Standards for Community Hospital Medical Cover

1. General Medical Practice

The duties of a doctor registered with the General Medical Council.

Patients must be able to trust Doctors with their lives and health. To justify that, Trust Doctors need to show respect for human life and must:

- Make the care of the patient their first concern.

- Protect and promote the health of patients and the public.

- Provide a good standard of practice and care
  - keep their professional knowledge and skills up to date
  - recognise and work within the limits of their competence
  - work with colleagues in the ways that best serve patients' interest
  - keep contemporaneous clinical records

- Treat patients as individuals and respect their dignity

  - treat patients politely and considerately
  - respect patients' right to confidentiality

- Work in partnership with patients

  - listen to patients and respond to their concerns and preferences
  - provide patients with information that they require in a form that they can understand
  - respect patients' right to be involved in decisions regarding their treatment and care
  - support patients in caring for themselves to improve and maintain their health

- Be open and honest and act with integrity

  - Act without delay if there is good reason to believe that a colleague may be putting patients at risk
  - Never discriminate against patients or colleagues
  - Never abuse patients' trust in you or the public's trust in the profession

You are personally accountable for your professional practice and must be prepared to justify your decisions and actions

2. General Competences

- Patient Care
  - Practitioners are expected to provide care that is compassionate, appropriate and effective

- Medical / Clinical Knowledge
  - Practitioners are expected to demonstrate knowledge of established, evolving medical and social care and seek to improve knowledge and skills where deficits exist. They should demonstrate adherence to

relevant evidence based guidance eg NICE + NPSA and comply with Trust policies and procedures

- Interpersonal and Communication Status
  - Practitioners are able to establish and maintain professional relationships to facilitate effective team working and respect for professional colleagues

- Professionalism
  - Practitioners are able to demonstrate behaviour that reflects commitment to continuous professional development, ethical practice, and an understanding and sensitivity to diversity.

- General Requirements
  - fully registered with GMC
  - on Devon performers list
  - evidence of registration with a medical defence body
  - undergo annual appraisal which will include Hospital Practitioner work
  - prescribe responsibly with appropriate use of local formularies
  - keep clear contemporaneous medical records
  - understand and conform to infection control, health and safety, incident and risk reporting and additional governance requirements
  - take full clinical responsibility for each inpatient stay
  - discuss with and record patients' resuscitation status and complete treatment escalation plan documentation where necessary on admission using Trust documentation
  - complete discharge summary on day of discharge

- Clinical Competences
  - urinary catheterisation
  - intravenous cannulation and venesection
  - ECG and Xray interpretation

3. Standards for patient care

<u>Direct admission (from home)</u>

- Patients should have been assessed prior to admission by a GP who has experience of caring for patients in a community hospital
- Patients should be clerked by a GP on the day of admission
- Patients should be reviewed by a GP the day after admission
- Patients should be reviewed by a GP a minimum of three times a week until they are medically fit for discharge

<u>Transferred patients (from another hospital)</u>

- Patients should have been accepted by a GP who normally cares for patients in a community hospital
- Patients should be seen by a GP within 24 hours of admission
- Patients should be reviewed by a GP a minimum of three times weekly until they are medically fit for discharge

Medical Record Keeping Standards

1) The patient's medical record should be available at all times during their stay in hospital.

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2) Every page in the medical record should include the patient's name and NHS number

3) Practices should ensure that name of GP responsible for each patient is clear, including arrangements for cover, when named GP is absent

4) Documentation within the medical record should reflect the continuum of patient care and should be in chronological order.

5) On admission the history, examination, treatment and investigation plan should be recorded on the standardised proforma.

6) A printout of patients medical history should be present in the notes

7) Every entry in the medical record should be dated, timed (24 hour clock) legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed alongside the signature. Deletions and alterations should be countersigned, dated and timed.

8) Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant clinician goes off duty. If there is a delay, the time of the event and the delay should be recorded.

9) An entry should be made in the medical record whenever a patient is seen by a doctor.

10) Patients should be reviewed at least three times a week until they are documented as medically fit for discharge after which they should be reviwed at least once weekly

11) The discharge summary should be started on admission and sent to the patient's GP within 24 hours

12) When a patient will be discharged to the care of a new GP, a copy of the discharge summary should be sent with the patient

13) Resuscitation status, medication charts and VTE risk assessment should be completed on admission. Treatment escalation plans should be completed when clinically appropriate.