



Jersey Care Commission
Care Standards
Service Specific Requirements
Surgical 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 Requirement

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

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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 The service has an admission policy in place that sets out safe and agreed criteria for the selection and admission of people using the service. This policy ensures that urgent and elective admissions are conducted in a systematic and consistent manner, prioritising patient safety and appropriate care delivery.
- 3.2.3 The service ensures that appropriate pre-operative assessments are recorded by implementing a structured assessment protocol that includes detailed documentation of the patient's medical history, current health status, and any relevant risk factors. This protocol is consistently followed by all staff involved in pre-operative care.

- 3.2.4 For cosmetic surgery, the service ensures that consultations take into account the nationally recommended key aspects (example, from Royal College of Surgeons of England), including identifying psychologically vulnerable patients who may require further psychological assessment before undergoing surgery.
- 3.2.5 The service consistently conducts pre-operative safety briefings to discuss anticipated issues and other important considerations for surgery.
- 3.2.6 The service ensures compliance with the 5 steps to safer surgery, World Health Organization (WHO) surgical checklist, including marking of the surgical site, to enhance patient safety and reduce the risk of surgical errors.
- 3.2.7 The hospital implements the WHO surgical checklist for radiological interventions and adapts it to fit local practice, ensuring that essential safety checks are conducted before performing procedures involving radiological interventions.
- 3.2.8 The Surgical Safety Checklist for Cataract Surgery is utilised to ensure safe and effective practices during cataract surgery procedures, reducing the risk of adverse events and improving patient outcomes.
- 3.2.9 All patients admitted acutely are continually assessed using the National Early Warning System (NEWS) to monitor their clinical status and identify any signs of deterioration promptly. The service demonstrates timely intervention and appropriate escalation of care when necessary.
- 3.2.10 Access to consultant medical input is ensured through established processes and protocols, allowing patients to receive timely specialist assessment and management as needed for optimal care outcomes.
- 3.2.11 There is evidence of the use of a sepsis screening tool and sepsis care bundle for the management of patients with presumed/confirmed sepsis, including an escalation policy for patients who require immediate review.

- 3.2.12 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.
- 3.2.13 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.
- 3.2.14 The service ensures that appropriate 24-hour emergency call or hotline arrangements are in place following discharge, with access to a named suitably-qualified person. Through this, the service ensures patients have access to support and advice in case of post-operative complications or concerns, promoting their safety and well-being.
- 3.2.15 When emergency surgery is undertaken, American Society of Anesthesiologists (ASA) Score (or equivalent) is assessed on admission. If the pre-operative mortality risk is assessed at >10%, patients are reviewed by a consultant within 4 hours, and the procedure is overseen by a consultant surgeon/anaesthetist irrespective of the time of day or night.
- 3.2.16 24/7 access to interventional radiology (IR) and therapeutic endoscopy is available, either on-site or through networked arrangements, ensuring timely access to essential diagnostic and therapeutic procedures for patients requiring urgent intervention.
- 3.2.17 Adequate planning ensures the availability of level 2 post-operative care for high-risk patients, ensuring that patients with complex needs receive the appropriate level of care and monitoring post-operatively to minimise risks and complications.

- 3.2.18 Protocols, including service level agreements (SLAs), are in place for the transfer of patients using services to the NHS in the event of complications from surgery or other appropriate facilities. This ensures that people receive timely and appropriate care in the event of adverse events or complications.
- 3.2.19 The service ensures appropriate falls assessment and subsequent action is taken as necessary to prevent falls and minimise the risk of injury for patients, promoting their safety and well-being throughout their care journey.
- 3.2.20 In cases of life-threatening haemorrhage, tested arrangements are in place to ensure immediate availability of blood for transfusion, access to emergency equipment, and effective communication systems. These emergency arrangements are tailored to the range of surgeries undertaken and the degree of geographical isolation from other healthcare services, ensuring a rapid and coordinated response to critical situations.
- 3.2.21 Processes are in place to escalate patients who are in need of a higher level of care.
- 3.2.22 GPs have direct access to the service, including the ability to speak to a surgical consultant or Specialist Registrar (SpR) for advice over the phone. This facilitates prompt communication and support for patient management.
- 3.2.23 Medication changes, particularly for older individuals with complex needs, are promptly communicated to the GP, care home staff or home care staff if applicable, as well as to those holding power of attorney. This ensures that all relevant parties are fully informed about adjustments to the patient's medication regimen.
- 3.2.24 The service ensures that consultants' operating records and the patient's clinical record are integrated into the hospital record for the patient. This integration supports comprehensive and cohesive patient care documentation.

- 3.2.25 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.
- 3.2.26 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.
- 3.2.27 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.
- 3.2.28 The care provider ensures timely transfer of information between multiple IT systems, such as Electronic Patient Records and a separate cancer information system.
- 3.2.29 Patient records include all multi-disciplinary team staff involved in the patient's treatment, with a clear MDT plan, including other providers, to support the patient through the pathway.
- 3.2.30 The provider 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, medical implants, or medication changes to ensure effective continuity of care in the community.

SAFE

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 Requirements

- 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 Risk assessments are used and in place, and timely referrals are made to relevant agencies such as safeguarding and police.
- 4.2.4 There is individualised and effective multi-agency follow-up, and leaflets with support contact details are available and offered
- 4.2.5 There is an “abduction policy” and staff is aware of it.
- 4.2.6 There are policies and procedures in place for extra observation or supervision, lawful restraint, and, if needed, rapid tranquilisation.
- 4.2.7 The responsibility for post-operative care lies with a designated team, and there is medical input to ensure comprehensive care.
- 4.2.8 For services treating patients under the age of 18, appropriate child safeguarding arrangements are in place.

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Standard 6. Safe Environments

We detect and control possible risks in the care environment. We make sure that the equipment, facilities, and technology support the delivery of safe care.

What this means to people:

- I feel safe in the care environment.
- I am protected from harm caused by the use of faulty equipment.
- I am protected from harm caused by any defect in the building where my care is provided.
- Staff who care for me, or support me, are trained to operate equipment and know what to do when things go wrong.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 9A Need for consent
Regulation 8 Person-centred care
Regulation 11 Safeguarding
Regulation 18 Premises and equipment

6.2 Service Specific Requirements

- 6.2.1 The service ensures a minimum Level 2 post-operative care is provided and appropriately trained healthcare professionals capable of providing the necessary level of care, monitoring, and intervention for post-operative patients staff these areas.
- 6.2.2 If bariatric surgery is carried out, the equipment used is safe and appropriate for this patient group. This includes specialised bariatric equipment such as operating tables, surgical instruments, and monitoring devices designed to accommodate larger patients and support their specific needs during surgery and recovery.
- 6.2.3 Instruments, equipment, and implants are in compliance with Medicines and Healthcare products Regulatory Agency (MRHA) requirements, and there are processes in place for providing feedback on product failure to the appropriate regulatory authority. Any issues with equipment or implants are reported promptly, investigated thoroughly, and addressed to prevent recurrence and ensure patient safety.

- 6.2.4 Recording systems are in place to allow details of specific implants and equipment to be provided rapidly to the healthcare products regulator. This facilitates efficient communication and reporting of any adverse events or incidents related to medical devices, implants, or equipment, enabling regulatory authorities to take appropriate action as needed.
- 6.2.5 Facilities, surgical, and anaesthetic equipment, including resuscitation and anaesthetic equipment, are available, fit for purpose, and checked in line with professional guidance. Regular equipment maintenance, servicing, and calibration are conducted to ensure optimal performance and safety standards are upheld in accordance with industry best practices and regulatory requirements.

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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. There is training available in sepsis management and recognising signs of sepsis.
- 7.2.2 The Consultant will either deliver or closely supervise surgery ensuring that experienced and highly qualified professionals oversee and perform surgical procedures, optimising patient outcomes and safety.
- 7.2.3 Guidance on theatre staffing levels, as set out by recognised professional bodies, is followed. This includes maintaining the appropriate number of skilled and qualified personnel in operating theatres to ensure patient safety and the smooth operation of surgical procedures.
- 7.2.4 The service ensures that the consultant or a nominated (equivalent) deputy is always contactable 24 hours a day and within a 30-minute time frame if required to attend a patient.

- 7.2.5 The service ensures that the anaesthetist is always available post-operatively if required. Anaesthetists are on standby and able to attend promptly, providing necessary post-operative care and managing any complications that may arise, thus ensuring patient safety and comfort.
- 7.2.6 An ST3 (Specialty Trainee Year 3 or equivalent) or someone with MRCS (Membership of the Royal Colleges of Surgeons) and ATLS (Advanced Trauma Life Support) should be available to assess and manage urgent patients within an appropriate and safe response time following their arrival at the hospital. This ensures that urgent patient needs are promptly addressed by appropriately trained and qualified staff, enhancing the quality and timeliness of care provided. The response time should be aligned with clinical guidelines and hospital policy to prioritise patient safety and effective care delivery.
- 7.2.7 Staff have received training to make them aware of the potential needs of people with mental health conditions, learning disabilities, autism, and dementia.
- 7.2.8 There is appropriate access to Clinical Nurse Specialist staffing or other appropriate care coordinators for all cancer patients.
- 7.2.9 The service ensures that consultant surgeons only perform surgery for which they are skilled, competent, and experienced.
- 7.2.10 The service ensures that first assistants for consultant surgeons, such as advanced scrub practitioners (ASPs), are appropriately qualified and competent.
- 7.2.11 The service ensures that anaesthetists possess and demonstrate the relevant skills and expertise for the procedures being undertaken.
- 7.2.12 For procedures involving intravenous sedation, the service ensures that practitioners administering sedation have received appropriate training and are competent in airway management and resuscitation.

- 7.2.13 The provider ensures that surgeons performing cosmetic surgery undergo a multi-source feedback exercise during their revalidation cycle, which includes their cosmetic practice.
- 7.2.14 All surgeons undertake relevant continuing professional development (CPD) activities, including in the area of professional behaviours.
- 7.2.15 Regular case reviews of complex cosmetic surgery cases are conducted and acted on.
- 7.2.16 All surgeons performing cosmetic surgery have operative exposure in their area of certification, as recommended by the RCS, ensuring they carry out the requisite minimum number of procedures in their certification area.

SAFE

Standard 8. Infection prevention and control

We assess and manage the risk of infection. We detect and control the risk of infection spreading and share any concerns quickly with the right people.

What this means to people:

- I can expect to receive care and treatment in a clean and safe environment
- I will not be exposed to a higher risk of infection when in hospital or in any other care setting
- I will be cared for in a way that reduces the risk of cross infection if I have a contagious condition
- I feel protected and appropriately cared for and do not feel isolated or alone.

Relevant regulatory requirements

Regulation 12 Cleanliness and infection control
Regulation 18 Premises and equipment

8.2 Service Specific Requirements

- 8.2.1 The service ensures that systems, processes, and practices reflect NICE guidance regarding surgical site infection by implementing evidence-based protocols for preoperative, intraoperative, and post-operative care. These protocols include proper skin antisepsis, antibiotic prophylaxis, and surgical technique, as well as monitoring and auditing infection rates to ensure compliance and continuous improvement.
- 8.2.2 The service screens new admissions for MRSA, C. difficile, MSSA, and GNBSI using established screening protocols that involve taking swabs or samples upon admission and conducting laboratory tests to identify any infections promptly.
- 8.2.3 There are adequate and appropriate arrangements to isolate people awaiting elective procedures from those requiring emergency surgery to prevent cross-contamination. This includes using separate wards or designated areas and ensuring strict adherence to infection control practices.

- 8.2.4 The service follows the decontamination guidance outlined in the management and decontamination of flexible endoscopes Health Technical Memorandum by implementing rigorous cleaning, disinfection, and sterilisation procedures, ensuring all endoscopic equipment is properly maintained and decontaminated after each use.
- 8.2.5 The service manages and decontaminates reusable medical devices in line with national guidance such as the Health Technical Memorandum on decontamination. This includes using validated decontamination processes, maintaining detailed records of decontamination cycles, and regularly auditing compliance to ensure patient safety and adherence to best practices.

SAFE

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 Surgery is managed in accordance with the specified principles and guidelines such as National Confidential Enquiry into Patient Outcome and Death (NCEPOD), Royal College of Surgeons (RCS) for Unscheduled Surgical Care, Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines, Breast and Cosmetic Implant Registry (BCIR).

11.2.2 The service regularly conducts internal audits and peer reviews of peri-operative care and implements a structured morbidity and mortality review process to identify and address areas for improvement (NCEPOD recommendations).

11.2.3 The service has a monitoring system in place to ensure that unscheduled surgical care adheres to the Royal College of Surgeons (RCS) standards for Unscheduled Surgical Care. This should include regular training sessions, compliance audits, and feedback mechanisms.

- 11.2.4 The service ensures anaesthetic practices follow the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines by incorporating them into standard operating procedures and providing continuous education for anaesthesia staff.
- 11.2.5 The service has standardised clinical pathways for elective hip and knee surgeries, ensuring adherence to evidence-based practices for pre-operative, intra-operative, and post-operative care.
- 11.2.6 The service integrates regular VTE risk assessments into the patient care protocol and uses clinical decision support tools to guide the use of prophylactic measures.
- 11.2.7 The care provider actively participates in national benchmarking clinical audits to measure performance against national standards. The audit results are used to identify areas for improvement and implement changes.
- 11.2.8 The care provider adheres to national recommendations and the RCS Professional Standards for Cosmetic Surgery and conducts thorough pre-operative assessments, including psychological evaluations where appropriate.
- 11.2.9 The care provider follows professional guidelines for recording and managing medical device implants, including participation in national registries like the Breast and Cosmetic Implant Registry (BCIR).
- 11.2.10 The service has a clinical audit programme to support and monitor the implementation of guidelines, uses NICE implementation support tools and participates in the NICE shared learning database.
- 11.2.11 The care provider encourages early mobility post-surgery by minimising the use of drips and catheters, following best practices for enhanced recovery.

- 11.2.12 The care provider uses electronic prescribing systems that link the clinical indication with the antimicrobial prescription to ensure appropriate use and reduce the risk of antimicrobial resistance.
- 11.2.13 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.
- 11.2.14 Patients suspected to be experiencing depression are referred for a mental health assessment.
- 11.2.15 Staff handovers routinely refer to the psychological and emotional needs of patients and their relatives/carers.
- 11.2.16 Relevant staff are trained to deal with violence and aggression appropriately.
- 11.2.17 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.
- 11.2.18 Healthy food and drink choices are available within the department for the well-being and satisfaction of patients and their accompanying individuals.
- 11.2.19 The service has effectively implemented the latest Faculty of Pain Medicine's Core Standards for Pain Management in its practices.
- 11.2.20 The service ensures that people are given effective management of nausea and vomiting following surgery.
- 11.2.21 People using the service have access to dietitian services post-operatively.

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 colleagues attend as appropriate.

12.2.3 There is 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 other organisations for specialist advice.

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 People using services receive suitable and timely pain relief before physiotherapy sessions.
- 12.2.8 Safe discharge of patients undergoing elective surgery is facilitated by effective, tailored planning, including pre-operatively.
- 12.2.9 The service liaises with families and carers when discussing discharge plans to ensure they are properly involved and well informed about the process.
- 12.2.10 The service avoids people late at night if they have complex needs and live alone, to ensure their safety and well-being.
- 12.2.11 Key information about people with complex needs is communicated to members of the community health team on discharge. This includes sharing assessments, such as tissue viability (pressure risk) and nutritional assessments and risks.
- 12.2.12 Medical consultants are actively involved in the care of surgical patients when needed.
- 12.2.13 The service ensures that the resident on-call team covering specialty always receives appropriate information about the patients and the surgeries being undertaken at any time, especially when the surgeon and/or anaesthetist leave the premises before the patient is fit for discharge home.

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, if applicable, such as:

- National Bowel Cancer Audit (Health Quality Improvement Partnership (HQIP))
- Head and Neck Oncology (HQIP)
- Oesophago-Gastric Cancer (HQIP)
- Prostate Cancer (HQIP)
- Cardiac Surgery Audit
- National Joint Registry
- Hip fracture audit
- Hips and Knees (Patient Reported Outcome Measures (PROMs))
- Falls and Fragility Fractures
- Trauma Network
- National Emergency Laparotomy (HQIP)
- Audits on sepsis

- UK Carotid Endarterectomy Audit
- National Joint Registry and Patient Reported Experience Measures (PREMs)

14.2.2 The service ensures that care bundles are in place as required to improve people's outcomes, such as reducing surgical site infections.

14.2.3 The service reviews and improves people's outcomes through the use of performance dashboards, including RCS surgical quality dashboards and other relevant tools.

14.2.4 The service participates in the Anaesthesia Clinical Services Accreditation scheme (ACSA) and holds a specified level of accreditation.

14.2.5 The service ensures waiting times for diagnostic procedures are monitored and reports on whether PROMs data for the service has improved over time.

14.2.6 For cancer care, the service regularly reviews the effectiveness of care and treatment through local and national audit participation, comparing outcomes with benchmarks. Action is taken where needed to improve performance.

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 in respect of 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 service 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 an article 36 order, ensuring access to an identified place of safety that can adequately meet their medical and mental health needs. There is 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 practice ensure there is no evidence of the 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.
- 15.2.7 The service ensures that informed consent is given by speaking to patients pre and post-operatively about their understanding of their surgery. Interventional procedures are consented for appropriately, ensuring patients are fully informed of the risks and benefits.
- 15.2.8 When cosmetic surgery is being carried out, the consultant surgeon ensures the expected outcomes and risks are thoroughly explained to the patient.
- 15.2.9 The service ensures a two-week cooling-off period between the patient agreeing to undergo cosmetic surgery and the surgery being performed, as set out in the RCS Professional Standards for Cosmetic Surgery.

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

16.2.2 Staff support people using services to be mobile and independent post-operatively by providing appropriate pain relief and encouragement, offering physiotherapy and mobility aids, and assisting patients with walking and other daily activities as soon as they are able.

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 patient focused and 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 plan service 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 Effective 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 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 1 hour for emergency referrals and routines up to 24 hours.
- 21.2.9 Complex discharges are supported effectively, with key information about 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.
- 21.2.10 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.
- 21.2.11 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.
- 21.2.12 Patients are given a choice on how they would like to receive results or bad news, whether by phone at home, face-to-face or in writing. 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 The service manages the provision of unplanned surgery, such as unexpected returns to the theatre, particularly at night, weekends, and public holidays, by maintaining a dedicated on-call surgical team. This team is available 24/7 to handle emergencies. The service ensures that operating theatres and necessary support staff are prepared and readily accessible during these times, guaranteeing timely and effective surgical care.
- 25.2.2 The number of surgical 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 conforming with best practice.
- 25.2.4 The average and maximum number of bed moves during patients stay are tracked.
- 25.2.5 The number of bed/patient moves occurring out of hours (between 10pm and 6am) is recorded.

- 25.2.6 Daily 'Board Rounds' are conducted to review patient status and discharge plans.
- 25.2.7 Flow within the hospital is coordinated by a designated site team, which works effectively with the rest of the hospital.
- 25.2.8 Operational pressure escalation policies are in place and are effectively implemented, particularly during high-pressure periods.
- 25.2.9 Escalation beds are opened and managed appropriately.
- 25.2.10 Discharges typically occur before 11am, and performance against this timing is monitored to ensure efficiency. Reasons for delayed discharges are identified and addressed.
- 25.2.11 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.
- 25.2.12 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 surgical beds 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 Innovative approaches are implemented to help ease staffing issues and foster workforce stability.

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

- 32.2.5 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.
- 32.2.6 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.
- 32.2.7 Managers have developed a plan to implement local safety standards for invasive procedures, assessing the need for these against all invasive procedures carried out.
- 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 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.

WELL-LED

Standard 34. Learning, improvement and innovation

We aim to continuously learn, be innovative, and get better in our organisation and the local system. We support new and creative ways to make sure everyone has equal experiences and a good quality of life. We take part in safe and effective practices and research to help improve care.

What this means to people:

I am looked after by a care provider that values continuous learning and improvement. As a result, practices are safe.

Relevant regulatory requirements

Regulation 19 Reviewing quality of service
Regulation 22 Complaints and representations

34.2 Service Specific Requirements

- 34.2.1 The service ensures that individuals considering or deciding to undergo cosmetic surgery are provided with the right information and considerations to help them make the best decision about their choice of procedure and surgeon.
- 34.2.2 Arrangements are in place for the service to encourage, record, and monitor Royal College of Surgeons (RCS) Certification by surgeons who carry out cosmetic surgery. These arrangements include attendance to an accredited masterclass on professional behaviour in cosmetic surgery as recommended by the RCS and Confirmation of knowledge and adherence to the General Medical Council's (GMC) guidance on cosmetic practice and the RCS's professional standards for cosmetic surgery.