and that they meet both clinical expectations and the expectations of people themselves.

What this means to people:

- The care and treatment I receive is constantly monitored so that improvements can be made.
- I receive the best care possible for my condition.
- I am consulted about new or recommended treatments for my condition.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 9A Need for consent

14.2 Service Specific Requirements

14.2.1 The service regularly reviews the effectiveness of care and treatment through local audit and national audit participation. This includes audits such as:

- National Asthma and COPD Audit Programme (NACAP) for Respiratory care.
- MINAP, Heart Failure Audit, National Audit of Cardiac Rhythm Management.
- Inflammatory Bowel Disease Audit and National Bowel Cancer Audit for Gastroenterology.
- National Dementia Audit, Stroke Audit, National Audit of Seizure Management, National Lung Cancer Audit, National Prostate Cancer Audit, Breast Cancer in Older People, and other relevant audits for Neurology and other specialties.

14.2.2 The Service participates in the UK Renal Registry, National Diabetes Inpatient Audit, Rheumatoid and Early Inflammatory Arthritis Audit, and Inpatient Falls Audit, among others.

14.2.3 The service participates in the Joint Advisory Group on GI Endoscopy (JAG) and holds accreditation.

14.2.4 Action plans are created to address deviations from national targets, and the organisation’s performance against national standards and benchmarks against similar services is regularly compared. Analysts' reports against these comparisons are used for the service assessment and improvement plans.

14.2.5 Regular audit meetings are held to review performance in patient outcomes, and evidence of quality improvement efforts is expected and checked for.

14.2.6 For cancer care, the service regularly reviews the effectiveness of care and treatment for cancer through local and national audit participation, comparing outcomes with benchmarks.

14.2.7 The proportion of cancer patients offered the opportunity to take part in clinical trials is monitored, and efforts are made to ensure all cancer patients are informed about ongoing trials.

14.2.8 Clinicians assessing patients acutely unwell with frailty are competent to identify the most appropriate care pathway, ensuring tailored care for patients with frailty.

14.2.9 The service has established effective processes for patient discharge into the community, ensuring continuity of care and appropriate support for patients post-discharge.

14.2.10 Evidence of multi-disciplinary and interagency working is apparent, especially when required for the safe discharge of patients with complex needs, demonstrating a commitment to comprehensive and collaborative care.

14.2.11 Staff are knowledgeable about and proficient in referring patients to local services when additional support is required, such as substance misuse services, contributing to holistic patient care.

14.2.12 Target time for first consultant review follows national guidance or local policy.

EFFECTIVE

Standard 15. Consent to care and treatment

We inform people about their rights regarding consent and always respect these rights when providing personalised care and treatment.

What this means to people:

- I am well-informed and understand my rights.
- Services and staff consistently respect and uphold my right of consent and choice.
- I understand I can change my mind at any time or an any particular treatment

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 9A Need for consent

15.2 Service Specific Requirements

15.2.1 In situations involving patients without the capacity to consent, the medical care follows a comprehensive approach to decision-making, which includes consultations with individuals holding powers under Deputyships or Lasting Powers of Attorney, as well as involving relatives and friends interested in the person's welfare.

15.2.2 A clear and pre-identified pathway is in place for patients placed under Article 36 of the Mental Health (Jersey) Law 2016, ensuring access to an identified place of safety that can adequately meet their medical and mental health needs. This demonstrates a systematic and organised approach to managing individuals under Article 36, emphasising patient well-being and appropriate care.

15.2.3 There is a sedation policy in use on wards which is clearly documented and followed by all relevant staff.

15.2.4 Systems and practices ensure there is no inappropriate use of sedation.

15.2.5 If any patients are detained under the Mental Health (Jersey) Law 2016, staff are aware that additional steps must be considered if the patient does not consent to treatment. They know where to get advice on these matters.

15.2.6 The service has considered and implemented national/international recommendations in relation to opioid medication administration (such as Gosport Inquiry report) to ensure best practices in patient care and safety.

CARING

Standard 16. Kindness, compassion, and dignity

We always treat people with kindness, empathy and compassion, and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

What this means to people:

- I am always treated with kindness, empathy, compassion and respect.
- I am listened to, and my views are taken seriously.
- I know how to complain when things go wrong.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 9A Need for consent

16.2 Service Specific Requirements

16.2.1 Staff take into account psychosocial aspects of care as well as physical aspects.

16.2.2 Staff respond to patients who might be frightened, confused, or phobic about medical procedures or any aspect of their care with empathy, patience, and appropriate support strategies, ensuring to address their concerns and provide reassurance.

CARING

Standard 18. Independence, choice and control

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and well-being.

What this means to people:
I am informed about my rights, and staff actively involve me in making choices and decisions about my care, treatment, and well-being.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 7A Visitors and involvement in the community
Regulation 8 Person-centred care

18.2 Service Specific Requirement

18.2.1 In open environments, staff assist distressed patients in maintaining privacy and dignity, demonstrating a proactive approach to addressing individual needs and preserving patient dignity.

RESPONSIVE

Standard 21. Person-centred care

We make sure people are at the centre of their care and treatment choices, and we decide, in partnership with them, how to respond to any relevant changes in their needs.

What this means to people:
I have care and support that is coordinated, and everyone works well together with me.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 9A Need for consent

21.2 Service Specific Requirements

21.2.1 The arrangements for ambulatory care, including opening hours, are clearly defined and communicated.

21.2.2 The needs of patients with mental health conditions, learning disabilities, autism, and dementia are routinely considered when the provider conducts impact assessments or undergoes changes.

21.2.3 The service implements a series of key interventions which, when delivered together, are likely to improve outcomes for people living with and beyond cancer (example, MacMillan Recovery Package).

21.2.4 There are systems and staff members in place to aid the delivery of care to patients in need of additional support, such as dementia champions, dementia symbols above beds, Learning Disability link nurses, and stickers on paper records.

21.2.5 The service provides excellent care for people living with dementia, featuring a dementia-friendly ward/area, with a significant number of staff trained in dementia care, and dementia assessments conducted upon admission.

21.2.6 Arrangements are in place for people who need translation services.

21.2.7 Suitable arrangements are in place for people with a learning disability.

21.2.8 The service provides comprehensive care for people with other complex needs, including those who are hearing-impaired, visually impaired, or require wheelchair access.

21.2.9 Single call access for mental health referrals is available 24 hours a day, seven days a week, with a maximum in-person response time of 1hour for emergency referrals and routines up to 24 hours.

21.2.10 Complex discharges are supported effectively, with key information about older people with complex needs communicated to community health team members upon discharge, including sharing assessments such as tissue viability (pressure risk) and nutritional assessment and risk.

21.2.11 Staff have access to communication aids to help patients become partners in their care and treatment, using the patient's preferred methods and making easy-read materials available and utilised.

21.2.12 The service avoids discharging people late at night if they have complex needs and live alone.

21.2.13 If people with a mental health condition, learning disability, autism, or dementia need extra support or supervision on the ward or in the clinic, this support is available.

21.2.14 Appropriate discharge arrangements are in place for people with complex health and social care needs, taking into account chaotic lifestyles when necessary.

21.2.15 Patients are given a choice on how they would like to receive results or bad news, whether by phone at home or face-to-face. Adequate and suitable space is provided for breaking bad news and supporting distressed patients, relatives, and staff, with access to the patient's Clinical Nurse Specialist (CNS) or equivalent available during these times.

RESPONSIVE

Standard 25. Equity in access

We ensure that there is equal access to care, support, and treatment and seek to ensure it is provided when it is needed.

What this means to people:
I am in control of planning my care and support. If I need help with this, people who know and care about me are involved.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 19 Premises and equipment

25.2 Service Specific Requirements

25.2.1 There are rapid access/'hot' clinics such as Transient Ischaemic Attack clinics and Rapid Access Chest Pain clinics.

25.2.2 The number of medical outliers is monitored, and arrangements for their review include being seen at the end of ward rounds or by a separate team.

25.2.3 There is an Out of Hours (OOH) discharge policy in place.

25.2.4 The average and maximum number of bed moves during a patient stay is tracked.

25.2.5 The number of bed/patients moves occurring out of hours (between 10pm and 6am) is recorded.

25.2.6 Discharge planning is initiated at the time of admission.

25.2.7 Daily 'Board Rounds' are conducted to review patient status and discharge plans.

25.2.8 Flow within the hospital is coordinated by a designated site team, which works effectively with the rest of the hospital.

25.2.9 Operational pressure escalation policies are in place and are effectively implemented, particularly during high-pressure periods.

25.2.10 Escalation beds are managed appropriately when open.

25.2.11 Discharges typically occur before 11am, and this timing is monitored to ensure efficiency. Reasons for delayed discharges are identified and addressed.

25.2.12 The service ensures that it meets clinical guidance for report turnaround times for medical staff requesting diagnostic imaging and endoscopy.

25.2.13 People with urgent mental health needs are seen within one hour of referral by an appropriate mental health clinician and assessed in a timely manner.

25.2.14 The flow between the service and other providers, including tertiary services, is effectively managed to ensure capacity to accept referrals and repatriation of patients.

WELL-LED

Standard 32. Governance, management, and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment, and support. We act on the best information about risk, performance, and outcomes, and we share this securely with others when appropriate.

What this means to people:

- I am looked after by an organisation where staff are clear about their roles and work within their competencies.
- I can expect to receive the best care and treatment available.
- My care provider is committed to delivering safe care.
- I can rely on my care provider to be aware of the risks involved in delivering safe care and in preventing harm.

Relevant regulatory requirements

Regulation 17 Workers
Regulation 18 Premises and equipment
Regulation 19 Reviewing quality of service
Regulation 21 Notification of incidents, accidents, and other events
Regulation 24 Financial viability
Regulation 26 Commissioned services
Regulation 27 Absence of manager

32.2 Service Specific Requirements

32.2.1 Leadership is organised on a shift-by-shift basis, including designated nursing and medical leads.

32.2.2 All consultants have job plans, and these are addressed yearly to ensure ongoing clarity and alignment with service goals.

32.2.3 There is a designated lead for mental health within the service/department, with appropriate expertise or support from someone with expertise in the area.

32.2.4 Innovative approaches are implemented to help ease staffing issues and foster workforce stability.

32.2.5 Appropriate security arrangements are in place to ensure the safety and protection of staff and others, especially during weekends and out-of-hours.

32.2.6 Patients' mental health and emotional well-being are given significant prominence in day-to-day activities within the service, including handovers, record-keeping, and care and treatment plans.

32.2.7 There is a sepsis lead responsible for overseeing departmental sepsis management, including neutropenic sepsis. The service monitors and investigates unplanned re-admissions due to neutropenic sepsis and takes action to improve processes while disseminating learning.

32.2.8 The service participates in audits related to mental health and emotional wellbeing, with actions taken based on audit findings.

32.2.9 Relevant senior staff members are aware of risks or issues related to staff mental health and emotional wellbeing on the ward. These are recorded and appropriate actions are taken.

32.2.10 Support is available for non-mental health staff who may lack competency or confidence in addressing people's mental health or emotional needs.